

CHAPTER ONE

1.0 Introduction

1.1 Background Information

In the early days, human societies had creation of as many children as possible, a central value. Today however, relatively few societies can afford this perspective, resulting in increased attempts to limit and manage the birth rate of their families of which Ghana is no exception.

The negative effect of high fertility rate on women and their children, and the benefits of fertility control are well known. Too many or too closely spaced pregnancies, and pregnancies of a woman at too young or too old an age, give rise to health risks for mothers and the infant, with associated higher maternal and neonatal mortality rates. The health of other children in the family is also affected. These factors, among others provide health rationale for fertility regulation and family planning, which is now considered an essential element of preventive health care. The benefits from fertility regulation relate to the broader issue of the status of women. The ability of a woman to control her own fertility is one of her basic and important rights. It is presumed that a better regulated sexuality and fertility affects the status of the women socially and economically. This is perceived to be reflected in their educational, health, and economic status coupled with independence to take decisions on their role and be responsible for the total well-being.

Even though, trends of increase in contraceptive use have been acknowledged widely (RAND, 1998; Ann et. al, 2002), currently an estimated 650 million or 62 percent of the more than one billion married or in-union women in reproductive age are using contraceptives (RAND, 1998). Whereas in the developed nations, 70 percent of married women use contraceptive only 60 percent can be attributed in developing nations.

The situation in Africa is as low as 25 percent, the lowest among developing regions in the world (RAND, 1998; UNFPA, 2001). In West Africa, about 36 percent of women are using contraceptives and this rate varies from a low percentage of 22 percent in Mali, 26 percent in Togo, 32 percent in Burkina Faso, and 33 percent in Ghana (Dona et. al., 2008, UNDP, 2008).

In Ghana, a country with multiple ethnic sets and religious groupings, efforts made by the Ministry of Health (MOH) and other agencies on the use of contraceptives have resulted in a general increase over the last two decades (Duodo et.al., 1998, Ann et al 2002, UNDP, 2008). There has also been a drop in fertility rate from 6.4 percent in the 1970s to 4.4 percent in 2005 (Duodu et.al., 1998, UNDP, 2008). Currently, a national contraceptive use of 33 per cent has been estimated even though 43 percent of married women in the country desire to space their children and an additional 24 percent need to limit births. The disparity of use of family planning methods among the urban and rural, and rich and poor puts many women in most deprived settings at a disadvantage (GSS, 2003).

Offinso District in Ashanti region of Ghana implements and adheres to the policies and programme interventions of the MOH and other agencies in relation to increasing access to reproductive health services including family planning. These policies and programmes reflect in the Information Education and Communication strategies coupled with service counseling and outreach programmes that are instituted in the district. The district, largely rural and served predominantly by a Catholic Hospital, has consistently recorded low contraceptive rates in the region. The obvious consequences of the low use of contraceptives in the district on the social and economic development of the inhabitant especially mothers and children are of major concern.

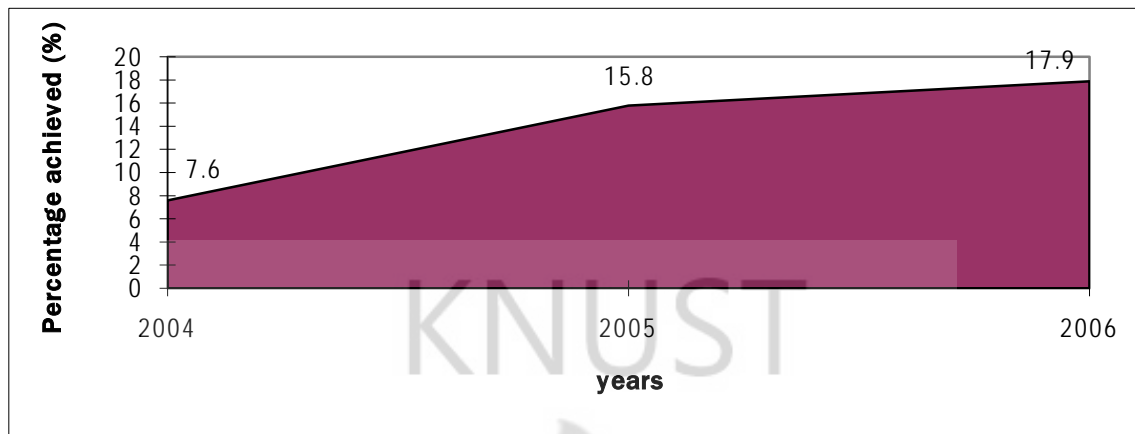
1.2 Problem Statement

The problems of unmet need of family planning for the less developed nations is considered as a major impediment to the development of its people, especially the vulnerable groups including women and children. The multiplicity of factors and the complex nature of the environments of developing nations, regarding access, influences decision on health services, and contraceptive measures for that matter, even though extensively examined by many scholars, have still not been subdued.

Even though the trends of family planning indicators, total fertility rate and contraceptive use in Ghana have been improving, there is a challenge of increasing access to many women who desire to limit or space births. The non-use of contraceptives by these women, has a commensurate effect on their total well-being and that of their children. The increase in maternal mortality rate from 210/100,000 live births in the 1990's to a projected 560 in 2005 (UNDP, 2008) is an indication of the consequence of complication resulting in pregnancies usually unplanned and unintended. In addition, risk of Human Immune Virus (HIV) and Sexually Transmitted Infections (S T I) abound. This trend is even higher in rural areas where there is largely limited access to quality care.

Offinso District has consistently been one of the lowest in terms of contraceptive use in Ashanti Region. The district, predominantly rural, recorded below a regional average of 24.9 percent (Ashanti Regional Health Report 2007) even though the trend from 2004 shows an increase as indicated in the graph below.

**Figure 1: Achievement on Contraceptive Acceptance rate, Offinso District, 2004
2006**



Source: Offinso DHMT Annual Performance Review 2004-2006

Despite the consistently low achievement on family planning acceptance rate in the district, there has not been any investigation as to the related causes of the trend. The district has never achieved its own target of 24 percent of prospective users in the district over the period. This study therefore sought to examine the extent to which prospective users of contraceptives in the districts, perceived and were influenced by contextual factors that could account for the poor response to services on family planning.

1.3 Rationale of the study

Unplanned and unintended pregnancies account to a large extent the poor state of health of women and children in most developing nations. The choice of women to control their own health and that of their children is challenged by Social and environmental factors that mitigate their ability to decide independently and freely on their reproductive and sexual choices. There are still unanswered questions based on local settings that have not been revealed and still worsens the situation of these vulnerable groups with regard to decision and choices to make in controlling child birth.

This study was conducted to provide local and contextual expressions by deprived women that could be incorporated locally into the design, administration and implementation of contraceptive programs in districts in Ghana and other rural

settings. It would also inform policy makers and programme managers of the missed opportunities worthy of consideration in the implementation of programmes. Further, it would yield information that would add to the existing knowledge in academia and research in the field of contraceptive uses and related issues.

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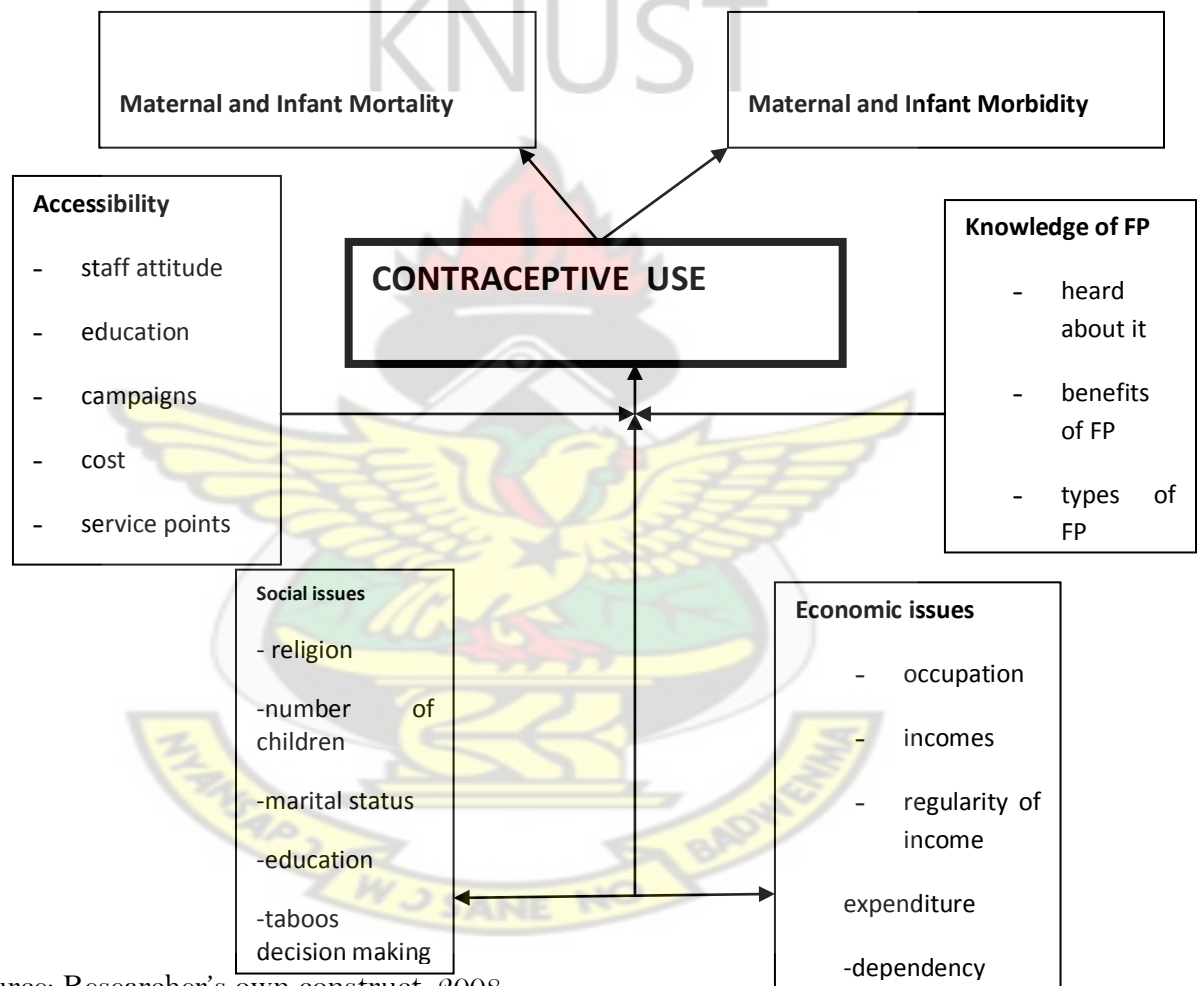


1.4 Conceptual Frame Work

Maternal and Infant health outcomes is presumed to be influenced by the use of contraceptives which is further influenced by the accessibility, social and economic

factors and knowledge about family planning. These factors have intertwined and interrelated to the use of contraceptive.

Conceptual Framework



Source: Researcher's own construct 2008.

Contraceptive use is influenced by accessibility based on the extent to which staff attitude, education and campaign programmes, cost and service points distribution are planned to promote the service. A poor accessibility could therefore lead to low use of contraceptives whereas the contrary would lead to an increase in use.

Further accessibility characteristics, which are connected and influenced by social issues that include religion, birth patterns, education and taboos that are local and further by decision making power distribution among prospective users. Poor social perspective on family planning due to religion, education, moral or cultural factors may limit the use of contraceptive acceptability and use.

In addition, economic status of users could empower their decision-making and further suppress negative social perspective of contraceptives hence, increase its use. However, unemployment which leads to economic dependency may affect one's decision making on birth control and therefore use or non-use of family planning methods.

Finally, knowledge and use of contraceptive information, has a direct and indirect influence on contraceptive use. Directly, a more enlightened person on contraceptive may use it but the less enlightened, may doubt its potency and its benefit and therefore may not find it attractive to use. Indirectly, issues of social and accessibility may affect the use of family planning. In some instances society may not accept contraceptives due to cultural, religious and economic reasons, coupled with poor provider attitude and cost of service. The more enlightened on contraceptive effects could suppress these hindrances and still pursue its use whilst the non-enlightened value such as social and access issues will make people decide not to use contraceptives.

1.5 Research Questions

1. How does the background of women in the district influence their knowledge on contraceptive use and choice?
- 2 To what extent does the socio-economic characteristics of women influence their decisions on contraceptive use in the district?

3 What factors account for the low patronage of family planning methods in the district?

4 What effect does staff attitude have on access to family planning services by women, in public service point in the district?

1.6 0 STUDY OBJECTIVE

1.6.1 General Objective

To assess the extent to which prospective users perceived and were influenced by local factors in using contraceptives and also to examine the contextual factors that had facilitated the consistently low contraceptive coverage in the Offinso District.

1.6.2 Specific Objectives

1. To determine the knowledge levels of respondents on contraceptive uses and choices in relation to their social backgrounds
2. To assess the extent to which the socio-economic characteristics of the women in Offinso District influence their decisions on the use of family planning methods
3. To identify the factors that account for the low patronage of contraceptive methods in the district and assess the correlates among the women in the district
4. To examine the extent to which staff attitude at public service centres affects women's decision in accessing family planning.
5. To make recommendations to major stakeholders and also suggest areas of further research.

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CHAPTER TWO

2.0 Literature Review:

2.1. Background to family planning

Improving human development is one of the cardinal objectives of the Ministry of Health 5 year programme of work (5YPOW) document with emphasis on providing quality services and empowering people to take control over their reproductive health, especially women (MOH, 2007). The attainment of a reduced and manageable population rate (Gribble, 2008) is a vital integral component of the

government's notional strategy to accelerate the pace of economic development, eradicate poverty and enhance the quality of life of all citizens as outlined in the vision 2020 plan of Action (GSS, 1999; Hogue, 2007). Since 1996, Ghana has been promoting the use of contraceptives (GSS, 2003) and several authors have provided evidence in relation to the access and use of contraceptives and with respect to specific characteristics of the general population.

2.2 Knowledge levels of contraceptives and social background

Knowing about contraceptives is presumed to be a first step in stimulating the desire for its use. Assessment of knowledge about contraceptives therefore does not only determine the extent of awareness and sensitization (Takyi, 2000; Kongnyey et al, 2007) but further provides the background for which use of the service is further evaluated. Evaluation in this sense relates with the background characteristics, principally social, of users that influence these awareness and sensitization levels.

Oral contraceptives (OCs) were the most popular form of contraception for sexually active Canadian women surveyed in 1998 (Fisher et al, 1998).

Seventy-three percent users at the time of the survey expressed a high degree of satisfaction with the pill, although misperceptions were prevalent. Few women knew it was safe for nonsmokers to take the pill after age 35, and that the pill reduces certain cancers. When asked whether taking the pill presented fewer health risks than pregnancy, just 4% strongly agreed.

Published literature on the efficacy of contraceptive counseling and education seems to reflect a significant gap between what providers think they offer and what consumers appear to receive. An audit of family planning users in Scotland revealed a 30% discrepancy between the number of women whom clinicians thought they had appropriately counseled and the number of patients who actually understood the teaching (Rajasekar et al, 1999). Oakley estimated that up to one third of women require more individualized counseling to use OCs effectively (Oakley et al, 1994). Getting the good news out about the many benefits of OCs will enable more women

to take advantage of their positive health effects and may help increase compliance (Rosenberg et al, 1998, Jenseen et al 2000, Shulman et al, 2000.) It was discovered that the knowledge of Canadian women on the pill regarding risks, benefits and side effects of the pill remains deficient in several key areas, but was increased by counseling.

According to the recent Ghana Demographic Health Survey, 2003, knowledge of family planning was defined operationally as having heard of a method. The survey, which used an interviewer prompt method, showed that knowledge of contraceptive was known by 98 percent of women and 99 percent of men (GSS, 2003) considering that these proportions represented Ghanaians who knew at least one method of contraception. Knowledge about modern and traditional contraceptive have changed over a decade and half ago. Whereas the latter was popular among Ghanaians, the former is now popular even though users of contraceptives use the traditional methods (Clemen et al 2004, Hoque, 2007). It is noted that contraceptive knowledge among unmarried women was found to be 100 percent. Condoms, diaphragm, the pill, implant, foam tablet and lactational amenorrhoea were among the methods commonly identified.

In a cross-sectional survey in Kinshasa, Democratic Republic of Congo, condom was the most widely known modern contraceptive method since it was cited by 43% of women; the Pill was by only 28%, Injectables 16.2%, IUD 8%, spermicidal foam 2%, and the diaphragm by less than 2%. Teenagers and young adults (15–24 years) were less knowledgeable of modern methods (Kayembe et al, 2003). In an assessment of gender issues relating to contraceptive use in Ebo State, Nigeria, Osaemwenkha observed that educated and sexually active youth had wide spread knowledge of contraceptives and this background correlates with the number of methods known (Osaemwenkha , 2004). Obviously, such wide knowledge does not necessarily mean that such persons have adequate exposure to the use of contraceptives because other decision-making influences could determine its use or otherwise. Even though Osaemwenkha, perceived that his respondents, 800 university female students, may

have had enough knowledge, he discovered that even among the enlightened, decision making on contraceptive use has the male involvement factor essential.

2.3 Extent of Influence of Socio-economic Characteristics on Decision to use Contraceptives

Deciding to use modern contraceptives is a difficult decision by most prospective users, especially women. The difficulties arise from the strength of the interplay of influences from close family relations. Furthermore, the economic dependency level of the woman on her close relations affect the decision process for the uptake of contraceptives (Benefo, 2005). The type of work and the amount of income earned by the woman in particular have a strong relation to use of contraceptives (Baiden, F., 2003; Sign, et al, 2003).

Studies during the past few decades have established a close and significant relation between contraceptive use and fertility preferences. Das and Deka (1982) have considered the cultural factors in fertility as there is evidence that the fertility behaviour changes with different cultural settings. The economic value ascribed to children enhances fertility among those who are economically poor. Narayan Das (1983) studied the socio-cultural determinants of fertility. In several studies on modernity and fertility, education is found to be the prime influencing factor.

Education may have a direct influence on fertility, since education affects the attitudinal and behavioural patterns of the individuals. Lactational amenorrhoea, which lasts for two to three years in some societies gives scope for longer birth intervals, thus affecting the fertility among such women (McNeilly, 1979).

As Anand (1968) and Chandrasekhar (1972) put it, the family welfare programmes, their reception, impact and utility have affected fertility in every society in this era of rapid population growth. Because of the government's policy on birth control, exhaustive efforts are made by the government to popularize the different family welfare methods. Results achieved so far in this direction can be attributed to the programme inputs. However, besides several cultural factors, non-availability

and/or lack of knowledge, attitude towards desired family size, traditional beliefs and practices play an important role in family planning. A number of KAP studies have been taken up covering different population groups. Gautam and Seth (2001) in their study among rural Rajputs and Scheduled Caste (SCs) found out that raise in education besides providing knowledge on the contraceptive methods helps in improving acceptance of family control devices. There are other studies also in similar lines taken up among tribal and rural populations (Meerambika Mahapatro et al, 1999; Sushmita and Bhasin, 1998 and Varma et al, 2002). However, the national programme should have group specific and area specific interventions with regard to family planning. In this background, an attempt was made in that paper to study 'knowledge and practice of contraception' among Racha Koyas, a tribal population from Andhra Pradesh. In this connection, it is pertinent to note that in the 'National Health Policy', the tribal groups need special attention as they are considered 'a special group'.

These among others account for the emphasis on the concept that contraceptive is a human rights issue. This concept does not only empower women to take control of their reproductive life but also develop themselves to be independent of others, so as to ensure their total well-being and that of their children. Many researchers have observed that, this concept is a borrowed one from the west and its adaptation in the African setting. Considering the complexity of influences on close and external relations on their lives, in addition to their socio-economic standing (White, 2002), needs extensive examination (RAND, 1998; White et al., 2002; Awusabo-Asare, 2004; Solo et al 2005). Level of education and socio-economic status of women have been identified to affect fertility decision directly (White, 2002). In addressing the distribution of financial resources in relation to AIDS and family planning methods use in Offinso, Ghana, Duodo and others implied that the inequitable distribution of resources to the detriment of rural communities affects contraceptive use (Duodo et al, 1998).

In a study on empowering women in Navrongo and its environs, Ghana, Solo and others observed that health decision making including the use of contraceptive is influenced by traditional beliefs, men animist rights and poverty (Solo and others., 2005). Despite these others have observed contrary relations of use of contraceptive with socio-economic variables. In his study on factors affecting contraceptive use in Ghana, Tawiah, using a regression analysis modelling identified that, respondent's age, type of place of residence, religion, ethnicity, desire for more children, marital duration, availability of electricity in the household, husband's approval of contraception, husband's education and occupation, have no significant effects on current use of contraceptives.(Tawiah, 1997).

In a cross-sectional survey of 21 countries in sub-saharan Africa, using demographic health survey data, Derose and others in 2004 established that discussions with partners on contraceptive informs women of their husbands' attitude towards contraceptive and therefore the intention for its use. The study also established that women usually do not discuss sexual plans and desire with their husbands especially on matters relating to the number of children to have and spacing of birth (Derose et. al. 2004).

2.4 Access to contraceptives and acceptance issues

For all persons to enjoy a choice among contraceptive options, a range of methods must be readily available. Yet measures of access show serious deficits that depress use of each method. Countries differ both in the number of methods offered and the extent to which each is made available. Information is therefore needed on how these factors have changed over time and how they have affected contraceptive use overall and use of individual methods.(John Ross et al,2002).

International Conference on Population and Development recognize that appropriate methods for couples and individuals vary according to their age, parity, family size-preference and other factors, and ensure that women and men have information and access to the widest possible range of safe and effective family

planning methods in order to enable them to exercise free and informed choice." (UNFPA1996),

The reality in most countries, however, is far different. Most countries offer only a limited choice of contraceptive methods, and couples cannot easily choose the method that best suits their reproductive needs. (Johnson et al., 1994) In fact, international programme effort scores for 1994 showed that large proportions of people in most developing countries did not have ready access to a variety of contraceptive methods. (Ross JA and Mauldin WP1996) Couples had essentially no access to the IUD in 30 countries, no access to female sterilization in 37 countries and no access to vasectomy in 61 countries. Many African countries had low access scores on almost every method. Five years later, in the 1999 ratings for 88 countries, only 65% of countries offered the pill to at least half their population, 54% the IUD, 42% female sterilization, 26% male sterilization and 73% the condom(Ross et al 1999).

Substantial evidence indicates that a restricted choice of contraceptive methods has constrained the opportunity of individual couples to obtain a method that suits their needs, resulting in lower levels of contraceptive prevalence. One study noted that in Taiwan, each new method seemed to add another layer of use to existing prevalence; similar increases were evident in South Korea, Thailand and Hong Kong. (Freedman R and Berelson B,1976) A second study found that broadening the choice of contraceptive methods increased overall contraceptive prevalence in Matlab, Bangladesh, where household provision of injectables in early 1977 helped raise contraceptive prevalence from 7% to 20%, the introduction of tubectomy services in 1978 helped increase prevalence by an additional 10 percentage points, and household insertion of IUDs in 1981 elevated prevalence yet further (Phillips et al 1989) Jain has estimated that the widespread addition of one method to the options available in a country would be associated with an increase of 12 percentage points in contraceptive prevalence. (Jain AK 1989) Behind these figures lie increased

numbers of satisfied couples, as well as fewer unplanned pregnancies, induced abortions and unwanted births.

Over the period 1982-1999, the average availability score for the group of four methods mentioned above rose from 1.5 to 2.6, the equivalent of access for 30-52% of the population. The availability of each individual method also rose substantially, from 25% to 35% for female sterilization, from 34% to 61% for the pill, from 26% to 50% for the IUD and from 34% to 63% for the condom.

Regional differences were considerable, with availability greatest in East Asia and least in Sub-Saharan Africa especially the francophone countries. The other regions were clustered in a middle range. East Asia attained a high level of availability early in the study period and experienced little change thereafter; on the other hand, Sub-Saharan Africa showed improvements, although at fairly low levels. Condom availability seems to have increased more sharply in Africa and Asia than in Latin America, while the availability of female sterilization appears to have risen most in Latin America.

Like availability, the prevalence of contraceptive use has risen markedly over the decades. The latest United Nations review, using surveys that cover 85% of the developing world's population, shows that "almost all of the less developed countries with trend data experienced an increase in the level of contraceptive use. (United Nations, 2000). Over an average period of 9.5 years, use increased by at least one percentage point per year, or 10 points per decade, in more than two-thirds of the countries and by two points or more annually in 11% of the countries. By region, the UN's medium estimate is highest for East Asia (83% of couples using a method), followed by Latin America and the Caribbean (66%), other Asian regions (44%), northern Africa (42%) and Sub-Saharan Africa (14%).

The Ministry of Health, Ghana, has a routine service aimed at increasing patronage and therefore coverage of family planning. However, these strategies are impinged on by other factors, which include social, economic, cultural and services factors

(Addai, 1999). Service strategies have not seemed to yield desirable results. A recent three arm experimental study in Navrongo, Ghana has shown that neither the effort of the community nor that of nurses or health workers alone could increase the uptake of contraceptives rather, a combination of community and health workers efforts could increase acceptance of the service (Depuur et al , 2002). In the study that involved 4300 women, it was established that, even though a combination of community effort increases awareness, knowledge and acceptance of contraceptives, there was no significant difference in the proportion of women who were using contraceptives after one year of evaluating the study (Depuur et al, 2002). This finding suggests that increasing coverage for family planning services does not necessarily result in usage and that a missing ingredient is required to achieve that, yet it is not known.

In a study in Punjab, Pakistan, Casterline in 2001, identified factors, which encapsulated the strength of motivation to avoid pregnancy, awareness and knowledge of contraception, the social and cultural acceptability of contraception and perceptions of the husband's preferences. The other factors identified were attitudes, health concerns, and perceived access to services. Such findings have also been noted in a three study of Ghana, Tanzania and Zimbabwe on modern contraceptive usage trends (Clement and Madise, 2004).

In terms of acceptance of a method; convenience, cost of service and availability informs continuous use or not. In a study in Nigeria, Osemwenkha noted that there was a strong correlation between contraceptive convenience, availability, cost, peer influence and its use. These relations observed vary depending on the type of contraceptives. For instance, the acceptance and use of contraceptives such as jellies, foam, and diaphragm is associated with affluent persons (Osemwenkh, 2004). In addition, the high correlation between availability and pill use instead of condom was attributed to issues relating to stigmatization. Convenience strongly correlated with Intra Uterine Device usage as compared to condom and the other modern methods.

2.5 Health Workers Attitude and Contraceptive Acceptance by Women

There is scanty literature on health workers attitudes on prospective users of contraceptives. Available documentation of staff attitudes has to do with the general provider-clients relations in respect of total quality assurance in services delivery.

Contraceptive provision in many settings continues to be based on outdated medical information, unproven theoretical concerns, and provider biases. Studies have found that in some developing countries 25-50% of women seeking contraceptives are refused services until they are menstruating.(Stanback. J. et al 1999). Coupled with effective training, checklists can be important tools for health care workers at various levels to apply the latest WHO medical eligibility criteria and guidelines for contraceptive use. The pregnancy, combined oral contraceptive (COC), depot-medroxyprogesterone acetate (DMPA), and intrauterine device (IUD) checklists allow health care workers to avoid medical barriers and better provide methods of contraception. [.maqweb.org](http://www.maqweb.org) (Dec.2008)

There has been evidence that service providers – usually private providers, especially, pharmaceutical and chemical shop owners easily perceived that persons who patronise condoms may be leading immoral sexual lives (Osemwenkha OS, 2004). Health workers attitude is also informed by societal perspective of contraception. In Nigeria, health workers are reluctant to provide adolescent with contraceptives yet are willing to counsel them on contraception (Arowojolu, 2000). The ability to divulge our professional responsibility from societal perspective on who is eligible to use contraceptives is the expected of the ideal health worker. Morhe and others, 2003 in a study of provider's perspectives on emergency contraceptives observed that physicians at Komfo Anokye Teaching Hospital, were

willing to play a role in the process of ensuring availability and access to emergency contraceptives. The reviewed works re-echo the complex nature in determining the factors that account for the low patronage and use of contraceptives am

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study Methods and Design.

The study was a descriptive study with a cross sectional design. It involved the collection of both qualitative and quantitative evidence from women of reproductive age, 20 – 49 years in the Offinso district, Ashanti region, Ghana.

It was carried out from August to December 2008.

3.2 Data Collection Techniques and Tools

The data collection technique used was the interview method. The instruments that were used for the women were a questionnaire containing close and open-ended questions and a focus group discussion guide. The questionnaire was used to ascertain a quantitative measure of the characteristics of the respondents on the use of family planning and the focus group discussion guide was employed to derive the qualitative details that would elucidate the quantitative measures. The health workers were also interviewed using a key informant interview guide.

3.3 Study Population

The study population were women in their reproductive age from 20 – 49 years in the Offinso district. The study unit was a woman age 20 – 49 years who has lived in the Offinso district for at least one year.

3.4.0 Profile of Study Area

3.4.1 Location and Size

Offinso district is one of the twenty one (21) districts in the Ashanti Region. It is 27 kilometres from the regional capital, Kumasi, and is located along the main Kumasi – Techiman trunk road. It shares boundaries with six others which are: Tano south, Techiman and Nkoranza (all in Brong Ahafo Region), Afigya Sekyere, Atwima Nwabiagya, Ahafo Ano South, Ejura Sekyeredumasi in Ashanti Region. The road network is not all that good and some portions are currently under construction. Majority of the populace are engaged in farming. Main crops cultivated are cocoa, plantain, yam, cocoyam maize and tomatoes.

3.4.2 Population Distribution

The population is 169842 with annual growth rate of 3.4%. The break down is as in Table 1. The district has been divided into five (5) sub -districts. Each of the sub-districts has a Health Management Team. The team implements its own action plan in conformity with that of the District Health Management Team.

Table 1.1: Population distribution in the district

Target Group	Percentage (%)	Population
0 - 11 moths	4	6780
0 – 23 moths	7.9	13390
0 - 5 years	16.5	27964
24 – 59 months	8.6	14575
WIFA	23.2	39320
EXPECTED PREG/DEL	4.0	6780
SCHOOL HEALTH	36.4	61691

Source: Offinso DHMT Report, 2007

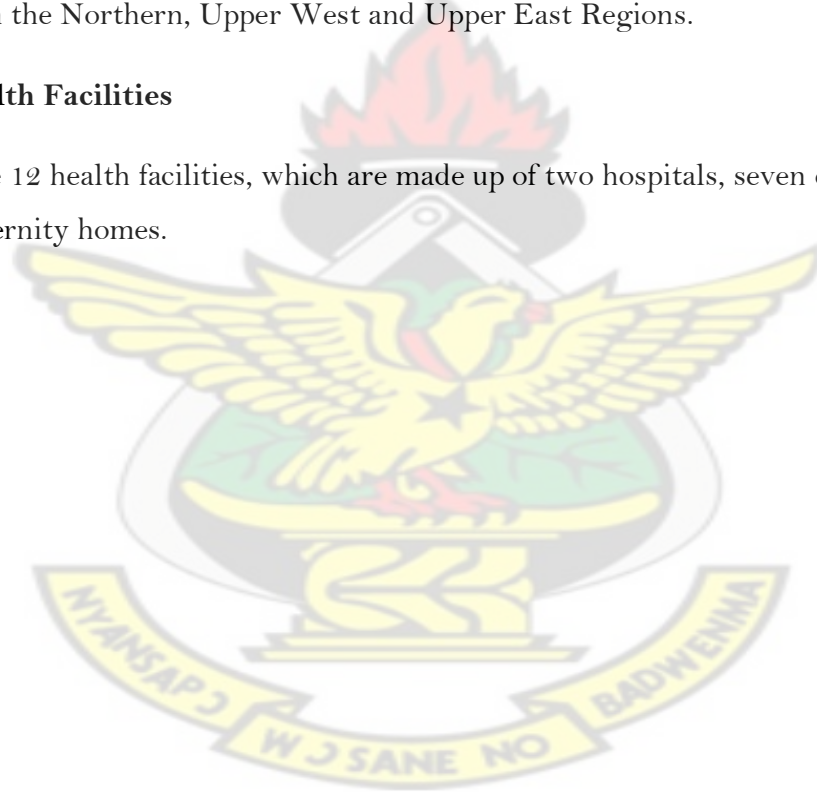
3.4.3 Religious Composition

There are three main religious groups in the district. The Christian groups comprise of 68%, Islam 16% and traditional 9%. A significant percentage of 7% of the population do not belong to any of the above mentioned religious denomination.

3.4.4 Ethnic Composition The district can be said to be homogeneous in terms of ethnic composition. The Asante ethnic group forms about 80% of the total district population. The remaining 20% consists of other ethnic groups of whom majority come from the Northern, Upper West and Upper East Regions.

3.4.5 Health Facilities

There are 12 health facilities, which are made up of two hospitals, seven clinics and three maternity homes.



3.4.6 Family planning performance indicators for the district.

Indicator	2005		2006		2007	
	Target	Achieved	target	Achieved	Target	Achieved
	24%	15.8	24%	17.9	24%	12.5
	WIFA					
	39338	6227	40676	7267	62438	5073

3.5 Study variable

The independent Variables were

- Table 3.1 Study variables, operational definition and indicators**

Variable	Operational definition	Indications	Measurements	Technology
Educational level	Educational level	Basic SSS Tertiary	Categorical	Questionnaire
Religion	As stated by respondent	Christian Moslem	Categorical	Questionnaire
Gender	Sex of the respondent	Male Female	Categorical	Interview
Staff attitude	Relationship b/w Client-health Provider	Good Poor	Categorical	Interview Observe
Staff motivation	Incentive to make staff give the best	Material Promotion Verbal appreciation	Categorical	Interview Questionnaire
Cultural belief	Responses given by the respondent	List of cultural believes	Categorical	Interview
Misconception	Negative perception against Family Planning	Good Bad	Categorical	Interview Questionnaire
Occupation	Daily work done	Self employed, House wife Unemployed Student	Categorical	Interview
Location of facility	Distance from respondent home to the facility	Walking distance to be reached by vehicle	Categorical	Interview
Accessibility	Whether they have family planning service at the community	Clinical based community based outreach	Categorical	Interview
Age	Age as at last birth day	20 – 24 25 – 29 30 – 34 35 – 39 etc	Categorical	Interview

Source: Field survey, 2008.

3.6.0 Sampling Procedure

A multistage sampling procedure was used in the selection of respondents from the community. For a better representation of the district, ten communities were selected using the communities' density per sub-district. Thus, the ten communities were conveniently chosen but randomly selected from the sub-districts. The stratified sampling was therefore, used in deciding on the proportional representation of the population per selected communities per sub-district.

In the selected community, the number of houses was determined and by computer-generated numbers, a random sampling was employed to select houses. The researcher entered the chosen houses, where an eligible respondent was enrolled. Where there were more than one eligible respondents residing in the chosen house, the simple random sampling method again was used to select one respondent.

Due to their special role and experience, the health workers who work in the family planning clinic and their direct supervisors were purposively selected for interview.

The stratification of the sample frame and number of communities selected are detailed in table 3.2

Table 3.2: Sample size distribution per sub-district

Sub district	Population	Percentage %	Sample representation	Number of communities.
Offinso central	53, 263	34.2	113	3
Bonsua	11, 255	7.2	24	1
Abofour	27, 925	18.0	59	2
Akomadan	32, 497	21.0	69	2
Nkenkenso	30, 436	19.6	65	2
Total	155,379	100	330	10

Source: Field data, 2008

3.6.1 Sample Size

A total of 330 eligible respondents were selected from the communities in the district. This was determined using sample size determination software, EPI STAT Calc Software version 4.0 based on a district population of 155,379, family planning use prevalence of 12.5% (DHMT, report) as the population parameter with a 8.94% lower margin expected, 0.5 margin of error and at a reliability coefficient of at 95% confidence interval.

3.7 Pre – Testing of Instruments

Following training of field workers, the data collection instruments were pre-tested at one of the suburbs, Anyankaso, in Offinso district. This was done to ensure validity. Lessons learnt from the test were used to make the necessary amendments to improve the reliability and validity of the data collection tools.

3.8. Data Handling

Filled questionnaires were numbered and checked for completeness, clarity and consistency at the end of interview. Recorded direct interviews were transcribed in sequence in a notebook kept at the investigators residence. Data was cleaned up and irrelevant materials sorted out.

3.9 Data Analysis

The data was analysed using Statistical Package for Social Scientist (SPSS) version 15.01. Descriptive and inferential statistics were used to describe and make inferences from the data where applicable. Chi square and confidence intervals of the main outcome variables were crossed analysed with independent variables including the social and economic characteristics of the women. The findings were presented in tables, graphs and charts.

3.10 Ethical Consideration

An informed consent form was used to seek the consent of respondents of the study. They were assured of confidentiality of their response and the null association of it to them now or in the future. In addition, they were assured that their participation would not affect the relations with health institutions now or in the future and that refusal to participate would not attract any penalty.

Further consent was sought from the District Health Management Team, Chiefs, Opinion Leaders and identifiable groups before the commencement of the study.

3.11 Limitation The instrument could have been limited in determining the anthropological details in relation to the use of contraceptives by the women. Considering the limitation in the use of qualitative tools however, this was minimized through the use of in-depth structured questionnaire , extensive interview during the focus group discussions with the women. Further, the use of local language (Twi), might have led to misunderstanding or misinterpretation of the import of the set questions and therefore led to inaccurate results. These limitations were curtailed to a minimum through training of field workers for standardization of the interpretation of the questions and through close monitoring by researcher of the data collected.

3.12 Assumption

It was assumed that:

Respondents were truthful with their responses.

The respondents understood the translation of the questionnaire.

All quality control measures were strictly adhered to by the researcher.

CHAPTER FOUR

4.0 RESULTS

4.1 Background of respondents

The average age of the respondents was 30.82 years with a standard deviation of 6.86. Fifty three percent (53%) of the respondents were above the age of 29 years. The minimum age was 20 years and maximum age was 48 years. Out of the 330 respondents, 102 representing 30.9% had not had any formal education whilst the rest, 69.1% had formal education. It is worth noting that 44.2% indicated that they could read and write. Over a quarter 39.7% were farmers, 29.7% traders and 6.7% salary workers. The unemployed accounted for 14.5%. The respondents who were working formed 69.1%,.The decision on the pattern of the amount of money to be spent on health were; 27.6% by the client 36.4% the husband and 29.1%. both partners. Over 80% of the clients had sexual partners. Out of these 57.3% indicated that they were married. Christians constituted the majority group among the respondents (70%) whereas atheists representing 2.4% formed the minority. As far as ethnic grouping was concerned the Akans formed 58.8%, Dagomba, 4.2%, Hausa, 9.1% and Ewe, 4.8% as detailed in table 4.1

Table 4.1: Background characteristics of respondents

Variable	Frequency (N = 330)	Percentage (%)
Age		
20 – 24	65	19.7
25 – 29	90	27.3
30 – 34	66	20.0
35 – 39	66	20.0
40 – 44	32	9.7
45 and above	11	3.3
Mean = 30.82; SD = 6.86; Minimum = 20; Maximum = 48		
Education level		

None	102	30.9
Primary	51	15.5
JHS	112	33.9
SHS/Voc/Technology	39	11.8
Tertiary	26	7.9
Able to read and write		
Can read and write	146	44.2
Cannot read and write	184	55.8
Occupation		
Salary worker	22	6.7
Trader	98	29.7
Farmer	131	39.7
Artisan (e.g. mason)	31	9.4
Unemployed	48	14.5
Income per day in GH¢		
1 - 2	228	69.1
3 - 5	90	27.3
6 - 8	10	3.0
9 - 10	2	0.6
Decider on health income		
Myself	91	27.6
Husband	120	36.4
Both partners	96	29.1
Relative/friends	23	7.0
Have sexual partner		
Have	276	83.6
Don't have	54	16.4
Marital status		
Single	38	11.5
Married	189	57.3
Cohabiting	91	27.6
Widow	8	2.4
Divorced	4	1.2
Religion		
Christian	231	70.0
Islam	65	19.7
Traditional	26	7.9
Athiest	8	2.4
Ethnicity		
Akan	194	58.8
Dagomba	14	4.2
Hausa	16	9.1
Ewe	16	4.8
Other Northerners	60	4.8

Source: Field data, 2008

4.2 Obstetrics history of clients

Out of the 330 respondents, 188 forming 57% desired to have up to 4 children and 142 representing 43.0 % wanted five or more children. This was reiterated by a focus group discussion where the group expressed that the women had an average of 3.16 pregnancies with 78% having an incidence of between 1 – 5 pregnancies with a maximum of 10. Over 50% of the clients had the first child birth when they were below the age of 20 years. Majority, (80.6%) of them did not plan their last

pregnancy. Two hundred and thirty eight (238) of the respondents had more than a child alive, with the birth interval of 2 years or more reflected in 63% of the respondents. Over 90% clients had live births in their last pregnancies, while 21 of them forming 6.4% aborted their last pregnancies as shown in Table 4.2

Table 4.2: Obstetrics History

VARIABLE	FREQUENCY (N = 330)	PERCENTAGE (%)
Desired number of children		
Up to 4	188	57.0
5 and above	142	43.0
Mean = 1.14; SD = 0.49, Minimum = 1, Maximum = 10		
Frequency of pregnancy		
zero	10	3.0
1 - 5	259	78.5
5 and above	61	18.5
Mean = 3.16; SD = 2.12, Mode = 2; Minimum = 0, Maximum = 10		
Age of having first child	(n=320)	
Up to 19 years	186	58.1
20 – 29	124	38.8
30 and above	10	3.1
Last pregnancy planned	(n=320)	
Planned	62	18.8
Unplanned	258	80.6
Birth interval	(n=238)	
< 2 years	88	37.0
2 years or more	150	63.0
Outcome of last pregnancy	(n=320)	
Live birth	297	90.0
Still birth	2	0.6
Aborted	21	6.4

Source: Field survey, 2008.

The frequency of pregnancy ($p=0.00$), number of children ($p=0.00$), and birth interval ($p=0.00$) were significantly associated with the use of FP methods whilst, age of first pregnancy ($p=0.10$), and outcome of last pregnancy ($p=0.08$) did not influence the use of FP.

Table 4.3: Influence of use of FP on obstetrics history of clients

Variable	Chi square or F-test	p-value
Frequency of pregnancy	17.02	0.00

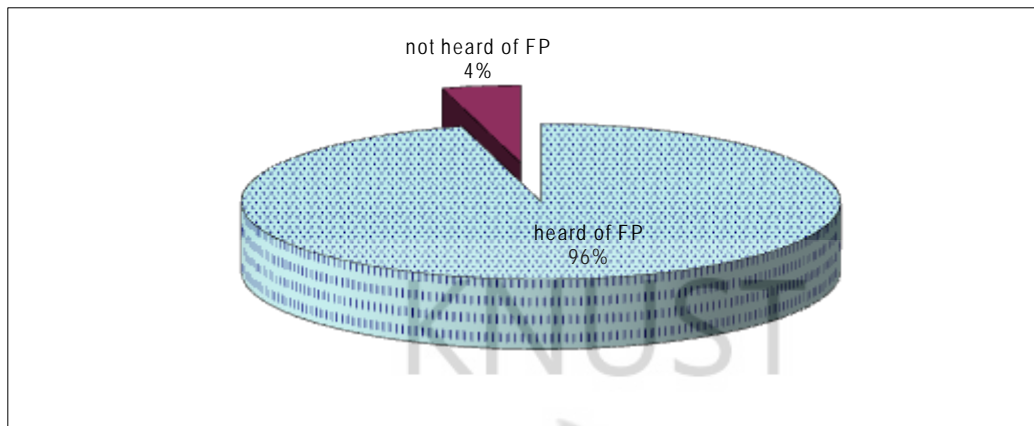
Age at first pregnancy	4.32	0.10
Number of children	39.56	0.00
Planning last pregnancy	23.88	0.00
Birth interval	29.10	0.00
Outcome of last pregnancy	5.04	0.08

Source: Author's field data, 2008

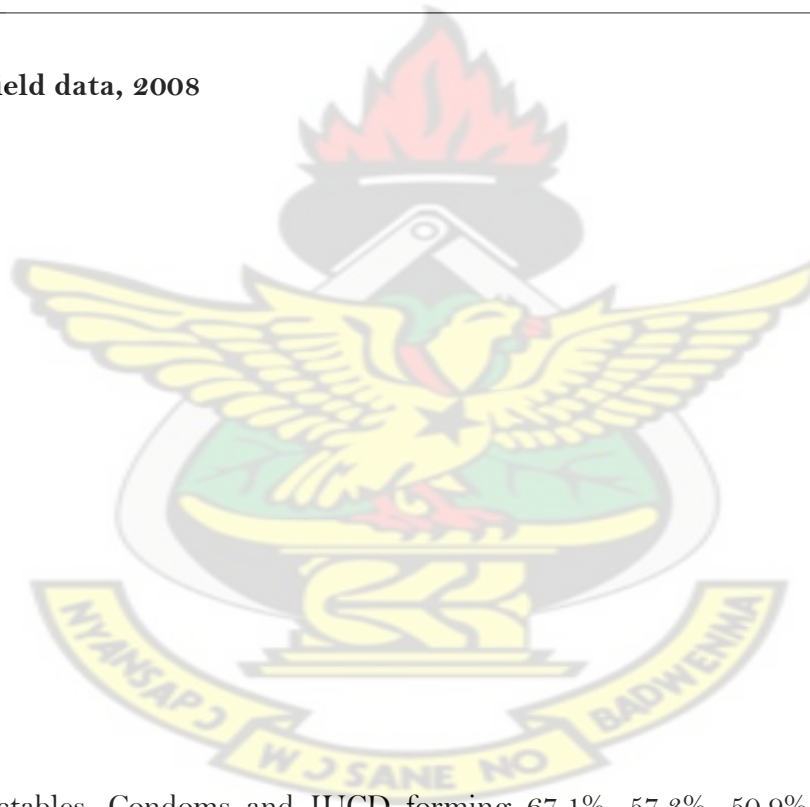
4.3 Knowledge on contraceptives and its relationship with background of respondents

As shown in Figure 4.1 below, 96% percent of the respondents had heard about FP services whilst 4% indicated that they had never heard about the services

Figure: 4.1: Hearing about FP method

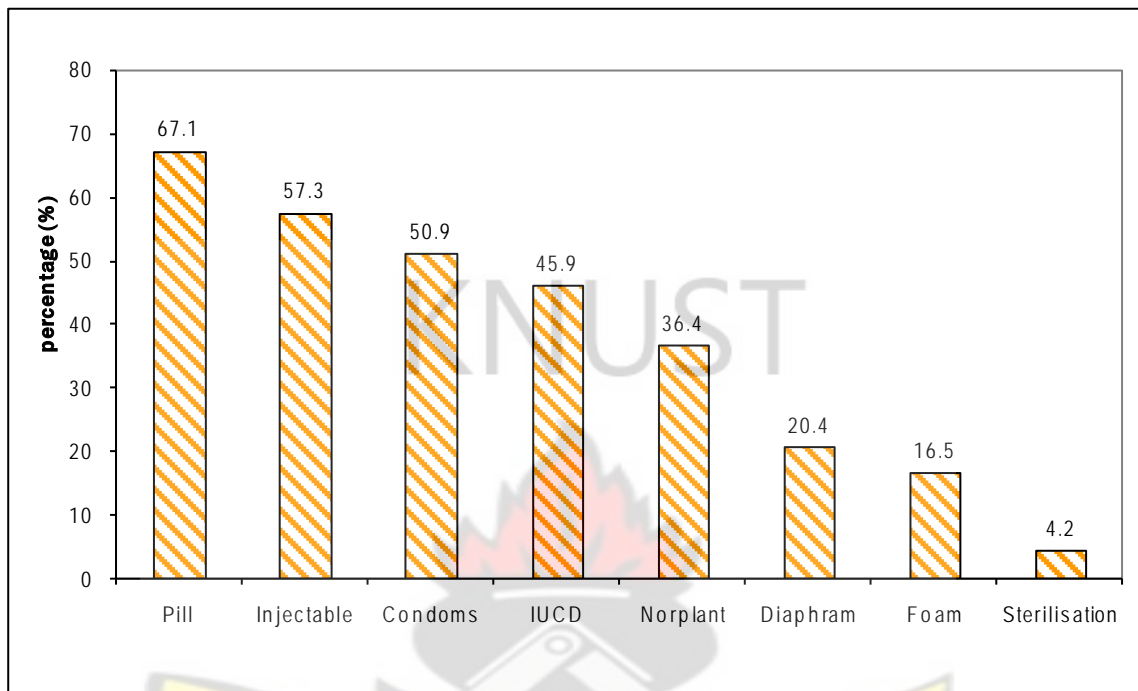


Source: Field data, 2008

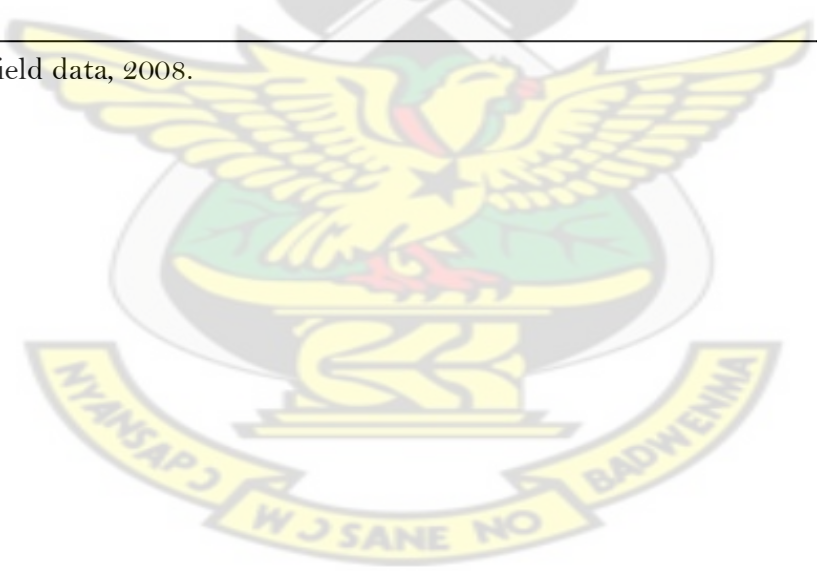


Pills, Injectables, Condoms and IUCD forming 67.1%, 57.3%, 50.9% and 45.9% respectively were the modern FP methods identified by the respondents. The others identified were Norplant, 36.4%, Diaphragm, 20.4% , Foam, 16.5%, and Sterilisation, 4.2% as shown in Figure 4.2

Figure 4.2: Type of modern FP methods identified



Source: Field data, 2008.



The major sources of information about contraceptive methods were radio 44.9% and television. As tabulated in Table 4.4, 47.8% considered family planning as important and 26.6% thought that it was not important.

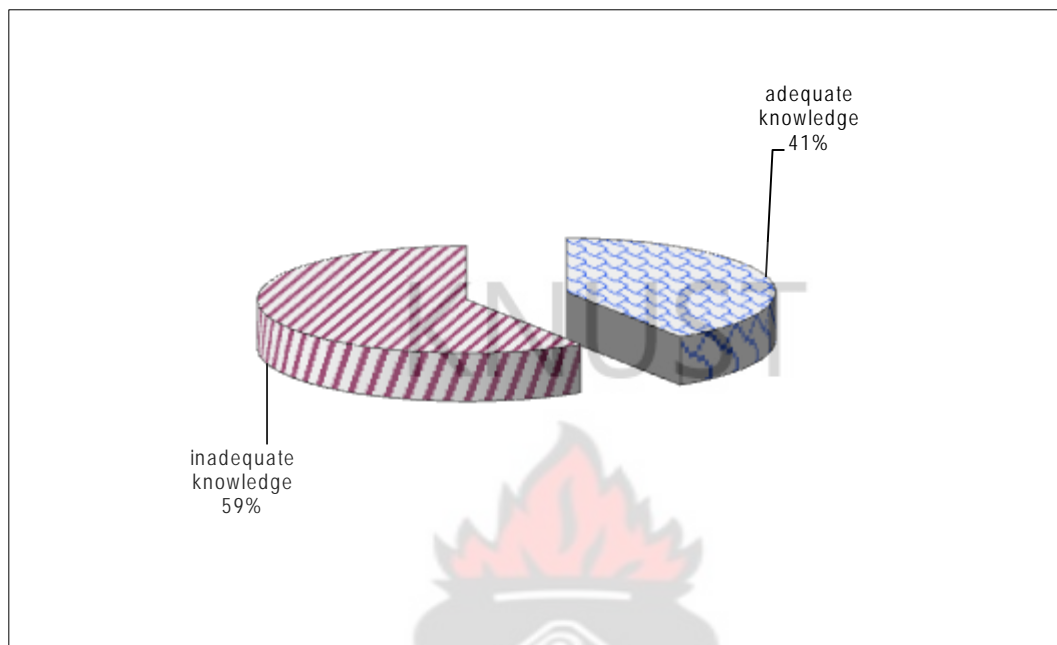
Table 4.4: Source of information and opinion on the importance of family planning.

VARIABLE	FREQUENCY (N=316)	PERCENTAGE (%)
Source of information on FP		
Television	77	24.4
Radio	142	44.9
Relatives/peers	55	17.4
Child Welfare Clinic	42	13.3
Opinion about FP		
Very important	54	17.1
Important	151	47.8
Not important	84	26.6
Don't know	27	8.5

Source: Field data, 2008

Fifty nine percent (59%) of the women had inadequate knowledge (i.e. ability to identify one to three contraceptives methods) and 41% had adequate knowledge (more than three contraceptives methods identified) as detailed in Figure 4.3

Figure 4.3: Level of knowledge (n = 316)



Source: Field data, 2008

Age of the respondents did not have any significant influences ($p=0.28$) on the knowledge levels on contraceptives. In addition, the education level ($p=0.42$), occupation (0.06), having a sexual partner ($p=0.85$) and marital status ($p=0.92$) did not also have any influence on the knowledge levels of clients on contraceptives. However, ability to read and write in any language had a significant ($p=0.04$).

Table 4.5: Influence of background characteristics on knowledge levels on contraceptives

VARIABLE	ADEQUATE KNOWLEDGE n=129 (%)	INADEQUATE KNOWLEDGE n = 187 (%)	Chi SQUARE OR F- TEST (p-value)
Age			

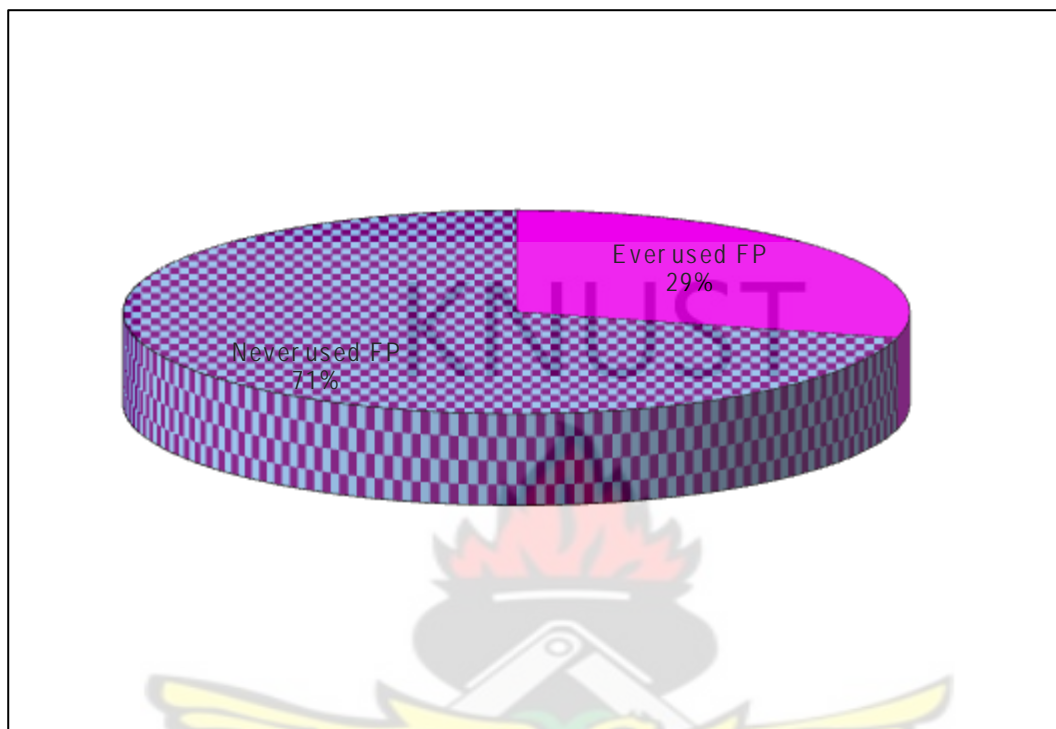
20 – 24	24 (18.6)	37 (19.8)	6.21 (0.28)
25 – 29	38 (29.5)	47 (25.1)	
30 – 34	26 (20.2)	39 (20.9)	
35 – 39	23 (17.8)	42 (22.5)	
40 – 44	16 (12.4)	13 (7.0)	
45 and above	2 (91.6)	9 (4.8)	
Education level			
None	37 (28.7)	61 (32.6)	3.87 (0.42)
Primary	16 (12.4)	35 (18.7)	
JHS	47 (36.4)	58 (31.0)	
SHS/Voc/Technology	18 (14.0)	21 (11.2)	
Tertiary	11 (8.5)	12 (6.4)	
Able to read and write			
Can read and write	64 (49.6)	71 (38.0)	4.23 (0.04)
Cannot read and write	65 (50.4)	116 (62.0)	
Occupation			
Salary worker	9 (7.0)	11 (5.9)	8.9 (0.06)
Trader	37 (28.7)	57 (30.5)	
Farmer	45 (34.9)	83 (44.4)	
Artisan (e.g. mason)	10 (7.8)	17 (9.1)	
Unemployed	28 (21.7)	19 (10.2)	
Have sexual partner			
Have	110 (85.3)	158 (84.5)	0.04 (0.85)
Don't have	19 (14.7)	29 (15.5)	
Marital status			
Single	16 (12.4)	20 (10.7)	0.95 (0.92)
Married	70 (54.3)	110 (58.8)	
Cohabiting	37 (28.7)	51 (27.3)	
Widow	4 (3.1)	4 (2.1)	
Divorced	2 (1.6)	2 (1.1)	
Religion			
Christian	81 (62.8)	138 (74.2)	5.57 (0.14)
Islam	34 (26.4)	30 (16.1)	
Traditional	11 (8.5)	15 (8.1)	
Artiest	3 (2.3)	3 (1.6)	

Source: Field data, 2008

4.4 Socio-economic influences on the use of FP methods

Out of the 330 respondents interviewed, 316 had heard about family planning methods, out of which 29% indicated that they had ever used family planning, and 71% had never used family planning as shown in Figure 4.4.

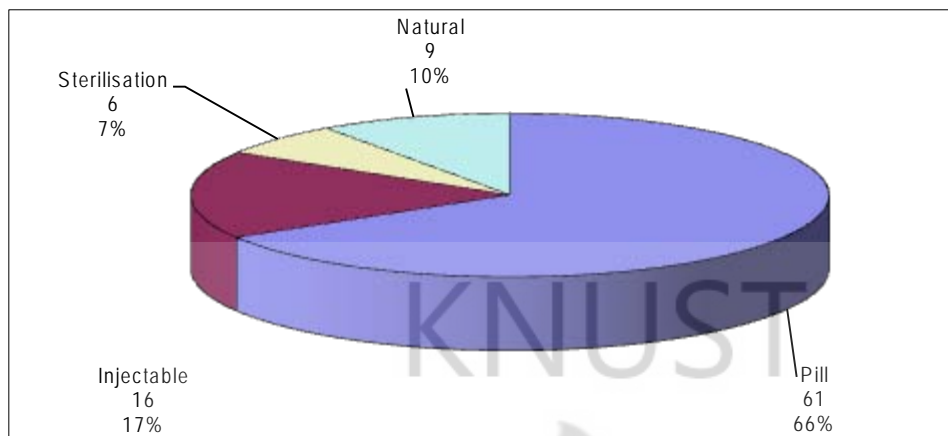
Figure 4.4: Use of FP method (n=316)



Source: Field data, 2008

Out of 92 respondents who had ever used FP methods, 66% used pill, 17% injectable, 10% natural and 7% sterilisation as shown in fig 4.5

Fig 4.5: Type of method used by clients (n= 92)

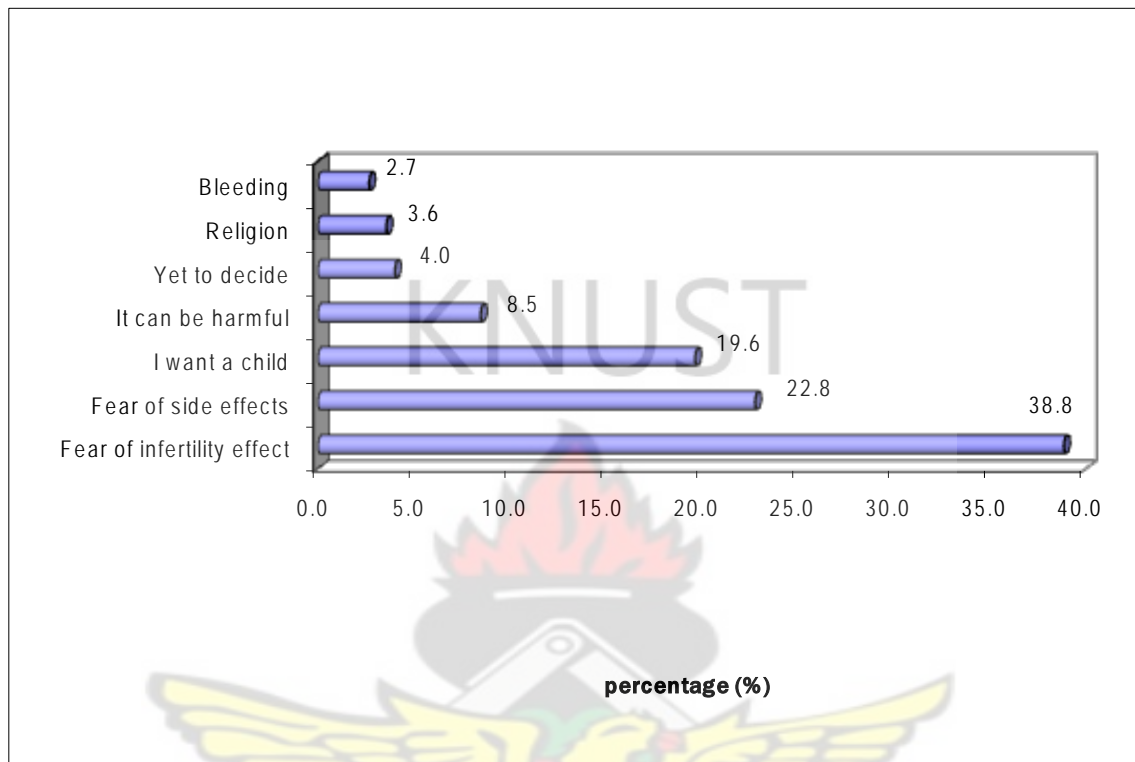


Source: Field data, 2008



The reasons accounting for the non-use of FP methods as shown Figure 4. 6 included fear of infertility effect, 38.8%; fear of side effects, 22.8%; wanting a child, 19.6% and that it could be harmful 8.5%. .

Figure 4.6: Reason for not using FP (n=224).



Source: Field data, 2008

Several socio-economic and obstetric factors of the women had significant influence on the use of FP. These included age ($p=0.00$), educational level, ($p=0.00$), occupation ($p=0.00$) and marital status ($p=0.05$). Also significant were number of times the respondent had been pregnant ($p = 0.00$), number of children ($p=0.00$), number of children ($p=0.00$), and birth interval between children ($p=0.00$). . On the other hand, client's ability to read and write, income spent per day, having a sexual partner, being married and age at first pregnancy did not have any significant influence on the use of contraceptives methods. These are shown in Tables 4.6.

Table 4.6: Socio-economic background influences on Use of FP.

VARIABLE	EVER USED FP N=92 (%)	NEVER USED FP N = 224 (%)	CHI SQUARE (P-VALUE)
Age			
20 – 24	8 (8.7)	53 (23.7)	30.27 (0.00)
25 – 29	25 (27.2)	60 (26.8)	
30 – 34	12 (13.0)	53 (23.7)	
35 – 39	32 (34.8)	33 (14.7)	
40 – 44	8 (8.7)	21 (9.4)	
45 and above	7 (7.6)	4 (1.8)	
Education level			
None	26 (28.3)	72 (32.1)	31.15 (0.00)
Primary	16 (17.4)	35 (15.6)	
JHS	25 (27.2)	80 (35.7)	
SHS/Voc/Technology	7 (7.6)	32 (14.3)	
Tertiary	18 (19.6)	5 (2.2)	
Able to read and write			
Can read and write	39 (42.4)	96 (42.9)	0.01 (0.94)
Cannot read and write	53 (57.6)	128 (57.1)	
Occupation			
Salary worker	14 (15.2)	6 (2.7)	18.88 (0.00)
Trader	21 (22.8)	73 (32.6)	
Farmer	34 (37.0)	94 (42.0)	
Artisan (e.g. mason)	8 (8.7)	19 (8.5)	
Unemployed	15 (16.3)	32 (14.3)	
Income per day			
> 3	60 (65.2)	159 (71.0)	1.01 (0.31)
3 or more	32 (34.8)	65 (29.0)	
Have sexual partner			
Have	81 (88.0)	187 (83.5)	1.05 (0.31)
Don't have	11 (12.0)	37 (16.5)	
Marital status			
Married	60 (65.2)	120 (53.6)	3.61 (0.05)
Not married	32 (34.8)	104 (46.4)	

Source: Field data, 2008

Factors that inhibit patronage of FP services

About fifty three percent (53.6%) of respondents spent less than 30 minutes to access the nearest health facility whereas 5.5% indicated that they spent over an hour as shown in Table 4.7. In the view of 90.3% of the respondents said that there existed no negative perceptions about the number of children. Of the 9.7% who indicated that such perceptions existed. They gave several reasons such as 9.4% said infertile person was the one who cannot have a child, 12.5% said having too many children was an indication of God's blessing, 21.9% respondents indicated that many children was a sign of fertility, 28.1%, of them said it was also an indication that you are a woman, 15.6% said that having many children is perceived to lead to

poverty, 12.5% also had a view that few children were desirable now as detailed in Table 4.8.

Table 4.7 Time to health facility.

Variable	Frequency	Percentage %
Time to nearest facility		
<30 minutes	177	53.6
30-39	105	31.8
40-49	24	7.3
50-59	6	1.8
60+	18	5.5

Source: Field data 2008

Table 4.8 Community perceptions on the number of children and reasons for those perceptions

	Frequency	Percentage
Yes	32	9.7
No	298	90.3
Perceptions that exist	(n=32)	
Infertile if unable to have a child	3	9.4
Too many children means God's blessing	4	12.5
Having many children means fertility	7	21.9
More birth means you are a woman	9	28.1
Few child birth desirable	4	12.5

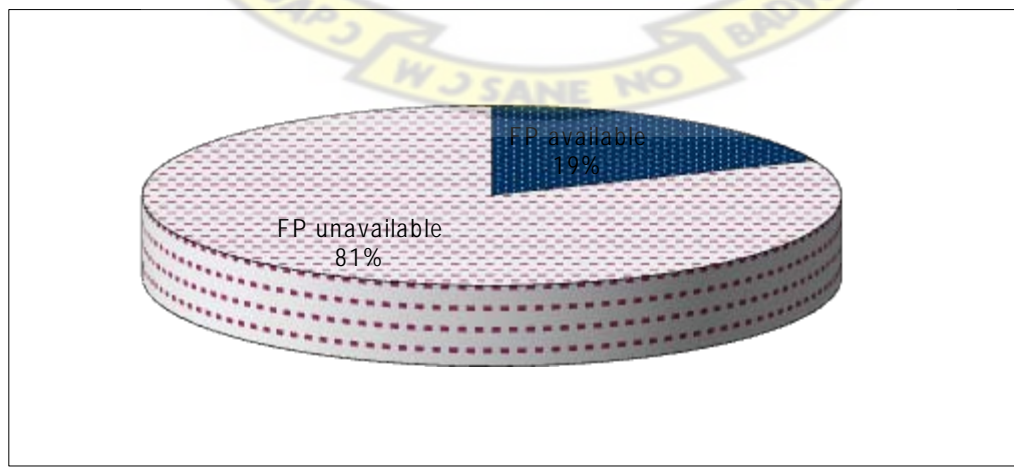
Many childbirth leads to poverty	5	15.6
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Source: Field data 2008

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Eighty-one percent (81%) of the clients said FP methods were not available to them but 19% disagreed as shown in Figure 4.7

Figure 4.7: Availability of FP service to client (n = 316)

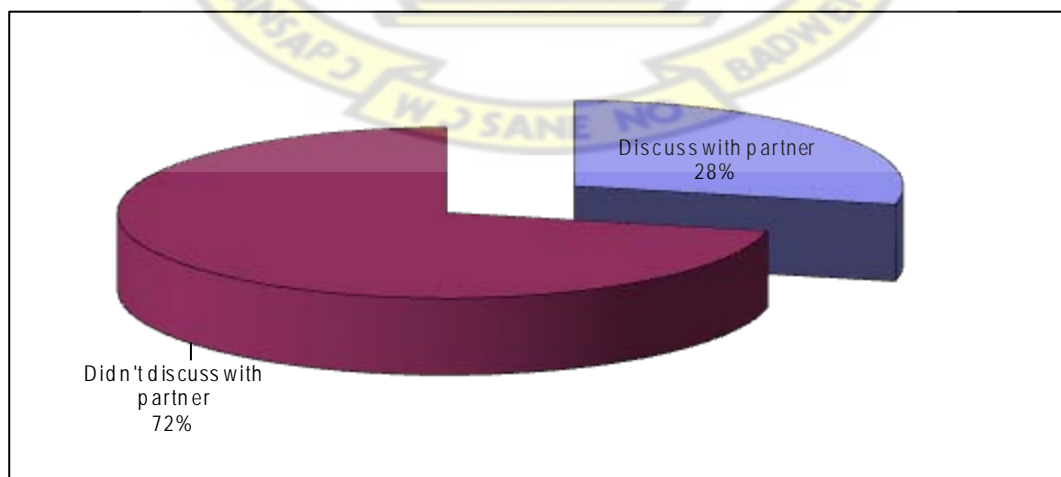


Source: Field data, 2008

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Twenty-eight percent (28%) of the respondents said that they discussed FP with their partners whilst the rest seventy-two percent (72%) did not as shown in Figure 4.8

Figure 4.8: Discussion of FP (n=316)



Source: Field data, 2008

Table 4.9 shows that, availability of FP methods to clients ($p=0.00$), perceptions about childbirth ($p=0.00$) and discussion FP with partner ($p=0.00$) however time to the nearest facility did not have any significant influence ($p=0.08$).

Table 4.9: Test of significance of access factors on FP use

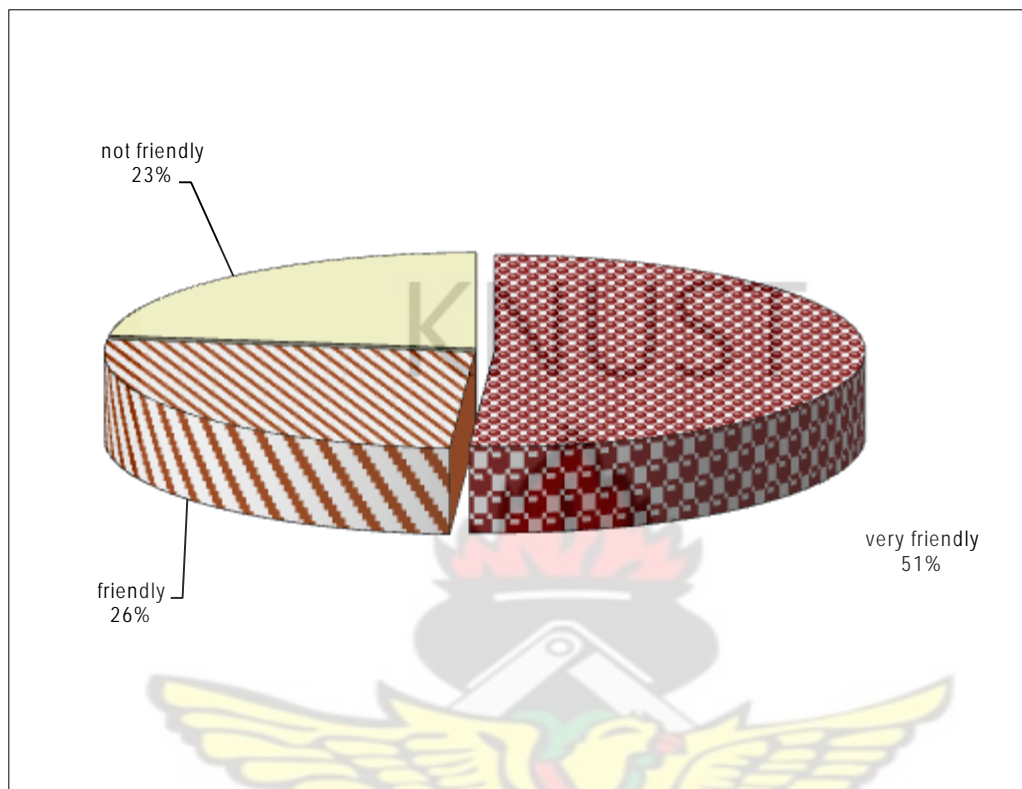
Variable	Chi square or F-test	p-value
Time to nearest health facility	8.36	0.08
Availability of FP to client	144.46	0.00
Perceptions about child birth	10.00	0.00
Discusses FP with partner	157.89	0.00

Source: Field data, 2008

4.6 Clients perceived satisfaction of health staff services on FP method

Out of the 92 clients who had ever used FP methods, 51% indicated the health staff were very friendly, 26% said they were friendly and 23% not friendly as graphically presented in Figure 4.9. .

Figure 4.9: Perceived reception of health staff on FP services (n=92)



Source: Field data, 2008

4.7 Findings from Health Workers

An interview conducted with five health workers revealed that FP clinics are evenly distributed in the district and generally FP acceptance rate was low. The common factors identified by the health workers as militating against the acceptance rate included, but not limited to, religious belief, fear of side effects such as infertility,

lack of male involvement and illiteracy. They also indicated that commodity supply from the region to the district has been irregular.

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CHAPTER FIVE

5.0 Discussions

5.1 Background of respondents

Majority of the women were above 30 years however, most of them could not read and write in any language. At a relatively older age, the women might have had a

high exposure to family planning issues that could be social, cultural or religious yet their inability to read or write in any language could affect the extent to which they can synthesize issues affecting their health including that related to family planning (Takyi, 2000). The level of exposure to sexual relations poses a challenge to many women. Legitimizing sexual relations in the form of marriage gives most women pride and respect in society yet this desirable state is hardly achieved by some of them. Most of the women in this study were in active sexual relationships but only 57.3% were married. The implication is that for most of the women who were unmarried, they may have desirable tendencies of preventing pregnancies, which is rarely done in most developing nations (GSS, 2003). The non-use of family planning methods among this group and even among those married, results in self-induced abortions with its resultant complications including anaemia, infertility and also death (Kongnyey, 2007). The socio-cultural context of family planning use could be weakened by mixed cultural settings where there is likely to be little dominance of a cultural stand on family planning use by a tribe over the others. The possible integration of socio-cultural ideas could influence acceptance or rejection of contraceptives. In this study, even though Akans formed the majority group, there was relatively enough representation of other tribes including Dagombas, Ewes and Hausas and this might have created intertribal marriages and therefore integration of cultural ideas on the use of family planning methods.

5.2 Obstetrics history

It is the desire of every woman to have a child. This desire is strongly embedded in African culture and Ghana is not an exception. This was reiterated by a focus group discussion where the group expressed that "...a woman should have about 5 – 6 children. All the women in this study agreed to this crave. The women exclaimed during the focus group discussion that "as a woman you should marry early and have your children as early as possible" (a 20 year old woman).! Meanwhile their previous pregnancy experiences and outcomes suggested that little or no plans were made to ensure that they achieve this safely. This is because; majority of them had

their first child at a teenage yet were not in good standing to bear the parental responsibilities. What is worrying is that, these women continue to engage in unprotected sex even into their 30s resulting in several unwanted pregnancies some of which ended up in abortions. This is reflected from the fact that over 80.6% did not plan their previous pregnancies. The unmet need of family planning - as determined by the desirable number of pregnancies, compared with the incidence of pregnancies and also the unplanned status of previous pregnancies – could be said to be very high in this rural district. These women in a relatively low socio-economic environment but with a high incidence of pregnancies could be vulnerable in many respects including exposure to complications of pregnancies, inability to fend for themselves and their children.

5.3 Knowledge on contraceptives and its relationship with background of respondents

Ninety-six percent (96%) of the respondents had heard about FP services whilst 4% indicated that they had never heard about the services. This means that most of the respondents were aware of family planning programmes. This is in line with the 2003 Ghana Demographic Health Survey. Knowledge of family planning was defined operationally as having heard of a method. The survey, which used an interviewer prompt method, showed that knowledge of contraceptive was known by 98 percent of women and 99 percent of men (GSS, 2003) Also in an assessment of gender issues relating to contraceptive use in Edo state, Nigeria, Osaemwenkha observed that educated and sexually active youth had a wide-spread knowledge of contraceptives. (Osaemwenkha, 2004). Obviously, such wide knowledge does not necessarily mean that such persons have adequate exposure to the use of contraceptives because other decision-making influences could determine its use or otherwise. Even though Osaemwenkha, perceived that Pills, Injectables, Condoms and IUCD forming 67.1%, 57.3%, 50.9% and 45.9% respectively were the modern FP methods identified by the respondents. The others identified were Norplant 36.4%,

Diaphragm 20.4% , Foam 16.5%, and Sterilization 4.2%. Radio 44.9% and television 24.4% were the major sources of information about contraceptives methods. 47.8% considered it as important and 26.6% thought that it was not important.

Fifty nine percent (59%) of the women had inadequate knowledge (i.e. able to identify one to three contraceptives methods) and 41% had adequate knowledge (more than three contraceptives methods identified). Age of the respondents did not have any significant influences ($p=0.28$) on the knowledge levels on contraceptives. In addition, the education level ($p=0.42$), occupation (0.06), having a sexual partner ($p=0.85$) and marital status ($p=0.92$) did not also have any influence on the knowledge levels of clients on contraceptives. However, ability to read and write in any language had a significant ($p=0.04$) influence on contraceptives use.

5.4 Socio-economic influences on the use of FP methods

The use of FP is very low in the district. Even the few people who had ever used FP could be said not be adherent to it. Out of the 330 respondents interviewed, 316 had heard about FP methods, out of which 29% indicated that they had ever used FP, and 71% had never used FP. Many women had decided not to use FP because of experienced or perceived side effects of the methods. This was confirmed during a focus group discussion which revealed that they don't use FP methods because "it gives health problems", "we are afraid" and "we don't want others to see that we are using contraceptives" the women said.

It has been reported (GSS, 2003; Hoque, 2007) that intermittent bleeding and other side effects of the methods in addition to the social stigma and fear related to the use of the methods could account for this position by some women. Modern

contraceptives use has been documented to cause temporal infertility due to delay ovulation as a result of hormone imbalance (Kayembe et.al, 2003; Hoque, 2007). Religious enculturation on the use of FP such as that claimed by women in the district is enshrined in the doctrine that God plan for humans is to multiply and that He takes care of all human the have and have not – and therefore, it is sinful if one attempts to interrupt or prevent the normal fertilization process. Several efforts are being made to allay the fears of women about the side effects of modern contraceptives but may not have yielded the desired results.

There are strong relationships between the socio-economic characteristics of women and the use of FP methods. Age, educational level, occupation and marital status had strong association with the use of FP. These factors have been also identified by White, 2002 but are dissimilar to Tawiah's observation in 1997. As women age, they make efforts to take control over unexpected pregnancies, especially when they have had the desired or more than expected number of children. Such decisions are taking due to high economic and social burden of fending for the children. Having a job to do could earn women some income (Sign, et al, 2003) to fend for themselves and their dependants and therefore a delayed decision to use FP methods. A similar observation was made by Baiden, 2003; and Benefo, 2005). Surprisingly women earning or expenditure per day is not associated with use of FP methods. Increased number of previous pregnancies and consequently the number of children influences the use of FP method among women because of the obvious burden. This was confirmed by the focus group discussion when a 32 year old woman and supported by others that “ the number of children affects the mother's health and also if one have many children one cannot get enough money for oneself thus one cannot buy so many clothes like other women who do not have many children do”.

Other reasons that could be assigned to this is the fact that most of the women did not have the free will to decide on the usage of FP methods as alleged by Benefo that deciding to use modern contraceptives is a difficult decision by most prospective users, especially women. The difficulties he said arose from the strength

of the interplay of influences from close family relations. Further, the economic dependence level of the woman on her close relations affect the decision process for the uptake of contraceptives (Benefo,2005).Other findings also attribute it to the type of work and the amount of income earned by the woman in particular have a strong relations to use of contraceptives (Baiden, F., 2003; Sign et al ,2003). In addressing the distribution of financial resources in relation to AIDS and family planning methods use in Offinso, Ghana, Duodo and other implied that the inequitable distribution of resources to the detriment of rural communities affect contraceptive use (Duodo et al, 1998). During the focus group discussion the women expressed that “they (referring to the health worker) treat us nicely, only that they don’t give us the method we like” The Nurse in-charge indicated that “staff attitude had improved”.

5.5 Factors that inhibit patronage of FP services

Over fifty three percent (53.6%) of respondents spent less than 30 minutes to access the nearest health facility whereas 5.5% indicated that over an hour spent. In the view of 90.3% of the respondents there existed no negative perceptions about the number of children. Of the 9.7% who indicated that such perceptions existed it included that: an infertile is the one who cannot have a child, 9.4%, having too many children is an indication of God’s blessing 12.5%, many children is a sign of fertility 21.9%, it is also an indication that you are a woman 28.1%. Others said that having many children is perceived to lead to poverty 15.6% and also that few children are desirable now (12.5%) . In a study conducted by Casterline in 2001 in Punjab, Pakistan, she identified factors, which encapsulated the strength of motivation to avoid pregnancy, awareness and knowledge of contraception, social and cultural acceptability of contraception and perceptions of the husband’s preferences. The other factors identified were attitudes, health concerns, and perceived access to

services. This was supported by the women during focus group discussion when they revealed that “when the health workers are coming for ante natal care in the communities they don’t bring the contraceptives so if you need some they will direct you to where family planning centre is” and “at times they don’t come early and you will sit there for a long time before they will attend to you”.

Such findings have also been noted in a three study of Ghana, Tanzania and Zimbabwe on modern contraceptive usage trends (Clement and Madise, 2004). Despite the closeness of facility and service there is a high sense among women that FP services are unavailable. Eighty one percent (81%) of the clients said FP methods were not available to them but 19% disagreed. Their assertion may have resulted from the non-promotion of FP by the district hospital, which is a catholic hospital which prohibits the use of modern contraceptive methods. It was observed that most of the women used this facility when pregnant yet, they were not stimulated to consider the use of FP methods irrespective of their social or obstetric history. This brings to question current strategies in reaching out to the women (Clement and Madise, 2004).

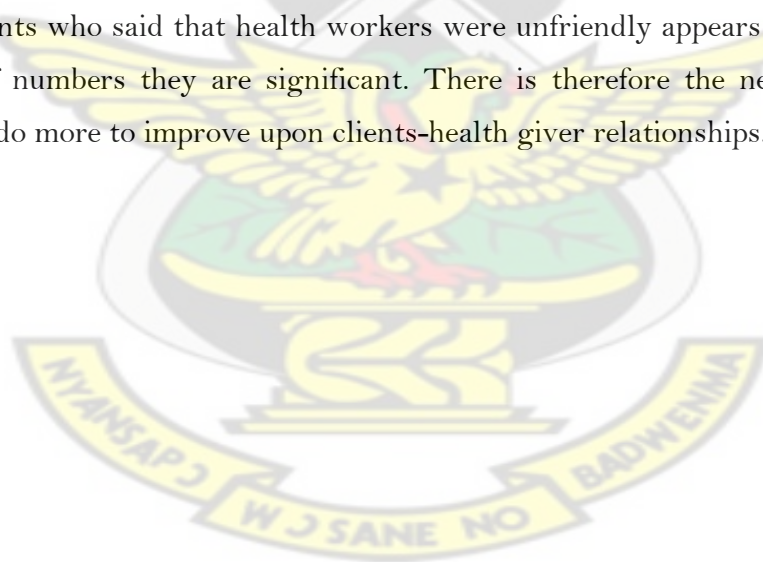
Availability of FP services, perception about child birth and the number of children a woman should have and having discussion with one’s partner could influence the use of FP. Many of the women did not discuss FP with partners and it suggested that a similar trend in sub-Saharan Africa as noted by Derosé and others, 2004. Discussing FP services with partners was done by 28% of the clients however, 72% did not as shown in Figure 4.8 . Table 4.9 shows that, availability of FP methods to clients ($p=0.00$), perceptions about childbirth ($p=0.00$) and discussion FP with partner ($p=0.00$) were significant however time to the nearest facility did not have any significant influence ($p=0.08$).

5.6 Clients perceived satisfaction of health staff services on FP method

Out of the 92 clients who had ever used FP methods, 51% indicated that health staffs were very friendly, 26% said they were friendly and 23% not friendly as

graphically presented in figure 4.9. Friendliness or unfriendliness could add on to or subtract from the poor social perception (Clement and Madise, 2004) and adaptation to information related to the use of FP methods, especially modern contraceptives. A professional behaviour is therefore expected of health workers to help allay the fears and anxieties of women on the side effects of FP methods.

The study found that the attitude of the workers towards clients was generally good. This was confirmed during the focus group discussion when the women expressed that the health workers treat them nicely, only that they don't give them the method they like. Among the reasons that could be assigned to this may be that they talked to them in a language the clients could easily understand as identified by Zeithaml and others. (1990), that Keeping customers informed in language they can understand and listening to them, enhances customer satisfaction. Though, 23% of respondents who said that health workers were unfriendly appears to be less but in terms of numbers they are significant. There is therefore the need for health workers to do more to improve upon clients-health giver relationships.



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CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 Knowledge on contraceptives and its relationship with background of respondents

The level of knowledge of contraceptive among the women in the district cuts across all ages, marital status and occupational backgrounds. Ninety-six percent (96%) of the respondents had heard about FP services whilst 4% indicated that they had never heard about the services. This means that most of the people have heard of the FP. But the knowledge does not commensurate with the use of contraceptives.

6.2 Socio-economic influences on the use of FP methods

Out of the 330 respondents interviewed, 316 had heard about FP methods, out of which 29% indicated that they had ever used FP, and 71% had never used FP. This means that though most of the respondents have heard about FP method but the level of usage was low. The situation in Africa is as low as 25 percent, the lowest among developing regions in the world (RAND, 1998; UNFPA, 2001). In West Africa, about 36 percent of women are using contraceptives and this rate varies from a low percentage of 22 percent in Mali, 26 percent in Togo, 32 percent in Burkina Faso, and 33 percent in Ghana (Dona et al. 2008, UNDP, 2008). Also it was found that decision to use FP is largely influenced by closed relatives.

6.3 Factors that inhibit patronage of FP services

Fifty three percent (53.6%) of respondents spent less than 30 minutes to access the nearest health facility whereas 5.5% indicated that over an hour is spent. The reasons accounting for the non-use of FP methods included fear of infertility effect, 38.8%; fear of side effects, 22.8%; wanting a child, 19.6% and that it can be harmful, 8.5%.

6.4 Clients perceived satisfaction of health staff services on FP method

Out of the 92 clients who had ever used FP methods, 51% indicated that health staffs were very friendly, 26% said they were friendly and 23% not friendly as graphically presented in figure 4. 9 . Generally staff attitudes towards clients were found to be friendly.

6.5 Recommendations

- ★ There is the need for intensification of public education at the community level with major emphasis on the use of FP. Effort must be made to explain to the people the benefits as well as possible side effects of the method one may wish to use. This will enable the people to make an informed decision in relations to the use of FP. This is necessary because the present situation shows that most people have heard of FP methods but they are not using them.
- ★ FP should form part of the curriculum of social studies at the basic level. This would make it possible for the children to be introduced to FP at the early stages in their lives.
- ★ FP centres should be established in the communities and be manned by trained personnel to address geographical accessibility to contraceptive use..
- ★ There is the need for inter-sectoral collaboration to empower women so that to a large extent they can take control over their lives in terms of the

use of the FP methods. This is necessary because it appears that their overdependence on the male counterparts and closed relative economically has over the years limited them from using family planning methods.

- * Study into the socio-cultural effects on FP usage is necessary to unearth the specific socio-cultural factors that are militating against the use of family planning.
- * The DHMT can make adequate use of the religious bodies especially the Christians to teach women and their husbands about the need to use contraceptives.
- * I also recommend a further research in the area of traditional and modern method of family planning .This is because the local people could be more comfortable and confident in the local methods such as the use of local herbs than foreign ones. This is because most research findings suggest that increasing coverage for family planning services does not necessarily result in usage and that a missing ingredient is required to achieve that, yet it is not known.

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