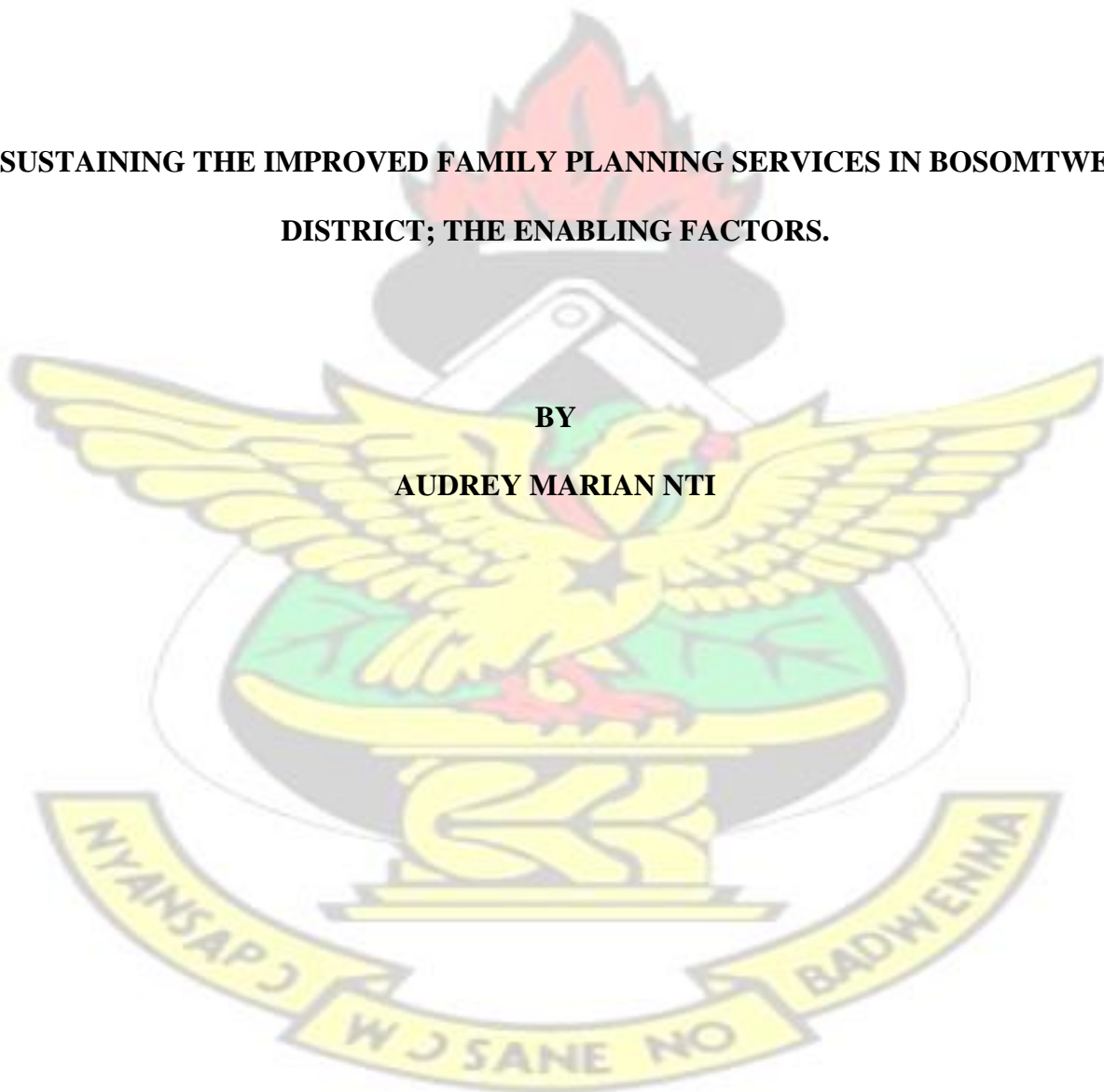


**KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY,  
KUMASI, GHANA  
COLLEGE OF HEALTH SCIENCES  
SCHOOL OF PUBLIC HEALTH  
DEPARTMENT OF POPULATION, FAMILY AND REPRODUCTIVE HEALTH**

**SUSTAINING THE IMPROVED FAMILY PLANNING SERVICES IN BOSOMTWE  
DISTRICT; THE ENABLING FACTORS.**

**BY  
AUDREY MARIAN NTI**



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**A THESIS SUBMITTED TO THE DEPARTMENT OF POPULATION, FAMILY  
AND REPRODUCTIVE HEALTH, SCHOOL OF PUBLIC HEALTH, COLLEGE OF  
HEALTH SCIENCES, KWAME NKRUMAH UNIVERSITY OF SCIENCE AND  
TECHNOLOGY, IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR  
THE AWARD OF THE DEGREE OF MASTER OF PUBLIC HEALTH IN  
POPULATION AND REPRODUCTIVE HEALTH.**

**JUNE, 2016.**

**DECLARATION**

I hereby do declare that except for references to other people’s work, opinions and observations which have duly been acknowledged, this piece of work is the result of my own composition and original research. I hereby declare that, this has neither in whole nor in part been presented for the award of a degree in this university or elsewhere.



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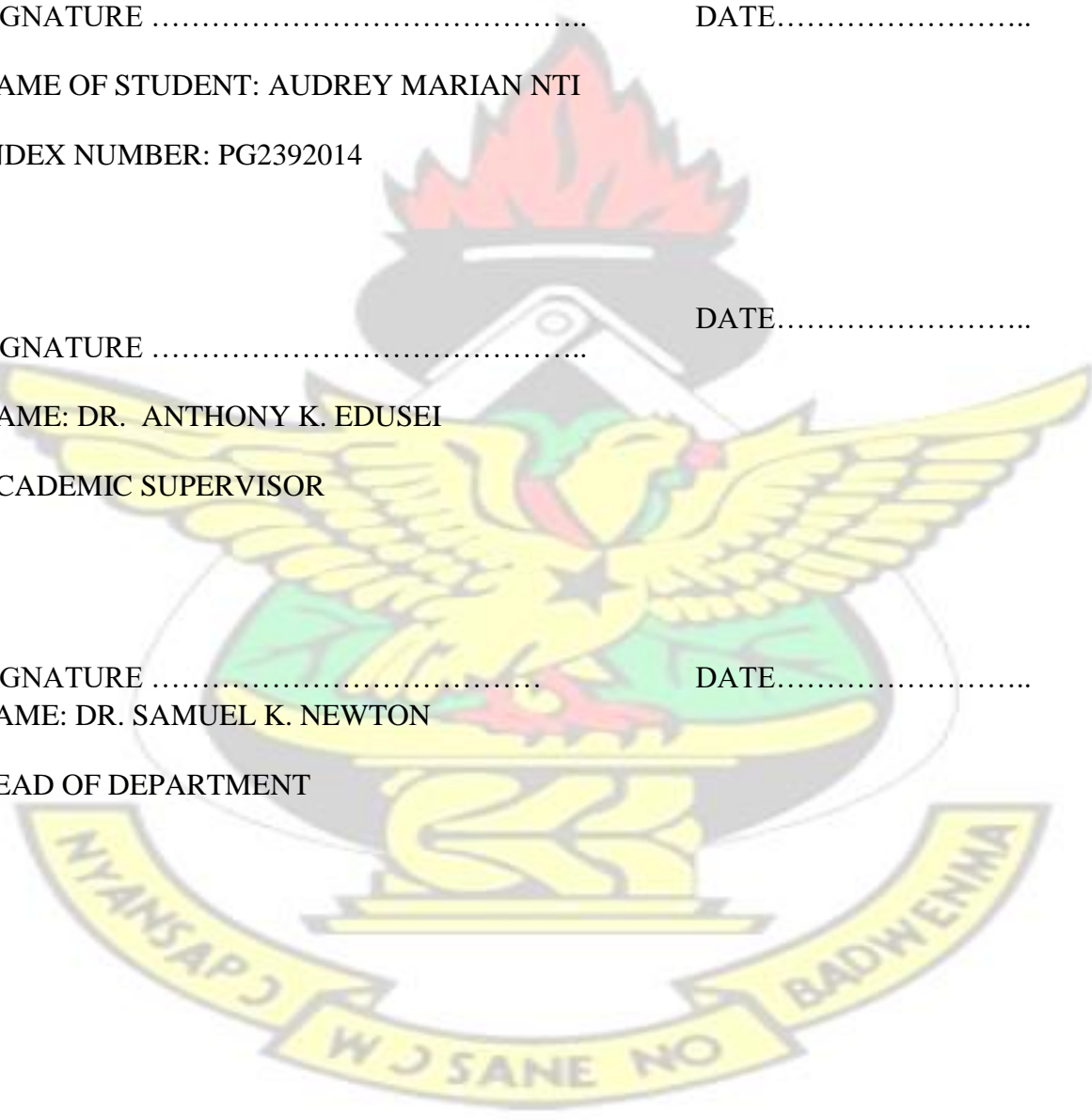
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## DEDICATION

I dedicate this work to my lovely daughter Peniel Nana Afua Asantewah Safo-Barnieh and my husband Mr. Sylvester Safo-Barnieh. My wonderful parents Madam Afua Sarpong and Mr. Kwaku Nti cannot be left out.

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## ABSTRACT

In many Africa countries and for that matter Ghana, the use of family planning services remain a challenge to many women. Most districts in Ghana still have acceptor rate for family planning far below the national target of 28%. However, some districts have had an acceptor rate above the national target, for which the Bosomtwe District is one, with acceptor rate of 49.3%. But the Bosomtwe District family planning acceptor rate has not translated into reduction in fertility rate, control of population growth; reduce maternal mortality and quality health care for mothers and children as it has been Ghana's expectation for accepting family planning services. The main issues then are; how can the high family planning acceptor rate of 49.3% be sustained in the district? How can this acceptor rate in the Bosomtwe translate into reduction in fertility rate, reduction in population growth, reduce maternal mortality, and promote quality health care for mothers and family in the district? In this regard the study sought to determine the knowledge of couple and individuals on family planning methods in the Bosomtwe District, assess the extent to which the socio-economic characteristics of couple and individuals influence their decisions on the use of family planning methods, identify ways of sustaining the current acceptor rate of family planning in the district, and suggest ways to ensure that increase utilization of family planning services lead to small family size. The researcher hypothesizes that: Women's education, women employment Status, marital status, religious background, ethnicity and place of residence influence the use of family planning services and methods in the Bosomtwe District. Sample size of 394 respondents was selected using simple random sampling technique. The Chisquare was used to test the hypothesis. The study revealed that 92.4% of women in the Bosomtwe District had knowledge on family planning services. It was also established that some family planning methods used by women included female condoms, Emergency Contraceptive Pill (ECP), Depo-Provera, sponge, vaginal contraceptive films, contraceptive foam, transdermal-contraceptives and many others. The study further discovered that 66.7%

of women use family planning for birth control and child spacing. The study found that the current Acceptor Rate of family planning service in the district could be sustained if there is education on the importance of family planning and free and affordable family planning services for women and education on the need for birth control, child spacing, the importance of family planning for mother's health, free and affordable family planning services.



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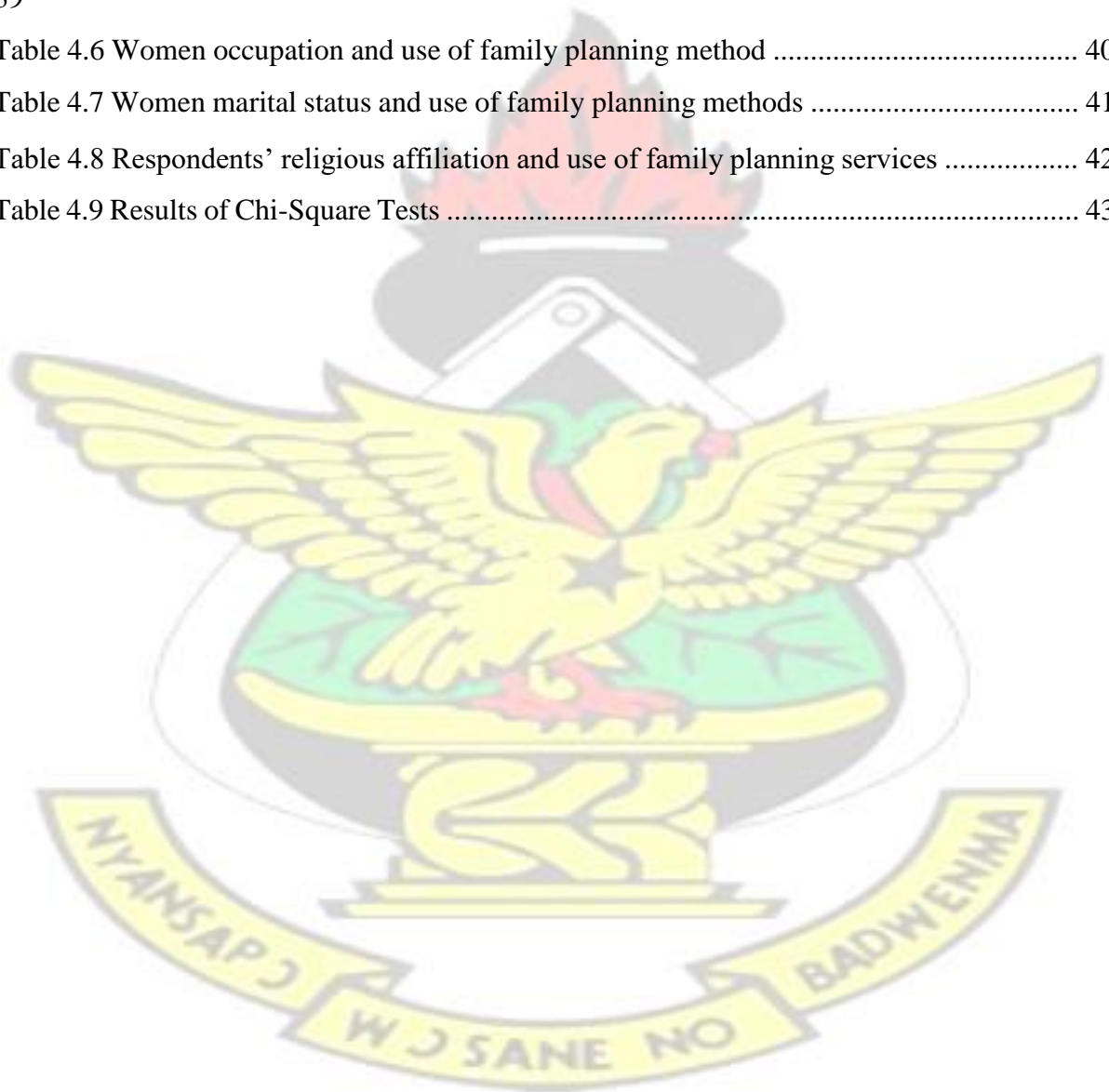
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## LIST OF ACRONYMS

DHS	-	Demographic and Health Surveys
GHSS	-	Ghana Health Service Survey
GSS	-	Ghana Statistical Service
GHS	-	Ghana Health Service
MOH	-	Ministry of Health
CHAG	-	Christian Health Association of Ghana
WIFA	-	Women In the Fertility Age
HTSP	-	Healthy Timing and Spacing of Pregnancy
FP	-	Family Planning
PAC	-	Postpartum and Post Abortion Care
UNFPA	-	United Nations Population Fund
SPSS	-	Statistical Package for Social Science
PASW	-	Predictive Analytical Software
DF	-	degree of freedom
Asymp. Sig	-	Significant value
STIs	-	Sexual Transmitted Infections
ECP	-	Emergency Contraceptive Pill

## CHAPTER ONE

### INTRODUCTION

#### 1.0 Background Information

All over the world, family planning services remain unmet (Lasie, and Backer, 2007). Even though many women desire to control the number of childbirth and conception in their lifetime, they have no access to effective family planning (Cleland, et al, 2006). The utilization of family planning services in many countries in Africa is low regardless of high total fertility rate in many African countries (Aryeetey, Kotoh and Hindin, 2010). However, majority of women in Africa still wish to have lesser number of children than they actually give birth to in their lifetime (Aryeetey, et al., 2010). Evidence from studies reveals that high total fertility rate can be reduced through promotion of family planning (Gizaw and Regassa, 2011). Many developing countries still have high total fertility rate which is around 4.6, with only 32% of women of reproductive age are using any form of Family planning method while only 28% use some modern contraception (Cleland, et al, 2006).

In sub-Saharan Africa, many countries have persistent high rates of unmet need for family planning and relatively low proportions of contraceptive use (Aryeetey, et al., 2010). The low rate of utilization of family planning is typically a function of both the inadequate capacity of the health care system and non-availability of family planning services in sub-Saharan Africa (ibid). Other factors affecting service provision include tenuous commodity security and suboptimal service factors (Cleland, Ndugwa, and Zulu, 2011). Within the individual woman level also, numerous obstacles work against the utilization of family planning service (Paul et al, 2014). Studies have shown that individual barriers to family planning services include risk perception, insufficient knowledge needed to make informed choices, opposition from male partners, and health service limitations (Paul et al 2014).

Aside very few exceptions, low contraceptive prevalence rates are found in Ghana (Aryeetey, Kotoh and Hindin, 2010). The delivery and utilization of family planning services in many districts in Ghana are a replication of the situation in Ghana (Ibid). A sequence of Demographic and Health Surveys (DHS) beginning from the late 1980s in Ghana describe a stable rise in modern contraceptive usage (GSS and GDHS, 2009). However, the 2008 DHS indicates utilization rate of only 17 percent amongst women of reproductive age; a slight decline from the 2003 utilization rate of 19 percent (Aryeetey, et al. 2010). Even though marginal improvements in infrastructure and consumable items needed for family planning service delivery have been observed in many parts in Ghana, the Ghana Health Service Survey in 2010 also noted many barriers to the utilization of family planning: according to the GHSS, (2010), these barriers include frequent periods of contraceptives being out of stock at the facility level, limited provider skills, limited use of educational tools, and limited number of methods. Low contraceptive use is attributed to a number of barriers acting at policy, facility, district, community and individual level (Benefo, 2005).

Within individual level, knowledge of family planning services and methods is crucial (Bamikale and Casterline, 2010). Whereas evidence from a number of researches around the world reveal a near universal knowledge on family planning methods among the women of the reproductive age, this has translated into increased utilization of these methods in the Bosomtwe District in the Ashanti Region of Ghana. Low usage of family planning services and methods has been widely attributed to the negative attitude towards the use of modern contraceptives (Addai, 2009). Specifically, approval / disapproval of the modern methods by self and partner, fear of harmful effects on health and low levels of education (Benefo, 2005), have been identified to influence use of modern family planning methods in Ghana, and for that matter the Bosomtwe District. Many related studies on family planning showed increasing knowledge on the methods can result to higher utilization of family planning services (Adjei,

Owusu, Asiedu and Acheampong, 2014). Women and their spouses therefore need to be empowered with sufficient knowledge on family planning particularly on the health effects of modern family planning services and methods to enable them make wise choices.

On the contrary Bosomtwe District in Ashanti Region of Ghana has high family planning acceptor rate as compared to other districts. This study therefore looks at factors that influence high utilization of family planning services at the Bosomtwe District in the Ashanti Region of Ghana with the aim of informing health care providers in other parts of the country to also achieve similar results.

### **1.1 Problem Statement**

Family planning and the use of contraception are one of the four important proximate determining factors of fertility identified by Bongaarts (1978). The role family planning plays in population reduction and women reproductive health can never be overemphasized (Lasie and Backer, 2007). However, in many developing countries, particularly sub-Saharan Africa and Ghana, utilization of family planning service and modern contraceptive use and prevalence is especially low and fertility is very high resulting in rapid population growth and high maternal and child mortality and morbidity (Asamoah, Agardh, & Per-Olof, 2013).

It is estimated that over 215 million women in the developing world have an unmet needs for modern contraceptives (The Guttmacher Institute, 2010). In Ghana, the situation is not different. As the country is determined to achieve the millennium development goals, it may find it difficult to do without the recognition of the role of family planning. Previously, within the Bosomtwe District, there were concerns about low rate of family planning among couple and individual. Fortunately, the district records show high family planning usage compared to other districts across the country. The family planning coverage in the Bosomtwe District from 2012 - 2014 are 25%, 39.5% and 49.3% respectively. The issue of concern now is; what account

for high utilization of family planning services in the district as it recorded 49.3% increase of family planning use higher than the national target of 28% in 2014? Other sources of worry are; whether both couples accept utilization of family planning services in the district. What can other districts learn from the increase of family planning utilization in the Bosomtwe District? Does increase in usage of family planning services leads to reduction in family size and good health condition for mothers and children in the Bosomtwe District? Is there gender difference in the utilization of family planning services in the Bosomtwe District?

On 28th September, 2012 the Ghana News Agency reported about poor patronage of family planning services expressed by the Ghana Health Service (GHS, 2012). It was noted that, the family health indicators show a low uptake of family planning services particularly in districts of Ghana with decreasing acceptor rate of 31% in 2009 to 24.9% in 2010 and relatively the same in 2011 (GHS, 2012). The problem with low rate of utilization of family planning services implies large or big family size and high population growth in Ghana. With high percentage of 49.3% acceptor rate of family planning usage in the Bosomtwe District, one is tempted to ask; whether the high family planning utilization in the Bosomtwe District brings about reduction in fertility rate in the district? And how the high acceptor rate of family planning could bring about small family size and low population growth in the Bosomtwe District?

Fascinating enough, Ghana has been endorsing the use of contraceptives more than three decade ago (GSS, 2008). Nonetheless there has not been substantial and steady proliferation in use of family planning services in many districts in Ghana over the years, equating to the determinations made to increase women utilization of family planning at districts level in Ghana. For instance, the number of women who use family planning services were 13 percent of married women in 1988; this improved to 25% by 2003, and dropped to 24 percent in 2008 (GSS, 2008).



Even though, the use of family planning services in the Bosomtwe District over the years have shown some improvement. Generally, women utilization of family planning services has increased in recent times. According to the Bosomtwe District Health Directorate, “Annual Performance Review, (2014), there has been an increase in Family Planning Acceptor Rate from 39.5% to 49.3% which is above the national target of 28%. However, this does not reflect in decrease in the fertility rate of women in the district as much need to be done to ensure that the increase utilization of family planning leads to reduction in fertility rate in the district. Many family planning services and contraception provided by the district health directorate are under-utilized by women in the Bosomtwe District despite increase family planning service usage in the district. The question then is; where do people within the district access family planning services? This has been a source of worry to the district since the ultimate goal of the district is to ensure that individuals utilize family planning services provided by the district health directorate so as to help reduce total fertility rate, reduce maternal and infant mortality in the district. Therefore makes it difficult for the district to ensure reduction in population growth and promote better health services for mothers and children in the Bosomtwe District as it cannot determine the effectiveness of family planning services provided outside the district health directorate.

This study consequently seeks to identify the factors that influence high utilization of family planning services in the Bosomtwe District in the Ashanti Region of Ghana.

## **1.2 Rationale for the Study**

The study aims at revealing the reasons for the use or non-use of family planning methods by couple in the areas and also come out with the possible ways to improve the usage of family planning methods by couples and individuals in the Bosomtwe District.

Utilization of family planning services all over the world is essential to assess the quality of health service provision for women and to identify areas where improvement is needed. In particular, family planning is one of the components of reproductive health services that will be focused on in this study. The study aims to come out with measures in order to provide quality family planning services, create awareness of women on the health needs of family planning among couples and individuals and increase the women's knowledge on variety of family planning services and methods available in the Bosomtwe District.

In Ghana, one of the issues affecting utilization of family planning services is the lack of knowledge on the need and available family planning services, negative attitude and perception toward the use family planning methods (GHS, 2010). This study will therefore help create awareness on available family planning services and methods in the Bosomtwe District so as to increase the utilization of family planning services in the district.

The study finding will provide policy makers with appropriate measures that can be learnt from the Bosomtwe District on how to raise family planning acceptor rate across the country. It will also provide policy makers with data on how to sustain the current family planning acceptor rate in the Bosomtwe District.

### **1.3 Hypothesis**

The study will be carried out to test the following hypothesis;

Research Hypothesis: A two – tail test of independence was performed to determine whether women's education, employment Status, marital status, religious background, ethnicity and place of residence influence the use of family planning services and methods in the Bosomtwe District.

## **1.4 Research Questions**

1. What is the perception of couples and individuals in the Bosomtwe District regarding family planning methods?
2. What is the attitude of couples and individuals towards the use of family planning methods?
3. What factors can influence the use of family planning methods in the district?
4. Why has increased utilization of family planning services not brought about decreased fertility rate in the Bosomtwe District?
5. What can be done to ensure that improved utilization of family planning services lead to small family size among couple in the Bosomtwe District?

## **1.5 General Objective**

The main objective of the study is to identify the factors that have contributed to the family planning services whilst examining outstanding societal issues to sustain the high utilization of family planning services in Bosomtwe District.

### **1.5.1 Specific Objectives**

1. To determine the knowledge of couple and individuals on family planning services and methods in the Bosomtwe District.
2. To assess the extent to which the socio-economic characteristics of couple and individuals influence their decisions on the use of family planning services and methods.
3. To identify ways of sustaining the current acceptor rate of family planning in the Bosomtwe district.
4. To ascertain why increased utilization of family planning services has not led to small family sizes in the Bosomtwe District.

5. Suggest ways to ensure that increase utilization of family planning services lead to small family size.

### **1.6 Profile of Study Area**

The study was carried out in the Bosomtwe District. Bosomtwe District is in the Ashanti Region of Ghana. It was formerly part of the Bosomtwe Atwima-Kwanwoma District and it was carved out by LI 1852 of 29th February, 2008. Kuntanase, the district capital is about 28 km from Kumasi. The district shares common borders with Ejisu-Juaben district and Kumasi Metropolis on the North; Bosome-Freho and Asante-Akim North district on the East, Atwima-Kwanwoma District on the West and Bekwai Municipality on the South.

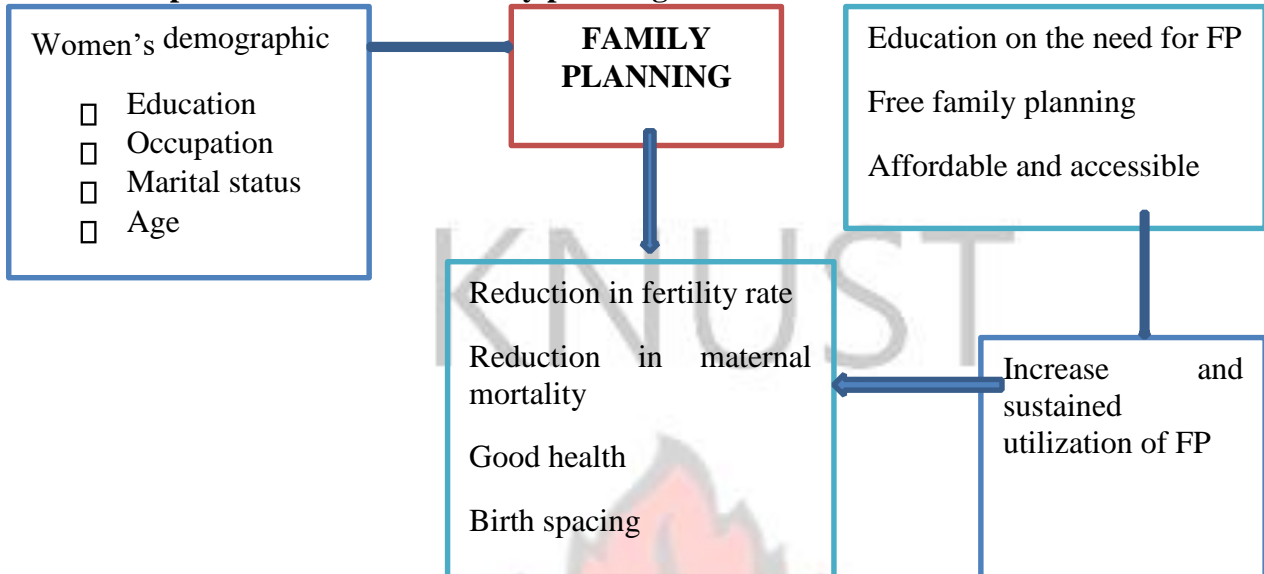
The district boasts of Lake Bosomtwe which is the only natural Lake in the Country. The district has a total population of 104,471, with 18 health facilities, 4 hospitals including health institutions such a Ghana Health Service, Christian Health Association of Ghana (CHAG), Private Health Facilities, M.O.H.

The study was carried out at the Bosomtwe District in the Ashanti. The area has combined features of urban and rural population which makes it suitable for the study of family planning in the area. It has 63 communities, with estimated population of 104,471 and with a number of health facilities around the district. This study will therefore focus on Women In the Fertility Age (WIFA) Bosomtwe District.

### **1.7 Scope of Study**

The study focused on the knowledge level of couple and individuals on family planning services and methods in the Bosomtwe District, the socio-economic characteristics of couple and individuals influencing their decisions on the use of family planning methods as well as suggest ways to educate the couple and individuals on the need for use of family planning methods in the area.

### 1.8 Conceptual framework on family planning



**Source; Researcher's Construct, 2015**

The researcher postulated that women's socio-demographic factors such as education, occupation, marital status, age and religious background influence their use of family planning services in the Bosomtwe District. Also, from the conceptual framework, it could be deduced that the education women receive regarding the importance and need for FP could positively influence their use of FP services. The study therefore hypothesizes to sustain the use of family planning services among women, there should be education for women on the need for them to use family planning services. Aside education, utilization of FP could be increased and sustained if there are free family planning services for women in the area.

Lastly, women's use of FP services could be sustained if FP services were made affordable and accessible to all women in the Bosomtwe District.

Increased and sustained family planning services will have positive outcomes such as reduction in fertility rate in the district which could reduce population growth in the area which is as a result of high birth rate, birth spacing, reduction in maternal mortality and good health for mothers and children in the Bosomtwe District.

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## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 Introduction

This chapter is devoted to an overview of the literature related to the study. This will allow readers to gain an absolute understanding of the many facets of the concept of family planning in contemporary literature. The review is based on the knowledge level of couple and individuals on family planning services and methods, the extent to which the socioeconomic characteristics of couple and individuals influence their decisions on the use of family planning services and methods, the ways of sustaining the current acceptor rate of family planning in the district and the ways to ensure that increase utilization of family planning services lead to small family size.

#### 2.2 Knowledge level of couple and individuals on family planning services and methods.

Previous studies have shown that knowledge of modern contraceptive methods is an important determinant of contraceptive use (Caldwell & Caldwell, 2007). Women who are well informed about the benefits of family planning tend to use it. However, women's perceptions that their health is at risk and their husbands oppose family planning are dominant factors discouraging contraceptive practice in a wide variety of settings (Elzanary, Sunita, & Casterline, 1999). The level of awareness of a range of contraceptive methods provides a rough measure of the availability of family planning information in the country. In countries where people have more exposure to family planning messages on radio and television, people are aware of more methods (Ngom & Binka, 2002).

According to a study conducted in Kwazulu Province in South Africa, Family planning clients are usually not provided with detailed information on family planning methods so that they can make an informed decision (Ngom & Binka, (2002).

Effectiveness, advantages, disadvantages, possible side effects, and the management of side effects are frequently not discussed with clients during FP counselling. More information is provided on advantages than on disadvantages, and less is provided on the management of side effects than on actual side effects. Providers do not mention the full range of contraceptives that are available to clients. That complete information on methods is not made available to clients (Ngom & Binka, 2002).

Lack of knowledge about contraceptive methods and concerns about health, side effects and effectiveness are also major barriers to adoption of family planning services. These factors may argue against increased continuity of contraceptive use. For example, Bangladeshi women wishing to delay or prevent pregnancy chose not to practice contraception because of some of the above factors (Bongaarts & Bruce, 1995; Casterline et al., 2001; Feyistan & Casterline, 1999). However, Luck et al. (2000), in a study of family planning services in Bangladesh, found that culturally appropriate counselling can mobilize the presumably latent demand for contraception by reassuring potential clients of the social acceptability and by allaying their fears about side effects of contraceptive methods .

A study conducted in Guatemala also indicated that the levels of modern contraceptive knowledge and use among people living in rural areas of Guatemala differ substantially from those of people living in urban areas. The results suggest that lack of knowledge and familiarity with modern contraceptive methods remains an important barrier to modern contraceptive use in Guatemala, particularly in the indigenous population. (IFPP, 2006).

Also, another study in the US has found that as black female teens-age, their knowledge about contraceptives increases and they are more likely to report having ever used contraceptives and currently using contraceptives. In particular, black female teens who had received formal sex education (i.e., in school, a clinic, a community organization, or church) were more likely



to have ever used contraceptives than black female teens who had not received such instruction (Topsever et al.,2006).

Various cross-national studies have also found that health and social concerns are the principal causes of the unmet need for contraception in many countries (Bongaarts & Bruce, 1995; Casterline & Sinding, 2000). Luck et al. (2000) concluded that individual face-to-face counselling by family planning service providers is an effective means of providing potential users with necessary information, particularly regarding their health concerns. For example, demand mobilization interventions resulted in increased knowledge and use of injectable contraceptives in rural Gambia (Luck et al., 2000). However, such interventions had little effect on women's knowledge and use of other methods.

### **2.3 Socio-economic characteristics of couple and individuals and use of family planning services and methods.**

Most countries of the world, particularly developing nations, still have male-dominated cultures. For example, in Sub-Saharan Africa ancestral customs give men rights over women's procreative power. In such situations, husband's approval may often be a precondition for a woman to use family planning. Studies in other regions have shown that one reason women give for non-use of contraceptives is husband's disapproval (Akininola et al., 1998). Even in developed societies studies have shown important effects of husband's desire on a couple's fertility (Wright, 2002). When women want to practice family planning, their husbands and in-laws will often not agree and they may be punished if they are caught, sometimes with physical violence. The fear of opposition and punishment has thus led to women using modern contraceptives in secret. Research has shown that the most popular modern contraceptives in areas where women have least control over their fertility are the ones that cannot easily be detected in particular, injectable (Wright, 2002). The cultural

importance of having adequate numbers of surviving children, sons and daughters, and, above all, of avoiding being childless, has been well-documented (Caldwell and Caldwell, 1990). However, recent research in the Kassena- Nankana area in the Upper East region of Ghana demonstrated that traditional religious messages regarding fertility behaviour can be influenced by the prevailing social and economic climate (Adongo et al. 1998).

Moreover, studies have shown that many women in rural Gambia perceive injectable contraceptives to be the most effective, private, and convenient contraceptive method. Similar results were reported from the Matlab region in Bangladesh (Phillips et al., 1988; Simmons et al., 1988). In both of these countries, many women often practice clandestine family planning (Biddlecom & Fapohunda, 1998). For example, Luck et al. (2000: 333) reported that “Bangladeshi and Gambian women hide their use of contraceptives from husbands, relatives, and neighbour’s. Crowded housing conditions and the general lack of privacy make clandestine storage and use of oral contraceptives difficult. In contrast, an injection is received only once every 3 months in the privacy of the room where a community health nurse provides maternal and child health services”.

Studies concerning the family planning beliefs of religious leaders are rare and, when conducted, have typically relied on small samples. For instance, a study of the family planning attitudes and practices of Ethiopian elites was conducted with a sample of 99 Orthodox Christian priests and 86 Muslim religious leaders. The authors found that 24% of Orthodox Christian and 80% of Muslim religious leaders had heard of family planning. Among those who were married (89% and 92% respectively), 6% of the Orthodox Christians and 26% of the Muslims practiced contraception. Religious leaders were found to be less favourably disposed toward family planning than other elite groups such as teachers and community leaders (Carol, 2000).

Casterline et al. (2001) noted that socio-cultural and religious disapprovals of contraception repeatedly emerge as important obstacles to the use of a contraceptive method. Wall (1998) identified a combination of these factors that obstruct contraceptive knowledge, adoption, and use among Hausa women in northern Nigeria. He asserted that few Hausa women have any knowledge of birth control and they consider family planning as the moral agnate of murder. This is because birth is an antidote for bereavement in the cultural idioms of this Islamic society and children are considered a divine benefaction. Children are the desired outcome of any Hausa marriage, and giving birth is traditionally viewed as the greatest fulfilment of being a woman (Wall, 1998). Such cultural beliefs and sentiments may render the adoption and use of contraceptive methods difficult in many sub-Saharan African communities.

In a survey of 81 African Independent Church leaders and 40 Muslim religious leaders residing in the Yoruba area of southwest Nigeria, 12% of the former and 78% of the later reported having preached against family planning (Carol, 2000). This suggests that religious leaders should not be ignored as potential proponent of family planning. Indeed, some studies have shown that religious leaders, as respected members of the community, can be effective advocates for family planning. The Islamic Republic of Iran, for example, has developed a highly successful family planning program in the past decade, and much of this success has been attributed to the support and guidance provided by the country's religious leaders (Ngom & Binka, 2002). Data from a study in Jordan show that four of five Jordanians – religious leaders and the general public alike – believe that family planning is consonant with Islam (Arowojolu, Adedimeji & Roberts, 2000).

Importantly, this demonstrates that most religious leaders interpret family planning to represent an action that is permitted within the Islamic world view. Religious leaders and, to

a lesser degree, the public in Jordan however, favour use of contraceptives to increase birth intervals and not, for the most part, to limit family size (Ngom & Binka, 2002).

According to data from Demographic and Health Surveys for nine Latin American countries, women with no education have large families of 6-7 children, analogous to those of women in the developed world (Martin; et al., 1996 ).

Better educated women have broader knowledge, higher socioeconomic status and less fatalistic attitudes toward reproduction than do less educated women. Results of a regression analysis indicate that these cognitive, economic and attitudinal assets mediate the influence of schooling on reproductive behaviour and partly explain the wide fertility gap between educational strata (Martin; et al., 1996).

#### **2.4 Ways of sustaining utilization of family planning services**

Family planning has been widely adopted throughout the world. More than half of all couples in the developing world now use a modern method of contraception for healthy timing, spacing, and limiting of births to achieve their desired family size. Few other public health measures have demonstrated so great a life-saving, health, and economic impact for such a low cost. Family planning has saved the lives of millions of mothers and their children and has improved the well-being of families and communities (Awusabo-Asare, Abane, & KumiKyereme, 2004).

The success of family planning has not been consistent across countries or even within countries. In some countries, the level of contraceptive use has remained low or risen slowly over the years. Even in countries where modern-method use is relatively widespread, there are populations without access to family planning services. In the developing world, an estimated 222 million women would like to space or limit their pregnancies but are not using a contraceptive method. South Asia has the highest number of women who want to avoid pregnancy and are not using a family planning method (Baiden, 2003).

Sub-Saharan Africa has the largest proportion of women who fall in this category. The United Nations estimates that the desire to use family planning will grow by 40% by 2050, as record numbers of young people enter their childbearing years (Benefo, 2005).

There are some women and couples who have access to family planning services and would like to use contraception but do not. These women say that the main reasons for not using contraceptives are side effects, infrequent sex, fear of their partner's disapproval, and religious beliefs that do not support family planning. These concerns can be addressed by trusted persons, such as health workers, religious leaders, friends, and journalists, who communicate key information effectively (Casterline, Sathar, & Haque, 2001).

Providing accurate and reassuring information to women and couples about family planning is an essential component of family planning promotion and advocacy. Those who do so do a great service to women, their families, and the community. Effectively promoting family planning will help people to start using contraception and motivate them to continue. This will improve their health and the health of their children. In turn, communities and nations will benefit from stronger, healthier, more productive citizens who can better care for themselves, educate their children, and put less strain on limited resources (Chandrasekhar, 2012).

According to a study carried out by Hamid & Stephenson, (2006) in Niger, Service integration, while convenient for clients, can also help to cut health costs by utilizing existing facilities and the skills of existing providers, thus providing increased services without a commensurate increase in expenditures. Integrating family planning services with other sectors also helps to strengthen overall health systems and makes family planning programs more sustainable.

Men are often the decision makers about sexual activity and the desired number of children in a family yet can be more difficult to engage in discussions around FP than women. Because

of this lack of engagement, men can cling to myths and misconceptions that influence their outlook on FP (Green, 1997; Greene, 2006). Studies have found that men are more supportive of FP when they are educated about the health benefits and understand the methods available to them and their wives (Lundgren, Cachan, & Jennings. 2011). It has also been found that mobilizing male engagement is a key strategy in increasing use of FP methods in conservative societies (Allison, 2012).

Focusing FP awareness to both members of a sexually active couple have been found to be more effective than efforts targeted to only one member of the couple (Becker, 1996; Boender et al., 2004 ; Cohen & Burger, 2000; Newmann et al., 2011; Rottach, Schuler, & Hardee, 2009).

In many communities, religious leaders, often predominantly male (Freij, 2009), have the unique advantage of being able to reach both men and women to promote HTSP and FP practices (Ngom & Binka, 2002). Emphasizing the benefits of FP to individual and collective physical, economic, social, and ecological health can help connect FP decisions to broader religious beliefs and practices. Faith leaders can provide guidance on health practices, especially FP, based on their knowledge and understanding of scriptures (VanEnk, 2012). Information about FP can be shared by faith leaders during marital counselling to couples , weekly religious services, small group gatherings, home visits, workshops, or community events (Ngom & Binka, 2002).

Yet without accurate information, faith leaders may also resist family planning because their traditional beliefs have not been addressed (Lundgren et al., 2011). As FP services have been demonstrated to be effective at reducing maternal and infant mortality rates (Campbell & Graham, 2006), it is vital to address traditional beliefs and help faith leaders understand how all methods of contraception work and the positive health benefits associated with them. In

many faith communities, it is of particular importance to convey that family planning does not include abortion, which may be contrary to deeply-held theological beliefs and values.

Freij (2009) states that, “When properly briefed and trained by respected religious scholars and trusted health professionals, religious leaders become powerful agents of social change and are able to shift their community’s opinions in support of family planning and reproductive health.”

A report released in 2014 by Aylward and Friedman provides comprehensive information on the role of faith leaders in FP promotion in 24 countries around the world. This report provides in-depth justification and support for the integration of faith leaders into FP promotion, including their influence on community members, media, government policies, and healthcare providers. It further emphasizes the need for continued integration of faith leaders into FP programs in developing countries. “The Role of Faith-Inspired Health Care Providers in Sub Saharan Africa and Public-Private Partnerships,” a discussion paper edited by Olivier and Wodon (2012), provides a comprehensive analysis of the often-faith-inspired non-governmental networks of health providers in Africa, including their role in successfully engaging religious leaders in reproductive health and FP services. Providing sufficient information and discussion around all HTSP and FP methods can dispel prevailing myths and give religious leaders and communities sufficient awareness, knowledge, and understanding in order to make FP decisions that are best suited to their needs, desires, and circumstances (Wodon, 2012).

Luck et al. (2000) found that the principal barriers to increased contraceptive use in rural Gambia are psychological. Village-based interventions designed to provide socially appropriate counselling to potential contraceptive users can help to overcome these barriers. The demand for contraception in Africa is driven by a wish to postpone and space births rather than a desire to control family size, and traditionally postpartum

abstinence was used to achieve these goals (Caldwell & Caldwell, 2002). Now, women in some regions of sub-Saharan Africa want a contraceptive they can control themselves and that can be reversed, thus avoiding spousal quarrels or marital dissolutions (Caldwell & Caldwell, 2002; Kenya & Macro International Inc., 1999). For such purposes, women tend to prefer hormonal methods including the pill or, somewhat less frequently according to some studies, an injectable contraceptive (Luck et al., 2000). However, the 2008/09 Kenya Demographic and Health Survey revealed that most married women aged 15–49 years preferred injectables (51.5%), pills (12.1%), female sterilization (8.4%), implants (7.7%), and male condoms (2.4%) (Macro, 2010).

### **2.5 Ways to ensure that increase utilization of family planning services lead to smaller family size**

Globally, over 222 million women not currently intending to get pregnant are not using any method of contraception (Singh & Darroch, 2012). Studies show that lack of access alone does not explain unmet need for contraception among women in developing countries. Information and counselling to help women and couples learn about all FP methods available to them could help meet the current unmet need (Sedgh & Hussain, 2014). Ringheim (2012) emphasizes the importance of family planning programming at the community level to “improve substantive understanding” and “reduce unintended pregnancies and abortions.” Mobilizing religious leaders to provide some of this information and counselling and to addresses FP issues within the values and belief systems of their communities could help reduce maternal mortality by 35%, cut abortion in developing countries by 70%, and lower infant mortality by 10 to 20% (Coleman & Lemmon, 2011), greatly improving the health and wellbeing of women, children, and families around the world.

Religious beliefs and principles are powerful influences on individual behaviours and community actions, including health-related practices. In sub-Saharan Africa, a 2006



survey found that people trust faith-based organizations more than they trust their own national governments (Tortora, 2007). As such, faith-based organizations and religious leaders have an immense opportunity to educate communities about healthy timing and spacing of pregnancy (HTSP) and methods of family planning (FP).

Moreover, a study by Topsever et al., (2006) found out that integrating family planning service provision with health services benefits both clients and providers has helped to increase the utilization of family planning practices. Priority service areas for integration with family planning include HIV treatment and prevention; maternal health including postpartum and postabortion care (PAC); and immunizations and well child care. Service integration helps target priority populations for family planning, takes advantage of opportune timing, and provides services to women with a proven need.

A study by Haile et al., (2000) found that family planning services are essential to fertility decline. The proximate determinant of on-going fertility decline in the developing world was seen as a result of the widespread adoption of contraception. Worldwide over 350 million couples (more than one-third of all couples) do not have access to a full range of modern family planning information and services, the United Nations Population Fund (UNFPA) has estimated (UNFPA, 2000).

In Zanzibar, for example, health professionals refuse to provide contraceptives to unmarried women. In Botswana, Burkina Faso and Senegal on the other hand, it is easier for unmarried women to get a contraceptive method than for married women because of requirements for husbands' consent for those who are married. In some countries (Kenya, Burkina Faso) there is a strict parity requirement to have an IUD (Olivier and Wodon, 2012),

In Zimbabwe, many service providers set minimum age requirement despite guidelines that allow the provision of family planning services to all without restriction (Rosen and Conly,

1998). In a few countries, overly restrictive medical requirements limit access to contraception. In a few countries, unnecessary restrictions include requiring oral contraceptive users to have blood tests every three to six months and prohibiting injectable contraceptive use in women without children. Provider bias against certain methods also influences the choices offered to clients (Olivier and Wodon, 2012),

Effective family planning services should offer a variety of methods and commodities so that the method most suitable for a client can be provided. Choice in family planning methods increases the level of acceptance and user continuation of services (Hatcher et al., 2001). Services also need to be available with a frequency convenient for clients.

“Accessibility” of family planning services generally refers to the extent to which appropriate contraceptive methods are available and the extent to which those in a given location who are seeking contraceptives can obtain services. In a broad sense, however, accessibility is a multidimensional concept that not only includes physical proximity and travel time to services, but also involves economic, psychological and attitudinal costs, cognition and the perceptions of potential clients. A study in Vietnam indicated that accessibility was positively associated with contraceptive use for several subgroups of women (Singh et al., 2000).

Accessibility was negatively associated with non-use of modern methods and with current use of traditional methods. The study confirmed that physical distance from family planning services does not have an important effect on use of modern methods as the proportion of women using modern methods did not differ much between rural and urban settings and among different types of communities, despite significant differentials in contraceptive access (Baiden, 2003).

However accessibility has a significant impact on nonusers of modern methods and on current users of traditional methods. This suggests that improved access could substantially reduce the

proportion of the population in these two groups. A considerable proportion of Vietnam's unmet need for family planning could be satisfied if the accessibility of different sources of services were increased. From a programmatic perspective, ensuring maximum access to contraceptive methods is a desirable goal that will strengthen programs among targeted populations (Bankole, 2002).

A study conducted in rural Pakistan revealed that increasing access to contraceptives through doorstep delivery increased contraceptive use by 50% in the experimental group as compared to those in control group (Baiden, 2003). Therefore, bringing health to the doorstep of rural people is essential to improve access. The experience and evidence from Navrongo highlights the impressive achievements in improving health when services are brought closer to people in need: "Because of social constraints, we need to get services as close to the client as possible for family planning. That is what works-decentralizing access and bringing it to the doorstep" (Olivier and Wodon, 2012)

## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.1 Introduction**

This chapter entails the various techniques that were employed by the researcher to collect the needed data for the study. It highlighted the procedure for selecting the sample, data collection and data analysis.

#### **3.2 Research Design**

This study employed cross-sectional design as the main framework for the collection and analysis of the data for the study. The cross-sectional design also known as the social survey is perhaps the most predominant design employed by researchers because of its advantages it

offers to the researcher. This design was used because it enabled the researcher to collect quantifiable data on more than one case at a time. The design helped the researcher to examine the larger society's views on how to sustain the current rate of family planning services utilization in the study area.

### **3.3 Population**

The study was carried out at the Bosomtwe District in the Ashanti. The area has combined features of urban and rural population which makes it suitable for the study of family planning in the area. It has 63 communities, with estimated population of 104,471 and with a number of health facilities around the district. This study focused on a sample 394 from a population of 24,237 women in the Bosomtwe District Women In their Fertility Age (WIFA) (between 15 and 49 years) were include in the study. Children and adolescents below 15 years and women above 49 years were excluded from the study. .

### **3.4 Sampling Technique**

The stratified and simple random sampling techniques were used to select the women for the study. The stratified sampling technique was used to group the women into groups of similar characteristics. Once the target groups have been identified and grouped, the researcher then used simple random sampling to ensure some level of randomization in the selection of the respondents. This technique gave all the target population an equal chance of being included in the sample size.

On the stratification, the women were put in group of similar feature. The study had two strata. One was the educated and the other was the uneducated women and this was to determine whether women's education have influence on their decision to use or not to use family planning services.

### 3.5 Simple Size Determination

The study involved a sample size of 394. The sample size for the research was computed from the records obtained from the population of Women In Fertility Age of 24,237. The sample size was determined using the relation below:

$$n = \frac{N}{1 + Ne^2} \quad (\text{Source: Rosendahi, 1997})$$

Where n is the sample size

N is the total population of Women In Fertility Age (WIFA) e

is the margin of error to be tolerated

$$\begin{aligned} \text{Thus } n &= \frac{24,237}{1 + 24,237(0.05)^2} \\ &= 394 \text{ Women In Fertility Age} \end{aligned}$$

### 3.6 Source of Data

The study employed both primary and secondary data as its main source of data for the study. Both primary and secondary data were used because information from the secondary data helped the researcher to make inference and deduction. The researcher used the secondary data as a benchmark for establishing the validity of the research findings.

The secondary data was sourced from books, journal, articles, documentaries, newspapers, conference proceedings, guidebooks, manuals, textbooks, electronic information, dictionaries, indexes, abstract, and others.

The primary data was collected directly from the respondents in the field. This data formed the main findings for the study. The primary data helped the researcher to know how to sustain the current rate of family planning services utilization.

### **3.7 Method of Data Collection**

Questionnaire was the main instrument for data collection. The researcher used questionnaire in the collection of data for the study because the use of questionnaire permitted the respondents to reflect on the questions asked by the researcher and provide answers at their own convenient. This technique was employed because it helped the researcher to cover the larger population of study easier, as compared to interviewing. It was cheaper and easy to carry out in the collection of the data for the study.

The researcher employed the services of research assistants to help in the distribution of the questionnaire to the respondents. Respondents were allowed to make a choice either to answer questionnaire intently or permitted to carry the questionnaire away with them to answer at the own convenient for the researchers assistants to collect later. Respondents were informed on the purpose of study to seek their full consent before participation.

### **3.8 Study Variables**

Independent variables of study include; women education, women employment Status, marital status, religious background, ethnicity and place of residence.

Intermediate variables include; Knowledge on available family planning services and methods in the district, Knowledge on source of family planning services and method and knowledge on the need of family planning.

Dependent variables include; use and non-use of family planning services and methods.

### **3.9 Data Processing**

Data processing is perhaps one of the most importance stages in every research work. Once data is collected from the field, the researcher has to put the data into shape for analysis. In data processing four main areas need to be looked at. These include data editing, coding, entry and data cleaning.

The first stage in the data process was data editing. This was done to detect and eliminate all errors in completing the questionnaire by the respondents to ensure accuracy and uniformity during the interpretation of data..

The second stage was coding of the data that was collected from the field. This helped in the classifying of the responses into meaningful categories. Close ended-questionnaire responses were pre-coded. The open-ended questionnaire responses were put into similar and meaningful categories in order to simplify the information into a more limited attributes for proper analysis. Each category was given numeric code to be transferred into the Statistical Package for Social Science (SPSS) now known as Predictive Analytical Software (PASW).

After coding, the data was entered into computer software called Statistical Package for Social Sciences (SPSS); known as (Predictive Analytical Software (PASW). At this stage the codes were transferred from the questionnaires into the computer using the SPSS data matrix. Each variable category was given code. Depending on the number of categories, the codes started from 1, 2, 3, 4, 5, etc. Each numeric code stood for a possible response or category. The variables were entered into the SPSS with their code for the categories as well. Then, the respondents' responses were entered.

The last stage in the data processing was data cleaning. This was the final stage of data processing; its main purpose was to eliminate errors which might have occurred due to incorrect coding and entry of data into the SPSS. The researcher checked to ensure that the actual variables and their categories' code were entered into SPSS. This follows with editing of charts and tables generated by the SPSS for analysis.

### **3.10 Method of Data Analysis**

The data that was collected was processed into a form appropriate for analysis. Editing, coding and entry into the computer software were the major activities carried out here. The SPSS

version 16 was employed to organize data for analysis and interpretation to arrive at the findings based on the research objectives.

The quantitative method of data analysis was employed. Descriptive statistics such as percentages and frequency tables were generated from the SPSS output and detail analysis were made on these tables. Statistical techniques such as Chi square and correlation were used to test a two tailed hypothesis at a significance level of 0.05.

### **3.11 Ethical Consideration**

Ethical clearance to conduct the study was obtained from KNUST's Committee on Human Research, Publications and Ethics (CHRPE).

The researcher also observed a number of ethical issues so as to conduct the study on a more ethical manner. Ethical issues such as informed consent, anonymity, confidentiality and privacy were observed in the conduct of the study.

Consent form was given to respondents and proper authority before the study was conducted. Respondents gave full information about the study and respondents were made to voluntarily part-take in the study.

Since the study was looking at more sensitive issues such as family planning, respondents' background were assured of anonymity and confidentiality of any information collected from them.

### **3.12 Limitations of the Study**

The major constraint the study encountered was the unwillingness of some respondents to take part in the study initially. For this reason, the researcher had to assure the women of the confidentiality of information and also have to motivate some respondents by giving them snacks for participation to encourage others to join the study.



## CHAPTER FOUR

### RESULTS

#### 4.0 Introduction

This chapter focuses on the presentation and analysis of relevant data collected from the field. The presentation and the analysis of the data covered responses gathered from women using questionnaire on sustaining the improved family planning services in Bosomtwe District. Both uni-variate and bi-variate analysis of variables were employed. The data was first analysed descriptively by the use of frequency tables and percentages. Cross tabulation and Chi square test for hypothesis was performed based on the research hypothesis; that is Women's education, employment Status, marital status and religious background influence the use of family planning services and methods in the Bosomtwe District.

#### 4.1 Background Characteristics of Respondents

Descriptive statistics was primarily used to provide information on the distribution of research variables on the respondents' background information. Table 4.1 depicts the summary results on the respondents' background information such as age group, marital status, religious affiliation, educational level, occupation, and number of children. The respondents' ages were grouped into six categories (less than 20 years, 20-25, 26-30, 31-35, 36-40 and 41 years and more). On the age group of the respondents, it was revealed that most of the respondents were within the age group of 20-25 years (n=113) representing 28.7% followed by 26-30 years (n=109) representing 27.7% of the respondents. Few respondents were within the age group of 36-40 years (n=26) representing 6.6% and 41 years and above (n=27) representing 6.9% of the respondents. Pertaining to the respondent's marital status, majority of the respondents (50.8%) were married. Out of the sampled population, those who were married at the time of the study formed the majority (n=200) representing 50.8%, the

second highest were those who were single (n=129) representing 32.7%. The study established that 3.3% (n=13) of the respondents were divorced, 1.5% (n=6) of the respondents were widow, 4.1% (n=16) were separated from their partners and 7.6% (n=30) were in cohabitation relationship. Overwhelming majority (86.8%) of the respondents were Christians. Very few respondents were Muslims (8.4%) and least was the traditional believers who formed 4.1%. However, some respondents (n=3) representing 0.7% do not belong to any of the three dominant religions in the study area. The study found that majority of the respondents had basic education (had been to school before). The results on the respondents' education depicted in table 4.1 showed that few respondents (n=53) representing 13.5% had no education. Most of the respondents 43.1% (n=170) had junior high education, followed by those who had only primary education (n=75) representing 19%. It was also revealed that 11.7% (n=46) of the respondents had secondary education, an equal percentage of the respondents had tertiary education as well whilst 1% (n=4) had technical and vocational education. Investigating on the respondents' occupation, it was revealed that most of the respondents (35.2%) were traders followed by those respondents who had no job, who formed a valid percentage of 21.1 (n=83). The study results also showed that 19.8% of the respondents were skilled workers (e.g. hair and dress makers, etc.), 14.5% of the respondents were government workers, 7.1% of the respondents were working in the private sector and 2.3% were seasonal workers and farmers. Concerning the number of children the respondents had, most of the respondents (25.6%) had two children, followed by those who had one child (22.3%). Out of the sampled population (N=394), 19.2% (n=75) of the respondents had no child, 15.2% of the respondents had three children, 12.4% of the respondents had four children and 5.3% had five and more children.

**Table 4.1 Distribution of background characteristics of respondents**

<b>Variables</b>	<b>Frequency</b>	<b>Percentage (%)</b>
<b>Age group</b>	<b>(n=394)</b>	

less than 20 years	48	12.1
20-25 years	113	28.7
26-30 years	109	27.7
31-35 years	71	18.0
36-40 years	26	6.6
41 years and above	27	6.9
<b>Marital status</b>		
Single	129	32.7
Married	200	50.8
Divorced	29	7.4
Widow	6	1.5
Cohabitation	30	7.6
<b>Religious affiliation of respondents</b>		
Christian	342	86.8
Muslims	33	8.4
Traditionalist	16	4.1
Others	3	.7
<b>Educational level of respondents</b>		
No education	53	13.5
Primary school level	75	19.0
Junior high school level	170	43.1
Senior high school level	46	11.7
Tertiary level	46	11.7
Others (technical and vocational school)	4	1.0
<b>Occupation of respondents</b>		
Trader	139	35.2
Skilled worker	78	19.8
Government worker	57	14.5
Private employee	28	7.1
Unemployed	83	21.1
Others (seasonal workers and farmers)	9	2.3
<b>Number of children</b>		
No child	75	19.2
One child	88	22.3
Two children	101	25.6
Three children	60	15.2
Four children	49	12.4
Five and more	21	5.3

**Source: Field Data, 2015**

#### **4.2 Knowledge level of couples and individuals on family planning services and methods**

One major objective of the research was to examine the knowledge level of couple and individuals on family planning services and methods within the Bosomtwe District. The result depicted in table 4.1 provides a summary on the respondents' knowledge level on family planning services. Frequency count and percentages were computed to determine the number of respondents who had idea about family planning services. The results showed that majority of the respondents 92.4% (n=364) had idea on family planning whilst only 7.6% showed no idea on family planning services and methods. Dealing more into the respondents' knowledge on family planning services and methods, the respondents indicated that they had knowledge on the following family planning methods and services; abstinence, withdrawal and pills, Depo-Provera, condoms and pill, Emergency Contraceptive Pill (ECP) and female condom. The respondents further demonstrated their knowledge on family planning services and methods by indicating uses of family planning methods and services. From Table 4.2, 45.9% (n=181) of the respondents stated that family planning services and methods is used for child spacing, 20.8% (n=82) of the respondents argued that family planning services is used for birth control, 24.4% (n=96) of the respondents claimed that family planning services is used to prevent of unwanted pregnancy and 1.3% (n=5) of the respondents argued that family planning services was used for the prevention of sexual transmitted Infections (STIs). The study further found that majority of the respondents had their source of information regarding family planning from the hospital and healthcare centre. The study revealed that 59.9% (n=236) had their information (knowledge) on family planning from the hospital, 28.9% (n=114) had their ideas about family planning from the health centre, 4.6% (n=18) had their knowledge on family planning from a private clinic they attended, 2.8% of the respondents had their ideas on family planning from the maternity home during child birth, and 1.8% (7) of the respondents had their ideas on family planning from the media, friends and relatives. The study

results showed that the most trusted and common source respondents acquire knowledge on family planning services and methods were from the hospital and health centre. Few people (1.8%) in the study area sourced their information on family planning from friends, media, and relatives. Respondents further indicated that nurses and midwives and community health workers were mostly in the position of providing women with knowledge on family planning in the study area.

**Table 4.2 Knowledge of couple and individuals on family planning services and methods**

<b>Variables</b>	<b>Frequency</b>	<b>Percentage (n=394)</b>	<b>Number of respondents who had idea about family planning services in the area</b>
Yes	364	92.4	
No	30	7.6	
<b>Family planning methods and services</b>			
	<b>Frequency</b>	<b>Percentage</b>	
Abstinence, withdrawal and pills	131	32.2	
Depo-provera, condoms and pill	68	7.3	
Emergency contraceptive pill	20	5.1	
Female condom, pill, depo-provera	147	38.3	
No respondents	28	7.1	
<b>Respondents' knowledge on family planning</b>			
	<b>Frequency</b>	<b>Percentage</b>	
It is about child spacing	181	45.9	
It is about birth control	82	20.8	
It is about prevention of unwanted pregnancy	96	24.4	
It is about prevention of sexual transmitted Infections (STIs)	5	1.3	
No responses	30	7.6	
<b>Places where respondents receive family planning education</b>			
	<b>Frequency</b>	<b>Percentage</b>	
Hospital (nurse and midwives)	236	59.9	
health centre community health workers)	114	28.9	

private clinic	18	4.6
maternity homes	11	2.8
Others (media, friends and relatives)	7	1.8
No responses	8	2.0

**Source: Field Data, 2015**

#### **4.3 Sustaining the use of family planning methods and services**

The results presented in table 4.3 provide possible measures according to the respondents as ways to sustain the use of family planning methods and services in the Bosomtwe District. To sustain the use of family planning methods and services, 41.9% (n=165) of the respondents argued that there should be emphasis on the need for family planning for all women of reproductive age, 39.8% (n=157) of the respondents stated that education on unwanted pregnancy and birth control is best way to sustain the use of family planning services, 3% (n=12) of the respondents indicated that there should be education on preventing sexual transmitted infection through family planning services and methods such as the use of condoms and abstinence and 2.5% (n=9) of the respondents argued that the use of family planning services and methods could be sustained if women are educated on the need for having few children and good health. The study further established that 35.5% (n=140) of the respondents would use family planning for the purpose of birth spacing, 41.4% (n=163) of the respondents would use family planning services in the future to prevent unwanted pregnancy, 1.3% (n=5) of the respondents would like to use faming planning services in the future to prevent sexual transmitted infection and 3.3% (n=13) of the respondents cited that they would like to use family planning in the future to have few children. The results in table 4.3 revealed that 16.2% (n=64) of the respondents suggested that the use of family planning service could be sustained if there is education on the need for reducing child birth, 34.8% (n=137) of the respondents suggested education on the need for child spacing and most of the respondents 39.6% (n=156) emphasis that education on the importance of family planning on mothers' health as ways to sustain the current utilization of family planning services with the Bosomtwe District. Few

respondents felt that they would continue to use family planning if the services are offered free of charge to them. Most respondents (41.4%) again indicated that they would continue to use family planning services if it was affordable, 14.7% (n=58) of the respondents stated that they would continue to use family planning service, if the services are accessible to them, 30.7% (n=121) of the respondent feel the health component of family planning was paramount to them and that they would continue to use family planning services provided the services was safe (no health implication).

**Table 4.3 sustaining the use of family planning methods and services**

<b>Variables</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Reasons for sustaining utilization of family planning services</b>		
Emphasis on the need for family planning	165	41.9
Education on unwanted pregnancy and birth control	157	39.8
Education on preventing sexual transmitted infection	12	3.0
To have few children and good health	10	2.5
Others	9	2.3
No responses	41	10.4
<b>Reasons respondents would like to use family planning in the future (Enabling Factors)</b>		
To space my children	140	35.5
To prevent unwanted pregnancy	163	41.4
To prevent sexual transmitted infection	5	1.3
To have few children	13	3.3
Others	8	2.0
No responses	65	16.5
<b>Suggestion to sustain family planning methods and services</b>		
Education on the need for reducing child birth	64	16.2
Education on importance of child spacing	137	34.8
Education on the importance of family planning on mothers' health	156	39.6
Other	20	5.1
No responses	17	4.3
<b>Ways to ensure that respondents continue to utilize FP services(Enabling Factors)</b>		
Free family planning services and methods	21	5.3
Affordable family planning services	163	41.4
Accessible family planning services and methods	58	14.7

Safe family planning methods (no health implication)	121	30.7
Others	13	3.3
No responses	18	4.6

**Source: Field Data, 2015**

#### **4.4 Ways to ensure that utilization of family planning services lead to reduction in fertility rate (smaller family size)**

The results presented in table 4.4 illustrate the respondents' views on ways to ensure that utilization of family planning services lead to reduction in fertility rate among Women in Fertility Age (WIFA) within the Bosomtwe District. From the results in table 4.4, 7.4% (29) of the respondents indicated that the time they use family planning services was after child birth (during breast feeding). Most of the respondents (39.8%) stated they used family planning services during the time they do not want to have children, 7.1% of the respondents use family services after sex, 18.3% of the respondents use family planning services before sex, 12.4% of the respondents use family planning services at any point in time and 5.6% of the respondents indicated that they do not use any family planning services. The study results further showed that 7.4% of the respondents indicated that the best time to use family planning services to reduce fertility rate among WIFA is during breast feeding. Most respondents (33.2%) suggested that family planning could be used as a way to reduce fertility rate if it is used before sex, 10.9% of them suggested after sex, 34.3% of the respondents suggested that when one had decided on the number of children to give birth to, 7.9% of them indicated that the time one wishes not to have children is the best time to use family planning services. Finally, on way to ensure that family planning services lead to reduction in fertility rate, 6.9% of the respondents when that family planning would be more effective in reduction fertility rate when one had had children from both sex, 40.6% of them suggested well education on the need to limit child birth through family planning, 34.5% of the respondents suggested easy access to family planning



services and 8.1% of them suggested emphasis on the health condition of mothers as ways to use family planning services utilization to reduce fertility among WIFA.

**Table 4.4 Ways to ensure that utilization of family planning services leads to reduction in fertility rate (small family size)**

<b>Variables</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Time respondents use family planning methods</b>		
After child birth (during breast feeding)	29	7.4
During the time I do not want to have a child	157	39.8
After sex	28	7.1
Before sex	72	18.3
Any time	49	12.4
Do not use any	22	5.6
No responses	37	9.4
<b>Best time/period to use family planning services to reduce fertility rate</b>		
When you are breast feeding your child	29	7.4
Before sex	131	33.2
After you have sex	43	10.9
When you have decided on the number of children to give birth to	135	34.3
During the time you do not want to have a child	31	7.9
No responses	25	6.3
<b>Ways to use family planning to limit child birth</b>		
When I have children of both sex	27	6.9
When I am well educated on the need to limit child birth	160	40.6
When I have easy access to family planning methods	136	34.5
Health of mothers	39	9.9
System	32	8.1

**Source: Field Data, 2015**

#### **4.5 Women's education, occupation, marital status and religion influence the utilization of family planning services and methods**

The researcher's hypothesis that Women's education, "women employment Status, marital status and religious background influence the use of family planning services and methods in the Bosomtwe District". To determine the relationship between the dependent and independent

variables, bivariate analysis and Chi-square test were computed on the women's education and use of family planning services, occupation and use of family planning services, marital status and use of family planning services and lastly religion and use of family planning services. On each of the variables computed, the significance value was used to determine whether the variables are dependent or not. Generally, the lower the significance value, the less likely it is that the two variables are independent (unrelated). Typically, a significance value less than 0.05 are considered "significant". A significant value of more than 0.05 means that the variables under consideration are independent (unrelated). Detailed analyses of the variables are discussed as follows;

#### 4.5.1 Women's education and use of family planning

The researcher first tested women's education and the use of family planning services. The cross tabulation table gives rough information on women's education and use of family planning services in term of percentage but does not actually show the significance of the relationship between the variables.

**Table 4.5 Respondent's educational level and Number of respondent who had used family planning services**

Variables	Number of respondent who had used family planning services N=381		
	Yes	No	Total
No education	33 67.3%	16 32.7%	49 100.0%
Primary school level	60 82.2%	13 17.8%	73 100.0%
Junior high school level	145 84.8%	26 15.2%	171 100.0%
Senior high school level	36 83.7%	17 14.3%	43 100.0%
Tertiary level	36 80.0%	9 20.0%	45 100.0%

Source: Field Data, 2015

**Note: The total valid count for women education and respondents who had used family planning services was 381 due to the fact that some respondents (3.9%, n=13) did not answer the question on “number of respondents who had even used family planning services”.**

From table 4.5, the study results showed that 67.3% (n=33) of uneducated women had even used family planning against 32.7% of uneducated women who had never used family planning services. For women who had primary education, 82.2% (n=60) had ever used family planning services whilst 17.8% had not used family planning services. 83.7% of women who had junior high education use family planning against 15.2% women who do not use family planning services. For women who had senior high school education 83.7% used family planning services against 14.3% women who did not use family planning services. It further recorded 80% of women who had tertiary education using family planning services against 20% of women with tertiary education who do not use family planning services

#### **4.5.2 Women’s occupation and use of family planning method**

This section examines the relationship between women’s occupation and use of family planning methods. The results in table 4.6a shows that regardless of the women’s occupation, most of the respondents within all the occupational background listed, those who use family planning services were more than those who do not use family planning services.

**Table 4.6 Women occupation and use of family planning method**

Variables	Number of respondent who had used family planning services N=381		
	Yes	No	Total
Respondents’ occupation			
Trader	109 79.0%	29 21.0%	138 100.0%
Skilled worker (e.g. hair and dress makers, etc)	64 84.2%	12 15.8%	76 100.0%
Government worker	44 81.5%	10 18.5%	54 100.0%
Private employee	23 85.2%	4 14.8%	27 100.0%
Unemployed	62 80.5%	15 19.5%	77 100.0%

Famers and seasonal workers	8 88.9%	1 11.1%	9 100.0%
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**Source: Field Data, 2015**

**Note: The total valid count for women occupation and respondents who had used family planning services was 381 due to the fact that some respondents (3.9%, n=13) did not answer the question on “number of respondents who had even used family planning services”.**

Table 4.6 shows that women’s occupation does not necessary influence the use of family planning services. The results revealed that most of the respondents 79%, (n=109) who were traders use family planning services. Within this occupational group of respondents most of them (n=170) use family planning services. Respondents who were farmers and seasonal workers were at the minority. Yet, this group of respondents also have most of them (8 out of 9 respondents) using family planning services. The same was observed within the various occupational backgrounds. For example skilled worker (e.g. hair and dress makers, etc) had 84.2% (n=64) using family planning against 15.8% (n=12) respondents not using family planning, 81.5% (n=44) government workers who use family planning against 18.5% (n=10) of government workers who do not use family planning. Also 85.2% (n=23) of respondents working in the private sector use family planning against 14.8% (n=4) of the respondents within the private sector not using family planning.

#### **4.5.3 Women marital status and use of family planning methods**

**Table 4.7 Women marital status and use of family planning methods**

Variables	Number of respondent who had used family planning services N=381		
	Yes	No	Total
Single	98 81.0%	23 19.0%	121 100.0%
Married	158 81.0%	37 19.0%	195 100.0%
Divorced	11 84.6%	2 15.4%	13 100.0%
Widow	3 60.0%	2 40.0%	5 100.0%
Separated	11	5	16

	68.8%	31.2%	100.0%
Cohabitation	29 93.5%	2 6.5%	31 100.0%

Source: Field Data, 2015

**Note: The total valid count for women marital status and respondents who had used family planning services was 381 due to the fact that some respondents (3.9%, n=13) did not answer the question on “number of respondents who had even used family planning services”.**

From table 4.7, the study results shows that 81% (n=98) of the respondents who were single use family planning services. Most of the respondents 81% (n=158) who were married use family planning services, 284.6% (n=11) of the respondent who were divorced women use family planning services, 60% (n=3), 68.8% (n=11) and 93.5% (n=29) of the respondents who were widows, separated from their partner, and in cohabitation relationship use family planning services respectively. On the respondents’ marital status, the study results showed that majority of the respondents use family planning regardless of their marital status.

#### 4.5.4 Respondents’ religious affiliation and use of family planning services

To determine the relationship between the respondents’ religious background and use of family planning services and methods within the Bosomtwe District, cross tabulation and chisquare test were performed on the variables. The study results in table 4.8a showed that majority (86.9%) of the respondents were Christian with few respondents (4.1%) coming from the traditional African religion. The results show clearly that the traditional Africa religion was losing it value in the people’s faith.

**Table 4.8 Respondents’ religious affiliation and use of family planning services**

Variable	Number of respondent who had used family planning services N=381		
	Yes	No	Total
Christian	268 80.7%	64 19.3%	332 100.0%
Muslims	25 78.1%	7 21.9%	32 100.0%

Traditionalist	17 100.0%	0 .0%	17 100.0%
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**Source: Field Data, 2015**

From table 4.8, the study results revealed that out of total 332 Christians, 80.7% (n=268) of them use family planning services, 19.3% (n=64) of the respondents who belong to the Islamic faith use family planning services against 21.9% (n=7) of them who do not use family planning services. All the sampled respondents who were traditional believers use family planning services. The results showed that respondents in all the three main religions within the study area use family services. However, the results in table 4.8 indicate whether the two variables are related or the relationship that exists between women's religious affiliation and use of family planning occur by chance or is significant.

**Table 4.9 Results of Chi-Square Tests**

Women's socio-demographic	p-value	95%
Education	0.041	0.034 - 0.042
Occupation	0.894	0.888 - 0.900
Marital	0.286	0.278 - 0.295
Religion	0.218	0.210 - 0.226
Age	0.002	0.001 -0.003

**Source: Field Data, 2015**

Table 4.9 shows that women education and their age have a significant relationship with use of family planning services and methods in the Bosomtwe District. The significance values for women's education and age in relations to their use of family planning services were 0.041 and 0.002 respectively. These values were far less than 0.05. This means that women's education and age significantly influence their use of family planning services. The others socio-demographic characteristics such as women's occupation, marital and religious affiliation have not significant relationship to their use of family planning services.

## CHAPTER FIVE

### DISCUSSION

#### 5.0 Introduction

This chapter provides detailed discussion on results obtained from the field study relating to the specific objectives. The study results were compared to prevailing literature and past researches on family planning to establish linkages between the study and existing literature.

It also relates the findings to the study's conceptual framework and research hypothesis.

#### 5.1 Background characteristics of respondents

From the study results obtained on the respondents' background information are: age group, marital status, religious affiliation, educational level, occupation, and number of children. It was revealed that most of the respondents were within the age group of 20-25 years (n=113) representing 28.8.7% followed by 26-30 years (n=109) representing 27.7% of the respondents. This showed that majority (56.5%) of the respondents were within the age range of 20-30 years. The higher percentage of respondents within this age group implied that if family planning services and method are taken serious and sustained, fertility rate will be reduced within the study area as the period Women In fertility Age will be reduced given the period that most women in the age of 20-30 years will be on family planning.

Pertaining to the respondents' marital status, majority of the respondents (50.8%) were married. Out of the sampled population, those who were married at the time of the study formed the majority (n=200) representing 50.8%. Since majority of the respondents were married couple, it means that their views were dominant in the study findings. Also regarding the use of family planning services among married couple in the study, the higher percentage of married couple indicated that married couples support the ideas of family planning in the Bosomtwe District.

Overwhelming majority (86.8%) of the respondents were Christians. Very few respondents were Muslims (8.4%) and least was the traditional believers who formed 4.1%. The higher percentage of Christians showed that the study area is dominated by Christians. This implied that Christian's values were dominant in the study results. This also implies that information on family planning services could be disseminated to women in the church.

The study found that majority of the respondents had basic education. Most of the respondents 43.1% (n=170) had junior high education. Very few (13.5%) respondents had no basic education. The fact that majority of the respondents had at least basic education meant that the respondents could understand the importance of family planning services better and how best family planning services could help reduce fertility rate within the study area.

Pertaining to the respondents' occupation, it was revealed that most of the respondents (35.2%) were traders. This means that the respondents could at least afford family planning services as they earn through their trade.

## **5.2 Knowledge level of couple and individuals on family planning services and methods**

Knowledge on family planning services and methods are very central to use of family planning services. According to Casterline et al., (2001) knowledge of modern contraceptive methods is an important determinant of contraceptive use. Women who are well informed about the benefits of family planning tend to use it (Elzanary, Sunita, & Casterline, 1999). The study results showed that majority of the respondents 92.4% (n=364) had idea on family planning whilst only 7.6% showed no idea on family planning services and methods. This study results confirmed the views of Bongaarts & Bruce (1995); Casterline et al. (2001); Feyistan & Casterline (1999) that most women in the urban centres have knowledge on family planning services. The study results revealed that women in the study area were well knowledgeable about family planning services and methods. Dealing more into the respondents' knowledge



on family planning services and methods, the respondents indicated that they had knowledge on the following family planning methods and services; abstinence, withdrawal and pills, Depo-provera, condoms and pill, Emergency Contraceptive Pill (ECP) and female condom. This study results is in line with the views of Bongaarts & Bruce (1995); Casterline & Sinding (2000); and Luck et al. (2000) that common family planning services includes; condoms, Emergency Contraceptive Pill (ECP), Depo-provera, sponge, vaginal contraceptive films, contraceptive foam, transdermal-contraceptives and many others. The fact that most of respondents did not only have knowledge of family planning services but could mention some types of family planning services and methods implied that they could use different types of family planning services they wish. It also means that implied women in the study area use different family planning services such as condoms, Depo-provera, pills, Emergency Contraceptive Pill (ECP), sponge, vaginal contraceptive films, contraceptive foam and transdermal-contraceptives.

The study results further revealed that women use family planning services for many reasons. From the field survey, it was established that family planning services and methods are used for child spacing, birth control, prevention of unwanted pregnancies and prevention of sexual transmitted Infections (STIs). The study again found that majority of the respondents had their source of information regarding family planning from the hospital and healthcare centre. The study revealed that 59.9% (n=236) had their information (knowledge) on family planning from the hospital, 28.9% (n=114) had their ideas about family planning from the health care centre, 4.6% (n=18) had their knowledge on family planning from a private clinic they attended, 2.8% of the respondents had their ideas on family planning from the maternity home during child birth, and 1.8% (7) of the respondents had their ideas on family planning from the media, friends and relatives. The study results confirmed the views of Wright (2002) that family planning services is used for birth control, child spacing, prevent of Sexual

Transmitted Infections (STIs). The present study showed that women in the Bosomtwe District were fully aware of the importance of family planning services and methods. The study results showed that the most trusted and common source respondents acquire knowledge on family planning services and methods were from the hospital and health centre. Few people (1.8%) in the study area source their information on family planning from friends, media, and relatives. Respondents further indicated that nurses and midwives and community health workers were mostly in the position of providing women with knowledge on family planning in the study area.

### **5.3 Sustaining the use of family planning methods and services**

Statistics from the Bosomtwe District showed that utilization of family planning services and methods are better than most districts in Ghana. According to the Bosomtwe District Health Directorate, “Annual Performance Review, (2014), there was an increase in Family Planning Acceptor Rate from 39.5% to 49.3% which is above the national target of 28%, however sustaining the Acceptor Rate is of key concern to stakeholders. The study results established that to sustain the use of family planning methods and services in the Bosomtwe District, there should be emphasis on the need for family planning for all women of reproductive age, 39.8% (n=157) of the respondents stated that education on unwanted pregnancy and birth control is best way to sustain the use of family planning services, education on preventing sexual transmitted infection through family planning services and methods such as the use of condoms and abstinence, education on the need for having few children and good health.

The study further established that the use family planning service could be sustained if there is education on the need for reducing child birth, 34.8% of the respondents suggested education on the need for child spacing, emphasis on the importance of family planning on mothers’ health as ways to sustain the current utilization of family planning services with the Bosomtwe District. Few respondents felt that they would continue to use family planning if the services

are offered free of charge to them. Most respondents (41.4%) again indicated that they would continue to use family planning services if it was affordable, 14.7% (n=58) of the respondents stated that they would continue to use family planning service, if the services are accessible to them, 30.7% (n=121) of the respondent feel the health component of family planning was paramount to them and that they would continue to use family planning services provided the services was safe (no health implication).

The study results confirmed the views of Awusabo-Asare, Abane, & Kumi-Kyereme (2004); Baiden (2003); and Benefo (2005) that family planning services could be sustained through education on the importance of family planning, free access to family planning services and methods. From the study results, it was revealed that education on the need for birth control, child spacing, and the importance of family planning for mother's health, free and affordable family planning services could help sustain the current Acceptor Rate of family planning in the Bosomtwe District.

#### **5.4 Ways to ensure that utilization of family planning services lead to reduction in fertility rate (smaller family size)**

According to Addai (2009) family planning services is one most important factor that had led to reduction in fertility in the developed countries. However, family planning services in the developing countries had not yielded much reduction in birth rate as compared in the Western World Anand (2008). The study results revealed several ways to ensure that family planning services lead to reduction in fertility rate. The study results showed that family planning could be used as a way to reduce fertility rate if it is used before sex, few respondents (10.9%) of them suggested after sex, 34.3% of the respondents suggested that when one had decided on the number of children to give birth to, 7.9% of them indicated that the time one wishes not to have children is the best time to use family planning services. Finally, the respondents indicated that family planning would be more effective in reduction of fertility rate when one

had had children from both sex, 40.6% of them suggested education on the need to limit child birth through family planning, 34.5% of the respondents suggested easy access to family planning services and emphasis on the health condition of mothers as ways to use family planning services utilization to reduce fertility among WIFA.

The study results clearly showed that utilization of family planning services could help reduce fertility rate if there is education on the need to have limited number of children, use of family planning services to prevent unwanted pregnancy, education on maintenance of mothers' health condition through family planning and the need for using family planning methods before sex.

### **5.5 Women's education, occupation, marital status and religion influence the utilization of family planning services and methods**

The researcher hypothesized that "Women's education, women employment Status, marital status and religious background influence the use of family planning services and methods in the Bosomtwe District". To determine the relationship between the dependent and independent variables, bivariate analysis and Chi-square test were computed on the women's education and use of family planning services, occupation and use of family planning services, marital status and use of family planning services and lastly religion and use of family planning services.

The study results showed that women's education significantly influence utilization of family planning service. The chi-square test yielded a significance value of 0.037, which means that there is significant relationship between women education and use of family planning services within the Bosomtwe District. The study results inveterate the findings of Arowojolu, Adedimeji, & Roberts (2000); Awusabo-Asare, Abane, & Kumi-Kyereme (2004); and Benefo (2005) that education influence women use of family planning service and that educated

women were more likely to use family planning methods and services than uneducated women. This study results implied that to sustained family planning services utilization in Bosomtwe District, there should be emphasis on women's education to increase the literacy rate in the area as a way of sustaining the current Acceptor Rate of family planning services.

The study results also showed that women's occupation, marital status, and religion were not significant determinants of women utilization of family planning services within the Bosomtwe District. The study results therefore revealed that regardless of the women religious background, occupation and marital status, family planning services could be accepted by all women from different occupational, religious and marital background. This implied that sustaining the current utilization of family planning Acceptor Rate could be done with less emphasis on the women background such as marital status, religion and occupation.



## CHAPTER SIX

### CONCLUSION AND RECOMMENDATIONS

#### 6.0 Introduction

This chapter provides conclusion based on the study objectives and offers some recommendations. The study involved a sampled population of 394 respondents, mainly women of fertility age within the Bosomtwe District. The field results were obtained through questionnaire administered to respondents selected using probability sampling techniques. The study sought to determine the knowledge of couple and individuals on family planning methods in the Bosomtwe District, assess the extent to which the demographic and socioeconomic characteristics of couple and individuals influence their decisions on the use of family planning methods, identify ways of sustaining the current acceptor rate of family planning in the district, suggest ways to ensure that increase utilization of family planning services lead to small family size.

The researcher hypothesized that women's education, employment Status, marital status, religious background, ethnicity and place of residence influence the use of family planning services and methods in the Bosomtwe District.

#### 6.1 Conclusion

Investigating on the knowledge level of respondents, the study established that majority (92.4%) of the respondents had knowledge on family planning services and methods. This was showed from the fact that respondents did not only mention some family planning services but had ever used many family planning services such as condoms, Emergency Contraceptive Pill (ECP), Depo-provera, sponge, vaginal contraceptive films, contraceptive foam, transdermal-contraceptives and many others. The study results further revealed that respondents were fully aware of the importance of family planning services and methods.

Some reasons respondents cited for the use of family planning services within the Bosomtwe District include to; control birth, spacing of children, limiting the number of children to give birth to, preventing of unwanted pregnancy, preventing of sexual transmitted infections and providing good health conditions for mothers. The respondents were aware and had used family planning services such as condoms, Depo-provera, pills, Emergency Contraceptive Pill (ECP), sponge, vaginal contraceptive films, contraceptive foam and transdermal-contraceptives. The study therefore concluded that family planning services and methods were not new ideas to the respondents. This was not surprising as the study area had a higher Acceptor Rate of family planning services according the Bosomtwe District health statistics on family planning utilization.

Pertaining to the socio-demographic features of respondents and the utilization of family planning services, the study results indicated that only women who are education had significant influence and relationship on utilization of family planning services. The study results revealed that women marital status, religion and occupation were less likely to influence utilization of family planning services. The study discovered that women occupation, religious background and marital status were not significantly related to utilization of family planning services.

On sustaining family planning services in the study area, the study results revealed on the need to limit child birth, child spacing, birth control, emphasis on good health condition for mothers through family planning services and methods could help sustain the current utilization of family planning services within the Bosomtwe District. The respondents stated that the current utilization of family planning could be sustained if there were education on the importance of family planning, free access to family planning services and methods to women, education on the need for birth control, child spacing, the importance of family planning for mother's health, free and affordable family planning services.

Last but not the least, the study investigated on the ways to ensure that utilization of family planning services and methods could lead to reduction in fertility. On this, study results clearly showed that utilization of family planning services could help reduce fertility rate if there is education on the need to had limited number of children and birth control through family planning, education on maintenance of mothers' health condition through family planning, use of family planning services to prevent unwanted pregnancy and the need for using family planning methods before sex. The study results have satisfied the researcher's objectives and have clearly indicated ways to sustain the current use of family planning services and how family planning services utilization could lead to reduction in fertility rate among Women In Fertility Age (WIFA) within the Bosomtwe District.

## **6.2 Recommendations**

Based on the study results, the researcher poses the following recommendation. The district should take women education seriously. Since there is Free Compulsory Basic Education (FCBE) in Ghana, the district health directorate and educational unit should ensure that all girl child of school going age are in school. For adult women who are uneducated, the nonformal education unit should be tasked to educate these women to ensure the sustainability of family planning services in the area.

Women should be enlightened on the need to keep their health condition through family planning services. There should be education on how family planning could help improve the health condition of women so as to ensure that women continue to use family planning services.

The researcher again recommended that emphasis should be on birth control, child spacing and the need to limit child birth for small family size. Women and if possible their husbands should be education on the need for family planning for birth rate control. There should be educated



on the need for small family size as the cost of living was very high for them to cater for large family size. Women should be made to know that family planning is the best way to control their birth rate.

Women who are not ready for child birth should always use family planning services and contraceptive to prevent unwanted pregnancy. For women who are single, they should be using family planning to help them not to get unwanted pregnancy.

The researcher further recommended that family planning services should be affordable and accessible to all women. The district health directorate could help in this by providing free condom to single women. There should also be media education on place women could easily get access to family planning services.

Women who are knowledgeable on family planning should make it possible to educate others at place and sources of family planning services. The hospital and clinic should intensify their education on family planning services in the area.

There should be education on prevention of sexual transmitted infections (STIs) through the use of family planning services and contraceptives like condoms.

### **6.3 Recommendation for further studies**

The researcher recommended that future studies should look at married and unmarried men perceptions and utilization of family planning services in the Bosomtwe District.

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## APPENDIX

### QUESTIONNAIRE ON FAMILY PLANNING

This is a study being conducted on family planning services in Bosomtwe District. This thesis is to be submitted in partial fulfilment for the award of MSc. Population and Reproductive Studies from the Kwame Nkrumah University of Science and Technology, Kumasi. Please, note that the responses you provide are for academic purposes and are completely anonymous and confidential. Thank you in advance for your cooperation.

#### SECTION A: SOCIO-DEMOGRAPHIC FEATURES OF RESPONDENT

1. Sex of respondent
  - a. Male  b. Female
2. Age (years) .....
3. Marital status of respondent
  - a. Single  b. Married  c. Divorced  d. Widow  e. Separated  f. Cohabitation
4. Respondent's religious affiliation
  - a. Christian  b. Muslim  c. Traditionalist  d. Others (specify) .....
5. Respondent's Educational Level
  - a. No education  b. Primary School level  c. Junior High school Level
  - d. Senior high School level  e. Tertiary Level  f. Others (Specify).....
6. Occupation of respondent
  - a. Trader  b. Skilled worker (e.g. hair and dress makers, etc.)  c. Government employee  d. Private employee  e. Unemployed  f. Others (specify) .....
7. How many children do you have?
  - a. One  b. Two  c. Three  d. Four  e. Five  f. Six  g. Seven and above (specify the number).....
8. Are you planning of having another child?



- a. Yes [ ] b. No [ ]

**SECTION B: KNOWLEDGE LEVEL OF COUPLE AND INDIVIDUALS ON FAMILY PLANNING SERVICES AND METHODS**

9. Do you have any idea about family planning?

- a. Yes [ ] b. No [ ]

10. If yes, what do you know about family planning?

- a. It is about child spacing [ ]  
b. It is about birth control [ ]  
c. It is about prevention of unwanted pregnancy [ ]  
d. It is about prevention of sexual transmitted Infections (STIs) [ ]  
e. Others (specify) .....

11. Where can you receive family planning service in the community?

- a. Hospital [ ]  
b. Health center [ ]  
c. Private clinic [ ]  
d. Maternity homes [ ]  
e. Others (specify) .....

12. Where do you receive family planning education?

- a. Hospital [ ]  
b. Health center [ ]  
c. Private clinic [ ]  
d. Maternity homes [ ]  
e. Others (specify) .....

13. Who provides you with family planning service in this community? a. Nurses [ ]

- b. Midwives [ ]  
c. Medical assistant [ ]  
d. Chemist [ ]  
e. Community health worker [ ]  
f. don't know [ ]  
g. Others (specify) .....

14. Have you even used any family planning method?

- a. Yes [ ] b. No [ ]

15. If yes to question 13, can you please indicate any family planning method you have even used? .....

16. . If your answer to question 13 was yes, give reasons, by selecting from these lists a.

Child spacing [ ]

b. Sexual enhancement [ ]

c. To avoid pregnancy [ ]

d. For health reasons [ ]

e. Few children [ ]

f. Others (specify) .....

17. What do you know about family planning?

a. Child spacing [ ]

b. Few children [ ]

c. Prevention of pregnancy [ ]

d. Use of contraceptives [ ]

18. Which of these family planning methods do you know of?(Tick as many as apply) a.

Abstinence [ ]

b. Withdrawal [ ]

c. Birth control pill [ ]

d. Condoms [ ]

e. Contraceptive Foam [ ]

f. Depo-Provera [ ]

g. Emergency contraceptive pill/morning after pill (ECP) [ ]

h. Transdermal - Contraceptive Patch (the Patch) [ ]

i. Female Condoms [ ]

j. Fertility Awareness [ ]

k. Intrauterine Device (IUD) [ ]

l. Sponge [ ]

m. Vaginal Contraceptive Film (VCF) [ ]

n. Vaginal Contraceptive Ring [ ]

19. Which of the family planning methods in question 18 do you use?

.....

20. Is family planning important?

a. Yes [ ] b. No [ ]

21. Can you please give reason for your answer?

- a. It saves money [ ]
- b. Prevents unwanted pregnancies [ ]
- c. Prevents sexually transmitted infections (STIS) [ ]
- d. Birth control and child spacing [ ]
- e. Promotes pre-marital sex among the youth [ ]
- f. Sexual promiscuity by married couples [ ]
- g. Others (specify) .....

**SECTION C: SUSTAINING THE USE OF FAMILY PLANNING METHODS AND SERVICES**

22. If you have ever used family planning method, what made you to use that method?

- a. To space my children [ ]
- b. To prevent unwanted pregnancy [ ]
- c. To prevent sexual transmitted infection [ ]
- d. To have few children [ ]
- e. Others (specify) .....

23. Will you like to use family planning method in the future?

- a. Yes [ ] b. No [ ]

24. If yes, what will make you to use family planning methods in the future?

- a. To space my children [ ]
- b. To prevent unwanted pregnancy [ ]
- c. To prevent sexual transmitted infection [ ]
- d. To have few children [ ]
- e. Others (specify).....

25. If no to question 22, what will make you not want to use family planning in the future?

- a. It is expensive [ ]
- b. It is not safe [ ]
- c. It is of no significant to me any more [ ]
- d. It is access to me any longer [ ]
- e. You partner will not allow you [ ]
- f. Others (specify) .....

26. Will you advise others to use family planning method?  
 a. Yes [ ] b. No [ ]
27. If yes, why will you advise others to use family planning?  
 a. So that they can also space their children [ ]  
 b. So that they can avoid unwanted pregnancy [ ]  
 c. So that they can prevent STIs [ ]  
 d. So that they can stay health by having few children [ ]  
 e. Others (specify) .....
28. What in your personal view can the use of family planning method be encouraged among couple and individual  
 a. Education on the need for reducing child birth [ ]  
 b. Education on importance of child spacing [ ]  
 c. Education on the importance of family planning [ ]  
 d. Others (specify) .....
29. Which of the following will make you use more family planning methods?  
 a. Few family planning services and methods [ ]  
 b. Affordable family planning services [ ]  
 c. Accessible family planning services and methods [ ]  
 d. Safe family planning methods [ ]  
 e. Others (specify).....

**SECTION D: WAYS TO ENSURE THAT UTILIZATION OF FAMILY PLANNING SERVICES LEAD TO SMALL FAMILY SIZE**

30. When do you use family planning method?  
 a. After child birth (during breast feeding) [ ]  
 b. During the time I do not want to have a child [ ]  
 c. After sex [ ]  
 d. Before sex [ ]  
 e. Any time  
 f. Do not use any [ ]  
 g. Others (specify) .....
31. What time in your view do you think is the best to use family planning methods?  
 a. When you are feeding your child [ ]

- b. When you are about to have sex [ ]
  - c. After you have sex [ ]
  - d. When you have decided on the number of children to give birth to [ ] e. Others (specify).....
32. Do you use family planning to help you have few children?
- a. Yes [ ] b. No [ ]
33. If yes, why do you use it for limiting the number of children to give birth to?
- a. I want to have many children but health ones [ ]
  - b. I do not decide the number of children I will have, my partner decide for me [ ] c. Don't know [ ]
  - d. Others (specify) .....
34. What will make you use family planning method to limit your child birth?
- a. When I have children of both sex [ ]
  - b. When I am well educated on the need to limit child birth [ ]
  - c. When I have easy access to family planning methods [ ]
  - d. Others (specify) .....

