Male Characteristics and Contraception In Four Districts Of The Central Region, Ghana

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Abstract

Introduction: A lack of male involvement in contraception can negatively affect its practice. This study focuses on the male characteristics that influence the practice of both traditional and modern methods of contraception.

Methods: This study is a secondary analysis of quantitative data obtained from the baseline assessment of the Ghana Community-Based Action Teams Study that aimed to prevent violence against women in the Central Region of Ghana in 2016. The analysis included 1742 partnered males aged 18-60 years. Chi-square test, t-test and logistic regression analyses were used to assess the association between male characteristics and the practice of contraception (significance level=0.05).

Results: The prevalence of contraception was 24.4% (95% CI=20.8-28.5). Significant male characteristics that predicted the practice of contraception in adjusted models were: post-primary education (AOR=1.44, 95% CI=0.92-2.25), male controlling behaviour (AOR=0.7, 95% CI=0.49-0.99); perpetration of Intimate Partner Violence (AOR=1.83, 95% CI=1.49-2.26); number of main sexual partners (AOR=1.78, 95% CI=1.15-2.75); and whether the first child was wanted (AOR=0.71, 95% CI=0.54-0.94).

Conclusion: Adequate measures need to be taken to actively involve men in family planning programs to promote the practice of contraception. Family planning sensitization and education programs should target males who are less likely to practice contraception.

Plain English Summary

To date, males are hardly involved in family planning programs since most of the research in this domain and the various ways of preventing pregnancy are mainly focused on females. This can negatively affect women's reproductive health, especially in developing countries (e.g., Ghana), where they constitute the household decision-making authority. This study focuses on the male characteristics that influence the practice of both traditional and modern methods of contraception. The study involved a secondary analysis of data obtained from male participants during the baseline assessment of the Ghana Community-Based Action Teams Study that aimed to prevent violence against women in the Central Region of Ghana in 2016. This study found that males who underwent formal education, perpetrated partner violence or had many main sexual partners were more likely to practice contraception. Also, participants who were controlling or wanted their first child at delivery were less likely to practice contraception. This means that measures need to be taken to actively involve men in family planning programs to promote the practice of contraception. Family planning sensitization and education programs should focus on males who are less likely to practice contraception.

Background

Family planning enables couples to have an optimal number of children and decide on pregnancy spacing. It is accomplished by knowledge, education, and the use of methods of contraception (Guttmacher Institute & BMGF, 2017). Contraception can broadly be classified into traditional and modern forms, with few of them dependent on males; condoms, withdrawal method, rhythm method and vasectomy (Ross & Hardee, 2017). Contraception has a couple of advantages, including a reduction in maternal and infant mortalities (Brown et al., 2015), reduction of adolescent pregnancy (Brown et al., 2015), prevention of sexually transmitted infections (Colquitt & Martin, 2017) and controlling population growth amongst others. Their use is often affected by individual and couple-level factors.

Often, there is a lack of male involvement in contraception. This can have serious consequences, especially in a developing country like Ghana, where they constitute the majority of household and nation's decision-making authority (Adegbola & Habeebu-Adeyemi, 2016). There is evidence that having good knowledge on contraception is generally considered a vital step towards its uptake (Biney, 2014; Huisman, 2012; Klutsey & Ankomah, 2014). The current evidence-based on the 2014 Ghana DHS data show an almost universal knowledge of one or more contraceptive methods among adult populations (GSS; GHS; ICF International, 2015). Despite this high level of awareness on this subject, and the availability of low-cost family planning services, its uptake in most households in Ghana is paradoxically very low. According to the Ghana DHS data in 2014, the prevalence of contraception among married women of reproductive age was 26.7% (22.2% for modern methods).

Furthermore, evidence from a maternal health survey showed that only one third (31%) of married women in the reproductive age group used contraception: 25% used modern while 6% practiced traditional methods of contraception (Ghana Maternal Health Survey, 2017). This prevalence is very low compared to a global modern contraceptive prevalence rate of 57% (WHO Contraception fact sheet, 2012). Globally, the prevalence of male methods of contraception in 2017 was 15.7%, while that of Ghana was 5.5% (Ross & Hardee, 2017). These findings highlight the low utilization of contraception in Ghana. In 2017, a study conducted in Ghana showed that only 7.2% of men accompanied their spouses to the clinic to seek family planning services (Atuahene et al., 2017). This is suggestive of poor male involvement in contraception, which can have implications for uptake. About 30% of Ghanaians have an unmet need for contraception (GSS; GHS; ICF International, 2015), and this situation will inevitably result in adverse outcomes. Globally, about 20 million cases of unsafe abortions are noted every year, with resultant 67,000 deaths, most of which occur in underdeveloped countries (WHO Contraception fact sheet, 2012). Ameyaw et al. (2019), reported, after an analysis of 2014 Demographic and Health Survey Data, an unwanted pregnancy rate of 28.9% in Ghana. An increased rate of unwanted pregnancies within households may result in abortion, most of which are unsafe in our settings, and this may impose severe consequences on the reproductive health of the people concerned (WHO Contraception fact sheet, 2012; Ziraba et al., 2015).

Even though some studies have explored male factors that influence contraceptive use, most of these studies involve female respondents. The relatively little attention paid to males, who make most of the household decisions in our milieu, can negatively impact the use of family planning services. This study

sought to determine the prevalence and predictors of contraception (traditional and modern methods) among men in the Central Region of Ghana.

Methods

Study design

This study is a secondary analysis of quantitative data obtained from the baseline assessment of a community randomized controlled trial in the Central Region of Ghana that run for three years starting from 2016. The aim of the trial, dubbed "the Ghana Community-based action teams (COMBAT) Health Promotion Study," was to evaluate the impact of the Rural Response System (RRS) at the community level to prevent violence against women in Ghana using Community-Based Action Teams (Addo-Lartey et al., 2019). The study was an unmatched cluster randomized controlled trial with two arms that utilized a multistage sampling technique involving both rural and urban communities. The intervention arm received the RRS intervention to prevent IPV for 18 months, while the control group did not receive any intervention. Quantitative data were collected at baseline and endpoint of the study, with the use of a well-structured interviewer-administered questionnaire, from women (18-49 years) and men (more than 18years) who lived in a particular household for at least one year, could communicate in English, Twi or Fante and did not have a mental illness (Addo-Lartey et al., 2019).

The current study involves the analysis of the quantitative data collected from partnered males (either married or had a girlfriend) at baseline and excluded those who were older than 60 years.

Study area

The study involved four districts that they were separated by at least one district to prevent the diffusion of the intervention from the intervention to the control arms. These districts include Upper Denkyira, Abura/Asebu/Kwamankese, Agona and Komenda/Edina/Eguafo/Abreim of the Central Region of Ghana. Ghana is located in West Africa with 27 million inhabitants (Population and Housing Census, 2010), and now has 16 administrative regions. The Central region has a total population of 2,413,050 (2013). About half of the adult inhabitants are literate, with men contributing to 69.8% of this proportion.

Study variables

The outcome variable is the male-reported practice of contraception between couples. The men were asked the question, "Are you and your partner (girlfriend/wife) doing anything to avoid pregnancy?" An affirmative answer to this question was considered as the practice of contraception.

The predictor variables considered in this analysis cut across socio-demographic, socio-cultural, behavioral, and sexual/reproductive factors.

Eight socio-demographic variables were assessed to determine their association with the outcome variable. The respondent's age and the age at which they first got married were recorded and used as continuous variables. The age difference with their partners, age at first birth, marital status, area of residence, income level, and education level were used as categorical variables.

The prevailing social norms, individual gender attitudes, controlling behaviour, perpetration of intimate partner violence (IPV), depression, substance use, decision-making authority and life satisfaction are the socio-cultural and behavioural factors that were considered in the study. The community's prevailing social norms concerns what the community thinks about the relations between males and females. Male controlling behavior was defined as a behaviour that a man takes charge of and determines his partner's actions (Johnson, 2006). Intimate Partner Violence was defined as any form of sexual, physical, emotional or economic violence perpetrated by the man against his partner within the past 12 months. In this study, the prevailing social norms, individual gender attitudes, controlling behavior, IPV and life satisfaction were assessed on a Likert scale containing some items (questions) using appropriate tools (Addo-Lartey et al., 2019; Ogum Alangea et al., 2020). Additive scores were then computed for each of these variables from this scale after Cronbach alpha was used to check for internal consistency (Addo-Lartey et al., 2019; Ogum Alangea et al., 2020). The obtained scores for the gender attitudes, controlling behavior and IPV were categorized into two while social norms and life satisfaction were measured on a continuous scale in this current analysis. Depression was assessed using the Center for Epidemiological Studies Depression (CES-D) scale for research. A composite score was generated (Cronbach's alpha coefficient = 0.86), with a high score indicating a higher probability of being depressed (Addo-Lartey et al., 2019). To assess substance use, they were asked if they took either alcohol or drugs in the past 12 months. The details of how these variables are measured are reported elsewhere (Addo-Lartey et al., 2019; Ogum Alangea et al., 2020).

Finally, the sexual/reproductive variables considered in this study were the number of biological children, main sexual partners, other sexual partners and whether they wanted their first child at birth (for those who had a child). The number of biological children was recorded as continuous variables while the others were categorized.

Data analysis

Data analysis was done using STATA version 16. The variables of interest were identified from the primary data set and kept along with unique identifiers in a separate STATA file. After this, the cleaning of the data by running frequencies of the various variables to identify and label odd or missing entries was also done. The variables of interest were recoded to obtain desired measures, and new variables and categories were created by transforming certain desired variables and saved for analysis. The complex nature of the survey, i.e., stratification and clustering, was considered during the analysis to obtain sample estimates that represent the districts involved.

Descriptive statistics were computed for the various variables: mean and standard deviation were calculated for continuous variables, while proportions were calculated for categorical variables. Bivariate analysis was done using the Chi-square test, students t-test and simple logistic regression (to measure crude associations between the outcome variable and the predictor variables). Variables that were significantly associated with the practice of contraception in bivariate analysis, together with some key socio-demographic characteristics, were moved to multiple regression models (multivariate analysis) to determine the predictors of contraception. The level of statistical significance was set at 5% (p-value of 0.05).

Ethical considerations

The candidate obtained permission from the primary investigators of the Ghana COMBAT study to use the de-identified data set for the current analysis. The primary investigators obtained ethical clearance from the Noguchi Memorial Institute for Medical Research Institutional Ethics Board (NMIMR-IRB), Legon, University of Ghana (number 006/15-16) and the South African Medical Research Council (EC031-9/2015).

Results

Out of the 2126 males that were interviewed at baseline, 1742 were eligible for this study.

Socio-demographic Characteristics Of The Participants

The socio-demographic characteristics of the respondents are summarized in Table 1 below. The study participants' age ranged from 18 years to 60 years, with a mean of 36.0 ± 11.3 years. Averagely, they first got married at the age of 25.8 (SD = 5.3) years. Among those who had at least a child, a greater majority of them (93.2%) had their first child after the age of 19 years. Most (62.8%) of the men were married, while the rest had at least one sexual partner. Up to 29.7% of the men did not earn any income, and only a very small proportion earned more than 1000 cedis during the month preceding the survey. About education, up to 17.7% did not have any formal education, while one-third (33.3%) attended at least junior secondary school.

Table 1
Male Socio-demographic characteristics and the practice of contraception

Respondent characteristics	Total (%)	Use of contraception		p-value
		Yes	No	
		N (%) / Mean $\pm$ SD	N (%) / Mean $\pm$ SD	
Age (years)		34.4 $\pm$ 10.3	36.8 $\pm$ 11.5	< 0.001*
Age at first marriage (years)		26.1 $\pm$ 4.8	25.8 $\pm$ 5.4	0.494*
Age difference with partner	792(47.6)	192(24.2)	600(75.8)	0.807
Partner $\geq$ 5 years younger	871(52.4)	217(24.8)	654(75.2)	
Partner < 5 years younger				
Age at first birth	88(6.8)	17(19.3)	71(80.7)	0.522
< 20 years	1205(93.2)	276(22.9)	929(77.1)	
$\geq$ 20 years				
Marital status	1094(62.8)	235(21.5)	859(78.5)	0.001
Married	648(37.2)	190(29.3)	458(70.7)	
Not married				
Income level (GHc)	469(29.7)	96(20.5)	373(79.5)	0.389
Nothing	460(29.2)	84(18.3)	376(81.7)	< 0.001
$\leq$ 200	527(33.4)	151(28.7)	376(71.3)	
201–1000	121(7.7)	51(42.1)	70(57.94)	
> 1000				
Educational level	309(17.7)	32(10.4)	277(89.6)	< 0.001
None	296(16.9)	53(17.9)	243(82.1)	< 0.001
Primary	581(33.3)	151(26)	430(74.0)	< 0.001
Junior secondary	352(20.5)	110(31.2)	242(68.8)	< 0.001
Senior secondary	204(11.6)	79(38.7)	125(61.3)	
Post-secondary				

*p-value from t-test

Respondent characteristics	Total (%)	Use of contraception		p-value
		Yes	No	
		N (%) / Mean $\pm$ SD	N (%) / Mean $\pm$ SD	
Area of residence	940(54.0)	191(20.3)	749(79.7)	0.006
Coastal	802(46.0)	234(29.2)	568(70.8)	
Inland				
*p-value from t-test				

Other Characteristics Of The Respondents

Half (50.0%) of the men had equitable gender attitudes, and 47.1% also reported controlling behaviour. Most of the participants (80.1%) believe that the man should be the one to make the household's final decisions. Slightly more than one-third (37.3%) of them reported that they had perpetrated at least one form of IPV, with the most common single forms being sexual IPV (17.5%) and physical IPV (12.8%). Less than one-third of the men (27.8%) did not want to have their first child when they had them. About three-quarters of the men (74.7%) had one main sexual partner. These characteristics are summarized in Table 2.

Table 2
Other male characteristics and the practice of contraception

Respondent characteristics	Total (%)	Use of contraception		p-value
		Yes	No	
		N (%) / Mean $\pm$ SD	N (%) / Mean $\pm$ SD	
Social norms score		32.5 $\pm$ 6.3	34.2(6.4)	< 0.001*
Individual gender attitudes	871(50.0)	248(28.5)	623(71.5)	0.001
Equitable	871(50.0)	177(20.3)	694(79.7)	
Inequitable				
Controlling behavior	921(52.9)	273(29.6)	648(70.4)	< 0.001
No	821(47.1)	152(18.5)	669(81.5)	
Yes				
Decision-making authority	347(19.9)	118(34.0)	229(66.0)	< 0.001
Not man	1395(80.1)	307(22.0)	1088(78.0)	
Man				
Perpetrate IPV	1093(62.7)	220(20.1)	873(79.9)	< 0.001
No	649(37.3)	205(31.6)	444(68.4)	
Yes				
Life satisfaction score		14.7 $\pm$ 4.0	15.1 $\pm$ 4.2	0.093*
Depression score		35.8 $\pm$ 9.2	36.6 $\pm$ 9.3	0.108*
Substance use	958(55.0)	241(25.2)	717(74.8)	0.428
No	783(45.0)	184(23.5)	599(76.5)	
Yes				
Number of children		3.57 $\pm$ 2.25	3.60 $\pm$ 2.17	0.878
No. of main sexual partners	1301(74.7)	333(25.6)	968(74.4)	< 0.001
One	181(10.4)	15(8.3)	166(91.7)	< 0.001
None	259(14.9)	77(29.7)	182(70.3)	
More than one				
*p-value from t-test				

Respondent characteristics	Total (%)	Use of contraception		p-value
		Yes	No	
		N (%) / Mean $\pm$ SD	N (%) / Mean $\pm$ SD	
Have other sexual partners	1315(75.7)	298(18.6)	1017(81.4)	0.002
No	422(24.3)	123(29.1)	299(70.9)	
Yes				
Transactional sex	1275(73.2)	283(22.2)	992(77.8)	0.001
No	467(26.8)	142(30.4)	325(69.6)	
Yes				
Wanted first child	360(27.8)	103 (28.6)	257 (71.4)	< 0.001
No	934(72.2)	190 (20.3)	744 (79.7)	
Yes				
*p-value from t-test				

Prevalence Of Contraception

Out of the 1742 males, 425 practiced contraception, i.e. prevalence was 24.4% (95% CI :20.8–28.5).

Predictors Of The Practice Of Contraception

Bivariate analysis

The association between socio-demographic characteristics of the males and the practice of contraception is summarized in Table 1. The average age of those who practiced contraception was significantly lower than that of those who did not (34.4 ± 10.3 vs. 36.8 ± 11.5 , p-value < 0.001). A lesser proportion of married men practiced contraception compared to their unmarried counterparts (21.5% vs. 29.3%, p-value = 0.001). Males with a higher income level were more likely to practice contraception than those who did not earn any income (p-value < 0.001). Formally educated males were more likely to practice contraception compared to those who did not attend school (p-value < 0.001). Significantly more men in inland areas practiced contraception compared to the coastal dwellers (29.2% vs. 20.3%, p-value = 0.006).

Other behavioral and sexual/reproductive characteristics of the males were also associated with the practice of contraception (Table 2). Favorable social norm was associated with a higher likelihood of

practicing contraception. The mean social norm score of the men who practiced contraception was significantly lower than that for those who did not (32.5 ± 6.3 vs. 34.2 ± 6.4 , $p\text{-value} < 0.001$). More men with gender-equitable norms practiced contraception compared to their counterparts with gender inequitable norms (20.3% vs 28.5%, $p\text{-value} = 0.001$). Participants who believed that males should be the ones to make the final decisions in the household were less likely to practice contraception compared to those who thought otherwise (22.0% vs. 34%, $p\text{-value} < 0.001$). A significantly higher percentage of men who had sexual partners other than their main sexual partners practiced contraception compared to those who did not have (29.1% vs. 18.6%, $p\text{-value} = 0.002$). Men involved in transactional sex were more likely to practice contraception than those who did not indulge in transactional sex (30.4% vs. 22.2%, $p\text{-value} = 0.001$). Controlling behavior, perpetration of IPV, number of main sexual partners and whether the first child was wanted were also associated with the practice of contraception.

Table 1: Male Socio-demographic characteristics and the practice of contraception

Table 2: Other male characteristics and the practice of contraception

Multivariate Analysis (Multiple Logistic Regression)

After controlling for age, marital status, income level, area of residence, social norms, individual gender attitudes, decision-making authority, having other sexual partners and the practice of transactional sex, five male characteristics emerged as significant predictors of contraception. They include the educational level, number of main sexual partners, perpetration of IPV, controlling behaviour and whether the first child was wanted. There was a statistically significant relationship between those who had post-primary school education and the practice of contraception. For instance, men whose highest level of study was junior secondary school had a 96% increased odds of practicing contraception compared to those with no education (AOR = 1.96, 95% CI: 1.27–3.04, $p\text{-value} = 0.003$). The odds of practicing contraception increased with higher levels of education, as illustrated in Table 3.

Table 3
Results of multiple logistic regression (multivariate analysis)

Respondents characteristic	Simple logistic regression	Multiple logistic regression	
	UOR (95% CI)	AOR (95% CI)	p-value
Age (years)	0.98 (0.97–0.99)	0.99(0.98-1.00)	0.093
Marital status	1	1	0.565
Married	1.52 (1.21–1.91)	0.89(0.58–1.35)	
Not married			
Income level (GHc)	1	1	0.285
Nothing	0.87 (0.63–1.21)	0.80(0.52–1.22)	0.125
≤ 200	1.56 (1.24–1.96)	1.23(0.94–1.61)	0.175
201–1000	2.83 (1.89–4.24)	1.52(0.82–2.81)	
> 1000			
Educational level	1	1	0.107
None	1.89 (1.37–2.60)	1.44(0.92–2.25)	0.003
Primary	3.04 (2.15–4.36)	1.96(1.27–3.04)	0.007
Junior secondary	3.93 (2.57–6.03)	2.03(1.22–3.38)	0.003
Senior secondary	5.47 (3.76–7.96)	2.56(1.41–4.66)	
Post-secondary			
Area of residence	1	1	0.814
Coastal	1.62 (1.16–2.25)	1.04(0.73–1.49)	
Inland			
Social norms score	0.96 (0.94–0.98)	0.98(0.95–1.02)	0.301
Individual gender attitudes	1	1	0.865
Equitable	0.64 (0.50–0.82)	0.97(0.71–1.33)	
Inequitable			
Controlling behavior	1	1	0.045
No	0.54 (0.42–0.69)	0.70(0.49–0.99)	
Yes			

Respondents characteristic	Simple logistic regression	Multiple logistic regression	
	UOR (95% CI)	AOR (95% CI)	p-value
Decision-making authority	1	1	0.121
Not man	0.55 (0.43–0.70)	0.72(0.47–1.10)	
Man			
Perpetrate IPV	1	1	0.018
No	1.83 (1.49–2.26)	1.51(1.08–2.13)	
Yes			
Num. of main sexual partners	1	1	0.009
One	0.26 (0.15–0.45)	0.34(0.15–0.75)	0.011
None	1.23 (0.93–1.63)	1.78(1.15–2.75)	
More than one			
Have other sexual partners	1	1	0.577
No	1.40 (1.15–1.72)	0.89(0.60–1.34)	
Yes			
Transactional sex	1	1	0.844
No	1.53 (1.23–1.93)	1.04(0.70–1.54)	
Yes			
Wanted first child	1	1	0.018
No	0.64 (0.56–0.81)	0.71(0.54–0.94)	
Yes			

Men who reported controlling behaviour had a 30% reduction in the odds of practicing contraception compared to those who did not (AOR = 0.70, 95% CI: 0.49–0.99, p-value = 0.045). Also, males who perpetrated any form of IPV in the last 12 months had 51% higher odds of practicing contraception than those who did not (AOR = 1.51, 95% CI: 1.08–2.13, p-value = 0.018). Men who did not have a main sexual partner had a 66% reduced odds of practicing contraception compared to those with one main sexual partner (AOR = 0.34, 95% CI: 0.15–0.75, p-value = 0.009). Furthermore, those who had more than one main sexual partner had a 78% higher odds of practicing contraception than those with one main sexual partner (AOR = 1.78, 95% CI: 1.15–2.75, p-value = 0.011). Lastly, participants who wanted their first child at the time of delivery had a 29% reduction in the odds of practicing contraception compared to those who did not want their first child at delivery (AOR = 0.71, 95% CI: 0.54–0.94, p-value = 0.018).

Table 3: Results of multiple logistic regression (multivariate analysis)

Discussion

This study found a 24.4% prevalence of contraception among men in the Central Region of Ghana. This prevalence is probably less than the actual prevalence for these districts because males are more likely to underreport the use of contraceptives compared to females (Wang & Higgins, 2018). This is because some females tend to conceal their use of some methods of contraception from their partners (Hameed et al., 2014).

Level of education emerged as one of the independent predictors of contraception in this study, consistent with other studies (Babalola et al., 2015; Kabagenyi et al., 2014; Sunnu et al., 2016). The higher odds of practicing contraception among educated males can be explained by the fact that educated people will easily access and comprehend information regarding family planning, understand the benefits of limiting birth or the disadvantages of large family size, and thus practice contraception.

Our findings of higher odds of practicing contraception among males who perpetrated violence against their partners is consistent with other studies. Kidman et al. 2015, for example, after analysing the DHS data for the Democratic Republic of Congo, found that households in which men perpetrated sexual IPV were more likely to use modern contraceptives than homes where IPV was not common. Furthermore, in Pakistan, women who experienced IPV had higher odds of practicing both modern and traditional methods of contraception compared to those who did not experience IPV (Murshid, 2017). These can be explained by the fact that the partners of males who experience IPV will most likely practice contraception to avoid unwanted pregnancies and thus empower themselves since sexual IPV was the most common form of IPV perpetrated by the males in this current study. Contrary to our research, Maxwell et al. 2018, discovered that in Uganda, perpetration of IPV resulted in reduced odds of using methods of contraception that require the cooperation of both partners like condoms. This due to the inability of the spouses of the males to negotiate the use of such methods (e.g. condoms) as a result of coercion or fear of violence which is common among men who perpetrate IPV (Maxwell et al., 2015).

This study's finding of an association between male controlling behavior and practice of contraception is similar to that obtained in Nigeria, after analysis of their 2008 DHS data. In the study, women whose husbands had a controlling behaviour had reduced odds of practicing contraception compared to women whose husbands did not have a controlling behaviour (Solanke & Shobanke, 2016). This is because such men tend to restrict their spouses from seeking family planning services with the excuse that it encourages women to be unfaithful to their husbands (Sakara et al., 2015).

The higher odds of practicing contraception among males who did not want their first child at delivery could be explained by an avoidance of potential stresses experienced in the past to cater for the mother during pregnancy and the child. This will mean that such men will most likely practice contraception to prevent future unwanted births. The higher odds of practicing contraception among respondents who had more than one main sexual partner compared to those with just one main sexual partner is consistent

with many studies in Africa (Ochako et al., 2017; Simbayi et al., 2014). People with multiple sexual partners practice contraception, especially barrier methods, to limit or prevent pregnancies and sexually transmitted infections (Chimbindi et al., 2010; Simbayi et al., 2014).

Conclusion And Recommendations

There is evidence that the prevalence of contraception in sub-Saharan African countries like Ghana is very low. This study points out that approximately one out of every four men practices contraception in the four districts of the Central Region of Ghana. Also, the educational level, perpetration of IPV, controlling behavior, number of main sexual partners and whether the first child was wanted are some male-specific characteristics that can predict the practice of contraception. Given these findings, there is a need for various stakeholders in the health sector to organize health campaigns aimed at educating men on the importance of contraception. Also, there is a need for multisectoral collaboration to discourage behaviors like male controlling behavior for example, that hinders family planning services' uptake. Finally, the Ghana Health Service must devise and implement strategies to render male-friendly services to involve men in family services.

Study Limitations

This study may have underestimated the prevalence of contraception among men mainly due to the possibility of covert usage of some modern methods by their partners. This study could also not report on specific forms of contraceptives used by men and or their partners. However, the evidence provided by this study can inform policymakers and program designers to ensure the successful design and implementation of family planning programs.

List Of Abbreviations

AOR Adjusted Odds Ratio

BMGF Bill and Melinda Gates Foundation

CI Confidence Interval

COMBAT Community-Based Action Teams

DHS Demographic and Health Survey

GHS Ghana Health Service

GSS Ghana Statistical Service

ICF International Coach Federation

IPV Intimate Partner Violence

RRS Rural Response System

SD Standard Deviation

UOR Unadjusted Odds Ratio

WHO World Health Organization

Declarations

Ethics approval and consent to participate: The primary investigators obtained ethical clearance from the Noguchi Memorial Institute for Medical Research Institutional Ethics Board (NMIMR-IRB), Legon, University of Ghana (number 006/15-16) and the South African Medical Research Council (EC031-9/2015). Permission to use the de-identified data set was obtained from the primary investigators of the Ghana COMBAT Study.

Consent for publication: Not applicable

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Authors' contributions: LTA and DOA conceived the tittle for the study, conducted the analysis, interpretation, reporting and writing of the manuscript. DOA, AAL and RMK are the primary investigators who conceptualized the study, designed and collected the data. AAL also reviewed analysis, reporting, and writing of the final manuscript. RMK and AAM critically reviewed the manuscript, especially the reporting, and interpretation of the study findings.

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