

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY,
SCHOOL OF GRADUATE STUDIES

Factors Influencing the Utilisation of Family Planning
Services In Kwabre District, Ghana

A Dissertation presented to the School of Graduate
Studies, Kwame Nkrumah University of Science and Technology,
in partial fulfilment of the requirement for the award of Msc
Degree (Health Education and Promotion)

SEPTEMBER, 2007

DECLARATION

I DO HEREBY DECLARE THAT, APART FROM OTHER REFERENCES WHICH HAVE BEEN DULY ACKNOWLEDGED, THIS IS MY OWN ORIGINAL RESEARCH AND NO PART OF IT HAS BEEN PRESENTED TO ANY UNIVERSITY FOR THE AWARD OF ANY DEGREE.

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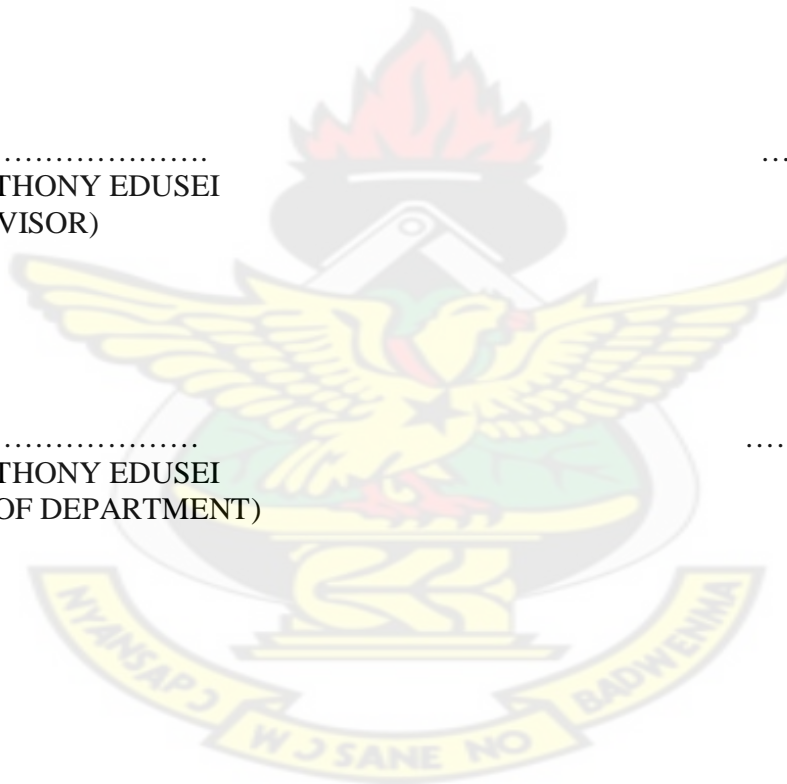
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DEDICATION

THIS WORK IS DEDICATED TO GOD ALMIGHTY, WHO GRANTED ME THE KNOWLEDGE, STRENGTH AND COURAGE THROUGHOUT THIS PROGRAMME.

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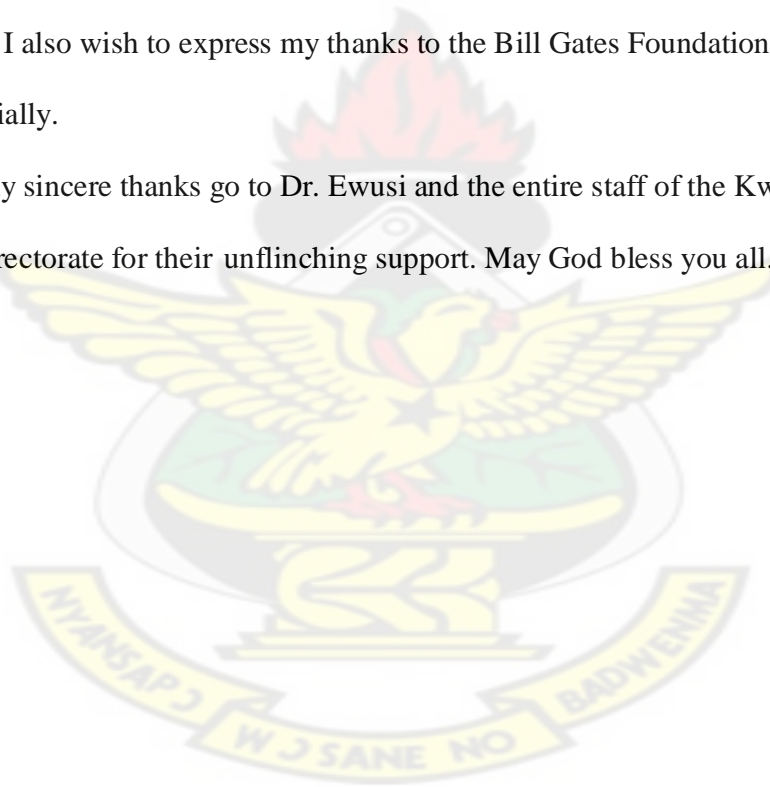


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LIST OF ABBREVIATIONS

AIDS.....	Acquired Immune Deficiency Syndrome
BMC.....	BioMed Central
CPR.....	Contraceptive Prevalence Rate
DHS.....	Demographic and Health Survey
FHI.....	Family Health International
FP.....	Family Planning
FTR.....	Fertility Rate
GHS.....	Ghana Health Service
HIV.....	Human Immuno Deficiency Virus
ICPD.....	International Conference on Population and Development
IFPP.....	International Family Planning Perspective
IPAFPP...	International Population Assistance and Family Planning Programmes
IUDs.....	Inter-Uterine Devices
JHUCCP.....	John Hopkins University Centre fo Communication Programmes
MOH.....	Ministry Of Health
NHRI.....	Navrongo Health Research Institute
PATH.....	Programme for Appropriate Technology in Health
PIP.....	Population Information Programme
RTIs.....	Reproductive Tract Infections
SSA.....	Sub-Sahara Africa
STIs.....	Sexually Transmitted Infections

IV

- UNFPA.....United Nations Fund for Population Activities
UNICEF.....United Nations International Children and Educational Fund
UNDP.....United Nations Development Programme
USAID.....United States Agency for International Development
VCT.....Voluntary Counseling and Testing
WHO.....World Health Organisation
WIFA.....Women In Fertility Age

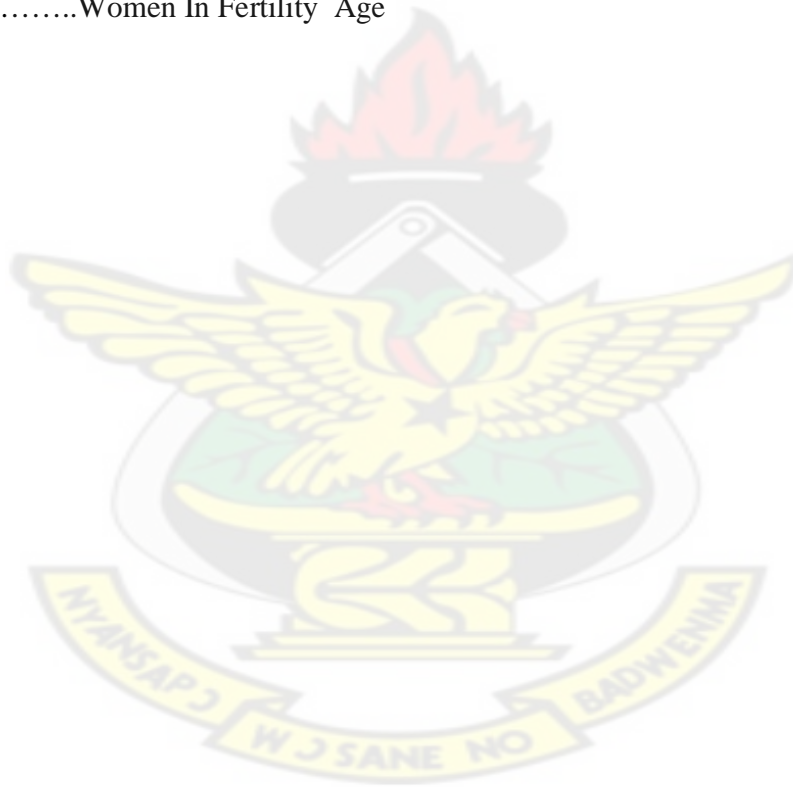


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ABSTRACT

In a cross sectional study to assess the potential barriers to the utilization of family planning services among women in fertility age (WIFA), 400 women from 6 communities in three sub-districts aged 15 – 49 years were selected by systematic sampling technique and then interviewed using structured questionnaire.

The findings of the study revealed that most of the women have high level of knowledge about contraceptive but this does not translate into the use of modern contraceptives. Most of the respondents (122) (30.5%) were aware of at least three methods of contraception while 47 (4.7%) were aware of seven to nine contraceptive methods. Also 367 (91.7%) of the respondents knew at least two contraceptive methods. It also came out that these women have access to family planning services but the quality of the services offered is quite low in terms of availability of different contraceptive methods.

The most common contraceptive methods available were contraceptive pill, contraceptive injection and the condom.

Besides, the fertility preference expressed by most of the respondents was high since as much as 300 (75%) wanted between 4 – 6 children in their entire life.

An improvement in the quality of service offered, increase public education on high fertility and integrating family planning services with other services are recommended for increase contraceptive use.

CHAPTER ONE

1.1: BACKGROUND INFORMATION

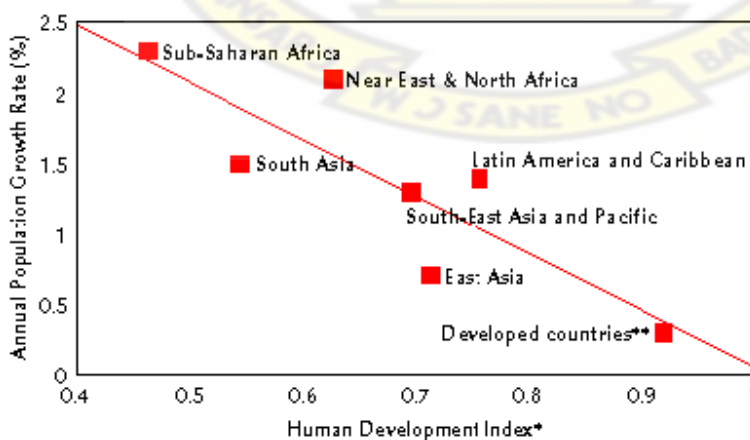
While global population growth has slowed, the world's population reached 6 billion in 1999, 6.5 billion in 2005, and is expected to rise to 9.3 billion by 2050, with most of the growth occurring in developing nations. In 1960, 70% of the world's population lived in developing countries; in 2005 the level had grown to 81% and these countries now account for 99% of world –wide population growth. (IPAFPP, 2006).

In theory, population growth might provide an economic advantage because more people could be working, produce more, and thus raise national income level. In reality, studies in many countries find that rapid population growth has resulted in more poverty for most people (JHUCCP, 1999)

In fact, the regions of the world where fertility and population growth rates are the highest rank lowest on the United Nations Human Development Index (JHUCCP, 1999)

Population Growth and Development

Annual Population Growth Rate by
Human Development Index, by Region 1997



SOURCE: UNDP, 1999

High fertility and rapid population growth can pose problems for developing nations. They can hinder opportunities for economic development, contribute to high levels of infant mortality, and strain public resources. In addition, high fertility runs counter to the preferences expressed by millions of women in developing countries who want smaller families, (Bulatao, 1998). As more people choose family planning, fertility falls and population growth slows. Although fertility has fallen throughout the world, further declines would make a crucial difference in many developing countries. (JHUCCP, 1999)

According to World Health Organization (2001) estimates, sexual and reproductive health problems account for 18 percent of the total global burden of disease and 32 percent of the burden among women of reproductive age (15 to 44 years old) worldwide (WHO, 2001). Each year some 50 million women suffer illnesses related to pregnancy and childbirth, and over 529,000 die (WHO, 2005). By using family planning to prevent unwanted and high – risk pregnancies and to space births more widely, women can substantially reduce the risk of mortality and morbidity associated with complications of pregnancy and childbirth (Norton, 2005; WHO, 1994). Further, when family planning service are sufficient to meet the growing demand for contraception, abortion rates decline (Deschner and Cohen, 2003) A recent analysis has estimated that the money spent on providing modern contraceptive services in the developing world – US\$ 7. 1 billion in 2003 – prevents 1 87 million unintended pregnancies, 60 million unplanned births, 105 million induced abortions, 22 million spontaneous abortions, 215, 0000 pregnancy-related deaths each year, and the loss of 60 million disability-adjusted life years (DALYs)-16 million among women and 44 million among infants and children (Singh et al., 2003). In other words, every \$33,000 invested in family planning prevents one maternal death (Singh et al., 2003). .

Family planning saves lives and has long been considered a key aspect to socioeconomic development. Although this is widely acknowledged and well – documented, in recent years the attention and resources directed toward improving family planning programs in developing countries have been decreasing, even though need remains high. By one estimate, satisfying the unmet need for contraceptive services in developing countries would avert 52 million unintended pregnancies a year, thereby saving 1.5 million lives and preventing 505,000 children from losing their mothers (Singh et al., 2003). Family planning has lost focus amid recent shifts in international development strategies and priorities. Yet there are 201 million women in developing countries who need, but are not using modern contraception: 137 million women at risk of unintended pregnancy are not using any method, and an additional 64 million are relying on a less effective traditional method (Singh al. 2003). Many vulnerable groups, including the poor and adolescents, do not have ready access to good-quality family planning services. And the continually growing number of contraceptive users is straining the ability of family planning programs to meet their needs (Singh et al., 2003).

Family planning programs can prevent sexually transmitted infections (STIs), including HIV, by promoting male and female condoms for dual protection (Dehne and Snow ,1999; WHO,2005). They can also help fight the AIDS epidemic by preventing unwanted pregnancies among women infected with HIV and thus averting mother to child transmission of the virus (Gillespie, 2004; Stover et al., 2004). The health of infants and children also benefits from mothers' ability to space births more widely and to prevent high-risk pregnancies. Babies are more likely to be born prematurely, have low birth weight, be small for gestational age, die in infancy, and suffer from malnutrition when they are closely spaced (Norton, 2005; Rutstein,2005; Zhu,2005).

The use of modern contraception in the developing world prevents 2.7 million infant deaths annually, meaning that every \$2,600 invested in family planning prevents one infant death (Sigh et al., 2003). Family planning also has the potential to advance gender equity (USAID and WHO, 2005). It can increase women's educational, work, and life opportunities by preventing early pregnancies that force adolescent girls to drop out of school and by letting women have smaller, healthier families that make fewer demands on their time (USAID , 2005).

Having fewer, healthier children can reduce the economic burden on poor families, allow them to invest more in each child's care and schooling, and thus help break the cycle of poverty (UNFPA, 2005; WHO, 1994). Investing in family planning also opens a window of opportunity for faster economic growth in nations as a whole by reducing fertility and changing the population's age structure and dependency ratio. As the number of workers increases relative to the number of children they must support, savings and investment can increase. Countries that pursue sound economic and social policies can translate these economic gains into improved living standards and lower levels of poverty (Bloom et al. , 2003; Merrick 2002). According to one recent analysis, opening this demographic window could lower poverty rates in developing countries by 14 percent between 2000 and 2015 (Mason and Lee, 2004).

Contraceptive prevalence in the developing world has risen dramatically over the past four decades, from about 10 percent of women in 1965 to about 60 percent in 2000 (Ross and Stover, 2004). In Asia and Latin America, contraceptive prevalence is now at 71 percent and 64 percent, respectively, indicating that much of the demand for contraception has been met. However, contraceptive use in Africa is low. Contraceptive prevalence has grown more slowly in Africa, where use of any method is 27 percent and most couples use family

planning to space rather than limit births (USAID,2004). Despite the increase in contraceptive prevalence over the past 40 years, many women remain unprotected against unintended pregnancies. An estimated 29 percent of women aged 15 to 49 in the developing world have an unmet need for modern contraception: that is, they are sexually active, can become pregnant, and do not wish to have a child ever or in the next two years-but they are not using a modern contraceptive method. Most (20 percent) are not using any form of contraception, while others (9 percent) are using traditional methods, such as periodic abstinence or withdrawal that have relatively high failure rates (Singh et al. 2003). Levels of unmet need are highest in sub-Saharan Africa (63 percent) and are actually rising there because of growing interest in limiting family size (Singh et al. 2003).

People's decisions to adopt a contraceptive method are based, first and foremost, on whether they want another child. Interest in family planning has grown as desired family size has declined around the world-although it has dropped less in Africa than elsewhere (Ross and Stover, 2004). Decisions also are deeply influenced by whether family, friends, and the larger community oppose or support family planning (Ashford 2003; UNFPA, 2000). There is a substantial need for family planning and reproductive health in Africa, particularly in rural areas. Surveys of 21 sub-Saharan countries with a combined total of 46 million rural women of reproductive age (between 15 and 49 years) showed that 18 percent had unmet needs for family planning and reproductive health (DHS, 2002).

Knowledge and use of family planning have increased markedly in Ghana, and the country is well on its way to achieving its population policy goals. According to the Ghana Demographic and Health Surveys, overall contraceptive use among married women has steadily increased over the last 15 years, from 13 percent in 1988 to 25 percent 2003, with

use of modern methods increasing from 5 to 19 percent. The total fertility rate (FTR) declined from 6.4 births per woman in 1988 to 4.4 in 2003 (Ghana Statistical Service et al., 2004). Despite these gains, family planning continues to be relevant to National population policy and national aspiration as the actual use of contraception is quite low as compared to other countries such as those in North Africa and Latin America.

1.2: PROBLEM STATEMENT

While the benefits of family planning for the health and well-being of families throughout the world have been well documented, family planning programmes throughout sub-Saharan Africa are losing grounds as other health and development issues capture the attention of government and donors (USAID, 2002).

In Sub-Saharan Africa, population growth is currently 2.5%, the highest rate of growth in the world. (USAID,2002). Fertility has declined throughout the world, but African women still have between 5 and 6 children and in a few countries it is as high as 7.(USAID,2002). Although the use of modern contraceptives continues to increase across sub-Saharan Africa, the current contraceptive prevalent rate (CPR) of 13% among married women of reproductive age lags far behind that of North Africa (40%), Asia (excluding China – 43%), and Latin America -59% (USAID, 2002).

Sub-Saharan Africa (SSA) has yet to complete its demographic transition –that is the shift from high birth rates and death rates to low birth and death rates. SSA has the highest fertility in the world – 5.5 births per woman on average – double that of Asia and almost four times that of Europe (USAID, 2002)

Africa's birth rates are so high that even in the face of high AIDS mortality in some countries. its mid -2006 population of 767 million is projected to increase to 1.2 billion by 2025,(USAID, 2002) A major factor underlying high birth rates is the low use of modern contraception: only 15 percent of married women in Sub-Saharan Africa make use of modern contraceptive methods and in Western Europe, 70 percent use these methods. (WHO/ UNICEF/ UNFPA 2000). Unfortunately in Ghana only 25% of currently married women are currently using modern contraceptives. (Ghana Statistical Service et.,2004). In the Kwabre District, the 2005 District Health Directorate Annual Report indicated that the contraceptive prevalence rate was 22% which is below the national figure of 25%. There is, however, no documentation on the causes of the low utilization of family planning services. This study therefore seeks to assess barriers to contraceptive use/ low utilization of family planning services with the view to provide new insight into problem of low contraceptive use among women in fertility age.

1.3: RATIONALE FOR THE STUDY

While the relationship between fertility and economic development is complex and often reciprocal – that is each affects the other – research in developing countries has shown that reducing fertility can yield economic benefits both at the household and national levels. Some Asian countries, for example, experienced a “demographic bonus” when declines in fertility led to fewer young dependents and allowed governments to invest in improving health, extending education, and training large numbers of people for modern jobs. A healthier, better-educated and skilled workforce benefited the economies of these countries and made them more competitive globally. Smaller family size can benefit household in

terms of improved women's and children's health, greater total assets and greater involvement of women in activities outside the home. (UNFPA, 1998).

Family planning is an essential tool to raise the status of women. Without the ability to space and limit births, poor reproductive health can make women's empowerment difficult if not impossible (FHI,2006). In a large study of women in Zimbabwe, (with the second highest rate of contraceptive use in SSA) women who used family planning at younger ages were more likely to report that they were currently working outside the home,(FHI,2006). Ninety-two percent of women in the study said family planning influences women's success. Conversely, a study in Ghana found that high fertility reinforces traditional sex role, because girls often withdraw from school to help care for younger siblings (Shareen et al., 2006) Findings from the 1993 Situation Analysis study were an important impetus in bringing about the development of standardized family planning guidelines,(FHI,2006).For example, this study had found that almost 90% of service providers would not give any contraceptive method to a woman with fewer than three children, and that many would require spousal consent or that a woman be married before they would provide methods. Training in Ghana has attempted to break down these barriers, and one innovative approach has been to bring in satisfied clients during provider training to address method-specific biases and misperceptions (FHI,2006).

Measuring and explicating the potential barriers to contraceptive use represents an important step in promoting the effectiveness of a strategy for improving their use. Further increase in contraceptive use resulting from government intervention requires the identification of policy- amendable barriers to contraceptive use. In addition, resource and capacity constraints require a strategic and efficient use of funds. Hence an analysis of their barriers

to contraceptive use could inform the effort of policy-makers and programme officers to identify action plan that are both cost-effective and health improving.

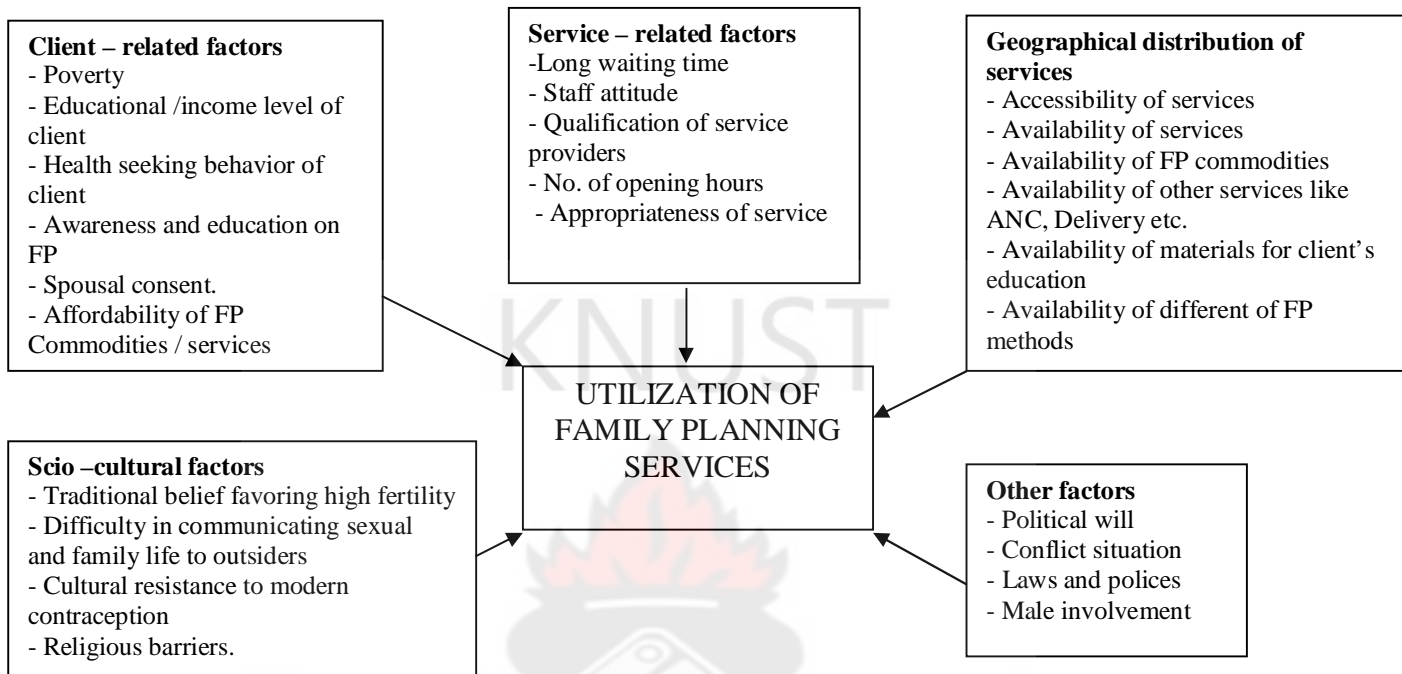
This study seeks to identify barriers to contraceptive use/low utilization of family planning services with a view to making recommendations as to how to tackle the problem of non consistent and non use of family planning services which has proven to significantly reduce abortion rate and unintended pregnancies. Data from this study and ongoing study could be used by the District Directorate of Health services in the District and collaborating organizations to develop and evaluate intervention to increase contraceptive use.

1.4: CONCEPTUAL FRAMEWORK

Family planning, identified as an essential component of primary health care in the Alma-Ata Declaration and of reproductive health at the International Conference on Population and Development, plays a major role in reducing maternal and newborn mortality. It contributes towards the achievement of the millennium development goals (WHO,2004)

The implementation of family planning services in Africa is challenged by poverty, poor access to family planning services and commodities, conflicts situations, inadequate coordination of programmes and dwindling donor funding. Traditional beliefs favouring high fertility, religious barriers and lack of male involvement have weakened family planning interventions.(WHO,2004).

Utilization of family planning services is determined by a lot of factors ranging from economic, religious, social, political and many others as illustrated below:



SOURCE: AKYEAH, JUNE 2007

1.5: RESEARCH QUESTIONS

- What is the level and knowledge of use of family planning services among women in fertility age (WIFA)?
- What are the socioeconomic and cultural factors that determine the utilization of family planning services?
- What is the quality of family planning services offered to client?
- What other service relevant to family planning are available?
- What is the fertility preference of the people in the Kwabre District?

1.6: PRINCIPAL OBJECTIVE

The main objective of the study is to assess the potential barriers to utilization of family planning services among women in fertility age (WIFA) in the Kwabre District.

1.6.1: SPECIFIC OBJECTIVES

- To assess the knowledge and use of family planning services.
- To assess the socio-economic and cultural factors that determine family planning acceptance and utilization.
- To assess the quality of family planning services offered to clients in the Kwabre District.
- To assess the geographical distribution and availability of family planning services.
- To determine the availability of other services relevant to client of family planning services.
- To determine the fertility preference of the people in Kwabre District.
- To assess the acceptance level of family planning services
- To assess the level of utilization of family planning services

CHAPTER TWO

LITERATER REVIEW

2.1: INTRODUCTION.

Universal human rights include freedom to decide when and how many children to bear and the right to attain the highest possible standard of reproductive and sexual health. Family planning programs can help achieve both of these rights by enabling people to space and prevent birth and to prevent HIV and other STIs (UNFPA, 2005).

Family planning has a major impact upon the health and well-being of families through reduction in maternal and child mortality, reduction of HIV transmission, and thereby, improvement in productivity and the socioeconomic status of society. Increased birth interval and a decrease in overall fertility can reduce infant mortality by as much as 50% and maternal mortality by 20%. Women living with HIV need to space and reduce births, not only to reduce mother to child transmission of HIV, but also to maintain their strength to enable them to take care of the children they have, thus ensuring their survival. (USAID, 2000)

Short birth intervals also decrease the survival chances of the preceding child. The arrival of a new baby means that breast-feeding stops suddenly and the mother has less time to devote to caring for the older child. A birth interval of less than 12 months raises the overall average risk of death for the preceding child between ages one and five by at least 70 to 80 percent; a birth within 18 months raises the risk by 50 percent or more (Hobcraft, 1987).

Postponing first births until the mother is at least 18 years of age is another important factor in reducing child deaths. An infant born to a teenage mother is more likely to be born too early and weigh too little at birth and is 24 percent more likely to die in the first month of

life than is an infant born to a mother aged 25-34 years; the increased risk continues through early childhood (Hobcraft,1991). Delaying first births until women are at least 18 years old could potentially reduce the risk of death for first born children by up to 20 percent on average and by up to 30 percent in a few countries (Hobcraft, 1991).

Having too many children also places children's health at risk. Using contraception to end childbearing after four births helps reduce infant mortality rates. Births of order four and higher are associated with higher infant mortality in Latin America and Asia (Ross and Frankenberg, 1993). A study in Bangladesh found that the infant mortality rate for women who had 5-6 children was about three times the rate of those with only two children (Rahman and Nessa,, 1989). A study in Egypt found 38 percent higher infant mortality among fifth and subsequent births than among third-and fourth-order births (Ibrahim, 1993).

The literature is reviewed under the following headings:

- a) Knowledge about family planning services and contraceptive use.
- b) Socio-economic and cultural factors that influence the utilization of family planning services
- c) The quality of family planning services offered
- d) Geographical distribution and availability of family planning services
- e) Integration of Family planning services with other services
- f) Fertility preference and utilization of family planning services

2.2: KNOWLEDGE ABOUT FAMILY PLANNING METHODS AND CONTRACEPTIVE USE

Modern contraceptive methods, by improving reproductive health, have a positive impact on women's overall health and quality of life. To exert this beneficial effect, correct and consistent use of the contraceptive method chosen by the clients is necessary. This is achieved by promoting correct knowledge via good quality family planning counseling. One of the factors which might affect efficacy of family planning counseling is the source of information or the counselor. It has been reported that, the most adequate source of information on family planning is the general practitioner but other sources of information on this topic have also been cited (Topsever et al., 2006)

To help people make informed choices, communication can stress people's right to information about personal health and their ability to make family planning decisions for themselves. Messages can point to the range of contraceptive methods available, describe the characteristics of specific methods, and tell where and how to find out family planning information and service. Communication can help people get the most out of family planning counseling by discussing the need and responsibility to ask questions and obtain answers from family planning providers. (JHUCCP, 2001)

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. (JHUCCP, 2001)

The purpose of family planning counseling is to help the client make informed choices about reproductive health and family planning issues. Informed choice, which should- among other topics-cover knowledge transfer about the mode of action of the chosen method, has been shown to improve efficiency and compliance to contraceptive method use. Thus, correct knowledge about the mode of action of the method chosen, can be considered an efficacy outcome for family planning counseling. (Topsever et al., 2006)

Family planning counseling which covers knowledge transfer about contraceptive mode of action, by enabling informed choice, improves compliance to and efficiency of contraceptive methods (Topsever et al., 2006). Urban areas provide greater exposure to information about family planning through print and broadcast media, and they provide a greater range and supply of family planning services and distribution outlets than rural areas, (IFPP, 2006).

A study conducted in Guatemala 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 have 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).

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 (USAID,2002). Effectiveness, contraindications, advantages, disadvantages, possible side effects, and the management of side effects are frequently not discussed with clients during FP counseling. 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 (USAID, 2002).

2.3: SOCIO-ECONOMIC AND CULTURAL FACTORS THAT INFLUENCE UTILIZATION OF FAMILY PLANNING SERVICES

Human reproduction is viewed in most of rural Africa as a natural process that should not be interfered with artificially. The lack of culturally – appropriate information and education reinforces this belief. And the fact that family planning services are almost exclusively targeted towards women excludes men who are, in most cases, responsible for making reproductive health decisions. For lack of adequate information and because of many unfounded rumors, rural African men are generally not in favor of family planning (Haile et al.,2000).

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 nonuse 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 1987; 1990). However, recent research in the Kassena- Nankana area in the Upper East region demonstrated that traditional religious messages regarding fertility behavior can be influenced by the prevailing social and economic climate (Adongo et al. 1998)

Studies concerning the family planning beliefs of religious leaders are rare and, when conducted, have typically relied on small samples. 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 favorably disposed toward family planning than other elite groups (such as teachers and community leaders (Carol, 2000).

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 latter reported having preached against family planning (Carol, 2000).

This suggests that religious leaders should not be ignored as potential proponents 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 (IFPP, 2000). 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.

Importantly, this demonstrates that most religious leaders interpret family planning to represent an action that is permitted within the Islamic world view (IFPP, 2000)

Religious leaders and, to a lesser degree, the public in Jordan however, favor use of contraceptives to increase birth intervals and not, for the most part, to limit family size. (IFPP, 2000)

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. (Castro 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 behavior and partly explain the wide fertility gap between educational strata. (Castro Martin; et al., 1996)

2.4: THE QUALITY OF FAMILY PLANNING SERVICE OFFERED

Access to quality family planning service can significantly reduce abortions. Research finding in various countries demonstrate that women who have access to better family planning services are more like to use contraception, are less likely to have unintended pregnancies, and thus have fewer abortions. In settings where family planning services are introduced and promoted, abortion-related deaths decline as contraceptive use rises (USAID, 2001).

Quality of care also influences contraceptive decision-making. Good care can encourage potential family planning clients to seek out, adopt, and / or continue using contraception – and to spread the word to others (Bertrand et al., 1995). Quality of care depends on offering clients a full range of methods, giving them accurate and complete information, ensuring providers' technical competence, enhancing interpersonal relations between providers and clients, providing follow-up and continuity mechanisms, and offering an appropriate constellation of services (Bruce, 1990).

Health advocates, human rights activists, researchers, program managers, governments and donors generally agree that quality of reproductive health care is important. Clients deserve to receive high-quality services and to be treated with dignity and respect when obtaining services. From this human rights perspective, there is little need to demonstrate that improvements in quality can affect clients' reproductive behavior and health. (IFPP, 2003).

Evidence from various settings suggests that receiving good-quality family planning services encourages acceptance or continuation of contraceptive use (IFPP, 2003)

Residing in an area with good-quality services tends to encourage contraceptive use. For example, a multivariate analysis using a linked Demographic and Health Survey and

situation analysis data set from Peru showed that women living in high-quality service environments were significantly more likely to be practicing contraception than were those living in poor-quality service environments (IFPP, 2003).

Other studies have reported similar findings. For example, a study in Morocco showed that availability of family planning clinics and the numbers of contraceptive methods available at the community level were associated with adoption, continuation and switching of contraceptive methods (Jacques et al., 2000)

The most rigorous analysis on this subject comes from a panel study in Bangladesh in which perceptions of good-quality care were linked to contraceptive use. In that study, persons who believed they had received good-quality care from fieldworkers were more likely to adopt and continue use of a contraceptive method. More than 3,000 reproductive-age women were asked about their perceptions of the care they received from a family planning fieldworker who visited them in their home. On the basis a multivariate analysis, the researchers concluded that women who reported receiving a high level of care were 27% more likely to adopt contraception in the next 30 months than were those who received medium or low levels of care (Susheela et al., 2000). Similar findings were reported on contraceptive continuation among 3,497 users of oral contraceptives, IUDs, injectable, condoms or vaginal foaming tablets who were followed from initial acceptance to method discontinuation, loss to follow-up or the end of the observation period. Women who reported receiving moderate (22%) or high (72%) quality care were more likely, to continue using a method (IFPP, 2003).

Research findings have indicated that receiving good-quality care at initiation of contraceptive use is positively associated with continuation of use (Larry et al., 2006).

Contraceptive decision-making is a complex process in which persons considers various factors, including the context of their lives, both familial and personal, as well as the psychological and physical ease with which they can obtain and use contraceptives. Given the many influences on contraceptive use, it is noteworthy; that quality of care emerges as a significant determinant in a multivariate model. (IFPP, 2003)

2.5: GEOGRAPHICAL DISTRIBUTION, ACCESSIBILITY AND AVAILABILITY OF FAMILY PLANNING SERVICES

It is widely accepted that family planning services are essential to fertility decline. The proximate determinant of ongoing fertility decline in the developing world has been the widespread adoption of contraception. Previous studies have shown that the availability and accessibility of family planning services is an important determinant of contraceptive use (JHUCCP, 2000).

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) have estimated (UNFPA, 2000).

The provision of family planning services in Africa is full of barriers that are unnecessary and often discouraging to potential users. Such barriers include age and parity requirements for certain methods, requirements of husbands' consent, refusal to serve unmarried women, opposition to outreach program , health professionals who believe that family planning should be provided only in a medical set up, and unnecessary and time-consuming medical and laboratory examinations. 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 (JHUCCP, 1999). 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. (JHUCCP, 1999).

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 nonuse 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. (IFPP, 2002) 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. (IFPP, 2005)

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." (NHRI, 2000).

2.6: INTEGRATION OF FAMILY PLANNING SERVICES WITH OTHER SERVICES.

The way in which reproductive health services are offered, or at least how policies recommend they should be offered, has been undergoing considerable revision over the past few years. In most cases, these revisions focus on reorganizing the way in which services are configured, and the configurations receiving the most attention are those that integrate

STI and HIV prevention, detection and management with family planning and antenatal care. There are several reasons for this in the Sub-Saharan region (Askew and Ndugga, 2002)

Reproductive tract infections (RTIs), particularly those that are sexually transmitted (STIs), continue to be a serious public health problem in Sub-Saharan Africa, with the World Health Organization (WHO) estimating that 12% of 15-49-year-olds have a curable STI. Not only are the prevention and management of STIs important public health concerns in themselves, but the presence of some STIs enhances the sexual transmission of HIV, and STI management has been shown to be effective in reducing HIV transmission (Ian Askew et al., 2002). Moreover, the Programme of Action of the 1994 International Conference on Population and Development (ICPD) emphasized reorienting health care systems to enable women to obtain comprehensive and quality reproductive health services. Finally, configuring services jointly rather than separately has perceived financial benefits for health systems (Ian Askew et al., 2002).

The clients of public-sector programs providing maternal and child health care and family planning services are almost exclusively women using family planning, pregnant women and women with newborn babies—women who usually are married and are considered at low risk for STIs. Data from a variety of sources indicate that in some populations, 2 – 7% of pregnant women and of women using family planning have a cervical gonorrhoea, Chlamydia or syphilis infections (Maggwa et al., 2002). Moreover, trichomoniasis—a sexually transmitted vaginal infection—has been diagnosed in 4 – 34% of such women. Non-sexually transmitted vaginal infections such as candidiasis and bacterial vaginosis are also common among these women— 8 – 38%— but present less serious consequences to the woman and her fetus or newborn (Ndugga, 2002). Finally, 25-30% of pregnant women in several

parts of the region are infected with HIV. These data indicate that many women served by maternal and child health and family planning programs should no longer be considered as low risk and that efforts to reach them through these programs are justifiable on a public health basis. (IFPP, 2002)

In the 1990s, several international reproductive health organizations heeded the call to link abortion clients with family planning services to break the cycle of unintended pregnancy and abortion. Post abortion family planning programs were implemented in a number of countries. Where abortion is illegal, these programs are geared toward linking women who have undergone treatment for incomplete abortion with family planning services. Where the procedure is legal, these programs focus on providing contraceptive information and services to abortion clients to help them avoid further unintended pregnancies (IFPP, 2002).

Turkey, which has a history of progressive policies and legislation designed to improve maternal and child health, legalized family planning education and the provision of temporary contraceptive methods in the mid- 1960s; legalization of abortion and sterilization followed later, in 1983. Currently, Turkey's family planning program is relatively advanced and has helped the country achieve a total contraceptive prevalence rate of 64% (Nguyen et al.,2002).

Turkey's abortion rate fell from 45 abortions per 1,000 women aged 15-49 in 1988 to 25 per 1,000 in 1998, and the proportion of pregnancies resolved by abortion decreased from 24 per 100 to 16 per 100 over the same period (IFPP, 2001)

A study in Zimbabwe found that relying on family planning clients to spontaneously report STI symptoms was less effective in identifying women with an infection than was asking all family planning clients about –and examining them for –symptoms and signs. With the latter approach, 64% of family planning clients who had laboratory evidence of an RTI were

identified and correctly manage. However, 27% of family planning clients without an infection were wrongly treated (FHI, 2004).

Another study in Mexico found that if women seeking family planning services are informed about family planning methods and STI risk factors and prevention, and are then given the responsibility of choosing a method, they are more likely than women whose method of choice is based on the physician's judgment to choose the condom rather than the IUD; this difference was even more pronounced for women having a cervical infection. This suggests that giving women sufficient information to assess their own risk and then giving them the responsibility of choosing a method themselves is as effective as, if not more effective than, risk assessment algorithms used by providers.

A rapid assessment of family planning and VCT services in Ghana was conducted in order to explore the opportunities for and challenges to strengthening the linkages between these two services. For the most part, the policy-makers, program managers, service providers, and clients interviewed as part of this assessment thought that integrating family planning and VCT services offers an opportunity to make the best use of available facilities, logistics, and personnel to provide comprehensive, convenient reproductive health care. (USAID, GHS, FHI, 2004)

2.7: FERTILITY PREFERENCE AND UTILIZATION OF FAMILY PLANNING SERVICES.

Until recently, fertility and family planning research in developing countries, as well as policy and program formulation, has generally relied on data collected from women.

Increasingly, however, attention is being paid to including men. This is because, information that has become available from surveys conducted over the past decade suggests that men

and women do not necessarily have similar fertility attitudes and goals. (Bankole and Singh, 1998)

Although women bear children and most modern contraceptive are female methods, childbearing has an impact on men's lives too. This impact may be felt financially, if men accept the responsibility of supporting their children, and in a range of other ways, including through the health and well-being of their wives and children. Often, a man's social status is also affected when he becomes a father. (Becker, 1996)

The male partner may play an important role in decision-making regarding contraceptive use and the timing and number of a couple's births. In some countries or among some social groups, the male partner has greater influence than his spouse. (Lasee .et all, 1997) In Ghana, the wife's attitude toward contraception is strongly influenced by the husband's attitudes and background characteristics, especially education, but the husband's views are not similarly influenced by his wife. (Ezeh , 1993)

The result of a survey conducted in 18 developing countries revealed that there is more agreement between spouses on the ideal number of children in Asia, Latin America and North Africa than in Sub-Saharan Africa. According to the survey, although levels of agreement as to fertility intention are similar across all regions, couples in Asia, Latin America and North Africa are more likely to agree to stop childbearing than to have another child, whereas the reverse is the case for couples in Sub-Saharan Africa. (IFPP, 1998)

Throughout Sub-Saharan Africa, husbands and wives whose fertility intentions agree generally want more children. Of all couples in agreement, the proportion who want more children ranges from 53% in Kenya to 99% in Niger. This supports the finding that a high proportion of both husbands and wives want a large family in Sub-Saharan Africa. (IFPP, 1998).

One important implication of disagreement about desired family size and fertility intentions relates to how it affects contraceptive use. However, even when spouses agree, potential areas of conflict remain. For instance, in many countries, the DHS asks men and women who say they intend to have another child how long they would like to wait before doing so; responses indicate that husbands and wives may disagree as to whether they want to have the next birth soon (within two years) or they want to postpone it. (IFPP, 1998)

Among couples in which both spouses want more children, the proportion who disagrees as to the timing of the next birth ranges from 21% in Brazil to 40% in Burkina Faso and Uganda. This implies that in the majority of couples, the spouses agree either to have another child sooner or to wait. Among those in disagreement, there is some evidence of a gender difference concerning which partner wants the child sooner than the other. In six of the nine Sub-Saharan African countries for which data are available, husbands want the next child sooner than their wives (IFPP, 1998).

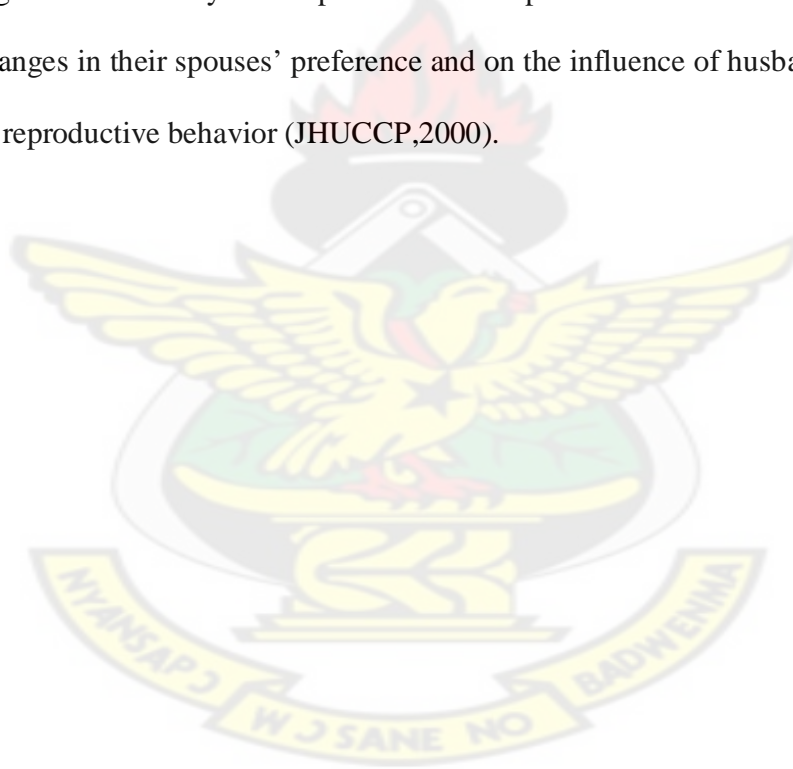
Another study also indicated that, polygamy may be associated with men's reproductive preferences: Men may either have more than one wife because they want many children or want many children because they have more than one wife. (Westoff . et al 1995)j

The fertility preferences of wives in polygamous unions are less clear: on the one hand, wives may want many children in order to compete favorably with co-wives in terms of childbearing and status in the household. (IFPP1999).

When spouses' fertility intentions disagree, there is no clear pattern with respect to the direction of contraceptive use. In some countries, modern contraceptive use is higher when only the husband wants to stop childbearing. In other countries, however, it is higher when only the wife wants to stop having children. (IFPP, 1998)

Findings suggest husbands' preferences have a greater influence than wives' preferences have on contraceptive use in Sub-Saharan Africa. (IFPP, 1998).

Furthermore, results indicate that married women probably have a better understanding of the benefit of spacing their children and the danger associated with having births in quick succession than their husbands have. Therefore, contraceptive use either to space births or to limit family size is likely to be initiated by wives rather than their husbands. But success in achieving a smaller family will depend on how responsive husbands' fertility preference are to the changes in their spouses' preference and on the influence of husbands' preferences on couples' reproductive behavior (JHUCCP,2000).



CHAPTER THREE

METHODOLOGY

3.1: PROFILE OF STUDY AREA

3.1.1: GEOGRAPHY

The Kwabre District is a new district and Peri-urban one in the Ashanti Region. The district was separated from Afigya-kwabre District.

It is closest to the Regional Capital Kumasi, which shares boundary on the South. On the north of the district is Afigya- Sekyere District. East is Ejisu-Jauben District and on the West are Ofinso and Atwima District. The district has total land area of about 1254.06km. The district capital is Mampong, situated 14.4km on the Kumasi-Mampong trunk road.

Kwabre has a very good trunk road running from Kumasi to Mampong Scarp. Meanwhile most of the feeder roads are not motorable and also do not have public transport plying on them.

Kwabre district has two (2) well defined seasons, which begins from December to February with the North East Winds.

3.1.2: DEMOGRAPHY DATA

The district is made up of eighty- nine (89) communities and has a total population of 194,631.as per the 2000 population census.

TARGET POPULATION	WIFA 15-49(24%)	EXP PREG/DEL (4%)	CHDN 0-59 MTHS (16:5%)	SCH AGE (36.4%)	ADOLESCENTS (21.8%)	ADULT <64 YRS (6.1%)	TOTAL
MAMPONTENG	18,684	3,689	14,985	33,567	20,103	5,6325	77,8527
ABOASO	6,540	1,035	4,209	9,429	5,647	15,80	27,248
ASONOMASO	8,408	1,118	4,544	10,178	6,095	17,06	35,035
ABOABOGYA	4,671	642	2,606	5,838	3,497	978	19,563

3.1.3: Sub district structure

The district is divided into five sub-districts or health areas after considering how accessible static health facility is to the people living in the various parts of the district.

These are :

- Mamponteng
- Afrancho
- Aboaso
- Aboabogya and
- Asonomaso

3.1.4: ADMINISTRATIVE STRUCTURE

The Kwabre District lies approximately between latitude 6.79 North longitude 1.56.

The District Administrative Structure is of both political and traditional. The political structure is made up of the District Chief Executive and District Co-coordinating Director controlling affairs. Traditional Chiefs and Queen Mothers of the various surrounding communities also have the Asantehene as their king and overlord chief .

The chiefs own the land and leave out portions to individuals when necessary. Wednesdays and Fridays are set aside from farming activities and most often these days are used for communal labour.

There are five police Stations in the District with its Headquarters found in Mampong. Apart from this, the district has a National Service Secretariat also at Mampong. Also a numbers of TBAs have been trained to help women during pregnancy and labour.

3.1.5: SOCIO-ECONOMIC ACTIVITIES

A greater number of people in the District are cash Crop farmers. Their main produce is a palm nut. Also every one in the district is a subsistence farmer. Foodstuffs grown include plantain, Cassava and Maize.

The MOH, District Administration, Ministry of Education and Education and Educational Institution offer a few clerical job existing in the district.

Most of the women engage in petty trading, whilst most of the men are wood carvers, stone and sand winners and Kente- weavers. Very little can be written about in terms of Social

Amenities. A pipe borne- water project, which was constructed, could only benefit inhabitants of Mampong the District capital. Majority of the inhabitants therefore obtain Water mainly from streams whilst a few others depend on hand dug wells.

3.1.6: ENVIRONMENTAL SANITATION

Generally Sanitation is poor in the district. There was no good water drainage system in the communities. Disposal of refuse in all cases was by crude dumping. However with respect to human excreta, disposal there was some few pit latrines and KVIPs in the District. Therefore the major public health problems of the district include inadequate supply of portable water and sanitation facilities.

3.1.7: SOCIAL AMENITIES

Most of the communities in the district are connected to the national electricity grid while others are still without electricity. Those without electricity obtain electricity form private fuel generation.

3.1.8: EDUCATIONAL FACILITIES

The following categories of educational facilities can be found in the district.

SSS	7
JSS	75
PRIMARY	91
NURSARY	83

The district can also boast of a library facility.

3.1.9: HEALTH INFRASTRUCTURE

The district has two (2) hospitals, Ten (10) Health Centers and three (3) Clinics and nine (9) maternity homes.

❖ GOVERNMENT	-	11
❖ MISSION	-	2
❖ PRIVATE CLINIC	-	2
❖ PRIVATE MATERNITY HOMES	-	8
❖ PHARMACY SHOPS	-	3
❖ chemical shops	-	67
TOTAL	-	94

3.2: STUDY METHODS AND DESIGN

The study made was a cross-sectional survey conducted in three sub-districts in the Kwabre District. The data were collected by interviewing respondents, health care providers and observing the process of providing family planning services for women in the clinics and exit interview of client.

The interview covered the range of family planning methods that are available, the facilities that are available and their states. Visits were conducted at the family planning clinic at the District Hospital and another health centre.

3.2.1: SELECTION PROCEDURE.

A multistage sampling method was used. By simple random sampling, three sub-districts were selected out of the five sub-districts in the Kwabre District. In each sub-district, two communities were selected. Below is the selection procedure:

Kwabre District



Sub - District



Communities



Compound



Household



Re spondent

3.3: DATA COLLECTION TECHNIQUES AND TOOLS

The study made use of only primary data. The main data collection tool was the questionnaire, and the data collection technique was interviews. Another data collection technique employed was observation. Two family planning clinics were also visited during which the processes of giving family planning services were observed. Client exit interviews were conducted to find out the relationship between family planning client and health providers in terms of how client are treated, the level of privacy enjoyed, the range of family planning methods made available to clients.

3.3.1: IN-DEPTH INTERVIEW

Here, the interviewer read the already prepared questions in the same manner for all respondents; allowing the same amount of time. Much care was taken in order to ensure that the level of literacy of the respondents did not interfere with obtaining the data.

Respondents were allowed to ask questions regarding reproductive health and others issues.

The questionnaires were checked for completeness after the respondent completed it, before the interviewer left the household.

3.4: STUDY POPULATION

The study population included women in fertility age (15-49 years). The study considered women who are using and those who are not using family planning methods and some health workers who provide family planning services to clients.

3.5: STUDY VARIABLES

VARIABLE	OPERATIONAL DEFINITION/INDICATORS	SCALE OF MEASUREMENT
Education	The completed level of formal education	Ordinal
Age	Number of completed years	Interval
Knowledge of respondent	Information provided during interaction which allows client to choose a method	Nominal
Socioeconomic and cultural factors	Income and educational level, the beliefs and practices of the people	Ordinal/nominal
Quality of service	Client-provider interaction, availability of different methods of family planning	Nominal
Geographical distribution and availability	Nearness of family planning centre to potential client	Nominal
Other services available	Services like ANC, VCT etc that are present in addition to family planning	nominal
Fertility preference	Ideal number of children a couple wants to have	ordinal

3.6: SAMPLE SIZE DETERMINATION

A sample of 400 respondents were randomly selected from 6 communities in the Kwabre District. Please see appendix A for sample size calculation.

3.7: PRETESTING

The pretesting of the interview guide was done at Mampong which has similar characteristics as the selected communities. Based on the outcome of the pretesting, the questions were modified accordingly by rephrasing sentences which were not clear and gave different intended meaning and understanding by the respondent.

3.8: DATA HANDLING

To check for completeness and accuracy of data, questionnaire administered were numbered serially. Also, completed questionnaire were checked thoroughly on daily basis for errors and mistakes. Quality control checks were also performed.

3.9: DATA ANALYSIS

The analysis of data was done at the end of the data collection. Analysis was done on computer using STATA. Dummy cross-tabulation were constructed and keyed into a computer from which were made graphs and pie charts.

3.10: ETHICAL CONSIDERATION

Ethical clearance was sought from the School of medical sciences, KNUST, Regional and District Directorates of Health Services and the District Assembly. Clearance was also sought from landlords/ladies in each household. Finally, participants were informed about the study and about their right to participate or not to participate in the survey.

3.11: LIMITATION OF THE STUDY

The study involves relatively small sample that may not be statistically representative of all women in fertility age in the Kwabre District. The conclusions and use of figures are therefore substantially limited to those who participated in the study.

Also, the time earmarked for the study was too short to be able to conduct such an intensive study.

3.12 ASSUMPTIONS

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

CHAPTER FOUR

RESULTS

This chapter presents the results obtained from the survey conducted between June and August 2007 in six communities randomly selected from three sub districts in the Kwabre District.

Table 4.1: DISTRIBUTION OF SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS.

Characteristic	(N=400)	%	Characteristic	(N=400)	%
Age			Level of education		
<20	73	19	No education	36	9
20-35	269	67	Primary	46	12
36-45	49	12	Middle or JSS	268	67
>45	9	2	Secondary or SSS	46	12
Total	400	100	Others or Tertiary	4	1
			Total	400	100
marital status			Occupation		
cohabitating	123	31	Apprentice	57	14
divorced	32	8	Dress making	20	5
married	181	45	Farming	44	11
single	64	16	Hair dressing	42	10.5
Total	400	100	Students	25	6
			Teaching	5	1
Religion			Trading	165	41
christian	369	92.3	Unemployed	42	10.5
muslim	18	4.5	Total	400	100
no Religion	12	3			
Traditionalist	1	0.25			
Total	400	100			

SOURCE: FIELD WORK. AUGUST 2007

As indicated in the above table, most of the women (269) (67%) included in the survey fall within the age group of 20-35 years; only a few (9) (2%) were above 45 years of age. Most

of them (181) (45%) were married .Those who were single were only a few (64) (16%), while 123 (31%) were not married but were in sexual relationship through concubinage.

Christians constituted the majority (369) (92.25%) of the sampled population, followed by Muslims (18) (4.50%).Some 12 (3%) of the respondents were not affiliated to any religion and only one was a Traditionalist.

About three out of five (67%) of the respondents were middle school or JSS leavers. Almost a tenth (46) (12%) had received secondary education. There were equal proportion (46) (12%) of primary and secondary school leavers in the sampled population.

Majority (165) (41%) of them were traders with the proportion of farmers and hair dressers being 11% and 10.5% respectively.

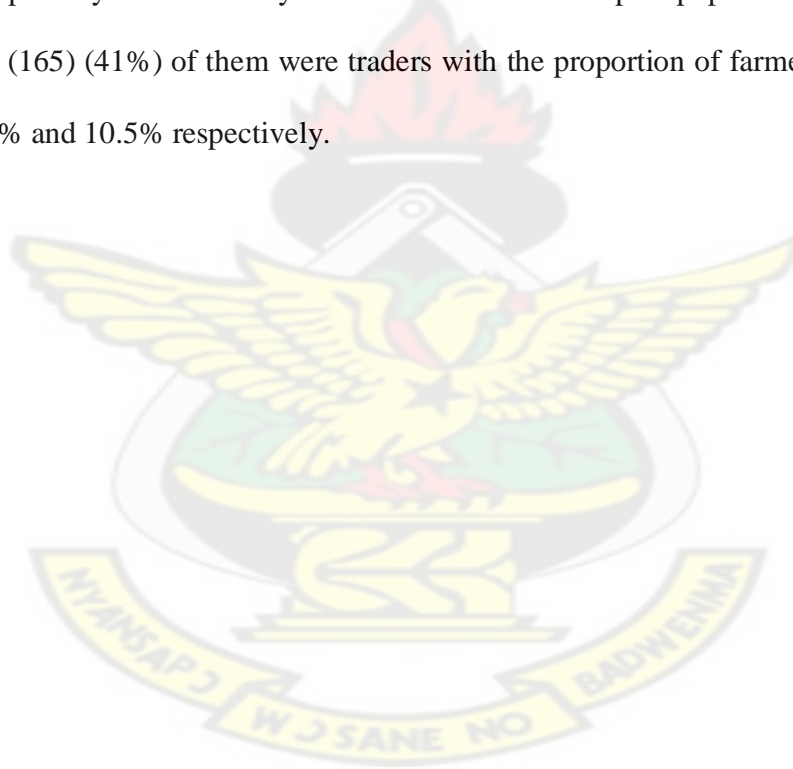


Table 4.2: DISTRIBUTION ON RESPONDENTS' AWARENESS OF CONTRACEPTIVE METHODS.

NUMBER OF CONTRACEPTIVE METHODS RESPONDENT IS AWARE OF	N=40 (freq)	%
0	6	1.5
1	27	6.77
2	83	20.75
3	122	30.50
4	64	16.00
5	51	12.78
6	28	7.02
7	12	3.01
8	4	1.00
9	3	0.75
Total	400	100

SOURCE: FIELD WORK, AUGUST 2007

Table 4.2 gives a summary of the range of family planning methods that respondents were aware of. Most of the respondents (122) (30.50%) were aware of at least three methods of contraception. Only a small proportion (6) (1.5%) were not aware of any method of contraception. Over a third (35.80%) of the respondents were aware of 4-6 contraceptive methods, while 19 (4.76%) were aware of 7-9 methods of contraception.

About 367 (91.73%) of the respondents knew at least two contraceptive methods, meaning that their level of knowledge of family planning was quite high.

4.1: KNOWLEDGE ABOUT FAMILY PLANNING AND CONTRACEPTIVE USE BY RESPONDENTS.

Out of the 400 respondents sampled, 237 (59.4%) had ever used contraceptive before, while 131 (32.8%) were using contraceptive as at the time of the survey. This implies that about 26.57% of the sampled population were using some form of contraceptive but had stopped.

Table 4.3 DISTRIBUTION OF CONTRACEPTIVE USE BY RELIGION.

RELIGION	USERS	NON-USERS	TOTAL
Christians	123	244	367
Muslims	4	14	18
No religion	4	10	14
Total	131	268	399

Out of the 367 Christians sampled in the survey, only 123 (33.5%) of them were using some form of contraception. Muslim users were only 4 (22.2%) out of the 18 Muslim respondents with the remaining not affiliated to any religion.

Table 4.4: DISTRIBUTION OF CONTRACEPTIVE USE BY EDUCATIONAL LEVEL.

Educational level	Users	Non-users	Total
No education	4	32	36
Primary	16	30	46
Middle/JSS	89	179	268
SSS/Secondary	21	25	46
Tertiary	1	3	4
Total	131	269	400

Out of the 36 respondents who had not receive any formal education, only 4 (12.5%) were using some form of contraception. There was a gradual increase of 16 (34.5%), 89 (33.2%), 21 (45.6%) and 1 (25%) for primary, middle/JSS, Secondary/SSS and tertiary school leavers, respectively.

A chi-square analysis revealed no association between educational level and use of contraception ($\chi^2_{df=4} = 9.4044, p > 0.05$)

Table 4.5: DISTRIBUTION OF CONTRACEPTIVE USE BY MARITAL STATUS

MARITAL STATUS	NON USERS	USERS	TOTAL
Cohabiting	64 (23.88%)	60 (45.80%)	124
Divorced	23 (8.58%)	9 (6.90%)	32
Married	121 (45.14%)	58 (44.27%)	179
Single	60 (22.38%)	7 (5.34%)	67
Total	268 (100%)	131 (100%)	399

Among current users, 58 (44.27%) were married women, 60 (45.8%) were in some form of sexual relation and the remaining were single and divorced women.

There were almost equal proportion of users and non-users of contraception among married women (45.1% non-users versus 44.3% users)

Table 4.6: DISTRIBUTION OF CONTRACEPTIVE USE BY OCCUPATION.

OCCUPATION	USERS	NON-USERS	TOTAL
Apprentice	21	36	57
Dress making	7	13	20
Farming	7	37	44
Hair dressing	16	26	42
Student	8	16	24
Teaching	1	4	5
Trading	57	108	165
Unemployed	14	28	42
Total	131	268	399

SOURCE: FIELD WORK, AUGUST 2007.

About half 57 (43.5%) of the users were traders, 21 (16%) were apprentice, 16 (12.2%) were hair dressers with the remaining 37 (28.2%) being farmers, students and others.

Table 4.7: DISTRIBUTION OF CONTRACEPTIVE USE BY AGE.

AGE (Years)	USERS	NON-USERS	TOTAL
Less than 20	19	54	73
20-35	95	173	268
36-45	14	35	49
Above 45	3	6	9
Total	131	268	399

4.2: FACTORS AFFECTING THE USE OF FAMILY PLANNING SERVICES.

The main reason cited by non-users for non use of contraception was their side effect. Most of them 94 (35%) reported side effect, 61 (22.7%) were not practicing sex and as such were not using any form of contraception and 54 (20.1%) desired to have more children and would therefore not use contraceptive methods.

Table.4.8: DISTRIBUTION OF REASONS FOR NON-USE OF CONTRACEPTIVE.

Reasons for non-use of contraceptive	N=268	%
Fear of side effect	94	35
Not practicing sex	61	22.7
Desire for more children	54	20.1
Lack of information	49	18.2
Non-affordability	10	3.7
Total	268	100

4.3: QUALITY OF FAMILY PLANNING SERVICES OFFERED TO CLIENTS.

Table 4.9: DISTRIBUTION OF AVERAGE TIME SPENT BY CLIENTS AT THE CLINIC.

Average time spent	N=36	%
Less than one hour	14	38.9
One hour	17	47.2
More than one hour	5	13.9
Total	36	100

Among the respondents who receive family planning services from clinics and hospitals, 29 (80.5%) responded that they spend less time at these centers during service delivery.

Again, most (60%) of them said many methods of family planning are mentioned to them and they were given the opportunity to choose a method that will suit them.

Table 4.10: DISTRIBUTION OF CONTRACEPTIVE METHODS CLIENTS WERE MADE AWARE OF AT CLINICS/HOSPITALS

No of methods	N=36	%
3	7	19.4
4	9	25
5	10	27.8
6	6	16.7
7	2	5.5
8	2	5.5
Total	36	100

Half 18 (50%) out of the 36 respondents who receive family planning services from hospitals and clinics said they arrived at their current family planning method by their own choice while 22.2% said they were imposed on them by the service providers.

Even though most respondents 31 (86.1%) attested to the fact that providers wanted to know their marital status and the number of children they have before offering a service, majority said they were satisfied with the service rendered to them by these providers.

Most, 23 (63.9%) out of the 36 respondents indicated that they were satisfied while about one third 10 (27.8%) said they were very satisfied with the services offered to them.

Again, four out of five 29 (80.6%) of the 36 respondents who receive family planning services from clinics and hospitals said that many methods of family planning were mentioned to them.

Based on the above results, potential clients must have access to various methods of contraception, but unfortunately the range of family planning methods offered to clients were few. According to interview with health providers, the main contraceptive methods offered are contraceptive pill, contraceptive injection and condom.

4.4: GEOGRAPHICAL DISTRIBUTION AND AVAILABILITY OF FAMILY PLANNING SERVICES.

A tour of the District showed that potential clients of family planning services needed not to travel long distances to access family planning services. Health providers also go on outreach programmes to offer both antenatal and family planning services to people in the remote parts of the District. Therefore, family planning services are readily available to the people.

4.5: INTEGRATION OF FAMILY PLANNING SERVICES WITH OTHER SERVICES

According to interview with health providers in the selected family planning clinic, there has been integration of only antenatal care services with family planning services. However, services like voluntary counseling and testing and STIs were not available at those clinics.

4.6: FERTILITY PREFERENCE OF RESPONDENTS

Among the 400 respondents interviewed 300 (75%) of them wanted four or more children in their entire life.

Table4.11: DISTRIBUTION OF RESPONDENTS DESIRED NUMBER OF CHILDREN

Desired No of children.	N=400	%
1	3	0.7
2	17	4.3
3	80	20
4	155	38.8
5	67	16.8
6	39	9.8
7	10	2.5
8	12	3
9	3	0.7
10	14	3.5
Total	400	100

Most 334 (83.5%) of the respondents wanted to have the next child after 3 years or more.

Table 4.12: DISTRIBUTION OF RESPONDENTS BY THEIR DESIRED SUCCESSIVE BIRTH INTERVAL.

Desired successive birth interval	N=400
1	5
2	61
3	111
4	76
5	74
6	23
7	6
8	10
9	15
10	14
11	4
Total	399

SOURCE: FIELD WORK, AUGUST 2007.

On sex preference, most of the respondents (245) (61.25%) attached importance to the sex of children they wanted to bear, but only a small proportion (35) (8.75%) responded that they would like to continue giving birth until their sex preference is met.

CHAPTER FIVE

5.0: DICUSSION.

5.1: KNOWLEDGE ABOUT FAMILY PLANNING AND CONTRACEPTIVE USE BY RESPONDENTS.

Most of the respondents (122) (30.5%) were aware of at least three methods of contraception. Only a small proportion (6) (1.5%) were not aware of any method of contraception. Less than half (143) (35.8%) of the respondents were aware of 4-6 contraceptive methods while (47) (4.7%) were aware of 7-9 methods of contraception.

About 367 (91.7%) of the respondents knew at least two contraceptive methods, meaning that their level of knowledge of family planning is quite high.

Unfortunately, these findings have no impact on contraceptive use in the Kwabre District. In spite of the high knowledge of modern contraception, only 131 (32.8%) of the respondents were using some form of contraception. These results suggest that knowledge and familiarity with modern contraception are not barriers to modern contraception use in the Kwabre District; hence use of contraception should have been high.

It is an acceptable fact that, the level of awareness of a range of contraceptive methods provides a rough measure of the availability of family planning information in a country and the level of contraception acceptance and use. In countries where people have more exposure to family planning messages on radio and television, people are aware of more methods and therefore practice family planning. (JHUCCP, 2001)

A study conducted in Guatemala 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)

However, this study was conducted in rural areas and though the respondents' level of knowledge about contraception was quite high and should therefore have translated to high prevalence of contraceptive use in the District, this was not the case.

5.2: FACTORS THAT INFLUENCE THE UTILIZATION OF FAMILY PLANNING SERVICES

The study established that some 54 (20.7%) of the respondents said they were not using any form of contraception, because they desired to have more children.

Caldwell et al., (1990) pointed out that, the cultural importance of having adequate numbers of surviving children, sons and daughters, and, above all, of avoiding being childless have been well-documented and have influence on contraception use. This confirms the reason for low use of contraceptive in the study area.

Besides, most of the respondents 94 (36%) cited side effect as the main reason for non use of modern contraceptives.

According to (USAID, 2002) providers of family planning services provide less or in some cases no information on the management of side effect of contraceptives. This, thus negatively affect contraceptive use as contraceptive users may either switch a method or entirely stop using contraception with even a minimal sign of side effect.

Also, in this study, it came out that about 4 (22.2%) of 18 Muslims sampled were using some contraception as against 123 (33.5%) Christians. This suggests that if religious leaders, as respected members of the community, freely preach in favor of family planning, there could be an increase in the utilization of family planning services in the district.

Carol (2000) indicated that religious leaders should not be ignored as potential proponents of family planning as some studies have shown that religious leaders, as respected members of the community can be effective advocates for family planning.

It also came out that only 58 (44.3%) out of 181 married women were using some form of contraception as against 60 (45.6%) of 123 cohabitators, while some (3) women reported lack of spousal consent as the reason for non use of contraception.

Wright (2002) pointed out that when women want to practice family planning their husbands and in-laws will not often agree and they may be punished if they are caught, sometimes with physical violence. It will therefore be necessary if men are involved in family planning decision-making.

Besides, it was established that only 4 (12.5%) out of 36 respondents who had no formal education were using contraceptives as against 21 (45.6%) out of 46 secondary school leavers. According to Castro Martin (1996), better educated women have less fatalistic attitudes towards reproduction and would therefore use contraception to space and limit family size. Education of women therefore plays an important role in terms of contraceptive use.

5.3 THE QUALITY OF FAMILY PLANNING SERVICES OFFERED TO CLIENTS

The results of the survey indicated that a wide range of family planning methods were mentioned to clients though, just a few were available at these clinics; namely contraceptive pill, contraceptive injection and the condom. This unfortunate situation might compel

potential clients to go to other places where they can obtain methods of their choice. Hence, in terms of availability of different methods, the quality of service offered is very low since according to Bruce (1990) quality of family planning depends on offering clients a full range of methods and giving them accurate and complete information.

However, most 29 (80.5%) reported that they spend less time in the clinic while 23 (63.9%) expressed satisfaction in terms of provider-client interaction. Half 18 (50%) of the respondents said they arrived at their current method of contraception on their own. These findings, to some extent, give an indication of a good quality of service offered and should have translated to high prevalence of contraceptive use as Bertrand et al., (1995) pointed out that good quality family planning services encourage potential family planning clients to seek out, adopt and/or continue using contraception (and to spread the message to others).

It has been established that access to quality family planning service can significantly reduce abortions. Research finding in various countries demonstrate that women who have access to better family planning services are more likely to use contraception, are less likely to have unintended pregnancies, and thus have fewer abortions. In settings where family planning services are introduced and promoted, abortion-related deaths decline as contraceptive use rises (USAID, 2001).

A study in Morocco showed that availability of family planning clinics and the numbers of contraceptive methods available at the community level were associated with adoption, continuation and switching of contraceptive methods (IFPP, 2003)

5.4: GEOGRAPHICAL DISTRIBUTION AND AVAILABILITY OF FAMILY PLANNING SERVICES.

Family planning services to some extent were readily available to potential clients as they do not have to travel long distance to access the service. Health providers also embark on

out-reach programs for those who cannot afford to travel to the family planning centre. However, the ranges of contraceptive services offered were few. But in spite of this, potential clients have access to some form of contraceptive methods and so can practice family planning.

According to UNFPA, (2002) over 350 million couples worldwide (more than one-third of all couples) do not have access to a full range of modern family planning information and services.

“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 which does not only include 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 (IFPP 2005). Hence contraceptive use should have been high since accessibility is not a major hindrance to contraceptive use in the district.

5.5: INTEGRATION OF FAMILY PLANNING SERVICES WITH OTHER SERVICES

It generally came to light that there has not been much integration of family planning services with other services like voluntary counseling and testing (VCT) and ante natal care services (ANC). These facilities stand in isolation in most of the clinics visited.

Programme officers acknowledge the fact that integrating family planning and VCT services offers an opportunity to make the best use of available facilities, logistics, and personnel to

provide comprehensive, convenient reproductive health care which in turn promote contraceptive use. (USAID, GHS, FHI, 2004)

A study in Mexico found that if women seeking family planning services are informed about family planning methods and STI risk factors and prevention, and are then given the responsibility of choosing a method, they are more likely to choose the condom rather than the IUD; this difference was even more pronounced for women having a cervical infection (IFPP 2002).

This means that if services like VCT and ante natal care services are integrated together with family planning, the incidence of STI including HIV/AIDS could be reduced. Also, unwanted pregnancy and abortion can be reduced drastically.

5.6: FERTILITY PREFERENCE AND UTILIZATION OF FAMILY PLANNING SERVICES.

The fertility preference expressed by the respondents was quite high as most of them, 300 (75 %) wanted between 4-6 children in their life. The implication is that couples who have not met their fertility intentions might not use any form of contraception: hence impacting negatively on the utilization of family planning services

. According to Bankole et al, (1998) a couples desired family size and fertility intentions relates to contraceptive use. In some countries, modern contraceptive use is higher when only the husband wants to stop childbearing but in other countries, however, it is higher when only the wife wants to stop having children. This means that contraceptive use tends to be higher when couples want to have small family size.

Furthermore, Bankole and Singh (1998) pointed out that, use of modern methods of contraception is highest when both spouses want to stop childbearing and lowest when they want to have more children.

The result of a survey conducted in 18 developing countries revealed that there is more agreement between spouses on the ideal number of children in Asia, Latin America and North Africa than in Sub-Saharan Africa. According to the survey, although levels of agreement as to fertility intention are similar across all regions, couples in Asia, Latin America and North Africa are more likely to agree to stop childbearing than to have another child, whereas the reverse is the case for couples in Sub-Saharan Africa, which partly accounts for the low utilization of contraceptives in Sub-Saharan Africa. (IFPP, 1998)

Throughout Sub-Saharan Africa, husbands and wives whose fertility intentions agree generally want more children. Of all couples in agreement, the proportion who want more children ranges from 53% in Kenya to 99% in Niger. This supports the finding that a high proportion of both husbands and wives want a large family in Sub-Saharan Africa. (IFPP, 1998).



CHAPTER SIX

6.0: CONCLUSIONS AND RECOMMENDATIONS

6.1 CONCLUSION

Utilization of family planning services in the Kwabre District is quite high as compared to the national prevalence rate (25% versus 32.8%). Knowledge level about modern contraceptive among respondent is also high, (91.7% knew at least two methods of contraception). However the quality of family planning services offered to clients is quite low in terms of the range of contraceptive methods available to clients. The main contraceptive methods provided are the pill, injection and condom.

Family planning services are also readily available to clients but for the high fertility preference expressed by most of the respondents' utilization would have been even higher. (As much as 75% of respondents wanted 4 to 6 children).

A chi-square analysis revealed no association between educational level and contraceptive use are also related. (At 95% confidence level X^2 computed is 9.4044 less than 9.488)

Besides, there was no integration of family planning services with other services like voluntary counseling and testing services in the facilities visited.

The results also indicated a high proportion of Christians in the District with only a small proportion of other religions, but this has no impact on contraceptive use in the District.

6.2 RECOMMENDATIONS

6.2.1 PUBLIC EDUCATION BY THE DISTRICT HEALTH DIRECTORATE

The Health Education and promotion unit within the District Health Administration should make it a priority to educate the general public on what to do when they experience any side effects in the course of using a contraceptive since many respondents were not using any contraceptive as a result of side effects they have experienced or because of fear of side effects.

The public must be educated on the need to space and limit births so as to decrease maternal and child mortality. The economic benefit a family derives from the use of contraceptives must also be made known to them.

6.2.2 IMPROVEMENT IN QUALITY OF SERVICE OFFERED BY THE MANAGEMENT OF THE VARIOUS HEALTH FACILITIES..

Most of the clinics visited were not providing a wide range of contraceptive services to potential clients. The most common ones provided were the contraceptive injection, the pill and the condom. This situation compels potential client to seek unavailable services elsewhere. The quality of the service must therefore be improved by increasing the range of contraceptive methods and ensuring providers technical competence through in-service training .

6.2.3 INTEGRATION OF FAMILY PLANNING SERVICES WITH OTHER SERVICES LIKE VCT/STIs BY THE MANAGEMENT OF HEALTH FACILITIES

The existing health facilities or family planning clinics should be integrated with VCT and ante natal services in order to increase the utilization of the family planning service, because it has been established that integrating family planning and VCT services offers an opportunity to make the best use of available facilities, logistics, and personnel to provide comprehensive, convenient reproductive care.

6.2.4 ADVOCACY FOR GIRL-CHILD EDUCATION BY THE DISTRICT EDUCATION DIRECTORATE

Though the study established no association between education and contraceptive use, the District Health Directorate should collaborate with the District Education Directorate to intensify campaign on girl-child education to increase the enrollment of girls at all levels of the educational ladder since education is known to improve the quality of life.

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APPENDIX A

SAMPLE SIZE DETERMINATION

For a large unknown population, the formula

$$n = \frac{z^2 pq}{d^2}$$

was used, where

n =desired sample size

z =desired level of confidence/reliability

p = proportion of population that benefitted from an intervention or that possess an attribute

d = desired amount of error/amount of error researcher is prepared to allow

$q = 1 - p$

The proportion of the population that used family planning service or contraception in the district cannot exceed 0.35%.

At 95% confidence level, $z = 1.96$, $d = 0.05$.

$q = 1 - 0.35 = 0.65$

Hence $n = \frac{(1.96)^2 (0.35) (0.65)}{(0.05)^2} = \frac{0.873964}{0.0025} = 350$

This sample size was increased to 400

May I talk to you for some few minutes? We are students from the Department of Community Health, School of Medical Science, KNUST. We are conducting a small survey on family planning. Would you mind participating?

Everything we discuss will be treated confidential (no one else will know who said what) But you should free to remain silent if you hesitate to answer a particular question. And if you have any questions for us please feel too ask.

Questionnaire number.....

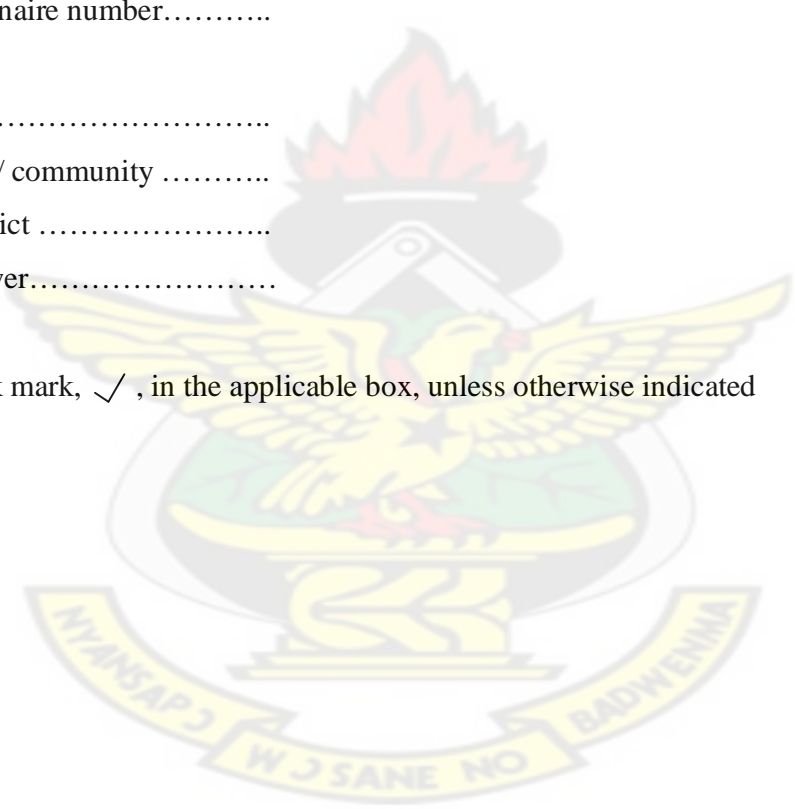
Date.....

Location/ community

Sub-district

Interviewer.....

Put a tick mark, ✓ , in the applicable box, unless otherwise indicated



QUESTIONNAIRE

APPENDIX B

RESPONDENTS KNOWLEDGE, ACCEPTANCE AND

UTILIZATION OF FAMILY PLANNING

1. Have you ever heard of family planning methods?

YES NO

2. Where do you obtain information on family planning? Radio, print media,
One-one-one counseling. Clinic/ Health Staff

3. If yes how many of the family planning methods are you aware of?

2 3 4 5 others

4. Which of the following do you know? Contraceptive pill. Contraceptive
Injection. Condom (male, female) IUDS, Rhythm method.
Implant method. Sterilization. Spermicides Diaphragm

5. Have you ever used any family planning methods before?

YES NO

6. Are you currently using any family planning method?

YES NO

7. If yes did you decide with your partner /husband?

YES NO

8. If no why are you not using any method?. Desired for more children fear of side
effect. Non-affordability, lack of information on family planning.
Lack of spousal consent

9. If yes, why are/were you practicing family planning? Limit family size space birth. Both, others (specify).....

10. Which of the methods are / were you using? Contraceptive pill contraceptive injection, condom, IUDS, Rhythm method, implant method, sterilization Diaphragm Spermicide

11. Where do /did you get the service? Hospital, pharmacy shop, health centre private maternity home, others

12. For how long have you been using this method? 6 months, 1 year 15 years, 2years, others.

13 What are the reasons for using the method ?

NO reason Minimal side effect
Affordable Convenient Easy to use

14 Have you ever changed a family planning method before?

YES NO

15 If yes why did you change the method? Side effect Cost
In-effectiveness of method perceived sickness

16. Will you advise a friend or relative to practice planning? YES NO

17 Is Yes /No why?

18. Is your partner aware that you are practicing family planning?

YES NO

19. If no why is he not aware?.....

20. If yes does he approve of it?

YES NO

21 Does he accompany you to the family planning clinic?

YES NO

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APPENDIX C

QUALITY OF SERVICE OFFERED

These questions do not apply for those not utilizing family planning services

1. Do you wait for a long time at the clinic before you are served?

YES NO

2. How many hours on the average do you spend at the clinic? 1 hours 1.5 hours
2 hours 2.5 hours others (specify)

3. What sort of information is give about contraceptive methods? Side effect correct
sue of method, advantage of method, mode of action. What to do for
side effect No information

4. How many methods are mentioned to you? 3, 4, 5, others (specify)

5. How did you arrive at the current method that you are using? Through a friend/relativ
own choice imposed by provide

6. Do providers make demands of any requirements before offering a service?

YES NO

7. IF Yes what sort of requirements do they demand? Spousal consent number of
children age others

8. Are you satisfied with way the providers interact with you during service?

No satisfied very satisfied

9. How will you describe the facilities the clinic?

Bad good better don't know

10. How much does it cost you to get contraceptives (for condom/ others) less
moderate, much

11. What is your reaction on the cost of getting contraceptives? Scares
Discourages me, motivates me, others.....s.

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APPENDIX D-RESPONDENT BACKGROUND

1. How old were you at your last birthday

2. What is the highest level of school you attended?

No education primary middle or J.SS Secondary or S.S.S Others or tertiary level

3. What work do you do? Farming Trading Hair dressing Dressing making Apprentice Student Others

4. To which ethnic group do you belong?.....

5. To which religion do you belong? Muslim christian
Traditional/spiritualist No religion

6. If a Christian which denomination? Catholic Pentecostal Protestant
spiritual

7. What is your marital status? Singl Married Divorced Cohabiting

8. Have you ever given birth?

YES NO

9. If how many children do you have at the moment?

10 if yes how many children do you have at the moment?

YES NO

11. IF /No why?.....

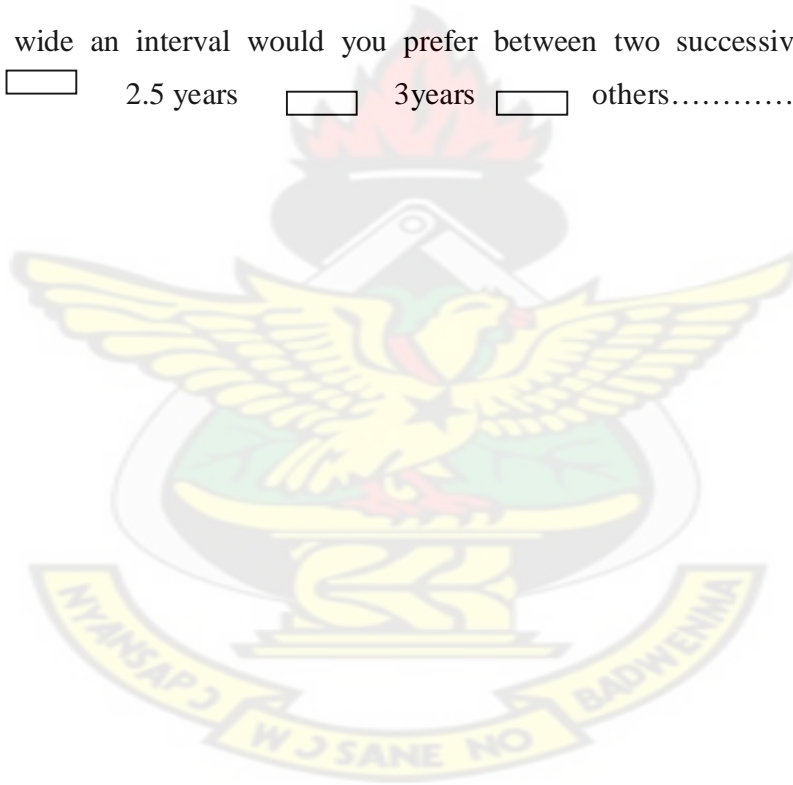
12. If you could choose exactly the number of children to have in your whole life how many would you choose? 2 3 4 5 6 others.....

13. Do you consider sex preference? Yes No

14. Assuming that due to circumstances beyond your control. You couldn't obtain the actual number of boys or girls you wanted but you have gotten the total number of children you want. Would you continue?

YES NO

15 How wide an interval would you prefer between two successive births? 1.5 year
2 years 2.5 years 3 years others.....



APPENDIX E

IN – DEPTH INTERVIEW GUIDE FOR SERVICE PROVIDERS

(KEY INFORMANT)

General information

Educational level of care provider

General Nursing

Community Health Nurse

Public Health Nurses

Others (Specify).....

How long have you worked in this clinic? 6months 1 years 1.5 years
2years 2.5 years 3years others.....

1. What sorts of essential equipments for family planning are available in this clinic?

Examination table Glovers Blood pressure gauge stethoscop
weighing scale vaginal speculum others.....

2. What facilities or equipments are lacking?

Examination table Gloves Blood pressure gauge stethoscope
weighing scale vaginal speculum other.....

3. What range of family planning methods do you provide in the clinic?

Contraceptive pill, contraceptive injection, condor IUDS
implant method, sterilization Diaphragm emergency contraceptive pill

4. Which of the methods of family planning are usually utilized?

Contraceptive pill, contraceptive injection, condom, IUDS
implant method, sterilization Diaphragm emergency contraceptive pill

5. Who are those who utilized you services more? Men women

6. Do you offer special services for adolescents?

YES NO

7. What other services apart from family panning are offered in this clinic? ANC
ACT/STIs others.....

8. How much it cost to provide contraceptive services? Less Moderate
much

9. What reaction do you receive from client / potential clinic on the cost of contraceptive
services? No reaction Discourages client Others

10. What do you to ensure that clines come to the clinic for follow- ups and other Services?
Out reach Counseling o

11. How long is the current waiting time from when a client calls until and appointment?
I hr 1.5 hrs 2hrs 2.5hrs 3 hrs others.....

12 How long does the clinic operate each day to provide family planning services for client?

Day	Open	Close
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

13 what materials for client education about family planning is available. Poster
Booklet pamphlet Brochure Flip chart

14 what consumable commodities relevant to family planning are available? Gloves steri
syringes bedles

15 Have you received in-service training in family planning especially in counseling?

YES NO

APPENDIX F
CLIENT EXIT INTERVIEW

1. What service did you request?

Contraceptive pill, contraceptive injection, condom,
IUDS plant method, sterilization Diaphragm
emergency contraceptive pill

2. Did you receive the service you wanted?

YES NO

3. If no why? Not available no qualified personnel did not meet requirement

4. Why did you request for that service? Minimal side effect affordable easy to use

5. What alternative service did you receive?.....

6. Were you counseled about the method?

YES NO

7. Were you told what to do if you experience side effect or problems?

YES NO

8. During your interactions with the provider were you treated with respect or courtesy?

YES NO

9. During the visit were you given the opportunity to ask questions?

YES NO

10. During the visit did the provider conduct any health examination or procedures?

YES NO

11. Did you have enough privacy during physical examination if any?

YES NO

12. If yes, did the provider explain the procedure or examinations before they were performed?

YES NO

13. Were the results of the procedure or examination explained to you?

YES NO

14. Are the opening hours of this clinic convenient for you?

YES NO

15. if No, what time will be convenient for you? Early morning in the morning
afternoon evening week ends.

16. How long did you have to wait between the time you first arrived at the clinic and the time you started receiving the services? 2hours 3hours 3.5hours
4hours.

17. Do you think that the waiting time is reasonable or too long? Reasonable too long.

18. Do providers make demands of any requirements before offering a service

YES NO

19. If yes what sought of requirement was demanded? Spousal consent age no
of children marital status

20 How will you describe the sate of the facilities at the clinic?

Bad good better don't know

21 Generally, are you satisfied with your visit today or not? Satisfied dissatisfied
other. (Specify)

22. If dissatisfied, why?

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