

**ENSIGN GLOBAL UNIVERSITY, KPONG
EASTERN REGION, GHANA**

**FACULTY OF PUBLIC HEALTH
DEPARTMENT OF COMMUNITY HEALTH**

**KNOWLEDGE, ATTITUDE AND PRACTICES OF FAMILY PLANNING AMONG
MALES AT KETU SOUTH MUNICIPALITY IN THE VOLTA REGION OF GHANA**

BY

DZAKPASU ALPHONSE MAKAFUI

(257100354)

MAY, 2026

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A THESIS SUBMITTED TO THE DEPARTMENT OF COMMUNITY HEALTH, FACULTY
OF PUBLIC HEALTH, ENSIGN GLOBAL COLLEGE IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE
MASTER OF PUBLIC HEALTH DEGREE

MAY, 2026

DECLARATION AND CERTIFICATION

I, Alphonse Makafui Dzakpasu, hereby declare that this thesis is the result of my original work undertaken in partial fulfilment of the requirements for the award of a Master's Degree in Public Health. To the best of my knowledge, this work does not contain any material previously published or written by another person, nor material which has been submitted for the award of any other degree in this or any other institution, except where appropriate acknowledgement has been duly made in the text.



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DEDICATION

This work is dedicated to God Almighty for His guidance and strength. To my family, whose support has been unwavering. And to all frontline health workers and leaders working tirelessly to strengthen primary health care systems and improve population health outcomes.

ACKNOWLEDGMENT

I give all glory and thanks to God Almighty for His unfailing grace, strength, and guidance throughout this academic journey.

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OPERATIONAL DEFINITIONS

Family planning: Refers to the use or understanding of methods that enable individuals or couples to control the number, timing, and spacing of their children, primarily through contraceptive use.

Family planning services: Refers to the educational, medical and social services available to individuals or couples in the Ketu South Municipality that support them in freely and responsibly determining the number and spacing of their children.

Family planning methods: Refer to the various techniques and practices that individual or couples use to plan and achieve their desired number of children and to determine the spacing and timing of their pregnancies. These methods encompass both contraceptive methods and other approaches, such as fertility awareness and treatment of infertility.

Contraceptive methods: Refer to the specific techniques or devices used to prevent pregnancy. These include modern methods such as oral contraceptive pills, implants, injectable, patches, vaginal rings, intrauterine devices (IUDs), condoms, male and female sterilization, as well as traditional methods like withdrawal.

Knowledge: Refers to what respondents know about family planning thus respondent's understanding of FP and their ability to correctly identify and recall information related to family planning.

Attitude: Refers to the respondent's personal feelings and beliefs regarding family planning.

Practices: Refers to the actions and behaviours of males in relation to family planning, including whether they have ever used any family planning method, the type of methods used, the frequency or consistency of use and their sources of family planning services.

LIST OF ABBREVIATIONS

Abbreviation	Full Meaning
AOR	Adjusted Odds Ratio
COR	Crude Odds Ratio
FP	Family Planning
FPS	Family Planning Services
GHS	Ghana Health Service
HIV	Human Immunodeficiency Virus
IUDs	Intrauterine Devices
LMICs	Low- and Middle-Income Countries
PI	Principal Investigator
SD	Standard Deviation
UNFPA	United Nations Population Fund
WHO	World Health Organization

ABSTRACT

Background: Family planning (FP) is an important component of reproductive health and contributes to reducing maternal and child morbidity and mortality. Although male involvement in FP is increasingly encouraged, participation remains limited by sociocultural, religious and gender-related barriers. In Ghana, FP programmes have traditionally focused on women, leaving knowledge gaps and misconceptions among men. In Ketu South Municipality, rising teenage pregnancy, fertility concerns and HIV prevalence make male involvement an important public health issue.

Aim: This study assessed the knowledge, attitudes and practices of family planning among males in Ketu South Municipality in the Volta Region of Ghana.

Methods: A community-based cross-sectional study was conducted among 368 men selected through multistage sampling. Data were collected through face-to-face interviews using a structured questionnaire administered via Kobo Collect in January 2026. Data were analysed with STATA version 17 using descriptive statistics and logistic regression. Statistical significance was set at $p < 0.05$.

Results: Awareness of FP was high (85.6%), but this did not fully translate into adequate knowledge or favourable attitudes. Only 54.9% of respondents had a positive attitude towards FP, while about 62% reported ever using an FP method. Sociodemographic factors were not significantly associated with knowledge. Tertiary education [AOR = 0.32, 95% CI: 0.12–0.83] and having five or more children [AOR = 0.23, 95% CI: 0.08–0.72] were associated with reduced odds of negative attitudes. FP use was significantly associated with age, tertiary education, self-employment, Islamic affiliation, higher parity and attitude towards FP.

Conclusion: Male awareness of FP was high, but comprehensive knowledge and positive attitudes remained limited. Education, religion, parity and attitude influenced FP practices. Male-centred interventions addressing misconceptions, sociocultural barriers and couple communication are needed to improve male participation in FP in Ketu South Municipality.

Keywords: Family planning, male involvement, knowledge, attitude, practices, Ghana

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CHAPTER ONE

INTRODUCTION

1.0 Background

Access to family planning services (FPS) is a crucial component of reproductive health and a key strategy for reducing maternal and child mortality rates (Ganatra et al., 2016). Family planning (FP) gives individuals and couples the power to plan and attain their desired number of children, the spacing and timing of their births through the use of contraceptive methods. Family planning comprises various contraceptive methods. It includes traditional methods like the calendar method and withdrawal as well as modern options such as condoms, pills, injectable, implants, intrauterine devices (IUDs) and sterilization (World Health Organization (WHO), 2023). These interventions play a crucial role in preventing unplanned pregnancies, reducing the rate of abortion and improving maternal and child health outcomes.

According to the United Nations Population Fund (UNFPA), 257 million women in low- and middle-income countries (LMICs) who want to avoid pregnancy are not utilizing safe and modern methods of contraception (United Nations Population Fund (UNFPA), 2022). Despite the availability of FPS, utilization remains low in many sub-Saharan African countries, including Ghana, due to various socio-cultural and gender-related barriers (Apanga and Adam, 2015).

Historically, the conversation around FP has focused primarily on women, but recent global efforts underscore the importance of involving men in reproductive health initiatives as supportive partners and decision-makers (Lantiere et al., 2022). Male involvement in family planning has gained attention in recent years due to its influence on contraceptive uptake, shared responsibility in reproductive decisions and its potential to shift gender dynamics in reproductive health (Mulatu et al., 2022).

Globally, contraceptive prevalence rates vary widely. In developed countries, male knowledge and participation and uptake in FP are relatively high, while in many African countries, knowledge and utilization of male contraceptive methods remain lower (Kaur, 2025; WHO, 2023; Ross and Hardee, 2017). For example, in Canada, 60.1% of men had ever used a contraceptive method (Rotermann and McKay, 2020). In contrast, many African nations experience lower male contraceptive use. For instance, a study in Uganda found that only about 53% of men had ever used a family planning method (Dougherty et al., 2018). In Ghana, 26.2% of men were reported to have used modern contraceptives (Butame, 2019). Despite increasing efforts to promote male involvement in reproductive health, gender norms, cultural and religious beliefs and misinformation continue to hinder progress (Teye, 2013) in many low- and middle-income countries.

In Ghana, although there are policies that promote universal access to reproductive health services (GHS, 2014), uptake and knowledge of FP remain low (Longla et al., 2023; Boateng, 2019). The 2014 Ghana Demographic and Health Survey reported that only a small proportion of men have comprehensive knowledge of FP methods and fewer used them. Religious and cultural beliefs also continue to negatively influence acceptance of FP among men (Sunny et al., 2016).

Despite the growing recognition of the importance for male involvement, most FP campaigns in Ghana continue to focus primarily on women (Adongo et al., 2013). Therefore, this study assessed the knowledge, attitude and practices of family planning among males in the Ketu South Municipality in the Volta Region of Ghana.

1.1 Problem Statement

Universal access to sexual and reproductive health services, including FP is a key target under Sustainable Development Goal 3. It aims to ensure healthy lives and promote good well-being for all. Achieving this goal requires comprehensive and inclusive FP initiatives that involve both men and women. Male involvement in FP is recognized as essential for increasing uptake of FP, preventing unplanned pregnancies and reducing sexually transmitted infections, including HIV (Tekakwo et al., 2023; Hylkema and Ilozumba, 2023).

In Ghana, while policy frameworks promote access to reproductive health services (Ghana Health Service [GHS], 2014), the use of FP services remains low among men (Longla et al., 2023; Appiah et al., 2019). This gap persists even with the increasing recognition of the importance of male involvement in FP (Lantiere et al., 2022; Mulatu et al., 2022). Most public health campaigns in Ghana continue to focus primarily on women, leaving male populations less informed and less involved in contraceptive use and FP decisions (Adongo et al., 2013; Boateng, 2019). As a result, male knowledge gaps and misconceptions about FP persist, which contribute to poor uptake of FP methods and public health challenges.

According to the Ghana AIDS Commission (2019), Ketu South has an HIV prevalence rate of 1.24% and it is among the nine municipalities in the Volta Region that collectively house 68% of the Region's estimated HIV-positive population (Ghana News Agency (GNA, 2023). At the same time, teenage pregnancy is on the rise in the Municipality. In 2024 alone, 885 cases were recorded, representing 16.9% of pregnancies up from 859 cases (13.8%) in 2023 (GNA, 2025). Additionally, while the total fertility rate in Ketu South is 3.1 slightly below the regional average of 3.4, the general fertility rate remains high at 88.7 births per 1,000 women aged 15–49 (GSS, 2021), showing an increase in reproductive activity among young women.

The confluence of high teenage pregnancy, high HIV prevalence and significant fertility levels emphasizes the need to investigate gaps in male knowledge, practices and attitudes toward FP in the Ketu South Municipality. Yet, few studies have focused on men's FP knowledge, attitude and practices in Ketu South Municipality, despite their potential influence on reproductive health outcomes. This study therefore seeks to bridge the literature gap and assessed the knowledge, attitudes and practices of FP among males in Ketu South Municipality in the Volta Region of Ghana.

1.2 Significance of the study

This study is essential because male use and knowledge of FP in Ghana is low (Longla et al., 2023; Boateng, 2019), despite the growing recognition of men's role in improving contraceptive uptake and preventing unplanned pregnancies and sexually transmitted infections, including HIV. This issue presents a significant barrier to achieving global and national health targets such as universal access to reproductive health services, reduced maternal and child mortality, and the control of HIV transmission.

To address this challenge, the study aimed to assess the knowledge, attitude and practices of FP among males in the Ketu South Municipality of the Volta Region of Ghana. The findings may provide evidence to inform the design of targeted educational and outreach interventions aimed at increasing male engagement in reproductive health decisions.

Currently, there is limited research specifically examining male knowledge, attitude and practices of FP in the Ketu South Municipality, despite the area experiencing pressing public health concerns. For instance, the Municipality has a high HIV prevalence rate of 1.24% and recorded 885 teenage pregnancies in 2024 representing 16.9% of all pregnancies in the

Municipality (GNA, 2023; GNA, 2025). These figures point to urgent reproductive health challenges that require improved action and investigations, especially among the men.

Identifying the knowledge level and attitudes of men toward FP can allow health authorities and policymakers to develop more inclusive and gender-responsive FP campaigns, in order to shift harmful gender norms and increase uptake. This aligns with the Ghana Health Service's goal of involving men more actively in reproductive health and addressing the social determinants of teenage pregnancy and high fertility rates.

In addition, the study contributes to the existing body of literature on FP among men by providing context-specific insights from a municipality with high HIV prevalence and a rising rate of teenage pregnancies. The findings may support efforts to reduce unplanned pregnancies, curb the spread of HIV and promote shared responsibility in reproductive health, thereby improving health outcomes for individuals and families in the Ketu South Municipality and beyond.

1.3 Research Questions

1. What is the level of knowledge towards family planning among males in Ketu South Municipality in the Volta region of Ghana?
2. What is the attitude towards family planning among males in Ketu South Municipality in the Volta region of Ghana?
3. What are the family planning practices among males in Ketu South Municipality in the Volta region of Ghana?
4. What factors influence knowledge, attitude and practices of family planning among males in Ketu South Municipality in the Volta Region of Ghana?

1.4 Research Objectives

1.4.1 General Objective

This study seeks to assess the knowledge, attitude and practices of family planning among males in Ketu south municipality in the Volta region of Ghana.

1.4.2 Specific Objectives

1. To determine the level of knowledge towards family planning among males in Ketu South Municipality in the Volta region of Ghana.
2. To identify the attitude of males towards family planning in Ketu South Municipality in the Volta region of Ghana.
3. To investigate family planning practices among males in Ketu South Municipality in the Volta region of Ghana.
4. To identify the factors that are associated with knowledge, attitude and practices of family planning among males in Ketu South Municipality in the Volta Region of Ghana.

1.5 Profile of Study Area

Ketu South Municipality is located in the southeastern part of Ghana within the Volta Region. It shares borders with the Ketu North to the north, the Gulf of Guinea to the south, the Republic of Togo to the east and Keta Municipality to the west. The Municipality covers a land area of approximately 254 square kilometers (GSS, 2021).

According to the 2021 Population and Housing Census, the total population of the Ketu South Municipality is 253,122, comprising 52.1% females and 47.9% males. This accounts for about 15.3% of the total population of the Volta Region (GSS, 2021). The Municipality is a blend of urban and rural settlements, with prominent towns including Aflao, Denu and Agbozume. Its

location along the Ghana-Togo border positions it as a key commercial and cultural center, especially for cross-border trade.

The Municipality has both public and private health facilities. There are 24 public and private health facilities concentrated in the urban areas of the Municipality (Ketu South Municipal Assembly, 2016). Notably, the Ketu South Municipal Hospital in Aflao serves as a referral center for the area (Ministry of Finance, 2023).

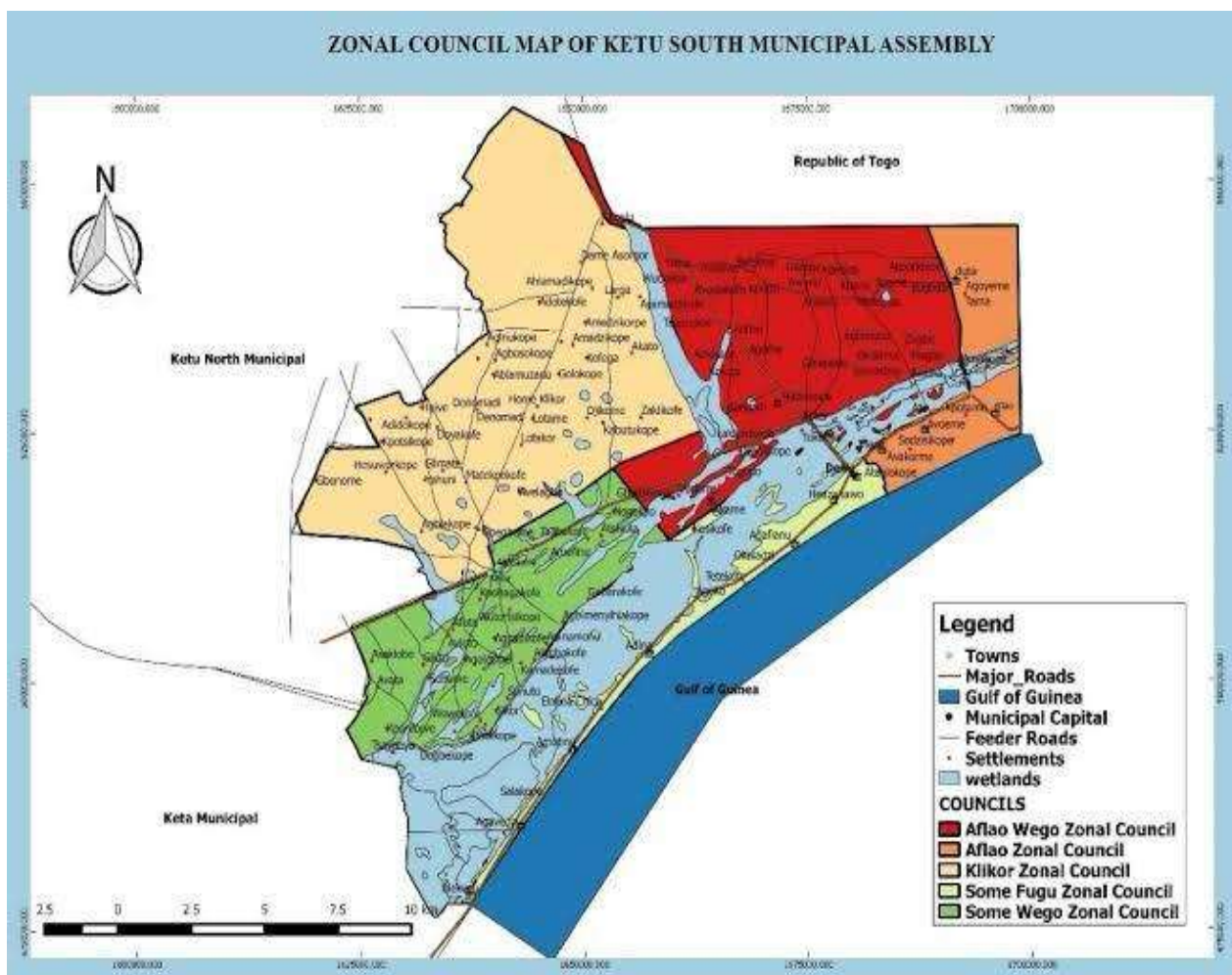


Figure 1.1: Map of Ketu South Municipality

1.6 Conceptual Framework

The conceptual framework was adapted from Turkson (2024) and modified to suit the objectives of this study. The framework illustrates the relationship between sociodemographic factors (independent variables) and knowledge, attitudes and practices of family planning (dependent variables) amongst males at Ketu South Municipality. Drawing from empirical literature, the framework posits that age, educational attainment, occupation, religious affiliation, marital status and number of children significantly influence men's family planning behaviours. These sociodemographic characteristics shape exposure to health information, cultural norms and economic resources, thereby affecting contraceptive knowledge levels.

Furthermore, they modulate attitudes towards family planning through social networks, religious teachings and gender role expectations. Consequently, these attitudes and knowledge levels determine actual contraceptive practices, including method adoption, spousal support and health-seeking behaviours. The study by mapping these interconnections, the framework operationalises the fourth research objective, providing analytical clarity for examining how demographic characteristics affect family planning outcomes. This conceptual model guides data collection, analysis and interpretation throughout the study.

Conceptual Framework

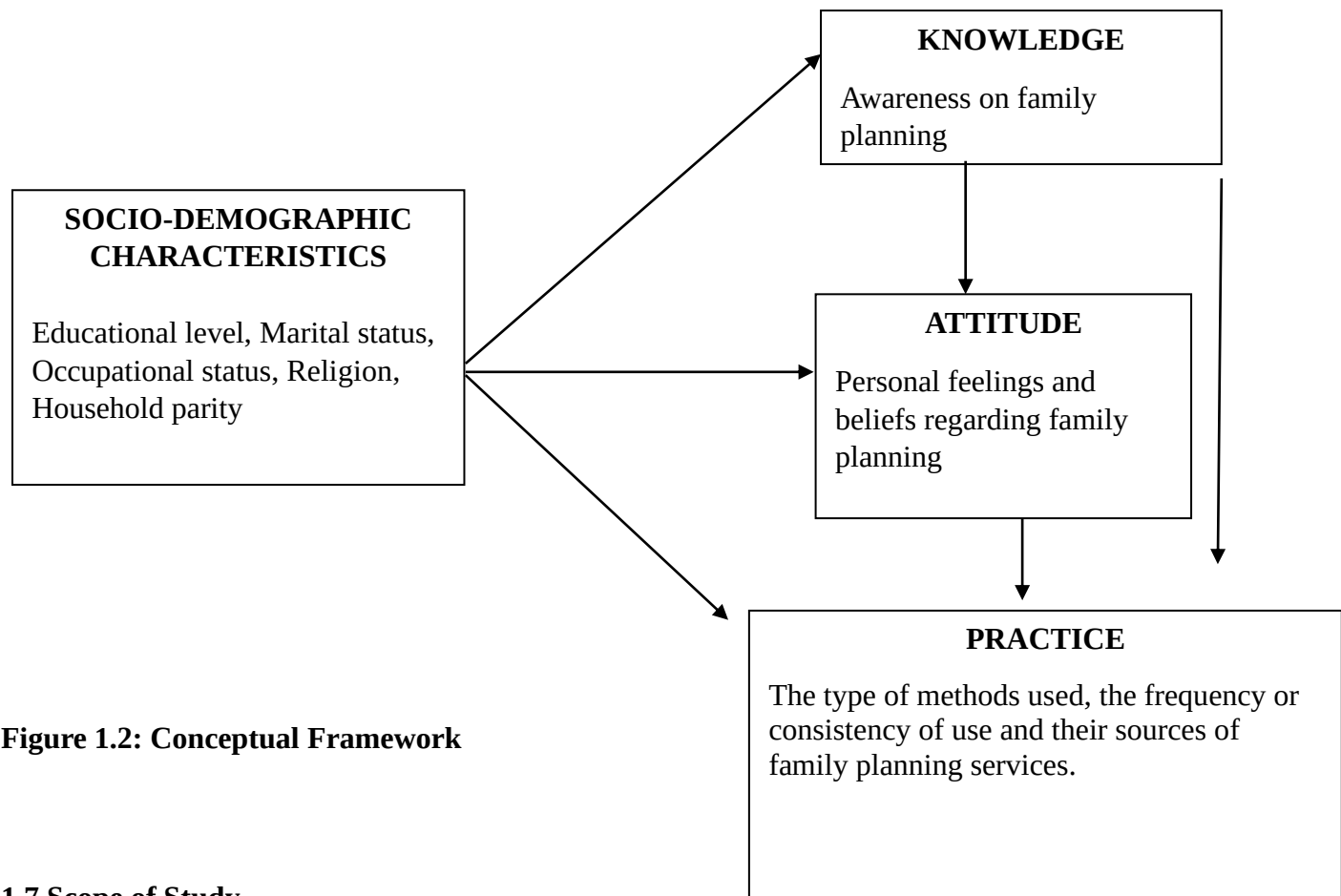


Figure 1.2: Conceptual Framework

1.7 Scope of Study

The study was about family planning among males in the Ketu South Municipality. The study used primary data to answers the research questions. Male aged 18-65 years who meet the eligibility criteria were interviewed with an online based questionnaire. The study determined the level of knowledge and attitude towards family planning, family planning practices and identified the sociodemographic factors that affect knowledge, attitude and practices of family planning among males in Ketu South Municipality in the Volta Region of Ghana.

1.8 Organization of Study

This study is organized into five main chapters. Chapter One presents the introduction, including the background to the study, problem statement, research questions, objectives, significance of

the study, profile of study area, conceptual framework, scope of study and the organization of the study. Chapter Two reviews relevant for the study related to the study's specific objectives. Chapter Three describes the methodology this how the study was carried out. It includes the study design, study site, population, eligibility, sampling and sample size, data collection, data analysis, ethical considerations and limitations of the study. Chapter Four presents the findings of the study. Chapter Five provides the discussion and finally the Chapter Six gives the conclusions, recommendations and implications for future studies.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter presents a comprehensive review of literature relevant to family planning knowledge, attitudes and practices amongst males. It examines conceptual definitions, theoretical underpinnings and empirical evidence from global, regional and local contexts. Furthermore, the chapter synthesises existing scholarship to identify knowledge gaps and establish the conceptual framework guiding this investigation. This structured approach contextualises the study within broader reproductive health discourse.

2.1 Conceptual Review

This section explores fundamental concepts underpinning the study, providing definitional clarity on family planning, male involvement and reproductive health services. By examining these constructs through multiple perspectives, the conceptual review establishes a common understanding of key terminology. Additionally, it contextualises how these concepts interrelate within the Ghanaian socio-cultural environment, thereby providing the foundation for subsequent theoretical and empirical discussions.

2.1.1 Family Planning

Family planning encompasses the deliberate processes, services and methods enabling individuals and couples to anticipate and attain their desired number of children whilst determining spacing between births (World Health Organization, 2023; Ganatra and Faundes, 2016). Historically, organised family planning emerged during the early twentieth century, evolving from birth control movements in Europe and North America into comprehensive reproductive health programmes worldwide. By the 1960s, international agencies recognised

family planning as fundamental to maternal health, economic development and gender equality, thereby catalysing global policy initiatives (Ganatra and Faundes, 2016; Aventin et al., 2023). Consequently, the International Conference on Population and Development in 1994 positioned family planning within broader reproductive rights frameworks, emphasising informed choice and quality services (United Nations Population Fund, 2022).

Globally, contraceptive prevalence amongst women of reproductive age stands at approximately 64%, with regional disparities reflecting economic development, cultural contexts and health system capacity (Kaur, 2025; Gelaw et al., 2023). Developed regions demonstrate usage rates exceeding 70%, whilst Sub-Saharan Africa records substantially lower figures, often below 25% (Kaur, 2025; Aventin et al., 2023). This disparity perpetuates high fertility rates, unintended pregnancies and maternal mortality in resource-limited settings. In Africa specifically, family planning uptake remains constrained by inadequate service infrastructure, sociocultural barriers and limited male involvement (Hylkema and Ilozumba, 2023; Adongo et al., 2013). West African nations exemplify these challenges, with contraceptive prevalence hovering around 20% despite sustained public health interventions (Hylkema and Ilozumba, 2023).

Within Ghana, family planning services have evolved significantly since independence, transitioning from population control paradigms towards rights-based approaches emphasising reproductive autonomy (Ghana Health Service, 2014). The National Reproductive Health Service Policy underscores universal access to contraceptive information and services, recognising family planning's contribution to maternal mortality reduction and sustainable development (Ghana Health Service, 2014; Ghana Statistical Service et al., 2015). However, national contraceptive prevalence remains approximately 22%, with pronounced rural-urban and regional variations (Ghana Statistical Service et al., 2015; Apanga and Adam, 2015).

The Volta Region, where Ketu South Municipality is situated, demonstrates persistently low uptake alongside elevated teenage pregnancy and fertility rates (Ghana News Agency, 2025; Ministry of Finance, 2023). These indicators underscore the relevance of examining male knowledge, attitudes and practices, given that men substantially influence household reproductive decisions yet remain inadequately engaged in family planning programmes.

2.1.2 Family Planning Practices

Family planning practices refer to the actual utilisation and adoption of contraceptive methods, alongside supportive behaviours facilitating reproductive health decision-making (Ross and Hardee, 2017; Butame, 2019). Historically, contraceptive practices evolved from traditional methods such as withdrawal and rhythm calculations towards modern biomedical interventions including hormonal pills, injectables, intrauterine devices, implants and barrier methods (World Health Organization, 2023; Ganatra and Faundes, 2016). Male-specific methods encompass condoms and vasectomy, though their uptake remains disproportionately low compared to female-oriented options (Ross and Hardee, 2017; Appiah et al., 2019). Traditional practices, whilst less effective, persist in many communities due to perceived safety and cultural acceptability (Teye, 2013; Dougherty et al., 2018).

Globally, contraceptive method mix varies considerably, reflecting service availability, cultural preferences and gender norms (Kaur, 2025; Aventin et al., 2023). Developed nations demonstrate high uptake of long-acting reversible contraceptives, whilst short-acting methods predominate in low-income settings (Rotermann and McKay, 2020; Gelaw et al., 2023). Male condom use constitutes the primary male contribution worldwide, accounting for approximately 15% of contraceptive prevalence amongst couples, whereas vasectomy uptake remains below 5%

globally (Ross and Hardee, 2017). This gender imbalance in contraceptive responsibility reflects deeply entrenched social norms positioning family planning as predominantly women's domain.

In Sub-Saharan Africa, family planning practices are characterised by low overall uptake, high discontinuation rates and substantial unmet need (Bawah et al., 2019; Gelaw et al., 2023). Injectable contraceptives dominate method mix in many African contexts, followed by pills and implants, whilst male method utilisation remains minimal (Dougherty et al., 2018; Mulatu et al., 2022). Cultural prohibitions, religious objections and misconceptions about side effects constitute significant barriers to consistent contraceptive practice (Donyi et al., 2020; Tekakwo et al., 2023). Furthermore, spousal disapproval, particularly male partner opposition, substantially constrains women's contraceptive autonomy and continuity of use (Apanga and Adam, 2015; Teye, 2013).

Within Ghana, contraceptive practices reflect national and regional heterogeneity, with urban areas demonstrating higher uptake than rural communities (Ghana Statistical Service et al., 2015; Sunnu et al., 2016). Injectables, pills and implants constitute the most commonly used modern methods amongst Ghanaian women, whilst male condom use occurs predominantly for HIV prevention rather than family planning purposes (Butame, 2019; Grindlay et al., 2018). Male involvement in family planning practices typically manifests through spousal approval, joint decision-making and financial support for women's contraceptive access rather than direct method adoption (Appiah et al., 2019; Boateng, 2019).

Studies in West Mamprusi and Talensi districts documented male family planning patronage rates below 40%, underscoring substantial gender disparities in contraceptive responsibility (Abudu, 2019; Apanga and Adam, 2015). In Ketu South Municipality specifically, elevated

fertility and teenage pregnancy rates suggest inadequate contraceptive practice amongst both men and women (Ghana News Agency, 2025). Consequently, this study examines male family planning practices within this context, recognising that men's contraceptive behaviours, spousal support and decision-making involvement fundamentally shape household reproductive outcomes and community health indicators.

2.1.3 Knowledge and Attitude Towards Family Planning

Knowledge towards family planning encompasses awareness of contraceptive methods, understanding of reproductive physiology, recognition of family planning benefits and comprehension of service access points (Chijioke, 2020; Lumor et al., 2023). Conversely, attitude reflects individuals' evaluative predispositions, encompassing beliefs, perceptions and emotional orientations towards contraceptive use and reproductive health services (Dougherty et al., 2018; Longla et al., 2023). These constructs critically influence contraceptive adoption, with adequate knowledge facilitating informed decision-making whilst positive attitudes promote sustained method utilisation (Butame, 2019; Grindlay et al., 2018).

Globally, contraceptive knowledge levels vary substantially across populations, though awareness of at least one modern method exceeds 90% in most regions (Aventin et al., 2023; Gelaw et al., 2023). However, comprehensive knowledge encompassing method effectiveness, side effects and appropriate usage remains considerably lower, particularly amongst men (Ross and Hardee, 2017; Dougherty et al., 2018). Similarly, attitudes towards family planning demonstrate geographical and cultural variation, with conservative religious contexts often harbouring negative perceptions regarding contraceptive safety and morality (Hylkema and Ilozumba, 2023; Lantiere et al., 2022). Studies across low-income countries document

widespread misconceptions linking contraceptives to infertility, cancer and sexual promiscuity, thereby undermining positive attitudinal dispositions (Tekakwo et al., 2023; Mulatu et al., 2022).

In Sub-Saharan Africa, male contraceptive knowledge remains inadequate despite high general awareness, with substantial gaps concerning long-acting reversible methods and male-specific options (Dougherty et al., 2018; Mulatu et al., 2022). Ugandan research revealed that whilst 98% of men demonstrated family planning awareness, only 16% possessed comprehensive knowledge of intrauterine devices and implants (Dougherty et al., 2018). Similarly, attitudes towards family planning amongst African men frequently reflect ambivalence, balancing recognition of economic benefits against cultural preferences for large families and religious prohibitions (Donyi et al., 2020; Tekakwo et al., 2023). Fear of contraceptive side effects constitutes the predominant negative attitude, with 82% of Ghanaian men citing this concern as a barrier to family planning involvement (Abudu, 2019).

Within Ghana, studies document high contraceptive awareness exceeding 80%, yet knowledge depth and accuracy remain inconsistent (Apanga and Adam, 2015; Sunnu et al., 2016). Research in West Mamprusi District reported 58.5% overall male knowledge of family planning, alongside 37.5% negative perceptions towards vasectomy (Abudu, 2019). Similarly, investigations in Talensi and Ho municipalities identified husband opposition and misconceptions as primary barriers to women's contraceptive access (Apanga and Adam, 2015; Sunnu et al., 2016). These findings underscore the necessity of examining male knowledge and attitudes in Ketu South Municipality, recognising that cognitive understanding and evaluative orientations fundamentally mediate contraceptive practices and reproductive health outcomes.

2.1.4 Sociodemographic Factors

Sociodemographic factors encompass individual and household characteristics including age, educational attainment, occupation, income, marital status, religious affiliation and family size that shape health behaviours and service utilisation patterns (Longla et al., 2023; Butame, 2019). These variables fundamentally influence contraceptive knowledge acquisition, attitude formation and practice adoption through multiple pathways including information access, economic resources, cultural norms and social networks (Apanga and Adam, 2015; Grindlay et al., 2018). Consequently, understanding sociodemographic determinants of family planning behaviours enables targeted interventions addressing specific population subgroups' needs and constraints.

Globally, educational attainment consistently emerges as a robust predictor of contraceptive use, with higher education correlating positively with knowledge, favourable attitudes and sustained method adoption (Gelaw et al., 2023; Aventin et al., 2023). Similarly, age demonstrates curvilinear relationships, whereby younger and older reproductive-age individuals exhibit lower contraceptive prevalence compared to those aged 25-39 years (Butame, 2019; Grindlay et al., 2018). Occupational status influences family planning through economic capacity and exposure to diverse information sources, with formal employment associated with higher contraceptive uptake (Longla et al., 2023; Mulatu et al., 2022). Religious affiliation modulates attitudes through doctrinal teachings, with conservative faiths often discouraging artificial contraception (Hylkema and Ilozumba, 2023; Donyi et al., 2020).

In Sub-Saharan Africa, sociodemographic disparities in family planning knowledge and practice remain pronounced, reflecting structural inequalities in education, healthcare access and gender empowerment (Dougherty et al., 2018; Tekakwo et al., 2023). Ugandan studies documented that men with primary education demonstrated 1.8 times higher contraceptive use compared to those

without formal schooling (Butame, 2019). Similarly, Ethiopian research revealed that spousal discussion of reproductive health and husband approval significantly predicted male family planning involvement (Mulatu et al., 2022). Marital status similarly influences contraceptive behaviours, with married men reporting higher awareness yet variable actual participation depending on decision-making dynamics (Longla et al., 2023; Abudu, 2019).

Within Ghana, sociodemographic determinants of contraceptive use mirror broader regional patterns, though specific influences vary across localities (Apanga and Adam, 2015; Sunnu et al., 2016). Research in Central Region identified post-primary education, non-perpetration of intimate partner violence and multiple sexual partnerships as significant correlates of contraceptive practice amongst males (Longla et al., 2023). Conversely, West Mamprusi investigations found that age category, educational level and occupation significantly influenced male family planning involvement (Abudu, 2019). These findings emphasise the importance of examining sociodemographic factors in Ketu South Municipality, particularly given the area's unique cultural composition, economic profile and health service configuration, thereby addressing the fourth research objective of identifying demographic influences on male family planning knowledge, attitudes and practices.

2.2 Empirical Review

This section synthesises findings from previous studies examining male involvement in family planning across diverse geographical contexts. By reviewing empirical evidence from international, African and Ghanaian settings, it identifies patterns, contradictions and gaps in existing knowledge. Moreover, the review highlights methodological approaches and outcomes that inform this study's design. This comparative analysis situates the current investigation within established scholarship.

2.2.1 Level of Knowledge Towards Family Planning Among Males

Dougherty et al. (2018) conducted a cross-sectional study in rural Uganda involving 178 men aged 18-71 years to quantify male knowledge of family planning methods and their sources of information. Using researcher-administered surveys, the study revealed that 98% of participants reported awareness of at least one family planning method, demonstrating remarkably high general knowledge. However, the study uncovered significant gaps in comprehensive understanding, with only 72% recognising male condoms, 54% aware of injectables, 52% knowing about pills, whilst merely 16% demonstrated knowledge of intrauterine devices and implants. Furthermore, whilst 73% obtained information through radio broadcasts, only 43% received knowledge from healthcare workers, highlighting critical deficiencies in professional health education channels. The study also documented that men identified common contraceptive side effects such as vaginal bleeding (31%), yet misconceptions regarding infertility and birth defects remained relatively uncommon at less than 10%. Nevertheless, the research failed to disaggregate knowledge levels by sociodemographic characteristics, thereby limiting understanding of which male subpopulations require targeted interventions.

Similarly, Donyi et al. (2020) examined male involvement in family planning across three rural communities in Krachi-Nchumuru District, Volta Region, Ghana, recruiting 164 men aged 20-59 years through random selection. The cross-sectional descriptive study employed SPSS version 22.0 for data analysis, revealing that 68% of respondents possessed some knowledge of family planning, with 37% attributing their knowledge to health facilities. Notably, 94% of knowledgeable participants had discussed family planning with their partners, suggesting knowledge translation into spousal communication. However, the study documented that 49% had never used any contraceptive method, with 50% citing religious beliefs as barriers and the

remainder identifying cultural taboos, cost and distance as obstacles. This study highlighted the disconnection between knowledge possession and practical application, yet failed to employ standardised knowledge assessment tools, thereby compromising comparability with other studies and limiting conclusions regarding knowledge depth versus superficial awareness.

Conversely, Abudu (2019) investigated male involvement in family planning within West Mamprusi District, Northern Ghana, employing a cross-sectional quantitative design with 140 male respondents selected through simple random sampling. Data analysis using STATA version 12.1 revealed overall male knowledge of family planning at 58.5%, representing moderate rather than high awareness levels. The study further documented that 38.6% of men had accessed family planning services with their partners, whilst 35% reported experiencing stigmatisation when involved in family planning activities. Additionally, the research identified substantial knowledge gaps regarding specific methods, particularly vasectomy, towards which 37.5% expressed negative perceptions and attitudes. Barriers to knowledge acquisition included time constraints (32.1%), stigmatisation and gossip (19.8%), shyness (16.1%), religious prohibitions (13.6%) and financial limitations. Importantly, 82.1% cited contraceptive side effects as major barriers, with specific concerns including abdominal pains and heavy menstrual flow (33.3%), delayed pregnancy or menstruation (22.9%), weight gain and obesity (13.3%), and dizziness and headaches (12.4%). Despite these comprehensive findings, the study's limitation to a single rural district restricts generalisability to urban or peri-urban contexts where information access patterns may differ substantially.

In contrast, Appiah et al. (2019) conducted research within Suame Magazine light industrial area in Ashanti Region, Ghana, sampling 384 men aged 18-45 years through cluster sampling methodology. Utilising descriptive cross-sectional survey design with SPSS version 16 for

analysis, the investigation demonstrated that 90% of participants exhibited very high knowledge about family planning concepts, representing substantially higher awareness than documented in Northern and Volta regional studies. The study revealed moderate involvement levels at 56%, encompassing both active and passive participation, though only 38.9% were currently adopting modern contraceptives. Significantly, merely 14% expressed willingness to assume sole responsibility for family planning, highlighting attitudinal barriers despite high knowledge levels. The research further identified that family planning services inadequately met men's needs, with service centres remaining unavailable within the study area. This spatial dimension of service provision emerged as a critical gap, yet the study's limitation to industrial workers potentially introduced occupational bias, as this population typically demonstrates higher education and information exposure compared to general male populations.

Furthermore, Chijioke (2020) explored knowledge, attitude and practice towards family planning amongst men in Abuja, Nigeria's Federal Capital Territory, though specific methodological details regarding sample size and analytical approaches were limited in the available documentation. Notwithstanding these methodological ambiguities, the study contributed to understanding male family planning knowledge within urban West African contexts, complementing predominantly rural investigations. The research highlighted urban-rural knowledge disparities, with city-dwelling men typically demonstrating superior awareness attributable to enhanced media exposure, educational attainment and healthcare accessibility. However, the study's failure to provide detailed methodological information, including sampling procedures, data collection instruments and analytical strategies, substantially undermines confidence in reported findings and prevents robust comparison with methodologically transparent investigations. Additionally, no studies examined knowledge retention over time or

evaluated knowledge acquisition interventions' effectiveness amongst males, representing critical gaps requiring further investigation.

2.2.2 Attitude Towards Family Planning Among Males

Lumor et al. (2023) investigated knowledge, perceptions and factors influencing contraceptive use amongst 350 married women aged 20-58 years residing at Uaddara Barracks, Kumasi, Ghana, employing cross-sectional design with structured questionnaires and R version 4.2.1 for analysis. Although focusing primarily on women, the study provided critical insights into male attitudes through spousal reports, revealing that 69.4% of participants held positive perceptions towards contraceptive use, whilst 80.3% received husbands' support for contraception. Significantly, husbands' supportive attitudes resulted in five times higher contraceptive usage amongst women (aOR = 5.35; $p < 0.001$), demonstrating the profound influence of male attitudinal dispositions on household reproductive behaviours. The research further documented that 80.6% of women reported autonomous decision-making regarding contraceptive use, yet this autonomy operated within contexts of spousal approval, suggesting that positive male attitudes enabled rather than constrained women's reproductive agency. However, the study revealed that women married to military personnel were 45% less likely to use contraceptives compared to civilian wives (aOR = 0.45; $p = 0.007$), indicating occupational influences on male attitudes potentially linked to masculinity norms within military culture. Despite these valuable findings, the study's reliance on women's reports rather than direct male attitude assessment introduces potential reporting bias and fails to capture nuanced attitudinal dimensions that men might express differently.

Similarly, Tekakwo et al. (2023) conducted qualitative research in Mbale, Eastern Uganda, between November and December 2022, employing three focus group discussions with male

partners (four participants each) and eight key informant interviews with midwives to explore enablers and barriers of male involvement in modern family planning. The thematic content analysis revealed that positive attitudes towards family planning, shaped by subjective norms and recognition of expected benefits including reduced gender-based violence and sexually transmitted infections, constituted primary enablers of male involvement. Conversely, the study documented substantial attitudinal barriers including social stigma surrounding male family planning participation, religious prohibitions against contraception, and perceptions that family planning constituted exclusively female responsibility. Furthermore, men expressed fears regarding contraceptive side effects and harboured misconceptions about long-term health consequences, reflecting negative attitudinal orientations rooted in inadequate information and cultural beliefs. The research additionally identified that uncondusive hospital environments characterised by perceived mistreatment and lack of consideration for male partner needs in family planning clinics reinforced negative attitudes towards service engagement. Nevertheless, this qualitative investigation's small sample size and geographic specificity limit generalisability, whilst the absence of quantitative attitude measurement prevents determination of attitudinal prevalence or strength across broader male populations.

Conversely, Abudu (2019) documented in West Mamprusi District, Ghana, that 37.5% of male respondents exhibited negative perceptions and attitudes specifically towards vasectomy, representing the most permanent male contraceptive method. This finding highlighted method-specific attitudinal variations, wherein men demonstrated differential acceptance across contraceptive types, with permanent methods eliciting substantially greater resistance than reversible alternatives. The study further revealed that 35% of men reported experiencing stigmatisation when involved in family planning with partners, indicating prevailing social

norms that construct male contraceptive participation as culturally inappropriate or diminishing masculinity. These stigmatising experiences, operating through gossip (19.8%) and social sanctioning, cultivated negative attitudes by associating family planning involvement with social costs exceeding perceived benefits. Additionally, religious prohibitions influenced 13.6% of respondents' negative attitudes, demonstrating faith-based attitudinal determinants operating independently of knowledge levels. However, the study's cross-sectional design prevented examination of attitude formation processes or attitudinal change over time, whilst failing to distinguish between deeply held convictions versus superficial attitudinal expressions influenced by social desirability bias.

In related research, Apanga and Adam (2015) investigated factors influencing family planning service uptake in Talensi District, Ghana, using systematic random sampling to recruit 280 women aged 15-49 years for a descriptive cross-sectional study analysed with SPSS version 21.0. Although women-focused, the study provided crucial evidence regarding male attitudes' impact, documenting that 90% of non-users cited husband opposition as the primary barrier to accessing family planning services. This finding underscored how negative male attitudes operated as structural constraints preventing women's contraceptive autonomy, even amongst women possessing adequate knowledge and positive personal attitudes towards family planning. The research additionally identified that 83% of non-users referenced misconceptions about family planning, many originating from or reinforced by male partners' attitudinal orientations shaped by incomplete or inaccurate information. These misconceptions encompassed beliefs regarding contraceptive-induced infertility, immorality of pregnancy prevention, and threats to male authority within households. Nevertheless, the study's limitation to female respondents

prevented direct assessment of male attitudinal intensity, sources of negative attitudes, or potential interventions addressing male misconceptions and attitudinal barriers.

Furthermore, Hylkema and Ilozumba (2023) explored male engagement in family planning through faith leaders' roles in urban Nigeria and Ghana, conducting 11 in-depth interviews with religious leaders. The exploratory findings indicated that faith leaders possessed adequate knowledge and surprisingly positive perspectives on male engagement and family planning, contradicting assumptions that religious institutions uniformly promote negative attitudes towards contraception. Faith leaders articulated recognition of family planning's health and economic benefits, expressing willingness to counsel congregants on responsible reproductive planning within religious frameworks. This finding suggested potential leverage points for attitude change interventions operating through trusted religious authorities who maintain influence over male congregants' belief systems and attitudinal formations. However, the study's small sample size, lack of congregant attitude assessment, and failure to examine denominational variations in faith leader perspectives substantially limit conclusions regarding religion's net influence on male family planning attitudes across diverse theological traditions and geographical contexts. Additionally, no studies examined attitude stability, measured implicit versus explicit attitudes, or evaluated attitude change interventions' effectiveness amongst males, representing critical research gaps requiring methodologically rigorous investigation.

2.2.3 Family Planning Practices Among Males

Mulatu et al. (2022) examined male involvement in family planning amongst 555 currently married men in rural Eastern Ethiopia using community-based cross-sectional survey design with simple random sampling and SPSS version 21 for logistic regression analysis. The study documented that 59.3% (95% CI: 47.1, 68.2) of participants demonstrated involvement in family

planning use, representing moderate practice levels. Significantly, spousal prior family planning use emerged as a strong predictor, with men whose wives had previously used contraception showing 2.37 times higher odds of current involvement (AOR: 2.37; 95% CI: 1.59, 3.52). Similarly, prior spousal discussion on sexual and reproductive health issues doubled male involvement likelihood (AOR: 2.05; 95% CI: 1.40, 3.02), whilst husbands' approval of family planning increased involvement odds 2.45-fold (AOR: 2.45; 95% CI: 1.34, 4.96). These findings demonstrated that communication patterns and attitudinal dispositions substantially influenced male contraceptive practices beyond knowledge factors alone. The research further revealed that male involvement primarily manifested through support for women's method use rather than direct adoption of male-specific contraceptives, reflecting gendered practice patterns wherein men's family planning participation occurs indirectly. However, the study's cross-sectional design prevented determination of whether spousal communication preceded or resulted from family planning involvement, whilst the 96.2% response rate, though excellent, introduced potential self-selection bias favouring men already comfortable discussing reproductive health topics.

Similarly, Appiah et al. (2019) documented amongst 384 Ghanaian men that whilst 90% possessed high family planning knowledge and 56% reported moderate involvement levels, only 38.9% were currently adopting or using modern contraceptives, highlighting substantial knowledge-practice gaps. The study revealed that merely 14% of participants expressed willingness to assume sole responsibility for family planning, indicating that male contraceptive practices predominantly involved supporting partners rather than direct method adoption. This finding aligned with global patterns documented by Ross and Hardee (2017), demonstrating that male contraceptive methods account for approximately 15% of overall contraceptive prevalence worldwide, with condoms constituting primary male contributions whilst vasectomy uptake

remains below 5% globally. Furthermore, Appiah et al. (2019) identified service availability deficits, with family planning centres remaining unavailable within the industrial study area, thereby constraining practice opportunities despite high knowledge and moderate involvement intentions. The research additionally documented that men's family planning needs remained inadequately addressed by existing service configurations designed primarily for female clients, perpetuating low male method uptake. Nevertheless, the study's geographic limitation to an industrial area and its cross-sectional design prevented examination of whether service expansion would translate knowledge and positive attitudes into sustained contraceptive practices amongst males.

Conversely, Abudu (2019) reported considerably lower male family planning practices in West Mamprusi District, Northern Ghana, where only 38.6% of 140 male respondents had accessed family planning services with their partners, substantially below the 59.3% documented in Ethiopia by Mulatu et al. (2022). This regional variation suggested that contextual factors including service infrastructure, cultural norms and community attitudes significantly modulated the translation of individual-level knowledge and attitudes into observable contraceptive practices. The study further documented that 35% of men experienced stigmatisation when involved in family planning with partners, representing a formidable barrier constraining practice even amongst men possessing positive personal attitudes towards contraception. Additionally, whilst overall male knowledge stood at 58.5%, major barriers affecting involvement included contraceptive side effects (82.1%), with specific concerns encompassing abdominal pains and heavy menstrual flow (33.3%), delayed pregnancy or menstruation (22.9%), weight gain and obesity (13.3%), and dizziness and headaches (12.4%). These side effect concerns, whether based on accurate information or misconceptions, directly constrained male willingness to

support or encourage partners' contraceptive use. However, the study failed to distinguish between men who never initiated family planning involvement versus those who discontinued due to negative experiences, preventing understanding of practice initiation versus continuation dynamics.

In related research, Donyi et al. (2020) investigated male involvement in Krachi-Nchumuru District, Volta Region, Ghana, recruiting 164 men aged 20-59 years through random selection for cross-sectional descriptive study. Despite 68% possessing family planning knowledge and 94% of knowledgeable participants having discussed contraception with partners, approximately 49% reported never using any family planning method. This substantial non-practice rate amongst knowledgeable men underscored that awareness and communication alone proved insufficient to generate contraceptive adoption without addressing deeper barriers. The study identified that amongst non-users, 50% attributed non-utilisation to religious beliefs whilst the remaining 50% cited cultural taboos, cost and distance to health facilities as primary obstacles. These findings demonstrated that family planning practices operated within complex webs of religious injunctions, cultural expectations and structural constraints that superseded individual knowledge or attitudinal dispositions. Furthermore, the research highlighted that male family planning practices in rural Ghanaian contexts remain profoundly shaped by community-level norms and institutional factors beyond individual characteristics. Nevertheless, the study's failure to quantify current versus ever-use rates, distinguish between method types, or assess practice consistency prevented comprehensive understanding of male contraceptive behaviour patterns.

Additionally, Grindlay et al. (2018) conducted cross-sectional survey research from September to December 2013 amongst 250 women and 100 men aged 18-24 years in Accra, Ghana, using descriptive statistics, chi-square tests and multivariable logistic regression for analysis. The study

documented that overall, 44% of participants reported current modern contraceptive use, representing relatively low practice levels amongst sexually active young adults averaging three lifetime sexual partners with 91% having one current partner. Multivariate modelling revealed that modern contraceptive use associated with higher education compared to primary schooling (AORs 2.1-4.3), ever talking with someone about contraception (AOR 4.7), feeling unsupported by healthcare providers (AOR 2.2), and paradoxically, not feeling at risk of unintended pregnancy (AOR 2.7). These complex associations suggested that contraceptive practices amongst young Ghanaians reflected multifaceted influences wherein perceived pregnancy risk, counter-intuitively, associated with lower rather than higher contraceptive use, potentially indicating fatalistic attitudes or risk compensation behaviours. The study further documented that nearly all respondents (91%) considered at least one modern method unsafe, substantially constraining practice through safety concerns regardless of actual contraceptive risk profiles. However, the research's focus on young adults aged 18-24 years prevented generalisation to older male populations with different reproductive histories, whilst the urban Accra setting limited applicability to rural contexts where service access and cultural norms differ substantially.

2.2.4 Sociodemographic Factors Influence Knowledge, Attitude and Practices of Family Planning Among Males

Butame (2019) analysed 2014 Ghana Demographic and Health Survey data from 3,373 sexually active men aged 15-59 years using descriptive statistics, chi-square tests and multivariable logistic regression to estimate modern contraceptive use prevalence and associated sociodemographic factors. The study documented that 26.20% of sexually active Ghanaian men used modern contraceptives, with educational attainment emerging as a robust predictor whereby

men with at least primary education demonstrated 1.80 times higher contraceptive use compared to those without formal schooling (AOR = 1.80; 95% CI = 1.23-2.63). Furthermore, men who had discussed family planning with healthcare workers showed significantly elevated contraceptive use relative to those lacking such professional interactions (AOR = 1.54; 95% CI = 1.14-2.08). The research additionally revealed that men undecided about having additional children exhibited 1.85 times higher odds of modern contraception use compared to those desiring more children (AOR = 1.85; 95% CI = 1.06-3.22), whilst men with multiple sexual partners demonstrated 1.42 times greater contraceptive use than those with single partners (AOR = 1.42; 95% CI = 1.09-1.85). These findings demonstrated that education, healthcare engagement, fertility preferences and sexual behaviour patterns collectively shaped male contraceptive practices through multiple intersecting pathways. However, the study's reliance on cross-sectional survey data prevented causal inference, whilst the broad age range spanning adolescents to late reproductive years potentially masked age-specific sociodemographic influences on family planning behaviours.

Similarly, Longla et al. (2023) conducted secondary analysis of baseline data from Ghana Community-Based Action Teams Study involving 1,742 partnered males aged 18-60 years across four Central Region districts, employing chi-square tests, t-tests and logistic regression analyses at 0.05 significance level. The investigation documented 24.4% contraceptive prevalence (95% CI = 20.8-28.5) and identified that post-primary education associated with 1.96 times higher odds of contraception practice compared to primary-level schooling (AOR = 1.96; 95% CI = 1.27-3.04). Interestingly, the study revealed that intimate partner violence perpetration correlated with significantly elevated contraceptive use (AOR = 1.83; 95% CI = 1.49-2.26), suggesting complex relationships wherein controlling behaviours potentially manifested through

reproductive coercion or enforced contraceptive use independent of women's preferences. Additionally, men with multiple main sexual partners demonstrated 1.78 times higher contraceptive practice odds (AOR = 1.78; 95% CI = 1.15-2.75), whilst wanting the first child (AOR = 0.71; 95% CI = 0.54-0.94) and male controlling behaviour (AOR = 0.70; 95% CI = 0.49-0.99) statistically significantly associated with reduced contraceptive use likelihood. These paradoxical findings regarding controlling behaviour's dual associations with both increased and decreased contraceptive use highlighted the need for nuanced understanding of how male characteristics influence family planning through potentially harmful pathways. Nevertheless, the study's cross-sectional design prevented temporal sequencing determination, whilst failure to disaggregate contraceptive types obscured whether sociodemographic factors differentially influenced male versus female method adoption.

Conversely, Abudu (2019) documented in West Mamprusi District that age category (OR=2.55; 95% CI 0.97-6.65; $p=0.05$), educational level (OR=0.19; 95% CI 0.39-0.94; $p=0.04$) and occupation (OR=0.37; 95% CI 0.15-0.84; $p=0.02$) constituted significant sociodemographic determinants of male family planning involvement amongst 140 respondents analysed using STATA version 12.1. The average age of interviewed males was 28.52 years (SD ± 7.30), with over three-quarters (87.1%) being married men, 83.8% having at least four children, and 72.3% reporting intentions for additional children. These demographic characteristics contextualised the finding that major decision-making regarding childbearing was determined by husbands in 41.3% of households, demonstrating how sociodemographic positioning translated into reproductive power dynamics. The study further revealed that educational level's protective effect against non-involvement suggested that formal schooling exposure enhanced family planning knowledge acquisition, reduced misconception susceptibility, and fostered more

egalitarian gender attitudes conducive to contraceptive adoption. Similarly, occupational status influenced involvement through economic capacity to afford contraceptive services and work environments providing diverse information exposure beyond community-based sources. However, the relatively small sample size of 140 participants limited statistical power for detecting modest sociodemographic associations, whilst the study's geographic restriction to a single rural district prevented examination of whether identified determinants operated similarly across urban and peri-urban contexts with different economic structures and educational infrastructures.

In related research, Apanga and Adam (2015) employed systematic random sampling to recruit 280 women aged 15-49 years in Talensi District, Ghana, for descriptive cross-sectional study analysed with SPSS version 21.0, revealing that parity and educational level positively associated with family planning service usage ($p < 0.05$). Although examining women rather than men directly, the study provided insights into how male sociodemographic characteristics indirectly influenced household contraceptive behaviours through decision-making authority and resource control. The research documented that 90% of non-users cited husband opposition as the primary barrier, whilst 83% referenced misconceptions, suggesting that male educational attainment and knowledge levels substantially determined household contraceptive access regardless of women's own characteristics. Furthermore, the study identified that major motivating factors for service usage included child spacing desires (94%) and pregnancy plus sexually transmitted infection prevention (84%), indicating that fertility preferences shaped by socioeconomic circumstances influenced contraceptive demand. Nevertheless, the study's women-only sample prevented direct assessment of male sociodemographic characteristics'

independent versus interactive effects with female characteristics in determining household family planning behaviours.

Additionally, Grindlay et al. (2018) documented amongst young Accra residents that modern contraceptive use associated with higher education levels compared to primary schooling (AORs 2.1-4.3), whilst controlling for other sociodemographic variables including age, employment status and relationship characteristics. The study revealed dose-response relationships wherein each educational level increment corresponded with progressively higher contraceptive use odds, suggesting that educational attainment operated through cumulative knowledge acquisition, critical thinking development and exposure to health-promoting norms rather than threshold effects. Furthermore, the research identified that feeling unsupported by healthcare providers paradoxically associated with increased contraceptive use (AOR 2.2), potentially reflecting that motivated contraceptive user persisted despite poor provider attitudes whilst less committed individuals discontinued attempts when encountering unsupportive services. However, the study's geographic limitation to urban Accra and age restriction to 18-24 years prevented generalisation to older males in rural settings where sociodemographic determinants' relative importance might differ substantially due to varying educational infrastructures, healthcare access patterns and cultural norms governing reproductive decision-making authority.

CHAPTER THREE

METHODS AND MATERIALS

3.0 Introduction

This section provides the approaches that were utilized to carry out this study among men in Ketu South Municipality in the Volta Region of Ghana. This section includes the study design, study site description, study population, sampling technique and sample size determination, data collection instrument and procedure, data analysis and ethical considerations.

3.1 Study design

The study used a quantitative research design. Specifically, a community-based cross-sectional approach. A cross-sectional study design involves collecting data at a single point in time. This made it suitable for assessing the practices, level of knowledge and attitude of family planning (FP). This study design was selected because it is less expensive and the time spent is minimal.

3.2 Study site

The study was conducted in the Ketu South Municipality, located in the southeastern part of the Volta Region of Ghana. The Municipality shares borders with Ketu North Municipality to the north, the Gulf of Guinea to the south, the Republic of Togo to the east and Keta Municipality to the west. For this study, respondents were recruited from six selected communities within the Municipality, namely Aflao, Avegato, Denu, Klikor, Agbozume and Adona. These communities were selected to provide representation from different parts of the Municipality.

3.3 Study population

The study population for this study was all males residing in the Ketu South Municipality.

3.4 Eligibility criteria

3.4.1 Inclusion criteria

This study included:

1. Males aged 18 to 65 years residing in Ketu South Municipality at the time of data collection. This age category ensured that all participants were legally able to provide informed consent without parental or guardian approval. In addition, this age category was set at 65 years to capture the extended reproductive potential of men and their continued involvement in sexual and reproductive health decision-making in the Ketu South Municipality.
2. Males who have lived in the municipality for at least six months prior to the study.
3. Males who consent to participate in the study willingly after being informed of the study's purpose and procedures.

3.4.2 Exclusion criteria

This study excluded:

1. Males with cognitive impairments or serious health conditions that make them unable to provide reliable responses.
2. Male health professionals or family planning providers, as their knowledge may not represent that of the general male population and could bias the findings.

3.5 Sampling Strategies

3.5.1 Sample size determination

The minimum sample size for this study was calculated using the single proportion population formula by Cochran, (1977) which is as follows

$$n = \frac{Z^2 \times P (1 - P)}{d^2}$$

Where; n= Sample size, Z = Z-score (1.96 at 95 % confidence interval) p= (proportion) d= (margin of error).

The sample size was estimated based on the level of knowledge of family planning which was 68% among men in the Krachi-Nchumuru District in the Oti Region of Ghana (Donyi et al., 2020). A confidence interval of 95%, a Z-score of 1.96, 5% margin of error and 5 % nonresponse rate will be used.

$$n = \frac{Z^2 \times P (1 - P)}{d^2}$$

$$n = \frac{1.96^2 \times 0.68 (1 - 0.68)}{0.05^2}$$

$$n = 334.37$$

Adjusting for an anticipated 10% non- response rate + 334.37

$$n = 368$$

Therefore, the sample size of 368 is required for the study.

3.5.2 Sampling Technique

This study employed a probability multi-stage sampling approach. Firstly, a stratified sampling technique was employed. This approach was chosen to ensure fair representation across the six sub districts of the Ketu South Municipality, while also maintaining feasibility in terms of logistics and participant recruitment. To ensure geographical representation across the municipality, all six sub districts of Ketu South, namely: Aflao East, Aflao West, Aflao Wego, Some Fugo, Some Wego and Klikor served as strata for sampling. The population size for each

subdistrict is as follows: Aflao East = 33343, Aflao West = 60883, Aflao Wego = 42812, Some Fugo = 50689, Some Wego = 47672 and Klikor = 37304 (Ketu South Municipal Assembly, 2025). The total population size is 272, 703.

The sample size for the study was 368. To ensure that each sub-district is represented in proportion to its population size, proportional allocation was employed. The sample size allocated to each sub-district was calculated using the formula:

$$n_h = \frac{N_h}{N} \times n$$

Where:

n_h = sample size for sub-district h

N_h = population size of sub-district h

N = total population size

n = total sample size

Sub-district	Nh	Calculation	Nh
Aflao East	33,343	$(33,343 / 272,703) \times 368$	45
Aflao West	60,883	$(60,883 / 272,703) \times 368$	82
Aflao Wego	42,812	$(42,812 / 272,703) \times 368$	58
Some Fugo	50,689	$(50,689 / 272,703) \times 368$	68
Some Wego	47,672	$(47,672 / 272,703) \times 368$	64
Klikor	37,304	$(37,304 / 272,703) \times 368$	51
Total			368

Within each sub-district, one community was selected using simple random sampling through a random number table generated in Microsoft Excel. A complete list of communities in each sub-district was obtained from the Municipal Assembly. Each community was assigned a unique identification number. The community unique identification numbers were entered into Microsoft Excel, where random numbers were generated. Communities were sorted and one community was selected based on the generated random numbers. This approach was adopted to eliminate selection bias and to ensure that all communities within each sub-district had an equal probability of being selected.

In the final stage of the multistage sampling process, simple random sampling was employed within each selected community to recruit eligible male participants. Trained research assistants moved from household to household to identify eligible men based on the inclusion criteria. Each research assistant was given the number of participants they are supposed to interview for the data collection period. In households where more than one eligible participant was present, one respondent was selected using simple random sampling (balloting). The simple random sampling technique ensured that each eligible individual had an equal and independent chance of being selected. This combined sampling strategy ensured representation from the sub districts in order to generalize findings on the Municipal level.

3.6 Data collection instrument

The data collection instrument for this study was a structured questionnaire to gather quantitative data on knowledge, attitudes and practices of FP among males aged 18 to 65 years in Ketu South Municipality. This instrument was appropriate for the community-based cross-sectional study design because enabled the collection of standardized responses aligned with the study's objectives.

The questionnaire was adapted from a similar study (Sultan et al., 2018) and further modified to include additional questions relevant to the Ghanaian context and study objectives. The adaptation process involved modifying certain terms and examples to reflect the local Ghanaian context, including references to family planning service providers, contraceptive brand names (e.g., Lydia or Postinor-2 or Secure), and service access points in Ketu South. Redundant or culturally irrelevant questions were removed. The adapted tool was reviewed by the research supervisor and pretested to ensure clarity and contextual appropriateness.

The questionnaire predominantly consisted of closed-ended questions to ensure ease of administration, consistency in responses and suitability for statistical analysis. Only age and number of children were collected as open-ended numeric responses. The instrument was structured into four main sections:

- **Section A: Socio-demographic Characteristics** – This section collected participants' background information, including age, marital status, educational level, occupation, religion and number of children.
- **Section B: Knowledge of Family Planning** – In line with Objective 1, this section explored participants' understanding of different contraceptive methods, the purpose of family planning and protection against STIs.
- **Section C: Attitudes towards Family Planning** – This section addressed Objective 2 by examining beliefs and perceptions about family planning, male involvement, religious or cultural objections and future intentions to use family planning services.
- **Section D: Family Planning Practices** – This section assessed the actions and behaviors of male respondents regarding family planning. It includes whether they have ever used a

family planning method, the types of methods used (past and present), frequency of use, reasons for using the method, discussion with their partner, and the source from which they obtained their most recent method.

In this study, attitude towards family planning were assessed among all respondents, including those who reported that they had never previously heard of family planning. This approach was adopted to capture baseline beliefs and respondents' personal feelings related to fertility regulation, which may exist even in the absence of prior formal knowledge or exposure to family planning information. Prior to administering the attitude questions, a brief, neutral, and standardized explanation of family planning was provided by the interviewer to respondents who indicated prior awareness. Family planning was defined as methods used by individuals or couples to prevent or delay pregnancy and to plan the number and spacing of children. This ensured a minimum shared conceptual understanding before responses to attitude-related items were elicited. The inclusion of respondents to answer all questions on attitude and practices irrespective of whether they have ever heard of FP or not was considered important. This allowed respondents who may not be familiar with the term "family planning" to still share their perceptions and experiences.

3.7 Data collection procedures

Data collection was carried out through face-to-face interviews with eligible male participants within selected communities across the six sub-districts of the Ketu South Municipality during the study period. Prior to data collection, the PI met with community leaders and opinion influencers to explain the purpose of the study and seek their support for data collection within their communities. Data collection was carried out using the structured questionnaire hosted on

Kobo Collect Toolkit, administered in either English or Ewe, based on participants' preferences. The interviews took place in private spaces to ensure confidentiality.

The data collection exercise was conducted over a one-month period (14th January to 14th February 2026), between 8:00 AM and 4:00 PM on weekdays, coinciding with peak community activity hours. The PI and trained research assistants conducted the interviews. The research assistants were health workers. Potential challenges, such as participant hesitancy were addressed by clearly explaining the study purpose, providing assurances of confidentiality and arranging interviews at participants' convenience.

3.8 Pretesting

To enhance the validity of the tool, questionnaire items were adapted, aligned with relevant variables identified through the literature review and conceptual framework and pretested. A pre-test was conducted with 50 males in the Keta Municipality. The pre-test helped assess the clarity of question, relevance, flow and average response time. Based on feedback from the pre-test, ambiguous questions were revised and redundant items were removed to enhance clarity and reliability before the commencement of the main data collection.

3.9 Data handling and analysis

Upon completion of data collection, responses were exported from Kobo Collect into Microsoft Excel for initial cleaning and preparation. Cleaned data was imported into STATA version 17 for analysis. Descriptive statistics were used to summarize the data. Continuous variables (such as age and number of children) were analyzed using means and standard deviations, while categorical variables (such as attitude, knowledge and practices) were presented as frequencies and percentages.

Objective 1 (Level of knowledge): All questions under the knowledge section (see Appendix II) were analyzed using descriptive statistics (frequencies and percentage). In order to assess the level of knowledge, all responses under the knowledge section (except question 08) were coded and summed to generate a composite knowledge score for each participant. The distribution of the total knowledge scores was then examined and the median score was automatically computed using the “summarize” command and the median score was 14. This median value was used as a cut-off point to categorize respondents into two groups: those with scores below the median were classified as having low knowledge, while those with scores at or above the median were classified as having high knowledge. The level of knowledge was illustrated with a pie chart.

Objective 2 (Attitude): All questions under attitude were Likert-scale item. Each Likert-scale item was coded and summed to generate a composite attitude score for each participant. The distribution of the total attitude scores was examined using descriptive statistics and the median score was automatically generated using the summarize command and the attitude score was 21. This median value was then used as the cut-off point to classify respondents into two categories: those scoring below the median were categorized as having a negative attitude toward family planning, while those scoring at or above the median were categorized as having a positive attitude. The results for overall attitude towards FP was represented with a pie chart as positive and negative.

Objective 3 (Practices): FP practices were summarized using frequency and percentages. To determine objective 4 thus to identify factors associated with knowledge, attitude and practices of family planning, each of the three KAP components were treated as dependent variables. Knowledge was categorized into high and low based on the median knowledge score, while attitude was categorized into positive and negative based on the median attitude score. For all

inferential analysis, practice was assessed based on whether respondents have ever used any family planning method and coded as a binary variable (Yes = 1, No = 0). Multivariate logistic regression analyses were performed for each outcome variable (knowledge, attitude and practice) separately to examine their associations with the independent variables.

In addition, binary logistic regression analysis was performed to assess the influence of knowledge on attitude, knowledge on practice and attitude on practice. Odds ratios (ORs) with 95% confidence intervals were reported and statistical significance was set at $p < 0.05$. All results were presented with tables and figures.

3.11 Ethical issues

Ethical approval for this study was solicited from the Ensign Global University Institutional Review Board. Permission was obtained from Ketu South Municipal Health Directorate prior to the commencement of data collection. Copies of clearance letters and permission documents were made available to any persons concerned.

The purpose and procedures of the study were thoroughly explained to all participants and an informed consent form were provided for them to sign as a confirmation of their voluntary consent. Participants were clearly informed that their involvement in the study is entirely voluntary, with no form of coercion or undue influence. They were made aware of their right to decline participation or to withdraw from the study at any point without any negative consequences.

There were no direct risks to participants arising from this study. However, participants' time was taken in order to gather data and some of the questions were sensitive. On the other hand, the findings gained is expected to contribute positively by improving the current health delivery

system and providing valuable insights for policymakers. Throughout the study, confidentiality and privacy were strictly maintained. Personal identifiers were not collected or recorded, thereby ensuring anonymity. All information provided by participants were treated with the utmost confidentiality and stored securely. The data collected for this study will be securely stored for a period of five (5) years after completion of the study. After this period, all electronic data will be permanently deleted, and any hard copies will be shredded to ensure confidentiality.

Participants did not receive any form of monetary or material compensation for their participation, but their time and contribution were acknowledged verbally with sincere thanks. All collected data were stored securely on a laptop owned by the PI, with a duplicate copy saved on an external hard drive. Both storage devices were password-encrypted to ensure data protection. Access to the data was restricted solely to the PI and the research supervisor. There were no conflicts of interest associated with this study. The PI, with no financial support from any external organizations or bodies, solely provided funding for the research.

3.12 Limitations of the Study

Despite the strengths of this study, several limitations should be acknowledged:

1. The cross-sectional design prevents establishing causal relationships between sociodemographic factors and FP knowledge, attitude or practices.
2. Self-reported data may be influenced by social desirability bias especially on sensitive topics like FP use.
3. Although the study employed a multistage sampling technique, the findings are specific to the Ketu South Municipality and may not be fully generalizable to other regions with different sociocultural contexts.

CHAPTER FOUR

RESULTS

4.0 Introduction

This chapter presents the results obtained from the quantitative analysis conducted on the primary data gathered. The study aimed to assess the knowledge, attitude and practices of family planning among males in Ketu south municipality in the Volta region of Ghana. The results are presented utilising tables and figures as needed. The sample size for the current study was determined to be 368, based on the sampling formula introduced by Cochran (1977). A total of 368 respondents participated in this study. Response rate was 100%.

4.1 Sociodemographic characteristics of respondents

The mean age of respondents was 33.4 ± 10.1 years. The majority of respondents were aged 30–44 years (44.3%, $n = 163$), followed by those aged 18–29 years (41.8%, $n = 154$), while a smaller proportion were aged 45–65 years (13.9%, $n = 51$) (Table 4.1). In this study, the largest proportion of the respondents had attained JHS education ($n = 107$, 29.1%), followed By SHS education ($n = 94$, 25.5%). Smaller proportions had tertiary education ($n = 63$, 17.1%) or no formal education ($n = 50$, 13.6%). Regarding marital status, the largest proportion of respondents were married ($n = 153$, 41.6%) and only few were either divorced or widowed ($n = 15$, 4.1%).

Table 4.1 shows that about half of the respondents were self-employed ($n = 186$, 50.5%), while nearly one-third were employed ($n = 117$, 31.8%). Less than one-fifth were unemployed ($n = 65$, 17.6%). In terms of religion, majority of the respondents were Christians ($n = 225$, 61.1%). The mean number of children was 2.2 ± 2.8 children, while the mean desired number of children was 4.4 ± 5.5 children. About one-third of respondents had no children ($n = 113$, 30.7%) and 34% ($n=125$) reported that they had 1-2 children (Table 4.1).

Table 4.1: Sociodemographic characteristics of respondents

Variables	Frequency (n=368)	Percent (%)
Age	Mean=33.4 SD=10.1	
18-29	154	41.8
30-44	163	44.3
45-65	51	13.9
Educational status		
No formal education	50	13.6
Primary	54	14.7
JHS	107	29.1
SHS	94	25.5
Tertiary	63	17.1
Marital status		
Single	127	34.5
Cohabiting	73	19.8
Married	153	41.6
Divorced	10	2.7
Widowed	5	1.4
Employment status		
Self-employed	186	50.5
Employed	117	31.8
Unemployed	65	17.6
Religion		
Christianity	225	61.1
Traditionalist	86	23.4
Islam	30	8.2
Others	27	7.3
Parity	Mean=2.2 SD=2.8	
0	113	30.7
1-2	125	34.0
3-4	82	22.3
5+	48	13.0
Desired number of children	Mean=4.4 SD=5.5	

4.2 Knowledge towards family planning among males

The majority of respondents (n = 315, 85.6%) had heard of family planning (FP), while 14.4% (n = 53) had never heard of it. Among those aware, the most common sources of information were family or friends (n = 100, 31.7%) and health facilities (n = 92, 29.2%), with other sources such as radio, school and community outreach contributing less frequently (see Table 4.2). Among

respondents who had ever heard of family planning (n = 315), most of the respondents knew of at least one health facility offering FP services in their community (n = 273, 86.6%) and were aware of where to access these services if needed (n = 276, 87.6%). Regarding male-specific methods, 62.8% (n = 198) knew that some FP methods are available to men (see Table 4.2).

Condoms were the most commonly recognized method among respondents (n = 261, 82.9%), followed by oral contraceptive pills, injectable contraceptives, withdrawal and vasectomy, while awareness of other methods such as tubal ligation, spermicides and IUDs was low. Half of the respondents (n = 158, 50.2%) identified the main purpose of family planning as preventing pregnancy, with 43.2% (n = 136) noting its role in planning and controlling the number, timing and spacing of children (see Table 4.2). Most respondents were aware that condoms can also protect against sexually transmitted infections (n = 262, 83.2%). When asked specifically about methods intended for men, nearly all respondents recognized male condoms (n = 289, 91.8%), while knowledge of other male methods such as withdrawal and vasectomy was moderate. Overall, 62.2% of the respondents (n = 229) demonstrated a high level of knowledge of FP and 37.8% (n = 139) had low knowledge (see Figure 4.1).

Table 4.2: Knowledge towards family planning among males

Variables	Frequency (n=368)	Percent (%)
Ever heard of FP		
No	53	14.4
Yes	315	85.6
<i>How did you first hear about family planning? (n=315)</i>		
Family or friend	100	31.7
Health facility	92	29.2
Radio	44	14.0
School	28	8.8
Community outreach/education	19	6.0
Television	16	5.0
Social media	12	3.8
Others	4	1.1
<i>Do you know of any health facilities in your community that provides family planning services? (n=315)</i>		
Do not know	32	10.2
Know	273	86.6
Uncertain	10	3.2
<i>Do you know where to go if you or your partner needs family planning services? (n=315)</i>		
Do not know	31	9.8
Know	276	87.6
Uncertain	8	2.5
<i>Do you know that some family planning methods are available to men? (n=315)</i>		
Do not know	102	32.4
Know	198	62.8
Uncertain	15	4.8
Knowledge of FP methods among males (n=315)	Know (n)	Know (%)
1 st Condom	261	82.9
2 nd Pills	92	29.2
3 rd Injectable	89	28.3
4 th Withdrawal	87	27.6
5 th Vasectomy	75	23.8
6 th Tubal-ligation	22	7.0
7 th Spermicides	21	6.7
8 th Others	18	5.7
9 th IUD	15	4.8
Knowledge of main purpose of FP (n=315)		
To prevent pregnancy	158	50.2
To plan and control the number, timing and spacing of children	136	43.2
To prevent STI	11	3.5
To increase the number of sexual partners	2	0.6

Variables	Frequency (n=368)	Percent (%)
I do not know	8	2.5
<i>Which family planning method also protect against sexually transmitted infections (STIs)? (n=315)</i>		
Condoms	262	83.2
Withdrawal	2	0.6
Pills	1	0.3
Injectables	1	0.3
I don't know	49	15.6
FP methods Intended for use by men (n=315)	Know (n)	Know (%)
1 st Male condom	289	91.8
2 nd Withdrawal	83	26.4
3 rd Vasectomy	73	23.2
4 th Spermicides	17	5.4
5 th I don't know	17	5.4
6 th Oral contraceptive pills	3	1.0
7 th Injectable contraceptives	3	1.0
8 th Female condom	1	0.3

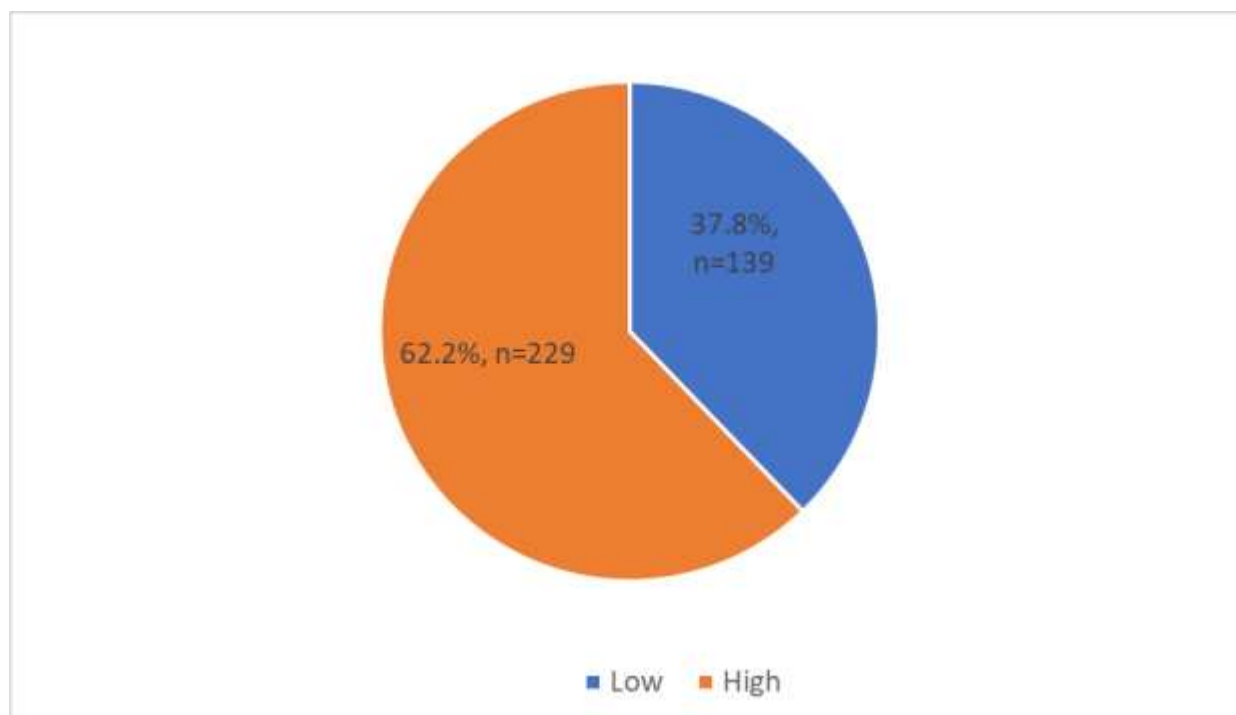


Figure 4.1: Level of knowledge of FP among males

Level of knowledge was assessed using a composite knowledge score generated from the knowledge-related questions. Each respondent's correct responses were coded and summed,

excluding question 08, which was not used in the knowledge score. The median knowledge score was 14, and this was used as the cut-off point for classification. Respondents who scored below 14 were classified as having low knowledge, while those who scored 14 or above were classified as having high knowledge. Based on this classification, 229 respondents (62.2%) had high knowledge of family planning, while 139 respondents (37.8%) had low knowledge.

4.3 Attitude of males towards family planning

Regarding the perception of FP as a good practice, the majority agreed, with 38.8% (n = 143) agreeing and 31.8% (n = 117) strongly agreeing, while 14.1% (n = 52) were neutral, 10.6% (n = 39) disagreed and 4.6% (n = 17) strongly disagreed (Table 4.3). On the question of whether men are also responsible for FP, nearly two-thirds of respondents agreed, with 44.8% (n = 165) agreeing and 20.9% (n = 77) strongly agreeing. However, 15% (n = 56) were neutral, 14.1% (n = 52) disagreed and 4.9% (n = 18) strongly disagreed (Table 4.3).

The perception that FP is only for married individuals was also common, with 47.6% (n = 175) agreeing and 24.7% (n = 91) strongly agreeing. Only 9% (n = 35) were neutral, 10.8% (n = 40) disagreed and 7.3% (n = 27) strongly disagreed (Table 4.3). Concerning the belief that FP affects sexual performance, 25.8% (n = 95) agreed, 8.4% (n = 31) strongly agreed and 17.9% (n = 66) were neutral. On the other hand, 35.6% (n = 131) disagreed and 12.2% (n = 45) strongly disagreed. Religious or moral concerns were less prevalent. Less than 40% (n = 142) of the respondents disagreed that FP is against God's will and 12.0% (n = 44) strongly disagreed. Meanwhile, 16.3% (n = 60) agreed, 7.6% (n = 28) strongly agreed and 25.5% (n = 94) were neutral (Table 4.3).

Interest in learning more about FP was high, with 46.2% (n = 170) agreeing and 29.1% (n = 107) strongly agreeing that they desired further information. About 12.5% (n = 46) were neutral, 8.7% (n = 32) disagreed and 3.5% (n = 13) strongly disagreed (Table 4.3). Regarding intention to use FP, 47.5% (n = 175) agreed and 20.3% (n = 75) strongly agreed. Only 11% (n = 43) were neutral, 13.6% (n = 50) disagreed and few 6.8% (n = 25) strongly disagreed. Overall, 54.9% (n = 202) demonstrated a positive attitude towards FP, whereas 45.1% (n = 166) had a negative attitude towards FP (Figure 4.2).

Table 4.3: Attitude of males towards family planning

Variables	Frequency (n=368)	Percent (%)
FP is a good practice		
Strongly agree	117	31.8
Agree	143	38.8
Neutral	52	14.1
Disagree	39	10.6
Strongly disagree	17	4.6
Men are also responsible for FP		
Strongly agree	77	20.9
Agree	165	44.8
Neutral	56	15.2
Disagree	52	14.1
Strongly disagree	18	4.9
FP is for married people only		
Strongly agree	91	24.7
Agree	175	47.6
Neutral	35	9.5
Disagree	40	10.8
Strongly disagree	27	7.3
FP affects sexual performance		
Strongly agree	31	8.4
Agree	95	25.8
Neutral	66	17.9
Disagree	131	35.6
Strongly disagree	45	12.2
FP is against God's will		
Strongly agree	28	7.6
Agree	60	16.3
Neutral	94	25.5

Variables	Frequency (n=368)	Percent (%)
Disagree	142	38.5
Strongly disagree	44	12.0
Desire to learn more about FP		
Strongly agree	107	29.1
Agree	170	46.2
Neutral	46	12.5
Disagree	32	8.7
Strongly disagree	13	3.5
Intention to use FP		
Strongly agree	75	20.3
Agree	175	47.5
Neutral	43	11.6
Disagree	50	13.6
Strongly disagree	25	6.8

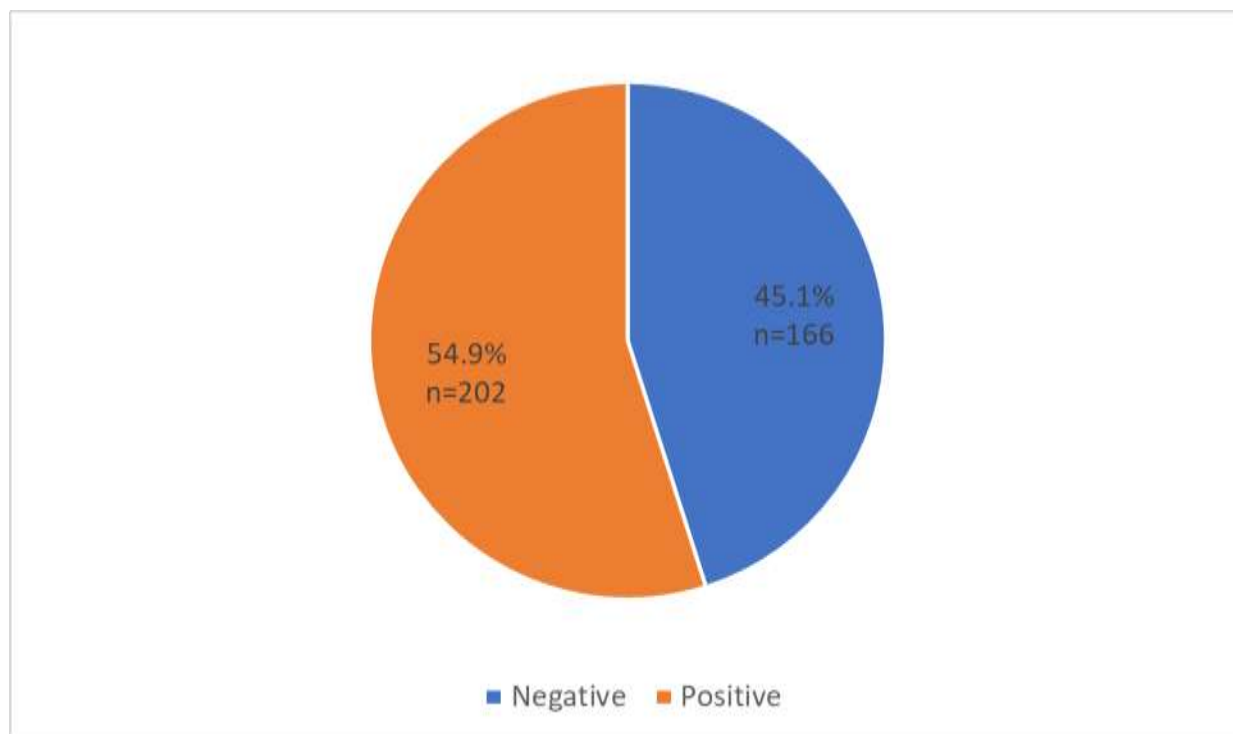


Figure 4.2: Attitude towards FP among males

4.4 Family planning practices among males

The study assessed respondents' FP practices, including discussions with partners, past and current use, reasons for use or non-use and sources of FP methods. Up to 53.8% (n = 198)

reported that they had never discussed FP with their partner (see Table 4.4). Most 62.0% (n = 228) reported that they have ever used FP, whereas 38.0% (n = 140) had never used FP (see Figure 4.3).

Among those who had never used FP, the main reasons included religious and cultural reasons 18.6% (n = 26) and fear of side effects 17.9% (n = 25). Fertility preferences accounted for 10.7% (n = 15), while knowledge or access barriers 5.0% (n = 7), spouse or partner opposition 3.6% (n = 5) and health reasons 3.6% (n = 5) were less frequently reported (see Table 4.4). Among respondents who had ever used FP, the primary motivation was spacing and delaying children, reported by 52.6% (n = 120). Preventing sexually transmitted infections (STIs) was reported by 21.9% (n = 50), financial constraints by 12.7% (n = 29), partner or wife request by 7.0% (n = 16) and reaching the desired number of children by 2.2% (n = 5). The FP methods ever used by respondents were dominated by male condoms, reported by 89.8% (n = 203), followed by withdrawal at 31.9% (n = 72) (see Table 4.4).

Among respondents who had ever used FP, just over half were currently using a FP method, with 50.9% (n = 116) indicating current use. Among those currently using FP, the male condom remained the most common method at 85.3% (n = 99), followed by withdrawal at 14.7% (n = 17). Frequency of FP usage among current users revealed that 56.9% (n = 66) used FP sometimes, 21.6% (n = 25) often, 11.2% (n = 13) always and 9.5% (n = 11) rarely. The main reasons for current FP use were child spacing, reported by 46.5% (n = 54), financial constraints 19.0% (n = 22), partner or wife request 9.5% (n = 11), reaching the desired number of children 8.6% (n = 10), and other reasons 16.4% (n = 19). Regarding sources of the most recent FP method, 37.9% (n = 44) obtained it from a government health facility.

Table 4.4: Family planning practices among males

Variables	Frequency (n=368)	Percent (%)
<i>Have you discussed Family planning with your wife/partner before?</i>		
No	198	53.8
Yes	170	46.2
Reasons for never using FP (n=140)		
Religious and cultural reasons	26	18.6
Fear of side effects	25	17.9
Fertility preferences	15	10.7
Knowledge/access barriers	7	5.0
Spouse/partner opposition	5	3.6
Health reasons	5	3.6
Others	57	40.7
Reasons for ever using FP (n=228)		
Spacing and delay of children	120	52.6
To prevent STIs	50	21.9
Financial constraints	29	12.7
Partner/wife request	16	7.0
Reached desired number of children	5	2.2
Others	8	3.5
FP method ever used (n=228)	Ever used (n)	Percent (%)
1 st Male condom	203	89.8
2 nd Withdrawal	72	31.9
<i>Are you currently using any family planning method? (n=228)</i>		
No	112	49.1
Yes	116	50.9
Type of FP you are currently using (n=116)		
Male condom	99	85.3
Withdrawal	17	14.7
Frequency of FP usage (n=116)		
Never	1	0.9
Rarely	11	9.5
Sometimes	66	56.9
Often	25	21.6
Always	13	11.2
Reasons for currently using FP (n=116)		
For child spacing	54	46.5
Financial constraints	22	19.0
Partner/wife request	11	9.5
Reached desired number of children	10	8.6
Others	19	16.4
<i>Where did you or your partner obtain your most recent family planning method? (n=116)</i>		

Variables	Frequency (n=368)	Percent (%)
Government health facility	44	37.9
Pharmacy/over the counter	29	25.0
Community health worker	22	19.0
Private hospital/clinic	5	4.3
Others	16	13.8

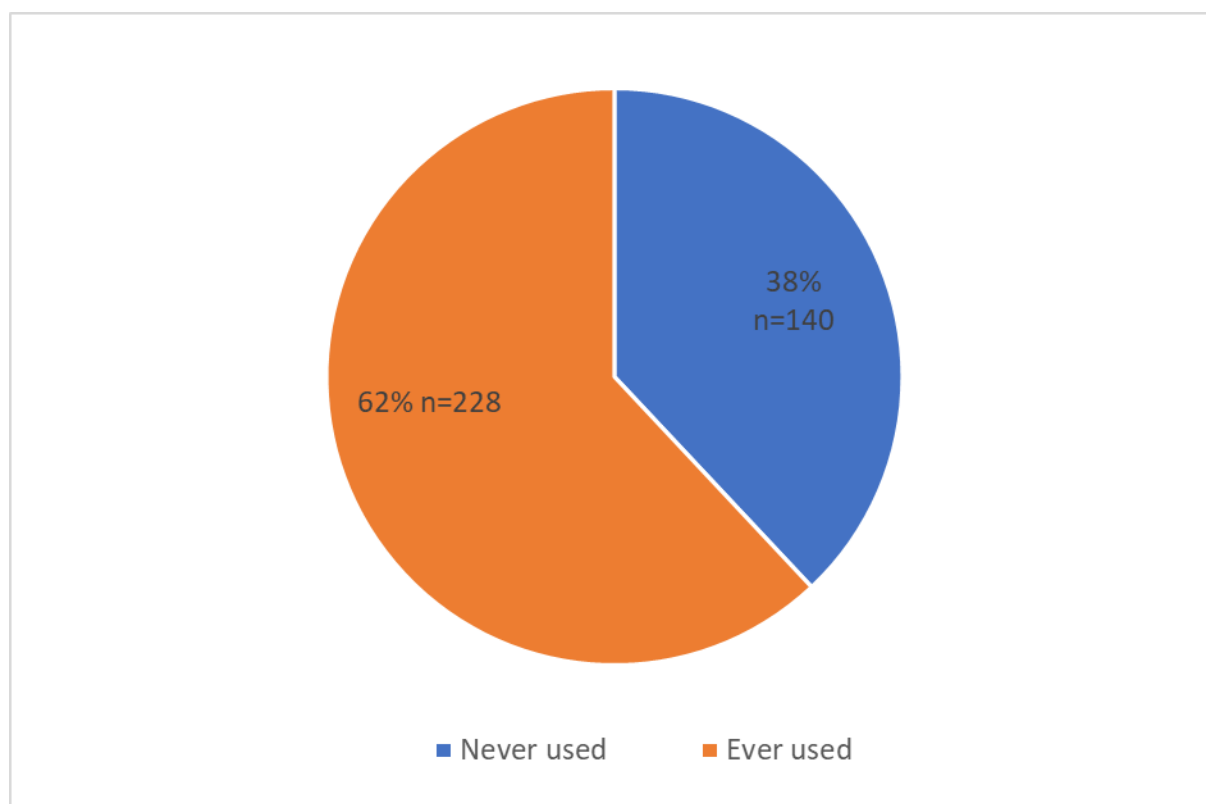


Figure 4.3: Usage of FP

4.5 Multivariate logistic regression of socio-demographic factors associated with knowledge

The study found that respondents aged 30–44 years [AOR = 0.93, (95% CI: 0.51–1.71), $p = 0.819$] had 10% decreased odds of having high knowledge of FP compared to those aged 18–29 years (Table 4.5). Respondents with tertiary education had 91% increased odds of having high knowledge of FP [AOR = 1.91, (95% CI: 0.70–5.25), $p = 0.209$] compared to those with no formal education. Divorced respondents had 4.8 times higher odds of having high knowledge of

FP [AOR = 4.80, (95% CI: 0.51–45.30), $p = 0.171$] compared to those who were single (Table 4.5).

Respondents who were employed [AOR = 1.74, (95% CI: 0.85–3.55), $p = 0.131$] had 74% increased odds of having high knowledge of FP compared to those who were unemployed. Compared to Christians, respondents who were Traditionalists had 26% decreased odds (AOR = 0.74, 95% CI: 0.41–1.33, $p = 0.314$) of having high knowledge of FP (Table 4.5). Respondents with 5 or more children had 56% increased odds of having high knowledge of FP compared to those with no children (Table 4.5). Overall, none of the socio-demographic factors were significantly associated with knowledge of FP among the respondents.

Table 4.5: Sociodemographic factors associated with high knowledge of FP

Variables	Adjusted Odds Ratio	95% CI	P-value
Age group			
18-29	Ref		
30-44	0.93	0.51 – 1.71	0.819
45-65	0.66	0.26 – 1.68	0.381
Educational status			
No formal education	Ref		
Primary	0.83	0.34 – 2.02	0.677
JHS	0.70	0.31 – 1.60	0.4
SHS	0.96	0.41 – 2.25	0.918
Tertiary	1.91	0.70 – 5.25	0.209
Marital status			
Single	Ref		
Cohabiting	0.67	0.34 – 1.32	0.245
Married	0.96	0.46 – 2.02	0.915
Divorced	4.8	0.51 – 45.30	0.171
Employment status			
Unemployed	Ref		
Employed	1.74	0.85 – 3.55	0.131
Self-employed	1.23	0.63 – 2.40	0.549
Religion			
Christianity	Ref		
Traditionalist	0.74	0.41 – 1.33	0.314

Variables	Adjusted Odds Ratio	95% CI	P-value
Islam	0.77	0.31 – 1.94	0.584
Others	1.7	0.65 – 4.42	0.281
Parity			
0	Ref		
1–2	1.25	0.62 – 2.53	0.529
3–4	1.5	0.59 – 3.77	0.393
5+	1.56	0.50 – 4.81	0.441

4.6 Multivariate logistic regression of socio-demographic factors associated with attitude

Table 4.6 below shows that age was not significantly associated with attitude towards FP. Respondents aged 30–44 years [AOR = 1.64, (95% CI: 0.91–2.99), $p = 0.102$] had 64% higher odds of having a positive attitude compared to those aged 18–29 years. Tertiary education was found to be significantly associated with attitude hence respondents with tertiary education had 68% lower odds of having a positive attitude towards FP compared to those with no formal education [AOR = 0.32, (95% CI: 0.12–0.83), $p = 0.020$].

Marital status was not significantly associated with attitude towards family planning. Respondents who were married [AOR = 1.78, (95% CI: 0.87–3.65), $p = 0.117$] had 78% higher odds of a positive attitude compared to single respondents (see Table 4.6). Employment status did not show a significant association with attitude. Respondents who were self-employed [AOR = 0.79, (95% CI: 0.41–1.53), $p = 0.479$] had 21% lower odds of a positive attitude towards FP compared to those who were unemployed (see Table 4.6).

Religion was also not significantly associated with attitude towards family planning. Compared to Christians, Traditionalists [AOR = 0.83, (95% CI: 0.46–1.49), $p = 0.528$] had 17% lower odds of a positive attitude. Having five or more children was found to be significantly associated with positive attitude towards FP. Respondents with five or more children had 77% lower odds of

having a positive attitude towards FP compared to those with no children [AOR = 0.23, (95% CI: 0.08–0.72), $p = 0.011$] (see Table 4.6).

Table 4.6: Sociodemographic factors associated with positive attitude towards family planning

Variables	Adjusted Odds Ratio	95% CI	P-value
Age group			
18-29	Ref		
30–44	1.64	0.91 – 2.99	0.102
45–65	1.73	0.70 – 4.26	0.237
Educational status			
No formal education	Ref		
Primary	0.61	0.25 – 1.48	0.275
JHS	0.77	0.34 – 1.74	0.533
SHS	0.51	0.22 – 1.20	0.122
Tertiary	0.32	0.12 – 0.83	0.020
Marital status			
Single	Ref		
Cohabiting	1.69	0.86 – 3.33	0.128
Married	1.78	0.87 – 3.65	0.117
Divorced	1.01	0.22 – 4.64	0.986
Employment status			
Unemployed	Ref		
Employed	1.09	0.54 – 2.20	0.800
Self-employed	0.79	0.41 – 1.53	0.479
Religion			
Chriatianity	Ref		
Traditionalist	0.83	0.46 – 1.49	0.528
Islam	0.73	0.29 – 1.82	0.503
Others	0.45	0.19 – 1.07	0.070
Parity			
0	Ref		
1–2	0.54	0.27 – 1.08	0.082
3–4	0.59	0.24 – 1.44	0.243
5+	0.23	0.08 – 0.72	0.011

4.7 Multivariate logistic regression of socio-demographic factors associated with FP practices

In this study, to measure FP practice for the purpose of inferential analysis, FP practices were defined as usage of FP method thus never used and ever used. The findings revealed that age was statistically significantly associated with ever use of FP. Respondents aged 30–44 years had 51% decreased of using FP compared to those aged 18–29 years [AOR = 0.49, (95% CI: 0.26–0.95), $p = 0.035$]. Similarly, decreased odd was observed among those aged 45–65 years [AOR = 0.25, (95% CI: 0.10–0.68), $p = 0.006$] (see Table 4.7).

Educational status was statistically associated with use of FP. Compared to respondents with no formal education, those with primary education [AOR = 2.59, (95% CI: 1.03–6.50), $p = 0.042$], JHS education [AOR = 4.16, (95% CI: 1.77–9.80), $p = 0.001$], SHS education [AOR = 8.60, (95% CI: 3.40–21.74), $p = 0.001$] and tertiary education [AOR = 7.47, (95% CI: 2.64–21.10), $p = 0.001$] had increased odds of using FP. Respondents who were married [AOR = 0.79, (95% CI: 0.35–1.77), $p = 0.566$] 21% decreased odds of using FP compared to those who were single (see Table 4.7).

In addition, self-employed was statistically associated with use of FP hence those were self-employed had 2.3 times higher odds of using FP compared to the unemployed [AOR = 2.31, (95% CI: 1.13–4.72), $p = 0.021$] (see Table 4.7). Belonging to the Islam religion was significantly associated with ever use of FP. Compared to Christians, those belonging to the Islam religion had 68% decreased odds of using [AOR = 0.32, (95% CI: 0.12–0.87), $p = 0.026$]. Parity was significantly associated with ever use of FP. Respondents with 1–2 children [AOR = 3.54, (95% CI: 1.64–7.65), $p = 0.001$], 3–4 children [AOR = 3.43, (95% CI: 1.30–9.08), $p =$

0.013] and five or more children [AOR = 5.07, (95% CI: 1.47–17.51), $p = 0.010$] had increased odds of using FP compared to those with no children (see Table 4.7).

Table 4.7: Sociodemographic factors associated with FP practice

Variables	Adjusted Odds Ratio	95% CI	P-value
Age group			
18-29	Ref		
30-44	0.49	0.26 – 0.95	0.035
45-65	0.25	0.10 – 0.68	0.006
Educational status			
No formal education	Ref		
Primary	2.59	1.03 – 6.50	0.042
JHS	4.16	1.77 – 9.80	0.001
SHS	8.6	3.40 – 21.74	0.001
Tertiary	7.47	2.64 – 21.10	0.001
Marital status			
Single	Ref		
Cohabiting	0.74	0.35 – 1.54	0.415
Married	0.79	0.35 – 1.77	0.566
Divorced	1.52	0.27 – 8.61	0.634
Widowed	0.24	0.02 – 3.89	0.318
Employment status			
Unemployed	Ref		
Employed	1.75	0.83 – 3.70	0.143
Self-employed	2.31	1.13 – 4.72	0.021
Religion			
Christianity	Ref		
Traditionalist	0.76	0.40 – 1.42	0.386
Islam	0.32	0.12 – 0.87	0.026
Others	0.65	0.26 – 1.61	0.347
Parity			
0	Ref		
1-2	3.54	1.64 – 7.65	0.001
3-4	3.43	1.30 – 9.08	0.013
5+	5.07	1.47 – 17.51	0.010

4.8 Binary logistic regression of knowledge associated with attitude

In table 4.8 below, the findings revealed that knowledge was not statistically significantly associated with positive attitude [COR = 0.80, (95% CI: 0.52–1.23), $p = 0.310$]. Respondents with high knowledge had 20% decreased odds of having a positive attitude compared to those with low knowledge.

Table 4.8 Binary logistic regression of knowledge associated with positive attitude

Variable	Crude Odds Ratio	95% CI	P-value
Knowledge			
Low	Ref		
High	0.80	0.52 - 1.23	0.310

4.9 Knowledge and Attitude association with family planning practice

The results showed that level of knowledge was not statistically significantly associated with the FP usage. Respondents with high knowledge had 16% increased odds of using FP compared to those with low knowledge [COR = 1.16, (95% CI: 0.76–1.79), $p = 0.490$]. In contrast, attitude was found to be statistically significantly associated with the use of FP among males in Ketu South Municipality. Those with a positive attitude towards FP had 64% decreased odds of using FP compared to those with a negative attitude [COR = 0.36, (95% CI: 0.23–0.56), $p = 0.001$] (see Table 4.9).

Table 4.9: Binary logistic regression of knowledge and attitude on family planning practice

Variables	Crude Odds Ratio	95% CI	P-value
Level of Knowledge			
Low	Ref		
High	1.16	0.76 – 1.79	0.490
Attitude			
Negative	Ref		
Positive	0.36	0.23 – 0.56	0.001

CHAPTER FIVE

DISCUSSION

5.0 Introduction

This chapter presents the discussion of the findings from this study on family planning (FP) among males in the Ketu South Municipality of the Volta Region, Ghana. The discussion is structured on the study's specific objectives, which sought to examine the level of knowledge, attitudes and practices (KAP) regarding FP, as well as the influence of sociodemographic factors on these outcomes.

5.1 Level of Knowledge Towards Family Planning Among Males

Awareness of family planning (FP) among men in the Ketu South Municipality was found to be high (85.6%), with most respondents familiar with at least one method and aware of where to access services within their communities. However, high awareness does not necessarily translate into comprehensive knowledge, as awareness may simply reflect having heard of FP without a clear understanding of specific methods, their effectiveness or potential side effects. This distinction highlights an important gap between general awareness and in-depth knowledge. Interpersonal networks, such as family and friends, together with health facilities, emerged as the primary sources of information on FP. Male-specific methods, particularly condoms, were widely recognized, whereas knowledge of other male-controlled methods such as withdrawal and vasectomy was comparatively limited. This suggests that although general awareness is widespread, understanding of the full range of available FP options especially those directly involving men remains inadequate.

The findings further revealed that a majority of respondents demonstrated a relatively high level of knowledge, with 62.2% (n = 229) classified as having high knowledge, while 37.8% (n = 139)

had low knowledge. This indicates that awareness and basic understanding of FP concepts are fairly common among males in the Ketu South Municipality. The relatively high level of knowledge observed may be attributed to ongoing public health interventions, including community outreach programmes, media campaigns and the role of health facilities in disseminating reproductive health information. Increased exposure to information through these multiple channels likely contributed to improved awareness and understanding of FP methods among men.

This finding is consistent with previous studies conducted in Ghana and other parts of sub-Saharan Africa, where awareness of FP among men often exceeds 80% (Appiah et al., 2019; Apanga and Adam, 2015). Similarly, Dougherty et al. (2018) reported near-universal awareness (98%) among men in Uganda, although detailed knowledge of modern contraceptive methods remained limited. However, the level of knowledge observed in the present study (62.2%) is somewhat lower than the 90% reported by Appiah et al. (2019) in the Ashanti Region, which may reflect differences in study settings, measurement approaches and access to information.

The findings of this study are also comparable to other studies. For instance, Donyi et al. (2020) reported that 68% of men in the Krachi-Nchumuru District had knowledge of FP, while Abudu (2019) found a knowledge level of 58.5% among men in the West Mamprusi District. These similarities suggest that moderate to high levels of knowledge are common across different regions of Ghana, although variations exist depending on contextual factors such as education, access to services and exposure to health information.

The present study assessed knowledge level of FP using a composite scoring approach, where individual responses were summed and categorized into high and low knowledge based on the median score. This differs from the approach used in previous studies such as Dougherty et al.

(2018), Apanga and Adam (2015), Appiah et al. (2019), Donyi et al. (2020) and Abudu (2019) which primarily relied on descriptive statistics such as frequencies and percentages to report awareness and knowledge levels without constructing composite scores. The use of a composite score in this study provides a more structured and measurable assessment of knowledge and this allows for better differentiation between respondents with varying levels of understanding. Despite these methodological differences, the overall findings remain comparable as high levels of awareness of FP have consistently been reported across studies.

5.2 Attitude of males towards family planning in Ketu South Municipality

In this study, just over half of the respondents (54.9%) demonstrated a positive attitude towards family planning (FP), while 45.1% held negative attitudes. This suggests that although many men generally support FP, a substantial proportion continue to hold reservations shaped by misconceptions, cultural beliefs and method-specific concerns. Most participants acknowledged FP as a good practice, and nearly two-thirds agreed that men share responsibility for reproductive health. These findings indicate a growing recognition of male roles in contraceptive decision-making. However, a significant number of respondents still perceived FP as primarily intended for married couples, this may be due to persistent societal norms that frame reproductive health as a marital, rather than an individual or shared responsibility.

Concerns about specific FP methods appear to influence attitudes. Abudu (2019) found that men were particularly resistant to permanent methods such as vasectomy, highlighting how acceptance varies by method type. Similarly, in this study, several respondents expressed concerns about the potential effect of FP on sexual performance, suggesting that worries about

side effects and perceived risks may shape overall attitudes. Such method-specific apprehensions could partly explain why a sizeable minority still holds negative views.

When compared to other contexts, the finding of 45.1% negative attitudes in Ketu South is lower than the approximately 56% negative attitudes reported among men across Malawi, Guinea, Nigeria and Senegal (Okonofua et al., 2025), but higher than the 27.2% negative attitudes reported in rural Ghana (Kwawukume et al., 2022). Similarly, studies in Nigeria have shown that higher awareness and knowledge are positively associated with favorable male attitudes (Olaoye et al., 2015). These comparisons suggest that differences in education, access to information and exposure to FP services may explain variations in attitudes across contexts. Local cultural norms and beliefs, as well as concerns about side effects or sexual performance, may also contribute to the negative attitudes observed in this study.

Interestingly, Aji and Omotara, (2018) reported negative attitudes among married Muslim men, whereas more than half of males in Ketu South showed positive attitudes. This may reflect changing perceptions among men in this community, possibly influenced by improved FP education, health facility outreach, media exposure and peer discussions. The findings indicate that male attitudes toward FP are shaped not only by knowledge but also by cultural norms, personal experiences and social expectations.

The reviewed studies assessed attitudes toward FP using different approaches, including descriptive statistics, perception-based variables and theme analysis, without the use of a composite scoring system. For instance, Abudu (2019), Longla et al. (2023) and Mulatu et al. (2022) relied mainly on frequencies, percentages and logistic regression analysis, while Tekakwo et al. (2023) explored attitudes qualitatively through thematic analysis. In contrast, this study

used a Likert-scale-based items and further used composite attitude score to classify respondents into positive and negative attitude groups using the median cut-off. This provided a more structured and quantifiable assessment of attitudes toward FP compared to previous studies.

5.3 Family planning practices among males in Ketu South Municipality

The findings indicate that male engagement in FP in Ketu South Municipality is moderate, shaped by a combination of social, cultural and personal factors. Over half of the respondents reported never discussing FP with their partners. This may hinder joint decision-making, reduce mutual understanding of reproductive goals and discourage consistent contraceptive use, a pattern observed in other Ghanaian studies (Donyi et al., 2020; Mulatu et al., 2022). Poor communication reflects entrenched gender norms where FP is often seen as a female responsibility, highlighting the influence of societal expectations on male participation.

This finding is comparable to earlier Ghanaian studies, although those studies often measured male involvement through modern contraceptive use, partner support, service patronage or approval of women's contraceptive use rather than direct male method use alone. For example, Abudu (2019) in West Mamprusi reported low male patronage of FP services with partners, while Apanga and Adam (2015) in Talensi showed that women's use of FP was strongly affected by husband opposition, misconceptions and social norms. These comparisons suggest that male FP practice in Ghana is shaped not only by the specific contraceptive method used, but also by men's approval, support and willingness to engage with FP services. Among non-users in the present study, the main barriers were religious and cultural beliefs and fear of side effects, which may reflect misinformation about modern contraceptives and community-level experiences shared through social networks.

Among men who had ever used FP, the primary motivation was child spacing and delaying births (52.6%), followed by prevention of sexually transmitted infections (21.9%) and financial considerations (12.7%). This may be because men engage in FP when they perceive clear benefits for household well-being, health or economic stability. These motivations are consistent with findings from Appiah et al. (2019) and Mulatu et al. (2022), who reported that men's participation is often driven by practical concerns, including support for partners and management of family size.

Male condoms were the most commonly used method, reported by 89.8% of ever-users and 85.3% of current users, followed by withdrawal. The low uptake of permanent male methods such as vasectomy reflects both global and regional trends (Ross and Hardee, 2017; Abudu, 2019) and highlights the indirect role men often play in FP. Men tend to participate through methods that are socially acceptable, easy to use and reversible, rather than adopting long-term contraceptives themselves.

Only 21.6% of current users reported frequent usage of FP and 56.9% using FP occasionally. This irregularity mirrors other Ghanaian studies (Grindlay et al., 2018; Appiah et al., 2019). This suggests that adoption of FP is influenced not only by knowledge but also by persistent sociocultural norms, misconceptions about side effects and limited male-friendly services. These findings show that understanding and experience alone are insufficient for sustained practice.

The majority of respondents obtained FP methods from government health facilities (37.9%), highlighting the role of accessible public services in facilitating use. This finding may be explained by the accessibility, affordability and trust associated with government health facilities. Many public facilities provide subsidized or free FP methods and are widely available within

communities, making them a convenient option. In addition, the presence of trained health professionals and integration of FP into routine healthcare services may increase confidence and encourage utilization. The observed findings from FP practices in this study collectively may be due to traditional beliefs, misinformation about contraceptive side effects and inadequate male-targeted services.

5.4 Factors that are associated with knowledge, attitude and practices of family planning among males in Ketu South Municipality

The findings of this study demonstrate that sociodemographic factors had varying influences on knowledge, attitudes and family planning (FP) practices among males in the Ketu South Municipality. While these factors did not significantly influence knowledge, they played a substantial role in shaping attitudes and practices. This highlights that male involvement in FP is not solely determined by awareness but is influenced by broader social, cultural and economic contexts.

5.4.1 Sociodemographic factors that affect knowledge of family planning among males in Ketu South Municipality

With regard to knowledge, none of the sociodemographic variables showed a statistically significant association. Although respondents with higher education, employment and higher parity demonstrated increased odds of having good knowledge, these relationships were not statistically significant. This suggests that knowledge of FP is relatively widespread across different demographic groups in the study area.

A possible explanation for this finding may be the broad dissemination of FP information through multiple channels such as health facilities, peers, media and community outreach

programmes, which may reduce disparities in knowledge across population groups. This supports the earlier finding that awareness of FP is high among men in the municipality.

However, this finding contrasts with other studies that identify educational status as a key determinant of FP knowledge (Gelaw et al., 2023; Butame, 2019). The difference may reflect contextual variations or methodological differences, particularly in how knowledge was measured. It is also possible that while awareness is widespread, the depth and accuracy of knowledge still vary across individuals.

5.4.2 Factors that affect attitude towards family planning among males in Ketu

South Municipality

5.4.2.1 Sociodemographic factors that affect attitude towards family planning

The findings from this study indicate that among the sociodemographic variables examined, only educational status and parity affect attitude towards FP. This suggests that while most sociodemographic characteristics may not influence attitudes, specific factors such as level of education and number of children play a meaningful role in shaping how individuals perceive FP.

Tertiary level education was significantly associated with attitude towards FP, with respondents having lower odds of a positive attitude compared to those with no formal education. This finding is consistent with evidence from other studies conducted in Ghana, which indicate that men with higher levels of education may not necessarily exhibit higher odds of a favourable attitudes towards FP. For instance, Klu et al. (2024) and Korsah et al. (2025) found that educated men may still hold negative views due to sociocultural beliefs, misconceptions and concerns about the social implications of contraceptive use. Similarly, Appiah et al. (2019) reported that

male involvement in FP remains low, partly due to persistent perceptions that FP is primarily a woman's responsibility.

The finding that tertiary level education is associated with positive attitude towards FP aligns with Gelaw et al. (2023) and Aventin et al. (2023) which report that higher educational attainment is associated with more positive attitudes towards FP. A possible explanation for this could be that individuals with higher education may be more inclined to critically evaluate family planning methods, including concerns about potential side effects and long-term implications, which may negatively influence their attitudes. It may also reflect sociocultural or personal preferences that are not solely determined by educational attainment. This finding highlights the complexity of attitudes, which are not always directly aligned with knowledge levels.

Parity demonstrated a statistically significant association with attitude towards family planning among males in Ketu South Municipality. Specifically, respondents with five or more children had lower odds of exhibiting a positive attitude toward family planning compared to respondents with no children. Evidence from Ethiopia suggests that a desire for more children and strong pronatalist values can act as barriers to male support for contraceptive use, which may explain why men with high parity hold less favourable attitudes (Kassa et al., 2014). Similarly, in Nigeria, prevailing norms regarding male authority and masculinity influence men's reproductive decisions and may reduce positive attitudes toward FP even among knowledgeable men (Amuzie et al., 2022). Evidence from Ghana indicates that the number of living children can shape men's engagement with FP, although most studies measured involvement rather than attitudes. For instance, men with higher parity were more likely to participate in FP services than those with fewer children (Kwawukume et al., 2022).

These findings suggest that the relationship between parity and male attitudes toward FP is context-specific: while higher parity may encourage involvement in some settings, strong cultural and gender norms may diminish support in others. In the context of Ketu South Municipality, sociocultural expectations and pronatalist beliefs may explain why men with five or more children exhibited lower odds of a positive attitude toward family planning. This finding is noteworthy, as it contrasts with the expectation that individuals with higher parity would be more inclined toward FP to limit or space births. A possible explanation is that men with larger family sizes may hold stronger pronatalist beliefs, have limited engagement with family planning services, or adhere to cultural and generational norms that favor larger families. These factors could collectively shape fewer positive attitudes toward family planning despite increased family size.

5.4.2.2 The influence of knowledge on attitude towards family planning

In this study, knowledge was not significantly associated with attitude towards FP. This finding is consistent with evidence from several studies in different countries. In the United Arab Emirates, Shahzad et al. (2026) reported that although respondents had high levels of knowledge on FP, this was not significantly associated with their attitudes towards FP. Similarly, Nmadu et al. (2024) in Nigeria found that knowledge was not significantly associated with attitude after adjusting for other variables. Peter-Kio and Boma (2023) also reported a similar pattern in Nigeria, where no statistically significant relationship was observed between knowledge and attitude towards FP ($p = 0.076$). In Ghana, Anaman-Torgbor et al. (2025) also found that knowledge was not associated with attitude towards FP among men in Ho Municipality. These studies collectively support the notion that knowledge alone may not be a sufficient determinant of attitudes towards FP. However, different evidence exists. Appiah et al. (2019) in Ghana found

that knowledge was significantly associated with positive attitudes towards FP and male involvement in FP decision-making. This suggests that in some contexts, increased knowledge can translate into positive attitudes and more engagement in FP services.

The differences in findings across studies may be because attitude towards FP is shaped by a wide range of factors beyond knowledge alone. While knowledge is an important prerequisite for informed decision-making, it does not automatically lead to positive attitudes. Instead, attitudes towards FP may be influenced by socio-cultural norms, religious beliefs, misconceptions, partner influence and personal experiences. In many contexts, individuals may possess adequate knowledge of FP methods but still hold negative attitudes due to fears of side effects, societal stigma or disapproval from partners or family members.

5.4.3 Factors that affect family planning practices among males in Ketu South

Municipality

5.4.3.1 Sociodemographic factors that affect family planning practices

The findings revealed that sociodemographic factors significantly affect men's use of family FP in the Ketu South Municipality. Specifically, age, educational status, employment status, religious affiliation and parity were associated with FP practices. These results highlight patterns in male FP behaviour consistent with broader evidence from sub-Saharan Africa and other low- and middle-income settings, where similar determinants have been linked to male participation in contraceptive use (Naidoo et al., 2024; Zambou Vouking et al., 2014).

The study revealed that younger men had higher odds of using family planning methods compared to older men.

This may be explained by greater exposure to sexual and reproductive health information through media, schools and peer networks, as well as shifts in attitudes toward modern methods of contraception (Naidoo et al., 2024). Conversely, older men may adhere more closely to traditional norms that valorize larger families or view FP as unnecessary, reflecting enduring sociocultural expectations around masculinity and fertility (Zambou Vouking et al., 2014). These findings align with Abudu (2019), who documented that age category was a significant determinant of male FP involvement in West Mamprusi District. These findings may be explained by educated men having better access to FP information, improved communication skills with partners and greater ability to challenge myths and misconceptions about contraception.

Educational status was associated with FP use, with men attaining higher education showing increased odds of engaging in FP practices. Education likely enhances knowledge of FP benefits, improves critical thinking regarding reproductive intentions, and empowers men to make informed decisions about family size and child spacing (Zambou Vouking et al., 2014; Naidoo et al., 2024). These findings are reinforced by Apanga and Adam (2015), who found in Talensi District, Ghana, that educational level positively associated with FP service utilization among women and by Longla et al. (2023), who reported that partnered males with post-primary education had higher odds of FP use compared to those with primary-level education.

The study also found that self-employment was associated with FP use, which may reflect the role of financial independence and flexibility in facilitating access to FP services and commodities. This supports evidence suggesting that economic empowerment enhances male participation in reproductive health decisions (Zambou Vouking et al., 2014; Abudu, 2019). Men who are financially independent may support FP use and engage in FP discussions with partners.

Islam religion was found to be associated with FP usage. Those in the Islam religion had a decreased odds of utilizing FP compared to those affiliated to the Christianity. This may reflect how religious norms and interpretations influence attitudes towards family size, contraceptive use and gender roles in reproductive decision-making. Where religion intersects with traditional gender norms, FP is often perceived as a “woman’s domain,” limiting men’s involvement (Makleff et al., 2019).

Furthermore, parity was associated with FP use, with men who had more children having increased odds of using FP compared with those without children. This suggests that men use FP to manage the number and spacing of their children, ensuring the wellbeing of their existing children and the household’s resources. Similarly, Apanga and Adam (2015), found that parity positively influenced FP service usage among men in Ghana and Longla et al. (2023) also reported a 24.4% contraceptive prevalence among partnered males, linking higher engagement to reproductive responsibility.

5.4.3.2 The influence of knowledge and attitude on family planning practices

Knowledge was not statistically significantly associated with use of FP. This could mean that having adequate knowledge of FP methods alone does not necessarily translate into actual FP practice among men. A possible explanation for this is that knowledge may increase awareness but may not always overcome socio-cultural, religious or personal barriers that influence behaviour. This finding is consistent with evidence from Uganda, where Benon (2024) reported that high knowledge of contraceptives did not correspond with high contraceptive practice among married men. Similarly, although Bag et al. (2020) found that knowledge was associated with FP involvement among men in India, the relationship was not strong enough to predict

consistent practice. In Ghana, Kwawukume et al. (2022) also observed that although men had high awareness and knowledge of FP, this did not translate into actual utilization.

In contrast, attitude was found to significantly influence family planning practice. Men with positive attitudes towards family planning had significantly lower odds of practicing family planning compared to those with negative attitudes. Although this finding differs from the expected pattern, it confirms that attitude plays a significant role in family planning practice. Similar studies have reported that attitude influences family planning uptake. For example, Aji and Omotara (2018) found that Muslim men's attitudes towards family planning significantly influenced family planning acceptance and use in Nigeria. Similarly, Kassa et al. (2014) in Ethiopia reported that men with favourable attitudes were significantly more likely to utilize family planning services. In Ghana, Appiah et al. (2019) also reported that positive attitudes significantly influenced male involvement in family planning service uptake.

However, not all studies have reported a consistent relationship. For instance, Donyi et al. (2020) found that although many men expressed positive perceptions towards family planning, attitude was not significantly associated with family planning involvement or use. This suggests that the influence of attitude may vary depending on contextual factors such as cultural beliefs, partner dynamics, and access to services. Supporting this, Adongo et al. (2013) highlighted that even when men express supportive attitudes towards family planning, actual involvement in family planning decision-making and use is often shaped more by sociocultural norms and health system factors than attitude alone.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.0 Conclusion

This study assessed the knowledge, attitudes and practices (KAP) of family planning (FP) among males in the Ketu South Municipality of the Volta Region of Ghana. Specifically, it examined the level of knowledge of family planning among men, explored their attitudes towards FP, assessed their practices and identified the factors influencing these outcomes. The findings provide important insights into male involvement in FP within the context of a municipality experiencing high teenage pregnancy rates, notable HIV prevalence and moderate fertility levels.

The study revealed that awareness of FP among men was high, with 85.6% of respondents having heard of FP. However, this awareness did not consistently translate into comprehensive knowledge, positive attitudes or sustained practice. Although a majority of respondents demonstrated moderate to high levels of knowledge, gaps remained in understanding the full range of FP methods, particularly male-specific options. Notably, none of the sociodemographic factors were significantly associated with knowledge.

Attitudes towards FP were mixed, with only 54.9% of respondents demonstrating a positive attitude. This indicates that sociocultural norms, misconceptions and religious beliefs continue to influence male perspectives on FP. Having tertiary level education and having five or more children were found to significantly influence attitudes.

FP practices among men were found to be moderate, with approximately 62% of respondents reporting ever using a method. However, this level of utilization remains suboptimal considering the high awareness observed. Age, educational status, self-employment, traditional religion,

parity and positive attitude were found to influence FP practices among males in Ketu South Municipality. Additionally, more than half of the respondents (53.8%) had never discussed FP with their partners, highlighting limited spousal communication, which may negatively affect joint decision-making and contraceptive use. In conclusion, the findings confirm that while awareness of FP is widespread among men in the Ketu South Municipality, significant gaps remain in translating knowledge into positive attitudes and consistent practice.

6.1 Recommendations

Based on the findings of this study, the following recommendations are proposed to improve knowledge, attitudes and practices of FP among males in the Ketu South Municipality:

1. Enhance FP Education and Awareness Programs: The Ketu South Municipal Health Directorate should implement targeted family planning education campaigns for men. Although awareness of family planning was high among respondents, awareness did not necessarily translate into adequate knowledge, positive attitudes, or informed family planning practices. Similarly, having knowledge of family planning did not always result in its utilization. Therefore, education campaigns should focus on improving men's understanding of the benefits of family planning, dispelling myths and misconceptions, and promoting the role of men in reproductive health decision-making. These interventions should utilize health facilities, community forums, social media platforms, and radio discussions to improve reach, engagement, and behaviour change, particularly among older men who may adhere to traditional norms.
2. The Ketu South Municipal Health Directorate should implement male-focused, community-based family planning outreach programmes that promote couple

communication and counseling. Despite high awareness of family planning, uptake remains suboptimal, and many men have never discussed family planning with their partners. Education through health facilities, community outreach activities, social media, and radio discussions should incorporate couple counseling and behaviour change communication to improve partner dialogue, address misconceptions, and enhance male involvement in family planning uptake.

6.2 Implications for Future Studies

Future studies should be conducted to:

1. Investigate barriers to FP use among older men and tertiary-educated males who may be aware of FP but less engaged using a cross-sectional study design at Ketu South Municipality
2. Consider qualitative approaches to better understand socio-cultural and religious influences on male Family Planning participation.

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APPENDICES

APPENDIX I: PARTICIPANT INFORMATION AND CONSENT

Section A- BACKGROUND INFORMATION

Title of Study: **KNOWLEDGE, ATTITUDE AND PRACTICES OF FAMILY PLANNING AMONG MALES ATs KETU SOUTH MUNICIPALITY IN THE VOLTA REGION OF GHANA**

General Information about Research Introduction

I am Alphonse Makafui Dzakpasu a Master of Public Health student from the Ensign University. I am carrying out research on the “Knowledge, Attitude and Practices of Family Planning Among Males at Ketu South Municipality in the Volta Region of Ghana”.

Purpose of the Study

I am asking you to participant in this study because I want to learn more the knowledge, attitude and practices of family planning among males in Ketu south municipality.

Nature of the Study

This study is all about family planning, and how socio-demographic characteristics will influence knowledge, attitude and practices of family planning. You were selected by chance like picking a toffee from a bowl of toffees. Participating in this study is voluntarily, and you can decide whether to take part or not. There will be no punishment if you refuse to take part. Interviews will take last for at most 15 minutes; it is only for a day and it is not intended to disrupt your activities.

Benefits/ Risks of the Study

There will be no direct benefit associated with your participation in this study. However, your responses would contribute to general interventions for family planning. This will help inform policy makers in decision-making process to develop and implement health interventions to tackle low uptake of family planning services among males. There are no potential risks associated with participating in this study. However, some of the questions are sensitive.

Confidentiality

Data obtained from this study will be handled anonymously hence your privacy and confidentiality are assured. Your name or any other personal information that would identify you will not be used in this study. A unique data code will be given to your responses on an encrypted laptop and external hard drive. To help protect your confidentiality, your information will not be disclosed to anyone. Data gathered will only be accessed by the Principal Investigator and research supervisor. Your name or any identifiable information will not be used during the dissemination of findings. Your personality is protected. I assure you!

Additional Costs

There will be no cost for you for taking part in this study.

Compensation

There will be no compensation for your participation in this research. Only words of appreciation will be offered by thanking you for spending your time, honesty and effort to participate in this research.

Withdrawal from the study

Participation in this study is voluntary and you are free to say you will not be able to continue with this research study at any point in time. There will be no risk associated with withdrawal during the study.

What happens after study or when the participant changes his mind

After the study, your data will be extracted into a Microsoft Excel Sheet and will be stored by the Principal Investigator on a laptop with password protection. The electronic data will be retained for possible future use. The results of the study will be communicated to you and other relevant stakeholders after a month's completion of the study. If you change your mind during the study, you will not be coerced to participate. You will not also be affected negatively in any way.

Provision of Information and Consent for participants

A copy of the Information sheet and Consent form will be given to you after it has been signed or thumb-printed to keep.

Who to Contact for Further Clarification/Questions:

For more clarification about the study, you can contact the following persons for further information

The principal investigator Alphonse Makafui Dzakpasu at the Ensign University.

Email: alphonse.dzakpasu@st.ensign.edu.gh Telephone: 0244835682

This research has been reviewed and approved by the Institutional Review Board (IRB) of Ensign Global University, Kpong. For inquiries about your rights as a participant, you may contact the IRB office at 0245762229 or registrar@ensign.edu.gh during working hours (8:00 am–5:00 pm).

Section B– CONSENT TO PARTICIPATE IN RESEARCH

Title of Study: **KNOWLEDGE, ATTITUDE AND PRACTICES OF FAMILY PLANNING AMONG MALES IN KETU SOUTH MUNICIPALITY IN THE VOLTA REGION OF GHANA**

Principal Investigator: Alphonse Makafui Dzakpasu

PARTICIPANTS' STATEMENT

I acknowledge that I have read or have had the purpose and contents of the Participants'

Information Sheet read and all questions satisfactorily explained to me in a language I understand (English, Ewe and Twi). I fully understand the contents and any potential implications as well as my right to change my mind (i.e., withdraw from the research) even after I have signed this form.

I voluntarily agree to be part of this research.

Name of Participant.....

Participants' Signature OR Thumb Print.....

Date.....

INTERPRETERS' STATEMENT

I interpreted the purpose and contents of the Participants' Information Sheet to the afore named participant to the best of my ability in the English, Ewe, Twi and other language to his proper understanding.

All questions, appropriate clarifications sort by the participant and answers were also duly interpreted to his/her satisfaction.

Name of Interpreter.....

Signature of Interpreter..... OR Thumb Print

Date.....

Contact Details.....

STATEMENT OF WITNESS

I was present when the purpose and contents of the Participant Information Sheet was read and explained satisfactorily to the participant in the language, he/she understood (English, Twi and others). I confirm that he/she was given the opportunity to ask questions/seek clarifications and same were duly answered to his/her satisfaction before voluntarily agreeing to be part of the research.

Name.....

Signature..... OR Thumb Print

Date.....

INVESTIGATOR STATEMENT AND SIGNATURE

I certify that the participant has been given ample time to read and learn about the study. All questions and clarifications raised by the participant have been addressed.

Researcher's name.....

Signature

Date

APPENDIX II: DATA COLLECTION TOOL

Questionnaire

	QUESTIONS	RESPONSES
	Section A: Sociodemographic Characteristics	
01	What is your age at last birthday	-----
02	What is your highest level of educational?	1. No formal education 2. Primary 3. JHS 4. SHS 5. Tertiary
03	What is your current marital status?	1. Single 2. Cohabiting 3. Married 4. Divorced/Separated 5. Widowed
04	What is your occupational status?	1. Unemployed 2. Employed 3. Self-employed
05	What is your religion?	1. Christianity 2. Islam 3. Traditionalist 4. Others
06	How many children do you have?	-----
07	What is the total number of children you would like to have in your lifetime?	-----
	Section B: Knowledge of family planning	
08	Have you ever heard of family planning?	0 No 1 Yes
	INTERVIEWER SCRIPT: Family planning refers to methods used to plan the number, timing, and spacing of children. This includes methods like condoms, pills, injectables, IUDs, and other approaches.	2
	If respondent answers “No” to Q8, skip Q9–Q13 and go to Q14 (Attitude section)	
09	How did you first hear about family planning?	1 Radio 2 Television 3 Social media (e.g., Facebook, WhatsApp, TikTok) 4 Newspaper 5 Health facility (e.g., hospital, clinic) 6 Community outreach/education 7 Family or friend 8 Religious institution

		9 School 10 Others
10	Do you know of any health facilities in your community that provides family planning services?	0 No 1 Yes 2 Uncertain
11	Do you know where to go if you or your partner needs family planning services?	1 No 2 Yes 3 Uncertain
12	Do you know that some family planning methods are available to men?	1 No 2 Yes 3 Uncertain
13	Which of the following methods do you know? (SELECT ALL THAT APPLY)	1 Condoms 2 Pills (e.g., Lydia or Postinor-2) 3 Injectable 4 IUD 5 Withdrawal 6 Vasectomy 7 Spermicides 8 Tubal-ligation 9 Others
14	Which of the following best describes the main purpose of family planning?	1 To prevent pregnancy 2 To prevent sexual transmitted infections 3 To increase the number of sexual partners 4 To plan and control the number, timing and spacing of children 5 I do not know
15	Which family planning method also protect against sexually transmitted infections (STIs)?	1 Condoms 2 Pills (e.g., Lydia or Postinor-2 or Secure) 3 Injectable 4 Intrauterine device (IUD) 5 Withdrawal method 6 I don't know
16	Which of the following family planning methods is intended for use by men? (SELECT ALL THAT APPLY)	1 Male condom 2 Female condom 3 Oral contraceptive pills 4 Injectable contraceptives 5 Intrauterine device (IUD) 6 Withdrawal method 7 I don't know
	On a scale of 1 to 5 where 1=Strongly agree 2=Agree 3=Neutral 4=Disagree 5=Strongly disagree tell me how much you agree with the following statement	
	Section C: Attitude towards family planning	

17	Family planning is a good practice	1 Strongly agree 2 Agree 3 Neutral 4 Disagree 5 Strongly disagree
18	Men should also be responsible for family planning	1 Strongly agree 2 Agree 3 Neutral 4 Disagree 5 Strongly disagree
19	I would support my partner in using family planning methods	1 Strongly agree 2 Agree 3 Neutral 4 Disagree 5 Strongly disagree
20	Using family planning is for married people only	1 Strongly agree 2 Agree 3 Neutral 4 Disagree 5 Strongly disagree
21	Family planning can affect sexual performance	1 Strongly agree 2 Agree 3 Neutral 4 Disagree 5 Strongly disagree
22	The use of family planning methods are is against the will of God	1 Strongly agree 2 Agree 3 Neutral 4 Disagree 5 Strongly disagree
23	I desire to learn more about family planning	1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree
24	I intend to use family planning methods in future	1 Strongly agree 2 Agree 3 Neutral 4 Disagree 5 Strongly disagree
	Section D: Family planning practices	
25	Have you discussed Family planning with your wife/partner before?	0. No 1. Yes
26	Have you ever used family planning?	0. No 1. Yes
	<i>If respondent answered YES to Q26, SKIP to 28</i>	

27	Why have you never used any family planning method?	1. To have more children 2. To have a male child 3. To have a female child 4. Cannot afford contraceptives 5. Do not know how to use contraceptives 6. Do not know where to get contraceptives 7. Spouse does not allow them 8. Do not use for health reasons 9. Do not use due to religious reasons 10. Fear of side effects
	<i>Q28 and Q29 below should be answered by those who responded YES to Q26 above</i>	
28	What was your reason for using family planning?	1. To space or delay children 2. I have reached my desired number of children 3. I cannot support another child at this time 4. My partner/wife requested or insisted on using FP 5. To prevent sexually transmitted infections (STIs) 6. Others
29	Which family planning method(s) have you used before? (SELECT ALL THAT APPLY)	1. Withdrawal 2. Male Condom 3. Vasectomy
30	Are you currently using any family planning method?	0. No 1. Yes
	<i>If respondent answered NO to Q30 end the interview here</i>	2.
31	Which family planning method do you currently use the most?	1. Withdrawal 2. Male Condom 3. Vasectomy
32	How often do you use your chosen family planning method (e.g., condom, withdrawal, vasectomy) stated above?	0. Never 1. Rarely 2. Sometimes 3. Often 4. Always
33	What is your reason for using the family planning method stated above?	1. For child spacing 2. I have reached my desired number of children 3. I can't support another child now 4. My wife/Partner insisted
34	Where did you or your partner obtain your most recent family planning method?	0. Government health facility 1. Private hospital/clinic 2. Pharmacy/Over the counter 3. Family planning outreach program

		4. Community health worker 5. Others
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APPENDIX III: APPROVAL LETTER



OUR REF: ENSIGN/IRB/EL/SN-354/02
YOUR REF:

December 4, 2025.

INSTITUTIONAL REVIEW BOARD SECRETARIAT

Alphonse Makafui Dzakpasu
Ensign Global University
Kpong.

Dear Alphonse,

ETHICAL CLEARANCE TO UNDERTAKE POSTGRADUATE RESEARCH

At the General Research Proposals Review Meeting of the *INSTITUTIONAL REVIEW BOARD (IRB)* of Ensign Global University held on Wednesday, December 3, 2025, your research proposal entitled "**Knowledge, Attitude and Practices of Family Planning Among Males in Ketu South Municipality in the Volta Region of Ghana**" was considered.

You have been granted Ethical Clearance to collect data for the said research under academic supervision within the IRB's specified frameworks and guidelines.

We wish you all the best.

Sincerely,

A handwritten signature in black ink, appearing to read "Rebecca Acquah-Arhin", is written over a horizontal line.

Dr. (Mrs.) Rebecca Acquah-Arhin
IRB Chairperson