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Assessing the Prevalence and Factors Influencing Male Involvement in Family Planning Services in an Urban Ghanaian Community

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ABSTRACT

This study explored factors influencing male engagement in FP in Madina, Ghana, to inform targeted interventions. A descriptive cross-sectional study was conducted in Madina, involving 390 married men aged 18-65 with at least one child. Data were collected through structured questionnaires and analyzed using SPSS version 22. Descriptive statistics and binary logistic regression assessed associations between male involvement in FP and various factors. The study revealed that 34.6% of participants discussed FP with their spouses, with most discussions occurring monthly. Current contraceptive use among participants and their spouses was 28.8%, with injectables and pills being the most common methods. Significant factors influencing male involvement included educational level and spousal communication. Higher education levels were associated with increased involvement (AOR = 0.66, 95% CI [0.517, 0.848], $p = 0.001$). Men who engaged in FP discussions with their spouses had markedly higher involvement (AOR = 8.23, 95% CI [4.703, 14.411], $p < 0.001$). However, age, religion, ethnicity, and intention to have more children did not significantly impact male involvement. Occupational status also did not show a significant effect on participation. The findings highlight the crucial role of education and spousal communication in enhancing male involvement in FP. To improve FP outcomes, interventions should focus on increasing educational opportunities and fostering open communication between partners. Addressing these areas could significantly boost male participation in FP programs in Ghana. Additionally, investigating the impact of tailored communication strategies and educational approaches on male involvement could provide further insights and enhance family planning practices.

INTRODUCTION

Reproductive health is a crucial societal concern that extends beyond women and requires comprehensive attention from all sectors of society (WHO, 2017). Family Planning (FP) is a key aspect of reproductive health, essential for controlling population growth and reducing unintended pregnancies (Itunnu *et al.*, 2019; Adane *et al.*, 2024). It provides significant benefits, including reducing HIV transmission to newborns, lowering maternal mortality and morbidity, decreasing neonatal and child mortality, reducing unsafe abortions, and improving educational and employment opportunities for women by delaying childbearing (Sherwood *et al.*, 2021). FP's full potential remains unrealized despite these benefits, especially in Africa and Ghana, where male involvement is notably low (Osuafor *et al.*, 2023). Factors contributing

to this low involvement include male perceptions of FP, socio-economic and demographic profiles, existing policies, media campaigns, interpersonal communication from health workers, familial advice, spousal dialogue, and health system constraints (Manortey & Missah, 2020). While women often bear the majority of reproductive health responsibilities and receive most FP services, men typically hold higher decision-making power regarding sexual relations, family size, and healthcare (Kwawukume *et al.*, 2022). Men's participation is crucial for effective FP programs and women's empowerment, as it is linked to better contraceptive acceptance, continuation, and safer sexual behaviors (Mosha *et al.*, 2013). Historically, reproductive health programs have focused on women, neglecting men's roles in FP. Most contraceptive methods are designed for women. There is a recognized need for

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male involvement in FP efforts, making it essential to explore husbands' contraceptive practices (Kushitor *et al.*, 2022). FP is vital for improving women's health and managing population growth, with benefits extending to economic and social outcomes for families (Starbird *et al.*, 2016). Global endorsement of FP highlights its role in spacing and limiting childbirth, reducing maternal and child mortality, and better family well-being (Koffi *et al.*, 2018). Despite growing recognition of the importance of involving men, many countries, including those in sub-Saharan Africa, lack extensive programs to engage men effectively (Kwawukume *et al.*, 2022; Montt-Maray *et al.*, 2023). In patriarchal societies, men often control decisions about family size and contraceptive use, which can hinder women's FP uptake (Nkonde *et al.*, 2023). The 1994 International Conference on Population and Development and the 1995 World Conference on Women emphasized the importance of male involvement in reproductive health (United Nations, 1994). However, sub-Saharan Africa faces high fertility rates and unmet FP needs due to low male involvement (Gahungu *et al.*, 2021). Ghana also faces socio-cultural barriers that affect male participation in reproductive health. Despite efforts to address high population growth through national policies and international funding, Ghana's contraceptive prevalence remains low (Atuahene *et al.*, 2017). This study aimed to bridge the knowledge gap by assessing male involvement in FP in the Madina area. It sought to understand men's knowledge, use and perspectives regarding FP, which was crucial for designing effective interventions and policies. The findings were intended to help authorities and policymakers develop strategies to enhance male engagement in FP, ultimately improving the effectiveness of FP programs and outcomes.

MATERIALS AND METHODS

Study Location

This study was conducted in Madina, a suburb within the La-Nkwantanang Madina Municipality in Ghana's Greater Accra Region. Madina covers an area of 70.887 square kilometres and has a population of approximately 79,832, while the total population of the municipality is 137,162. The area is divided into three administrative zones and is characterized by its economic activities in commerce, agriculture, services, and manufacturing. Notable economic activities include trading at the Madina market and operations in various manufacturing industries. The area benefits from good road connectivity and is served by three government hospitals and nine private health facilities.

Study Design

A descriptive cross-sectional exploratory design was utilized to examine the factors influencing male support for family planning in Madina. This approach allowed for a comprehensive evaluation of the determinants of male involvement in family planning within the specified population.

Study Population, Study Variables and Sample Size

The study targeted married men aged between 18 and 65 years who had at least one child. In-depth interviews were conducted with experienced nurses from a government health facility to gain insights into their perspectives and experiences related to family planning. These interviews followed a structured guide to ensure consistency and depth in the data collection.

The study investigated various explanatory variables related to male involvement in family planning. Socio-demographic factors examined included age, occupation, religion, ethnicity, and education. Additional social factors such as the number of children and occupation were also considered. Men's attitudes towards family planning were evaluated using a six-item Likert scale (Agree-Neutral-Disagree), with reliability assessed via Cronbach's alpha. Key variables included knowledge and use of family planning, the provision of emotional support, and spousal communication.

The sample size was determined using the Cochran's formula (1963):

$$N = \frac{Z^2 P(1 - P) \times Design\ Effect}{e^2}$$

where N is sample size, Z represents the Z-score for a 95% confidence interval (1.96), P is the estimated proportion of the population, and e is the maximum permissible error. A design effect of 1.2 was applied to account for cluster sampling, and the sample size was increased by 5% to account for non-response, resulting in a final sample size of 390.

Sampling Method, Data Collection Techniques and Tools

A multi-stage sampling technique was employed. First, stratified sampling was used to select sub-areas within Madina. This was followed by systematic sampling to select houses, where the first house in each stratum was chosen randomly, and subsequent houses were selected at every 20th interval from the starting point. Purposive sampling was then used to select married men with at least one child for participation in the study.

Data collection for this study was conducted over a period of two weeks, from June 13 to June 29, 2017. Structured face-to-face interviews were employed as the primary method for gathering data. The interviews utilized a questionnaire designed to capture a comprehensive range of information, including socio-demographic characteristics, knowledge and attitudes towards family planning, spousal communication, and barriers to male involvement in family planning. The questionnaire was carefully crafted to ensure that it addressed all relevant aspects of the research questions and was pre-tested for reliability and validity prior to data collection to enhance its accuracy and effectiveness.

The questionnaires were administered by the principal investigator and a team of trained research assistants. To maintain the integrity of the data, the completed forms

were collected directly by the principal investigator. This approach helped ensure that the data collection process was closely monitored and any potential issues were promptly addressed.

Data entry and analysis were performed using SPSS version 22. The data cleaning process involved running frequency distributions to identify and rectify any coding errors, which was crucial for ensuring the accuracy and reliability of the dataset.

Quality control measures were rigorously applied throughout the data collection process. Data collectors received comprehensive training to standardize the data collection procedures. Additionally, daily feedback was provided to address any issues and ensure adherence to the study protocols. A supervisor reviewed and signed completed forms before being transferred to the principal investigator. Each form was assigned a unique identification code to facilitate traceability and maintain data integrity.

Data Processing and Analysis

Data analysis was conducted using SPSS version 22.

Descriptive statistics, such as frequency tables and percentages, summarized the data. Binary logistic regression was used to assess the relationship between husbands' attitudes towards family planning and their involvement in family planning. Reliability was evaluated using Cronbach's alpha, while statistical significance was determined using Wald tests and p-values. Odds ratios (OR) and 95% confidence intervals (CI) were calculated to assess the strength of the associations.

RESULTS AND DISCUSSIONS

Socio-Demographic Characteristics of Respondents

Most participants were aged 30-39 years (55.6%) and were predominantly Christian (58%). The largest ethnic group was Northern (36.7%), with notable representation from the Akan (32.3%). Educationally, 37.7% had completed Senior High School, and 32.3% had tertiary education. In terms of occupation, self-employed individuals were most common (38.7%). Most participants had 1-3 children (87%), and the study areas were equally represented: Zongo, Welfare, and Estate (33.3% each).

Table 1: Socio-Demographic Characteristics of Study Participants

Variable/Category	Frequency (n=390)	Percent (%)
Age		
< 30	112	28.7
30 – 39	217	55.6
40 – 49	51	13.1
50 years and above	10	2.6
Religion		
Christian	226	58
Islamic	158	40.5
Traditional	6	1.5
Ethnicity		
Ga Adangme	62	15.9
Akan	126	32.3
Ewe	59	15.1
Northern	143	36.7
Level of Education		
None	13	3.3
Primary	28	7.2
J.H.S	76	19.5
S.H.S	147	37.7
Tertiary	126	32.3
Occupation		
Unemployment	27	6.9
Farmer/fisherman	18	4.6
Government worker	88	22.6
Self employed	151	38.7
Artisan	49	12.6
Private work	57	14.6

Number of Children		
1-3	339	87
4-5	45	11.6
6+	6	1.6
Type of area		
Zongo	130	33.3
Welfare	130	33.3
Estate	130	33.3

Knowledge and Use of Family Planning

The study revealed that all participants had heard of family planning (FP), with the majority learning about it through media (42.2%) and friends (25.4%). Knowledge about FP varied, with 42.1% having an average understanding and 33.1% possessing little knowledge. The most recognized FP methods were condoms (27.4%), pills (32.6%), and

injectables (29.0%). Most participants acknowledged the importance of FP for spacing births (41.8%) or limiting births (25.4%). A minority had used FP methods previously (43.6%), with the majority of past users having done so for up to two years. Current usage of FP was relatively low at 28.8%, with convenience being the most common reason for use (26.2%).

Table 2: Knowledge and use of FP

Variable/Category	Frequency	Percent (%)
Heard of FP		
Yes	390	100
No	0	0
Where you heard		
School	44	11.3
Church/Mosque	20	5.1
Parents	1	0.3
Friends	61	15.7
Health Facility	99	25.4
Media	164	42.2
Knowledge about FP		
Very Little	9	2.3
Little	129	33.1
Average	164	42.1
Adequate	88	22.5
FP method you know		
Condom	107	27.4
Pills	127	32.6
Injectable	112	29
IUD/Implanon	42	10.5
Traditional	2	0.5
Importance of FP		
Space birth	163	41.8
Limit birth	99	25.4
Both	123	31.5
None	5	1.3
Used any FP before		
Yes	169	43.6
No	221	56.4

Length of using		
6 Months	28	16.5
1 Year	53	31.2
1.5 Year	5	2.9
2 Years	53	31.2
>2 years	31	18.2
Reason for FP use		
No Reason	7	4.2
Minimal Side Effect	59	35.1
Affordable	16	9.5
Convenient	42	25
Easy to Use	44	26.2
Currently using FP		
Yes	112	28.8
No	278	71.2

Source: Field survey, 2017

Among participants whose spouses were currently using family planning methods, injectables were the most commonly used, representing 41.8% of the methods reported. Pills were the second most frequently used method, at 25.4%. Implants were used by 17.3% of

participants' spouses, while condoms and intrauterine devices (IUDs) were less common, at 8.2% and 6.4%, respectively. Sterilization was the least reported method, with only 0.9% of participants indicating its use by their spouses.

Table 3: Current use of FP Method

Variable	Frequency	Percent (%)
Pills	28	25.4
Injectable	46	41.8
Condoms	9	8.2
IUD	7	6.4
Implants	19	17.3
Sterilization	1	0.9

Source: Field survey, 2017

Spousal Communication on Family Planning

The findings indicate that 34.6% of participants discussed family planning (FP) with their spouses, while 65.4% did not. Among those who did engage in communication, 36.1% did so every week, 42.8% monthly, and 21.1% annually. Of those who did not

communicate, 43.2% deemed it unnecessary, 26.3% viewed it as a responsibility exclusive to women, 10.4% lacked time, and 20.1% felt uncomfortable. Additionally, 64.6% of participants had conversations with their spouses about the number of children they desired, while 35.4% did not.

Table 4: Spousal communication on FP

Statement	Frequency	Percent (%)
Communicate with wife		
Yes	135	34.6
No	255	65.4
How often		
Weekly	48	36.1
Monthly	57	42.8
Yearly	28	21.1
Why not communicate		
Not necessary	112	43.2

Women responsibility	68	26.3
Don't have time	27	10.4
Feel uncomfortable	52	20.1
Discussed number of children		
Yes	252	64.6
No	138	35.4

Source: Field survey, 2017

Male Involvement in Family Planning

The data reveal that only 14.9% of men had previously accompanied their wives to family planning (FP) services, with 85.1% not having done so. Of those who did accompany their wives, 62.1% cited support as the primary reason, 31.1% wanted to learn more about FP, and 6.9% did it to show affection. Conversely, the main reasons for not accompanying were lack of

time (43.1%), viewing FP as a woman's responsibility (30.4%), and unhelpful health staff (26.5%). Regarding support for FP, 63.6% of married men were supportive, while 36.4% were not. Accessibility issues were noted, with 43.1% of men living within walking distance of a clinic, 27.4% within a 20-minute drive, and 29.5% more than 20 minutes away. Most participants (75.6%) found FP services affordable, while 24.4% did not.

Table 5: Male Involvement in Family Planning

Statement	Frequency	Percent
Accompanied wife before for FP		
Yes	58	14.9
No	332	85.1
Reason for accompanying		
For support	36	62.1
To know about FP	18	31.1
To show love	4	6.9
Reason for not accompanying		
Don't have time	143	43.1
Women responsibility	101	30.4
Unfriendly health staff	88	26.5
Married men support to do FP		
Yes	248	63.6
No	142	36.4
Distance to clinic		
Walking distance	168	43.1
Less than 20 min. drive	107	27.4
More than 20 min. drive	115	29.5
Affordability of service		
Yes	295	75.6
No	95	24.4

Source: Field survey, 2017

Socio-Demographic Factors and Other Influences on Male Involvement in Family Planning

Pearson chi-square analysis was used to assess associations between male involvement in family planning and various independent variables. The analysis found significant relationships with educational level and occupation but not with age, religion, or ethnicity. Educational level was strongly associated with male

involvement ($\chi^2(4) = 21.264$, $p < 0.001$), indicating that higher education correlates with greater involvement. Occupation also showed a significant association ($\chi^2(5) = 15.499$, $p = 0.008$), with unemployed individuals and those in private work exhibiting higher involvement. Conversely, age, religion, and ethnicity did not show significant associations, with p-values of 0.13, 0.12, and 0.709, respectively.

Table 6: Socio-Demographic Factors Influencing Male Involvement in Family Planning

Variable/Category	Male involvement in FP?		Chi-square test	
	Yes	No	p-value	Chi-square χ^2
Background factors				
Age	24(21.4%)	88(78.6%)	0.130	5.643
< 30	67(31%)	149(69%)		
30 – 39	19(37.3%)	32(62.7%)		
40+	2(20%)	8(80%)		
Religion				
Christianity	74(32.7%)	152 (67.3%)	0.120	4.242
Islamic	37(23.6%)	120 (76.4%)		
Traditional	1(16.7%)	5 (83.3%)		
Ethnicity				
Ga Adangme	18(29%)	44 (71%)	0.709	1.386
Akan	37 (29.6%)	88 (70.4%)		
Ewe	20(33.9%)	39 (66.1%)		
Northern	37 (25.9%)	106 (74.1%)		
Level of Education				
None	2 (15.4%)	11 (84.6%)	P<0.000	21.264
Primary	2 (7.1%)	26 (92.9%)		
Junior High School (JHS)	12 (16%)	63 (84%)		
Senior High School (SHS)	46 (31.3%)	101 (68.7%)		
Tertiary	50 (39.7%)	76 (60.3%)		
Occupation				
Unemployed	12 (44.4%)	15 (55.6%)	0.008	15.499
Farmer/fisherman	1 (5.6%)	17 (94.4%)		
Government worker	27 (30.7%)	61 (69.3%)		
Self-employed	38 (25.2%)	113 (74.8%)		
Artisan	10 (20.8%)	38 (79.2%)		
Private work	24 (42.1%)	33 (57.9%)		

Source: Field survey, 2017

Intention to have more children was significantly associated with lower involvement in family planning ($\chi^2(1) = 10.883$, $p = 0.001$). Knowledge of family planning's importance was not significantly related ($\chi^2(3) = 6.618$, $p = 0.085$). However, spousal communication was a significant factor, with men who communicated about family planning being more involved ($\chi^2(1) =$

43.788, $p < 0.001$). Discussing the number of children was also positively associated with involvement ($\chi^2(1) = 8.88$, $p = 0.003$). These results emphasize the roles of education, occupation, intention to have more children, and spousal communication in influencing male participation in family planning.

Table 7: Spousal Communication, Knowledge and Intention Factors Influencing Male Involvement in Family Planning

Variable/Category	Male involvement in FP?		Chi-square test	
	Yes	No	p-value	Chi-square χ^2
Intention factors				
Intention to have more children?				
Yes	74 (24.7%)	226 (75.3%)	0.001	10.883
No	38 (42.7%)	51 (57.3%)		
Knowledge of importance of FP				
Space birth	56 (34.4%)	107 (65.5%)	0.085	6.618
Limit birth	22 (22.2%)	77 (77.8%)		

Both	34 (27.9%)	88 (72.1%)		
None	-	5 (100%)		
Spousal communication factors				
Communicate with wife about FP?				
Yes	67 (49.6%)	68 (50.4%)	P<0.000	43.788
No	45 (17.7%)	209 (82.3%)		
Discussed the number of children?				
Yes	85 (33.9%)	166 (66.1%)	0.003	8.88
No	27 (19.6%)	111(80.4%)		

Source: Field survey, 2017

Logistic regression analysis was conducted to explore factors associated with male involvement in family planning. The analysis revealed that higher levels of education were significantly associated with increased male involvement, with those having completed Senior High School (SHS) or higher serving as the reference group (AOR = 1.00), while those with Junior High School (JHS) or lower education had lower odds of involvement (AOR = 0.66, 95% CI [0.517, 0.848], $p = 0.001$). Occupation did not show a significant impact, with unemployed men having similar odds of involvement compared to employed men (AOR

= 1.16, 95% CI [0.965, 1.392], $p = 0.115$). Intention to have more children was not significantly related to male involvement (AOR = 0.90, 95% CI [0.503, 1.626], $p = 0.737$). However, effective communication with one's wife about family planning was strongly associated with higher involvement (AOR = 8.23, 95% CI [4.703, 14.411], $p < 0.001$). Discussion of the number of children did not show a significant effect (AOR = 1.48, 95% CI [0.850, 2.579], $p = 0.166$). These results underscore the importance of education and spousal communication in enhancing male participation in family planning.

Table 8: Sociodemographic and communication factors correlate of male involvement in Family Planning using logistic regression

Variable/Category	Male involvement in FP?		AOR (CI 95%)	P-value
	Yes	No		
Level of Education				
JHS or below	16(4.1%)	100(25.7%)	0.66(0.517 - 0.848)	0.001
SHS and above	96(24.7%)	177(45.5%)	1 reference	
Occupation				
Unemployed	12(3.1%)	15(3.9%)	1.16(0.965 - 1.392)	0.005
Employed	100(25.1%)	262(67.4%)	1 reference	
Intention to have more children?				
Yes	74 (24.7%)	226 (75.3%)	0.90(0.503 - 1.626)	0.737
No	38 (42.7%)	51 (57.3%)	1 reference	
Communicate with wife about FP?				
Yes	67 (49.6%)	68 (50.4%)	8.23(4.703 - 14.411)	P<0.000
No	45 (17.7%)	209 (82.3%)	1 reference	
Discussed the number of children?				
Yes	85 (33.9%)	166 (66.1%)	1.48(0.850 - 2.579)	0.166
No	27 (19.6%)	111(80.4%)	1 reference	

Source: Field survey, 2017

Source: Field survey, 2017

Discussion

This study investigated factors influencing male involvement in FP, focusing on knowledge, spousal communication, and socio-demographic influences. We compared these findings with recent literature and explore potential reasons behind the observed results. The study found that while husbands generally have a high awareness of FP methods, their understanding of

detailed aspects, such as side effects and management, was limited. This finding aligns with the GDHS report, which shows high general awareness but highlights a similar gap in detailed knowledge (Ghana Statistical Service, 2023). Recent studies reinforce this observation (Olufunke, 2023). For example, a 2021 study by Radzuma *et al.*, (2022) revealed that while men in low-resource settings are aware of FP methods, their understanding

of side effects and management is often superficial. This suggests that general awareness does not necessarily translate into comprehensive knowledge or effective use. However, this finding contradicts with findings in Ethiopia (Adane *et al.*, 2024).

The reliance on media and friends as primary sources of FP information, as noted in this study, is consistent with a study conducted to assess mass media influences on family planning knowledge, attitudes, and method choice among sexually active men in sub-Saharan Africa (Mutumba, 2022) and in Malawi (Osuafor *et al.*, 2023), which found that Radio exposure had the largest impact on FP knowledge, attitudes and method choice media significantly influences FP awareness in urban areas. However, reliance on media can result in fragmented or simplified information, lacking the depth needed for informed decision-making. According to a study in 2016 media campaigns often prioritize promoting methods over providing comprehensive education, leading to gaps in understanding (Ajaero *et al.*, 2016).

The limited depth of knowledge about side effects and their management also corroborates findings from (Takyi *et al.*, 2023), which noted that health providers often fail to cover the full range of contraceptives and their potential issues. This might be attributed to time constraints during counselling sessions or a lack of emphasis on detailed information in training programs for healthcare providers. The study highlights a significant deficit in spousal communication about FP, with many men not accompanying their wives to FP clinics and not discussing FP choices regularly. This aligns with (Manortey & Missah, 2020), who identified insufficient spousal communication as a major barrier to FP in Tema Metropolis, Ghana. Similarly, recent literature such as the 2023 study by Osuafor *et al.* (2023), emphasizes that low levels of spousal communication correlate with lower levels of FP use. Conversely, the study found that 34.6% of participants engaged in discussions about FP, suggesting that communication, when it occurs, is positively associated with involvement. This supports a study in Togo, which found that favourable spousal communication significantly improves male involvement in FP (Koffi *et al.*, 2018). The discrepancy in communication levels could be influenced by cultural norms or personal discomfort with discussing reproductive health, as identified by Dansereau *et al.* (2017), who found that cultural taboos and personal discomfort often inhibit open discussions about FP.

The study's finding of generally low male involvement in FP is consistent with findings from Atuahene *et al.* (2017) and Nkonde *et al.* (2023), who noted that cultural and gender norms often limit male participation in reproductive health.

This study extends this understanding by showing that men's perceived lack of relevance or responsibility for FP may also contribute to low involvement. This contrasts with (Kwawukume *et al.*, 2022) findings, which suggest that men do care about women's reproductive health

issues but may lack the means or motivation to act on this care.

Possible reasons for low male involvement could include entrenched gender roles, as discussed by Montt-Maray *et al.* (2023), who found that in many cultures, FP is still viewed primarily as a woman's responsibility. Additionally, logistical barriers, such as lack of time or perceived inconvenience, further discourage participation, as evidenced by the study's finding that many men did not accompany their wives to FP clinics.

The study revealed that educational level and occupation were significant factors in male involvement in FP, while age, religion, and ethnicity were not. This finding is consistent with recent literature suggesting that higher education is associated with increased FP involvement. For example, a 2020 study by Wondim *et al.* (2020) and a 2022 study by Oyefabi *et al.* (2022) found that higher educational attainment generally correlates with better knowledge and engagement in FP. However, the lack of significant associations with age, religion, and ethnicity diverges from other studies, such as those by Amuzie *et al.* (2022), which found that these factors can influence FP attitudes and behaviours.

The mixed results regarding socio-demographic factors may be due to variations in study contexts or methodological differences. For instance, different cultural or regional contexts might influence the relevance of these socio-demographic characteristics. Additionally, the use of different research methods, such as qualitative versus quantitative approaches, may yield different insights, as noted by MacHange and Munyogwa, (2022), who found varying impacts of socio-demographic factors depending on the study design.

To address the challenges identified, several strategies are recommended: enhancing comprehensive education by providing men with detailed information on side effects and their management through targeted programs and counselling; promoting spousal communication by encouraging open dialogues between partners with resources and training to overcome cultural or personal barriers; and improving accessibility and support by addressing logistical issues, ensuring FP services are more accessible, and training health workers to deliver comprehensive counselling. Implementing these strategies has significant implications for family planning programs and policies. By bridging gaps in knowledge, communication, and accessibility, these measures can enhance male involvement, improve support for partners, and lead to more effective use of family planning methods, ultimately contributing to better reproductive health outcomes.

Strengths and Limitations of the Study

This study provides a comprehensive analysis of male involvement in maternal health decision-making by employing a robust mix of quantitative and qualitative methods. It highlights key factors such as knowledge, spousal communication, and socio-demographic

influences, offering valuable insights into the barriers and facilitators of male engagement in family planning. Additionally, the study's use of diverse data sources strengthens the reliability and validity of its findings. The study is limited by its reliance on self-reported data, which may introduce response biases. Additionally, the cross-sectional design restricts the ability to establish causality between the identified factors and male involvement. The findings may also not be generalizable beyond the specific district studied, given the potential variability in socio-cultural contexts.

CONCLUSIONS

This study highlights the need to enhance male involvement in family planning by improving education and spousal communication and addressing logistical barriers. While men have basic knowledge of contraceptive methods, there is a gap in detailed understanding and active participation. Future research should focus on evaluating specific educational programs and communication strategies and conducting longitudinal studies to assess the long-term impact of these interventions in diverse contexts. These efforts will contribute to more effective and inclusive family planning practices.

RECOMMENDATIONS

To enhance male involvement in maternal health decision-making, the following actions should be implemented:

District Health Administration (DHA)

The DHA should prioritize educational campaigns that address the side effects and management of family planning (FP) methods. These programs should also emphasize the economic benefits of FP and the importance of birth spacing and limiting to overcome barriers related to side effects.

District Family Planning Coordinators

District Family Planning Coordinators should expand the range of contraceptive options available at local clinics. They should also ensure that providers receive ongoing technical training to improve service quality and address diverse client needs, reducing the need for clients to seek services elsewhere.

District Health Planning Units

The District Health Planning Units should focus on improving accessibility to FP services by addressing logistical barriers and creating a more male-friendly environment in FP units. This approach should encourage greater male involvement and support.

District Community Outreach Programs

Community outreach programs should engage with local leaders and organizations to promote male involvement in FP. They should establish support networks and peer education groups for men to foster inclusivity and shift cultural perceptions.

District Policy Makers and Local Government Officials

Policy makers and local government officials should develop and support district-specific policies aimed at increasing male involvement in FP. This includes securing funding and resources for expanding services and implementing educational programs to create a supportive policy environment.

Ethical Considerations

Ethical approval was granted by the Ghana Health Service Ethical Review Committee. Permissions were obtained from relevant health authorities and community leaders. Participants were informed about the study and gave written consent before participation. Privacy was maintained by conducting individual interviews and using identification numbers to protect anonymity. Data collectors and analysts were trained to uphold confidentiality throughout the study.

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