

1 **Prevalence and Determinants of male modern**
2 **contraceptive use in Togo: a quantitative study in the**
3 **maritime region**

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10

11 **Abstract**

12 **Objective:** In recent years, the importance of involving men in family planning initiatives and
13 understanding their perspectives on contraception has gained recognition. This study aimed to
14 investigate modern contraceptive use among men in Togo, focusing on factors that determine their
15 contraceptive use.

16 **Methods:** The study employed a cross-sectional quantitative data collection approach to conduct
17 a primary data analysis in two communities in Togo. Participants were selected using a two-stage
18 cluster sampling technique. Data were gathered through self-administered questionnaires and then
19 analyzed using Stata software version 15.0. The analysis encompassed descriptive statistics and
20 logistic regression to ascertain prevalence rates and identify factors that influence male
21 contraceptive use.

22 **Results:** Half of the participants (50.6%) were using modern contraceptive which was condoms.
23 The multivariate logistic regression showed that residents of Tabligbo (AOR = 0.45; 95% CI: 0.24-
24 0.86), Muslims (AOR = 0.08; 95% CI: 0.02-0.38), cohabiting with someone (AOR=7.11; 95% CI:

25 3.24-15.62), belief that contraception is useful for men and participant whose partner (AOR = 0.12;
26 95 % CI: 0.04-0.36); (AOR = 0.43; 95 % CI: 0.24-0.77) were found to be significantly associated
27 with current male modern contraceptive use.

28 **Conclusion:** This study highlights the importance of promoting modern contraceptive knowledge
29 and usage among men in Togo. While condom use is prevalent, there is a need to enhance
30 awareness of other male contraceptive methods. Targeted interventions should consider factors
31 such as residence, religion, contraceptive behavior of men to improve male contraceptive use and
32 reproductive health outcomes in Togo.

33 **Introduction**

34 Contraceptive use in Africa holds significant importance due to several key factors
35 (Palamuleni, 2013; Melesse *et al.*, 2020; Boadu, 2022). One such reason is its role in addressing
36 the challenge of rapid population growth that many African countries are currently grappling with
37 (Wulifan & Bagah, 2015; Ouedraogo *et al.*, 2021; Boadu, 2022). According to the United Nations,
38 the African population is projected to double by 2050, reaching 2.5 billion people (Chapman *et*
39 *al.*, 2022). This is a problem due to its strain on resources, environmental impact, pressure on
40 infrastructure, exacerbation of poverty and inequality, impact on health, urbanization, and pressure
41 on ecosystems (Hasan *et al.*, 2019; Osakede, 2022; Tuholske *et al.*, 2019; Vearey *et al.*, 2019).
42 Addressing these challenges requires sustainable practices, access to education, healthcare, and
43 family planning (Tuholske *et al.*, 2019). Contraception plays a crucial role in curbing population
44 growth, promoting sustainable development, and empowering women (Silumbwe *et al.*, 2018;
45 Boadu, 2022). It reduces strain on healthcare and social services, enables women to pursue
46 education and employment, and prevents unsafe abortions and maternal mortality (Aliyu, 2018;
47 Yaya *et al.*, 2018; Haakenstad *et al.*, 2022). Modern contraceptive method such as condom use
48 also contributes to HIV/AIDS prevention in sub-Saharan Africa (Ruiseñor-Escudero *et al.*, 2019).

49 In sub-Saharan African nations, including Ghana, Mali, Tanzania, Togo, and Uganda, there
50 are significant disparities in the utilization of contraceptives compared to Western countries
51 (Williamson *et al.*, 2009; Boadu, 2022; Haakenstad *et al.*, 2022). The prevalence of modern
52 contraceptive use in sub-Saharan Africa remains consistently low, typically below 34% (Biney *et*
53 *al.*, 2021; Boadu, 2022; Febon *et al.*, 2015; GSS *et al.*, 2018). This is in stark contrast to the United
54 States, where 54% of females aged 15 to 19 reported condom use during their most recent sexual
55 activity (Williamson *et al.*, 2009). The low usage of contraceptives in sub-Saharan Africa countries

56 contributes to high rates of unintended pregnancies, unsafe abortions, and maternal deaths (Beson
57 et al., 2018; Bishwajit et al., 2017; Kiene et al., 2013). Several factors contribute to the low
58 utilization of contraceptives in these countries. Socio-cultural norms play a significant role,
59 shaping attitudes towards contraception and influencing decision-making around its use (Schuler
60 et al., 2011; Ohn Mar et al., 2019). Limited knowledge about contraceptive methods and where to
61 access them also hinders uptake (Ochako et al., 2017; Ahinkorah et al., 2020; Asiedu et al., 2020;
62 Boadu, 2022). Economic constraints and financial barriers pose challenges for individuals in
63 obtaining contraceptives (Palamuleni, 2013; Butame, 2019). Additionally, negative experiences
64 with health services, including issues such as stigma or disrespectful treatment, can deter
65 individuals from seeking contraception (Bishwajit et al., 2017).

66 Engaging communities and stakeholders is essential to foster positive attitudes towards
67 contraception (Yee & Simon, 2010; Hailu et al., 2022; Mbachu et al., 2023). Despite global efforts
68 to address these challenges, contraceptive use remain low, mostly in African countries, leading to
69 rapid population growth (Thummalachetty et al., 2017; Boadu, 2022). The latest Togo
70 Demographic and Health Survey indicated that modern contraceptive prevalence rate among all
71 women in Togo is 23% , indicating a low uptake of contraception (Febon et al., 2015). Unmet need
72 for contraceptives in Togo is high at 33%, and socio-cultural norms, low levels of knowledge about
73 where to access services, economic constraints, long travel distances, and negative experiences
74 with health services contribute to the low contraceptive use (Bellow et al., 2023). Additionally,
75 there are taboos related to culture and religious affiliation that hinder the use of contraceptive
76 methods in Togo (Adama-Hondegla et al., 2015).

77 Factors influencing contraceptive use in Togo include the impact of youth-friendly projects
78 on contraceptive use by young people and the positive influence of spousal communication on

79 contraceptive use (Arnold *et al.*, 2016). Meanwhile one study conducted in Uganda explored the
80 perceptions of men and women regarding barriers to involvement of men in positive reproductive
81 health behaviors (Kabagenyi *et al.*, 2014). The study identified five themes as rationale for limited
82 contraceptive uptake in men, including perceived side effects of female contraceptive methods that
83 disrupt sexual activity, limited choices of available male contraceptives, gender norms and
84 traditional family planning communication, and fear and concerns relating to vasectomy
85 (Kabagenyi *et al.*, 2014). These findings suggest that concerns about side effects and limited
86 options for male contraceptives can hinder male involvement in contraceptive use (Koffi *et al.*,
87 2018).

88 Men reported concerns about adverse side effects of contraceptives, including changes in
89 weight, vaginal lubrication, hypertension, and the development of infections or fibroids in the
90 reproductive organs of women (Thummalachetty *et al.*, 2017; Koffi *et al.*, 2018). These concerns
91 may contribute to hesitancy or reluctance among men to use modern contraceptives. False beliefs
92 and fears about side effects of modern contraceptive methods were also observed in studies study
93 conducted in Malaysia and rural Uganda (Dougherty *et al.*, 2018; Ohn Mar *et al.*, 2019). Men
94 expressed concerns about excessive menstrual bleeding, weight changes, and the potential for
95 abnormalities and deformities in children of women who use contraception (Dougherty *et al.*,
96 2018). These findings highlight the importance of addressing misconceptions and providing
97 accurate information about contraceptive methods to men.

98 Here, we assessed male knowledge and perception towards modern male contraceptive use.
99 This is crucial for promoting informed decision-making, addressing misconceptions, involving
100 men in family planning discussions, and developing male-centered contraceptive options. By

101 understanding and addressing the factors that influence male contraceptive use, healthcare
102 providers can contribute to improved reproductive health outcomes for both men and women.

103 **Methods**

104 The study employed a quantitative cross-sectional design conducted between April and
105 May 2019 within the communities of Lomé (6° 8' 11.86" N and 1° 13' 19.86" E), an urban area,
106 and Tabligbo (6° 34' 59.99" N and 1° 30' 0.00" E), a semi-urban area, both located in Togo. The
107 selection of Lomé and Tabligbo as study locations aimed to capture diverse sociodemographic and
108 economic contexts, ensuring a comprehensive analysis.

109 This cross-sectional study was conducted among sexually active males, aged between 15
110 and 59 years, residing in the selected locations. Females and males who were not sexually active
111 and below age of 15 and above 59 were excluded from the study. A minimum sample size of 272
112 was determined using the Cochran formula (Cochran, 1997):

$$113 \quad n = Z^2pq/d^2$$

114
115 where n is the desired sample size, Z (Z-score) = 1.96; p (given that the prevalence of male
116 contraceptive use in Togo is unknown, we made an estimation based on the contraceptive use rate
117 among women in the country), which stood at 0.23 as per the 2016-17 FP2020 annual report; $q =$
118 0.77; and d (margin of error) = 0.05. Considering a 15% non-response rate, a final sample size of
119 313 was considered in the study. A convenience sampling was employed to solicit participation
120 from sexually active males. Potential participants were identified and approached in various public
121 spaces and workplaces and informed about the study objectives. Eligibility was confirmed based
122 on age and sexual activity criteria, after which participants were presented with an informed
123 consent form. The form was read and its terms thoroughly explained to the potential participants

124 to ensure full understanding before signing, thereby formalizing their voluntary involvement in the
125 research.

126 Data was gathered from participants through a carefully pretested, structured self-
127 administered questionnaire. This questionnaire was developed after studying related literature and
128 previously used questionnaires (Schuler *et al.*, 2011; Kabagenyi *et al.*, 2014). Initially designed in
129 English, it was translated into French for administration. The questions were further translated into
130 local dialects, primarily Ewe for participants who were not fluent in French. The preliminary test
131 of the questionnaire was conducted with a sample of 20 sexually active men from Kpalime, who
132 had characteristics similar to the main study group. This pilot allowed the research team to refine
133 the questionnaire, ensuring it was relevant and comprehensible for the study participants.

134 The questionnaire was structured into three parts: the first delved into socio-demographic
135 characteristics; the second explored the knowledge of participants concerning male modern
136 contraceptives; while the third section focused on their use of contraceptives and the influencing
137 factors. Given the nature of the study topic and to ensure participants felt comfortable, only male
138 data collectors were engaged. They underwent a two-day training session to familiarize themselves
139 with the research objectives and the proper way to use the research tools. Even though the study
140 relied on convenience sampling with participants approached in public areas, their privacy was
141 prioritized, and they were identified solely by numbers to maintain anonymity.

142 *Ethical considerations*

143 The study obtained ethical approval from the Ethical Review Committee of the Togolese
144 MoH, denoted by the Protocol ID Number: 119/19. This clearance ensured the rights and privacy
145 of the participants were maintained. Additionally, verbal permissions were procured from the
146 chiefs and elders of the community, underscoring the regard for the local governance systems.

147 Prior to their participation, individuals gave their informed consent in writing, confirming their
148 voluntary participation.

149 *Data analysis*

150 The collected data was entered into Microsoft Excel and subsequently analyzed using Stata
151 software version 13 with descriptive statistics presented in tables, graphs, and charts. Additionally,
152 Pearson Chi-Square test and multiple logistic regression analysis has been performed to investigate
153 the correlation between modern contraceptive use and predictors.

154

155 **Results**

156 *Participant sociodemographic characteristics*

157 The study had a response rate of 99%, with a total of 308 participants ($N = 311$; Table 1).
158 Among the participants, 49.4% resided in the urban area of Lomé, while 50.6% lived in the semi-
159 urban area of Tabligbo ($N = 308$; Table 1). The age of the respondents ranged from 15 to 50 years,
160 with a mean age of 29.3 ($N = 308$; Table 1). The largest proportion of participants, 44.5%, were
161 married, and the majority, 79.2%, identified as belonging to the southern ethnicity ($N = 308$; Table
162 1). In terms of religion, 63% of the participants identified as Christian, and 40.3% had completed
163 secondary school education ($N = 308$; Table 1). Among the respondents, 54.3% reported being
164 single, 61.4% reported not having any children, and 38.6% were self-employed ($N = 308$; Table
165 1).

166

167 **Table 1** Background characteristics of participants.

Variables	Frequency (N)	Percentage (%)
Age		

15-24	81	26.3
25-34	146	47.4
35-44	62	20.1
45-50	19	6.2

Marital status

Single	76	24.7
Married	137	44.5
Cohabiting	95	30.8

Ethnicity

Southern ethnicity ^a	244	79.2
Northern ethnicity ^b	56	18.2
Other ethnicities ^c	8	2.6

Religion

Animism	50	16.2
Christian	194	63.0
Islam	22	7.1
No religion	42	13.6

Educational level

No education	28	9.1
Primary	56	18.2
Secondary	124	40.3
University	100	32.5

Number of children

0	189	61.4
1	33	10.7
2	44	14.3
3+	42	13.6

Employment status

Public sector	40	13.0
Private sector	34	11.0
Self-employed	119	38.6

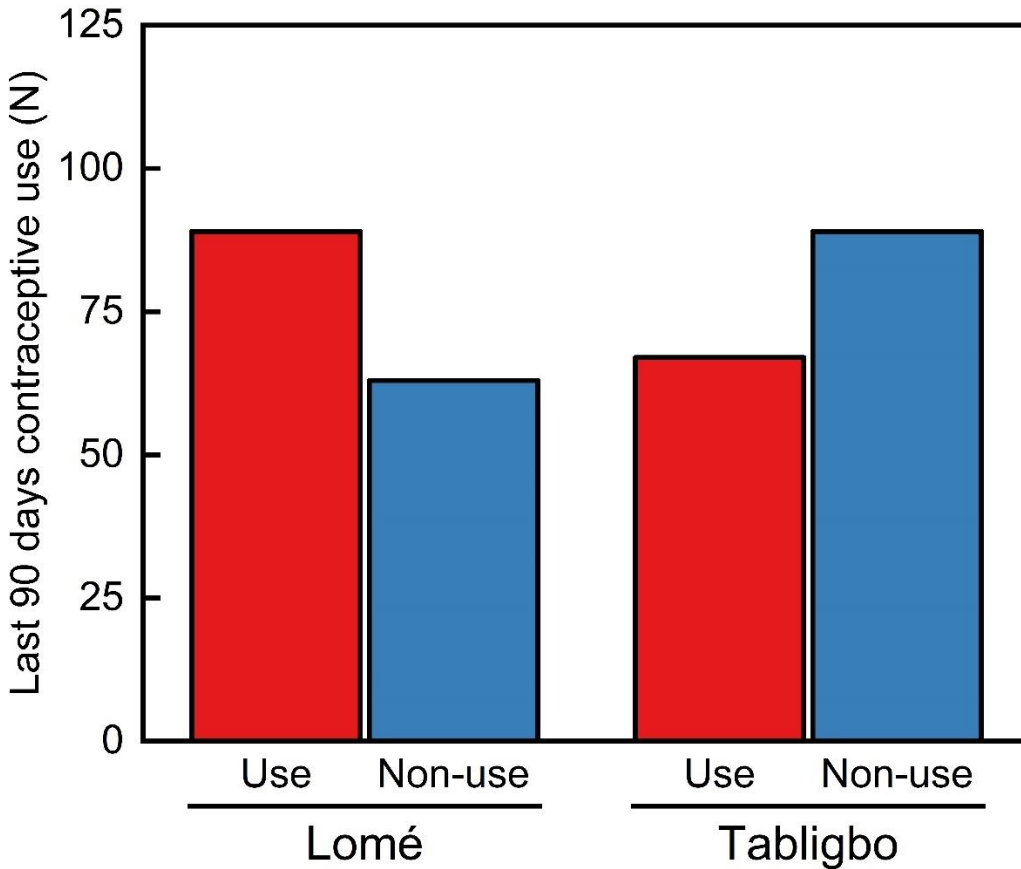
Students	109	35.4
Unemployed	6	2.0
Place of residence		
Lomé	152	49.4
Tabligbo	156	50.6

168 ^a includes Ewe, Mina, Ouatchi, Akposso, Guin, and Ife; ^b includes Kabyés, Mobas, Lambas, les
169 Haoussa, les Peuhls, les Mossis, Tamberma, and Tchokossi; ^c includes Bassar, Kotokoli, Watchi,
170 and Fon.

171

172 *Prevalence of modern contraceptive use among participants*

173 In this study, male modern contraceptive use was assessed by determining the current
174 utilization of modern contraceptives based on participants' responses to the question, "Are you
175 using any male modern contraceptive to avoid pregnancy?" The findings revealed that the
176 prevalence of male modern contraceptive use among the study participants was 50.6% ($N = 308$;
177 Figure 1). Specifically, in the urban area of Lomé, the prevalence of modern contraceptive use
178 among participants was 58.5% ($N = 152$; Figure 1). In comparison, the prevalence in the semi-
179 urban area of Tabligbo was found to be 42.9.6% ($N = 156$; Figure 1).



180

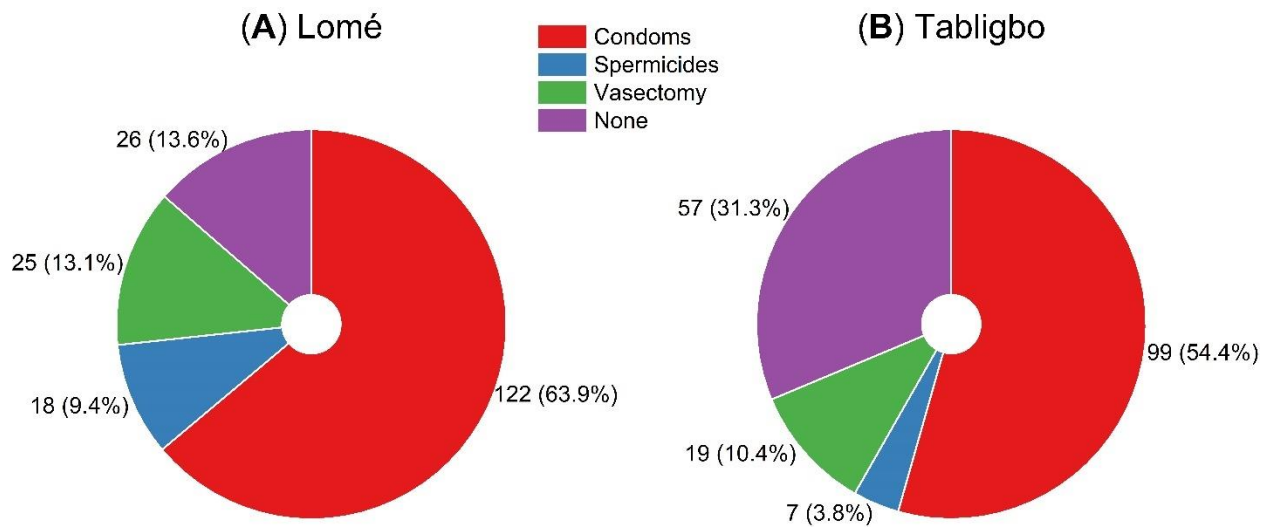
181 **Figure 1:** Prevalence of modern contraceptive use among men in Lomé and Tabligbo counties in
 182 Togo.

183

184 *Knowledge of male modern contraceptives*

185 The three contraceptive methods that were mentioned by the respondents were condoms,
 186 vasectomy, and spermicides, as indicated in Figure 2. Among these methods, condoms were the
 187 most commonly mentioned, accounting for 71.7% of the total mentions ($N = 308$; Figure 2).
 188 Vasectomy was mentioned by 14.29% of the respondents, while spermicides were mentioned by
 189 8.12% ($N = 308$; Figure 2). Notably, in the specific location of Lomé, 13.6% of the participants
 190 were unable to name any male modern contraceptives ($N = 152$; Figure 2A), whereas in Tabligbo,
 191 the percentage was higher at 31.3% ($N = 156$; Figure 2B).

192



193

194

195 **Figure 2** Knowledge of male modern contraceptives among men in Lomé (A) and Tabligbo (B)

196

197 *Attitudes towards male modern contraceptives*

198 In Lomé, the results indicated that 38% of the respondents reported that their partners were

199 using contraceptives ($N = 152$, Figure 3A). Furthermore, 84% of participants had heard of

200 contraceptives, and 86% acknowledged their usefulness to men ($N = 152$, Figure 3A). However,

201 only 53% reported having discussions with their partners about contraceptives, while 28% stated

202 that they have visited a family planning facility ($N = 152$, Figure 3A). In Tabligbo, 40% of the

203 respondents ($N = 156$, Figure 3B) reported their partners were using contraceptives. The majority

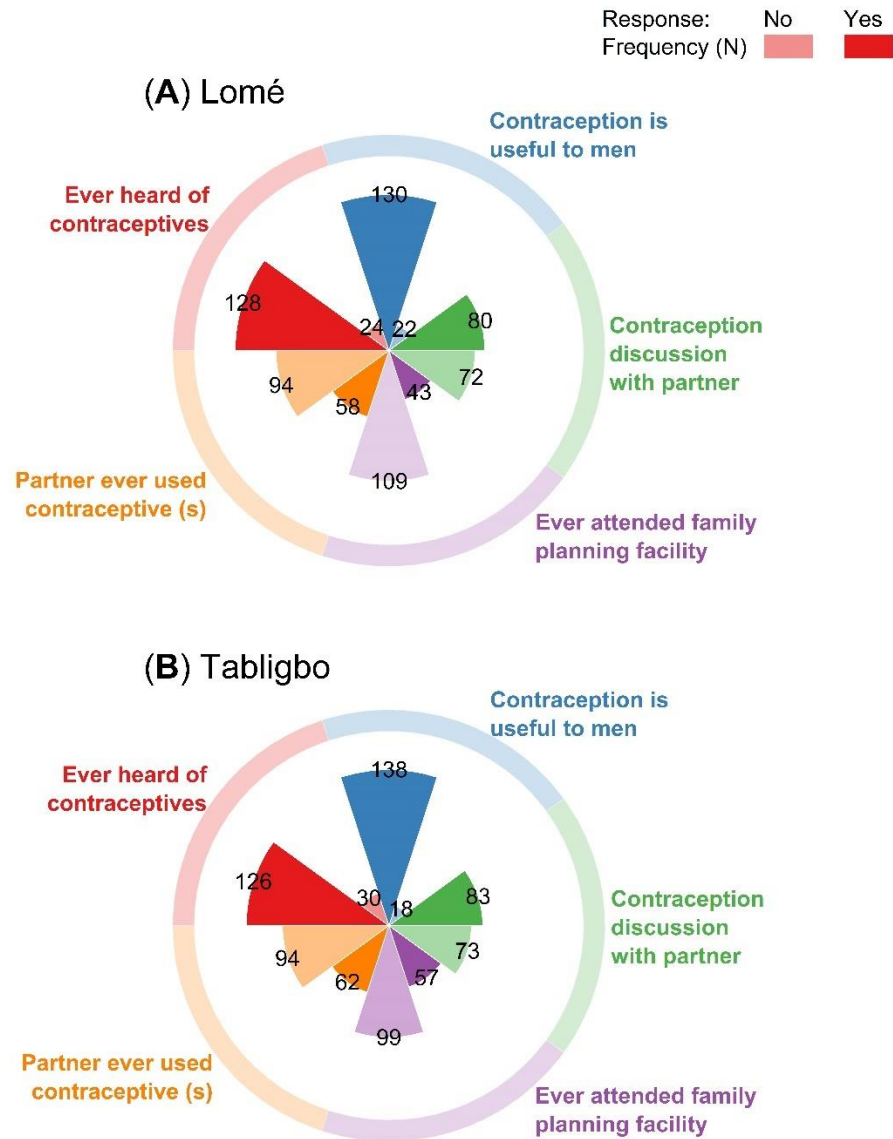
204 of participants (81%, $N = 156$, Figure 3B) were aware of male contraceptives, while a small

205 percentage (11%) had doubts about their utility. Moreover, a majority of respondents (53%, $N =$

206 156, Figure 3B) engaged in contraceptive discussions with their partners. Notably, a considerable

207 number of respondents (63%) reported that they have never visited a family planning facility.

208



209

210 **Figure 3** Attitudes of participants towards male modern contraceptive use in Lomé (A) and Tabligbo (B).

211

212 *Factors influencing modern contraceptive use among the study participants*

213 Bivariate analysis via Pearson Chi-square test has been performed to test any association

214 between current male modern contraceptive use and the independent variables. Thus, variables

215 which has been shown to be associated to the dependent variable were: place of residence, religion,

216 education level, marital status, contraceptive knowledge, belief that contraception is useful from

217 men, contraceptive discussion between partners, and participants whose partners were using
 218 contraceptives (P-value < 0.05; Table 2). After controlling for confounders through multivariate
 219 logistic regression, the analysis showed that place of residence, religion affiliation, belief that
 220 contraception is useful for men, and contraceptive use of partner (s) of participant were found to
 221 be significantly associated with current male modern contraceptive use with (P-value <0.05; Table
 222 3). The odds of using male modern contraceptives were low among residents of Tabligbo (AOR =
 223 0.45; 95% CI: 0.24-0.86) compared with residents in Lomé. Muslims were less likely to use male
 224 modern contraceptives (AOR = 0.08; 95% CI: 0.02-0.38) compared with participants with no
 225 religion. Cohabiting with someone increased the odds of using male modern contraceptives by
 226 seven (AOR=7.11; 95% CI: 3.24-15.62). However, the odds of using male modern contraceptives
 227 were low for participants who believed that contraception is not useful for men, and participants
 228 whose partners were using any form of contraceptives (AOR = 0.12; 95 % CI: 0.04-0.36); (AOR
 229 = 0.43; 95 % CI: 0.24-0.77).

230

231 **Table 2: Bivariate analysis of associated factors of male contraceptive use in Togo**

Variables	N= 308	Contraceptive use		X ² (P-value)
		Yes n (%)	No n (%)	
Age				
15-24	81	34 (42%)	47(58%)	3.8 (0.285)
25-34	146	76 (52.1%)	70 (47.9%)	
35-44	62	35 (56.4%)	27 (43.6%)	
45-54	19	11 (57.9%)	8 (42.1%)	
Place of residence				
Lomé	152	89 (58.5%)	63 (41.5%)	7.5 (0.006)**
Tabligbo	156	67 (42.9%)	89 (57.1%)	
Ethnicity type				
Southern ethnicity	244	125 (51.2%)	119 (48.8%)	3.4 (0.338)
Northern ethnicity	56	29 (51.8%)	27 (48.2%)	
Central ethnicity	3	0 (0.0%)	3 (100%)	

Other ethnicity	5	2 (40%)	3 (60%)	
Religion				
Animism	50	27 (54%)	23 (46%)	12.6 (0.006)**
Christian	194	98 (50.5%)	96 (49.5%)	
Islam	22	4 (18.2%)	18 (81.8%)	
No religion	42	27 (64.3%)	15 (35.7%)	
Education level				
No education	28	11 (39.3%)	17 (60.7%)	10.1 (0.018)**
Primary	56	23 (41.1%)	33 (58.9%)	
Secondary	124	59 (47.6%)	65 (52.4%)	
University	100	63 (63%)	37 (37%)	
Marital status				
Single	76	20 (26.3%)	56 (73.7%)	38.5 (0.000)**
Married	137	66 (48.2%)	71 (51.8%)	
Cohabiting	95	70 (73.7%)	25 (26.3%)	
Number of children				
0	189	95 (50.3%)	94 (49.7%)	0.2 (0.982)
1	33	16 (48.5%)	17 (51.5%)	
2	44	23 (52.3%)	21 (47.7%)	
3+*	42	22 (52.4%)	20 (47.6%)	
Employment status				
Private sector	34	18 (52.9%)	16 (47.1%)	2.1 (0.720)
Public sector	40	24 (60.0%)	16 (40.0%)	
Self-employed	119	56 (47.1%)	63 (52.9%)	
Student	109	55 (50.5%)	54 (49.5%)	
Unemployed	6	3 (50.0%)	3 (50.0%)	
Ever heard of contraceptives				
Yes	254	138 (54.3%)	116 (45.8%)	7.8 (0.005)**
No	54	18 (33.3%)	36 (66.7%)	
Contraception is useful to men				
Yes	268	150 (56.0%)	118 (44.0%)	23.4 (0.000)**
No	40	6 (15.0%)	34 (85.0%)	
Contraception discussion with partner				
Yes	157	97 (61.8%)	60 (38.2%)	12.7 (0.000)**
No	139	57 (41.0%)	82 (59.0%)	
Partner contraceptive use				
Yes	120	78 (65.0%)	42 (35.0%)	16.2 (0.000)**
No	188	78 (41.5%)	110 (58.5%)	
Ever attended FP facilities				
Yes	100	58 (58.0%)	42 (42.0%)	3.2 (0.074)
No	208	98 (47.1%)	110 (52.9%)	

234 **Table 3: Predictors of male modern contraceptive use in Togo (N = 308).**

Variables	Current male contraceptive use				
	Users N (%)	COR (95%CI)	P-value	AOR (95%CI)	P-value
Place of residence					
Lomé (Urban)	89 (58.5)				
Tabligbo (Semi-urban)	67 (42.9)	0.53 (0.34-0.84)	0.006	0.45 (0.24-0.86)	0.015
Religion					
Animism	27 (54.0)				
Christian	98 (50.5)	0.87 (0.46-1.62)	0.660	0.42 (0.19-0.93)	0.032
Islam	4 (18.2)	0.19 (0.06-0.64)	0.007	0.08 (0.02-0.38)	0.002
No religion	27 (64.3)	1.53 (0.66-3.56)	0.319	1.08 (0.39-2.96)	0.877
Education level					
No education	11 (39.3)				
Primary	23 (41.1)	1.07 (0.43-2.72)	0.875	0.98 (0.33-2.88)	0.975
Secondary	59 (47.6)	1.40 (0.61-3.24)	0.428	1.74 (0.65-4.68)	0.267
University	63 (63)	2.63 (1.11-6.22)	0.027	1.84 (0.64-5.26)	0.254
Marital status					
Single	20 (26.3)				
Married	66 (48.2)	2.60 (1.41-4.79)	0.002	1.67 (0.78-3.53)	0.181
Cohabiting	70 (73.7)	7.84 (3.95-5.55)	0.000	7.11 (3.24-15.62)	0.000
Ever heard of male contraceptives					
Heard of MMC	138 (54.3)				
Never heard of MMC	18 (33.3)	0.42 (0.23-0.77)	0.006	0.71 (0.33-1.49)	0.365
Contraception is useful to men					
Useful	150 (56.0)				
Not useful	6 (15.0)	0.13 (0.05-0.34)	0.000	0.12 (0.04-0.36)	0.000
Contraception discussion with partner					
Discussion	97 (61.8)				
No discussion	57 (41.0)	0.47 (0.29-0.74)	0.001	0.72 (0.38-1.33)	0.295
Partner is using contraceptive (s)					
Yes	78 (65.0)				

No	78 (41.5)	0.38 (0.24- 0.61)	0.000	0.43 (0.24-0.77)	0.005
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235 COR: Crude Odds Ratio; AOR: Adjusted Odds Ratio; CI: Confidence Interval; N: Sample size MMC: Male
 236 Modern Contraceptives

237

238 Discussion

239 This study examined the prevalence of male contraceptive and identifying factors
 240 influencing male use of modern contraceptives. There was a disparity in the male modern
 241 contraceptive use among the participants, with a higher rate in the urban area of Lomé County than
 242 semi-urban area of Tabligbo County. The study identified place of residence, religious affiliation,
 243 belief in the usefulness of contraception for men, and the contraceptive use by the partner(s) as
 244 influential factors for modern contraceptive use among men in the study areas.

245 The study revealed a significant difference in contraceptive use between urban and semi-
 246 urban areas. Urban areas, such as Lomé, offer better access to healthcare facilities, including
 247 reproductive health services, family planning clinics, and contraceptive supplies. Lomé, being a
 248 major city in Togo, benefits from a higher density of healthcare providers and better information
 249 sources, making contraceptives more readily available to the population. According to previous
 250 studies, urban environment may foster greater education and awareness about contraceptive
 251 methods due to increased exposure to information and resources (Gourbin *et al.*, 2017; Ochako *et*
 252 *al.*, 2017; Asiedu *et al.*, 2020; Seidu *et al.*, 2022)(Gourbin *et al.*, 2017; Ochako *et*
 253 *al.*, 2017; Seidu *et al.*, 2022)[23], [36], [37](Gourbin *et al.*, 2017; Ochako *et al.*, 2017;
 254 Seidu *et al.*, 2022). Consequently, the higher prevalence of modern contraceptive use in Lomé
 255 compared to semi-urban areas like Tabligbo county, can be explained by the fact that healthcare
 256 facilities and information may be more limited in the later county.

257 Consistent with previous research, our study also revealed that respondents with no religion
 258 had higher odds of using modern contraceptives compared to those who declared their religious

259 affiliation. Meanwhile, the impact of religious affiliation on decision-making processes regarding
260 contraception has been well-documented (Agadjanian, 2013; Beson *et al.*, 2018; Thakuri *et al.*,
261 2022). For instance, a study conducted in Ghana found that participants who considered their
262 religious beliefs when making decisions about modern contraceptives had lower odds of using
263 them compared to those who did not consider their religious beliefs (Beson *et al.*, 2018). The
264 influence of different religious teachings and doctrines on the beliefs and behaviors of individuals
265 regarding contraception is evident, with certain religions discouraging or imposing restrictions on
266 contraceptive use based on moral or religious grounds (Ochako *et al.*, 2017; Aragaw *et al.*, 2023;
267 Sarfraz *et al.*, 2023). These religious barriers can present obstacles to the adoption of
268 contraceptives among individuals who adhere strictly to these teachings (Agadjanian, 2013;
269 Thakuri *et al.*, 2022; Sarfraz *et al.*, 2023). Understanding the role of religion in shaping
270 contraceptive beliefs and behaviors is crucial for developing effective interventions and programs
271 that respect the religious value of individuals while promoting access to comprehensive sexual and
272 reproductive healthcare. Indeed, our study found that the participants' belief in the usefulness of
273 contraception for men is another important factor.

274 Respondents who perceived male contraceptives as effective and beneficial were more
275 likely to use them. Our finding is supported by similar studies that have shown that positive
276 attitudes and beliefs towards contraceptives are associated with higher usage rates among men
277 while negative thoughts or misconceptions lead to less contraceptive uptake (Asiedu *et al.*, 2020;
278 Mishra *et al.*, 2014). Education and awareness campaigns that emphasize the benefits of male
279 contraception can contribute to changing attitudes and promoting its uptake. We did not see any
280 significant association between age, ethnicity, number of children and contraceptive use. This
281 could be due to the homogeneity of the study sample in term of gender.

282 The contraceptive use of the participant's partner(s) also emerged as a significant factor
283 while contraceptive discussion was significant at only bivariate analysis. This could be due to the
284 effect of other confounders. However, this showed that couples' dynamics and communication
285 play a crucial role in contraceptive decision-making and uptake (Butame, 2019). Our finding is
286 supported by other studies that found that partner support and joint decision-making contribute to
287 higher contraceptive use among women and men (Mishra et al. 2014, Butame, 2019). When
288 partners mutually discuss and agree upon contraceptive use, it can positively influence male
289 involvement and adoption of contraception. Thus awareness towards contraceptive discussion
290 among couples is very essential to improve contraceptive uptake in men.

291 **Study strength and limitation**

292 Our study comes with both strengths and limitations. One notable strength is the innovative
293 focus of the study on male contraceptive use, an area largely neglected in similar research, which
294 generally targets women. This is particularly significant given that men often hold the primary
295 decision-making role in African households. Also, our study addresses the dearth of information
296 concerning the behaviors of men in Africa, specifically in Togo, when it comes to contraceptive
297 use. By doing so, we shed light on the modern contraceptive prevalence and factors influencing its
298 use among males. Additionally, the determinants identified in our study could assist policymakers
299 and stakeholders in devising effective strategies to address the contraceptive needs of the
300 population.

301 Regarding the limitations, there might be instances of participants over reporting their use
302 of contraceptives. The utilization of a convenience sample might skew the results, making them
303 less applicable to a broader population. Additionally, there is a possibility that biases from the

304 researchers could have swayed the participants to give responses they believe were desired by the
305 researchers.

306 **Conclusion**

307 The findings indicated that the overall current contraceptive use in this study was average,
308 nevertheless, a notable disparity emerges in the utilization of modern contraceptive methods
309 between inhabitants of Tabligbo and Lomé. Various factors, such as religious affiliation,
310 geographical residence, the contraceptive use of the partners of participants, and awareness of
311 contraceptive options, are identified to have significant influence on modern contraceptive use
312 among Togolese men. Furthermore, the perception of men towards the usefulness of modern
313 contraceptives and their attitude in having contraceptive discussion with their partners emerged as
314 crucial determinants in their contraceptive usage. In light of these findings, it is very important to
315 focus family planning and behavioral change interventions on men in both semi-urban and urban
316 areas to amplify the uptake of modern contraceptive methods.

317 **Authors' contributions**

318 EEKF participated in the overall conceptualization and inception of the idea of this
319 manuscript, with lead roles in writing the background, methodology, data analysis, writing the
320 results and discussion sections. AMK provided overall guidance in writing the background,
321 methodology, analysis, and review of the manuscript with attention on how it fit with other
322 literature.

323 **Ethics approval**

324 Ethical approval has been sought from the Research Ethics Committee of the Ministry of
325 Health, Togo (N^o 119/19). All participant provided written and signed informed consent.

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331 **Declaration of competing interests**

332 The authors declare that they have no known competing financial interests or personal
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