

**ENSIGN COLLEGE OF PUBLIC HEALTH, KPONG,
EASTERN REGION, GHANA**

**MALE ATTITUDES TOWARDS CONDOM USE AS A PREVENTIVE MEASURE OF
STIs AT NUASO IN THE LOWER MANYA KROBO MUNICIPALITY OF EASTERN
REGION OF GHANA**

BY

MICHAEL BROWN ADDO

A Thesis Submitted to Ensign College of Public Health, Kpong

in partial fulfilment of the requirements for the Degree

MASTER OF PUBLIC HEALTH

JULY 2016

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Supervisor: Dr. (Mrs) Henrietta Odoi-Agyarko

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DECLARATION

I, Michael Brown Addo, declare that this submission is my own work towards the MPH and that to the best of my knowledge, it contains no material previously published by another person nor material which has been accepted for the award of any other degree, except where due acknowledgement has been made in the text.

Michael Brown Addo Date

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Certified by:

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(Supervisor)

Certified by:

Dr Christopher N. Tetteh Date

(Dean)

DEDICATION

I dedicate this thesis to my dear wife Mrs Mercy Ablah Addo for the moral and financial support she gave to me throughout my MPH course.

ACKNOWLEDGEMENT

My foremost gratitude goes to the almighty GOD for successfully seeing me through the course.

I would like to extend my heartfelt appreciation to my thesis Supervisor Dr. (Mrs) Henrietta Odoi-Agyarko a lecturer at Ensign College of Public Health for the immense support, direction and guidance she gave to me through this undertaking. My profound gratitude goes to Dr. Aba Obrumah Crentsil a Research Fellow at the institute of Statistical, Social and Economic Research (ISSER) at the University of Ghana for her massive support and guidance to complete the work.

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ABSTRACT

Introduction

Sexually transmitted infections (STIs) are a major cause of acute illness, infertility, long-term disability and death with serious medical and psychological consequences of millions of men, women and infants. Correct and consistent use of male condom remains the most effective way to reduce STIs including HIV. The aim of this study was to determine the level of awareness of condom availability, condom accessibility, affordability and the identification of factors affecting condom use in the study population which may contribute to the uptake of condom as an important public health strategy for HIV and other STIs prevention in Lower Manya Municipality.

Methods

Both qualitative and quantitative methods were used in the study. A cross-sectional study design was used to determine the level of awareness on correct and consistent use of condom, condom availability, accessibility, affordability and to identify factors affecting condom use among men at Nuaso community.

Results

The respondents demonstrated a high level of Awareness (100%) of condom availability in both the focus group discussions (FDGs) and the questionnaire administration. About 65% of the participants use condom correctly and consistently whereas 35% said they never use condom. About 44.7% of the participants disagreed to the question that condoms are hard to come by, 6% strongly agree and 6.6% agreed. With condom affordability, 45.2% of the participants disagreed to the notion that condoms are too expensive, 34.3% strongly disagreed, 6.2% strongly agreed and 7.5% agreed. Variables such as wives think husbands have sex with other women when they use condom, had a P-value of 0.007, condom use at first sexual intercourse had a P-value

of < 0.001 , condom use at last sexual intercourse had a P-value of 0.002, condom use with recent partner had a P- value of 0.002, awareness of female condom had a P-value of 0.026, and condom breaks or slips during sexual intercourse had a P- value of < 0.001 , were identified as the factors that affect condom use in the study population because they are statistically significant. Qualitative results indicated a positive attitude towards the use of condoms. There were further indication that condom is available, accessible and affordable.

Conclusion

Majority of the participants used condom during heterosexual intercourse to protect themselves from STIs because of the knowledge of the presence of HIV/AIDS in the Municipality.

Recommendation

The Lower Manya Municipal Health directorate should intensify its education on the health benefits of condom use at their various Sub- municipal health directorates to ensure that a lot more people use condom.

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ABBREVIATION

AIDS	Acquired Immune Deficiency Syndrome
CHPS	Community-based Health Planning and Services
CI	Confidence Intervals
FGD	Focus Group Discussion
FSW	Female Sex Workers
HBM	Health Belief Model
HBV	Hepatitis B Virus
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HSV	Herpes Simplex Virus
ICHD	International Course in Health Development
ICPD	International Conference on Population and Development
KP	Key Population
MOH	Ministry of Health
NACA	National Agency for Control of Aids
SDG	Sustainable Development Goal
STI	Sexually Transmitted Infections
USAID	United State Agency for International Development
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

1.1 Background

Globally, Sexually transmitted infections (STIs) are a major cause of acute illness, infertility, long-term disability and death with serious medical and psychological consequences of millions of men, women and infants (World Health Organization 2012). There are over 30 bacterial, viral and parasitic pathogens that have been identified to date that can be transmitted sexually (World Health Organization 2012). The WHO (2012) estimates that about 498.9 million new cases of the four main curable STIs (*Chlamydia trachomatis*, *Neisseria gonorrhoeae*, *Treponema pallidum* [syphilis] and *Trichomonas vaginalis*) occur every year globally in adults aged 15 to 49 years.

In the African region, the total incidence of curable STIs is 92.6 million, with 8.3 million cases of *C. trachomatis*, 21.1 million cases of *N. gonorrhoeae*, 3.4 million cases of syphilis and 59.7 million cases of *T. vaginalis* (WHO 2008). While *T. vaginalis* and bacterial STIs such as *C. trachomatis*, *N. gonorrhoeae* and *T. pallidum* are curable, viral STIs such as Herpes Simplex Virus (HSV) are deemed to be persistent and incurable (Kaushic et. al., 2011). Controlling STIs is the principal aspect of the WHO's Global Strategy on Reproductive Health [4], and essential for achieving Sustainable Development Goals health (Goal 3), education (Goal 4) and gender equality (Goal 5).

In Ghana, Epidemiological and biological studies provide evidence that on the individual level, STI and HIV are co-factors for HIV acquisition and transmission especially for specific STIs,

which cause genital ulcer disease (UNAids 2014) Studies indicate an especially potent interaction between very early HIV infection and other STIs. STI clients have a higher prevalence of HIV infection (UNAids 2014) .

Condom use has been proven to be the most effective method of preventing HIV and many other sexually transmitted infections (STIs) (Bankole et al. 2004).

The global pandemic of HIV, sexually transmissible infections and unintended pregnancy necessitated the use of condoms. According to the global health organization, the male latex condom is the single, most efficient, available technology to reduce the sexual transmission of HIV and other STIs (Richard Crosby, 2012). They are the only method of contraception which is both easily available and proven to reduce the risk of contracting STIs and HIV (Carson 2015) With irregular use, they are approximately 84% effective, but with consistent and correct use, their effectiveness jumps up to 98% (Carson 2015) . By using condoms, people significantly decrease their chances of contracting an STI.

1.2 Statement of the Problem

Sexually transmitted Infections (STIs) are among the first ten causes of unpleasant diseases in young adult males in developing countries (Da Ros CT1 2008) and the second major cause of unpleasant diseases in young adult women (Da Ros CT1 2008). Adolescents and young adults (15-24 years old) make up only 25% of the sexually active population, but represent almost 50% of all new acquired STIs (Da Ros CT1 2008).

Despite extensive efforts in promoting condom use, young people in Sub-Saharan Africa still engage in risky sexual behaviors and condom use remains relatively low (Bankole et al. 2004). A multitude of factors may impede young people's ability to protect themselves by using condoms, including attitudes towards condoms and ineffective use of the method. Numerous studies have found that young people's perceptions of condoms tend to be negative (Bankole et al. 2004).

According to the United Nation's subsidiary responsible for the fight against HIV/AIDS, (UNAids 2014) in Ghana, there is very low patronage of condoms. Their study further showed that below 10 percent of Ghana's middle class use condoms (Citifmonline 2014). Male and female condoms are the only devices that both reduce the transmission of HIV and other sexually transmitted infections (STIs) and prevent unintended pregnancy (UNFPA 2014).

The National HIV Prevalence in Ghana in 2013 was 1.3% and that of the Eastern region was 3.7% which was the highest prevalence rate among the ten regions in Ghana out of which Agormanya in the Lower Manya Municipality alone had a prevalence rate of 11.6% (Ghana AIDS Commission 2013). Nuaso is about 2 kilometers away from Agomanya. Condoms, when used consistently and correctly prevent the sexual transmission of HIV and other sexually transmitted infections (STIs) (UNFPA 2014). It was against this background that this study was based on male attitudes towards condom use as a preventive measure of STIs at Nuaso in the Lower Manya Krobo Municipality of Eastern region of Ghana among 15 to 59 year old men.

1.3 Justification

Male and female condoms are the only devices that both reduce the transmission of HIV and other sexually transmitted infections (STIs) and prevent unintended pregnancy (UNFPA 2014). However in Africa specifically Ghana, female condoms are not popularly used because most

men feel uncomfortable when their partners use them so female condom does not find its place in Ghana (UNFPA 2014). According to the global health organization, the male latex condom is the single, most efficient, available technology to reduce the sexual transmission of HIV and other STIs.(Richard . Crosby 2012)

Ghanaian women have little power over sexual decisions affecting their health and lives (Skaer & Ebin 2006). Men turn to play the powerful role in sexual decision- making and are mostly the source of spread/ transmission of STIs. A number of sexual risk behaviors, such as early age of sexual activity, having multiple partners and marrying more than one are all characteristics of men (Baumeister & Twenge 2002). In general men are sexually active at all age levels however, this study limited itself to men aged 15 to 59 because they are the main sexual risk group.

A report from Country AIDS Response programme shows that, The Ghana Health Service sought to increase the number of persons treated for STIs according to national guidelines from 7% in 2009 to 50% by 2015 (UNAids 2014). The prevalence of HIV/AIDS in Lower Manya is 11.6% (UNAids 2014) the highest in the whole country (Ghana) however no study is than on condom use in the municipality. Condom effectiveness in preventing HIV and other STIs is 98% (Carson 2015).

The findings of the study will assist the Municipal Health Directorate of Lower Manya and the Ghana Health Service to improve guidelines and action plans on male condom use among the sexually active men (15-59) in the Municipality.

1.4 Aim of the Study

The aim of the study is to investigate the attitudes of males between the age brackets of 15-59 towards condom use and purchasing of condoms and how these attitudes are related to their sexual experiences in the Nsuaso community.

The specific objectives of the study are:

1. Determine the level of awareness on correct and consistent use of condom among study targets.
2. Assess the availability, accessibility and affordability of condom among the study target group.
3. Identify factors affecting condom use among the study group.

1.5 Significance of the Study

Despite the fact that the government has implemented different programs to educate people regarding HIV/AIDS and different preventive methods, Ghana's infection rate remains high. According the UNAids (2014) the prevalence of HIV/AIDS in Lower Manya is 11.6%, which is the highest in the whole country (Ghana). However no study has been conducted on condom use in the municipality. Condom effectiveness in preventing HIV and other STIs is 98% (Carson 2015). Knowledge, attitudes and practices of condom use in an era of HIV increase among the general community in the Eastern region of Ghana are not well documented. Thus this formative assessment is believed to provide baseline information on the level of awareness and use of condom among males in the Nuaso community. The result can be used to strengthen existing programs working towards 100% condom use. Beside, this assessment may initiate similar large scale studies which can generate comprehensive and reliable data concerning awareness and condom use among males

The findings of the study will also assist the Municipal Health Directorate of Lower Manya and the Ghana Health Service to improve guidelines and action plans on male condom use among

the sexually active men (15-59) in the Municipality. Men are perceived to be the source of transmission of STIs hence the study on male condom.

1.6 Definition of Key Concepts In The Study

This section defines the key concepts used and variables investigated during the study.

1.6.1 Male Condom

A condom is a rubber tubular sheath used during sexual intercourse to form a two way barrier that prevents the passage of genital fluids and their contents, including organisms, between sex partners (Kabikira 2010). Both male and female condoms are available. The male condom is a rubber sheath worn on an erect penis. In this study, condom was taken to mean the “male condom”

1.6.2 Condom use

Condom use in this study refers to the correct enclosure of the penis in a male condom before and during sexual intercourse.

1.6.3 Attitude

Attitude refers to someone’s opinion or feelings about something that may be expressed through behaviour. Cambridge advanced learner’s dictionary (2010) defines attitude as “a feeling or opinion about something or someone, or a way of behaving that is caused by something.” Oxford online dictionary (2010) defines attitude as “a settled way of thinking or feeling about something”. In this study, attitude refers to the opinions and the feelings of the respondents regarding the use of male condoms.

1.7 Organization of Chapters

The research report (dissertation) is arranged as follows:

Chapter 1: Introduction and overview

This chapter is made up of the following:

- Background information
- Statement of the problem
- Justification of the study
- Aim of the study
- Specific Objectives
- Significance of the study and
- Definition of key concepts in the study.

Chapter 2: Literature review.

This chapter is made up of the related literature review of the study.

Chapter 3: Research design and methodology

This chapter consist of

- The Research method used in the study
- Study Area
- Study Design
- Study Unit
- Sample size
- Data Collection Techniques And Tools
- Study Population
- Administration f Instrument
- Data Management And Analysis

- Ethical consideration and
- Limitation of the study

Chapter 4: Presentation of the data

This chapter shows the presentations of the findings

Chapter 5:

This chapter is made up of the discussion of the findings

Chapter 6:

This chapter shows the conclusion and the recommendations

References

Appendix

The appendices provide copies of the questionnaire and evidence of other administrative measures carried out to ensure the successful and ethical outcome of the research.

CHAPTER TWO

LITERATURE REVIEW

2.1 Sexual and Reproductive Health Issues

Sexual and Reproductive (Odoi-agyarko 2003) health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes. Sexual and reproductive health is important to us all, at all stages of our lives. Yet far too many people are denied their right to sexual and reproductive health (Department for international Development 2004). Sexual and reproductive health is a human right so the International Conference on Population and Development (ICPD) set goals and targets on reproductive health and rights for all by 2015 (Department for international Development 2004).

Reproductive health implies that people are able to have a responsible, satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. One interpretation of this implies that men and women ought to be informed of and to have access to safe, effective, affordable and acceptable methods of birth control; also access to appropriate health care services of sexual, reproductive medicine and implementation of health education programs to stress the importance of women to go safely through pregnancy and childbirth could provide couples with the best chance of having a healthy infant (WHO 2013a). Sexually transmitted infections (STIs) affect reproductive and sexual health, having a profound negative impact worldwide (WHO 2013a)

World Health Organizations' (WHO) assessment in 2008 shows that Reproductive and sexual ill-health accounts for 20% of the global burden of ill-health for women, and 14% for men (WHO 2013a).

Sub-Saharan Africa is especially deficient in areas of sexual and reproductive health crucial for meeting the Sustainable Development Goals (SDGs) for child and maternal health (Gribble & Haffey 2008). There are approximately 157 million young adults ages 15 to 24 in sub-Saharan Africa; by 2015, this number is expected to increase to 198 million as growing numbers of young people enter their reproductive years and will need significantly expanded reproductive health services. A study in Ghana on Adolescent's sexual and Reproductive health showed that in 2005, 4.3% of young women and 1.5% of young men in Sub-Saharan Africa were estimated to be living with HIV, prevalence rates higher than in any other world region (Kumi-kyereme & Awusabo-asare 2007). Young people in sub-Saharan Africa have particular reproductive health vulnerabilities (Gribble & Haffey 2008).

Ghana moved from Maternal and child health/ Family Planning (MCH/FP) to the broader coverage of services of Reproductive Health (Odoi-agyarko 2003) by endorsing the Programme of Action of ICPD and adopted the ICPD definition of reproductive health which has the following components, safe motherhood, family planning, prevention and management of unsafe abortion and post abortion care, prevention and management of reproductive tract infections including sexually transmitted Infection (STI) and HIV/AIDS, prevention and management of infertility, prevention and management of cancers of female and male reproductive system, responding to concerns about menopause, discouragement of harmful traditional practices, gender based violence and reproductive health care, sexual health and information, education and communication (Odoi-Agyarko, 2003). Young people in Ghana constitute a sizable and numerous group whose sexual and reproductive health needs cannot be overlooked. (Kumi-kyereme & Awusabo-asare 2007).

2.2 Sexually Transmitted Infections.

Sexually transmitted infections (STIs) are among the most widespread infectious diseases, exacting substantial social and economic burden on families and communities worldwide. They remain important causes of morbidity and mortality due to common complications such as pelvic inflammatory disease, infertility, ectopic pregnancy, miscarriage, fetal deaths and congenital infections. Moreover, HIV epidemics develop more rapidly and spread more widely in places where other STIs are poorly controlled (WHO 2013b).

Globally, It is estimated that more than 340 million new cases of curable sexually transmitted infections, namely *Chlamydia trachomatis*, *Neisseria gonorrhoeae*, syphilis and *Trichomonas vaginalis* occur worldwide each year in adult men and women between 15 and 49 years of age (WHO 2001). In WHO's 2005 report the estimates increased globally by 32% in the number of new cases (Lewis 2011). Syphilis, gonorrhea and chlamydia remain major causes of disability and death despite being curable with antibiotics. Viral STIs, including herpes simplex virus (HSV), human papillomavirus (HPV), hepatitis B (HBV) and human immunodeficiency virus (HIV), are incurable and even more prevalent. Infection with multiple STIs is common and greatly facilitates sexual transmission of HIV. The largely preventable burden of disease attributable to sexual transmission, together with increasing resistance of *Neisseria gonorrhoeae* to available antibiotics, argue for a strong public health response (WHO 2013b). The World Bank has estimated that STIs, excluding HIV, are the second commonest cause of healthy life years lost by women in the 15–44 year age group, responsible for some 17% of the total burden of disease in women of reproductive ages, outranked only by causes of maternal morbidity (Mayaud & McCormick 2001)

Sub-Saharan Africa accounted for 20% of the global STI estimates, which is the highest prevalence and incidence rates in the regions of the world (Mayaud & McCormick 2001). The overall yearly

incidence rate of curable STIs in Africa is estimated at 254 per 1000 people in reproductive ages (15–49 years). (Mayaud & McCormick 2001).

STIs impose an enormous burden of morbidity and mortality, both directly through their impact on reproductive and child health, and indirectly through their role in facilitating the sexual transmission of HIV infection and the greatest impact can be seen among women in whom severe complications include pelvic inflammatory disease, chronic pain, and adverse pregnancy outcomes (ectopic pregnancies, endometritis, spontaneous abortions, stillbirths and low birth weight) (Mayaud & McCormick 2001). In both men and women, STIs play a major role in infertility (Mayaud & McCormick 2001). A growing number of malignancies are also attributed to STIs, notably cervical, anal and penile cancers as well as hepatocellular carcinoma and congenital infections in the new-born include congenital syphilis, ophthalmia neonatorum and pneumonia. (Mayaud & McCormick 2001)

In Ghana Epidemiological and biological studies provided evidence that, on the individual level, STI and HIV are co-factors for HIV acquisition and transmission especially for specific STIs, which cause genital ulcer disease (UNAids 2014). Studies indicate an especially potent interaction between very early HIV infection and other STIs for that matter, STI clients have a higher prevalence of HIV infection (UNAids 2014) Further studies in Ghana on STI among Female Sex Workers (FSWs) and other Key Populations (KPs) indicated a decline in STI in sex workers who have been targeted by interventions (UNAids 2014). Available data indicated that only 21,004 (6.5%) and 23,075 (7.1%) of STI cases were treated in 2008 and 2009 according to national STI treatment and management guidelines (UNAids 2014). The National Strategic Plan (NSP) seeks to increase the number of persons treated for STI according to national guidelines from 7% in 2009 to 50% by 2015. (UNAids 2014).

2.3 Condom Use

Condom use is a critical component in a comprehensive and sustainable approach to the prevention of HIV and other sexually transmitted infections (STIs) and are effective for preventing unintended pregnancies (UNFPA 2014). Male and female condoms are the only devices that both reduce the transmission of HIV and other sexually transmitted infections (STIs) and prevent unintended pregnancy (UNFPA 2014). Laboratory studies showed that, condoms provide an impermeable barrier to particles the size of sperm and STI pathogens, including HIV (UNFPA 2014). With irregular use of condom, the effectiveness of HIV and other STIs prevention is approximately 84%, but with consistent and correct use, the effectiveness jumps up to 98% (Carson 2015).

At the end of 2013, there were an estimate of 35 million people living with HIV globally (UNAIDS 2013).

The Global AIDS Response Programme estimated that new HIV infections among adults through sexual transmission be reduced to 50% by 2015 globally (UNAIDS 2013). Condoms remain one of the most efficient technologies available to prevent sexual transmission of HIV (UNAIDS 2013). Approximately 2.4 billion male condoms and 31.8 million female condoms were donated in 2012 as compared to 3.4 billion male condoms and 43.4 million female condoms in 2011 globally (UNAIDS 2013).

Of all the old boys and young men in the world, 47% reported to have use a condom at the last time of high-risk sex (Anon 2006). The region with highest condom use is North America at 63.5% and the lowest is Middle East which is 36.8% (Anon 2006).

Of the estimated 35 million people living with HIV globally, Sub-Saharan Africa made up 71% of the estimates (UNAIDS 2013)

Despite high levels of HIV prevalence in sub-Saharan Africa, levels of condom use remain below what is necessary to arrest the HIV epidemic (Agha et al. 2002). In 1999 in Sub-Saharan Africa, instead of an estimated 24 billion condoms that were needed to protect sexual acts, only 6 to 9 billion condoms were actually used (Agha et al. 2002). Another surveys on a large population of women in regular partnerships in 15 Sub-Saharan African countries suggest that Less than 7% of women used a condom in the last sex act with their main partner (HIVTools Research Group 2003).

A study in Ghana showed that, the extent to which condoms are used by people who are likely to have high risk sex is a measure of risk reduction measures being taken by such persons (UNAids 2014). In the same study in 2008, 26.2% of male respondents aged 15–49 who had more than one sexual partner in the past 12 months reported the use of a condom during their last intercourse and for females in high risk sex (defined as sexual intercourse with a non-marital, non-cohabiting partner), 25.4% used condoms at their last sexual intercourse of risk (UNAids 2014). This indicator for men according to the study showed a gradual increase till age 25 and when it drops dramatically thereafter (UNAids 2014). According to the 2008 Ghana Demographic and Health Survey male condom use was 2% of the overall 17% of married women using modern method of family planning and more than one-third of unmarried, sexually active women were using a modern method of family planning—most commonly the male condom (18%) (GDHS 2008)

2.4 Global Context of Predictors of Condom.

This section discusses broadly four factors; individual, partner-related, provider-related and environmental factors which influences condom use.

2.4.1 Individual factors

Literature suggests a strong association between socio-demographic characteristics and condom use. Research from Bankole et. al (2004) using data from the 2004 National adolescent Survey among 12-19 year old male and females in Burkina Faso, Ghana, Malawi and Uganda, show that being exposed to condom use exhibition, age, sex education, exposure to mass media and education were found to be important in the decision to use condoms. This study employed a multi stage sampling as such its findings are generalizable (Abdulai 2012).

Similarly, Sunmola (2004) conducted a study among 710 sexually active men and women working in a brewery in Nigeria to examine the consistency of condom use (Sunmola 2004). The study demonstrates an association between condom use and marital status and the number of years of education. Men who had had 12-18 years of education were associated with more condom use and 7-12 years of education among women was related to condom use. The main reason for non- use of condoms in this population was reported to be due to the well documented reason of reducing sexual pleasure and intimacy (Sunmola 2004)

Again, in response to the trends of HIV epidemic in Thailand, a 100% programme that promoted condom use among sex workers achieved great behavioural change strides; increasing condom use among sex workers (Abdulai 2012). The programme enjoyed strong political commitment and support from various public and private institutions. Whilst promoting condoms which is pivotal to the success story, the programme also focused on education which raised awareness on personal risk, control of STI and provision of clinical care to diseases germane to HIV (Abdulai 2012). In addition, Akarro examined the reasons for which barmaids; an identified key population in Tanzania use condoms, He launched an anthropological study using data from a survey carried out between 2004 and 2005 (Abdulai 2012). The analysis focused on socio-

economic and socio-demographic characteristics of the barmaids such as age, marital status, education and fertility. The study showed positive association between condom use and age, marital status, education and number of children. Moreover, Hounton et al in their study among 250 men and women in Benin sought to identify predictors of condom use based on the Health Belief Model (HBM) (Abdulai 2012). The study concluded that strategies for HIV incidence reduction based on the perception of risk and severity of HIV is less likely to induce condom use. Agha and colleagues investigated the effects of religious affiliation on sexual debut and how it influences the risk of young Zambian women to HIV infection. The study indicated that, religious affiliation had both positive and negative effects on determining the sexual behaviour of women. The study suggested that positively, age at first sex was delayed which served as a protective factor, however, due to limited information on safe sex, the woman's vulnerability increases since they are unlikely to negotiate the use of condoms once they start having sex. As such the positive and negative influence of religious affiliation neutralises each other. They concluded that religious affiliation is not likely to provide protection overall against HIV infection because its protection is only short-term.

2.4.2 Partner related factors

According to Do et al in his study among married women in Vietnam, women who reported the ability to negotiate safe sex at last sex with their husbands were more likely to have consistently used condoms in one year compared to those who reported low self-efficacy (Thi et al. 2016). The study found an association between women's education, self-efficacy and condom use (Thi et al. 2016). Zubia et al explored the effect of gender dynamics among couples and the influence it exerts on the overall access to property and condom use (Abdulai 2012). Using DHS surveys of Uganda and Zimbabwe, the study indicated that, women were mostly employed in the

informal sector characterised by low wages compared to men. As such, even though women from both Zimbabwe and Uganda were employed, it did not influence their capacity to make decisions concerning safe sexual practices. This was because they still economically depended on their partners which largely influence their assertiveness. This finding challenged the extent to which a woman's employment status signifying income levels increases their assertiveness for safe sexual practices. The study found a correlation between education and condom use among married women in both countries (Abdulai 2012). Agha et al points out in their multi-country study in eight countries in Sub Saharan Africa that, trusting among partners influenced the decision to use condoms during sexual intercourse (Abdulai 2012). The study stressed the need to incorporate behaviour change campaigns encouraging sexually active men and women to adequately access their personal risk of acquiring HIV. In addition, a research using data from the National sexual and behaviour survey among heterosexual Thai males aimed to determine factors associated with condom use and sex with both regular and casual partners (Mark et al. 2002). The findings of the study revealed an association of low condom use among non-skilled jobs like labourers, married couples and a shorter duration of relationship/marriage. The study emphasized the importance of risk perception and the need to consider these in partner related approach in HIV interventions (Mark et al. 2002).

2.4.3 Provider related factors.

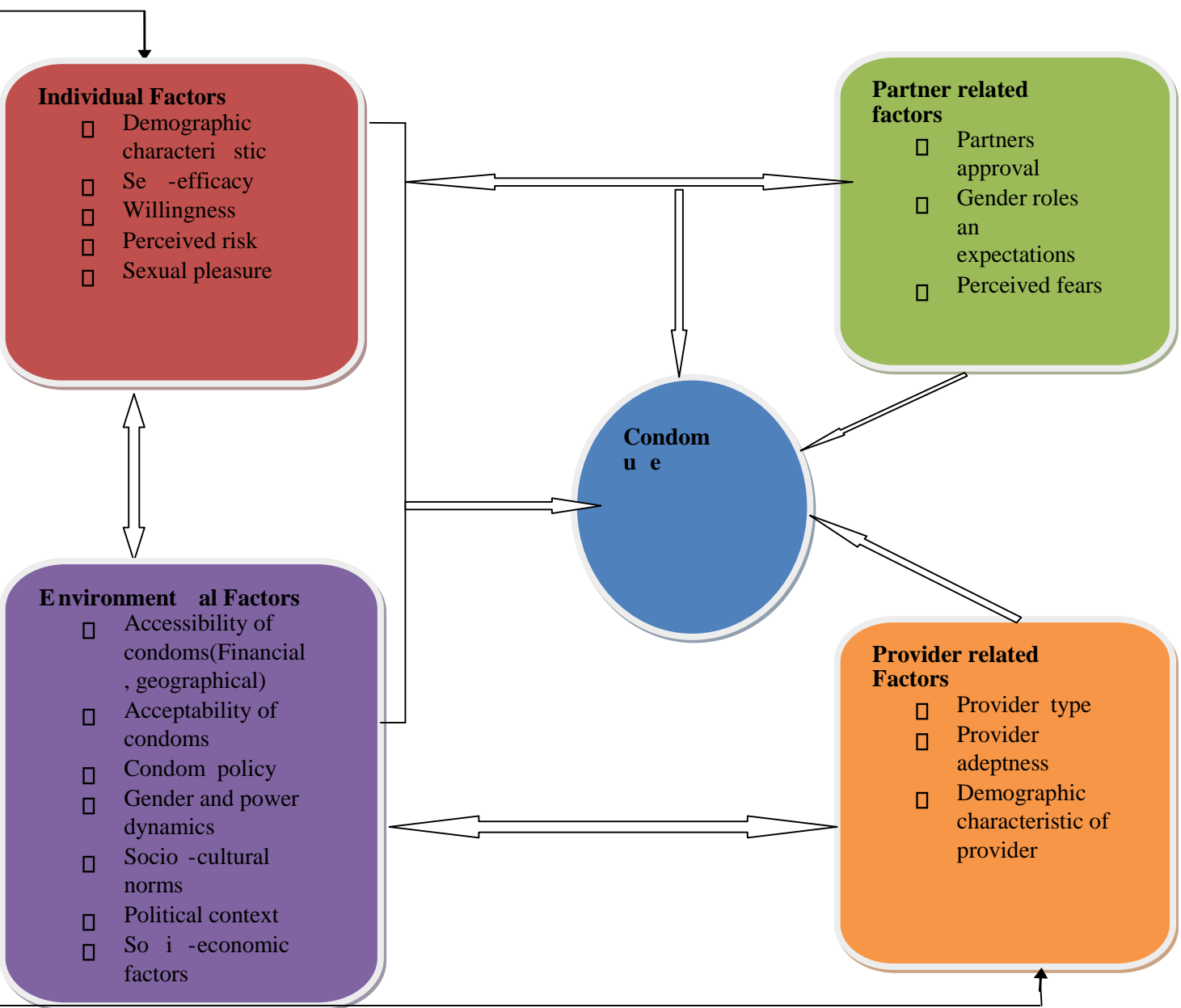
Some attitudes of providers that are rooted in their socio-cultural and personal religious belief could overshadow their sense of professionalism. From my experience these biases and prejudices tend to make them judgmental which hinder women accessibility of condoms. Even though provider related factors are recognized as an important determinant of condom use

presently there is insufficient evidence in literature that supports this as far as we know (Abdulai 2012).

2.4.4 Environmental factors

Gender and power dynamics is entrenched in socio-cultural norms which defines the roles of both men and women. Gender and power dynamics influences and rewards female passivity and male conquest which put both sexes at risk (Abdulai 2012). For example, this may hinder a woman's ability to freely communicate and negotiate condom use. This could serve as an enabler or otherwise to condom use (Abdulai 2012). Molla and colleagues, in their study among the youth in rural Ethiopia, assessed the traditional significance of virginity in shaping the sexual behaviour of the youth before and after marriage (Jimma & Kumsa 2015). Using univariate analysis, the study revealed that, delaying sexual debut is essential; especially in rural areas where information on safe sexual practices is inadequate, but it increases the woman's vulnerability once they initiate sex not using condoms assuming marriage as an assurance for protection against HIV and other STIs (Abdulai 2012). Considering that, multiple concurrent partnerships are comparatively high in sub-Saharan Africa; this increases the vulnerability of women if they assume such an assurance. The policy and political environment within which condom distribution intervention takes place influences its uptake. Literature shows that strong political commitment influences the accessibility (financial and geographical), acceptability and availability of condoms (Abdulai 2012). The National Agency for Control of AIDS (NACA) of the federal republic of Nigeria has a political commitment ensuring universal access to the general population (Nigeria 2014). It has sale outlets at established locations to be easily accessed by the general population especially the key populations (people who are key to exposure and response) and distribute condoms with education on how to correctly use and

dispose condoms. Socio-economically, women's uneven representation in poverty, education and property rights increases their economic and infection vulnerability; where they are overly reliant on their partners to satisfy their basic needs (Nigeria 2014). Environmental factors were not collected as part of the available dataset as they are not individual factors. Statistical analysis of environmental factors was therefore not done (Abdulai 2012). However, environmental factors are important, and the findings of this study must be considered in light of the environmental factors outlined in this literature review (Abdulai 2012). Based on the available evidence, the determinants of condom use can be outlined using the following conceptual framework in Figure 1. The framework recognizes the interplay of individual, partner, provider and environmental factors (Abdulai 2012).



Source: ICHD 2011-2012

Figure 1: Conceptual framework for discussing factors influencing condom use among men.

2.4.5 Conclusion.

The above literature provided a very good ground for the analysis of the Data collected. In the literature review, it was evidence that some factors such as individual factors, Partner related

factors, Provider related factors and environmental factors had a great influence on condoms use.

The framework above demonstrates how condom use is in association with these factors.

Although individual, partner and provider related factors influence the decision to use condoms, environmental factors which represent the macro context also influences condom use. The framework recognizes policy, accessibility (financial and geographical), acceptability of condoms, gender and power dynamics.

CHAPTER THREE

RESEARCH METHOD

3.1 Introduction

This chapter presents the procedures that were implemented during collection of data from the respondents, its processing and eventual analysis.

3.2 Research

This section begins by presenting definitions of some key terminologies that were used in this report. The section ends with outlining the research design adopted. Research theory is defined and the application of theory in practice substantiated.

3.3 Study Area

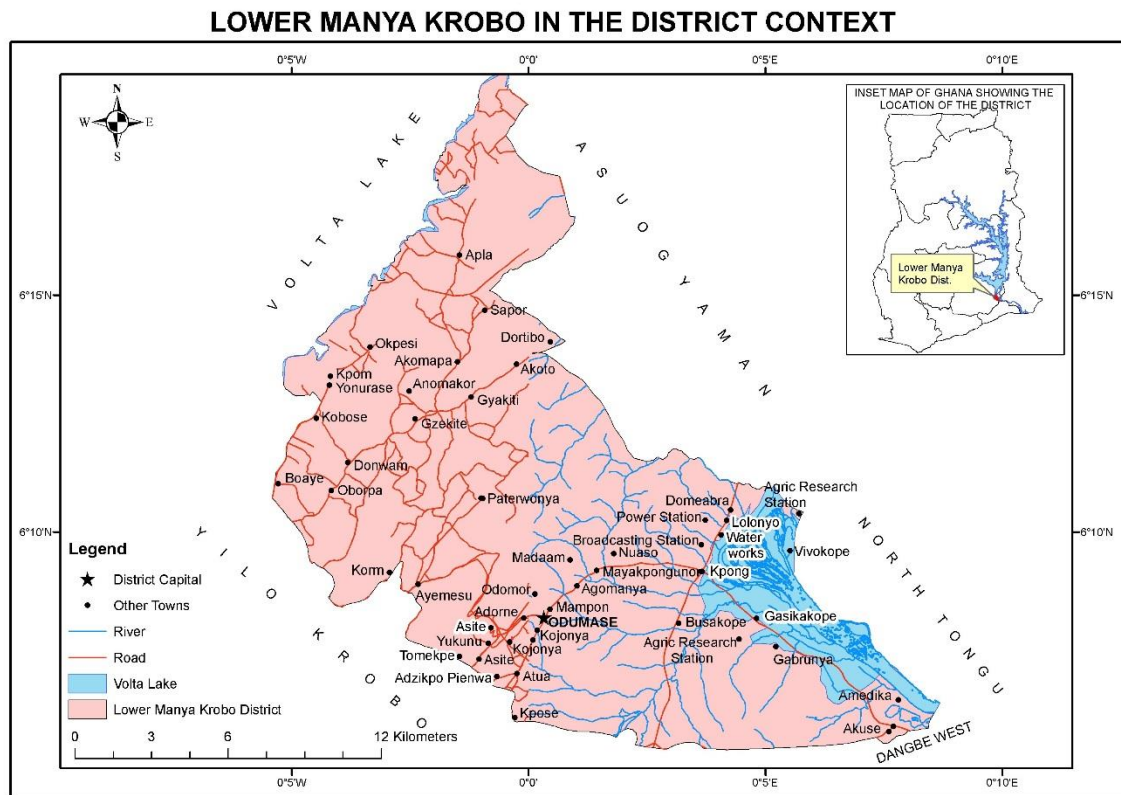


Figure 2: The map of Lower Manya Municipality.

Nuaso is a town which shares boundaries with Kpong, Kpongunor and the Mountain Yogaga in the southern part, all in the Lower Manya Krobo Municipality in the Eastern region of Ghana. It has a total population of 7,484 (Bondy 2010). Nuaso is made up of old town and new town. The new town is one community while the old town is made up of five communities. Nuaso has one Community-based Health Planning and Services (CHPS) compound which is supervised by the Kpong Sub Municipal health directorate. Data from the CHPS compound shows that the common disease in the area is tuberculosis and HIV/AIDS.

3.4 Study Design

Both qualitative and quantitative method (mixed method) of study design were used in the study. Specifically Cross-sectional survey and focus group discussion (FGD).

3.5 Study Population.

One hundred and fifty (150) structured questionnaires were administered to 150 men aged 15 to 59 and two (2) focus group discussion of men aged 15 to 35 in one group and 36 to 59 in another group. Each group of the FGD was made up of six (6) men. This is because the study was on male attitude towards condom use.

3.6 Study Unit.

The main targeted groups of the study were men aged 15 to 59.

The inclusion criteria for the targeted groups were men:

(1) Living in study area for over 1-year

(3) Working or studying in the study area for the past one year

(3) Who were capable of independent communication and signed a consent form willing to be part of the Study.

3.7 Sample Size.

The sample size calculation was based on 95% confidence intervals with $\pm 5\%$ margin of error, 8% national prevalence rate of condom use among active unmarried women per the Ghana Demographic and Health Survey 2014 hence the expected frequency of condom use used was 8% with the total targeted (15-59) population of 2054 per the 2010 Lower Manya population census which gave a total sample size of 108. However, 150 questionnaires were distributed and twelve (12) men in two (2) separate FGDs of six (6) each in a group aged 15 to 59 living in the Nuaso township. A convenient sampling techniques was used in choosing the sample units.

Nuaso Township is made up of Nuaso old town and Nuaso New town. The two (2) FGDs of twelve (12) men were selected from the new town being one community and the 150 for the structured questionnaires were selected from the old town which is made up of five (5) communities. Thirty (30) men were selected from each community.

3.8 Data Collection and Study Instruments.

Quantitative and qualitative methods were used in this cross-sectional study for the data collection.

3.8.1 Quantitative

Questionnaire

Structured questionnaires (**Appendix 1**) were developed based on Socio-demographic data (Name not included) and the bi-dimensional (positive and negative) “Attitudes toward Condom Use Scale” (ATCS) used in sexual health and HIV research. The questionnaire explored topics

reflecting the objectives of the study as stated above. As much as possible closed ended questions were used to make for less interviewee interpretation and bias. The questionnaire were administered by three (3) completed Senior High School graduates whom I trained in addition to myself. The questionnaire forms were filled on the very day and collected back. All the 150 participants responded to the questionnaire.

3.8.2 Qualitative

Focus group discussion (FGD)

Two focus groups discussions were carried out involving a total of 12 (twelve) participants, 6 (six) in each group. All participants were men. One group was made up of men aged 15 to 39 and the other group was also made up of men aged 40 to 59. The two (2) FGDs of twelve (12) men were selected from the new town being one community. A discussion guide (**Appendix 2**) was to capture information on morality of condom use, partner influence of condom use, the main reasons for condom use, factors that affect condom use in the heterosexual intercourse, affordability and accessibility of condom and any general issues from the participants on condom use. Participants were allowed to give as long an answer as they deemed appropriate. The FGD was conducted in the vernacular language (Krobo language) and lasted one to two hours per each FGD. The researcher moderated, facilitated and recorded the discussion electronically and later transcribed the discussion into English language. The FGD were conducted in March, 2016.

3.9 Data analysis and presentation.

The data (responses) which were captured on interview transcripts, field notes and questionnaires were blended throughout the study, coded, and analyzed. Data entry (double entry) and cleaning was done using Excel platform and statistical analyses was done with STATA 14. A descriptive statistics analysis done included frequency analysis (distribution). Bar

chart, pie chart, histogram doughnut chart and tables were used to present the data. Bivariate analyses was performed to access the determinants of condom use. A test for association was considered significant with the p-value < 0.05.

3.10 Ethical consideration.

Ethical clearance and approval for this study was obtained from the Institutional Review Board of Ensign College of Public Health. Informed Concern Form (**Appendix 3**) was administered to the participant of the study to seek their concern of participation.

3.11 Limitation of the study.

Condom is used by two persons that is, someone and the partner (male and female). However, the study focused on only the male partner. More so, convenience sampling method in research is not the best method and the sample size of 150 also might not bring out the true reflection of the situation of the study out come on the town with a total population of 7,484. Financial constraint was the factor that necessitated the above mentioned conditions. Almost all the participants were demanding condoms after they fully responded to the questionnaires but we could not provide any.

CHAPTER FOUR

RESULTS

This chapter presents findings of both the quantitative and the qualitative analysis.

4.1 Socio- Demographic Characteristics of Participants

The total number of participant in the study was 150. They were all men aged 15 to 59 with a mean (m) age of 24.69 and standard deviation (SD) of 7.51. All the participants responded to the questionnaire hence 100% response rate. The table below shows the Socio- Demographic Characteristics of the Participants. The socio - demographic characteristics considered were age group, marital status, education attainment and religious background.

Table 1: Socio-demographic information of the participants (N = 150), min. 15, max. 55

Variable	Characteristics	N =150	(%)=100
Age Group	15-25	100	66.7
	26-36	39	26.0
	37-47	9	6.0
	48-59	2	1.3
Marital Status	Married	19	12.7
	Single	80	53.3
	Divorced	2	1.3
	Separated	4	2.7
	Widowed	2	1,3
	Co-habiting	43	28.7
	Tertiary	3	2.0
	Secondary	53	35.3

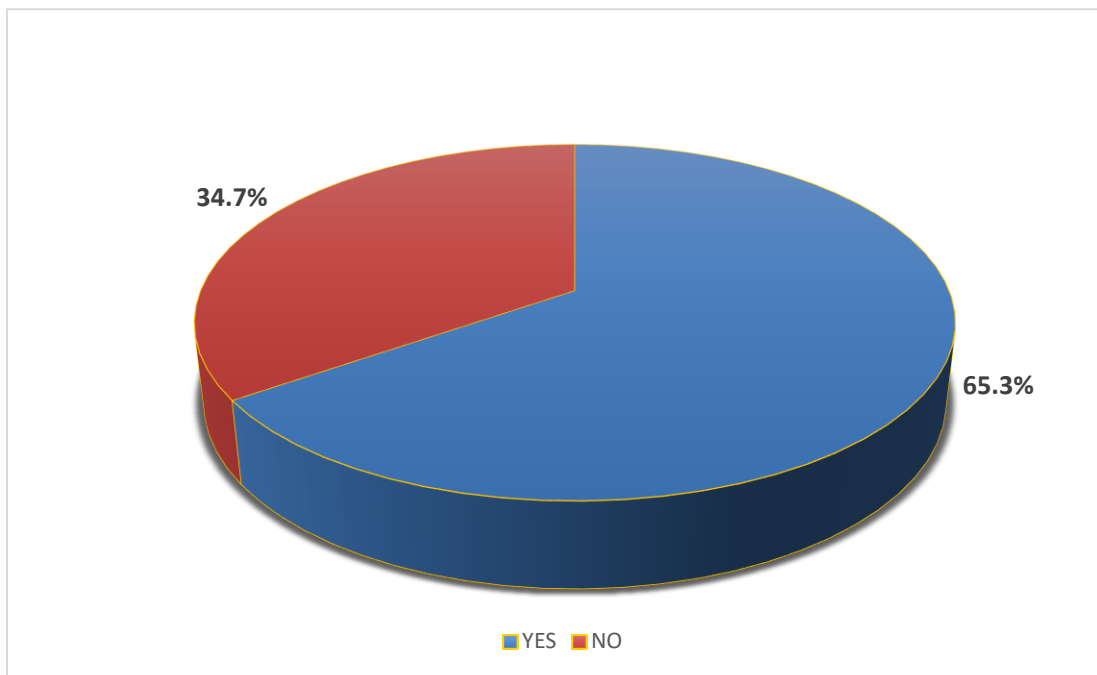
Educational Level	Elementary	94	62.7
Religious Background	Christianity	138	92
	Islamic	4	2.7
	Traditional	8	5.3

Source: Field data, 2016

Table 1 above shows the characteristics of the participant in the study. Of the 150 participants, 66.7% between the ages 15 to 25 formed the majority in the study and age 48-59 were the minority with a percentage of 1.3%. 53.3% of the participants were not married and only 12.7% were married. A higher number of the participants (62.7%) had their highest educational level being elementary and just 2% of the participants had tertiary education. Almost all the participant were Christians with a percentage of 92%. 2.7% were Muslims and 5.3% were traditionalist. The minimum and the maximum age of the participant in the study were 15 and 55 respectively.

4.2 Condom Awareness and Usage

All the 150 (100%) participants responded they were aware of condom availability. Figure 3 below shows the responses of participants whether one uses condom or not during heterosexual sexual intercourse.

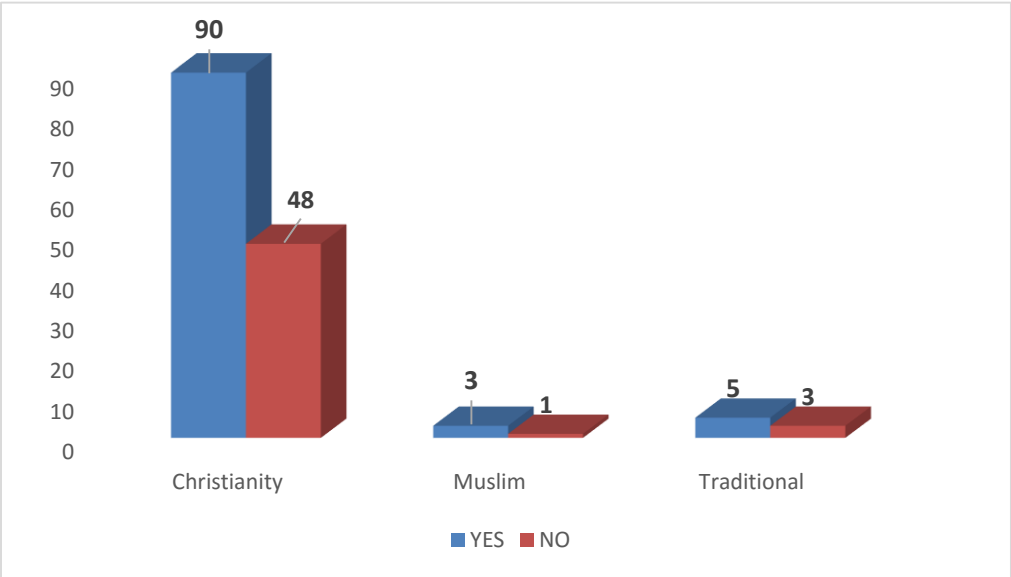


Source: Field data, 2016

Figure 3: Condom use.

65.3% of the respondents reported they used condom consistently and 34.7% reported they never use condom and will never use it.

Figure 4 below shows the number of participants who use condom in relation to their religion.



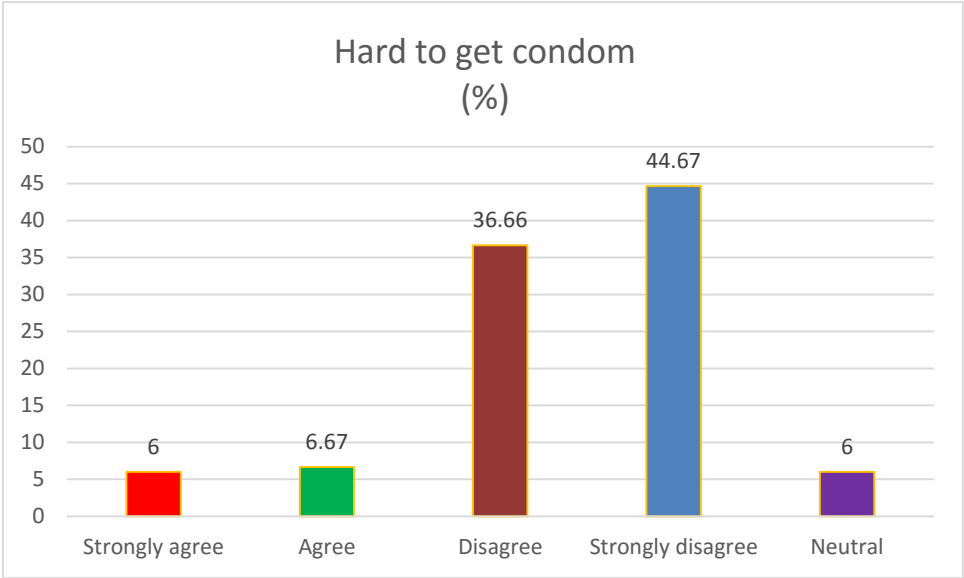
Source; Field data, 2016

Figure 4: Condom Use and Religious Background

Almost two-third (90) of the participants who responded they were Christians ever used condom out of the 138. Out of the four (4) Muslims, three (3) ever used condom and three (3) out of the eight (8) Traditionalist never use condom.

4.4 Condom Accessibility

Figure 5 shows the responses whether condoms are accessible.



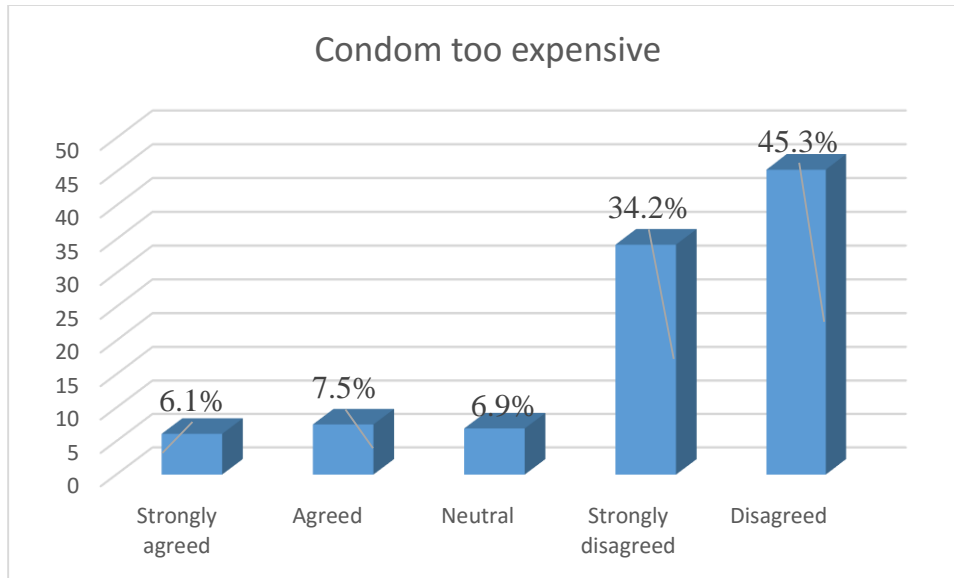
Source: Field data, 2016

Figure 5: Hard to get condom

67 (44.7%) of the participants strongly disagree that condoms are very hard to come by. 55(36.7%) disagreed and 10 (6.7) agreed that condoms are difficult to come by.

4.5 Condom Affordability.

This question was scaled and respondents were to choose from the scale, strongly agree, Agree, Neutral, Strongly disagree, and Disagree. Figure 6 shows the responses with respect to condom affordability.



Source: Field data, 2016

Figure 6: Condom affordability

67 (45.3%) participants disagreed to the notion that condoms are too expensive, 53 (34.2%) strongly disagreed and 9 (6.1%) strongly agreed that condoms are too expensive

4.6 Determinant of association between Condom use and Socio- Demographic factors.

Table 2 Bivariate analysis of Socio- Demographic factors and condom use.

<i>Indicators</i>	<i>Ever use condom</i>		<i>P-value</i>
Age Group	Yes n=98(%)	No n=52(%)	0.340
15-25	61 (62.24)	39 (75)	
26-36	30 (30.61)	9 (17.31)	
37-47	6 (6.12)	3 (5.77)	
48-59	1 (1.02)	1(1.92)	

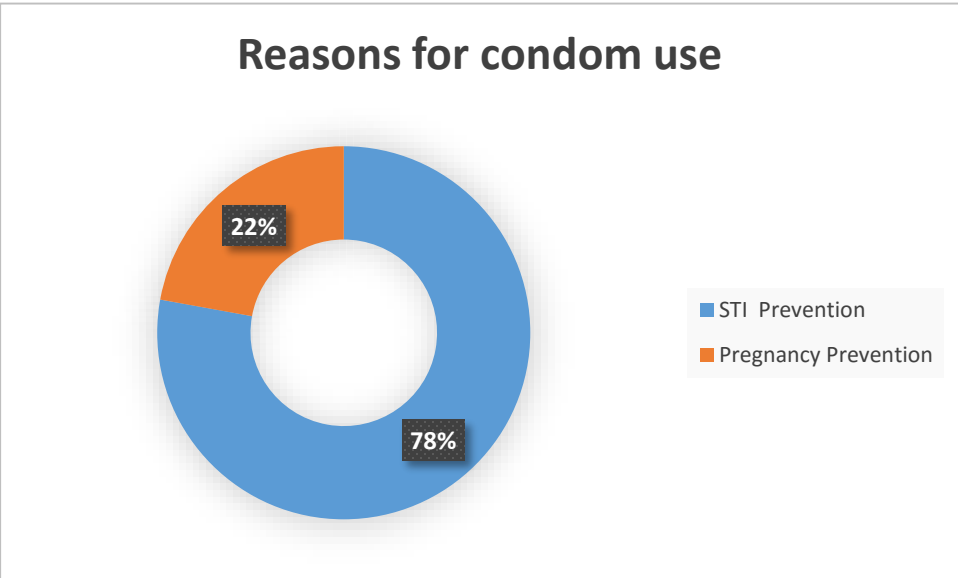
Marital Status			
Married	14(14.29)	5(9.62)	0.427
Single	47(47.96)	33 (63.46)	
Divorced	1 (1.02)	1(1.92)	
Separated	3 (3.06)	1(1.92)	
Widowed	1(1.02)	1(1.92)	
Co-habiting	11(21.15)	32(32.65)	
Educational			
Level	2(2.04)	1(1.92)	0.874
Tertiary	36(36.73)	17(32.69)	
Secondary	60(61.22)	34(65.38)	
Elementary			
Religious Background			
Christianity	90 (91.84)	48(92.31)	1.000
Islamic	3(3.06)	1(1.92)	
Traditional	5(5.10)	3(5.77)	

Bivariate analyses was used to measure the relationship between the socio-demographic variables (age, marital status, educational level and religious background) and condom use of

the participant. Table 2 above shows that, condom use has no statistical significant association with age, marital status, educational level and religious affiliation.

4.7 The main aim of condom use.

Participants were asked the main reason why they use condom or any reason they know (participant who responded they never use condom) men use condom. The responses are displayed in figure 7 below:



Source: Field data, 2016

Figure 7: Main Reason for condom use

Of the one hundred and fifty participant (n=150), 116 (78%) indicated men use condoms to prevent sexually transmitted infections (STIs) and 33 (22%) said men use condoms to prevent pregnancy

4.8 Determination of factors affecting condom use

Table 3 shows the results of logistic regression that analyses the association between condom use and some selected variables.

Table 3: Test of association of Condom use and some factors.

Variable	OR	95% C I	P value
Partner might think he does have sex with another woman	0.8	0.65 - 0.93	0.007
Sex does not feel good when use condom	0.9	0.75 - 1.12	0.388
Condom is expensive	1.0	0.82 - 1.24	0.907
Use condom at first sexual intercourse	40.2	5.31 - 303.75	< 0.001
Use condom at last sexual intercourse	24.6	3.24 - 186.61	0.002
Men look silly when using condom	1.0	0.82 - 1.22	0.966
Use condom with most recent partner	25.28	3.33 - 191.66	0.002
Condo make it hard for a woman to have orgasm	0.83	0.68 - 1.02	0.080
There is female condom	6.39	1.24 - 32.96	0.026
Condom breaks or slips off during Sexual intercourse	5.10	2.06 - 12.63	< 0.001

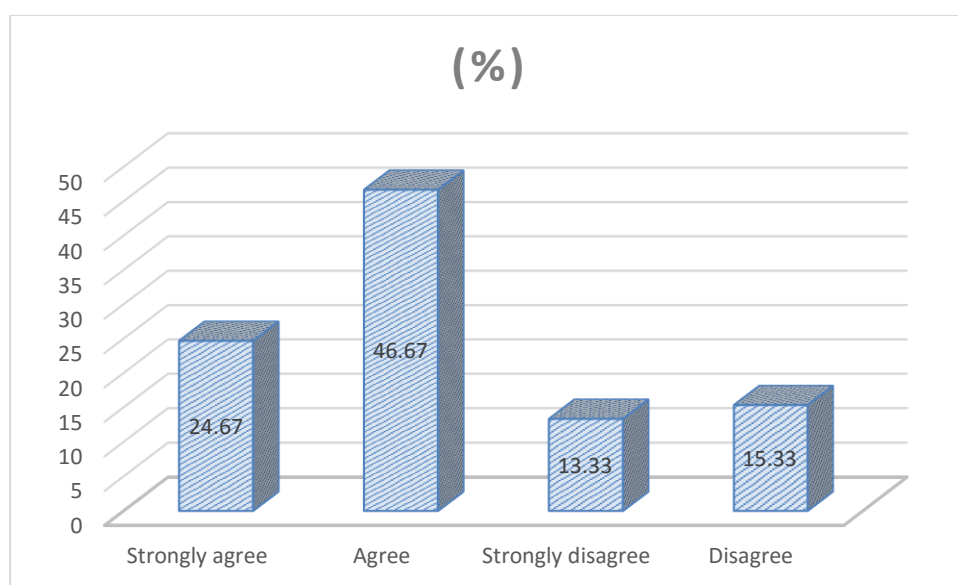
It is hard to find a place to buy condom.	1.10	0.92 - 1.33	0.272
Condom takes the pleasure out of sex	0.94	0.77 - 1.15	0.579
It is embarrassing to buy condom	0.99	0.80 - 1.23	0.94

Source: Field data, 2016

Table 3 above shows how some variables have an association with male condom use and can be used for prediction because they are statistically significant (P-values < 0.05). These are the factors that affect the use of male condom in the study population. Variables such as wives indicated that husbands do have sex with other women when they use condom has a P-value of 0.007, OR= 0.8 (95%, CI 0.65-0.93), condom use at first sexual intercourse has a P-value of < 0.001, OR= 40.2 (95%, CI 5.31-303.75), condom use at last sexual intercourse has a P-value of 0.002, OR= 24.6 (95%, CI 3.24-186.61), condom use with recent partner has a P- value of 0.002, OR= 25.28 (95% CI 3.33-191.66), awareness of female condom has a P-value of 0.026, OR= 6.39 (95%, CI 1.24-32.96) and condom breaks or slips during sexual intercourse has a P- value of <0.001, OR= 5.10 (95% CI 2.06-12.63). These factor can be used to determine condom use among the study participants. All the other factors in the table does not affect male condom use because they are not statistically significant so they cannot be used to predict male condom use in the study population. Sex does not feel good when use condom has P- value of 0.388, OR= 0.9 (95% CI 0.75-1.12) condom is expensive has a P- Value of 0.907, OR= 1.0 (95% CI 0.82-1.22), condom make it hard for a woman to reach orgasm has a P-value of 0.080, OR= 0. 83 (95% CI 0.68-1.02), it is hard to find a place to buy condom has a P- value of 0.272, OR= 1.10 (95% CI 0.92-1.33), condom takes the pleasure out of sex has a P- value of 0.579, OR= 0.94

(95% CI 0.77-1.15) and it is embarrassing to buy condom has a P-value of 0.94, OR= 0.99 (95% CI 0.80-1.23).

The factors (variables) which are statistically significant (P-value < 0.05) in table 3 and can be used to predict condom use in the study population are discussed below. The response to the question “Your partner might think you do have sex with another woman” is displayed on figure 8.



Source: Field data, 2016

Figure 8: Perceived unfaithfulness on the part of men who use condom.

Out of the 150 respondents 70 (46.7%) agreed that when a man uses condom, the partner may suspect him of having sex outside their relationship, 37 (24.7%) strongly agreed and 20 (13.33%) strongly disagreed.

Condom use at first sexual intercourse.

65% of the participant in the study did not use condom in their first sexual intercourse and 35% use condom in their first sexual intercourse.

Condom use at last sexual intercourse

73% of the respondents use condom at their last sexual intercourse where as 27% did not use condom at their last sexual intercourse.

Condom use with most recent partner.

59.9% of the participants used condom with their most recent partners and 40.1% respondent in the study population did not use condom with their most recent partners.

Awareness of female condom.

94.6% of the participants in the study are aware of female condom as compared to 5.4% of the respondent who said they are not aware of the availability of female condom.

Condom breaks or slips off during sexual intercourse

60% of the participants said they had experienced condom break or slip off during sexual intercourse and 40% said they never had that experience.

4.9 Focus Groups Discussion (FGD)

The second component of the study involved focus group discussion (FGD). Two focus groups discussions were held involving a total of 12 (twelve) participants, 6 (six) in each group. All participants were men. One group was made up of men aged 15 to 39 and the other group was made up of men aged 40 to 59. The mean age and the standard deviation of the participants in

the aged group 15 to 39 were 29.5 and 3.0 respectively and that of age group 40 to 59 were 43.2 and 4.1 respectively.

4.9.1 Morality of Condom Use/ Religion and condom use.

Most of the participants who are Christians said condom use is an immoral act (it is a sin) according to the Bible. According to them, condom use is the same as causing abortion. Below are some of the responses from the focus group discussions.

“Even though the Bible does not talk about condom, it talked about abortion and using condom is the same as causing abortion, hence it is immoral” (34yr old unmarried man).

“For me, biblically, using condom is a sin but personally I don’t see it to be a sin so I use it. Bible says that when sperm is thrown out, it is the same as causing abortion but because I do not want to be infected by any disease, I use it even though the Bible sees it to be a sin” (45yr old married man).

Almost all of the participant further indicated that though condom use is immoral, they use it for various reasons. Few of them said, they never considered using condom as a sin so they will continue to use it.

“I do not consider condom use as a sin or immoral because it helps to protect me from contracting some diseases that will kill me” (27yr old unmarried man).

“Using condom is a very good practice because, it helps to organize ones family and it protects us from getting diseases so I do not see condom use as a sin or immoral” (19 yr old unmarried man).

“It is the same God who said if your one arm is disturbing you, chop it off so it does not send you to hell. When you do not control your family and you give birth to a number of children you

cannot care for, you have another question to answer from God. I will continue to use condom today and forever” (44yr old unmarried man)

Few of the participants said they did not use condom and will never use it because using condom is a sin and I quote:

“I think condom use is immoral. I say this because God said we should marry and give birth but when you use condom it means you disobey God. Condom use is the same as abortion so I do not use condom am faithful to my wife so I am safe from any sexual transmitted infections” (49 yr old married man)

“Men who use condom are immoral and one day they have a question to answer from God. For me the Bible said we should not do abortion and condom use is a form of abortion” (52yr old married man)

4.9.2 Partners Influence of Condom Use

Almost all respondents who use condoms indicated that, their partners influenced them to use condom. Except the few who said they do not use condom at all because they saw it to be a sinful practice. When they were asked in what way did their partners influence them to use condom, Some said, their partners do not trust them hence anytime they travel for a long period and came back, the first attempt to have sex with their partners, they were made to use condom up to a period after which they were allow without condom. All of them indicated that, when their partners are in unsafe period where they are likely to get pregnant and are not ready for such pregnancy, they were made to use condom or no sex. Some of them also stated that their partners force them to use condom when they suspected them to be having sex outside their relationship or the marriage. Some also indicated during the discussion that even though they have partners, they are not legally married and for that matter any time they want to have sex with such partners, they were forced or made to use condom to prevent unwanted pregnancies. These are illustrated by the following quotes.

“Yes, she sometimes asks me to use condom because we are not fully married for that matter we are not ready for children so at her unsafe period, she tells me to use condom as a must even though I may not like it” (28 yr old man)

4.9.3 Main Reason for Condom Use.

These discussions brought out the reasons for condom use. All the respondents mentioned that condoms are effective in protecting them from Sexually Transmitted Infections and prevention of unwanted pregnancies hence they use condom. Below are narrations from the FGDs.

“The main reason why I use condom is that, with my wife before we entered into marriage, we went for a lab test and both of us were not having any of the STIs. However, other women I had sex with apart from my wife because we could not go through the test I had to use condom so I cannot be infected with any disease so also I do not infect my wife in the house” (43 yr old married man)

“I use condom to protect myself from STIs and unwanted pregnancies” (44yr old unmarried man)

Some respondents went on further to say that, friends told them condoms are also used to collect sperm for medicine and ritual purposes. Ritually, sperms are used for occultism such as “sikaduro” now known as “sakawa” so the person can have enough money. Some also said sperm was used to cure pimples in the face so some people use condom to collect sperm for that purpose. When they were asked if there was any medical prove, they responded, “No, but it does really cure the pimples” (27 yr old unmarried man).

It also came out during the discussion that some women who never want to carry pregnancy or some men who did not want their partners to carry pregnancy use condom to collect sperms and send to a laboratory to produce babies. This was what a participant said and I quote:

“I am told by a lady friend that, sperm is effective in curing pimples in the face so they use male condom to collect sperm to cure pimples, to produce babies in the laboratory without the woman carrying the pregnancy and for occultism (sakawa)” (31 yr old unmarried man).

4.9.4 Challenges (factors affecting) in Male condom Use in Heterosexual intercourse

Majority of the participants complained of condom burst as a major challenge in the heterosexual intercourse. According to them when that happened, the purpose of which the condom is being used is defeated. This was what a participant said;

“My main challenge in condom use is that at times when using it gets burst in the process which means some of the materials used for condom are not quality enough and because I may be at the peak of the action, I may not be able to stop and withdraw. Sometimes, it leads to pregnancy which we are not prepared for” (46 yr old married man).

During the discussion, some participant mentioned they were allergic to some of the lubricants that are used for condom. Whenever they use condom, they experience some rashes around the neck of the penis which gave them a whole lot of troubles. This is what one said

“Any time I use condom, I experience some rashes around the neck of my penis. I have to go and buy another medicine to cure that so I decided not to use condom but my wife would not allow me without it sometimes” (33 yr old married man).

Others also talked about the length of some of the condoms. This could only be detected when the condom is removed from the pack when the action is about to start. This then lead to some psychological disturbances within the period. This is illustrated below with the quote

“For me some of the condoms are too short and because it cannot be tested at where it was bought it becomes a problem when the action is to begin and that is detected. It brings about

some disturbances in the mind and the whole body if my partner insisted that without condom she will not give in” (22 yr old unmarried man).

Some of the participants also said with passion that, they feel cheated when they use condom and that the right satisfaction is not got.

“With me, I feel cheated when I put on condom, but because I was forced to use it, I do not have a choice but it is a problem to me. I prefer flesh to flesh. Also, some condoms have expiring date and when that is not checked at the point of purchase, when I use it I develop some rashes around the penis.” (30 yr old unmarried man).

Only one participant complained that the price of condom is high. Almost all the other respondents reacted to the point raised about the price of condom that they did not agree that the price of condom is high. A participant said;

“For me, the price of condom is too cheap. The reason being that, when you fall sick as a result of STIs the money you will spend to cure yourself as compared to the price of condom will be very high. The consequences or the dangers involved when you get STIs is great as compared to the price of condom. (46 yr old married man).

“When you consider the work that condom does, I can say it is the cheapest commodity on the market” (33 yr old married man).

“Comparing the dangers involved when you acquire HIV and other STIs, the price of condom is too cheap”(31 yr old unmarried man).

4.9.5 Condom accessibility.

During this discussion almost all the respondents said condoms are very much accessible because every chemical store whether licensed or no licensed sells condoms. This is what some of them said;

“Getting condom is not difficult at all, just move to any drug store and you will get some to buy”

(54 yr old married man)

“Even some hospitals give out condoms freely without you paying anything” **(27 yr old**

unmarried man)

CHAPTER FIVE

DISCUSSION

5.1 Introduction:

The study was conducted to explore male attitude toward condom use as a preventive measure of STIs. Guided by the specific objectives for the study namely;

1. To determine the level of awareness on correct and consistent use of condom.
2. To determine the availability and affordability of condoms among the study target group and
3. To identify factors affecting condom use among the study group.

Both Cross-Sectional and a Focus Group Discussion (FGD) study designs were used.

5.2 Findings

Cross- Sectional Survey

The respondents (n=150) demonstrated highest level of Awareness (100%) of condom availability. This result is in line with a demographic and health survey conducted in Uganda in 2001 where the knowledge of condom is over 80% (Kabikira 2010). For correct and consistent use, 65% said they use condom correctly and consistently whereas 35% said they never use condom and will never use it. One can therefore conclude that majority of the study participant use condom consistently and correctly. Even with religious background which one thought could be a setback for condom use, 90 participants of the n=138 who said they were Christians use condom, 3 of the 4 Moslems use condom and 5 out of 8 respondents who said they are traditionalists use condom. Based on the analyses, it can be said that, there is a positive attitude towards condom use in the study participants. 44.67% of the participants disagreed to the

question that condoms are hard to come by, 6% strongly agree and 6.67% agreed. It is therefore evident in the study that condoms are very much available. With the affordability, 45.21% of the participants (n=150) disagreed to the notion that condoms are too expensive, 34.25% strongly disagreed, 6.16% strongly agreed and 7.53% agreed. One can therefore conclude that condoms are affordable in the study population.

A test of association between condom use and some socio-demographic factors showed that age, marital status, education and religious background are not factors that affect condom use in the study population. This is in line with a cross-sectional study by Martha Ali Abdulai on factors influencing condom use among women in rural Ghana where a test of association showed that only educational background among the socio-demographic characteristics was statistically significant and can be used to predict condom use (Abdulai 2012). Condom use at first sexual intercourse, condom use at last sexual intercourse, awareness of female condom, condom breaks or slips during sexual intercourse and condom use with most recent partner are factors that affect condom use in the study population. These factors are statistically significant with their P-values < 0.05 .

It was also clear in the study that the main reason for condom use in the study population is for STIs prevention. This is because majority of the respondent 116(78%) out of the study participants (n=150) said their main aim of using condom is to prevent STIs and 33(22%) responded condoms are used to prevent pregnancy. This is in contradiction with a study by Ismael and Sabir on knowledge, attitude and practices of condom use among male aged 15 to 49 in Erbil Governorate where 91.7% of the study participants said their main reason for using condom was to plan their family (prevention of pregnancy) even though they were aware of STIs (Ismael & Sabir Zangana 2012).

Focus Group Discussion

The second component of the study is the FGD which was also conducted base on the specific objective of the study. All the participants in the study group said they were aware of the existence of condom. Majority of the participants said they use condoms consistently and correctly. Only few participants responded they did not use condoms and will not use it because it is an immoral act. They said condom use is the same as causing abortion. Even the majority who said they use condom agreed with the above statement however, they use it and said they will continue to use condom. This has emphasized the fact that there is a positive attitude towards condom use in the study population. The discussion also points out that condoms are available, accessible and affordable.

Some factors mentioned by the participants that affect condom use in the study population were;

- Condom breaking or slipping during heterosexual intercourse.
- Experiencing of rashes around the penis after the use of condoms.
- Lack of full satisfaction during sexual intercourse.
- Sexual intercourse with a first time partner.
- The length of some condoms (too short).
- Expiry date on condoms.

It came to light during the discussion that the main objective of condom use in the study population is to prevent STIs, specific example given was HIV/AIDS. This therefore means that the study participant are aware of the high rate of HIV/AIDS in the Lower Manya Municipality and thereby protecting themselves with the use of condom.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

This study represents one of the few studies that looked at male attitude towards condom use and wish to conclude that, the study revealed a high level of condom knowledge among men in the study population. Findings of the study also showed that majority of the participants used condom during heterosexual intercourse to protect themselves from STIs because of the knowledge of the presence of HIV/AIDS. The study also identified the following; Condom use at first sexual intercourse, condom use at last sexual intercourse, awareness of female condom, condom breaks or slips during sexual intercourse and condom use with most recent partner as factors that affect condom use in the study population even though the attitudes towards condom use in the study area was positive. The study further revealed that condoms are accessible and affordable in the study area. Health promotion education programs should be geared towards the solution of the problems identified to motivate men to use condoms.

6.2 Recommendations.

- The Lower Manya Municipal Health directorate should intensify its education on the health benefits of condom use at their various Sub- municipal health directorates to ensure that a lot more people use condom.
- Ministry of Health (MOH) should institutionalize programs that frequently supervise the activities of condom providers to stop selling condoms which dates have expired.
- Health promotion education programmes should be geared towards the solution of the problems identified to motivate men to use condoms.

- This study recommends future research involving nationally representative sample of equal number of male and females that examines the attitude towards condom use in general (male and female condoms) not limiting it to only men.
- A more qualitative approach to explore the motivations for some of the variables that were investigated in this study would be needed.

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APPENDICES

Appendix 1

STUDY QUESTIONNAIRE

MALE ATTITUDES TOWARDS CONDOM USE AS A PREVENTIVE MEASURE OF
STIS AT NUASO IN THE LOWER MANYA KROBO MUNICIPALITY OF EASTERN
REGION OF GHANA

Introduction:

I am from Ensign College of Public Health at Kpong and I am conducting a study on the topic “male attitude towards condom use”. I will need your participation by providing answers to the following questions. Please take all the time you need to read the questions carefully or listen as I read. You may ask me any question about anything you do not understand at any time.

Name of Interviewer:

Date of Interview:.....

DEMOGRAPHIC, SOCIO CULTURAL&SOCIO ECONOMIC INFORMATION

1. What is the name of your locality / town?

2. How long have you been staying here/there?

3. What is your House Number? _____/_____

4. What is your date of birth? _____
Age: _____
(dd/mm/yyyy)
5. Sex of the respondent
[] - Male
[] - Female

6. What is your marital status?

- Single
- Married
- Separated
- Widowed
- Divorced
- Co-Habiting

If married or co-habiting, currently do you stay with your spouse? Yes No.

7. What ethnic group do you belong to?

- Krobo
- Ada
- Ewe
- Akan
- Ga
- Others Specify:.....

8. What is the highest level of school you completed?

- None
- Primary (Class 1 to 6)
- Jr. Secondary/ (Middle Form 1 – 4)
- Sec/Tech./Voc. School
- Six Form/ Polytechnics /University
- Others: Please specify

.....

9. Do you have any children of your own?

- Yes
- No

If Yes, how many

10. What type of family do you belong to?

- Nuclear
- Extended
- Others: Please specify

11. If you stay here less than 5 years which region did you migrate from?.....

12. What is your occupation?

- Civil Servant
- Business Personal
- Peasant Farmer
- Trader
- Driver
- Artisan – Specify
-
- Others: Please specify
-

13. What is your income level?

- Daily
- Weekly
- Monthly.....

14. What is your religion?

- Christianity (Specify Denomination):.....)
- Islamic:
- Traditional
- Others: Please specify
-

KNOWLEDGE AND ATTITUDES OF CONDOM USE

15. Have you ever used a condom during sexual intercourse?

Yes..... (GO TO Q 16).....1

No.....(GO TO Q 17).....2

16. **(IF NEVER USED CONDOMS READ)** Now, I am going to read to you a list of statements people have made about condoms, do you think you would agree or disagree that.....(READ EACH ITEM BEGINNING WITH Q Q18)

17. **(IF USED CONDOMS READ)** Now, I am going to read to you a list of statements about condoms. Even though you have never used a condom, do you agree or disagree that.....(READ EACH ITEM BEGINNING WITH Q 18)

[PROMPT “Do you (Strongly Agree, Agree, Neutral, Strongly disagree, Disagree, Decline to Answer)?]

		Strongly Agree	Agree	Neutral	Strongly disagree	Disagree	Decline To Answer
18.	Using condoms is immoral	1	2	3	4	8	9
19	It is embarrassing to buy condoms in a store	1	2	3	4	8	9
20	Condoms take all the pleasure out of sex	1	2	3	4	8	9
21	Using condoms is a good way to protect your sex partner from diseases people can get through sex.	1	2	3	4	8	9
22	It’s hard to find places to buy condoms	1	2	3	4	8	9
23	Condoms are expensive to buy	1	2	3	4	8	9
	Most of your friends think that condoms are just too much of a hassle to use.	1	2	3	4	8	9
24	Most of your friends think people should always use a condom when having sex with a new person.	1	2	3	4	8	9

26	Sex doesn't feel good when you use a condom	1	2	3	4	8	9
27	Condoms often break or slip off during sex	1	2	3	4	8	9
28	Condoms make a man look silly before his partner	1	2	3	4	8	9
29	It is embarrassing to put on a condom	1	2	3	4	8	9
30	If a woman wants her partner to use a condom, her partner might think she was having sex with other people.	1	2	3	4	8	9
31	If a man wants to use a condom, his sexual partner might think he was having sex with other people.	1	2	3	4	8	9
32	Most of your friends use condom when they have sex with a new partner	1	2	3	4	8	9
33	Most of your friends think people should use condom whenever they have sex, including their main partner.	1	2	3	4	8	9
34	Condoms make it hard for a woman to have an orgasm.	1	2	3	4	8	9
35	Most people of your age are using condoms these days.	1	2	3	4	8	9
36	Condoms are inexpensive to buy.	1	2	3	4	8	9

37 There is a female condom Yes No

38 If Yes, has any sexual partner of yours use it before Yes No

39 Sex feels good with female condoms **1 2 3 4**

8 9

[IF USED CONDOM] Please answer Q37 to Q51]

40 Where do you get your condom most at times

buy from store/pharmacy/chemical store

my partner

friend

family member

others.....

41 What is the common or favorite brand you see?

- KISS
- PANTHER
- PROTECTOR GOLD
- FIESTA
- BE SAFE
- CHAMPION CONDOM
- Other

42 Where do you keep condoms before using it?

- Pocket
- bag
- Drawer
- Under car seat
- Others, Specify

43 When you use condom, what is your main objective?

- Prevent STI's (HIV/AIDS, Gonorrhea)
- Prevent Pregnancy
- Others, specify.....

44 In the past six months how many sexual partners have you had.....

FREQUENCY OF CONDOM USE Did you use Condom at first sexual intercourse

- Yes No

45 Did you use Condom at last sexual intercourse Yes No

46 Have you use Condom in the last four weeks Yes No

47 Do you use Condom with your most recent partner Yes No

CONDOM USE SKILLS

49. have you had the experience of condom breaking or slipping off during sex

- Yes No

50. If Yes, in the last 12 months, how many times has a condom slipped off or break during vaginal intercourse.

a.Time

b. Don't know []

51. Do you often seek help from your partner when putting on condoms [] Yes

[] No

[PROMPT “Do you (Strongly Agree, Agree, Neutral, Strongly disagree, Disagree, Decline to Answer)?”]

52. It's good to seek help from my partner to put on a condom 1 2 3 4
8 9

53. When condom feel dry during sex I use.....: to lubricate it.

[] Cream/pomade

[] Water

[] Saliva

[] Oil, specify.....

[] Others

54. How do you dispose condom after use?

[] Open ground

[] Dust bin

[] Flush in the toilet

[] Others, Specify

Thanks for your time and willingness to participate on the study.

Appendix 2

MALE ATTITUDE TOWARDS CONDOM USE AS A PREVENTIVE MEASURE FOR SEXUALLY TRANSMITTED INFECTIONS (STIs)

Focus Group Discussion (FGD) Guide.

Part I

Demographic, socio-cultural & socio-economic information

No.	Locality	Duration in Locality	Sex	Age	Marital Status	Level of Edu.	No. of Children	Types of Family	Occupation	Religious background	Income	Ethnicity
1.												
2.												
3.												

4.												
5.												
6.												

PART II

Knowledge, attitude, Frequency and skills of condom use.

1. Why do you think men who use condom are moral or immoral?
2. Does your partner influence your condom use? In what way?
3. What is the main reason why you think you or men use condoms.
4. What are some of the factors that affect condom use in the heterosexual intercourse
5. What do you have to say about the affordability and accessibility of condom

Do you have anything in general you want to say about condom use by men

participate in the study.

Thanks for your time and willingness to

Appendix 3

CONSENT FORM

Part	1.	Participant	Information
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Introduction

I am from Ensign College of Public Health in Kpong and I am conducting a study on the topic male attitude towards condom use. I will be explaining all about the study to you and I will need your participation. Please take all the time you need to read this carefully or listen as I read. You may ask me any question about anything you do not understand at any time. You are a volunteer. You can choose not to take part and if you join, you may quit at any time. There will be no penalty if you decide to quit the study.

Why you are being asked to participate

You have been asked to take part in this study because you live in Nuaso in the lower Manya Krobo Municipality in the Eastern Region of Ghana. Specifically, I am interested in talking to men of ages: 15 to 59.

Procedures

If you agree to be part of the study, a questionnaire form would be issued to you and will take about 45minutes of your time. Your responses will be recorded on the form and later entered into a computer database by study staff and will be used for analyses.

Risk and Benefits

I anticipate minimal or no risk to you. There is no direct benefit to you for being in the study; however, study outcomes may lead to better understanding of the use of condoms in the area for healthy life.

Confidentiality All data from your responses will be kept private. Your identifiable data such as name or date of birth will not be used in documents, reports, or publications related to this research. I will keep all documents secured and under lock. When typing your survey responses into the computer, all data will be entered without any information that will make it possible for your identity to be known. The information you provide will be kept strictly confidential and will be available only to persons related to the study (myself and my supervisors). The Office of Ethical Review Board of Ensign College may also have access to study records upon their request.

Your responses will not be shown to other participants or community members. The original paper survey forms will be destroyed once data entry and all analysis is complete.

Volunteerism and Withdrawal

Your participation in the study is completely voluntary and you reserve the right not to participate. This is your right and the decision you take will not be disclosed to anyone. If you join the study, you can change your mind later. You can choose not to take part and you can quit at any time. There will be no negative consequences if you choose not to participate in the study. Please note however, that some of the information that may have been obtained from you without identifiers, before you chose to withdraw, may be used in analysis reports and publications. You can opt not to have me use it.

Cost/Compensation

Your participation in this study will not lead to you incurring any monetary cost during or after the study.

Who to contact

This study has been approved by the Institutional Review Board of Ensign College. If you have any concern about the conduct of this study, your welfare or your rights as a research participant if you wish to ask questions, or need further explanations later, you may contact me, Addo Michael Brown (0243223137) of Ensign College of Public Health or my supervisor Dr. Agyarko (02081829770). You may also contact the administrator of the Institutional Ethics Committee of the Ensign College of Public Health at +233 245762229. Thank you.

Do you have any questions?

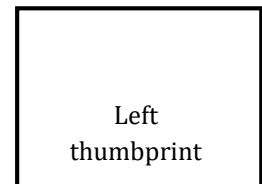
Part 2. CONSENT DECLARATION

“I have read the information given above, or the information above has been read to me. I have been given a chance to ask questions concerning this study; questions have been answered to my satisfaction. I now voluntarily agree to participate in this study knowing that I have the right to withdraw at any time without affecting future health care services”

Name of **participant** _____

Signature of **Participant** _____

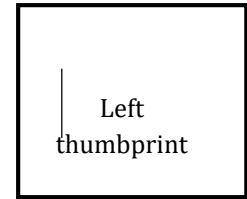
Date: / / 2016



Name of **witness** _____

Signature of **witness** _____

Date: / / 2016



| Name of **investigator** _____

Signature of **investigator** _____

Date: / / 2016