

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY, KUMASI

SCHOOL OF MEDICAL SCIENCES

DEPARTMENT OF COMMUNITY HEALTH



**FEMALE HEAD-PORTER ACCESS TO FAMILY PLANNING SERVICES IN
EJURA MUNICIPALITY, GHANA**

A dissertation submitted to the School of Graduates Studies, Kwame Nkrumah
University of Science and Technology, Kumasi in partial fulfillment for the award of
MPH in Population and reproductive health.

BY

MERCY ADZO KPORKU

SEPTEMBER, 2014

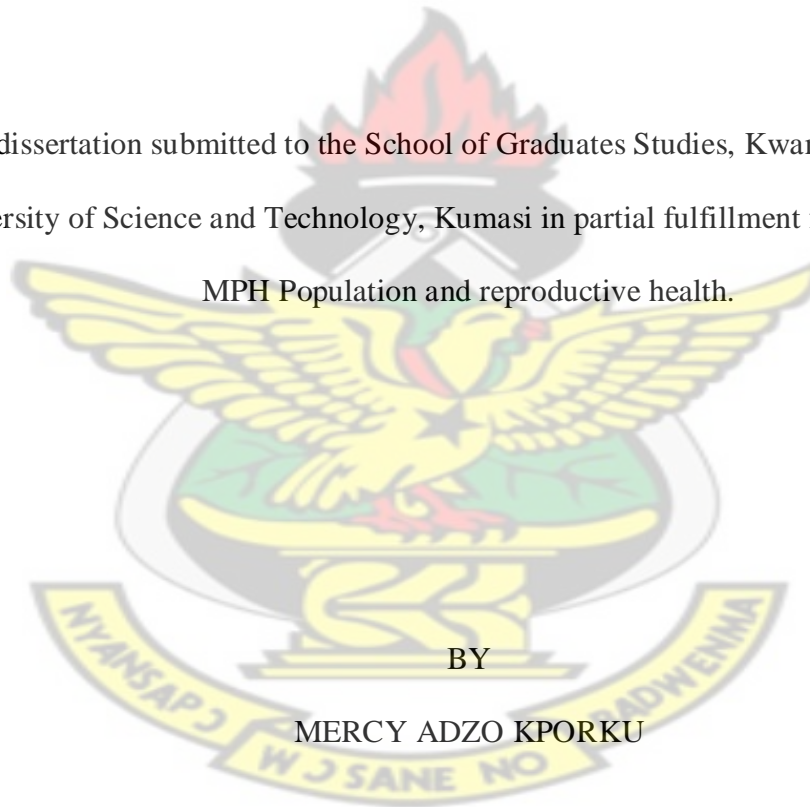
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DECLARATION

I hereby declare that except for references to other people's work, which have been duly acknowledged, this work is the result of my own original research. I hereby declare that this work has neither in whole nor in part been presented for any degree elsewhere.

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MERCY ADZO KPORKU

(STUDENT)

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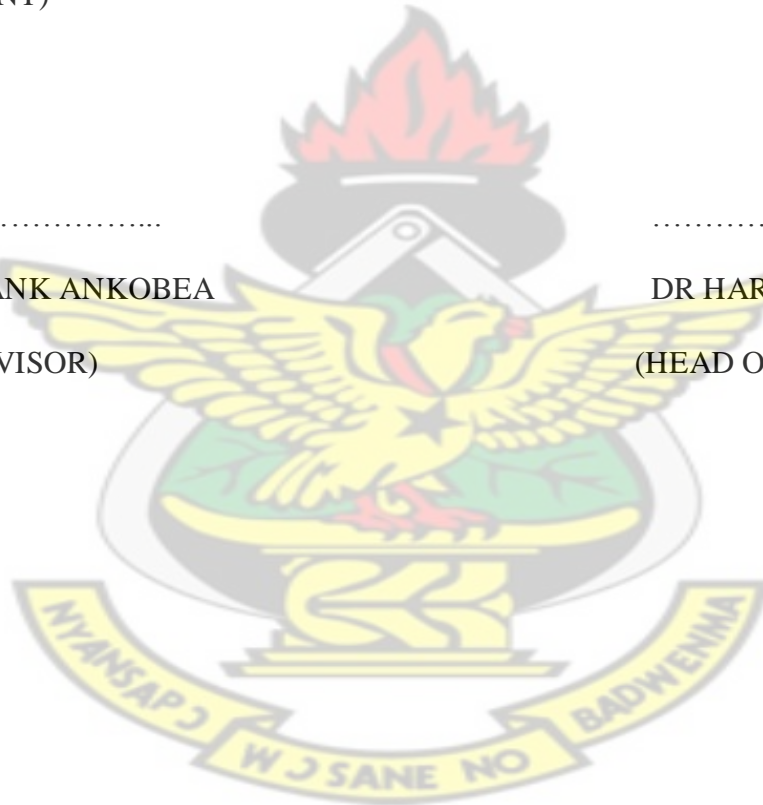
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DEDICATION

I dedicate this work to my children, Deladem and Immanuel. You are my inspiration.

KNUST



ACKNOWLEDGEMENT

I thank God so much for all His mercies and goodness to me. My deepest and sincerest gratitude goes to my supervisor, Dr. Frank Ankobea who diligently guided and gave me useful suggestions in the writing of this research work.

My next appreciation goes to Dr. Harry Tagbor, head of department and all the lecturers at the department of Community health, KNUST, for expanding my horizon.

Am also grateful to the staff of Ghana Education Service-Ejura Municipality, especially, Nana Owureduwaa Asante, affectionately called “girl child” for her dedication and support.

I am deeply indebted to the respondents (female head porters) for their time and contribution- life will get better.

I also like to mention Mr. Seidu Baba for helping me from the beginning of the data collection till the work was completed. God richly bless you.

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Finally, to my family, friends and loved ones who wished me well in the course of my studies. May God expand your territories.

LIST OF ABBREVIATIONS

ASRH	Adolescent Sexual and Reproductive Health
GDHS.....	Ghana Demographic and Health Survey
IUD.....	Intra-uterine Device
JHS.....	Junior High School
KNUST.....	Kwame Nkrumah University of science and Technology
SRH.....	Sexual and Reproductive Health
SSS.....	Senior High School
STI.....	Sexually Transmitted Infection
TFR.....	Total Fertility Rate
UNFPA.....	United Nation Population Fund
WHO.....	World Health Organization

ABSTRACT

Family planning is unique among health interventions in the breadth of its benefits—family planning decreases maternal and child mortality, empowers women, reduces poverty and it lessens stress on the natural and political environment’. In many resource-poor settings, the growing unmet need for contraception is astounding. Couples who wish to have fewer children are unable to determine the size of their families as family planning funding continues to become scarce and existing programmes and services fail to meet the concerns and desires of their users. It is important to emphasize not telling women how many children they should have, but underscore that they have a right and the freedom to choose how to control their own fertility.

Similarly the introduction of family planning programmes in the Ejura municipality seems not to have achieved the desired result. According to the Ejura Municipal Health Directorate Annual Report for 2010 family planning acceptance rate is percent. The extent of meeting the needs of vulnerable groups such as female head porters have not been determined through any investigation. The research therefore assessed the Female head porter’s access to contraceptives in the Ejura Municipality, Ashanti Region, specifically on, Source of contraception information, education and service, attitudes towards contraceptives, Preferred contraceptive methods and reasons for use and common barriers and concerns and fashion out recommendations that will serve as possible basis for future strategies. In a cross sectional study to assess the accessibility of contraceptives to female head porters between the ages of twelve and thirty five in the Ejura Municipality, two hundred and seventy two female head porters were selected

from Ejura market using systematic and random sampling who were interviewed using structured questionnaire.

The research revealed that knowledge level of respondents about contraceptives is high (92% of respondents).

In addition, majority (57.7%) of respondents receive information on contraceptive from health care providers. Most respondents (88%) accept the attitude of health care providers to be friendly, 80% of them accept there is always privacy when service is provided. 71% accepted that they were counseled before product was supplied. Furthermore, most of them, between 74%-94% accept their choice of contraceptive to be safe, cheap, always available, convenient, reliable, and simple, without side effect, does not interfere with sexual intercourse and within their reach.

Surprisingly, usage of contraceptive was very low, 60% of respondents indicated they never use contraceptive and only 40% claimed to have ever used contraceptives. Injectable seem to be the most (48%) preferred contraceptive. Furthermore, between 74%-94% accept their choice of contraceptive to be safe, cheap, always available, convenient, reliable, and simple, without side effect, does not interfere with sexual intercourse and within their reach. Undesirable side effect of contraceptive, religion and cultural acceptance are the main barrier to the use of contraceptive. Religion and cultural acceptance was a controversy. Some of the respondents (63%) agreed their religion and culture accept their use whilst others (35%) disagreed.

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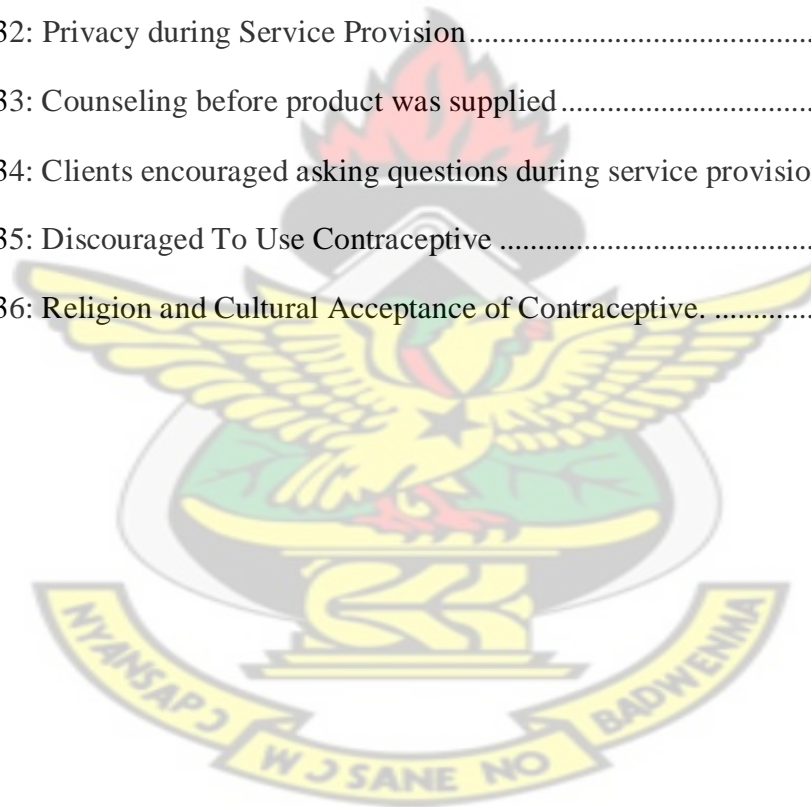
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CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Globally an estimated 80 million pregnancies occur each year unintended (WHO et al 2011b). Worldwide more than 215 women say they would prefer to avoid pregnancy but are not using any form of contraception or they are using methods which are less effective means of contraception (Singh et al, 2010). Family planning programmes in resource-poor settings are usually fragile, show signs of poor performance and are both dependent on international funding and constrained by existing policies or lack thereof. However, it is exactly in those settings where family planning programmes are most needed. If countries aim to reduce inequalities in health, reduce maternal and child mortality rates, alleviate poverty and foster economic development these services must be updated and improved and made easily accessible to all who need it most.

Voluntary family planning is an effective way of controlling fertility within a human rights framework by giving couples the ability to have their desired family size (Prata 2007). In the 1993 World Development Report entitled 'Investing in Health'; the World Bank considered family planning a highly cost-effective public health intervention. As Cleland *et al.* (2006) write, 'The promotion and availability of family planning in resource-poor settings represents one of the most significant public health success stories of the past century.'

Family planning is unique among health interventions in the breadth of its benefits—family planning decreases maternal and child mortality, empowers women, reduces poverty and it lessens stress on the natural and political environment’.

In many resource-poor settings, the growing unmet need for contraception is astounding. Couples who wish to have fewer children are unable to determine the size of their families as family planning funding continues to become scarce and existing programmes and services fail to meet the concerns and desires of their users. It is important to emphasize not telling women how many children they should have, but underscore that they have a right and the freedom to choose how to control their own fertility.

To control fertility effectively, women and couples need to have access to correct information about contraceptive methods and be able to afford the method of their choice. The end result at the family level will positively impact the health of women and children, easing pressure on family resources and increasing a family's chances to escape the trap of poverty (Cleland *et al.* 2006).

The report by the UK's All Party Parliamentary Group on Population, Development and Reproductive Health entitled *Return of the population growth factor: its impact upon the millennium development goals* shows clearly that poverty and socioeconomic disparities are closely linked to unchecked population growth. The poorest of the poor tend to have not only the lowest contraceptive prevalence, but the highest total fertility rate (TFR) and the highest unmet need for family planning (Prata 2006, 2007). Population growth also remains a significant issue with respect to increasing levels of education or

improving the income gap. The 'Return of the population growth factor' report analysis shows that, as a result of rapid population growth, the developing world must train two million additional teachers every year to keep education levels at where they are today—with no level of improvement. With increasing population levels, however, even this will not be enough.

A large part of the burden of disease linked to maternal health which poor countries are facing today is also reflective of undesired fertility. It is unjust that women are dying simply because of unmet need for contraception and yet this remains to be the case. Cleland *et al.* (2006) estimate that promotion of family planning in high fertility countries has the potential to avert 32 per cent of all maternal deaths and nearly 10 per cent of childhood deaths. It is estimated that 25 per cent of HIV-positive women have an unmet need for family planning. Unfortunately, even though contraception is also more cost-effective than Niverapine to prevent mother-to-child-transmission (Reynolds *et al.* 2006), family planning is often not an integral part of HIV prevention programmes.

Health disparities are increasing over time and this in turn poses a significant problem for quickly growing populations living on extremely scarce resources (Ezeh *et al.* 2009). Until family planning is made accessible to address the large burden of unmet need for contraception, countries will be unable to provide their citizens with even their basic human needs.

Within the past one and half decades many efforts have been made to improve the availability and access to adolescent sexual and reproductive health services. Despite these efforts, adolescents still face a number of sexual and reproductive health problems. Young people, (15 to 24 years old) who represent one sixth of the world population, face a number of sexual and reproductive health problems. Key among these are sexually transmitted infections (STIs) especially HIV, teenage and unwanted pregnancies

Globally, adolescent girls (15 to 19) account for 14 million births annually. These births put them at high risk of death and lifelong complications because they are still not well developed to start child bearing. The birth rates among female between 15 to 19 years in Africa is estimated at 143 per 1000, which is two times more than the world average of 65.

According to the United Nations Population Fund (UNFPA 2009) reports, sub-Saharan Africa has the lowest demand (30%) and use (20%) of contraceptives among 15-19 year olds. They further commend that lack of access to family planning services and negative attitudes of health workers towards adolescent contraceptive use have contributed to high rates of pregnancies among adolescent.

The problems faced by adolescents in Ghana are not too different from their counterparts all over Africa. They include teenage pregnancies, low knowledge and usage of contraceptives, high fertility rates and high incidence of HIV. For example

between 2008 and 2010 the HIV prevalence among young people (15 to 24 years old) in the country increased from 1.9% to 2.1% 7. According to the 2008 Ghana Demographic and Health Survey (GDHS) about 14% of all Ghanaian female adolescents have started child bearing, with only 8.0% of them using contraceptives.

1.2 Importance of the Study

This is an issue that highlights the importance of having a stable health care system. African countries facing the problem of maternal mortality are losing an important component of their human capital. This is certainly an issue that affects the globe as a whole. This study will add to the reflection/evaluation papers that take a look at what exists, what can be done and what needs to be taken into consideration to achieve the desired goal. One part of public health's goal is to make health care accessible to all people. A concentrated effort is needed to reach out to those who are currently excluded from sexual and reproductive health care.

1.3 Problem Statement.

According to the 2008 Ghana Demographic and Health Survey (GDHS) about 14% of all Ghanaian female adolescents have started child bearing, with only 8.0% of them using contraceptives. Adolescents in Ghana have also been reported to have a generally poor knowledge on contraceptives. According to Kumi-Kyereme et al, pre-marital pregnancies and HIV are the main health problems of adolescents in Ghana. They have

also been reported to have the greatest unmet need for family planning (want to delay or stop childbearing but are not currently using contraceptives). About 62% of them have unmet need as compared to 33% among 30-34year olds. Unfortunately the pre-marital sex especially among adolescents is highly unacceptable in all Ghanaian cultural and religious settings. This makes it difficult for the adolescents to discuss any sexual problems they might have with adults for support.

Anecdotal evidence shows that some health workers even turn away young adolescents who come to their health facilities to seek for family planning services.

According to (Kumi-Kyere 2011) there have been a number of studies carried out on youth sexual and reproductive health (SRH) in Ghana. These studies however present little information on the behaviour of adolescents over time. Most of the recent studies focus on specific regions, districts or communities within the country; they therefore fail to give a clear picture of adolescent sexual and reproductive health (ASRH) in the country. Nonetheless, national level information is needed to assess how the country is meeting the SRH needs for the adolescents.

Despite programmes and messages encouraging delayed sexual debut and abstinence, many youth have unplanned intercourse. Some youth have sex sporadically, which makes contraceptive use difficult. Others experience contraceptive failure — and their failure rates may be higher than adults due to their inexperience. Also, many young women experience coerced sex, including rape especially the female head porter most of whom adolescent without formal education, school drop-out and are also a potentially neglected group for family planning services.

Contraceptives use increases a woman's opportunity in the modern economic world and better qualifies her for a long period of work.

There is a gap in the usage of contraceptives. The usage is higher for the educated young woman than the uneducated. The low usage of contraceptives among female head porters contributes to increased unwanted pregnancies maternal and infant mortality and morbidity, streetism which are all closely linked to under development among the female head porters in the Ejura municipality in the Ashanti region. The study was conducted to find out access to contraceptives by the female head porters.

1.4 Purpose of the Study

Contraceptive services is one of the important health services intended not only to reduce fertility but to also improve women's health in general by avoiding unwanted pregnancy and STIs and maternal death. Though MOH and GHS has step up effort over the years in education and provision of contraceptives, there are still unserved group of communities of female head porters. It has been noted and more often reported to have the greatest unmet need for family planning (want to delay or stop childbearing but are not currently using contraceptives). About 62% of them have unmet need as compared to 33% among 30-34year olds.(GDHS 2008) Unfortunately the pre-marital sex especially among adolescents is highly unacceptable in all Ghanaian cultural and religious settings. This makes it difficult for the adolescence to discuss any sexual problems they might have with adults for support.

Based on the above, the study examined the problems that hinder accessibility of contraceptive use by the female head porter in order to reduce the rate of unwanted pregnancies and STIs and maternal death. The study determined source of contraceptive information, education and services, found out the head porter's attitude toward contraceptive used identify preferred contraceptives methods and reason for use and ascertain common barriers and concerns to contraceptive use.

1.5 Hypothesis

The access to contraceptives services (family planning) among female head porters is low.

1.6 Study Objectives

1.6.1 Main Objectives

To assess the accessibility to contraceptives (family planning) by female head porters

1.6.2 Specific Objectives

- I. To determine source of contraceptive information, education and services
- II. To find out head porters attitudes towards contraceptive
- III. To identify preferred contraceptives methods and reason for use
- IV. To ascertain common barriers and concerns

1.7 Research Questions

What are the sources of contraceptive information, education and services?

What are the attitudes of female head porters towards contraceptives?

What is the preferred contraceptives methods and reason for use?

What are the common barriers and concerns?

1.8 Profile of the Study Area

The study was conducted in Ejura Municipality of the Ashanti region. The area is about 254square kilometer. It has a population of 1,604909, (source KMA2007). Since human beings are the ultimate beneficiaries of the development plans, programs and projects, it is imperative for planning to take cognizance of population dynamics of the municipality.

Ejura/Sekyedumase district is one of the twenty seven districts of the Ashanti Region. It was carved out of Sekyere West district in 1992. Ejura is the District capital. It is one of the two districts farthest from the regional capital, Kumasi and has a projected population of 120,565 based on the 2000 census with an annual growth rate of 3.4%. The district covers a total landmass of 1,780.55sq. Km.

The district lies within the double belt climate with very good fertile soil. About 76% of the populace are mainly farmers. The population is mainly migrant farmers from the Northern regions of Ghana. The remaining are either artisans, traders, civil or public servants. The main languages spoken are Akan, Hausa, Dagbani, Gonja, Frafra, Sisala and Kotokoli. The rainfall pattern consists of a wet season, generally extending from March to October, interrupted by a minor dry season in July and August. The month December through February is virtually rainless.

CHAPTER TWO

LITERATURE REVIEW

2.1 Source of Contraceptive Information, Education and Services

A report on adolescents' sexual reproductive health in Ghana has revealed that they do not use contraceptives to prevent pregnancy or Sexually Transmitted Infections, (STIs) because of lack of knowledge.

The depth of their knowledge is said to be inadequate even as majority of them are afraid to get pregnant. Among adolescents aged 15-19, only 28% of females and 21% of males had detailed knowledge about pregnancy prevention; awareness of a woman's fertile period, ability to reject several popular misconceptions about pregnancy and familiarity with at least one modern method of contraception.

Other findings emphasize that adolescents have received little information about using contraceptives and so have misconceptions about them. 31% of both males and females did not know that condoms should be used only once.

29% of females and 39% of males in this age group believed that using a condom was a sign that one did not trust one's partner. In the 2004 National Survey of Adolescents, over 90% of respondents reported that they had heard of at least one modern contraceptive method.

The best known methods were the male condom; familiar to 88% of females and 91% males, the female condom: 70% of females and 73% of males, the injectable: 57% of females and 56% of males and the pill: 53% of both females and males.

According to the report, adolescents have fair knowledge about HIV/AIDS and other STIs. This influences their decision about the use of contraceptive, particularly the condom.

According to the report although knowledge does not guarantee that adolescents will change their sexual behaviour, it can empower them to make informed decisions about their reproductive health and may increase the odds that they will choose to protect themselves from unintended pregnancy and HIV/AIDs. Adolescents' preferences are overwhelmingly for public clinics, with strongly positive perceptions of confidentiality, accessibility and cost.

2.2 Attitudes of Female Head Porters towards Contraceptives.

A 2004 research revealed that although about two-thirds of 15-19-year-olds (female and male) approve of family planning, most sexually active teenagers in Ghana do not use contraceptives. Among sexually active adolescents in this age-group, 80% of females and 63% of males do not use any modern method.

The report said adolescents in general expressed little confidence that they could properly use the male condom which is the most common method of protection in this age group. Biddlecom et al (2004) reported that adolescents' views of and preferences for sexual and reproductive health services highlight promising directions and persistent challenges in preventing pregnancy and HIV and treating sexually-transmitted infections (STIs) in this population. Results from nationally-representative surveys of 12–19 year-olds in Burkina Faso, Ghana, Malawi and Uganda in 2004 show that contraceptive and

STI services and HIV testing are still under-utilized. A substantial proportion of sexually-active adolescents do not know of any source to obtain contraception or get STI treatment, and social-psychological reasons (e.g., embarrassment or fear) and financial cost remain common barriers to getting services. Adolescents' preferences are overwhelmingly for public clinics, with strongly positive perceptions of confidentiality, accessibility and cost.

2.3 Preferred Contraceptives Methods and Reason For Use

Trends in modern contraceptive use in resource-poor settings seem to be associated with the level of international community's support for family planning and local resources, thus affecting the pace of fertility decline in such settings. For example, in sub-Saharan Africa, many countries experienced substantial gains in contraceptive prevalence rates (CPR) in the 1980s and 1990s, followed by a diminished or stalled progress in the 2000. In the 1990s, modern method use almost quadrupled in Malawi, substantially increasing in all wealth quintiles, despite the widespread poverty, and more than doubled in Tanzania and Uganda

According to the Office of National Statistics (ONS), the Pill and the condom remain the most widely used methods in Britain. Both are employed by about 25 per cent of sexually active couples.

A study conducted in Kumasi on at risk women published in Acta Obstet Gynecol Scand. 2010 Aug;89(8):1105-7.revealed that male condom was the commonest form of contraception (32%) followed by the pill (16%).

2.4 Common Barriers and Concerns to Contraceptives Services

The little evidence that does exist suggests that, in many cases, training in contraception is insufficient. An editorial published in *Contraception* reports that lack of training is the primary reason cited by health care practitioners for not taking a sexual health history from patients on a routine basis, followed by clinician embarrassment and a belief that sexual health is not relevant to the patient's visit.

In Britain a review and commentary published in the *Journal of Sexual Medicine* seconds the findings in this editorial, stating that "In all countries, medical students, house staff, and practicing physicians currently receive variable, non-standardized, or inadequate training in sexual history taking and sexual medicine assessment and treatment. There remain significant physician-patient barriers to discussing sexual issues; and patients feel that their physicians are reluctant, disinterested, or unskilled in sexual problem management. There is a knowledge gap between developments in sexual medicine and the clinical skills of practicing physicians.

Over and over again during the advisory group meetings, panelists observed that many practicing providers are reluctant to embrace new contraceptive methods or protocols, particularly when these developments conflict with more traditional beliefs and values. This reluctance is exacerbated by a lack of continuing education on contraceptive issues and methods.

During the advisory group meetings, providers repeatedly cited a lack of reimbursement for certain procedures, particularly when combined together (e.g., delivery and tubal ligation or abortion and IUD insertion), as a major barrier to contraceptive success. The

literature also cites the high cost of certain methods (e.g., the IUD and other long-term methods), lack of or low level of reimbursement from Medicaid and Title X for these methods, and insurance prohibitions against dispensing more than a 1-month supply of a contraceptive as other economic barriers.

The literature review and the advisory group meetings both highlighted a lack of awareness of important contraceptive issues among consumers, as well as a lack of true understanding of contraception, pregnancy, and sexual function. Members of the group expressed concern that while education and understanding pertaining to sex, pregnancy and contraception have declined and unrealistic sexual content in the media has increased, there have been few countervailing social messages to promote better understanding regarding the importance of contraception and the methods available.

A 2007 survey of 500 girls age 13-18, sponsored by Seventeen magazine and The Candie's Foundation, found that nearly half think it is possible they might become pregnant in the next 5 years; 70% say if guys played more of a role in using birth control it would help prevent unplanned pregnancy; 67% have friends who are or became pregnant as teenagers; and two-thirds are more worried about STIs than an unplanned pregnancy. Seventy percent of the teen girls said that having a plan for the future would help prevent unplanned pregnancies.

Consumers, particularly young men and women in their teens and 20s, live in a highly charged, sexually confusing era. Sexual content in media is pervasive and often presented out of context to its risks (e.g., pregnancy and STIs). In some schools, abstinence-only programs focus solely on the risks of using birth control methods, and

there has been much less education about the benefits of contraception in preventing pregnancy, STIs, and preserving health (noncontraceptive benefits).

In addition, the risks and side effects of contraception are often presented in contrast to the risks of not using birth control, rather than more realistically to the health and social risks of pregnancy. One survey found that a third of teens have not received any formal instruction about contraception, according to 2002 data—impacting them not only in their teen years but in their 20s. A fifth have received abstinence-only education with no instruction in birth control methods.

There are also many myths and fallacies circulating about the so-called dangers of IUDs and other methods. Similarly, consumers may simply have poor awareness of highly efficacious, long-term methods of contraception such as the IUD and Implanon, or hormonal alternatives to the pill such as the vaginal ring and patch (which are replaced monthly and weekly, respectively, rather than taken daily as the pill must be).

Teens age 15 to 17 surveyed for the Kaiser Family Foundation in 2004 reported they are concerned about their sexual health, whether they've had sex yet or not. Most have a fairly high degree of awareness about various methods, but have significant gaps in their knowledge. They were most familiar with condoms (85%) and birth control pills (77%). Many teens underestimate the effectiveness of birth control options, particularly newer methods.

Other restrictions include what level of provider can/should provide certain contraceptive methods. For example, rural women in many part of Africa receive services from community-based distributors (CBDs), but CBDs are only allowed to

distribute pills and condoms. However, it is exactly in rural areas of sub-Saharan Africa that women prefer injectable contraceptives. Depo-provera provision by community-based workers was used in many parts of Asia and Latin America, and it was recently demonstrated in pilot projects in Uganda, Madagascar and Ethiopia. However, in most of sub-Saharan Africa, Depo-provera provision is restricted to skilled providers, despite the evidence showing its safety, feasibility and acceptability at the community level (Stanback et al. 2007). Similarly, the satisfactory provision of IUD insertion by non-physicians has been established since the 1970s (Eren et al. 1983; Farr et al. 1998), but today these services are provided mostly by physicians and in some places selected mid-level providers such as clinical officers when, in fact, provision of non-surgical long-term methods of contraception should be an integral part of pre-service training for all levels of health workers, not only those working on higher level facilities.

The reproductive rights of all women of reproductive age, regardless of age, marital status and place of residence, need to be protected and facilitated by non-restrictive laws.

Facility-based barriers are not codified in law, but their de facto practice creates unnecessary barriers to accessing family planning services such as clinics refusing to see adolescent patients or only providing contraceptive services on specific days of the week. In addition, provision of services of poor quality, including limited contraceptive choice and inability to switch methods if unsatisfied with the prescribed one, are all facility restrictions imposed on clients that hinder access.

Finally, *provider-based barriers* prevent women from accessing certain methods of contraception through discouragement or non-evidence-based clinical practices that emerge from personal biases and beliefs. Providers have been widely documented to discourage individuals from accessing hormonal methods by insisting on costly and medically unnecessary pelvic examinations, blood tests or making it difficult (or impossible) for women to obtain the method of their choice if they are nulliparous, have recently had an abortion or are of a certain age. Moreover, women using oral contraceptives are often required to visit the provider every month.



CHAPTER THREE

METHODOLOGY

3.1 Profile of the Study Area

The study was conducted in Ejura Municipality of the Ashanti region. The area is about 254square kilometer. It has a population of 1,604909, (source KMA2007). Since human beings are the ultimate beneficiaries of the development plans, programs and projects, it is imperative for planning to take cognizance of population dynamics of the municipality.

Ejura/Sekyedumase district is one of the twenty seven districts of the Ashanti Region. It was carved out of Sekyere West district in 1992. Ejura is the District capital. It is one of the two districts farthest from the regional capital, Kumasi and has a projected population of 120,565 based on the 2000 census with an annual growth rate of 3.4%. The district covers a total landmass of 1,780.55sq. Km.

The district lies within the double belt climate with very good fertile soil. About 76% of the populace are mainly farmers. The population is mainly migrant farmers from the Northern regions of Ghana. The remaining are either artisans, traders, civil or public servants. The main languages spoken are Akan, Hausa, Dagbani, Gonja, Frafra, Sisala and Kotokoli. The rainfall pattern consists of a wet season, generally extending from March to October, interrupted by a minor dry season in July and August. The month December through February is virtually rainless.

Table 1: Population distribution of study area.

2012	PERCENTAGE (%)	ACTUAL
POPULATION	100%	92,556
<1 YEARS	3%	2777
<5 YEARS	16.5%	15272
WIFA	26.7%	24,712
EXPECTED PREGNANCIES	3%	2777
EXPECTED DELIVERIES	3%	2777

Within the past three years, in an attempt to improve physical accessibility so that no one needs to travel more 10 km to access health care, the number of health facilities has improved from 6 in 2010, 7 in 2010 to 9 in 2012

Major concerns as reported by the district health administration at the beginning of the year included

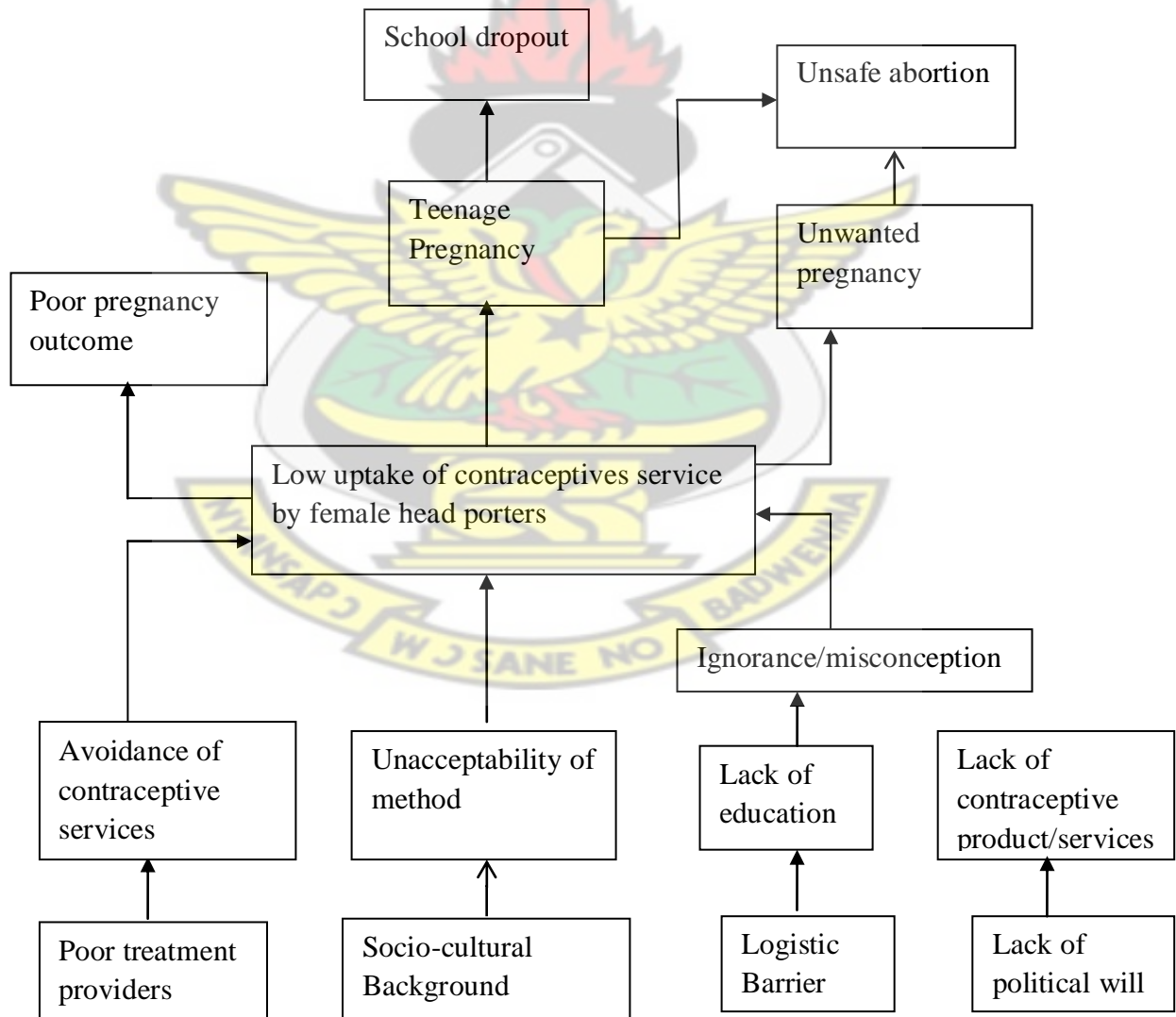
- Staff development through in-service training
- Quality health delivery in all facilities and outreach points
- Reproductive Health/ Family Planning
- School Health Services

Improve family planning coverage through health staff capacity building, male involvement, improved client enrollment & data validation

3.2 The Study Population

The study population comprised female head porters. The female head porters are mostly made of people from the north of the country who are usually between the ages of eight to twenty five. The common language spoken is Hausa making communication difficult. They are also predominantly Catholics and Moslems.

Figure 1: Conceptual Framework



The need for accurate information and knowledge on contraceptive is essential to increase the uptake of contraceptives.

Low contraceptives services may be due to lack of education on contraceptive, unacceptability of method and lack of contraceptive methods.

Misconceptions about contraceptives and cultural barriers have also been identified as drawbacks in the uptake of contraceptives.

The results of these are teenage pregnancy which can lead to unsafe abortion and sometimes death

3.3 Study design

Cross-sectional survey was the study design used. The main data collection tool was a questionnaire, and the data collection technique was interviews. Questionnaire was used to collect data from the female head porters aimed at identifying the access to contraceptives.

3.4 Data Collection Techniques And Tools

The data collection instruments adopted to assemble the information was questionnaire and interview. Field assistants were trained on data collection techniques such as interviewing, administration of questionnaire and reviewing available information.

3.5 Study Area

The study was conducted in Ejura Municipality in Ashanti region of Ghana. The study was done specifically in the Ejura market where the female head porters conduct their activities

3.6 Study Population

The population of this study involved female head porters who were between the age of twelve (12) and thirty five (35) who are sexually active.

3.7 Sampling Size

The Snedecor and Cochran, 1989 formula was used to calculate the sample size.

$$N_o = \frac{Z^2 pq}{e^2}$$

Where N_o = required sample size

P = probability that female head porters have access to contraceptives.

q = probability that female head porters have no access to contraceptives.

Z = confidence interval

e = margin of error or degree of precision.

Since we do not know the degree of operation of the laws, we assume that, the probability of having access to contraceptives to be 0.5 and having no access to contraceptives to be 0.5.

Therefore at a confidence level of 90% with a standard value of 1.6449,

$$Z=1.6449, p=0.5, q= (1-0.5) \text{ and } e=0.05$$

$$\text{Therefore } N_o = \frac{(1.6449)^2(0.5)(0.5)}{(0.05)^2}$$

$$= 270.57$$

$$= 270.57$$

Hence the sample size of the study was 271 respondents.

Table 2: Study Variables

Variable	Operational definition	Scale of measurement	Objectives to be addressed
Age	Age of last birth day	Ratio 1. 2- 20 2. 21 -35	To access female head porters Access to contraceptives and socio demographic variables.
Educational background	Level of education attained	Ordinal 1. No school 2. Primary 3. JHS/Middle school 4. SHS 5. Tertiary	To access female head porters Access to contraceptives and socio demographic variables.
Marital status	Marriage relation of respondent	Normal 1. Single 2. Married 3. Not married but in relation 4. Widow/divorced	To access female head porters Access to contraceptives and socio demographic variables.
Number of children	Number of children alive or dead	Discrete To be stated by respondent	To access female head porters Access to contraceptives and socio demographic variables.

Religion	Type of belief system one subscribes to with regard to a supreme being	Normal <ol style="list-style-type: none"> 1. Islam 2. Christianity 3. African traditional religion(ATR) 	To access female head porters Access to contraceptives and socio demographic variables.
Ethnicity	Ethnic background of respondent	Normal <ol style="list-style-type: none"> 1. Akan 2. Northerner 3. Ewe 4. Fante 5. others 	To access female head porters Access to contraceptives and socio demographic variables.

Source author 2014

3.8 Sampling Technique

The focus of the study was on female head porters ages 12-35 who are sexually active.

Systematic sampling was employed to select the respondents for the study. An estimated population of female head porters of 587 was divided by the required sample size of 271, giving as a k^{th} element of 2. We proceeded with the selection of every k^{th} element from then onwards. In this case, $k = (\text{population size/sample size})$ as calculated above.

The 1st person of interview was randomly selected. Every other second person of contact who qualifies for the study was selected and interviewed until the required sample size of 271 was obtained.

3.9 Measures to ensure data quality

3.9.1 Pre –testing

The pretesting of the questionnaire was done at Mampong market which has female head porters with similar characteristics as the selected markets. Based on the outcome of the pretesting, the questions were modified accordingly by rephrasing sentences which were not clear and gave different meaning and understanding by the respondent.

3.9.2 Field supervision/ Checks.

To check for completeness and accuracy of data, questionnaires were numbered serially. Also, completed questionnaires were checked thoroughly on daily basis for errors and mistakes. The respondents were prevented from discussing their responses with their peers.

3.10 Data Analysis Plan

The data from the survey was checked for accuracy and consistency and then data was cleaned and analyzed using SPSS version 16 and Microsoft excel. The results were converted into percentages and displayed using figures.

3.11 Ethical Considerations

Permission was obtained from Ejura health directorate and informed consent from the respondents. The respondents were assured of confidentiality which was indicated on the questionnaire. This information was available in English and translated into Hausa a

local language to ensure comprehensive understanding of the study objectives, potential risks, and benefits.

3.12 Limitation of the Study.

The study did not cover the entire municipality. Only a representative sample was reached.

Another limitation was the interpretation of the questionnaire into the local dialect of the respondents most of which are illiterate.

There could be a bias as a result of translation of questionnaire from English into Hausa the commonest language of the head porters. The study involved relatively small sample that may not be statistically representative of all head porters in the municipality. The conclusions and use of figures are therefore substantially limited to those who participated in the study.

3.13 Assumptions

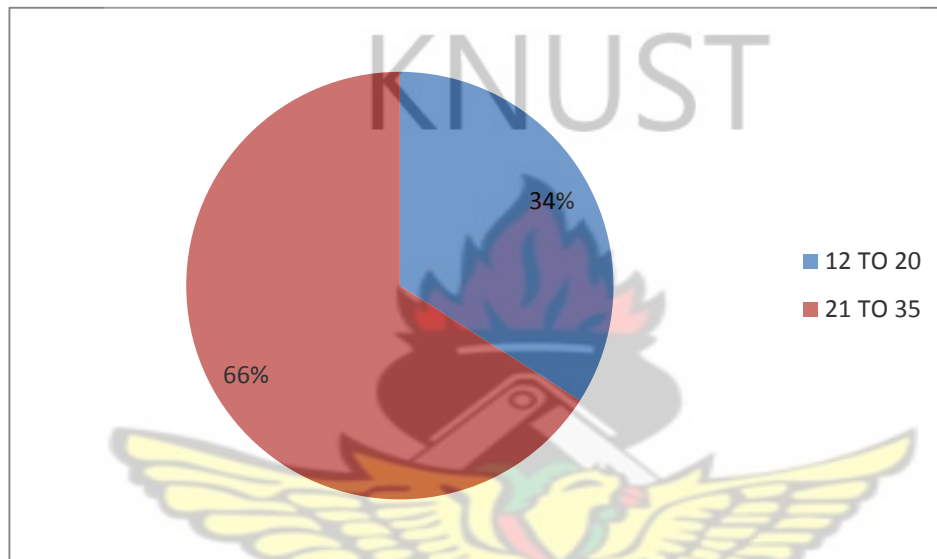
It was assumed that the questionnaires for in-depth interview were correctly answered.

CHAPTER FOUR

RESULTS

Age of Respondents

Figure 2: Age of Respondents

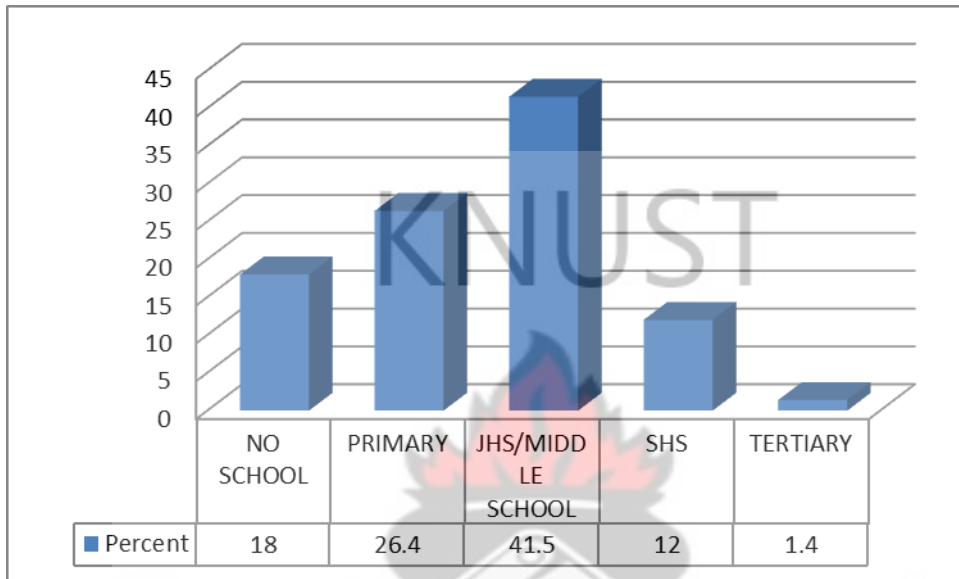


Source; Field Survey

Out of the 272 female head porters interviewed, 34% of them were between the ages of 12 to 20 years and 66% of them were between the ages of 21 to 35 years.

4.2 Educational Background

Figure 3: Educational Background

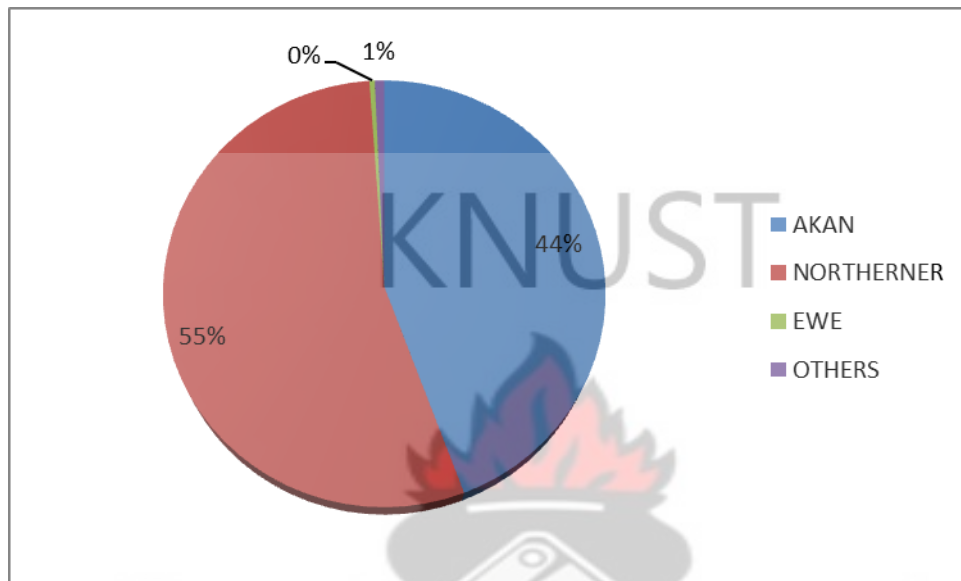


Source; field survey

The research revealed that 18% of the female head porters had no formal education, 26.4% attended primary, and 41.5% and 12% have attended JHS/Middle School and SHS respectively. Whiles 1.4% are tertiary school leavers. (FIG. 1)

4.3 Ethnicity

Figure 4: Ethnicity



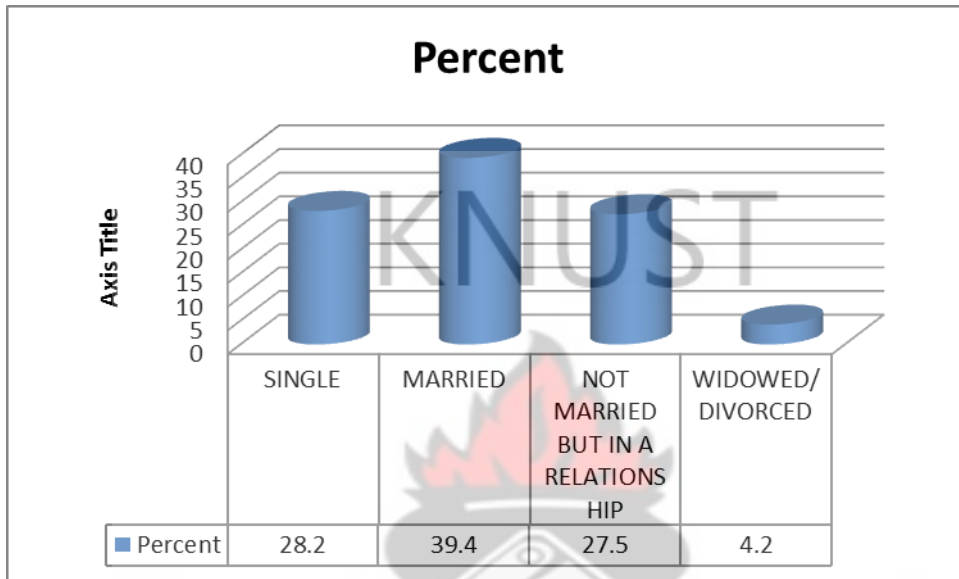
Source; field survey

From the survey conducted, 44% of the respondents are Akans and 55% are northerners.

1% for Ewes.

4.4 Marital Status

Figure 5: Marital status

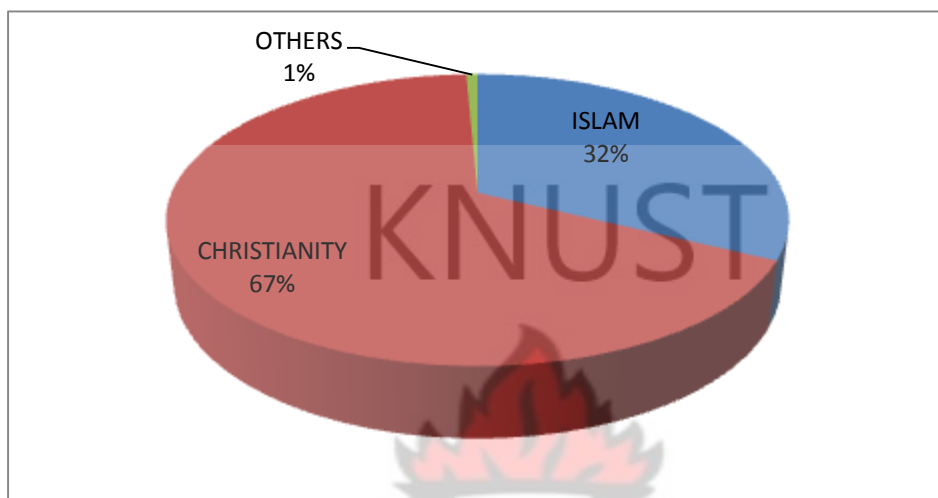


Source; field survey

It was reveal from the research that, 28.2 of respondents are single, 39.4% are married, 27.5% are not married but are in a relationship and 4.2 are either widowed or divorced as shown in figure 4 above.

4.5 Religion of Respondents

Figure 6: Religion of Respondents

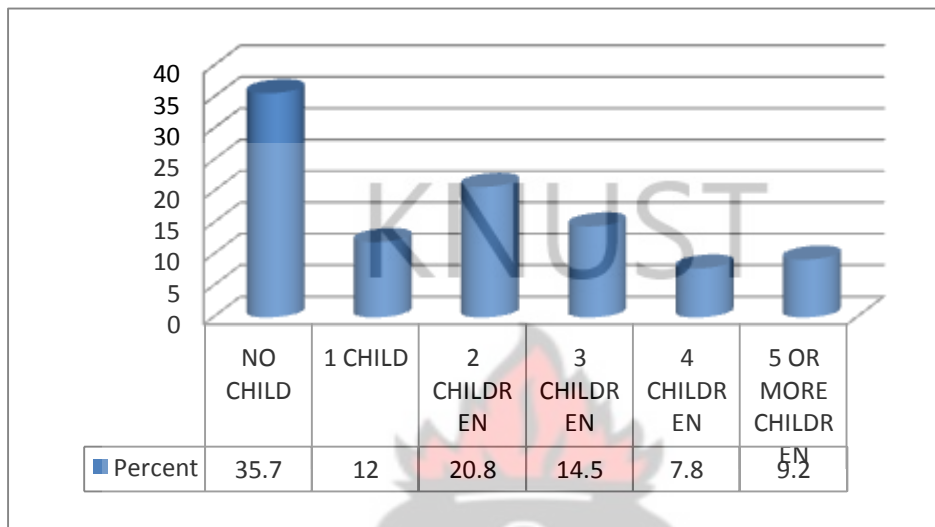


Source; field survey

From the survey 32% of respondents are Moslems and 67% are Christians, and 1% neither Christian or Moslem.

4.6 Number of Children of Respondents

Figure 7: Number of Children of Respondents

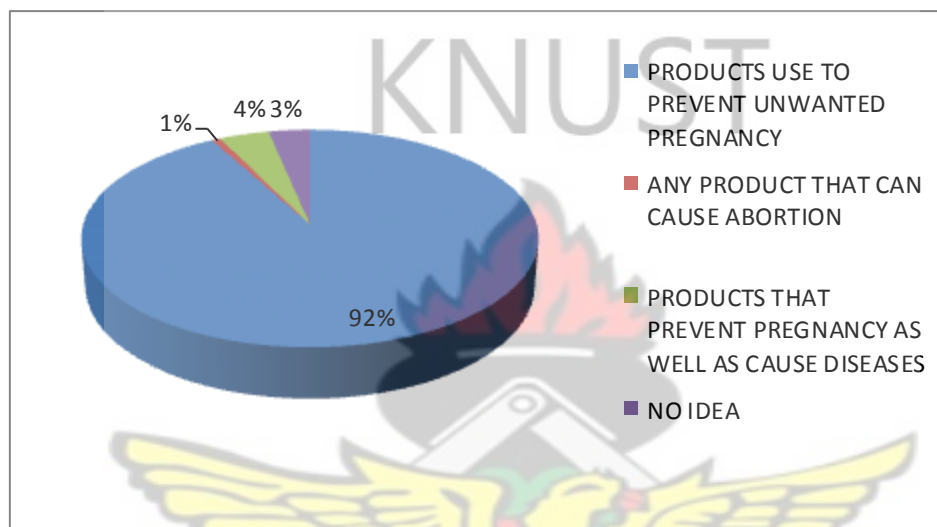


Source; field survey

From the above figure 35.7% of the respondents had no child, 12% had 1 child, 20.8% had 2 children, 14.5% and 7.8% of them had 3 or 4 children respectively while 9.2% had 5 or more children.

4.7 Respondents Understanding Contraceptive

Figure 8: Respondents Understanding Contraceptive

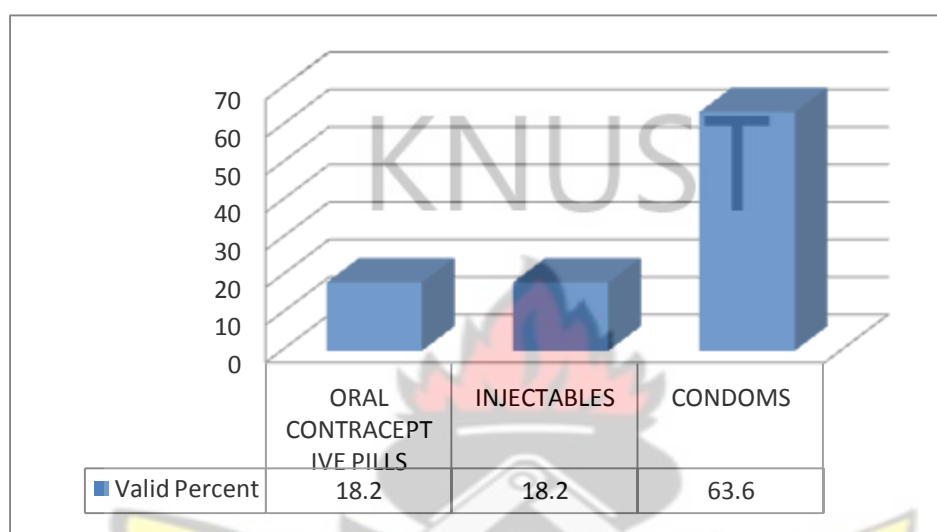


Source; field survey

Knowledge level of respondents about contraceptives was high. 92% Of respondents know contraceptives to be products used to prevent unwanted pregnancy. 1% of them claim contraceptives are used to cause abortion whiles 4% of them said they prevent pregnancy as well as cause diseases. 3% of them of could not tell what contraceptives are as depicted in the figure above.

4.8 Known Contraceptive(s) by Respondents.

Figure 9: Known Contraceptive(s) By Respondents

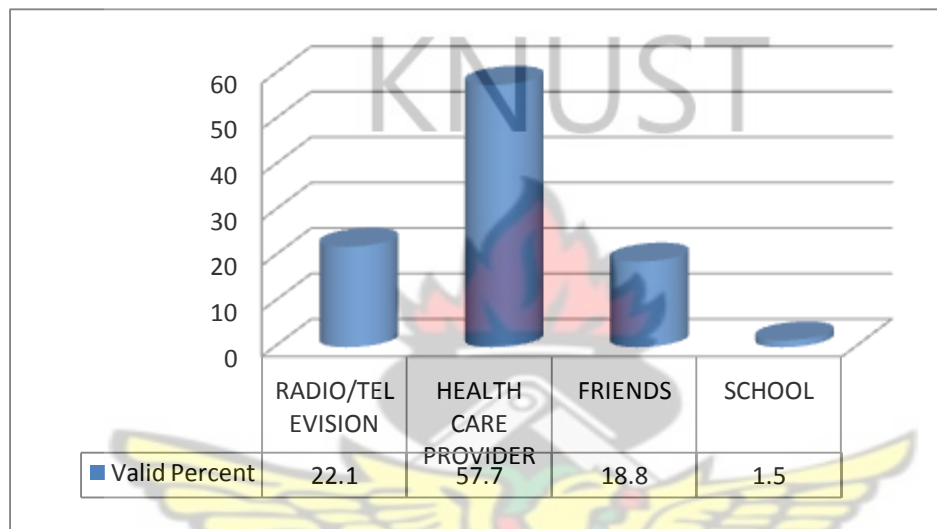


Source; field survey

When respondents were asked about the type(s) of contraceptive they know, 18.2% of them said they have heard of both oral contraceptives and injectable whiles 63.6% knew condoms. (fig 8).

4.9 Source of Information on Contraceptives

Figure 10 : Source of Information on Contraceptives

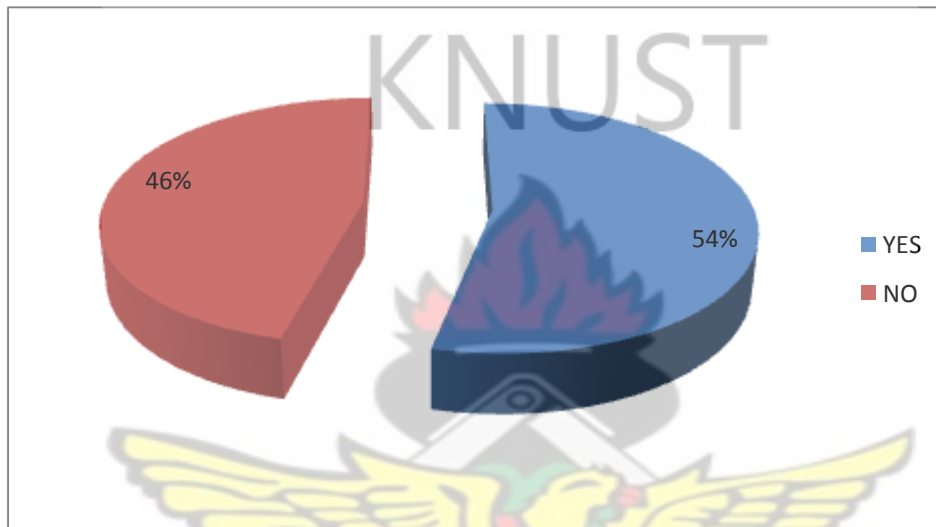


Source; field survey

From the survey, 57.7% of respondents indicated they obtained their information on contraceptives from health care providers, 22.1% from radio/television, 18.8% from their friends and 1.5% from school as shown in the table above.

4.10 Counseling on the Use of Contraceptives.

Figure 11: Counseling on the Use of Contraceptives.

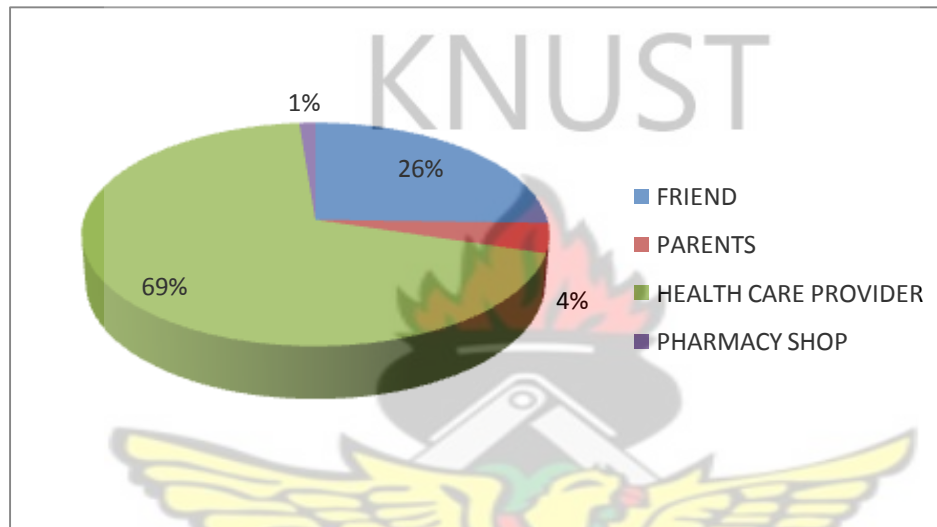


Source; field survey

From the survey, 54% of respondents indicated they have received counseling on contraceptive while 46% had not receive counseling on contraceptive.

4.11 Place Where Counseling Was Received

Figure 12: Place Where Counseling Was Received

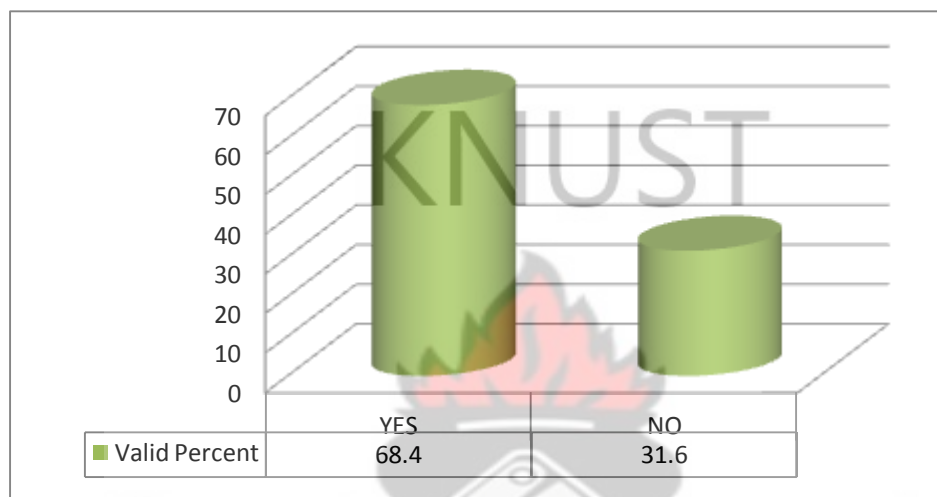


Source; field survey

From the survey, majority (69%) of respondents had received their counseling from health care provider, 26% from friends, 4% from parents, while 1% of them received counseling from pharmacist.

4.12 Adequacy of Counseling to Prevent Unwanted Pregnancy

Figure 13: Adequacy of Counseling to Prevent Unwanted Pregnancy

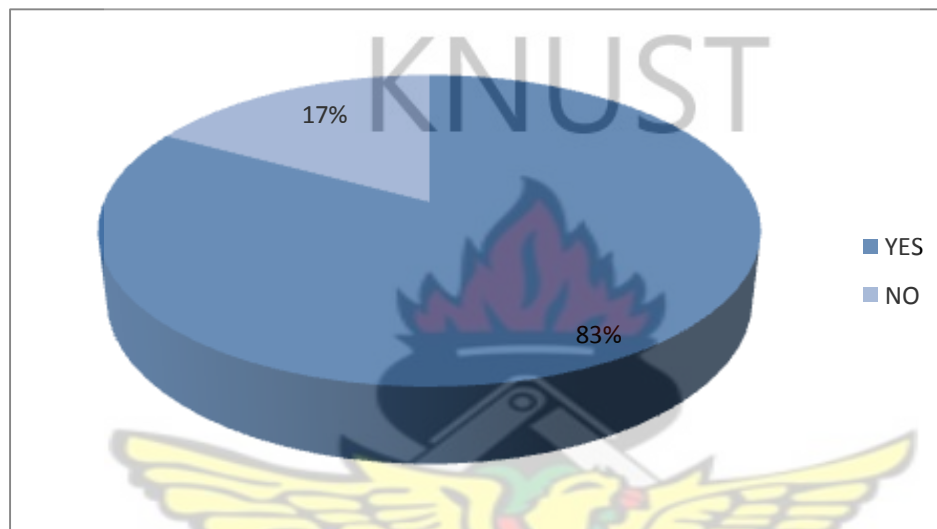


Source; field survey

From the survey, 68.4% of respondents indicated they had enough counseling on contraceptive whiles 31.6% indicated the counseling was not adequate for them. (Fig. 12)

4.13 Prevention of Pregnancy Using Contraceptives

Figure 14 : Prevention of Pregnancy Using Contraceptives

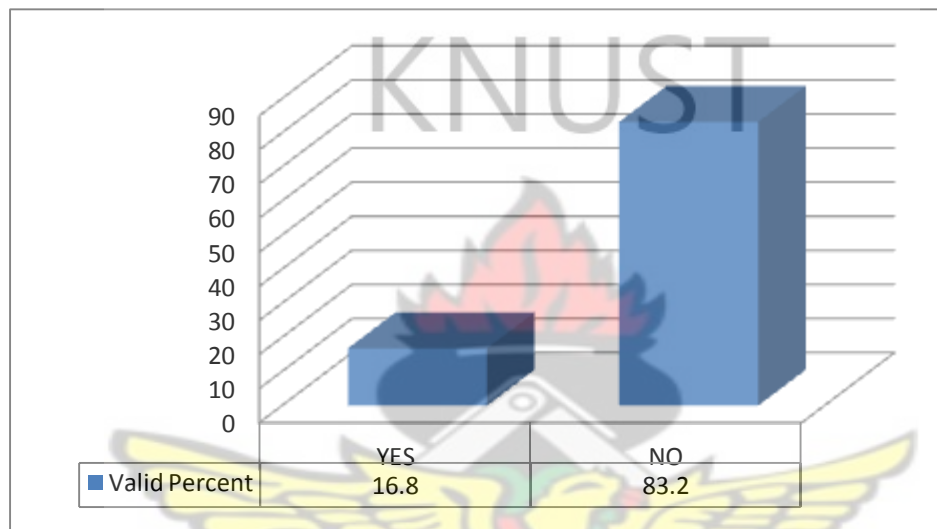


Source; field survey

From the survey 83% of respondents indicated they believe contraceptives prevent pregnancy. However, 17% do not believe contraceptives prevent pregnancy. (Fig 13).

4.14. Other Known Products That Prevent Unwanted Pregnancy

Figure 15: Other Known Products That Prevent Unwanted Pregnancy

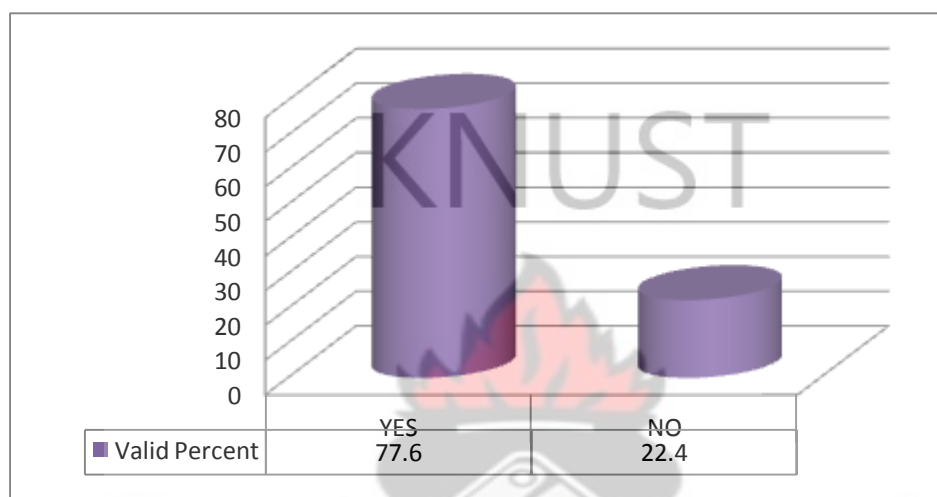


Source; Field Survey

From the survey, 16.8% of respondents indicated they know other products apart from modern contraceptives while 83.2% only knew modern contraceptives depicted in the figure above.

4.15 Education of Sexually Active People on Contraceptives

Figure 16: Education of Sexually Active People on Contraceptives

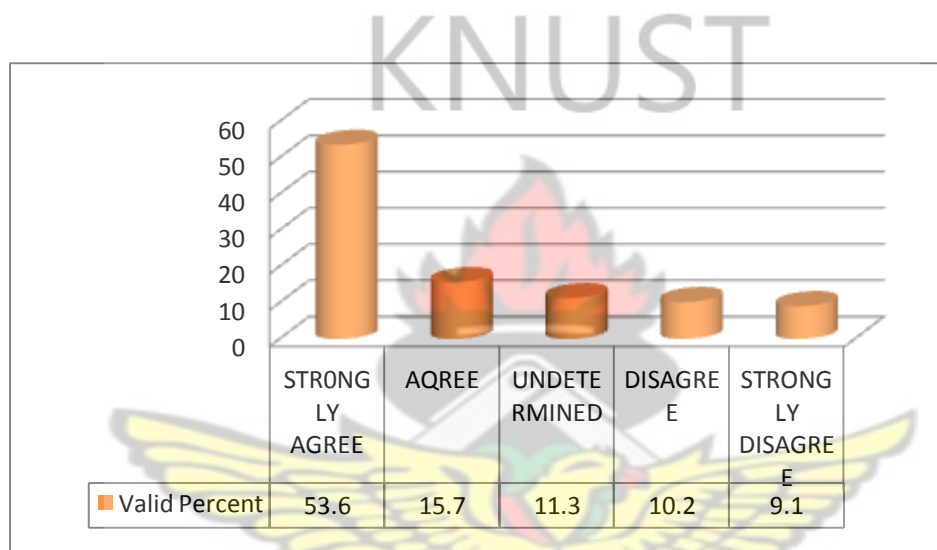


Source; field survey

From the survey, majority (77.6%) of respondents indicated the need for us to educate all sexually active people on contraceptives while 22.4% disagree.

4.16 Health Implication of Young People Using Contraceptive to Prevent Unwanted Pregnancy

Figure 17: Health Implication of Young People Using Contraceptive to Prevent Unwanted Pregnancy

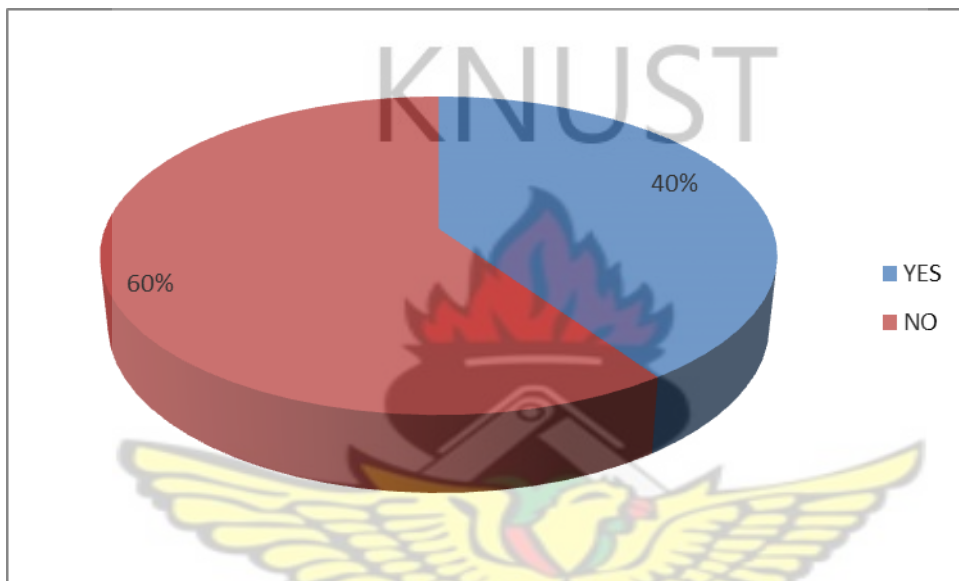


Source; field survey

From the survey, 69.3% agreed (strongly agree + agree) that, it is healthy for young people to use contraceptive to prevent pregnancy, 11.3% could not determine, while 19.3% disagreed (strongly disagree + disagree) as depicted in the figure above.

4.17 Usage of Contraceptive to Prevent Unwanted Pregnancy

Figure 18 : Usage of Contraceptive to Prevent Unwanted Pregnancy

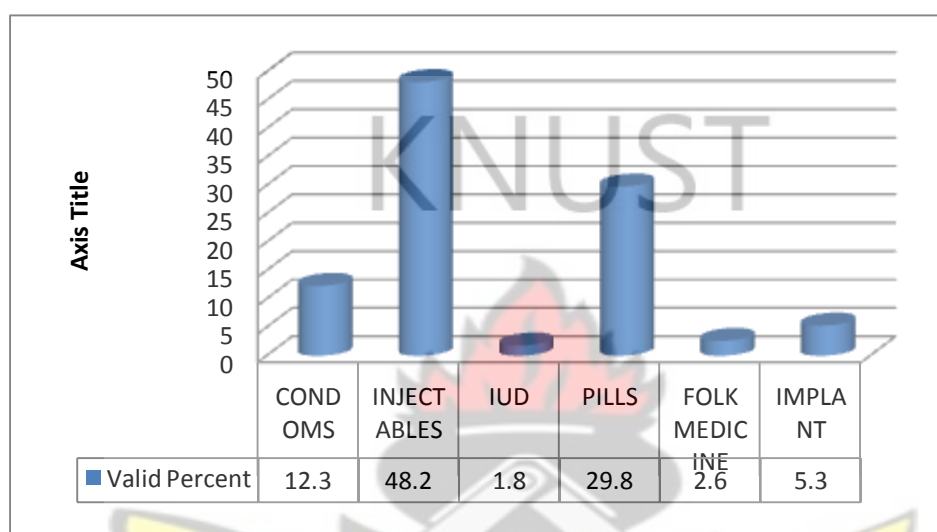


Source; field survey

From the survey as depicted in the figure above, 40% of respondents indicated they have ever use contraceptive whiles 60% indicated they have never use contraceptive.

4.18 Respondents Choice of Contraceptives

Figure 19: Respondents Choice of Contraceptives

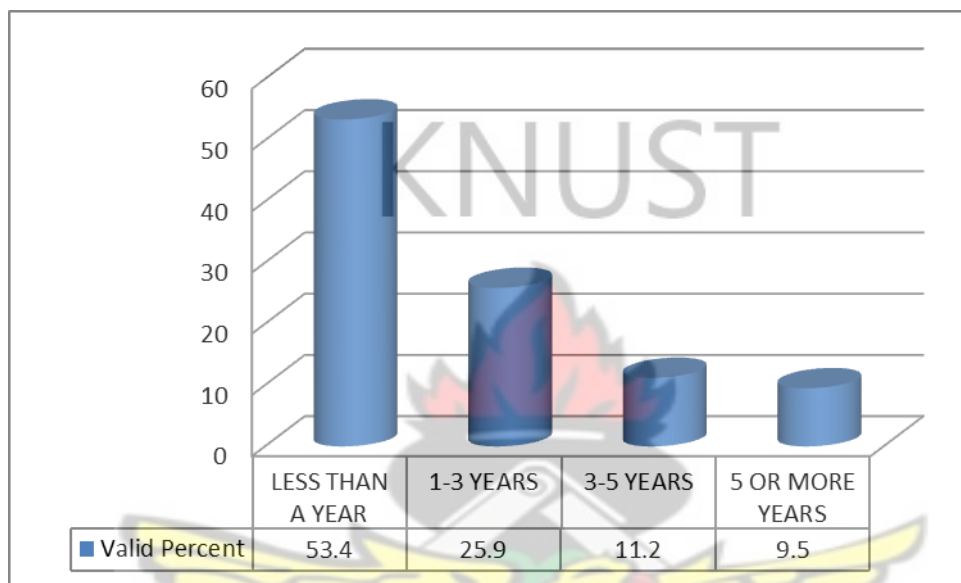


Source; field survey

Out of respondents who have ever use contraceptive before, 12.3% indicated they used condoms, 48.2% used injectable, 1.8% for IUD, 29.8% used pills and 5.3% used implants. However, 2.6% resulted to folk medicine.

4.19 Length of Contraceptive Usage

Figure 20: Length of Contraceptive Usage

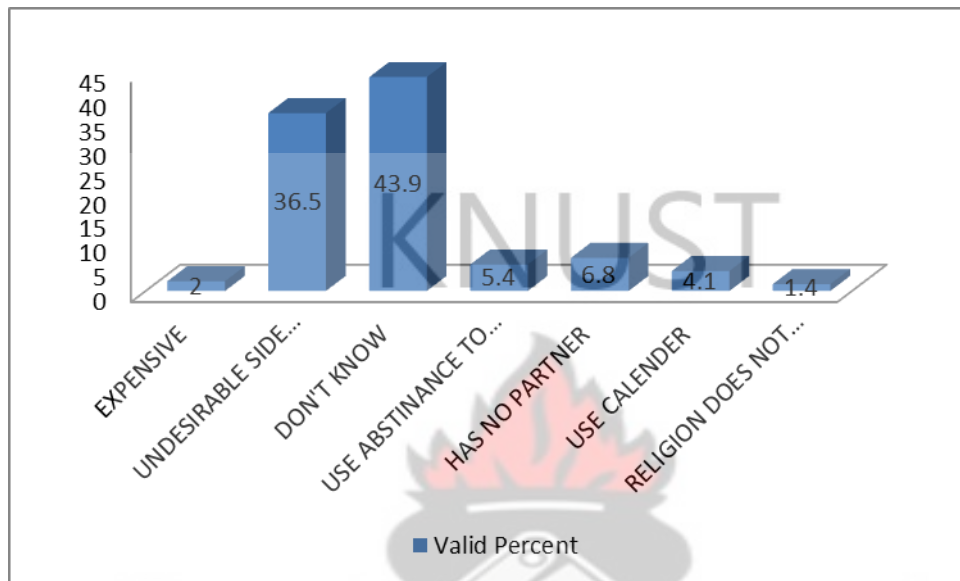


Source; field survey

From the survey, 53.4% indicated the used of contraceptive for less than a year, 25.9% had used for 1 to 3 years, 11.2% for 3 to 5 years and 9.5% had use contraceptive for 5 or more years as shown in the figure above.

4.20 Reasons for Non Use

Figure 21: Reasons for Non Use

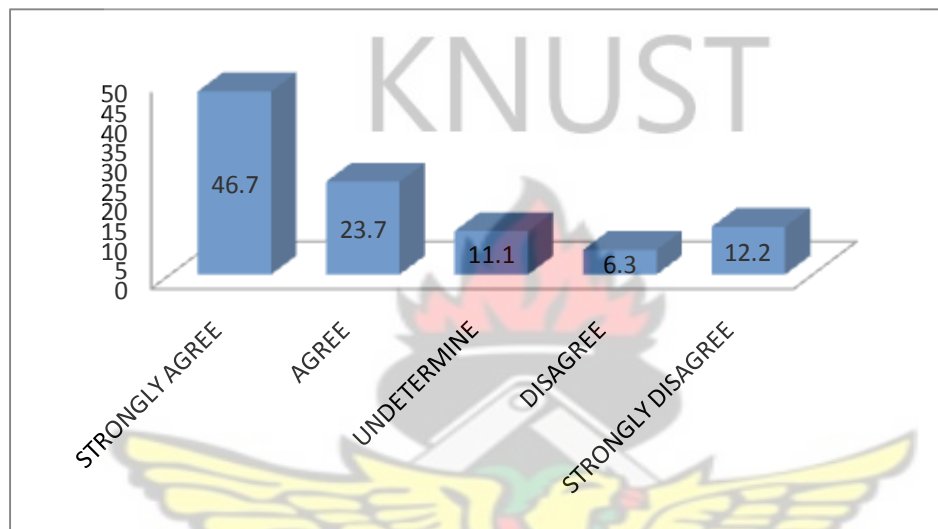


Source; field survey

Out of the respondents who indicated they have never use contraceptive, 36.5% of them complained of undesirable side effects, 2% indicated it is expensive for them, 43.9 indicated they did not know, 5.4% use abstinence, 4.1% use calendar method, 1.4% complain their religion does not approve, while 6.8% indicated it has no use because they have no partner.

4.21 Restrictions to Contraceptive Use by Sexually Active Young Adults

Figure 22: Restrictions to Contraceptive Use by Sexually Active Young Adults

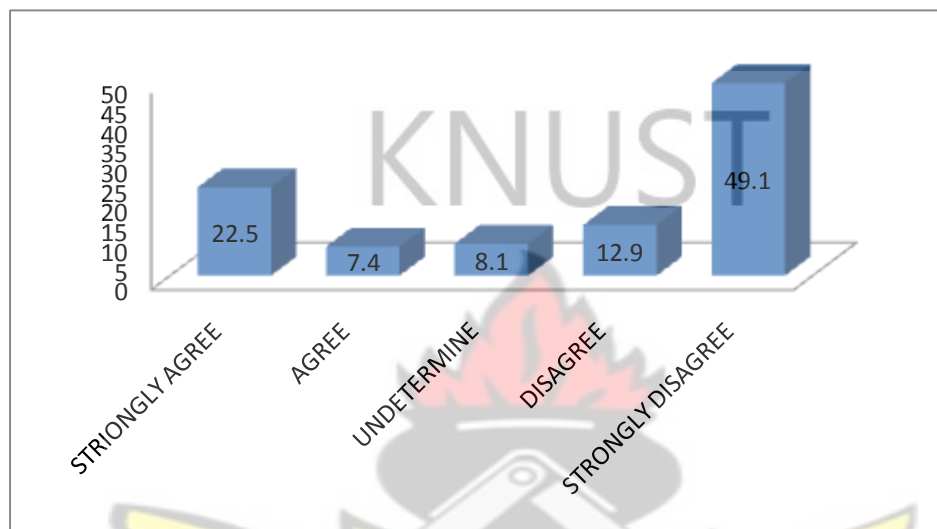


Source; field survey

From the survey, 70.4% agree young, sexually active people should not feel restricted to ask for contraceptives, 11.1% were undetermined, while 18.5% disagree.

4.22 Use of Contraceptives by Unmarried People

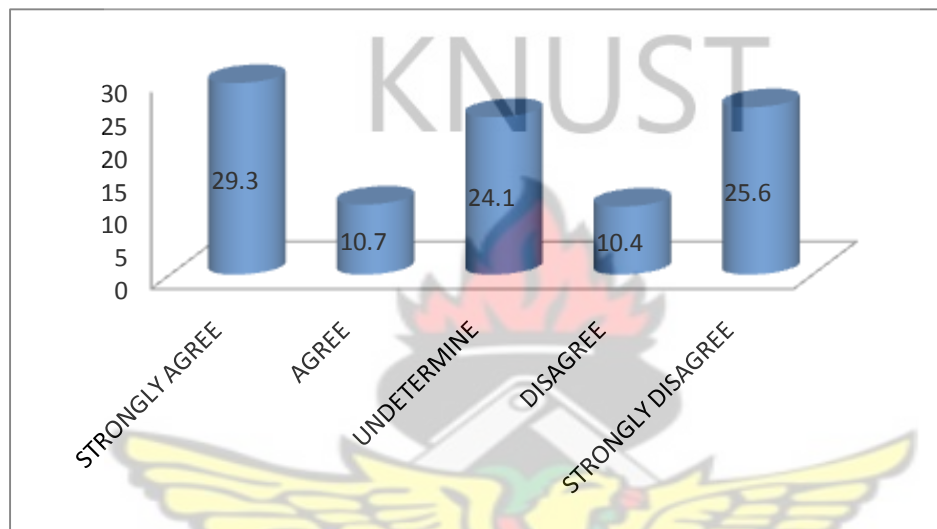
Figure 23 : Use of Contraceptives by Unmarried People



According to the survey, 22.5% of respondents strongly agree that contraceptive should be used by married people only, 7.4% agree, 8.1 undetermined, 12.9% disagree whiles majority (49.1%) strongly disagree as shown in the figure above.

4.23 Association of Promiscuity to the Use of Contraceptives

Figure 24: Association of Contraceptives usage to Promiscuity.

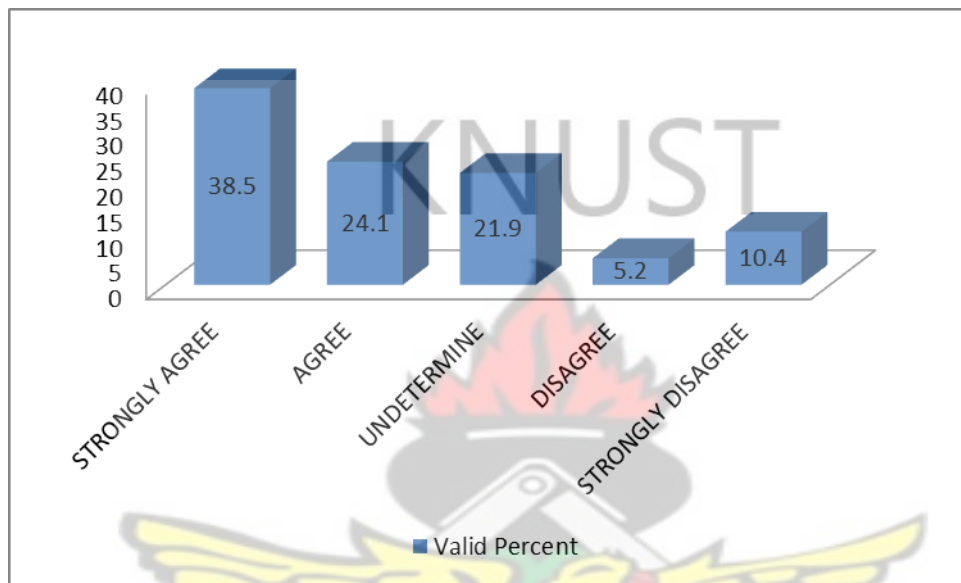


Source; field survey

From the study, 40% of respondents indicated that the use of contraceptive makes one promiscuous, 24.1 undetermined, whiles 36% of them disagree. (Figure 23).

4.24 Contraceptive Usage and Sickness

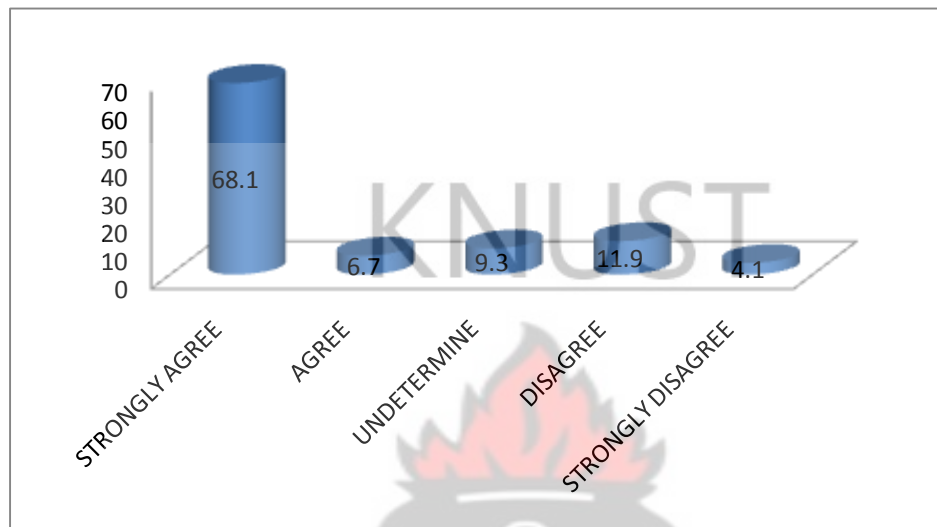
Figure 25: Contraceptive Usage and Sickness



Most of the respondents agree contraceptives make the user sick, 21.9% were undetermined, while 15.6% disagree. (Fig. 24)

4.25: Woman as the Main User of Contraceptive.

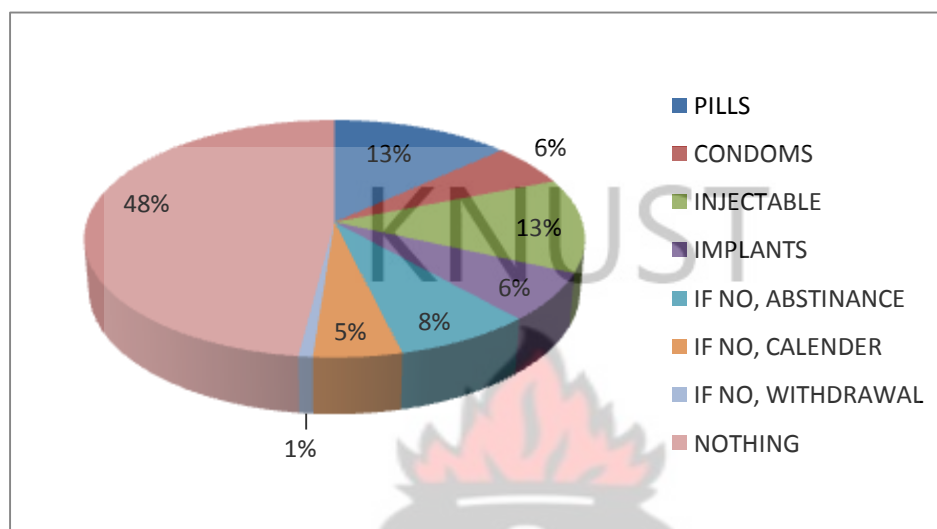
Figure 26: Woman as the Main User of Contraceptive.



Majority (74.8) of respondents indicated, women should be the main user of contraceptive, 9.3 were undetermined, while 16% disagree as shown in the figure above.

4.26; Current Contraceptives Used By Respondents.

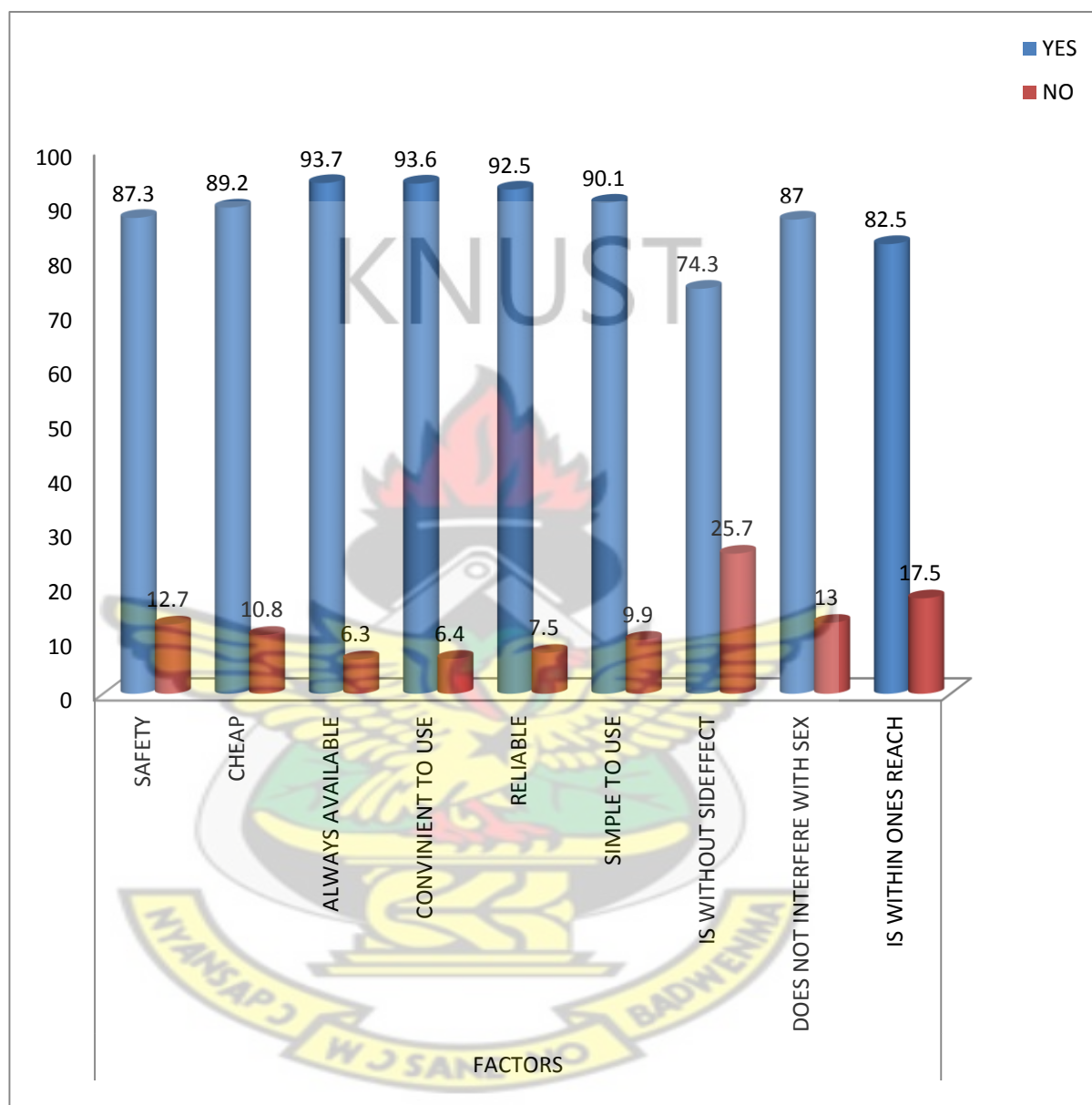
Figure 27 : Current Contraceptives Used By Respondents



The figure above illustrates the choice of contraceptive of respondents. 13% of respondents use pills, 6% use condoms, 13% use injectable, 6% use implants whiles the others use abstinence, calendar or withdrawal method to prevent pregnancy. However, 48% of them do nothing to prevent pregnancy.

4.27 Factors Influencing the Choice of Contraceptives

Figure 28: Factors Influencing the Choice of Contraceptives



Source; field survey

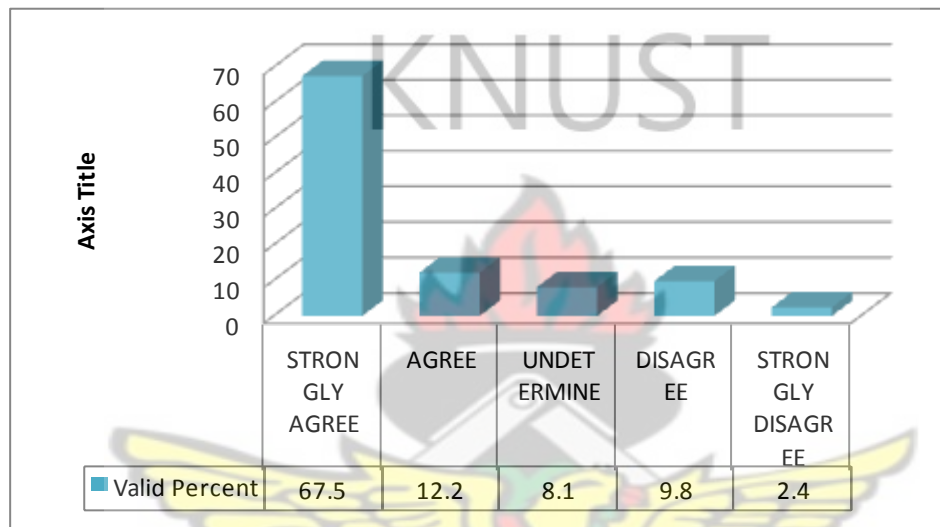
According to the research, between 74% to 94% of respondents accept their choice of contraceptive to be safe, cheap, always available, convenient, reliable, and simple,

without side effect, does not interfere with sexual intercourse, and within their reach.

However between 6% to 26% disagree as shown in figure 26 above.

4.28 Average Time Spent At the Service Centre

Figure 29: Average Time Spent At the Service Centre

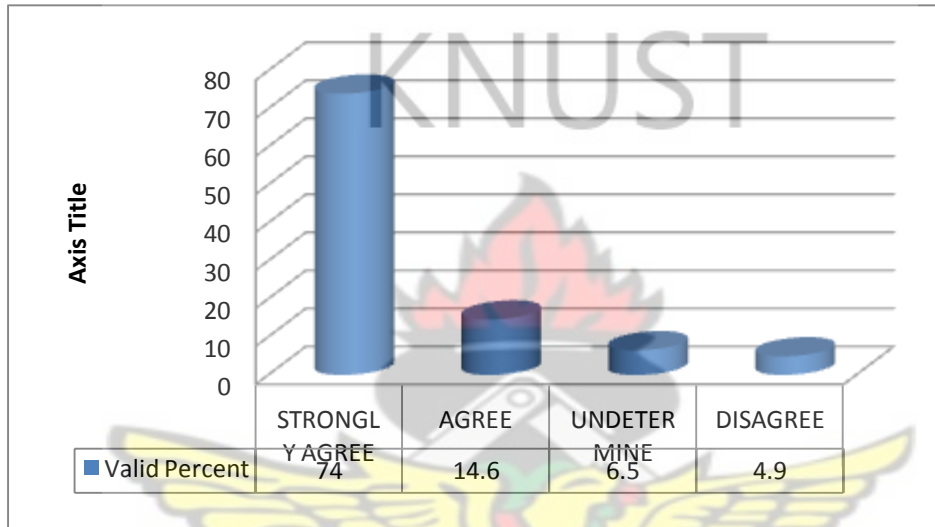


Source; field survey

78% agree of respondents accept the average time spent at the service center is usually less than 1 hour whiles 12% disagree. 8% were undetermined.

4.29 Attitude of the Provider.

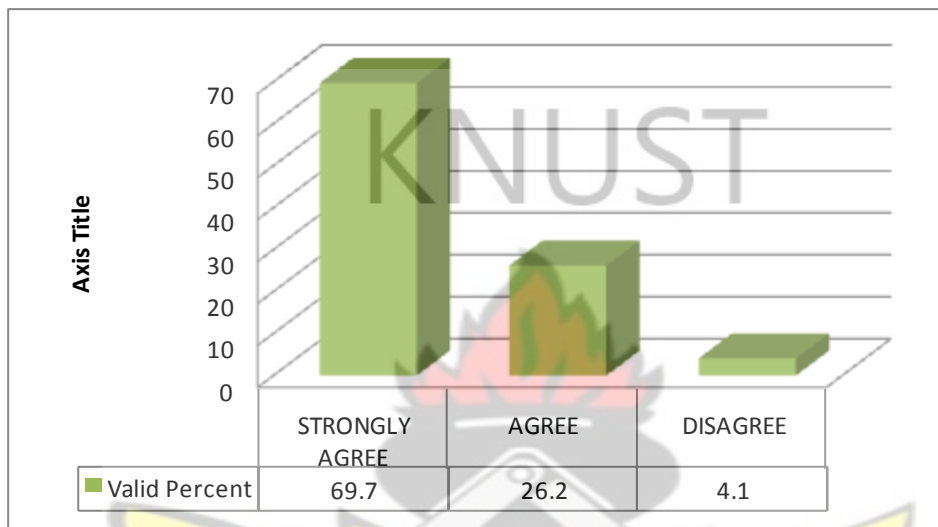
Figure 30 : Attitude of the Provider.



From the survey, 88% of respondents accept the attitude of health care provide be friendly whiles 5% disagree. 7% could not accept or disagree.

4.30 Providers Ability to Communicate Effectively

Figure 31: Providers Ability to Communicate Effectively

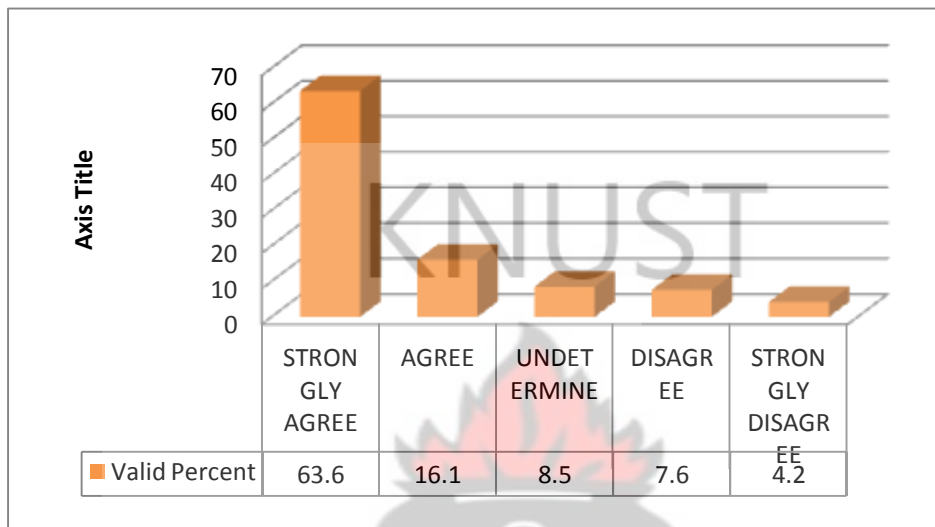


Source; field survey

From the figure above, 70% of respondents accept service providers communicate in a language they understand whiles 4% disagree. 26% were undetermined.

4.31 Privacy during Service Provision

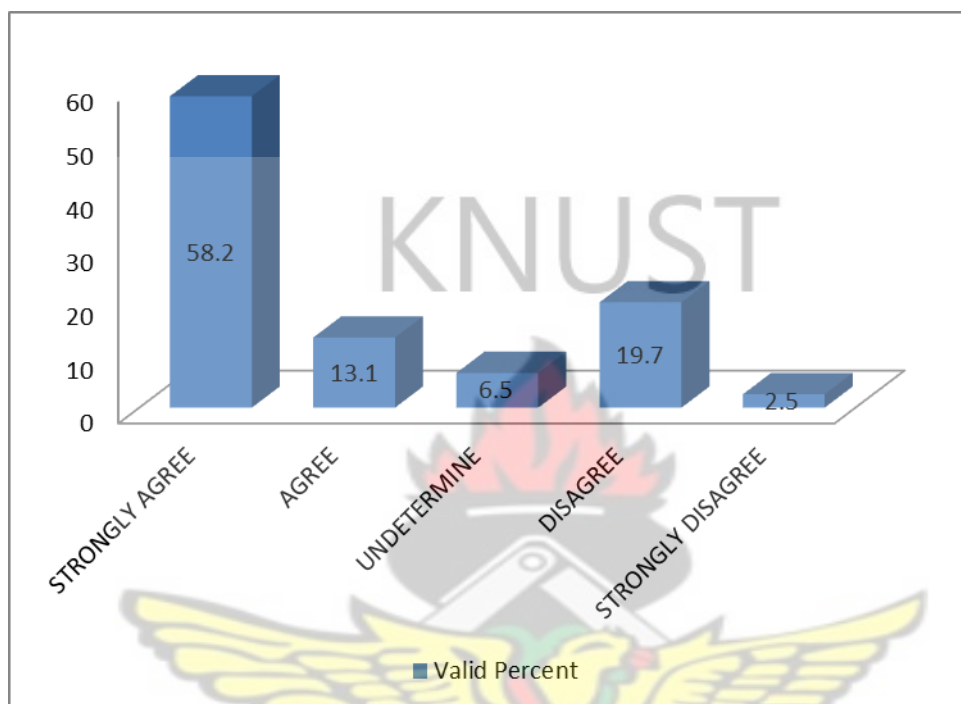
Figure 32: Privacy during Service Provision



From the survey 80% of respondents accept there is always privacy when service is provided whiles 12% disagree. 8% were undetermined.

4.32 Counseling Before Product Was Supplied

Figure 33: Counseling before product was supplied

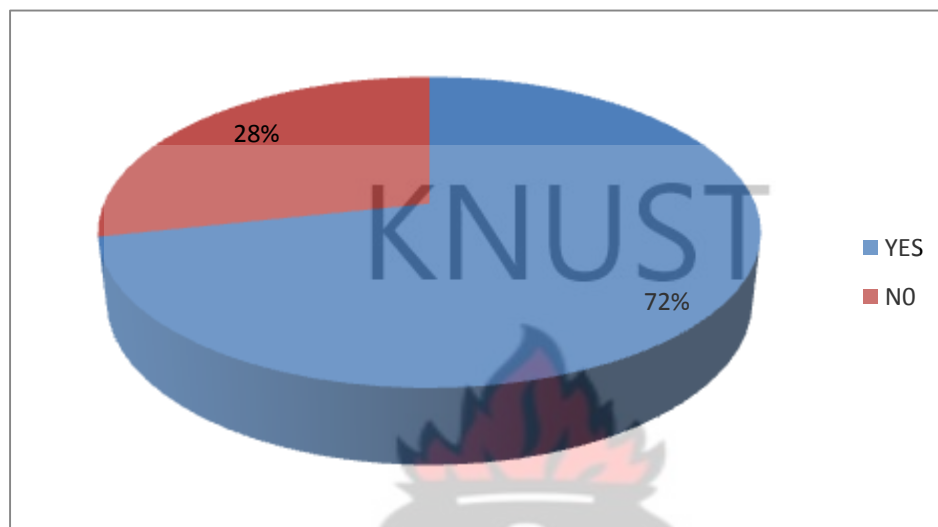


Source; field survey

71% accept they were counseled before product was supplied to the whiles 22% disagreed. 7% of respondents were undetermined.

4.33 Clients encouraged asking questions during service provision

Figure 34: Clients encouraged asking questions during service provision

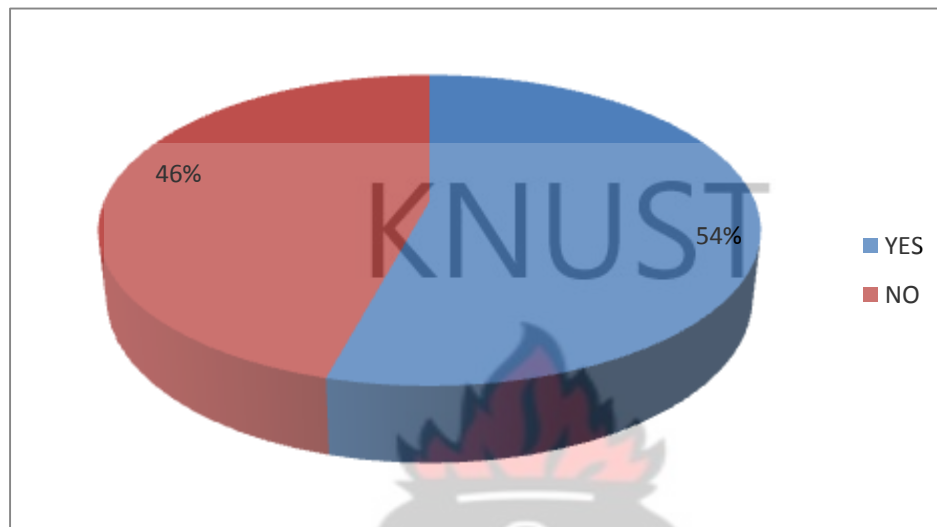


Source; field survey

From the survey, 72% of respondents indicated they are always encouraged to ask questions any time they seek the service whiles 28% disagreed as shown in the figure above.

4.34 Discouraged To Use Contraceptive

Figure 35: Discouraged To Use Contraceptive

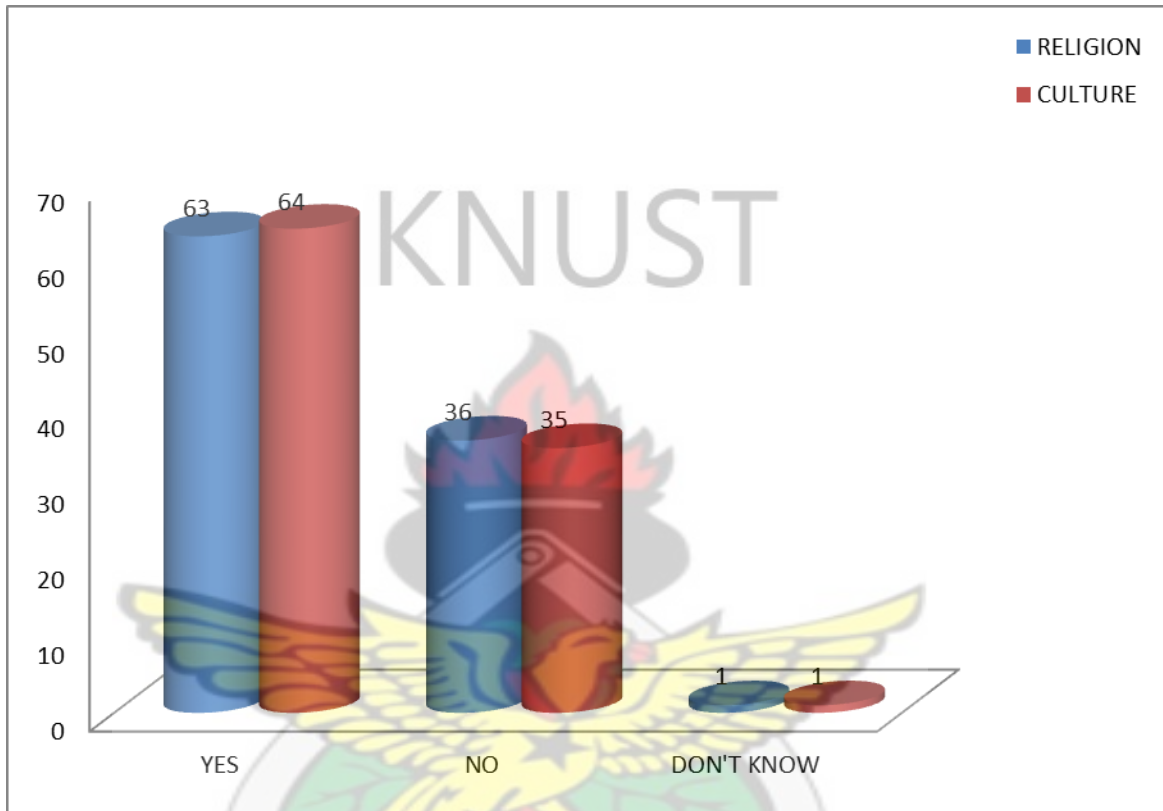


Source; field survey

From the study, 54% of respondents indicated they feel discourage to continue the use of contraceptive whiles 46% did not feel discourage to continue the use of contraceptive.

4.35 Religion and Cultural Acceptance of Contraceptive.

Figure 36: Religion and Cultural Acceptance of Contraceptive.



SOURCE; FIELD SURVEY

From the survey, 63% of respondents indicated their religion and culture accept the use of contraceptive. While 35% indicated their religion and culture do not approve the use of contraceptive. 1% of the respondents could not tell their religion and cultural stand on the use of contraceptive.

CHAPTER FIVE

DISCUSSION

5.1 Knowledge/ Information

One of the objectives is to assess the knowledge information level of contraceptives among females head porter in the Ejura municipal.

The research however reveals that 92% of the respondents have knowledge and information on contraceptives. And at least 62% know the usage of condom in the prevention of unwanted pregnancy

According to the 2008 Ghana Demographic and health survey, the best known methods were the male condom , familiar to 88% of females and 91% males , the female condom 70% of females and 73% of males , the inject able, 57% females and 56% of males and the pills ,53% of both females and males.

According to the 2008 Ghana Demographic and health survey (GDHS) the problem faced by adolescent s in Ghana, include teenage pregnancies, low knowledge and usage of contraceptives.

From the survey obtained respondents have their information on contraceptives from health care providers which implies that Reproductive Healthcare delivery is effective.

However ,according to(Green et al 2002) most adolescent prefer their parent to discuss with them issues of sexuality and relationships with the opposite sex .However , this research reveals that majority (69%) had their counseling from health care providers.

This may suggest that parent may not be willing to talk about sexuality and relationships with the opposite sex with their children.

5.2 Attitude / Practice

Teenage pregnancy is one of the problem faced by adolescents (UNFPA) due to lack of education on contraceptives .

The practice of contraceptives is low among adolescent according to the Ghana Demographic health survey (GDHS 2008).

From the survey 78% of respondent agreed that sexually active people should be educated on contraceptives, this may reduce the prevalence of unwanted and teenage pregnancy dramatically.

In the 2004 National Survey of adolescents although knowledge does not guarantee that adolescent will change their behavior however it can empower them to make informed decision about their reproductive health and may increase the odds that they will choose to protect themselves from unwanted pregnancy.

From the survey 69% of the respondent agreed that it is healthy for young adolescent to use contraceptives to prevent unwanted pregnancy.

From the survey, 22% agreed that only married people should use contraceptives , however 62% disagreed .Respondents were of the opinion that the use of contraceptives makes one promiscuous , sick and their culture and religion does not approve the use of contraceptives.

A 2004 Ghana Demographic Health Survey research revealed that although about two /third (2/3) of 15 to 19 years old (females and males) approve of family planning , most

sexually active teenagers in Ghana do not use contraceptives . Among sexually active adolescents in this age group, 80% of females and 63% of males do not use any modern method.

Also majority (75%) of respondents indicated that, women should be the main user of contraceptives. This reveals their low knowledge on male contraceptives. Similar findings were reported by (GDHS 2008) on adolescent reproductive health.

Out of the 271 respondents surveyed, 40% indicated that they have ever used contraceptives, such as condoms (12%), injectable (48%), IUD (1.8%), pills (29.8%), implants (5.8%). Out of the 40% (114 respondents) only 55 respondents (48%) were still using the contraceptives .It can be deduced from the survey that the decline in the usage of the contraceptives might be due to religious and cultural unacceptance , perception and the misconception that contraceptives makes one promiscuous and sick.

5.3 Factors Influencing Preferred Contraceptives.

To control fertility effectively, women and couples need to have access to correct information about contraceptives method and be able to afford the method of their choice. The end result at the family level will positively impact the health of women and children, ease pressure on family resources and increasing a family chance to escape the trap of poverty (Cleland et al, 2006).

The survey revealed that 74% to 94% of respondent accept the choice of contraceptives to be safe , cheap, always available, convenient, reliable, simple without side effect within their reach and does not interfere with sexual intercourse.

5.4 Barriers to Contraceptives Usage

According to the Ghana Demographic Health Survey (GDHS 2008), evidence shows that some health care workers turn away young adolescent who come to their health facilities to seek for family planning service. However the survey revealed that 88% of respondent accept that the attitude of health care providers to be friendly, (88%) communicate in the language they understand (70%).

Also the respondent indicated that they are attended to quickly any time they went for contraceptive services (78%), privacy (80%). In addition, (71%) of respondents accepted they were counseled before and encouraged to ask questions before products were supplied.

Again 94% of respondents indicated contraceptives were always available any time they went for services .From the above indicators, it can be concluded that there is less facilities barrier to the use of contraceptives.

Surprisingly, usage of contraceptive was very low (40% of respondents), despite all favorable conditions to access contraceptive as indicated by respondents themselves. Injectable seem to be the most (48%) preferred contraceptive.

Nevertheless 35% indicated that their culture and religion does not permit the usage of contraceptives. In addition, 63% of respondents indicated the usage of contraceptives make one sick (undesirable side effect) which might be a major barrier to the use of contraceptives.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

The research revealed that knowledge level of respondents about contraceptives is high as 92% of respondents know contraceptives to be products used to prevent unwanted pregnancy

In addition, majority (57.7%) of respondents receive information on contraceptive from health care providers.

Most respondents (88%) accept the attitude of health care providers to be friendly, 80% of them accept there is always privacy when service is provided. 71% accepted that they were counseled before product was supplied.

Furthermore, most of them, between 74%-94% accept their choice of contraceptive to be safe, cheap, always available, convenient, reliable, and simple, without side effect, does not interfere with sexual intercourse and within their reach.

Surprisingly, usage of contraceptive was very low, 60% of respondents indicated they never use contraceptive and only 40% claimed to have ever used contraceptives.

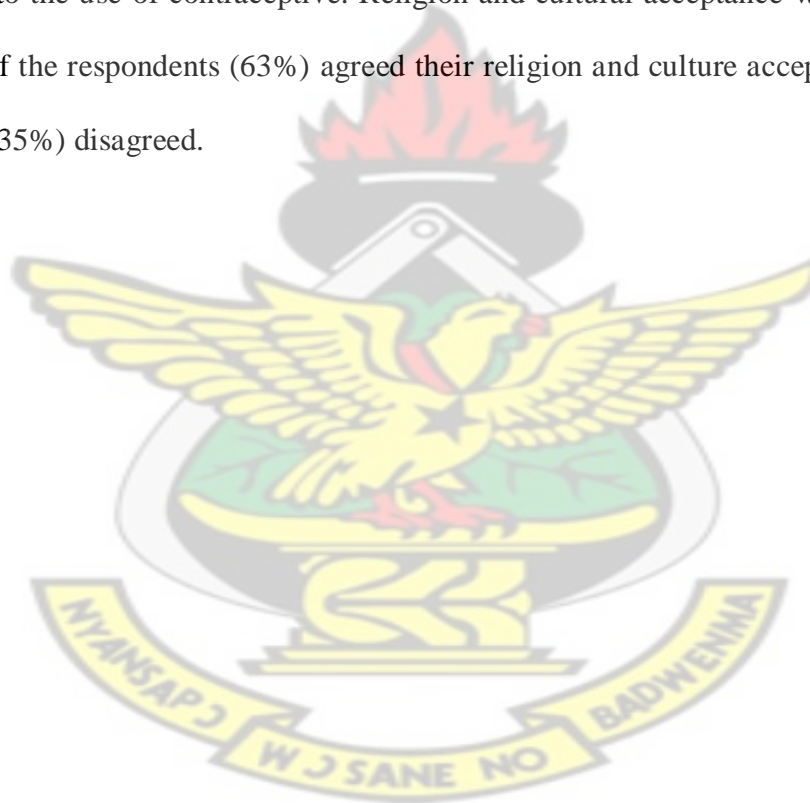
Injectable seem to be the most (48%) preferred contraceptive.

Majority, 70.4% of respondents agreed young sexually active people should not feel restricted to ask for contraceptives. However, 22.5% of respondents strongly agreed that contraceptives should be used by only married people. And 40% of them indicated

that, the use of contraceptives makes one promiscuous and sick (62.6%). Majority (74.8%) of respondents indicated women should be the main users of contraceptives.

Furthermore, between 74%-94% accept their choice of contraceptive to be safe, cheap, always available, convenient, reliable, and simple, without side effect, does not interfere with sexual intercourse and within their reach.

Undesirable side effect of contraceptive, religion and cultural acceptance are the main barrier to the use of contraceptive. Religion and cultural acceptance was a controversy. Some of the respondents (63%) agreed their religion and culture accept their use whilst others (35%) disagreed.



6.2 Recommendations

The following recommendation may help increase the usage of contraceptives among females head porters.

- It is critical that providers and women have access to accurate information on menstrual cycle as well as side effect of contraception so that they are not rejected for invalid reasons

The cost and benefit of using contraceptives and not using them should be emphasized during counseling to enable client make informed choice.

Health care workers should be given advance education and continuously updated on new trend on contraception.

- Health care workers should intensify the education on contraceptives to the general public (misconception example sick, infertility, promiscuity) and expand the reach of contraception education.
- They should also intensify awareness campaign tailored to the needs of the vulnerable groups e.g. Female head porters

All stakeholders, especially traditional and religious leaders should be involved in the planning and implementation of contraceptives programmes. This will help increase their participation and eventually increase the usage of modern contraceptives.

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APPENDIX I: RESEARCH QUESTIONNAIRE

QUESTIONNAIRE ON, ASSESSING THE KNOWLEDGE, INFORMATION AND EDUCATION ON CONTRACEPTIVE SERVICES IN EJURA MINICIPALITY

Informed Consent

Good morning. My name is (Mercy Adzo Kporku) a student at the Kwame Nkrumah University of Science and Technology conducting a study on the topic “A Study Into The Access To Contraceptive Services (family planning) By Female Head Porters In Ejura Municipality” I would like to have an interview with you on the topic and would very much appreciate your participation in this study. This interview usually takes between 20 and 30 minutes to complete. All of the answers you will give will be confidential and will not be seen by anyone other than members of our team. If we should come to any question you don't want to answer, just let us know and we will go on to the next question. However, we hope you will participate fully in the survey since your views are important.

Research Questionnaire

Section A: Socio-Demographic Characteristics of Female Head Porters.

1. ID Number:.....

2. Age:1. 12 to 20 [] 2. 21 to 35 []

3. Educational Background.

1. No School [] 2. Primary [] 3.JHS/Middle school[] 4. SHS [] 5.Tertiary

[] 6.Others (Specify).....

4. Marital Status: 1. Single [] 2. Married [] 3. Not Married but in a Relationship []
4. Widowed/Divorced []
5. Number of children
6. Religion: 1. Islam [] 2. Christianity [] 3. ATR [] 4. Others specify.....
7. Ethnicity; 1. Akan [] 2. Northerner [] 3. Ewe [] 4. Fante [] 5. Others.....

Section B: Knowledge and Information on Contraceptives

8. How do you understand contraceptives?
1. Products used to prevent unwanted pregnancy []
 2. Any products that can cause abortion []
 3. Products that prevent pregnancy as well as cause diseases []
9. What type(s) of contraceptives do you know?
1. Oral contraceptive pills [] 2. Injectable [] 3. Condoms [] 4. Implants [] 5. IUD []
10. Which of the following is your source of information on contraceptives?
1. Radio/ Television [] 2. Health care provider [] 3. Friends [] 4. Parents []
 5. Others []
11. Have you ever received counseling on the use of contraceptives before? 1. Yes []
2. No []
12. Where did you receive counseling on the use of contraceptives?
1. Friend [] 2. Parents [] 3. Health care provider [] 4. Pharmacy shop [] 5. Nowhere []
13. Was the counseling on contraceptives adequate to prevent unwanted pregnancy?
1. Yes [] 2. No []

C. Attitudes, Practices of Female Head Potters towards Contraceptives.

14. Do you believe that contraceptives really prevent unwanted pregnancy?

1. Yes [] 2. No []

15. Do you know of other products that prevent unwanted pregnancy apart from modern contraceptives?

16. Anybody who is sexually active should be educated on contraceptive usage?

1. Yes [] 2. No []

17. It is healthy for young people to use contraceptive to prevent unwanted pregnancy?

1. Strongly Agree [], 2. Agree [], 3. Undetermined [], 4. Disagree [], 5. Strongly disagree []

18. Have you ever used a contraceptive to prevent unwanted pregnancy? 1. Yes []

2. No []

19. If yes to Q18, which of these methods listed below did you use to prevent unwanted pregnancy?

1. Condoms [], 2. Injectable [], 3. IUD [], 4. Pills. [] 5. folk medicine []

20. If yes to Q18, how long did you use the contraceptive?

1. Less than 1 year []

2. 1-3 years []

3. 3-5 years []

4. 5+ years []

21. If no to Q18, why? 1. Expensive [] 2. Undesirable Side effect 3. Partner

disagreement [] 4. Don't know []

22. Young and sexually active people should not feel restricted to ask for contraceptive if they

think they are exposed to unwanted pregnancy.

1. Strongly Agree [], 2. Agree [], 3. Undetermined [], 4. Disagree [], 5. Strongly disagree []

23. Contraceptives should be used by married people only

1. Strongly Agree [], 2. Agree [], 3. Undetermined [], 4. Disagree [], 5. Strongly disagree []

24. Give reason to Q23 above

25. The use of contraceptives to prevent unwanted pregnancy makes one promiscuous

1. Strongly Agree [], 2. Agree [], 3. Undetermined [], 4. Disagree [], 5. Strongly disagree []

26. Most contraceptives make the user sick

1. Strongly Agree [], 2. Agree [], 3. Undetermined [], 4. Disagree [], 5. Strongly disagree []

27. A woman should be the main user of contraceptives.

1. Strongly Agree [], 2. Agree [], 3. Undetermined [], 4. Disagree [], 5. Strongly disagree []

D. Preferred Contraceptives Methods and Reason for Use

28. What contraceptives are you using now?

1. Pills [], 2. IUD [], 3. Condoms [], 4. Injectable [], 5. Implants []

Use The Question below to respond to Question 3, 4, 5, 6, 7 And 8

Why do you prefer using your current method?

29. Safe? 1.Yes [] 2.No []

30. Cheap? 1.Yes [] 2.No []

31. Always available? 1.Yes [] 2.No []

32. Convenient to use? 1.Yes [] 2.No []

33. Reliable? 1.Yes [] 2.No []

34. Simple? 1.Yes [] 2.No []

35. Is without side effect 1.Yes [] 2.No []

36. Does not interfere with sexual intercourse 1.Yes [] 2.No []

E. Common Barriers Associated to Access to Contraceptives

37. Is the source of your contraceptives easily within your reach? 1.Yes [] 2.No []

38. The average time spent at the service center is usually less than 1 hours

1.Strongly Agree [], 2.Agree [], 3.Undetermined [], 4.Disagree [], 5.Strongly disagree []

39. The attitude of the provider is friendly?

1. Strongly Agree [], 2.Agree [], 3.Undetermined [], 4.Disagree [], 5.Strongly disagree []

40. The contraceptive products are always available.

1. Strongly Agree [], 2.Agree [], 3.Undetermined [], 4.Disagree [], 5.Strongly disagree []

41. The provider is able to communicate in a language that you understand

1.Strongly Agree [], 2.Agree [], 3.Undetermined [], 4.Disagree [], 5.Strongly disagree []

42. There is always privacy when service is provided.

1. Strongly Agree [], 2. Agree [], 3. Undetermined [], 4. Disagree [], 5. Strongly disagree []

43. There is always counseling before product was supplied.

1. Strongly Agree [], 2. Agree [], 3. Undetermined [], 4. Disagree [], 5. Strongly disagree []

44. The counseling process was adequate before method was provided?

1. Strongly Agree [], 2. Agree [], 3. Undetermined [], 4. Disagree [], 5. Strongly disagree []

45. Are you encouraged to ask questions anytime you visit your family planning service provider? 1. Yes [] 2. No []

46. Do you feel discouraged to use contraceptive? 1. Yes [] 2. No []

47. Does your religion permit you to use contraceptives? 1. Yes [] 2. No []

48. Does your culture permit you to use contraceptives? 1. Yes [] 2. No []

49. Unmarried people who access contraceptives to prevent unwanted pregnancy are considered promiscuous.

1. Strongly Agree [], 2. Agree [], 3. Undetermined [], 4. Disagree [], 5. Strongly disagree []

THANK YOU

