

**UNIVERSITY FOR DEVELOPMENT STUDIES**

**KNOWLEDGE AND UTILIZATION OF FAMILY PLANNING AMONG WOMEN  
AGED 15-49 YEARS ATTENDING BAWKU PRESBYTERIAN HOSPITAL IN THE  
BAWKU MUNICIPALITY**

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BAWKU MUNICIPALITY**

**BY**

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**A THESIS SUBMITTED TO THE DEPARTMENT OF PUBLIC HEALTH, SCHOOL OF  
ALLIED HEALTH SCIENCES, UNIVERSITY FOR DEVELOPMENT STUDIES IN  
PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER  
OF PHILOSOPHY DEGREE IN COMMUNITY HEALTH AND DEVELOPMENT**

**FEBRUARY, 2018**



**DECLARATION**

I, Salifu Sharif Alhassan hereby declare that this submission is my own work towards the award of Master of philosophy degree in Community Health and Development and that, to the best of my knowledge it contains no materials previously published by another person nor material which has been presented for the award of any degree of the University, except where due acknowledgement has been made in the text.

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I/We hereby declare that the preparation and presentation of the thesis was supervised in accordance with the guidelines on supervision of thesis laid down by the University for Development Studies.

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## **DEDICATION**

I dedicate this piece of work to the Almighty Allah, my late parents Mr. Alhassan and Madam Hadijatu, my wife (Hikmat) and children who inspired me to achieve greater heights in life and my academic supervisor.



## ACKNOWLEDGEMENT

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## ABSTRACT

There is limited use of family planning services in the study area. This study was conducted to assess the knowledge and utilization of family planning among women aged 15-49 years who attended the Bawku Presbyterian Hospital in the Bawku municipal. Descriptive cross sectional survey design was used to conduct the study with simple random sampling technique used to sample the respondents from the study area. In all, 344 respondents were sampled from the study area. Structured questionnaire as a tool was used to obtain the necessary information. Data was entered and analyzed using SPSS version 21.0, and computed using descriptive and inferential statistics. Findings from the research revealed that respondents' knowledge on family planning was adequate. From the results, there was a relationship between respondents age and having used family planning methods ( $\chi^2 = 315.55$ ;  $p < 0.001$ ). Hundred (29.1%) respondents said they had ever used injectable before. Most 134 (39%) considered socio-cultural factors as hindrance to family planning services uptake. It showed that there was a significant association in terms of education of respondents and having access family planning services (ANOVA;  $p < 0.001$ ). It showed that 226 (65.7%) respondents said their husbands approved family planning services for them whilst 118 (34.3%) respondents said their husbands do not approve family planning services for them. The study concludes that family planning usage in the study area was not impressive. The study recommends that awareness creation on the importance of family planning among women at the study institution is necessary.



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## LIST OF ACRONYMS

ANVOA	Analysis of Variance
BMHD	Bawku Municipal Health Directorate
CPR	Contraceptive Prevalence Rate
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
IUS	Intrauterine System
IUCDs	Intrauterine Contraceptive Devices
IUD	Intrauterine Device
LAM	Lactational Amenorrhoea Method
MOH	Ministry of Health
PoPs	Progestogen-only Pills
PPAG	Planned Parenthood Association of Ghana
TFR	Total fertility rate
UNPFA	United Nations Population Fund
WHO	World Health Organization



WIFA

Women in Fertile Age



## CHAPTER ONE

### 1.1 Introduction

The chapter contains the background of study, problem statement, research questions, research objectives, significance of the study, scope of the study, conceptual framework of the study, theoretical foundation of the study, operational definitions of key terms and organization of the thesis.

### 1.2 Background of the study

Globally, the issue of family planning has attracted attention due to its importance in decision making about population growth and development issues (WHO, 2012; Madhukumar and Pavithra, 2015). In Africa, it is well documented that men's general knowledge and attitudes concerning the ideal family size, gender preference of children, ideal spacing between child births, and contraceptive method use greatly influence women's preferences and opinions on family planning information and services (Jaya and Hindin, 2012; Madhukumar and Pavithra, 2015).

Family planning has been defined in different ways in literature, but essentially it implies enabling individuals and couples to attain the desired number, spacing and timing of their children, through the use of modern or traditional (also called natural) contraceptive methods (Madhukumar, and Pavithra, 2015; Obare, Keesbury and Liambila, 2010; Nuruzzaman, 2010; Odimegwu, 2013).

The term birth control is sometimes used as a synonym, but its connotation is more on preventing pregnancies and limiting the family size than on planning families (Maudlin, 2015). The World Health Organisation (WHO, 1971; p 45) defined family planning as "the practice that helps individuals or couples to attain certain objectives such as avoiding unwanted pregnancies,



bringing about wanted babies at the right time, regulating the interval between pregnancies, controlling the time at which birth occurs in relation to the ages of the parents and determining the number of children in the family”. John (2010) also described family planning as activities by individuals and couples to plan the timing, number and spacing of the children that they desire in order to promote the health and wellbeing of the family group.

Nevertheless the most significant definition of family planning was according to the (WHO, 1971) because it buttresses the importance of family planning on the woman’s health and outcome of her pregnancy. In Ghana, family planning has remained a delicate issue that is still reluctantly being accepted based on religious belief and the perception that it is synonymous with population control (Nketiah-Amponsah, Arthur and Abuosi, 2012).

Consequently, this makes it difficult for women to come out openly or voluntarily to seek for ways to improve their reproductive health. Various factors have been identified as the reasons for the low contraceptive prevalence among women mostly in developing countries. They include among others; poverty, ignorance, low educational level, desire for large family size, poor access to family planning information and services, community pressure, male or husband dominance, and religious/cultural beliefs (WHO, 2015).

The realization that human fertility can be regulated by using family planning methods and the speed with which this knowledge was put to practice by millions of people worldwide are perhaps the most remarkable achievements since the 1960s (Najafi, Rahman and Juni, 2011). Family planning is a key to attaining sexual and reproductive health, but it also impacts on social and economic development of most people (Najafi, Rahman and Juni, 2011; Maudlin, 2015). Family planning is now an integral part of the health system of most countries in the world because of its significant benefits (Najafi, Rahman and Juni, 2011).



A higher number of unintended pregnancies may occur due to non-use of family planning methods (Odimegwu, 2013). Many of these may be terminated unsafely where induced abortion is legally restricted, causing grave danger to the lives of women and a drain on national health services in dealing with complications of unsafe abortion (Odimegwu, 2013). It is therefore rightly stated that "family planning saves lives" (Olakojo, 2012; Maudlin, 2015; Odimegwu, 2013).

The social and economic implications of family planning are no less significant. Family planning provides opportunities to women to pursue studies and engage in productive activities (Kamal, 2012). In countries with high levels of family planning use and consequently lowered fertility, savings made in addressing maternal and child ill-health can be invested in social and economic development and improving the quality of life of people (WHO, 2015; Odimegwu, 2013; Helzner, 2013).

The most obvious examples of economic prosperity and development, partially as a result of lowered fertility, include China, Republic of Korea, Singapore and Thailand (Maudlin, 2015; Jaya and Hindin, 2012; Jaya and Hindin, 2013).

Thus family planning extends to techniques commonly used to actualize sexuality education, prevention and management of sexually transmitted diseases, pre-conception counseling, management and infertility management (Okech, Wawire and Mburu, 2011). However, family planning is usually used as synonym for the use of birth control. It is mostly adopted by couples who wish to limit the number of children they want to have and control the timing of pregnancy, which is also known as spacing of children (Odimegwu, 2013). Family planning may encompass sterilization, as well as pregnancy termination.





It also includes raising a child with methods that require significant amount of resources such as time, social, financial and environmental considerations (Kanitkar and Kulkarni, 2012; Nasir, 2010; Philips, 2015). Family planning measures are designed to regulate the number and spacing of children within a family, largely to curb population growth and ensure each family has access to limited resources (Neville and Golden, 2010).

Family planning is credited primarily for its role in bringing down the birth rates globally and particularly in developing countries (UNPFA, 2010). From 1950 to 2000, the global fertility has fallen by about half - from five children per woman in 1950-1955 to 2.7 children in 2000-2005 (UNPFA, 2010).

However, less well recognized is the contribution of family planning to the major social change around the world whereby couples are empowered in regulating their fertility instead of considering it as a matter of God's will or destiny which in this case could be an expansion of freedom of choice and action to shape one's life (Ogunjuyigbe, 2013). Family planning also has an impact on reproductive health and development, an aspect that is often glossed over (Philips, 2015; Ogunjuyigbe, 2013; WHO, 2015).

Unintended pregnancy can be devastating to individuals and to the larger society (Maudlin, 2015). Mothers of unintended births face increased risk of single parenthood, incomplete education, poverty, unemployment, and welfare dependency (WHO, 2015; Renjhen, 2013; Tuladhar and Marahatta, 2010). Those who do marry are at a greater risk of separation and divorce (Maudlin, 2015).

Compared to a mother with a planned pregnancy, a mother with an unintended pregnancy is less likely to seek prenatal care in the first trimester and more likely to obtain no prenatal care at all (Sharma, Mohan and Awasthi, 2012; Maudlin, 2015). Children of unintended pregnancies are at



greater risk of dying in their first year, of being abused, and of not receiving sufficient resources for healthy development (Philips, 2015; Woldemicael and Beaujot, 2011; Maudlin, 2015).

Furthermore, these children face greater risks of living in poverty, living with a single parent, and having health and developmental problems (Ogunjuyigbe, Ojofeitimi and Liasu, 2013). The factors that influence the knowledge and utilization of family planning among women aged 15-49 years in the Bawku Municipality and its environments patterns are as yet poorly understood. This poses a range of major public health problems including an increased risk of complications associated with illegal abortions in the municipality and may be associated with dropout and non-completion of education amongst students due to unintended pregnancies.

This area of research has not been given much attention within the Bawku Municipality context due largely to the protracted chieftaincy conflict and, to date, only a few non-research-based reports exist, with much of the discourse being conducted within mass media outlets and health facility based.

The total fertility rate usually 4.8 births per woman and is considerably higher in the rural than the urban areas and its country specific within the sub-Saharan region (Rajaretnam and Deshpande, 2014; Madhukumar and Pavithra, 2015). Observed fertility rates among women are 33% higher than the wanted fertility rates (UNPFA, 2010; Phipps, 2012; Raju and Leonard, 2013b). In absolute numbers, this means 0.6 additional children are usually added in the line of child birth in a woman life (Sterley, 2011; Rutenberg, 2013; Schoenmarkers, 2013).

The lack of usage of family planning services among married women mostly is attributed to lack of knowledge, socio-economical problem, fear of side effects, religious cause, insufficiency of family planning information and services, uncooperative husband and limited supply of family



planning commodities and high cost of commodities sometime affect their usage of family planning services (Tuladhar and Marahatta, 2010; Schoenmakers, 2013).

### **1.3 Problem statement**

In Ghana, findings revealed that there is 99% and 98% awareness of family planning among men and women respectively (GDHS, 2014). This high awareness level has however not been sufficiently translated into practice especially among women. Available data from the Ghana Demographic and Health Survey (GDHS, 2014) showed that the trend in the use of contraceptive has declined from high percentage of 7.3 in 1993 to 4.5% in 2014, representing a fall in contraceptive usage. The report by the GDHS for 2014 indicates contraceptive prevalence (CPR) rate of 23.7% for Upper East Region (GDHS, 2014).

According to Bawku Municipal Health Directorate (BMHD, 2014) report, the acceptor rate of family planning services is on the decline from 46.8% in 2011 to 30.3% in 2014 despite the education at all delivery points, community meetings and durbars organised within the Bawku municipal to stress on the importance of family planning services.

This background dictates a need for primary research to offer empirical insights into the reasons for the low uptake of family planning among women age 15-49 years as a first step toward the reduction of unwanted pregnancy among women. In keeping with this imperative, the current study looks specifically at the knowledge and utilization of family planning among women age 15-49 years attending the Bawku Presbyterian Hospital in Bawku Municipality.



#### **1.4 Research questions**

1. What is the knowledge level of women aged 15-49 years attending Bawku Presbyterian Hospital on family planning services?
2. What are the various types of family planning methods known to women aged 15-49 years attending the Bawku Presbyterian Hospital?
3. What are the factors that account for the unmet needs of family planning services among women aged 15-49 years attending the Bawku Presbyterian Hospital?
4. What is the level of male involvement in family planning services among women aged 15-49 years attending the Bawku Presbyterian Hospital?

#### **1.5 Research objectives**

##### **1.5.1 General objective**

The main objective of the study was to assess the knowledge and utilization of family planning among women aged 15-49 years attending the Bawku Presbyterian Hospital on family planning

##### **1.5.2 Specific objectives**

- 1) To assess the knowledge of family planning among women aged 15-49 years attending the Bawku Presbyterian Hospital on family planning services
- 2) To identify the various types of family planning methods known to women aged 15-49 years attending the Bawku Presbyterian Hospital
- 3) To examine the factors that account for the unmet needs of family planning services among women aged 15-49 years attending the Bawku Presbyterian Hospital
- 4) To examine the level of male involvement in family planning services among women aged 15-49 years attending the Bawku Presbyterian Hospital



### **1.6 Significance of the study**

Unplanned and unintended pregnancies account to a large extent the poor state of health of women and children in most developing nations (WHO, 2015; Maudlin, 2015). The choice of women to control their own health and that of their children is challenged by social and environmental factors that mitigate their ability to decide independently and freely on their reproductive and sexual choices (Maudlin, 2015). There are still unanswered questions based on local settings that have not been revealed and still worsens the situation of these vulnerable groups with regard to decision and choices to make in controlling child birth.

This study conducted in the Bawku Presbyterian Hospital in the Bawku municipal would provide contextual findings that would increase knowledge and add to literature in this academic field as well as open up issues affecting the wellbeing of women in fertile age (WIFA) in accessing family planning information and services in the Bawku municipality and possibly trigger further research.

The research findings would also serve as information to governments, policy makers and implementers such as the Ministry of Health (MOH), Ghana Health Service (GHS), non-governmental organizations and all stakeholders in finding sustainable solutions to the plight of women in accessing sexual and reproductive health services. Further, it would yield information that would add to the existing knowledge in research in the field of family planning information and services uses and related issues in the Bawku Presbyterian Hospital and Ghana as whole. Other researchers would also benefit from the study findings if published.



### **1.7 Scope of the study**

There are several dimensions of family planning which could be worthy of investigating by the researcher. However, within the context of this research work, the focus was on only assessing the knowledge and utilization of family planning among women age 15-49 years attending the Bawku Presbyterian Hospital in Bawku Municipality.

The research delve into the knowledge of women in their reproductive age in the study on family planning, examine their knowledge level on the various types of family planning methods known to them especially at the Bawku Presbyterian hospital, identified barriers to the use of family planning services among women in their reproductive age and explored how their male counterparts are involved in family planning information and services at the study area.

### **1.8 Conceptual Framework of the study**

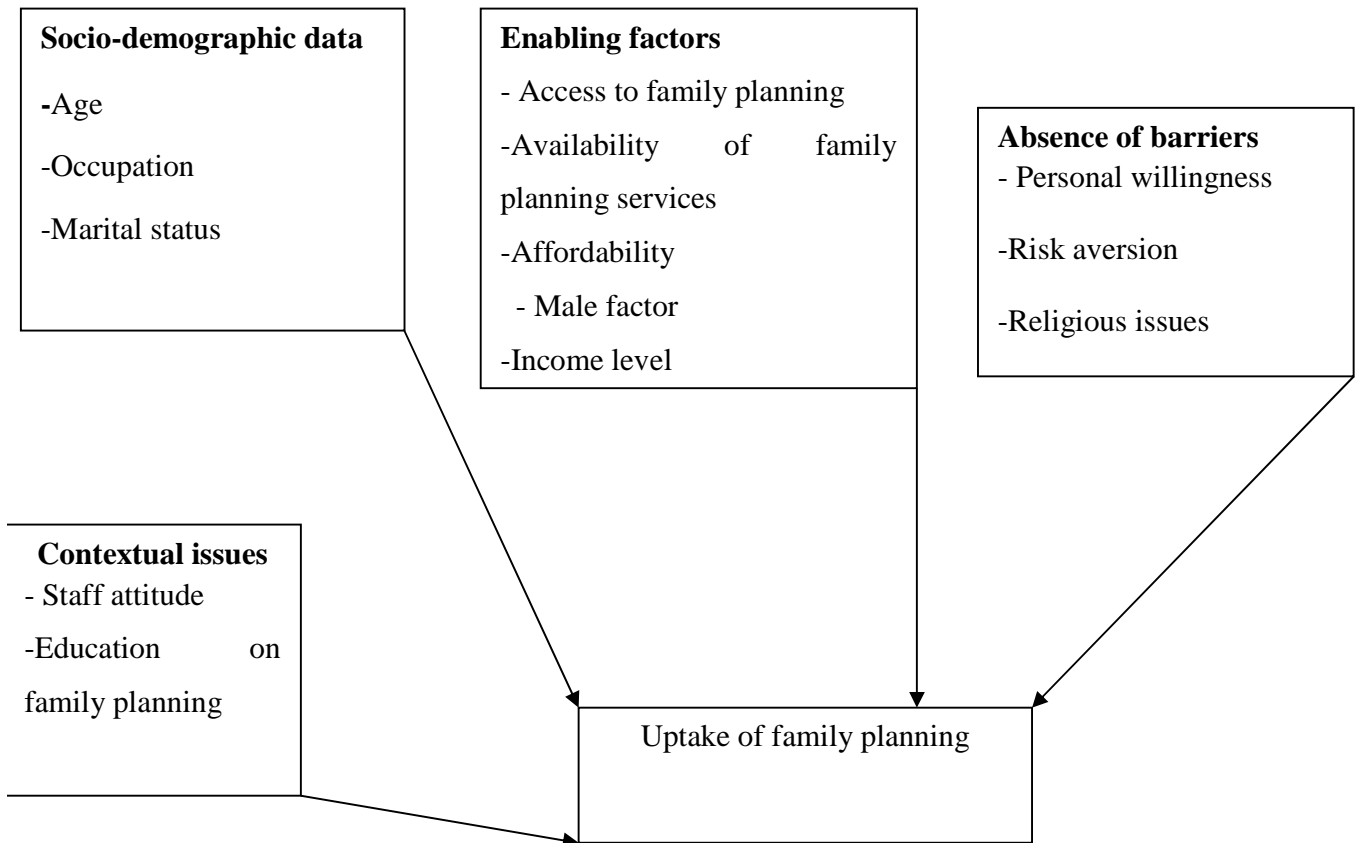
A conceptual framework used in a study is a set of highly abstract related constructs whose purpose is to explain a phenomena of interest, express assumptions and reflect a philosophical stance (Hamid and Stephenson, 2013). This study adopted a similar conceptual framework model by John (2010) on factors influencing family planning information and services delivery among rural women in their reproductive age. This framework illustrates the pathways by which family planning services delivery achieve their objectives.

This framework maps the pathways through which family planning information and services could achieve results, and it constitutes a logical framework for developing an evaluation plan with appropriate indicators. According to the framework, family planning is a complex process governed by psychological and physiological factors that in turn condition a wide spectrum of environmental, socio-economic and cultural factors (John, 2010).



These factors affect family planning information and services delivery in different ways and to varying degrees depending on culture, religion, enabling factors and barriers. For the purpose of this research, the conceptual framework model was employed to assess the demographic characteristic of women that could affect their usage of family planning service, knowledge on family planning, socio-economic factors and contextual factors such as accessibility and attitude of health workers that could influence either negatively or positively on family planning information and services utilization among women in fertile age (WIFA) attending the Bawku Presbyterian Hospital in the Bawku Municipality.





**Figure 1.1: Conceptual framework**

**Source: John, 2010**

The column on the far left defines the socio-demographic data in which the model operates. The age, occupation of the women, the religious/cultural affiliations of the women and marital status of the women in a given society, including that society's reproductive health programs could affect the utilization of family planning information and services positively or negatively. Poor social and cultural perspective on family planning information and services due to religion, moral or cultural factors may limit the utilization and acceptability of family planning among women. In addition, economic status and women empowerment in their decision-making could further suppress negative and social perspective of family planning service, and increase its utilization or vice versa.





However, unemployment which leads to economic dependency may affect women decision making on birth control and therefore determines the practice of family planning uptake. The top middle side of the conceptual framework model, outlines the role of enabling factors in the effectiveness of a given place or community that could promote the utilization of family planning information and services among women.

Communities or places in which the population actively wants the services "high demand" based on societal norms and preferences will have a far easier time achieving results than those in which the population is indifferent or outwardly negative toward family planning information and services.

From the model, enabling factors such as availability of family planning information and services, the income level of the women if it is good, male support for the use of family planning services and easily access to family planning information and services would lead to improve family planning services among women.

The lower left-hand side of the framework lists factors in the supply environment which could affect family planning service uptake among women. Service providers with strong social and economic development programs on family planning information and services would provide a more conducive environment in which to promote family planning information and services than those without systems to support such efforts. Good health provider attitude "staff attitude" also facilitates implementation, and usage by many women.

Whereas poor health providers' attitude may discourage women from accessing family planning services. Contextual variable that would influence family planning usage among women in their reproductive age today is the active design interventions (e.g., campaign/ education) with the aim of shaping the policy environment.



The box labeled "absence of barriers" represents the objective of most family planning programs. That is, the behaviors that service providers of the intended audience are encouraged to discourage. Perceived severity of the condition may affect women from freely accepting to practice family planning or to discontinue if she has already started it. Religious issues may also influence women negatively.

The entire chain of relationship show events leading to specific behavior, improved knowledge of women on family planning practice. The more enlightened a women is with family planning could suppress these hindrances and still pursue its practice whilst the non-enlightened value such as social and cultural issues which will make them not to practice family planning.

The Theory of Comfort developed by Katharine Kolcaba in the early 1990s has also provided the general theoretical perspective for this research. Kolcaba's Theory of Comfort is a family theory that was first developed in the 1990s by Katharine Kolcaba (Kolcaba, 2015). It is a middle-range theory for health practice, education, and research. It has the potential to place comfort in the forefront of healthcare.

According to the model, comfort is an instant necessary outcome of nursing care. Kolcaba described comfort existing in three forms: relief, ease, and transcendence (Kolcaba, 2015). Also according to Kolcaba's Theory of Comfort (Kolcaba, 2015), the four contexts in which patient comfort can occur are: physical, psycho spiritual, environmental and socio-cultural.

The Theory of Comfort considers patients to be individuals, families, institutions, or communities in need of health care. The environment is any aspect of the patient, family, or institutional surroundings that can be manipulated by a nurse or loved one in order to enhance comfort for the person. In the model, nursing is described as the process of assessing the comfort



needs of a patient, developing and applying appropriate nursing care plans as well as assessing the patient's comfort after the implementation of the care plans.

Nursing care includes the intentional assessment of comfort needs, the design of comfort measures to address those needs, and the reassessment of comfort levels after implementation.

The theory is applicable to the study because it would help to explain how women of child bearing age can achieve comfort, through relief and ease regarding their reproductive lives. Thus, they would be able to make an informed family planning choice that would transcend to a happy family life.

### 1.9 Operational definition of terms

- **Culture;** is the term that describes the socially acquired and transmitted behavior patterns of a group, community, society or nation. It includes language, skill and beliefs, arts, science, laws, forms of government, religious beliefs and normal or ethical standards within a nation, especially a large and populous nation such as united states, there are many subcultures each differing from the others in some of the characteristics that are part of the overall national cultural mosaic.
- **Unmet need for family planning:** The unmet need for family planning refers to the proportion of married women or those living in consensual unions of reproductive age, presumed to be sexually active, but are not using any method of contraception.
- **Modern Family Planning:** A program which enables couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so, and to have informed choice and access to a full range of safe and effective modern methods of preventing pregnancy.



### **1.10 Organization of the thesis**

This dissertation is organized into six chapters. Chapter one comprises the background to the study, the problem statement, the study objectives, the significance of the study, scope of the study, conceptual frame work of the study, theoretical foundation of the study and the operational definitions of key terms. Chapter two examines the review of relevant literature in relation to the study.

Chapter three presents profile of the study area, study design, data collection tools, sampling procedure and sample size determination, study population, sources of data, data collection methods and techniques, data analysis and ethical considerations. Chapter four presents the results whilst the discussion of the results and findings of the study are done in chapter five. Chapter six contains the summary, conclusion and recommendations of the study.



## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 Introduction

This chapter presents the review of related literature on family planning. Literature review is a process that involves reviewing relevant literature to a broad background of the information that is available and related to a problem under study (Creswell, 2005). Relevant materials were researched and presented under headings and subheadings for easy understanding.

#### 2.2 An overview of family planning and its importance

Family planning remains one of the most cost-effective public health measures available in developing countries (WHO, 2012; Hausmann-Muela, Muela and Nyamongo, 2013). Family planning and contraception has been given several definitions (Woldemicael and Beaujot, 2011; Nuruzzaman, 2010; Madhukumar and Pavithra, 2015). However, all the definitions have the same central message of limiting, spacing births and prevention of unintended pregnancies which buttresses the slogan of the first birth control clinic that was established in the 1920s which said that “children by choice, not chance” (UNPFA, 2010; Hausmann-Muela, Muela and Nyamongo, 2013). Among the several definitions, Sonenstein (2011) defined family planning services as methods and practices that are used to space births, limit family size and prevent unwanted pregnancies among women.

According to UNPFA (2010), pregnancy by choice and not by chance is a basic requirement for women’s health. Renjhen (2013) also considered family planning as any deliberate practice or technique undertaken by couples to reduce the risk of conception. Similarly, family planning is defined by Olakojo (2012) as the deliberate employment of a technique or a device to prevent conception or pregnancy. Beyond the health and survival implications of high levels of closely



spaced and unintended births, high fertility rates accelerate population growth, undermining development efforts across all sectors not just the health sector (Parr, 2013; Ogunjuyigbe, 2013; Neyaz, Ahmed and Sahu, 2015) To reduce the menace of maternal deaths attributed to unplanned pregnancies, Mai and Nami, (2012) and Najafi, Rahman and Juni (2011) in their study stated that if women had only the number of pregnancies they wanted or planned and had these pregnancies at the intervals they wanted, then maternal mortality would drop by about one-third. In emphasizing the importance or contribution of family planning services as recipe to lower or reduce maternal mortality, Mekonnen and Worku (2011) stated that women with birth-to-pregnancy intervals of less than five months experience a risk of maternal death that was 2.5 times higher than women with birth-to-pregnancy intervals of 18 to 23 months.

To achieve the desired birth to pregnancy intervals couples have to employ the use of contraceptives and family planning services (Madhukumar and Pavithra, 2015; Liston, 2014; Najafi, Rahman and Juni, 2011). Even though pregnancy or childbirth is seen as a blessing and welcomed by most women, yet the risks of illness and death associated with these events are very high in some parts of the world (WHO, 2011; Najafi, Rahman and Juni, 2011). According to Kamal (2012) in developing countries, a woman's lifetime risk of dying due to pregnancy and childbirth is 1 in 75, or almost 100 times higher than the 1 in 7,300 risk in developed countries. The World Health organization (WHO, 2015) reported that more than 500,000 women die every year due to pregnancy-related problems and that the use of methods for family planning reduces maternal mortality prevents unwanted and highly risky pregnancies and also prevents the need for safe and unsafe abortions. Accordingly, it provides protection from sexually transmitted diseases (Gupta, Mohapatra and Kumar, 2016).



According to Gupta, Mohapatra and Kumar (2016) approximately 120 million couples in the world do not use family planning services and 300 million are not satisfied with the family planning methods applied (Gupta, Mohapatra and Kumar, 2016; Gizaw and Regassa, 2011). Again, the African Population and Health Research Center (2011) reported that, globally, 600,000 women die annually of pregnancy-related causes, and 75,000 die as a result of unsafe abortions (Chapagain, 2013; Karra, Stark and Wolf, 2013). The African Population and Health Research Center (2011) further reported that mothers who have unintended births tend to suffer non-psychotic or postpartum depression, feelings of powerlessness, increased time pressures, and a reduction in overall physical health. According to Gizaw and Regassa (2011); Karra, Stark and Wolf (2013), women have unintended births tend to poorer quality relationships with all their children, tending to physically abuse them more and spend less leisure time with them. Governments of various countries especially developing countries are struggling to reduce fertility rates due to the pressure it poses on every sector of development (Gille, 2015). Foreman and Mia (2011) in their study entitled the proximate determinants of fertility in sub Saharan Africa stated that contraception is the most proximate determinant of fertility.

It therefore stands to reason that governments and policy makers who want to check fertility rates should promote the use of contraceptives and working on the underpinning factors that influence contraceptives use (Foreman and Mia, 2011). They again stated in their study that the proximate determinants of fertility are the biological and behavioural factors through which social, economic, and environmental variables affect fertility (Foreman and Mia, 2011). Demographers find the study of contraception as a crucial issue in demography since there is a strong association or relationship between contraception and fertility (Aryeetey, Kotoh and Hindin, 2010; Madhukumar and Pavithra, 2015).

Alluding to this fact, Aggarwal, Bhasin and Rajoura (2013) stated that family planning in its broader meaning; is part of the entire demographical and population policy of each country and the planet as a whole. In almost every surroundings, the objectives of family planning commonly highlighted include unwanted pregnancy prevention, extensive population growth reduction, and health improvement of women, children and population as a whole (Freedman, 2014; Aggarwal, Bhasin and Rajoura, 2013). There are variations in the levels of family planning methods use in the world. There are different levels of use between continents and countries (WHO, 2015). Within countries, there are also regional and zonal differences in the use of family planning services (Aggarwal, Bhasin and Rajoura, 2013). According to Chapagain (2013), the differences in levels of family planning service use accounts for or explain about 92 per cent of the variation in fertility and argued that where family planning service use is widespread, fertility is expected to decline and birth spacing is equally widespread. Thus, family planning service use is important not only for its effect on fertility but also because it has health implications for both mother and child (Madhukumar and Pavithra, 2015; Chapagain, 2005).

Edwards (2014) stated that promotion of family planning in countries with high birth rates has the potential of reducing poverty and hunger, while at the same time averting 32 percent of all maternal deaths and nearly 10 percent of child mortality. This would contribute substantially to women's empowerment, achievement of universal primary schooling or education and long term environmental sustainability (Edwards, 2014). Other substantial economic benefits could include demographic bonus or dividends (Foreman and Mia, 2011; Fuse, 2010; Coverdale, Turbott and Roberts, 2014). Demographic bonus exists when there is a shrinking share of the population consisting of dependent children at the same time as a greater share consisting of working-age adults (Edwards, 2014). According to Chacko and Kabagambe (2013) when this occurs, it boosts





productivity and allows added savings or investment. They again observed that family planning services help to reduce the number of high-risk pregnancies that result in high levels of maternal and child illness and death.

According to Gelaye and Mekonen (2014), the use of family planning services is an important issue for a developing country like Ghana. Furthermore, the uptake of family planning services widened choices available to people, particularly women, by allowing individuals and society more opportunities for social and economic development (Hausmann-Muela, Muela and Nyamongo, 2013). Muia, Blanchard and Lukhando (2012) observed that countries with high “population pressure” or with rapidly growing populations may not be able to meet the large education, labour, health, and infrastructure-related demands of the population. Neville and Golden (2010) noted that population growth affects the environment and raises concerns about food security, safe drinking water and availability of arable land. Najafi, Rahman, and Juni (2011) observed that reducing fertility can help alleviate poverty and stimulate economic growth.

### **2.3 History/overview of family planning**

Contraceptives have been used in one form or another for thousands of years throughout human history and even prehistory (Coverdale, Turbott and Roberts, 2014). In fact, family planning has always been widely practiced, even in societies dominated by social, political, or religious codes that require people to be fruitful and multiply (Karra, Stark and Wolf, 2013; Coverdale, Turbott and Roberts, 2014). Various family planning methods have been used by different societies and cultures in history (Coverdale, Turbott and Roberts, 2014). According to Planned Parenthood Federation of America (2012), past family planning methods such as drinking of lead and mercury, wearing testicles of a weasel, wreath of herbs, desiccated cat liver, shred of bones from



cat and others such as women walking round the spot where a pregnant wolf has urinated were not only unreliable but also highly dangerous.

People have tried very hard to understand women's fertility and human reproduction since the first families were formed (Chacko and Kabagambe, 2013). It's not entirely surprising that only a few figured out what exactly sex had to do with pregnancy (Chacko and Kabagambe, 2013). Scientists did not identify sperm until 1678 (Bullough and Bullough, 1987; Chacko and Kabagambe, 2013). In ancient India, vaginal intercourse was encouraged during menstruation because it was believed that menstrual blood was women's semen and babies were formed when it combined with men's semen (Bullough and Bullough, 1987; Chapagain, 2013). In 1970, the Ghana National Family Planning Programme was established under the Ministry of Finance and Economic Planning with the belief that it is a fundamental human right that couples should have the opportunity to decide freely the number and spacing of their children (Karra, Stark and Wolf, 2013). The primary focus of these projects was to augment demand and use of modern methods of family planning through the use of social marketing strategies.

The main goal of the family planning programme was to aid couples and individuals of all ages to attain their reproductive goals and advance their general reproductive health through information and counselling on contraception and other reproductive health services (Asamoah, Agardh, and Per-Olof, 2013). Afterwards Maternal and Child Health (MCH) and the Ghana National Family Planning Programmes were combined under the Ministry of Health. It then became MCH/FP. In the 1994, the International Conference on Population and Development (ICPD) was held in Cairo. As an outcome of the conference, Ghana endorsed the Programme of Action of ICPD and adopted the ICPD definition of reproductive health (UNPFA, 2010). The components of the ICPD are — safe motherhood, family planning, prevention and management



of unsafe abortion and post abortion care, prevention and management of reproductive tract infections including sexually transmitted diseases (STI) and HIV/AIDS, prevention and management of infertility, prevention and management of cancers of female and male reproductive system, responding to concerns about menopause, discouragement of harmful traditional practices, gender based violence and reproductive health care, sexual health and information, education and communication (UNPFA, 2010). In 1983, the Ministry of Health took over the accountability for organizing the information and education phase of the family planning programme. Organizations like Planned Parenthood Association of Ghana and the Christian Council of Ghana partook actively in the activities of the National Family Planning Programme. The Catholic Secretariat placed more importance on the rhythm/ovulation method. Volunteers from the community were also employed in some projects for the circulation of contraceptives and private medical practitioners offered family planning services (Aryeetey and Hindin, 2010).

#### **2.4 State of family planning in Ghana**

Family planning activities in Ghana started in 1961 when the Committee on Christian Marriage and Family Life of the Christian Council of Ghana opened the first family advice centre in Accra with the objective of offering advice to married couples on family planning and responsible parenthood (Aryeetey and Hindin, 2010). This was followed by the activities of the Planned Parenthood Association of Ghana (PPAG) and later the establishment of the Ghana National Family Planning Programme in 1970 after the adoption of the Ghana Population Policy in March 1969 (Aryeetey and Hindin, 2010). Since then, family planning services have become an integral part of the health care delivery system as well as a means for the promotion of responsible parenthood in the country (Aryeetey and Hindin, 2010). Some of the policies and programmes



that have focused on family planning in Ghana include the National Population Policy of 1969 which was revised in 1994, the National Reproductive Health Policy which among other things also covers safe motherhood and family planning, and the Adolescent Reproductive Health Policy which aims at promoting the rights of adolescents to sexual and reproductive health information and services in a caring and friendly atmosphere (Asamoah, Agardh and Per-Olof, 2013).

The Ghana Health Service (2000) of the Ministry of Health and its partners is of the belief that the impact of population growth on development of a nation is critical and worth noting. The GHS is therefore of the view that the growth of the population should be in tune with economic growth which enables development to take place (Asamoah, Agardh and Per-Olof, 2013). According to Bawah, Simmons and Phillips (2013) without sufficient support for family planning, the quality of the population will be compromised. Again, it states that without the support for family planning, the achievements made in the Total fertility rate (TFR) of Ghana will be lost as evidenced in the low uptake of family planning services which has led to a low contraceptive prevalence rate. Despite these advances, the prevalence of contraceptive use is still lowest among currently married women in the youngest (15-19) and oldest (45-49) age groups (19% and 18%, respectively). Similar proportions of urban and rural married women use contraceptives (26% and 27%, respectively). By region, the contraceptive prevalence rate (CPR) among married women is highest in Volta (32 %) and lowest in the Northern region (11%).

The WHO further says that family planning plays a major role in reducing maternal deaths, which is currently at 380 per every 100,000 live births in Ghana, and newborn morbidity and mortality, which also stands at 78 per every 1,000 live births (WHO, 2011). The three main family planning methods used in Ghana are the short-term methods, which are the pills,



condoms, injectables and spermicide; long term which are the Intrauterine Device (IUD), implants and intrauterine system (IUS); and finally the permanent methods which include vasectomy and female sterilization (GHS and GSS, 2014)

## **2.5 Knowledge level of women on family planning services**

Worldwide contraceptives prevalence (the percent of couple currently using contraception) is estimated to have reached 58% (UNPFA, 2010; Chacko and Kabagambe, 2013). At 70%, the average level of use is higher in the more developed region than in the less developed regions, where average use is estimated at 55% (WHO, 2015; UNPFA, 2010). While overall levels of contraceptive use remain higher in the more developed regions the gap is narrowing developing countries (WHO, 2015; UNPFA, 2010). Knowing about family planning services is presumed to be a first step in stimulating the desire for its use. Assessment of knowledge about family planning service therefore does not only determine the extent of awareness and sensitization (Woldemicael and Beaujot, 2011) but further provides the background for which use of the service is further evaluated. Knowledge of people concerning family planning always influences their decision to use or not to use a particular family planning method (Schoenmarkers, 2013; Kanitkar and Kulkarni, 2012). In a cross sectional survey conducted by Obare, Keesbury and Liambila (2010) in Kenya it was discovered that all the women who were sampled for the survey for the research said they had ever heard of family planning before. Similarly, Najafi, Rahman and Juni (2011) reported that women had a very good knowledge concerning family planning methods but felt reluctant to use it during sexual intercourse in Malaysia.

In Ghana, Parr (2013) findings revealed that women had high knowledge on family planning with their sources of information as the media, friends and relatives. A study done by Chacko and Kabagambe (2013) among women in their reproductive age in Uganda revealed that that



most of the non-literate lack adequate knowledge about the use of family planning services and they lack positive attitude towards its use. The knowledge level of the respondents on family planning was low largely due to illiteracy and their level of exposure on family planning information and service. It was also as a result of their lack of accessibility to information, limited availability and access to modern family planning services, poor family planning services, insufficient numbers of trained service providers, poor interpersonal skills on the part of service providers and limited essential commodities on family planning services. As a result of their partial knowledge on family planning, this might have led to their negative attitude towards the use of family planning method and because of the myths, rumors on the use of it, misconception/ doubt or wrong notion that it has a negative side effect to the health of women (Chacko and Kabagambe, 2013). In Nigeria, Olakojo (2012) revealed that women said they were not going to practice family planning because it was not effective. They stated that those who had practiced family planning before complained of it not being effective.

However, in a similar study conducted in Lagos, Nigeria, by Odimegwu (2013) it was showed that women said they were practicing family planning because it was effective against unintended pregnancies. In an evaluative study done by Muia, Blanchard and Lukhando (2012) in Kenya among women, it was revealed that most of the respondents had high level of knowledge about family planning but this did not translate into the use of modern methods of family planning. From the analyses of their findings, it was showed that, there was no statistical relationship between age and using family planning methods among the women ( $\chi^2=35.55$ ;  $df=3$ ;  $P = 2.22$ ). In a related development, World Health Organisation (2012) report revealed that women had high level of knowledge concerning family planning in the world. Similarly, in a cross sectional descriptive survey conducted by Tajure and Pharm (2010) among female students



of Jimma University, Southwest Ethiopia showed a high knowledge concerning family planning. However, a study by Rutenberg (2013) showed that women in a rural village in Uganda had no knowledge on family planning. Past studies show that Radio use to be the highest source of information on family planning closely followed by friends and television (DeClerque, Tsui and Barcelona, 2014). Similarly study undertaken in Basrah city South of Iraq showed that health personnel 54%, relatives 41.2% and friends 4.8% were the major sources of information of study participants' knowledge of family planning (Ebrahim and Muhammed, 2011). In contrast, a study conducted in Delhi, India showed that, the common sources of information were mass media (35%) followed by health personnel 31.3%, magazines 20.0% and personal relations i.e. spouse friends and relatives 13.8% (Jaya and Hindin, 2012).

In a study conducted by John (2010) among women revealed that there was an association between women age and knowledge concerning family planning information and service. The analysis of the results was found to be statistically significant at  $p > 0.001$ . But contrary to that results studies done in South Indian by Karra, Starkand and Wolf (2013) revealed no statistical significant association between women age and they having knowledge on family planning service  $p > 0.008$ . On the other hand, according to Qatar, Varanasi and Maudlin (2015), there was an association between women educational level and knowledge of family planning service. However, a study by Ebrahim and Muhammed (2011) among educated women revealed that out of 566 study participants 85.7% were not currently using any family planning method. According to a study done by Mengistu (2010) in Oromia Regional state, Arsi Zone, Asella town, South-East Ethiopia among women concerning family planning usage, showed that, only 71.5% were current users.



Similarly, a study conducted in Cambodia showed 56% of respondents were using one method of family planning at the time of the study (Neville and Golden, 2010). According to Mengistu (2010) women who were aged 30 years and above were 2 times more likely to make the choice to use family planning methods as compared to those who were less than 30 years (OR = 2.0; 95% CI: 0.9– 4.2; P = 0.000). Implying that age of women was a significant factor for family planning service usage. A study conducted in Egypt by Giusti and Vignoli (2012) indicated that the levels of family planning knowledge and use among people living in rural areas of Egypt differ substantially from those of people living in urban areas. The results suggest that lack of knowledge and familiarity with modern family planning methods remains an important barrier to modern contraceptive use in Egypt, particularly in the indigenous population (Giusti and Vignoli, 2012). The analyses of variance and means showed that there was no statistical relationship between marital status of the people and practicing family planning.

However, according to Aryeetey, Kotoh and Hindin (2010), there was a statistical relationship between women marital status and using family planning methods in Ghana. Similarly, marital status was found to be a predictor of women using family planning methods in Kenya (Neville and Golden, 2010). Similarly, Wablembo, Ntozi and Kwagala (2011) found that use of family planning methods increases with education from 19 % for currently married women with no education to 34 percent of women with a tertiary education. Somewhat different patterns are observed for use of modern methods; their use is highest among women with primary education (27%) and lowest among women with no education (17%). Occupation of women was found not to be a significant factor of them using family planning according to a study done by Sonenstein (2011). In the same vein, a descriptive sectional study of women in Kenya revealed that there was no statistical association between occupational status of women and using family planning





methods (Postlethwaite, 2013). Renjhen (2013) also observed that women husbands' occupational status did not significantly influence them to go in for family planning service.

However, according to Rajaretnam and Deshpande (2014) women whose husbands were employed in the formal sector were 4.5 times more likely to influence them to use family planning methods as compared to those whose husbands were not working (OR =4.5; 95% CI: 0.9–4.2; P= 0.003). Maudlin, (2015) did not however, find any significant association between women husbands' occupation and having positive knowledge on family planning service in Tanzania.

## **2.6 Various types of family planning methods known to women**

Family planning methods are varied. Some are permanent and the others are reversible. Some of the methods are classified as modern while the others are traditional (Neyaz, Ahmed and Sahu, 2015). The continuation of use and the switching between various types of family planning methods is insightful to assess the implications of contraceptive used patterns for unintended pregnancies (Mahaini, and Mahmoud, 2013). Modern family planning methods are more widely known than traditional methods; almost all women 99% know of a modern method, compared with 85% who know of a traditional method (Maudlin, 2015; Chacko and Kabagambe, 2013).

Among modern methods, the male condom 96%, injectables 92%, the pill 91%, and female condoms 87% are the most commonly known modern methods among women (Chacko and Kabagambe, 2013). When compared with other modern methods, lactational amenorrhoea is known by a relatively small percentage of women 16% (Chacko and Kabagambe, 2013). Although about 7 in 10 women are aware about female sterilization, just about one-third are aware about male sterilization (Maudlin, 2015; Chacko and Kabagambe, 2013).



Among traditional methods, rhythm and withdrawal are known by about three-quarters of all women 77% and 74%, respectively (Chacko and Kabagambe, 2013). The extent of and patterns in knowledge of modern and traditional methods of family planning among currently married and sexually active unmarried women are similar (Maudlin, 2015). Specific knowledge of women on various family planning methods have improved over the years (WHO, 2015). For instance knowledge of family planning methods has improved significantly from the baseline of 2006 to the mid survey of 2009. Likewise, majority (67%) of women had ever heard of the IUD in 2006, this increased to 75% in 2009 (WHO, 2015). However, nearly half (49%) of women of reproductive age had ever heard of traditional methods in 2006, this has increased to 66% in 2009 (WHO, 2015). The mean number of family planning methods known has increased from 7.2 to 7.6 among women of reproductive age (WHO, 2015). According to Helzner (2013) the most common method of family planning identified by respondents known and ever used was the male condom, others identified the pills whilst few mention injectable (depo-provera).

Knowledge of people concerning family planning always influences their decision to use or not to use a particular family planning method. In across sectional survey conducted by Wablembo, Ntozi and Kwagala (2011) in Uganda it was discovered all the women who were sampled for the survey for the research said they have ever heard of family planning methods before. Similarly, Tamire and Enqueselassie (2010) reported that women had a very good knowledge concerning family planning methods but felt reluctant to use it during sexual intercourse in Tanzania. In a cross sectional survey carried out by Sonenstein (2011) in rural Kenya among married women, it was reported that most of the respondents could not mention one example of family planning method but only stated that it was against their religious beliefs. A study done among female university students in Lesotho on the awareness and use of and barriers to family planning



services found out that 97.5% of the students were aware of contraceptives and family planning methods. Many of the respondents (69.4%) knew about family planning methods while still in secondary schools and the primary source of information about family planning methods and contraceptives was through media (57.8%), 4.4% of the respondents knew through internet which was the least common source of information (Raju and Leonard, 2013b). In Kenya, knowledge of family planning methods among married women of reproductive age of 15-49 is above 90% giving a contented demand of 63% (WHO, 2012). In fact only 2% of married women were currently not using family planning methods due to lack of knowledge (WHO, 2012).

Renjhen (2013) in recounting the contribution of economic status to family planning methods said that many developing economies are characterized by rapid population growth that is partly attributed to low contraceptive prevalence rate, high fertility rate, high birth rates accompanied by steady declines in death rates, and high but declining mortality rate. Owusu-Agyei, Adda and Mbacke (2012) opined that the overriding factors that influence people use of family planning methods were widespread myths and misconceptions about family planning for women and men.

Majority of the males in Somalia have indicated that family planning makes a woman cold in bed, while many others elicited fears that vasectomy would render them unable to have sex (Phipps, 2012).

They held that this would harm their standing in society, as well as cause their spouses to look for other partners (Rajaretnam and Deshpande, 2014). Olakojo (2012) has therefore advocated that health care givers need to dispel such rumors in order to increase uptake of family planning methods among women. For example, vasectomy, regarded as one of the most effective means of birth control, should be offered free of charge. The fear of what might happen in the event that a man loses children either through death or divorce, given that vasectomy is irreversible, is also



a fear of women in using family planning methods (Olakojo, 2012). In a related development, a study by Giusti and Vignoli (2012) revealed that women had knowledge about family planning methods in Egypt. This assertion was based on the high knowledge of women on vasectomy, injectables, pills and IUDS as effective birth control methods. However, in a cross sectional survey carried out by DeClerque, Tsui and Barcelona (2014) in rural Egypt among married women, it was reported that most of the respondents could not mention one example of family planning method but only stated that it was against their religious beliefs.

In a related development, women in Nepal cited that there were two methods of family planning; permanent and temporal and stated that they like the temporal since it was flexible (Chapagain, 2013). The family planning effect can be obtained through temporary or permanent means. Temporary methods include: periodic abstinence during the fertile period; coitus interruptus (withdrawal); the naturally occurring periods of infertility (e.g., during breast-feeding and postpartum amenorrhea); use of reproductive hormones (e.g., oral pills and long-acting injections and implants); placement of a device in the uterus (e.g., copper-bearing and hormone-releasing intrauterine devices); interposing a barrier that prevents the ascension of the sperm into the upper female genital tract (e.g., condoms, diaphragms, and spermicides) (Brown and Eisenberg, 2013). Permanent methods of contraception are male and female sterilization (vasectomy and tubectomy, respectively) (Brown and Eisenberg, 2013).

In a study done by Beekle and McCabe (2013), Depo-Provera was the most well known device (100%) in temporary family planning devices followed by Condom (98.2%), Oral Pills (93.6%), Implant (71.6%) and Copper-T (61.5%) among women which is in contrast to the study done in Khotang by Brown and Eisenberg (2013) where Depo-Provera (86.6%), oral pill (83.0%), condom (75%), Implant (57.1%) and Copper-T (40.2%) were known among women. Male



sterilization was the most known (91.7%) permanent method of family planning than female sterilization. Among sexually active unmarried women most of whom were young the most common methods of family planning known were; the male condom and the pill 23% each, followed by injectables and rhythm (12 % each), and implants 10% in Lagos, Nigeria (Bhattarai and Panta, 2013). Use of a traditional method is notably higher among sexually active unmarried women (13 %) than women who are currently married 5% (Asamoah, Agardh and Per-Olof, 2013).

In Nepal, a study by Chapagain (2013) revealed that Injectables were the most widely used modern method among currently married women (87%), followed by the implants and the pill (13 % each). According to the Ghana Demographic Health Survey, (2014), acquiring knowledge about contraceptive methods is an important step towards gaining access to family planning services and adopting a suitable contraceptive method. The ability to recognize a family planning method when it is described is a simple test of a respondent's knowledge of the method but not necessarily an indication of the extent of his or her knowledge. The 2014 GDHS collected information on knowledge of contraception by asking respondents whether or not they had heard about eight modern methods (female and male sterilization, intrauterine contraceptive devices (IUCDs), injectables, implants, the pill, male and female condoms, lactational amenorrhoea method (LAM), emergency contraception, and two traditional methods (rhythm and withdrawal). It is noted that contraceptive knowledge among unmarried women was found to be 100 %. Condoms, diaphragm, the pill, implant, foam tablet and Lactational amenorrhoea were among the methods commonly identified.

Knowledge about modern and traditional contraceptive has changed over a decade and half ago. Whereas the latter was popular among Ghanaians, the former is now popular even though users



of contraceptives use the traditional methods (Bawah Akweongo and Phillips, 2010). Bhattarai and Panta (2013) showed that knowledge on at least one modern method of family planning in Nepal is universal among both women and men. Knowledge of modern contraceptives among the respondents is universal, with 99% of women being aware of at least one modern method of family planning. The same goes for another study done in Cambodia showed that 99.3% of respondents had heard about family planning methods (Andersch, 2012). Sonenstein (2011) observed that most women like to use the pills as form of family planning methods. Use of a traditional method is highest among women with no children (7%) and lowest among those with five or more children (3%) (Bhattarai and Panta, 2013; Madhukumar and Pavithra, 2015). According to Olakojo (2012), most women in Lagos, Nigeria, stated that they had ever used spermicidal before as a form of family planning method.

Contrary, to this finding was the study done in Kenya by Obare, Keesbury and Liambila (2010) where women admitted they had never used spermicidal as a form of family planning method. It had been reported by Olakojo (2012) that the use of family planning methods increases with increasing number of children, from 21% for women with no living children to 30% for those with three or four children, and to 27% for women with five or more children. The same pattern is observed for use of most modern methods, with the exception of male condom use, which decreases with increasing parity. In Butajira Division, South Central Ethiopia it was revealed that Depo-Provera and pills were known by more than 97% of married women (Neyaz, Ahmed and Sahu, 2015). This was followed by male condom and Norplant by about 82% and 75% of the respondents, respectively. In this study also the least known modern contraceptive method was foam/jelly (14%). There was a low level of knowledge on traditional methods such as rhythm method (21.3%), lactational amenorrhea method (LAM) (31%) and withdrawal (20.2%) among



married women of reproductive age (Neyaz, Ahmed and Sahu, 2015). Attitude has always been a subject of interest to many researchers as well as psychologist. It is considered as exciting and mysterious to some researchers (Phipps, 2012). It can function as a shield to someone or it can even function as a weapon to someone (Anand, 2013; Owusu-Agyei, Adda, and Mbacke, 2012). Having a certain attitude in life is crucial to people so as to help them live in harmony and towards better understanding of things around them (Anand, 2013). Attitudes play a major part in determining a person's personality. This is because attitude affects the way people perceive and act towards issues, objects or events that they encounter. Besides that, attitudes can also have an effect on one's social interactions and health seeking behavior in the community (Abera, and Tebeje, 2010; Madhukumar and Pavithra, 2015).

According to a study done by Sharma Mohan and Awasthi (2012) concerning women attitude towards emergency contraceptives usage in Thailand, findings revealed that most were not using emergency contraceptives and stated that emergency contraceptives have been stocked in the Pharmacy units for quite a long time and their efficacy was in doubt. Similarly, in Uganda, most women showed a bad attitude towards emergency contraceptives and when they were asked they said they have ever used it before and it did not work (Abera, and Tebeje, 2010). This could be explained to mean that attitudes are evaluative reactions to person's perception of an idea, objects, and events (Anand, 2013). And it may include the beliefs of positive and negative feelings about the attitude object (Anand, 2013). According to a cross sectional survey conducted by Sonenstein (2011) concerning attitude of women towards emergency contraceptives usage in Nepal, most of the women had positive attitude towards emergency contraceptives. This they researchers stated that attitude can guide the experiences and decide the effects of experience on the behaviours of people. It is importance to state that, a momentary feeling does not count as an



attitude (Debpuur Ogunjuyigbe, Ojofeitimi and Liasu, 2013). According to them attitudes are lasting since it remains across time (Debpuur et al., 2013). Positive attitude from a woman is required in order to be effective in the usage of emergency contraceptives (Parker, 2010). In Nigeria, teenager girls indicated that adults discouraged them from using emergency contraceptives for fear they might become barren in the future (Debpuur et al., 2013). In Tanzania, women had negative attitude towards emergency contraceptives since they believed that emergency contraceptives promotes unfaithfulness, among women and is only women who want to have sexual multiple partners that would go in for emergency contraceptives to prevent pregnancy (Parr, 2013).

In Ghana, women attitude towards emergency contraceptives is not encouraging as many of them said they had never recommended it to a friend before (Parr, 2013). In Ethiopia, most women had bad attitude toward emergency contraceptives since they perceived it to be too costly to purchase (Quraishi, 2013). Despite these, others have observed contrary relations to the use of emergency contraceptives with women. Correct information about emergency contraceptives has been linked to more favourable attitudes towards eemergency contraceptives usage especially among teenagers in England (Rimal, 2013). Qualitative research among South Africa youth found positive attitudes towards emergency contraceptives based on beliefs that eemergency contraceptives prevents pregnancy and cause minimal reproductive health problems (Sonenstein, 2011). Mixed attitudes towards eemergency contraceptives were also reported in Ghana and were based on the belief that eemergency contraceptives promote barren among women whilst other stated that emergency contraceptives prevents pregnancy (Sterley, 2011). Kenya's Demographic and Health Survey (married women only) found that non users who did intend to use emergency contraceptives in the future (Rimal, 2013). Lower levels of prescription have





been found in studies in developing countries concerning emergency contraceptives in health centres (Maudlin, 2015). In Nairobi, Kenya, 15% of family-planning service providers reported having prescribed emergency contraception, and only 20% of primary healthcare workers recommended emergency contraceptives for clients to use (Nuruzzaman, 2010).

In other studies, all the respondents did not believe that emergency contraceptives were 100% effective but believed that emergency contraception is safe and effective (Mengistu, 2010). In Bangladesh, a study by Nuruzzaman (2010) showed that women stated that they had ever used withdrawal method as a family planning method with their husbands. In northern part of Nigeria, Ogunjuyigbe (2013) observed that women said they were not using withdrawal method as a family planning method with their husbands and even wondered how effective it was. In Malaysia, a study done by Najafi, Rahman and Juni (2011) found that women had ever used calendar method as a natural family planning method whilst Obare, Keesbury and Liambila (2010) observed that in Kenya, women were not comfortable with the calendar method of natural family planning. Okech, Wawire and Mburu (2011) also found that marital status of women did not influence their knowledge on calendar method as a method of natural family planning. According to a study conducted in Uganda by Sargent and Cordell (2012) among women on their knowledge concerning the calendar method, only few said they like it because it was effective whilst others said they were not comfortable with it.

### **2.6.1 Contraceptive methods available for use**

- Dual protection and dual method use (Condom plus emergency contraceptive)
- Barrier methods (male and female condom, jellies, cervical cap and spermicidal foam)
- Emergency contraception (Combined Oral Contraceptives-COCs and Progestogen-only Pills- PoPs)



- Low-dose combined oral contraceptives (COCs)
- Combined injectable contraceptives (CICs)
- New hormonal delivery systems
- Progestogen-only pills (POPs)
- Progestogen-only injectables
- Progestogen-only implants
- Intrauterine devices (IUDs)
- Natural family planning/fertility awareness based methods
- Lactational amenorrhoea method (LAM)
- Withdrawal (BMHD, 2014)

### **2.7 Factors that account for the unmet need for family planning services among women**

The unmet need for family planning is defined as the proportion of married women or those living in consensual unions of reproductive age, presumed to be sexually active, but are not using any method of contraception (Chapagain, 2013; Chacko and Kabagambe, 2013). These women would either like to postpone the next pregnancy (unmet need for spacing), or do not want any more children (unmet need for limiting), (Chacko and Kabagambe, 2013). In other words, the concept of unmet need for family planning refers to the discrepancy between individuals' family planning use and their stated fertility intentions (Bhattarai, and Panta, 2013; Asamoah, Agardh and Per-Olof, 2013).

Throughout the whole world, there has been a progress in the access to family planning services and products, but the unmet needs for family planning continue to remain high (WHO, 2015; Chacko and Kabagambe, 2013). In the developing countries, the number of individuals wishing to use family planning supplies and services but do not have access to modern contraceptives



still remain high (Asamoah, Agardh and Per-Olof, 2013; Albsoul-Younes and Saleh, 2012). Limited attention has been paid to determine the causes of the unmet need for family planning especially among low income urban residents, despite family planning being an important issue in public health policy for women in the entire population (Adanu, Darko and Rosemary, 2014). Religions and traditionally held beliefs are factors affecting the usage of contraceptives services in Ghana (Coverdale, Turbott and Roberts, 2014; Ebrahim and Muhammed, 2011). On the issue of use, inadequate information and the spread of rumors have affected many women's attitude towards adopting modern planning methods (Beekle and McCabe, 2013). There are mild effects experienced with the use of contraceptives but these are not that serious and are usually short lived, but these have been so grossly exaggerated to the extent that, a lot of women are skeptical in using modern family planning methods (Gelaye and Mekonen, 2014). In a across sectional study conducted by Bawah, Simmons and Phillips (2013) in Ghana, it was discovered that most men do not like to use family planning methods during sexual intercourse. It was revealed that majority of the respondents mentioned that the use of the male condom interfered with sexual pleasure, wasted their time and was not always available.

According to Aryeetey and Hindin (2010; p 12) "It is men who usually decide on the number and variety of sexual relationships, timing and frequency of sexual activity and use of contraceptives, sometimes through coercion or violence". In their study, it was found that husbands prevent their wives from using family planning especially the pills that are usually taken to the house. Attitude of women towards family planning can influence them positively or negatively on how often they use family planning. According to Gille (2015) women who were sampled on how often they use contraceptives during sexually encounters revealed that majority of the respondents said they were not using contraceptives during sexual intercourse whilst a relatively fewer number



indicated that they were using contraceptives during sexual intercourse (Hausmann-Muela, Muela and Nyamongo, 2013).

Among the currently married women of reproductive age in Kenya, 25 % have unmet need for family planning (WHO, 2012). Despite all the efforts made to increase the uptake of family planning methods the total met need has hardly changed over time (WHO, 2011). However, there are wide regional variations in total unmet need, but determinant variables of unmet need in many regions are more or less the same. Several groups of women continue to have high unmet need for family planning which includes younger aged, older age, low or uneducated, having higher number of living children, women with low knowledge on contraceptives and those not exposed to mass media and women in lowest wealth quintiles (Kanitkar and Kulkarni, 2012; Coverdale, Turbott and Roberts, 2014). Karra, Stark, and Wolf (2013) revealed that women in India mentioned that it was easy to get access to family planning services.

Wealth is important for utilization of family planning services (Coverdale, Turbott and Roberts, 2014). Studies have showed that women who are poorer tend to have a higher unmet need. There were higher proportions of unmet need among poorer women than the richest women in Tanzania (Coverdale, Turbott and Roberts, 2014). According to Asamoah, Agardh and Per-Olof (2013) most women were not having access to family planning services in Ghana most especially those in rural areas. Similarly, Bawah, Akweongo and Phillips (2010) findings stated that women in northern Ghana mentioned that the attitude of service providers at the hospital was bad and this affected them in accessing family planning services. Many studies have documented that women living in slums generally receive inadequate services to deal with their reproductive health care, and immediate attendants often lacked the knowledge to deal with these issues when they occur in the neighborhood (Kamal, 2012; Corker and Ligne, 2010). Many couples are



sexually active and prefer not becoming pregnant, but they are not using any contraceptive method. These women are considered to have unmet need of family planning (Helzner, 2013; Corker and Ligne, 2010).

In Zambia, according to a cross sectional survey carried out by Hamid and Stephenson (2013) it was discovered that most men (80%) said they had no intention of using family planning methods because it was against their religious practices, 11% respondents mentioned that the use of condom was interfering in sexual pleasure whilst 9% respondents however revealed that they were ready to use contraceptives. Similarly, in Ghana, most men prevented their wives from going in for family planning because according to them family planning leads to infertility and difficulty in child bearing later in the life of the women (WHO, 2015). Chapagain (2013) cited side effects of family planning as one of the reasons women said they were not going to use family planning services in Nepal. In the similar vein, Bawah, Akweongo and Phillips (2010) found that side effect of family planning was cited by most women in Northern Ghana as one of the reasons for their failure to use family planning services. In Ghana, according to a cross sectional survey carried out by Adjei et al. (2014), it was revealed that most men did not permit their wives to go in for family planning because they perceived family planning to be used by women who wanted to engage in sexual activities. However, according to Baumgartner, Johnson and Nyamhanga (2010), most men in Tanzania allowed their wives to go in for family planning because they wanted smaller family size.

In a related development, a study in Zimbabwe by Bhattarai and Panta (2013) revealed that most men allowed their wives to go in for family planning because they wanted smaller family size. In Urban Pakistan, however, a study conducted by Hamid and Stephenson (2013) revealed that most men sparingly discussed sexual issues with their wives and this affected their use of family



planning service. There are several reasons as to why few women in Uganda who want to delay or avoid a future birth are not using contraception (Obare, Keesbury and Liambila, 2010). The most frequently cited reason for not currently using a method was the fear of side effects (29%), followed by the woman who was breastfeeding (20%); or the woman who was having infrequent or no sex (14%). A number of women also said that they were not using a method because their husband or partner was opposed to the use of a method (Obare, Keesbury and Liambila, 2010). The study noted that more than one in three currently married women who have an unmet need and do not intend to use a method in future mentioned fear of side effects as the main reason for not intending to use a contraception while 13% said they would not use a contraception in future because they had infrequent or no sex and 12% reported that they were sub fecund (Obare, Keesbury and Liambila, 2010).

In Egypt, DeClerque, Tsui, and Barcelona (2014) cited socio-cultural factors affecting family planning use among women. In Nigeria, Catholic women have the highest level of unmet need for contraception among all the religious groups and a higher proportion of rural than urban women have unmet need than their urban counterparts (Obare, Keesbury and Liambila, 2010). Low perception of pregnancy risk is another critical factor in influencing attitudes about family planning use. Chapagain (2013) revealed that women said their husbands did not support family planning service and this affected their patronage of it even in the future. In a facility-based research carried out in Nigeria, it was found that husband's disapproval, fear of side effects and religious beliefs were the main constraints to the use of family planning service (Okech, Wawire and Mburu, 2011). It was also documented that there is a significant association between husband education and unmet need of family planning among women in Zaria (Okech, Wawire and Mburu, 2011).



Beekle and McCabe (2013) observed that there was no statistical association between men education and supporting family planning among their wives. Similarly, Bhattarai and Panta (2013) did not find any association between women husbands educational status and using family planning methods in Jimma, Ethiopia. Opposition to the use of family planning among women by their husbands accounts for a significantly large percentage of the unmet need (WHO, 2012). In Bangladesh, most men never approved the use of contraceptives for their wives because they perceived it to be against their religious practice, causes infertility among women and promoted sexual promiscuity among young and married women leading to unmet needs of family planning services (Islam, Padmadas and Smith, 2013). In South Central Ethiopia, reasons for the high unmet need included erratic supply of commodities, religion, and complaints related to providers and methods (Jain, Visaria and Visaria, 2013). A study in India documented a positive relationship between number of children surviving and a woman's probability of having an unmet need; women with four or more living children were more likely to have unmet need compared with women with fewer children (Giusti and Vignoli, 2012). In Kuwait and Ethiopia, educated women are more likely to use contraception and women's education is a better predictor of unmet need than autonomy (Freedman, 2014).

An illiterate woman in Mexico is 1.6 times less likely to practice contraception when compared with a woman who attended secondary school (Philips, 2015; Parr, 2013). Women who have ever discussed contraception are 2.2 times more likely to use a family planning method (Chacko and Kabagambe, 2013). A woman with employment is more likely to use modern contraceptives just as a woman with higher parity (3 or more children) is more likely to use any modern family planning method compared with those who have 2 or less children (Omo-Aghoja, Omo-Aghoja and Aghoja, 2012). Many women fear the side effects of contraceptives, having heard rumours



or experienced some side effects themselves; these constitute 39% of women with unmet need in sub-Saharan Africa (WHO, 2011). In a facility-based research carried out in Nigeria, it was found that husband's disapproval, fear of side effects and religious beliefs were the main constraints to the use of contraceptives (Giusti and Vignoli, 2012). It has also documented that there is a significant association between parity and unmet need (Postlethwaite, 2013). A study conducted by Rajaretnam and Deshpande (2014) on factors affecting family planning use among women was presumed to be influenced by many psychosocial factors.

Some of these factors included; education, place of residence, employment status, marital status, religion, ethnicity, region of residence, knowledge of family planning method and knowledge of source of family planning method. It stated that demographic variables influence current family planning use (Sargent and Cordell, 2012). It is assumed that the independent variables influence the dependent variable indirectly through the intermediate variables as stated in the study (Raju and Leonard, 2013b). The determinants for not using contraception or family planning services are varying due to differences in social, economic and cultural backgrounds among married women (WHO, 2011). High quality family planning services and appropriate contraception may be inaccessible, unavailable, or costly for many women, especially in low-income countries (Sterley, 2011). There is also limited choice of family planning methods which may be due to the contraceptive cost, side effects, dislike, or beliefs (Sharma, Mohan and Awasthi, 2012). Determinants of the unmet need for family planning services may be due to economic reasons, social, cultural and/or lack of knowledge on family planning service (Tajure and Pharm, 2010). According to Chapagain (2013), factors that influence directly or indirectly women from using family planning methods are; education, place of residence, employment status, marital status,





religion, ethnicity, region of residence, knowledge of method and knowledge of source of method.

Unmet need for family planning services varies between regions of the world, countries or within countries and is determined by several socio-cultural factors such as women autonomy (Schoenmakers, 2013), by socio-demographic factors such as women's age, age at marriage, sons preference and number of children surviving, and by socio-economic factors such as work status, educational level of both couples, and standard of living (Tamire and Enqueselassie, 2010). A study done by Coverdale, Turbott and Roberts (2014) found out that resident women residing in rural areas were significantly more likely to be affected by all types of unmet need for family planning (spacing, limiting and total unmet need) with OR=4.79, 2.46 and 3.63, respectively). Studies in other sub-Saharan African countries also showed that rural women had significantly higher unmet need compared to urban women (Coverdale, Turbott and Roberts, 2014). When women are economically empowered their decision making on fertility is affected which has implication for contraceptive use. It was known in a study that mother's occupation in India revealed a significant association with number of living children (Bawah, Akweongo and Phillips, 2010). Further analysis shows that economic dependence level of woman on her close relations affected her family planning service decision process (Schoenmakers, 2013). A study carried out in Nepal found out that there was a significant association between unmet need for family planning services and gender preference for children (It states that women would prefer to have more sons as compared to girl child (Tafforeau, Damiba and Maternowska, 2013).

Therefore, if a woman wants probably more extra sons there is a high tendency of this group of women having unmet need (Tuladhar and Marahatta, 2010). It was revealed in this study that family planning was more commonly used in women having "male" as their first child as



compared to the women who had female as their first child showing strong son preference in the studied population. Several studies show that women's work status is related to unmet need (Wablembo, Ntozi and Kwagala, 2011). Women who are working outside the home have a lower probability of having unmet need than those who work at home or indoors (Wablembo, Ntozi and Kwagala, 2011). One other study done in southern Sudan found out that unmet need for family planning declines with a woman's educational achievement and employment status, as the woman become more and more empowered (Woldemicael and Beaujot, 2011).

In East Africa, studies document that unmet need for family planning is lower for women with better education (WHO, 2012). For instance in Uganda, unmet need was lower for women with secondary or higher education and in Kenya, women with primary incomplete education were 2 times more likely to experience unmet need for family planning compared to those with primary complete or higher education (Rutenberg, 2013). The same case applies with place of residence and husband's education. When both husband's and wife's education were put in the same model, husband's education became insignificant, suggesting that wife's level of education was more important if couple's unmet need were to be reduced (Schoenmarkers, 2013). Another study done in Pakistan found out that although socio-demographic factors were important in determining couple's unmet need, some of them proved rather significant, for example, religion (Tuladhar and Marahatta, 2010). Religion has been shown in other studies as a key factor that may determine the use of family planning, particularly Catholic and Muslim. Muslims had significantly higher unmet needs than Hindus (29.7% vs.19.8%;  $p = 0.04$ ) (Rao and Sinha, 2011). Unmet need for limiting was highest (15.2%) where as spacing method constitutes at 9.4%. Culturally, in some communities the use of contraception may be taken as a cause of sexual unfaithfulness among the taker. It is also believed that married women may need partners



consent to access family planning services or contraceptive use at an individual level (UNFPA, 2010; Wablembo, Ntozi and Kwagala, 2011). Numerous studies have shown that the foremost determinant for an unmet need are lack of knowledge about family planning methods (Subhash, 2003), health concerns or fear of the side effects of contraception, and opposition of husbands, other relatives, or lack of self-rule among women themselves (Sterley, 2011; Sonenstein, 2011). Nearly half of the respondents (46.1%) in a study done in Gazipur Division in India were not using contraceptives in fear of side effect, religious prohibition, partners' non cooperation, lack of knowledge about method, lack of information on family planning by health worker and economical constraints (Rimal, 2013). Surveys of pharmacists have identified lack of knowledge, negative attitudes, low level of comfort, and lack of adequate continuing education in family planning as hindering the ability of pharmacists to meet the needs of their clients (WHO, 2011). A study conducted in Iraq also revealed that, the main reasons for not using family planning services were side effects (44.4%), followed by the desire to have children as stated by 23.2% of the respondents and other reasons were husband objection, cost of contraceptives and religious beliefs respectively (Rajaretnam and Deshpande, 2014).

## **2.8 Level of male involvement in family planning services**

Husband's support is found to be a good predictor of future practice and continued use of family planning (Wablembo et al, 2011). Studies done in the Philippines indicated that the continuation rate among women whose husbands supported their contraceptive practice is much higher than those whose husbands did not give support to their wives (Quraishi, 2013). In South Korea researchers found that 71 percent of women whose husbands approved family planning had used contraception at some time, compared with 23 percent of women whose husbands did not approve (Raju and Leonard, 2013b). In Madagascar, Norplant continuation rates were higher



after one year among couples in which the husband had been involved in the decision-making process, and among these couples both wives and husbands were more satisfied with Norplant than those in which only the wife was counseled (Parr, 2013). In an evaluation studies conducted by Okech, Wawire and Mburu (2011) absence of the husband was the reason most often reported for discontinuing use of the pill, condom, rhythm method, and withdrawal among women. A national survey carried out to ascertain the interaction between family planning attitudes and use in Nigeria by Odimegwu (2013) showed that while almost 75% of women registered a high level of support for men playing a role in family planning, only about 30% of the men did.

Other studies carried out in various sections of the country supported this finding, such as Odimegwu (2013) whose work on men in Northern Nigeria shows a highly negative attitude towards family planning. A study carried out among married women in Ibadan Oyo state of Nigeria, showed 54% of the women surveyed perceived husband's opposition as a constraint to using a family planning method but one is not sure of the educational or literacy status of these women (Ogunjuyigbe, Ojofeitimi and Liasu, 2013). Nasir (2010) found that men in Uganda feel they should have a major role in the decision to limit fertility but that the responsibility for actual use of contraceptives lies predominantly with women. Mengistu (2010) found that 91% of non use of family planning methods among married women in a community in Enugu State of Nigeria was as a result of their husband being against it. An earlier study by Mekonnen and Worku (2011) in rural Kenya community also indicated that among married women who wished to attend family planning clinics, only one third of them would be allowed to attend by their husbands. Traditionally, most Ghanaian cultures are highly patriarchal, value high fertility and male child preference. A report on reproductive motivation and family size preferences among Ghanaians men concludes that the characteristic male dominant and patrilineal traditions support



large family sizes and that men's reproductive motivation to a large extent, affect the reproductive behaviour of their wives (Najafi, Rahman and Juni, 2011).

These cultural values could have a negative impact on the utilization of family planning services among women (Karra, Stark and Wolf, 2013). Spouse communication is positively associated with family planning use: Demographic Health Survey data from seven African countries (Botswana, Burundi, Ghana, Kenya, Senegal, Sudan, and Togo) show that the percentage of women using modern family planning methods is consistently higher in the group that had discussed family planning with their husbands in the year before the interview than in the group that had not (Jaya and Hindin, 2013). It has been observed that couples who talk to each other about family planning and reproductive health can reach better, healthier decisions (Gupta, Mohapatra and Kumar, 2016). Studies have noted that successful inter-spousal communication is a key strategy to fostering shared decision-making and responsibilities on reproductive health matters (Giusti and Vignoli, 2012).

Globally, the Demographic and Health Surveys report low communication between spouses about family size and family planning in many countries in Asia and sub-Saharan Africa (Ebrahim and Muhammed, 2011). However, where there is communication on these matters, studies have also reported a positive association between spousal communication and family planning, though this association entails problems of causality when cross sectional data is used, as they often are (Gizaw and Regassa, 2011). However, in the Indian context, family planning decision-making goes beyond the couple. This is particularly true in cultures where extended kinship relationship and lineage structures have a socially determining role (Freedman, 2014; Chacko and Kabagambe, 2013). Also, involving men in reproductive health is crucial to promote gender equality in all spheres of life and encourage and enable men to take responsibility for



their sexual and reproductive behaviour and their social and family roles (Brown and Eisenberg, 2013; Hatcher, Sharon, Parag and Collins, 2011).

Successful male involvement is critically dependent on addressing the social and cultural norms that impede health (Gelaye and Mekonen, 2014). It is very difficult for men to access accurate, timely and good quality reproductive and sexual health information and services (Bawah, Simmons and Phillips, 2013). More recently, however, male involvement in reproductive health has become a popular area among reproductive health programme designers, policy makers, and population researchers (Hatcher, et al. 2011). Still, the meaning of “male involvement” has divergent interpretations (Albsoul-Younes and Saleh, 2012). In the patriarchal culture predominantly prevalent in most of India, husbands have the authority to make legitimate decisions on behalf of their wives, and reviews have suggested that they are also involved in making decisions about their wives’ reproductive health, including contraceptive usage, visit to the health facility and family composition and size (Adanu, Hill and Rosemary, 2013; Aggarwal, Bhasin and Rajoura, 2013).

Besides the husbands, in the South-Asian context, the influence of family elders, for example, the mother-in-law or the elder daughter-in-law is also significant as decision makers for the young couple on reproductive health issues (Adjei et al. 2014; Baumgartner, Johnson and Nyamhanga, 2010; Bhattarai and Panta, 2013; Coverdale, J. Turbott and Roberts, 2014). Men’s participation has been conceptualised in several ways since then, for instance: (1) men’s involvement in decisions about family size and family planning; (2) men’s responsibility to reduce risky sexual behaviour and prevent spread of sexually transmitted infections; (3) men’s support for the reproductive health of women; and (4) men’s own reproductive and sexual health needs (Gelaye and Mekonen, 2014; Edwards, 2014). Men obviously make up a significant new



clientele for reproductive health programmes (DeClerque, Tsui and Barcelona, 2014). They constitute an important asset in efforts to improve women's health and efforts to involve them in ways that transform gender relations and promote gender equity and thus contribute to a broader development and rights agenda (DeClerque, Tsui and Barcelona, 2014).

In West Africa, about three quarters of men and women had not discussed family planning with their spouse in the year preceding the survey, except in Ghana and Cameroon where the proportions were about one-half and two-thirds respectively (Bawah, Akweongo and Phillips, 2010). In East Africa, the figure is less than 40 %, except in Burundi and Tanzania (Asamoah, Agardh and Per-Olof, 2013). In Burundi, 94 % of men surveyed approved of contraceptive use, but only 48 percent had discussed it with their wives in the preceding year (Ebrahim and Muhammed, 2011). In across sectional survey conducted by Chapagain (2013) in Nepal it was discovered that all the men who were sampled for the survey for the research said they have ever heard of family planning before except that they were not supportive of it. Similarly, Giusti, and Vignoli (2012) reported that men had a very good knowledge concerning family planning methods but felt reluctant to use it during sexual intercourse.

In a cross sectional survey carried out by Islam, Padmadas and Smith (2013) in rural Kenya among married men, it was reported that most of the respondents could not mention one example of family planning method but only stated that it was against their religious beliefs. A study by Gille (2015) revealed that some men were knowledgeable about family planning. This assertion is based on the high knowledge of men on vasectomy, injectables, pills and IUDS as effective birth control methods. The study however, blamed men's low approval of family planning services in the matrimonial homes. There is the need for a broader approach to be used to address the challenge of male participation in family planning (WHO, 2012). According to Hamid and



Stephenson (2013) health authorities should employ a community health strategy which will offer a comprehensive approach to addressing all health issues including family planning, spelling out participation of men.

Research showed that men not only acted as ‘gatekeepers’, restricting women and children’s access to health services, but also through abuse or neglect, men’s actions had direct bearing on the health of their partners and their children (Karra, Stark and Wolf, 2013). Initially, the way to deal with what increasingly had come to be regarded as ‘the problem of men’ was thought to be to foster women’s empowerment through working directly with women (Jaya and Hindin, 2012). Men, often identified as uncaring and unconcerned about the well-being of their partners, were ignored, and as a result, many health promoters began working directly with women in the communities as a means to empower them and protect them from the impact of men’s behaviour on their lives. This strategy was focused mostly in the area of sexual and reproductive health (Kanitkar and Kulkarni, 2012). Studies have also reported that there was a higher probability of the couples adopting a modern contraceptive method when the mother-in-law was not living with them (Mekonnen and Worku, 2011). A Bangladesh study has in fact reported that a positive impact on enhancing the intimacy between husbands and wives and thereby facilitating mutual decision-making in family planning can be attributed to the breakdown of joint families dominated by mothers-in-law (John, 2010). Studies have also observed that mothers-in-law influence the number of children that the couples should have (Muia, Blanchard and Lukhandu, 2012). Two studies (Najafi, Rahman and Juni, 2011; Nuruzzaman, 2010) have reported that husbands and mothers-in-law have power over women’s lives. The only source of power for the young daughter-in-law is producing offspring, preferably sons (Odimegwu, 2013).





Conversely, educated mothers-in-law have been found to be more supportive of family planning as reported by (Ogunjuyigbe, 2013). He reported that adoption of family planning rose as level of education of mothers-in-law and fathers-in-law increased in Nigeria. Specifically, one south Asian study (Olakojo, 2012) found, that it was either discussion between daughters-in-law and mothers-in-law, or the mere presence of mothers-in-law in the household that influenced family planning adoption or family size decision among young couples. In India, according to a cross sectional survey carried out by Schoenmakers (2013), it was revealed that most men did not permit their wives to go in for family planning because they perceived family planning to be used by women who wanted to engage in sexual activities. However, according to Rajaretnam and Deshpande (2014), most men in Nigeria allowed their wives to go in for family planning because they wanted smaller family size.

In a related development, a study in Vietnam by Raju and Leonard (2012a) revealed that most men allowed their wives to go in for family planning because they wanted smaller family size and were deeply involved in family planning issues. In Bangladesh, however, a study conducted by Philips (2015) revealed that most men sparingly discussed sexual issues with their wives. In Kenya most men never approved the use of contraceptives for their wives because they perceived it to be against their religious practice, causes infertility among women and promoted sexual promiscuity among young and married women (Rimal, 2013). In West Africa, about three quarters of men and women had not discussed family planning with their spouse in the year preceding the survey, except in Ghana and Cameroon where the proportions were about one-half and two-thirds respectively. In East Africa, the figure is less than 40%, except in Burundi and Tanzania (Helzner, 2013). In Burundi, 94% of men surveyed approved of contraceptive use, but only 48% had discussed it with their wives in the preceding year (Gizaw and Regassa, 2011).



## **2.9 Conclusion on Literature Review**

The literature review has shown that several important factors operating at individual, household and community levels affect the uptake of family planning services among women. Men education, wives' education, men exposure to media, men's working status, age, parity and socio-economic status are variables which are assumed to have positive or negative association with the utilization of family planning services.



## CHAPTER THREE

### METHODOLOGY

#### 3.1 Introduction

This chapter presents the methodology that was used to conduct the study. The subsections include; brief profile of the study institution, research design, study population, sample size determination, sampling procedure, research instruments, data collection procedure, limitations of the study, quality control, data analysis and ethical considerations.

#### 3.2 Profile of the study institution

The study was conducted in the Bawku Presbyterian Hospital in the Bawku Municipal in the Upper East region. The Bawku Hospital was established in 1953 by government of Ghana and was handed over to the Presbyterian Church in 1956 (The Hospital Report, 2015). The hospital is made of 331 bed capacity of 12 wards. The hospital has major specialty areas/departments such as; Obstetrics/Gynaecology, Orthopedic/Physiotherapy, Eye, General Surgery, Ear/Nose and Throat, Dental, Family Planning units as well as general out patients departments and Medical/Surgical and Paediatric Wards.

The Obstetric/Gynaecology department is made up of maternity block of 35 bed capacity which is currently under expansion; it also has separate antenatal and postal clinics, family planning unit and child welfare clinic. The department is the referral center for the various health facilities within the Bawku Municipal (Bawku hospital records department, 2015).

The hospital is headed by the general manager appointed by the Presbyterian Church and various line managers to support in the administrative activities of the hospital. The line managers are however appointed by the general manager in consultation with the Presbyterian board. The



study institution is found in the Bawku municipality. The Bawku Municipality is one of the thirteen districts and municipalities of the Upper East region in Ghana.

The municipality has a total land area of 247.23720 (sq.km) and it is located approximately between latitudes 11° 11' and 10° 41' North and longitude 0° 18' W and 0° 61' E in the north-eastern corner of the region. It shares boundaries with Pusiga District to the North, Binduri District to the South, Garu-Tempene District to the East and to the West with Bawku West. It should also be noted that it borders Togo to the North of Togo and Burkina Faso to the South of Burkina Faso internationally (GSS, 2010).

### **3.2.1 Demography of the Bawku Municipality**

The total population in the municipality is 98,538 constituting 9.4 percent of the regional population of 1,046,545. Out of the total Municipal population, 52 percent are females and 48 percent, males. The age cohort with the highest proportion of the population is the 5-9 age groups (14.1%), followed by the age cohort 0-4 (13.5%). It also shows that the age 0-24 (youth) constitute 59.8 percent of the total population (BMA Profile, 2014).

In the Bawku Municipality, out of total population of 98,538 in the municipality, 3.7 percent are Traditionalists, 80.9 percent are Muslims and 14.7 percent are Christians. Less than 1.0 percent (0.6%) indicated not to belong to any religion. Catholic (6.1%) constitutes the largest denomination among the Christian groups.

### **3.2.2 Economic and Cultural Activities of the Bawku municipality**

According to the Ghana Statistical Service, (2010) Population and Housing Census skilled agricultural, forestry and fishery work remains the dominant occupation for both males (47.8%) and females (46.3%). The census also revealed that, many more females (32.1%) than males



(14.3%) are engaged as service and sales workers. With regards to craft and related trade workers, many more males (14.5%) than females (11.1%) are engaged (GSS, 2010).

The data on employment status shows that the majority (66.3%) of the economically active population are self-employed without employees. About two-thirds (62.8%) of the self-employed without employee(s) population in the municipality are males, while 69.3 percent are females and less than one percent each (0.6%) being casual workers and domestic employees (house help) (GSS, 2010).

The traditional authority is represented by the Bawku Traditional Council under the presidency of the Bawku Naaba, the Paramount Chief of the Bawku Traditional Area. Matters concerning chieftaincy, culture and tradition are handled by the traditional council. The ethnic groups in the Municipality are the Mole-Dagbon, Grusi, Mande-Busanga and Gurma. The major ethnic groups in the Municipality are Kussasis, Mamprusis, Bissas and Moshies. The inhabitants practice the patrilineal system of inheritance and mostly practice polygamous marriage system probably due to their religious beliefs as Muslims.

### **3.2.3 Health**

Health care in the Bawku Municipality is provided through hospitals, health centres, private clinics and traditional healers. There are seven (7) sub-districts and twenty (20) electoral areas in the municipality with the following health facilities, two hospitals, seven health centres, nine clinics, twelve CHPS compounds, and one maternity home. The Doctor – Patient Ratio is 1:8315 and Nurse – Patient Ratio is 1:551 in the municipality.

Malaria as usual is the leading cause of admission for all cases admitted at the health facilities contributing 35.6% and 40.0% of all cases admitted in 2012 and 2013 respectively (Bawku Municipal Health Record, 2014 Report). The infant mortality rate for the municipality is 47 out



of 10,000, Under 5 deaths (0-59 months) 107 out of 10,000 and maternal mortality rate for the municipality is 8 out of 10,000 (BMHD Records, 2013).



**Table 3.1: Selected Health facilities in Bawku Municipal**

S/N	Health Facility	Ownership	Type	Location
1	Bawku Presbyterian Hospital	CHAG	Hospital	Bawku
2	Vineyard Hospital	Private	Hospital	Bawku
3	Islam Maternity Home	Private	Maternity Home	Bawku
4	Urban West Health Center	Government	Health Center	Bawku
5	Urban East Health Center	Government	Health Center	Bawku
6	Mognori Health Center	Government	Health Center	Mognori
7	Bugre-Corner Health Center	Government	Health Center	Bugre-Corner
8	Quality Medical Center	Private	Health Center	Bawku
9	Millennium LaafiDoog	Private	Clinic	Bawku
10	Everjoy Medical Center	Private	Clinic	Bawku
11	Case Medical Center	Private	Clinic	Bawku
12	Baribari CHPS	Government	CHPS	Baribari
13	Bador CHPS	Government	CHPS	Bador
14	Asikiri CHPS	Government	CHPS	Asikiri

**Source: BM-GHS Report 2014**



### **3.3 Research design**

The research used a facility based descriptive cross-sectional study as views and experiences of a cross section of women in the hospital were sought. The researcher considered that women were exposed to family planning in the study institution and the outcome was their knowledge and utilization in relation to family planning. This type of research design allows either the entire population or a subset to be selected (Creswell, 2005). This type of research design was considered because the researcher was not able to sample all the study population at the study setting.

### **3.4 Research population**

In this study, all women in the study area who attended the Bawku Presbyterian Hospital were considered as the target population. The accessible population was drawn from this population particularly women in their fertile age (WIFA) who met the study inclusion criteria.

#### **3.4.1 Inclusion criteria**

- Only women aged (15-49) years were considered
- Only women who attended the Bawku Presbyterian Hospital at the time of the research were considered
- Only women who were willing to be used as study participants were contacted

### **3.5 Sample size determination**

A total population of 344 women were sampled. This sample size was calculated using Snedecor and Cochran (1989) formula.

Formula;  $n = z^2pq/d^2$





Where;

n= sample size

p= estimated women using family planning services

q= 1-p, estimated population not using family planning services

z= statistical certainty chosen (confidence level)

d= precision desired (type one error)

If the acceptor rate of family planning is 30% (BMHD, 2014) (p=0.30), d=5% (0.005) and

z=95% (1.96)

Then;

$$n= z^2pq/d^2$$

$$n= (1.965)^2(0.30)(0.70)/(0.005)^2$$

$$n= 322.7$$

An additional value of 21.7 was added to 322.7 to obtain a sample size of 344

### **3.6 Research variables**

#### **3.6.1 Dependent variable**

The depended variables included knowledge of women on family planning, usage of family planning and barriers affecting family planning usage

#### **3.6.2 Independent variables**

The independent variables in this study included age, education level, marital status and occupation.



### **3.7 Sampling technique**

This research employed a simple random sampling technique to sample respondents in the hospital. Women who attended the facility on daily basis were asked to pick pieces of papers after they had consented to take part in the study from a bowl. These pieces of papers contained “yes” or “no” All those who picked yes were used as study participants.

Simple random sampling technique was used in order to avoid bias and to ensure that each woman had an equal chance of being selected for the study. This was done at the time women were waiting for their turn to be attended to by health care personnel.

### **3.8 Data collection instruments**

A structured questionnaire with both closed and open-ended questions was used in this study to collect the primary data. The questionnaire was designed in line with the study objectives. The questionnaire was administered to the women in the hospital setting. Research assistants were employed to read and administer the questionnaire to women who could not read and write.

The research assistants were employed to do the exercise because of the large numbers of respondents. The researchers took four weeks to collect the data from the respondents in the hospital environment.

### **3.9 Reliability and validation of the instrument**

The initial draft of instrument was subjected to face validation. The essence of validating the instrument was to ensure that it would elicit the information it was designed for. According to Creswell (2005), validity refers to the extent to which an empirical measure adequately reflects the real meaning of a concept under consideration. The relevance of the items to the purpose of



the study was checked, clearly stated and confirmed to be capable of eliciting for the right response from the respondents.

To determine the reliability of the instruments, the research instrument was tried and tested using 10 randomly picked women in the Urban East Health Center located in 'North Natinga' closer to the hospital in the Bawku municipality. The pretesting was done to get firsthand information on the trends in the difficulty of questions expressed by respondents.

The questions were then restructured and the necessary corrections made before the actual field work was carried out. To avoid false information during the actual field study women used for the pre-test were different from those used for the actual study. Lessons learnt from the test study were used to make the necessary amendments to improve the reliability and validity of the study in general.

### **3.10 Sources of data**

Data was gathered from primary sources. Primary data was obtained using a structured questionnaire. Copies of the questionnaires were administered by the researchers at the study area.

### **3.11 Data analysis and presentation**

The completed questionnaires were crossed checked for completeness and accuracy. The data was analyzed using Statistical Package for Social Science (SPSS) software package (version 22.0). Descriptive and inferential statistics such as Analysis of Variance (ANOVA) and Cross tabulations were used to describe the data where applicable. The findings are presented mainly in tables and charts.



### **3.12 Ethical considerations**

The head of the study institution granted the permission for the study to be conducted with women attending the hospital. Written consent was obtained from each woman participating in the study after the researchers explained about the purpose of the study. No compensation was rendered as direct incentive to the participants.

No harm or discomfort was inflicted on any respondent or any non-respondent. The decision to participate or not rested solely with each woman.



## CHAPTER FOUR

### RESULTS

#### 4.1 Introduction

This chapter presents the study results. It is presented largely descriptively in the form of tables and charts. The analysis is organized into five main headings in line with the study objectives. ANOVA and cross-tabulations involving P values and Chi square tests were carried out to test associations between certain variables to establish their significance. All statistical tests were performed using two-sided tests at the 0.05 level of significance. P values less than 0.05 was considered significant.

#### 4.2: Demographic characteristics of respondents

The demographic background of the respondents is shown in Table 4.1 with the following variables; age, religion, marital status, educational status, occupational status, educational status of their husbands and occupational status of their husbands.



**Table 4.1: Demographic characteristics of respondents**

<b>Variable</b>	<b>Frequency</b>	<b>Percent (%)</b>
<b>Age (years)</b>		
15-24	127	36.9
25-34	191	55.5
35-45	26	7.6
<b>Total</b>	<b>344</b>	<b>100</b>
<b>Educational status</b>		
No formal education	46	13.4
Primary	41	11.9
Middle/JHS	75	21.8
SHS	62	18.0
Tertiary	120	34.9
<b>Total</b>	<b>344</b>	<b>100</b>
<b>Marital status</b>		
Single	65	18.9
Married	269	78.2
Divorced	10	2.9
<b>Total</b>	<b>344</b>	<b>100</b>
<b>Occupational status</b>		
Salaried workers	142	41.3
Non salaried workers	202	58.7
<b>Total</b>	<b>344</b>	<b>100</b>
<b>Husband occupational status</b>		
Salaried worker	144	41.9
Farmer	89	25.9
Unemployed	72	20.9
Student	39	11.3
<b>Total</b>	<b>344</b>	<b>100</b>

Source: Field data, 2016



Age is very important factor in maternal health. From Table 4.1, the demographic profile of the respondents in this study showed that majority of them (55.9%) were in the age group (25 to 34) years old, 36.3% were in the age group of (15 to 25) years old and 7.6% were in the age group (35 to 45) years. The mean age was of the respondents was 22.2 (SD 2.9). From the Table 4.1, there was a married preponderance of 78.2% whilst 18.9% respondents were single or in a consensual relationship and 2.9% respondents claimed there were divorced from their husbands. The average age of marriage among the respondents was found to be 21.1 years and the average age of first pregnancy was found to be 22.8 years (Table 4.1).

The educational background of the respondents is also important since it could contribute to the reliability of the results as respondents could have a fair understanding of the variables that were investigated. Analyses showed that 18% respondents had at least some form of Senior Secondary School education (SHS), 34.9% respondents had at least some form of Tertiary education, 21.8% respondents had at least some form of Junior Secondary School (JHS) education and 13.4% respondents had no formal educational training (Table 4.1).

From the analyses, majority of the respondents were from the Islamic faith (61.3%) whilst 36% respondents and 2.7% respondents were from the Christianity faith and the African Traditionalist Religions (ATRs) respectively. This finding of the study is not surprising as many people in Bawku Municipality are predominantly Muslims (Table 4.1).

The occupational status of the respondents was assessed. From the results in Table 4.1, (58.7%) of the respondents were in the informal sector while 41.3% respondents were salaried workers. the mean occupational status of the respondents was  $1.40 \pm 0.61$  (mean  $\pm$  SD). The educational level of respondents' husbands was also assessed. From the results in Table 4.1, most of them

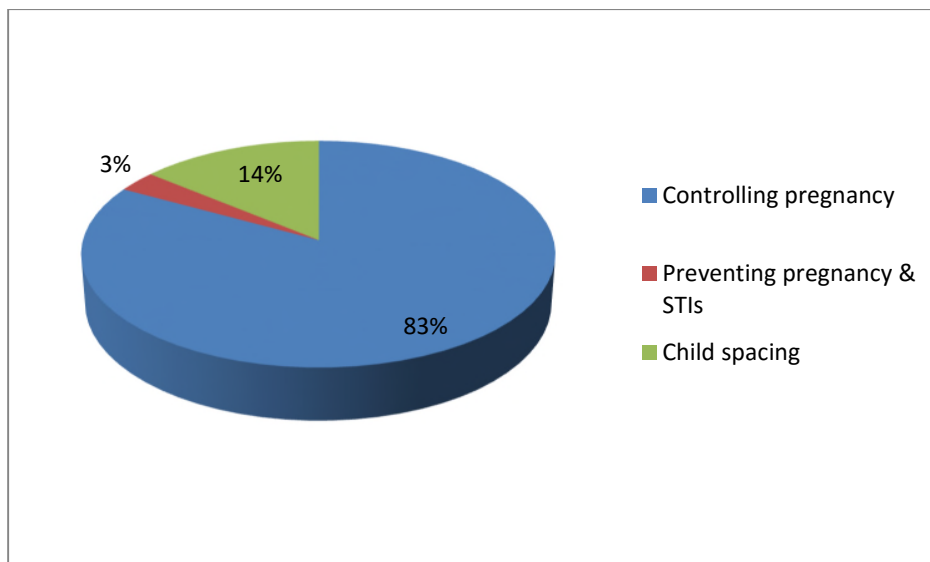


representing 31.1% had some form of Secondary school education whilst few (25.6%) had no form of any educational training.

From the results in Table 4.1, also, most of respondents' husbands were salaried workers (41.9%) whilst others were unemployed (20.9%). Respondents were asked to indicate the number of children they were currently having. More than half 55% said they had 1-4 children, 25% said they had 1-2 children, 10% respondents were evenly distributed at having 4 or more children and primigravida (Table 4.1).

#### 4.3 Knowledge level of respondent's on family planning

Inadequate knowledge concerning family planning have continuously exacerbated the vulnerability of women, culminating into high maternal and infant mortality, increasing hard core poverty, disintegration of the extended family system, high incidence of HIV/AIDs and sexually transmitted infections among other (WHO, 2015). The study sought to assess respondents' knowledge and practices related to family planning at the study institution.



**Figure 4.1: Meaning planning of family**

**Source: Field data, 2016**





From analyses in Figure 4.1, majority of the respondents 320 (93%) said they had ever heard of family planning before at the time of the research work from various sources whilst 24 (7%) however, claimed they have never heard of family planning. Among the former, the following were identified as their sources of information; school, media, health centre, market, relatives and friends. This result shows that, the respondents who heard of family planning, had at least one source of information centre that they could get health information from.

From Figure 4.1, respondents were asked to explain how they conceptualized and understood family planning, among those who said they had heard of it, majority of them (83%) explained family planning in the context of controlling pregnancy and 14% respondents said family planning is spacing birth.

With this number of respondents perceiving family planning to be primarily the use of birth control methods to choose the number and timing of children born into a family, this opinion is not comprehensive enough as it does not include those outside family setting that may need to practice safe sexual relationship especially for the unmarried. Whilst 3% respondents said family planning is preventing sexually transmitted infections (STIs) and pregnancy.

This is worth stating that with this number of respondents conceptualizing family planning services to be prevention of STIs is good since the first step in seeking health care is the knowledge of the condition. If these women are aware of the fact that if they do not use family planning methods they are susceptible to STIs during sexual episodes, it means they could be the possibility of most of them taking measures to prevent such occurrence or taking steps to reduce the occurrence during sexual intercourse.

From the analyses, 110 (32%) had used family planning before at the time of the study whilst 234 (68%) said they had not used any form of family planning services. with this huge number of



respondents stating that they had never used family planning mean health workers would have to roll out modalities of improving and raising the awareness and importance of women accessing family planning services especially at the health centres since most women attend ANC during pregnant.

The concept of informed choice in family planning can be applied to a wide range of sexual and reproductive health decisions. It focuses on whether to seek, to avoid pregnancy, whether to space one's childbearing, whether to use contraception, what family methods to be used, and whether or when to continue or switch methods. The term family planning choice could also refer to the family decision making.

**Table 4.2: Duration of use of family planning methods**

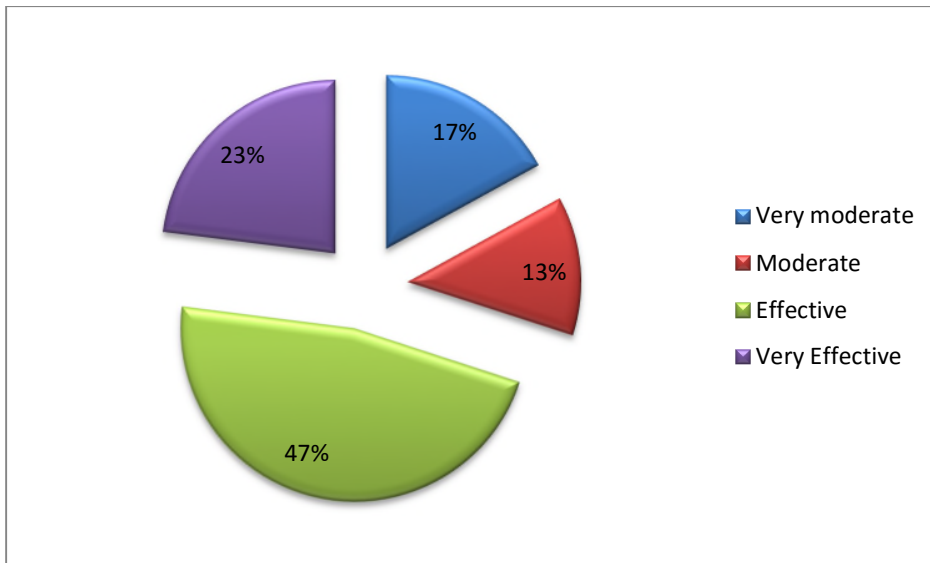
Variable	Frequency	Percent (%)
<b>Duration of family planning</b>		
Less than 1 year	74	40
1-2 years	82	44.3
3-4 years	20	10.8
5 years and above	9	4.9
<b>Total</b>	<b>185</b>	<b>100</b>
<b>Contraceptive use after birth</b>		
Immediately	49	26.5
Within 1-3 months	92	49.7
4-5 months	44	23.8
<b>Total</b>	<b>185</b>	<b>100</b>

**Source: Field data, 2016**

From Table 4.2, most 82 (44.3%) of the respondents who were using contraceptives at the time of the research said they had used it between 1-2 years and 74 (40%) said they had used it less than a year. It also showed that 49 (26.5%) respondents said contraceptives can be used



immediately after birth whilst 44 (23.8%) respondents said contraceptives can be used after birth between 4-5 months. The rest are showed in the Table 4.2. Having the right knowledge of when to use family planning service could prevent unwanted pregnancies especially immediately after birth.



**Figure 4.2: Effectiveness of family planning methods used by respondents**

**Source: Field data, 2016**

From Figure 4.2, most (47%) of those who had ever used family planning service before said it was effective. With this number of respondents testifying to the effectiveness nature of family planning methods may motivate them to still continue to adopt family planning or even be in the position to encourage others to also take family planning services and information issues seriously whilst 13% respondents said it was moderate.

The rest are showed in the Figure 4.2. From the analyses, 161 (46.8%) respondents said they had ever heard of emergency contraceptive whilst 183 (53.2%) respondents said they had never. Among those who had ever heard of it, they explained it as any contraceptive taken immediately after having unprotected sexual intercourse to prevent pregnancy.



Unintended pregnancy poses a major challenge to the reproductive health of young adults in developing countries. With decreasing age of menarche and onset of sexual activity, young people are exposed early to unplanned and unprotected sexual intercourse leading to unwanted pregnancy and invariably abortions. Emergency contraception may be an effective way to reduce the number of unwanted pregnancies and induced abortions.

In the past it has also been known as postcoital contraception or “morning after pills”. Emergency contraception is needed when intercourse is unexpected and without prior contraceptive coverage. Other indications include failure of barrier methods like the slipping or breakage of condoms, and after rape. Emergency contraception is essentially female driven, so its use and success rests mainly on how women perceive and practice it.

**Table 4.3: Age and use of contraceptives**

Variable			Ever used		Total
			Yes	No	
Age		Count	127	0	127
	15-24	% within Age	100.0%	0.0%	100.0%
		% of Total	36.9%	0.0%	36.9%
		Count	191	0	191
	25-34	% within Age	100.0%	0.0%	100.0%
		% of Total	55.5%	0.0%	55.5%
		Count	2	24	26
	35-45	% within Age	7.7%	92.3%	100.0%
		% of Total	0.6%	7.0%	7.6%

**Source: Field data, 2016**

From Table 4.3, there was a statistical relationship between respondents age and usage of family planning methods ( $\chi^2=315.55$ ;  $P < 0.001$ ). From the analyses also, there was a



statistical relationship between respondents educational status and usage of family planning methods ( $\chi^2=48.16$ ;  $P < 0.001$ ). This could possibly be due to the fact that educated women might have been informed of the benefits of using family planning services at various places or by reading more about them. It could also be due to the fact that educated women may dispel rumours associated with the usage of family planning services being spread around even by non-users.

**Table 4.4: Marital status and usage of contraceptive**

Variable			Usage		Total
			Yes	No	
<b>Marital</b>	Single	Count	51	14	65
		% within marital	78.5%	21.5%	100.0%
		% of Total	14.8%	4.1%	18.9%
	Married	Count	269	0	269
		% within marital	100.0%	0.0%	100.0%
		% of Total	78.2%	0.0%	78.2%
	Married	Count	0	10	10
		% within marital	0.0%	100.0%	100.0%
		% of Total	0.0%	2.9%	2.9%

**Source: Field data, 2016**

From the results in Table 4.4, there was a statistical relationship between respondents marital status and having used family planning service before ( $\chi^2= 174.76$ ;  $P = 0.004$ ). This could suggest that married women could have been receiving some form of social and financial support from their partners and that could account for their comparative advantage of being more likely to use family planning methods over their single counterparts.



It could also be due largely to the fact that married women were more likely to be influenced by their husbands to use family planning to curb the number of children they were more likely to give birth to. It could also be due to the fact that married women may have been influenced by significant others to stop using family planning methods.

**Table 4.5: Occupation and ever used contraceptive before**

Variable		Usage		Total	
		Yes	No		
Count		118	24	142	
<b>Occupation</b>	Salaried workers	% within Occupation	83.1%	16.9%	100.0%
		% of Total	34.3%	7.0%	41.3%
	Count		202	0	202
	Non salaried workers	% within Occupation	100.0%	0.0%	100.0%
	% of Total	58.7%	0.0%	58.7%	

**Source: Field data, 2016**

From the results in Table 4.5, there was no statistical relationship between respondents occupational status and respondents ever using family planning services before ( $\chi^2= 36.70$ ;  $P = 1.104$ ). This could explain that both employed and unemployed were found to be using family planning services and provided respondents could get the cost of the service they were offered.

This could be so because women's empowerment was often measured by these three proxies, thus education, employment and knowledge. In their assessment, these proxies or characteristics were important but conceptually distant, and they do always reflect women empowerment on how the make certain decisions in life.



**Table 4.6: Husband occupation and ever used contraceptives**

Variable			Ever used		Total
			Yes	No	
<b>Husband occupation</b>		Count	144	0	144
	Salaried worker	% within husb.occup.	100.0%	0.0%	100.0%
		% of Total	41.9%	0.0%	41.9%
		Count	89	0	89
	Farmer	% within husb. occupa.	100.0%	0.0%	100.0%
		% of Total	25.9%	0.0%	25.9%
		Count	72	0	72
	Unemployed	% within husb. occupa.	100.0%	0.0%	100.0%
		% of Total	20.9%	0.0%	20.9%
		Count	15	24	39
	Student	% within husb. occupa.	38.5%	61.5%	100.0%
		% of Total	4.4%	7.0%	11.3%

**Source: Field data, 2016**

From the results in Table 4.6, there was a statistical association between respondents husbands occupational status and respondents ever using family planning service before ( $\chi^2=201.77$ ;  $P < 0.001$ ). This could explain that respondents who husbands were not workers and wanted to get a proper work because they begin to start child bearing may have been influenced by that to allow their wives to use family planning methods.

It could also suggest that respondents who husbands were workers in the health related sector and had proper knowledge on family planning might have encouraged their wives to use family planning methods. There was however, no statistical relationship between respondents husbands educational status and respondents ever using family planning service before ( $\chi^2=16.70$ ;  $P = 0.714$ ).



#### 4.4 Various types of family planning methods known to respondents

Respondents' knowledge about the various methods of family planning was assessed.

**Table 4.7: Family planning methods known**

Variable	Yes	No
Pills	119 (34.6%)	225 (65.4%)
Intrauterine device	6 (1.7%)	338 (98.3%)
Injectable (depo-provera)	100 (29.1%)	244 (70.9%)
Norplant	46 (13.4%)	298 (86.6%)
Condom	101 (29.4%)	243 (70.6%)
Spermicidal	4 (1.2%)	340 (98.8%)
Tubal Ligation (female)	2 (0.6%)	342 (99.4%)
Sterilization	4 (1.2%)	340 (98.8%)
Periodic abstinence/ calendar	52 (15.1%)	292 (84.9%)
<b>Natural family planning methods</b>		
Withdrawal method	137 (39.8%)	207 (60.2%)
Calendar method	194 (56.4%)	150 (43.6%)
SDM	9 (2.6%)	335 (97.4%)
Basal temperature	48 (14.0%)	296 (86.0%)
Lactational amenorrhea	78 (22.7%)	266 (77.3%)

**Source: Field data, 2016**

Respondents' knowledge on the various types of family planning methods available in the hospital was assessed. From the analyses, 320 (93%) said there were various types of family methods to choose from whilst 24 (7%) said they had no idea. Among the former, the various methods were mentioned; Pills, intrauterine device (IUCD), injectable (depo-provera), norplant





(buried under skin), condom, spermicidal, tubal ligation/female, sterilization, vasectomy/male sterilization and periodic abstinence/calendar.

From Table 4.7, 119 (34.6%) respondents indicated that they had ever used pills before whilst 225 (65.4%) said they had never used it before. From the table 4.7, only 4 (1.2%) respondents said they had ever used spermicidal before whilst 340 (98.8%) respondents said contrary.

Additionally, 100 (29.1%) respondents claimed they had used injectable before whilst the rest said contrary. The rest of the results are shown in the table 4.7. Respondents' knowledge on natural family planning methods was assessed. From the table 4.7, 194 (56.4%) said they were aware of the calendar method, 137 (39.8%) respondents said they were aware of the withdrawal method whilst 78 (22.7%) respondents said they were aware of lactational amenorrhea. The rest of the results are shown in the Table 4.7.





**Table 4.8: Marital status and knowledge of calendar as a natural method**

Variable			Calendar		Total
			Yes	No	
Single		Count	0	65	65
		% within Marital	0.0%	100.0%	100.0%
		% of Total	0.0%	18.9%	18.9%
<b>Marital</b>	Married	Count	195	74	269
		% within marital	72.5%	27.5%	100.0%
		% of Total	56.7%	21.5%	78.2%
Married		Count	0	10	10
		% within marital	0.0%	100.0%	100.0%
		% of Total	0.0%	2.9%	2.9%

Source: Field data, 2016

From the results in Table 4.8, there was a statistical association between respondents marital status and knowledge of calendar as natural family planning methods ( $\chi^2=125.21$ ;  $P < 0.001$ ). Socially, women believed that the use of emergency contraceptives, can lead to brake in marriage, it encourages promiscuity, it may also cause stigma, protrude stomach (even when they are not pregnant) and it may finally lead to untimely death.

The opportunity to initiate emergency contraceptive is time-limited, and therefore, using it soon after unprotected intercourse is critical to its effectiveness. Women must know about it before they need it or quickly upon identification of need.

#### 4.5 Factors that account for the unmet need for family planning services



**Figure 4.3: Access to family planning services in the hospital**

**Source: Field data, 2016**

From the analyses, most of the respondents (56%) said it was easy to get access to family planning service whilst 44% respondents said it was not easy to get access to family planning



service. From Figure 4.3, most (38%) respondents said their impressions on access to family planning service in the hospital is good, 7% respondents said it was excellent whilst 13% respondents said it was very bad.

The rest are shown in figure 4.3. From the analyses, 45% respondents said they knew other places aside the hospital where they could go for family planning services whilst the rest said they do not know of any place where they could go for family planning services.

**Table 4.9: Means of transport to the hospital**

Variable	Frequency	Percent
Walk	145	42.2
Transport	199	57.8
<b>Total</b>	<b>344</b>	<b>100</b>

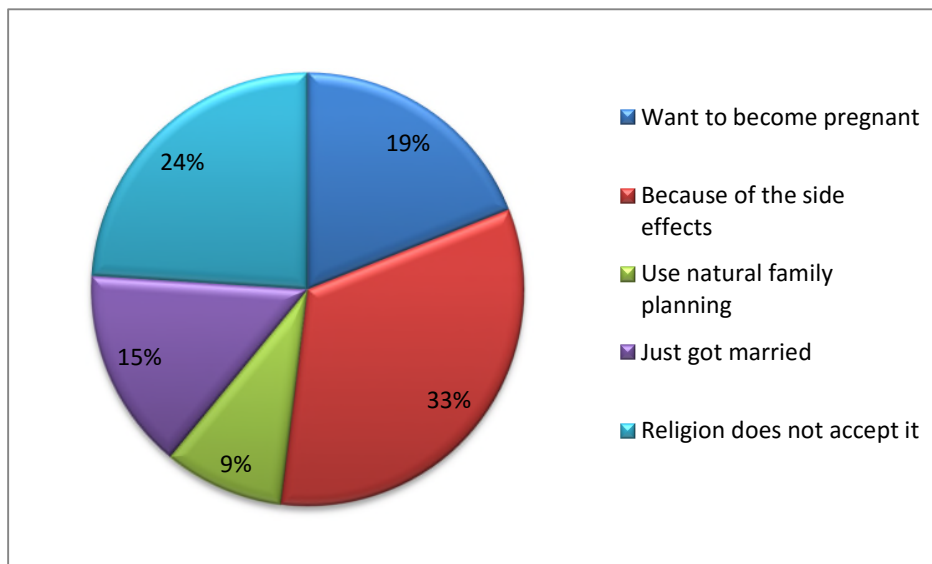
**Source: Field data, 2016**

From Table 4.9, most of the respondents (57.8%) said they used transport to the hospital whilst 42.2% respondents said they walk to the hospital. From the analyses, 256 (74.4%) said distance affect their utilization of family planning service whilst 88 (25.6%) distance does not affect them on the utilization of family planning services. From the analyses, 209 (60.8%) respondents said they had planned for their pregnancy whilst 135 (39.2%) respondents said they had not planned for their pregnancies.

Limited attention has been paid to determine the causes of the unmet need for family planning especially among low income urban residents, despite family planning being an important issue in public health policy for women in the entire population. Unmet need does not necessarily mean that family planning services are not available but may be due to women lack information,



or that the quality of the services on offer does not inspire the necessary confidence, or that women themselves have little say in decision making which can be evidenced in urban regions. Among the former, 104 (49.8%) said it was convenient for them whilst 105 (50.2%) respondents said they needed children at the time they became pregnant. However, among the latter, 67 (49.6%) respondents said they were not ready for their pregnancies whilst 68 (50.4%) respondents said they were not married and did not want to get pregnant.



**Figure 4.4: Reasons for not using family planning**

**Source: Field data, 2016**

The results showed that 185 (53.8%) respondents said they were currently using family planning services at the time of the research whilst 159 (46.8%) respondents said they were not using any form of family planning services. From Figure 4.4, among those who were not using family planning methods, 33% cited side effects of family planning as a reason, woman who experiences side effects from oral contraceptives, including severe headaches, blood loss or depression may believe that they are responsible for the way she feels and she may quit taking it.



It also showed that, 24% cited religious belief, 15% respondents said they just got married and wanted children whilst 9% respondents said they use natural family planning methods.

The findings had helped to assess the level of knowledge and practice towards family planning methods of women which would help to design education programs regarding family planning methods. Furthermore, it would help the policy makers to formulate their plans and policies to increase the use of family planning methods which would ultimately help to reduce the problem of population growth and improve the health of women

**Table 4.10: Barriers to family planning services (multiple responses)**

Variable	Yes	No
Socio-cultural factors	134 (39.0%)	210 (61.0%)
Physical access	134 (39.0%)	50 (14.5%)
Hours of opening and waiting	31 (9.0%)	313 (91.0%)
Interpersonal relations	36 (10.5%)	308 (89.5%)
Affordability/cost	256 (74.4%)	88 (25.6%)
Competent of service provider	308 (89.5%)	36 (10.5%)
Religion	174 (50.6%)	170 (49.4%)

**Source: Field data, 2016**

From Table 4.10, most 134 (39%) considered socio-cultural factors as hindrance to family planning services uptake whilst 210 (61%) did not consider it as a barrier to family planning uptake. The cultural practices of people not only affect their health but also affect all aspects of life including social relationships, contribution to societal functioning and disease condition. The results further showed that 256 (74.4%) respondents considered affordability of family planning services as barrier to its uptake whilst 88 (25.6%) respondents did not consider it as such.



Majority (89.5%) did not consider the interpersonal relations of other significant figures in influencing them in accessing family planning services. This is worth saying because, the interpersonal level which involves relationships with family, friends, peers and others that may influence a woman's decision to use family planning services.

Majority of the respondents (89.5%) considered the competent of the service provider as a major barrier to family planning services. The factor at this level is the doctor-patient relationship. Women who perceive their doctor as someone who is trustworthy and trying to help may be more likely listen to the doctor's advice.

Conversely, a woman who views the doctor-patient relationship as one where she feels discriminated against or disempowered may be less likely to listen to her doctor's advice and subsequently may not go for family planning services. From the results, 174 (50.6%) said religion was a barrier to family planning practice among the respondents. It is important to also emphasize that religious beliefs of respondents also affected how they participate in family planning and reproductive health issues.

Despite the divergent religious views of respondents particularly with respect to Islam and Christianity, there was still a misconception that family planning adoption among believers of both sects is a violation of their own religious beliefs and practices. As already known, religion forms an essential component of the individual's life and therefore has enormous influence on their decisions, depending on the type of religion they belong to, and the doctrine of their religion. The research findings indicated that, majority of the Moslems and the Christian sects, mentioned emphatically that their practices abhor family planning in any form and therefore do not see any reason for either supporting or practicing it.



Most Christians and Muslims believe that each couple should use their own judgment when making decisions about child birth.

**Table 4.11: Education and access to hospital for family planning services**

Variable	Sum of Squares	df	Mean Square	F	Sig.
Education of respondents	497.278	1	497.278	910.945	0.000
	497.278	0	497.278	910.945	0.000
	497.278	1	497.278	910.945	0.000
Access to family planning	186.695	342	0.546		
<b>Total</b>	<b>683.974</b>	<b>344</b>			

**Source: Field data, 2016**

From Table 4.11 one way ANOVA of the results showed that there was a statistical significant association in terms of education of respondents and having access to the hospital to access family planning services (ANOVA;  $P < 0.001$ ). But there was however, no relationship between respondents marital status and having access to the hospital for family planning services (ANOVA;  $p = 1.111$ ). This could be that educated people were more likely to be empowered to have their own means of transport which they could use at any time.

#### **4.6 Level of male involvement in family planning services among women aged (15-49) years**

Family planning programmes focused attention primarily on women because of the need to free women from excessive child-bearing and to reduce maternal and infant mortality through the use of modern methods of contraception. Most family planning services were offered within

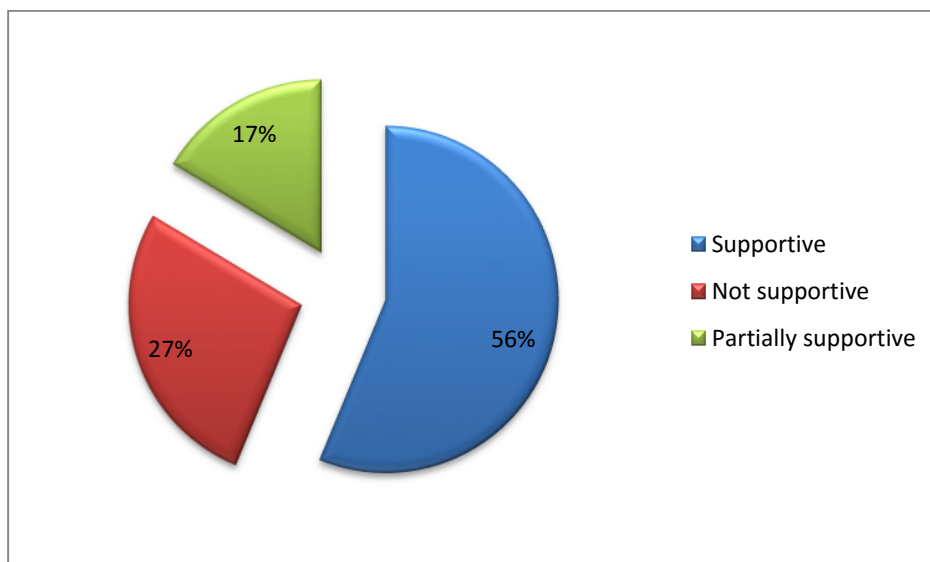




maternal and child health (MCH) centres. In addition, most research and information campaigns focused on women. This focus on women has reinforced the belief that family planning is largely a woman's business, with a man playing a peripheral role. Male involvement is more than just increasing the number of men using condoms and having vasectomies.

It includes the number of men who encourage and support their partner and their peers to use family planning and who influence the policy environment to be more conducive to developing male-related programmes. It has been recognized within health promotion, that men were an important factor in the health of women and children.

Although most would now agree that men's involvement is important, the introduction of programmes that aim to involve men pose some serious questions about the effects of involving men in areas that have traditionally been considered the preserve of women, such as childcare, pregnancy and fertility control. Moreover, there is a fundamental question, as far as the strategy is concerned, about whether men's involvement actually increases men's power over their female partners or whether it will help empower women.



**Figure 4.5: Male position towards the use of family planning**



**Source: Field data, 2016**

From the analyses, it showed that 226 (65.7%) respondents said their husbands approved family planning services for them whilst 118 (34.3%) respondents said their husbands do not approve family planning services for them. From Figure 4.5, 27% respondents said their husbands were not supportive towards family planning, 56% respondents said their husbands were supportive towards family planning whilst 17% respondents said their husbands were partially supportive of family planning.

The application of family planning methods is often facilitated when couples discuss and agree on the matter. Some women secretly use family planning methods without knowledge of their spouses and hence administer contraceptives in a manner that could lead to reduced effectiveness or failure.

For instance, some client's unpacked contraceptive pills from their original packs so that they appeared like ordinary pills. By doing so, clients might not comply with the instructions for pill use. Such women when faced with side effects of the contraceptive merely stop the method rather than switching to a method that might be detected by her husband, thereby making informed choice loses its meaning.



**Table 4.12: Awareness of male in family planning**

<b>Variable</b>	<b>Frequency</b>	<b>Percent</b>
<b>Seek partner's consent</b>		
No consent is sought	106	30.8
Consent is sought	238	69.2
<b>Total</b>	<b>344</b>	<b>100</b>
<b>Discussion of family planning with husband</b>		
Once in 3 months	88	25.6
Once in 6 months	58	16.9
Once a year	82	23.8
Never	116	33.7
<b>Total</b>	<b>344</b>	<b>100</b>
<b>Birth spacing</b>		
1-2 years	171	49.7
3-4 years	158	45.9
5-6 years	14	4.1
6 and above	1	0.3
<b>Total</b>	<b>344</b>	<b>100</b>
<b>Role of husband in birth spacing</b>		
Husband decides everything	65	54.6
Husband is less concerned	54	15.7
<b>Total</b>	<b>344</b>	<b>100</b>

**Source: Field data, 2016**



From Table 4.11, majority of the respondents (69.2%) said they have to seek consent from their partners before attending family planning clinic whilst 30.8% said contrary. From the Table, 33.7% respondents said they had never discussed any family planning service with their husbands before, 16.9% respondents said they discussed with their husbands concerning family planning services every six months whilst 23.8% respondents said once a year. On the other hand, couples have a right to choose and decide upon the number of children they desire. This means that both partners have the right to be involved in fertility matters and as such husbands play a crucial role in fertility decision-making in most of the world.

Men's fertility preferences and attitudes towards family planning seem to influence their wives attitudes towards the use of modern family planning services. Therefore, programs that attempt to promote reproductive health through increasing the use of modern family planning services need to target men specifically at all levels of the program.

Hence, men should be actively involved at the 'knowledge' level (the concept of family planning), the 'supportive' level (being supportive for other to use contraception) and the 'acceptor' level (as contraceptive user). Their decision-making role should be taken into account in order to promote family planning services use. In communities, lack of family planning services for women who want to prevent or postpone future pregnancies inevitably leads to increased rates of high births, morbidity, and has both social and economic costs on the families involved.

It is important to mention that, women who have recurrent pregnancies leading to live births and breastfeeding are stripped of valuable minerals and resources needed to maintain a healthy lifestyle. Such stores of minerals and resources are also critical for women to withstand the process associated with childbirth. It was also showed that 49.7% respondents said they space



their birth between 1-2 years whilst 49.5% respondents said they space their children between 3-4 years.

It was however, observed that, 54.6% respondents said their husband decide how they should space their children whilst 54 (15.7%) respondents said their husbands were less concerned about it. On the other hand, couples have a right to choose and decide upon the number of children they desire. This means that both partners have the right to be involved in fertility matters and as such husbands play a crucial role in fertility decision-making in most of the world. Clearly, male-involvement in family planning has positively affected family planning services use and has caused an overall decline in fertility in the developing world.

This result suggests that, in the patriarchal culture predominantly prevalent in most of Northern Ghana, husbands have the authority to make legitimate decisions on behalf of their wives, and reviews have suggested that they are also involved in making decisions about their wives' reproductive health, including family planning services usage, visit to the health facility and family composition and size.

Besides the husbands, in the Ghanaian context, the influence of family elders, for example, the mother-in-law or the elder daughter in-law is also significant as decision makers for couple on reproductive health issues. From the analyses, 203 (59%) said they had never discussed with their husbands the number of children they would like to have whilst 141 (41%) said they had ever discussed with their husbands.

Among the latter, 20 (14.2%) respondents said their husbands do not like the same number of children they suggested, 89 (63.1%) respondents said they had no idea whether their husbands like the number of children they suggested whilst the rest said their husbands like the number of children they suggested. This in a way could influence their unmet needs of family planning.



**Table 4.13: Husband occupation and position on family planning**

Variable		Supportive			Total
		Supportive	Not supportive	Partially supportive	
<b>Husband occupation</b>	Count	122	20	2	144
	% within husb. occup.	84.7%	13.9%	1.4%	100.0%
	Salaried worker				
	% within Supportive	63.5%	21.1%	3.5%	41.9%
	% of Total	35.5%	5.8%	0.6%	41.9%
	Count	32	36	21	89
	% within H occupation	36.0%	40.4%	23.6%	100.0%
	Farmer				
	% within Supportive	16.7%	37.9%	36.8%	25.9%
	% of Total	9.3%	10.5%	6.1%	25.9%
	Count	27	23	22	72
	% within husb. occupation	37.5%	31.9%	30.6%	100.0%
Unemployed					
% within supportive	14.1%	24.2%	38.6%	20.9%	
% of Total	7.8%	6.7%	6.4%	20.9%	
Count	11	16	12	39	
Student					
% within husb. occupation	28.2%	41.0%	30.8%	100.0%	



	% within supportive	5.7%	16.8%	21.1%	11.3%
	% of Total	3.2%	4.7%	3.5%	11.3%

**Source: Field data, 2016**

From the results in Table 4.13, there was a statistical association between respondents husbands occupational status and being supportive of family planning method ( $\chi^2= 95.21$ ;  $P<0.001$ ). In discussion the role of men power in the context of employment status, power suggests that in intimate relationships, power is relative, multidimensional, and may influence the behaviors of others. it could be explained that culture confers power on individuals by defining the values and meanings associated with men’s and women’s roles and statuses; that power involves some degree of inequity in the distribution of resources, and that the concept of power embodies both a sense of personal control and the ability to influence the behaviors of others.

**Table 4.14: Husband education and position on family planning**

Variable	Sum of Squares	df	Mean Square	F	Sig.
	138.287	2	69.143	41.238	0.000
Between	96.164	0	96.164	57.354	0.000
Groups	129.302	0	129.302	77.118	0.000
	8.985	1	8.985	5.359	0.021
Within Groups	571.748	341	1.677		
Total	710.035	344			

**Source: Field data, 2016**



From Table 4.14 one way ANOVA showed that there was a statistical significant association in terms of education of respondents' husband and being supportive of family planning services (ANOVA;  $P < 0.001$ ). Increase in the education level of women and their spouse is found to be significantly associated with increase in the use of family planning methods.

Better education leads to delayed age of marriage further delaying the age at first conception leading to better understanding of women's own reproductive health issues including better likelihood of family planning services use. Furthermore, higher educational status of men improved the use of family planning methods among their women.

Men have the ability to use or not use certain methods of family planning services such as periodic abstinence, condoms, and vasectomy independent of women's contraceptive intentions and methods. Included in their role to control fertility is their support, or lack thereof, around their female partner's decision about family planning. Men's involvement in family planning, evidence from many cultures suggests that men's resistance to women's use of contraception is common. Such resistance can influence women's decisions about family planning services use.





## CHAPTER FIVE

### DISCUSSION OF RESULTS

#### 5.1 Introduction

This chapter presents the discussion of the results from the research findings. The discussion of these results is based on the specific objectives of this study. Key among the issues is the extent to which findings agree with or at variance with the reviewed literature.

#### 5.2 Knowledge level of respondent's on family planning

Family planning is a word that has been heard frequently in the medical profession. It can be said to be as old as man himself and to this effect, there are more than 500 definitions of family planning. World Health Organization (2012) defined family planning "as something that allows individuals and couples to foresee and achieve their desired number of children as well as the spacing and timing of their births. It is accomplished through use of different contraceptive methods and the treatment of involuntary infertility.

The ability of a woman to space and limit her pregnancies has a direct effect on her health and well-being as well as on the outcome of each pregnancy. Knowledge on family planning services is an important factor for an individual to use and not use the methods, so that the status of knowledge has the paramount importance for policy makers and programmers.

In this study, 320 (93%) respondents said they had ever heard of family planning before. This is not surprising at all since there have been campaigns on family planning at the study place due to the declining level of subscribers in the municipality. This finding from the study is similar to the report presented by the World Health Organization (2012) where it was revealed that women had high level of knowledge concerning family planning in the world.



The result of this study also concurs with that of Tajure and Pharm (2010) where female students of Jimma University, Southwest Ethiopia had high knowledge concerning family planning. The study results however, disagree with the findings presented by Rutenberg (2013) where women in a rural village in Uganda had no knowledge on family planning.

The results showed that, majority of the respondents identified friends, health centres and workshops they had ever attended and the media among others as their main sources of information on family planning services. This finding from the study is similar to the findings presented by Parr (2013) where women in Ghana identified similar sources concerning family planning services and information. From the results, most (47%) of those who had ever used family planning services before said it was effective for them.

This finding from the study disagrees with the findings presented by Olakojo (2012) where women in Nigeria said they were not going to practice family planning because it was not effective. However, the results agree with the findings presented by Odimegwu (2013) where women in Nigeria said family planning was effective and were encouraging others to go in for it to prevent unwanted pregnancy.

Family planning practices help individuals or couples to avoid unwanted pregnancies, regulate the intervals between pregnancies, control the time of birth in relation to the age of the parents and determine the number of children in the family. Though contraceptive use has increased worldwide over the last couple of years, the contraceptive prevalence rate (CPR) in low resources countries is very low.

While the overall increase in contraceptive prevalence at the global level has been spectacular, the progress in the effectiveness of family planning programs and in the range contraceptive methods used has been uneven at the community level. In 2007, Africa had the lowest level of



contraceptive prevalence of 28 % as compared to 71 % in Latin America and the Caribbean and 68 % in Asia (WHO, 2012).

Additionally, there was a statistical relationship between respondents age and usage of family planning methods ( $\chi^2=315.55$ ;  $P < 0.001$ ). This finding from the study is at variance with the findings presented by Muia, Blanchard and Lukhando (2012) where there was no statistical relationship between age and using family planning among women in Kenya in an evaluative studies ( $\chi^2=35.55$ ;  $df=3$ ;  $P = 2.22$ ).

However, the results is similar to the findings made by Mengistu (2010) where women who were aged 30 years and above were two times more likely to make the choice to use family planning methods as compared to those who were less than 30 years (OR =2.0; 95% CI: 0.9–4.2;  $P < 0.001$ ).

The practice of family planning helps in reducing the rates of unintended pregnancies, of maternal and child mortality and of induced abortions. In addition, using family planning services has been shown to promote a woman's sense of autonomy and increase her ability to make decisions in other areas of her life. Reproductive health for a woman includes her ability to space, delay or limit children, as well as her experience with infertility, child loss or planned or unplanned childlessness.

Furthermore, the results showed that there was a statistical relationship between respondents marital status and having used family planning service before ( $\chi^2= 174.76$ ;  $P < 0.004$ ). This could be due to the fact that married women were being supported by their husbands to go in for family planning. This finding from the study is at variance with the findings made by Giusti and Vignoli (2012) where there was no significant association between marital status of women and usage of contraceptives methods in Egypt.



However, the results support the findings made by Aryeetey, Kotoh and Hindin (2010) where marital status was found to be a strong predictor of women using family planning in Ghana. The results also concur with that of Sargent and Cordell (2012) and Wablembo, Ntozi and Kwagala (2011) where marital status in all their studies was a significant factor in women using family planning methods.

The results revealed that there was no statistical relationship between respondents occupational status and respondents ever using family planning services before ( $\chi^2= 36.70$ ;  $P = 1.104$ ). This could possibly be due to the fact that family planning services were available for everyone to use.

This finding from the study supports the study done by Sonenstein (2011) and Postlethwaite (2013) where occupation was found not to influence women usage of family planning methods.

From the results there was no statistical relationship between respondents husbands educational status and respondents ever using family planning services before ( $\chi^2= 16.70$ ;  $P = 0.714$ ).

This finding from the study concurs with the findings made by Renjhen (2013) where women husbands' occupational status did not significantly influence them to go in for family planning.

However, the findings disagree with Rajaretnam and Deshpande (2014) where women husbands occupational status was 4.5 times more likely to influence them to use family planning service compared to those who husbands were not working ( $OR =4.5$ ;  $95\% CI: 0.9- 4.2$ ;  $P< 0.003$ ).

### **5.3 Various types of family planning methods known to respondents**

From the results, respondents had knowledge on the various types of family planning methods available for them to choose from except that usages of these available methods were not



being utilized. It was revealed that only 119 (34.6%) respondents said they had ever used the pills before.

This finding from the results supports the study done by Sonenstein (2011) where women in a cross sectional study mentioned that they had ever used the pills before. The study also showed that nearly all the respondents' 98.8% said they had never used spermicidal before. This finding from the study is at variance with the finding made by Olakojo (2012) where women in Nigeria stated that they had ever used spermicidal before. However, the study concurs with Obare, Keesbury and Liambila (2010) where women in Kenya stated that they had never used spermicidal before.

Natural methods of family planning among respondents were also assessed. Findings indicated that 137 (39.8%) said they had ever used withdrawal method as a natural family planning methods before. This finding from the study supports the study done by Nuruzzaman (2010) where women in Bangladesh stated that they had ever used withdrawal method as a family planning method with their husbands.

The finding however disagrees with Ogunjuyigbe (2013) where women in Nigeria stated that their husbands did not like withdrawal method as a natural family planning method. It is said that some men are knowledgeable about family planning. This assertion is based on the high knowledge of men on vasectomy, injectables, pills and IUDS as effective birth control methods (Ogunjuyigbe, 2013). The study however, blamed men's low approval of family planning method in the matrimonial homes.

There is the need for a broader approach to be used to address the challenge of male participation in family planning. Family planning services use helps couples achieve their



reproductive intentions and improve their lifestyles socially, economically, and directly leading to a reduction in maternal and child mortality.

Neoclassical theory suggests that as investment in human capital increases and as more women participate in the labour market, the fertility behaviour of households is bound to change, in favour of fewer children (Sterley, 2011). From the study also, 194 (56.4%) respondents said they had ever used calendar method as a natural family planning methods.

This finding from the study supports the study done by Najafi, Rahman and Juni (2011) where women in Malaysia stated that they had ever used calendar method as a natural family planning method before. The findings however, disagrees with the findings made by Obare, Keesbury and Liambila (2010) where women in Kenya stated that they did not know of the calendar method as a natural family planning method since the calendar kept changing and was not reliable for them to observed.

Additionally, there was a statistical association between respondents marital status and knowledge of calendar as natural family planning method ( $\chi^2= 125.21$ ;  $P < 0.001$ ). This finding from the study is at variance with the study done by Okech, Wawire and Mburu (2011) where women who were married had good knowledge on the use of the calendar as natural family planning method than those who were not married.

The ability of women to start a successful, uninterrupted and suitable family planning method is influenced by different factors; such as poor access to the health center, community and cultural attitudes as well as individual attitude can all be considered as obstacles to the use of appropriate and effective method of family planning for women.

Due to the increasing number of therapeutic abortion, lack of awareness of woman of their right to a have a healthy reproductive life, the stress of family and societal demands on women as well



as their ability to be able to cope with motherhood and her role in society, identifying possible methods of family planning that could make it easy for them is vital.

#### **5.4 Factors that account for the unmet need for family planning services**

Throughout the whole world, the unmet need for family planning data has become a very useful tool in measuring and predicting the contraceptive needs of a population. Access to family planning services and awareness has improved greatly, but the unmet need for family planning continues to remain high. Although around half of married women worldwide now use a modern method of contraception, an estimated 200 million women in the world who wish to stop having children or delay their next birth for at least 2 years are not using an effective contraceptive method (WHO, 2015).

Results from the study showed that 54% respondents said it was not easy to get access to family planning service. This finding from the study supports the study done by Karra, Stark, and Wolf (2013) where women in India mentioned that it was easy to get access to family planning services. The results also concurs with the findings made by Asamoah, Agardh and Per-Olof (2013) where women in Ghana also stated that it was not easy to access family planning services. For a long time, international family planning and reproductive health programmes focused exclusively on women.

As a consequence, population policies were implemented almost exclusively through basic family planning programmes serving women. If men were involved, it was in a limited way, often to ensure contraceptive continuation and acceptability or to promote the diagnosis and treatment of sexually transmitted infections. Although both men and women have responsibilities and interest in reproductive health and family planning, demographic studies on fertility and



family planning have overwhelmingly focused on women. In practice, the effect that men have on their own and on women's reproductive lives may be more varied.

To exclude men from information, counseling, and services is to ignore the important role men's behaviour and attitudes may play in couples' reproductive health choices. For example, in some countries, societal norms, religious practices, and even legal requirements provide men great influence over decisions that affect their family's reproductive health. Women who want to postpone their next birth for two or more years or who want to stop childbearing altogether but are not using a contraceptive method are considered to have an unmet need for family planning.

Pregnant women are considered to have an unmet need for family planning if their pregnancy was mistimed or unwanted.

Similarly, amenorrhoeic women who are not using family planning and whose last birth was mistimed or unwanted have an unmet need. The public health relevance of family planning is enormous. In the absence of family planning, the level of childbearing will be high resulting in a greater demand for obstetric and infant/child health services. In such situations maternal morbidity and mortality will be high. Shorter spacing between births, because of non-use of family planning methods, is linked with increased risk of fetal death, low birth-weight, prematurity and of infant and child death.

From the results, 38% respondents said their impression on access to family planning service in the hospital is good. This finding from the study is at variance with the finding made by Bawah, Akweongo and Phillips (2010) where women in northern Ghana mentioned that the attitude of service providers at the hospital was bad. From the results, 33% respondents mentioned the side effects of family planning as barriers for them going in for family planning services.





This finding from the study collaborates with the study done by Chapagain (2013) where women in Nepal cited side effects of family planning as a major barrier to family planning uptake. The results are also similar to the findings of Bawah, Akweongo and Phillips (2010) where women in Northern Ghana cited side effects of family planning as major barrier to adoption of family planning service.

Similar research indicates that women's feelings about their partners and about involving men in contraceptive and reproductive decisions must always be taken into account. Women acceptance of children as God's will, attitudes towards preventing pregnancy, knowledge on different family planning method choice and the understanding of the side effects of different methods are among the factors related to family planning method use.

Moreover, studies on perception of spousal approval and opposition from husbands are positively associated with low family planning method use. From the study, 36 (10.5%) respondents identified interpersonal relation as a barrier to effective family planning usage. The doctor-patient relationship, her partner's attitude about using condoms may influence a woman's own attitude about using condoms and other contraceptive methods. In some cultures if a woman asks her partner to wear a condom, she runs the risk of his beating her or leaving her because he may think she is cheating on him.

A man's use of condoms is associated with having affairs. Women are among the poorest of the poor; they may not be willing to take the chance of raising children as a single mother and therefore will not utilize a method that will drive their partner away. Another example of an interpersonal level factor is the peer influence. If the peer group has decided to take control of their sexual health and have supported each other through the process of getting family planning services, a woman may be more likely to also utilize family planning services.



If the group is against the idea of using family planning entirely, the woman who chooses to utilize family planning services may be shunned by her group of friends. Women stand together to help with each other's families; being shunned or ridiculed for being different would harm a woman's relationships with her "helpers."

Social and cultural beliefs and practices are still traditionally rooted in the minds of most people living in rural communities in Ghana which is negatively influencing basic maternal health care, yet little is known about these factors even when they influence a woman's choice of family planning methods. Understanding of variables surrounding availability of these social and cultural beliefs and practices would remove the bottlenecks hence increasing women health seeking behavior positively which would lead to low or no maternal and infant morbidity and mortality.

From the results 134 (39.0%) respondents said they were socio-cultural factors affecting family planning use among them. This finding from the study concurs with the findings made by DeClerque, Tsui, and Barcelona (2014) where women in Egypt cited similar reasons. From the results, one way ANOVA showed that there was a statistical significant association in terms of education of respondents and having access to the hospital to access family planning services (ANOVA;  $P < 0.001$ )

It is believed that the more a woman advances in education there is a high tendency of higher levels of contraceptive prevalence rate, smaller family size, and lower levels of unmet need (Rao and Sinha, 2011; Sterley, 2011). Women's work status is related to unmet need. Women who are working outside the home have a lower probability of having unmet need than those who work at home or indoors as the woman become more and more empowered. In East Africa, studies



document that unmet need for family planning is lower for women with better education (Sterley, 2011).

For instance in Uganda, unmet need was lower for women with secondary or higher education and in Kenya, women with primary incomplete education were 2 times more likely to experience unmet need for family planning compared to those with primary complete or higher education (Omo-Aghoja, Omo-Aghoja and Aghoja, 2012). When both husband's and wife's education were put in the same model, husband's education became insignificant, suggesting that wife's level of education was more important if couple's unmet need were to be reduced.

### **5.5 Level of male involvement in family planning services among women**

Male involvement in reproductive health and family planning has recently been understood as an important area among reproductive health programme designers, policy makers, and population researchers for the overall reproductive well-being of the couple. Non-involvement of males in such areas contributes to major initiatives failing to achieve their desired objectives.

To implement effective programmes to include men, it is therefore essential to first understand whether men are at all interested to be part of reproductive health programmes, and the barriers that they face while accessing services and how best can these be overcome. Despite almost two decades since the call to involve men actively in such programmes, men still feel ignored or are missing from such initiatives.

The results showed that 226 (65.7%) respondents said their husbands approved family planning services for them whilst 118 (34.3%) respondents said their husbands do not approve family planning services for them. This finding from the study confirms the study done by Chapagain (2013) where women said their husbands did not support family planning service. In other



instance where men are not supportive, some women have fled for their lives, chased away by hostile men for using family planning.

Women in most African countries do not have the liberty to use family planning because it is their husbands who decide on their fertility. Health practitioners and governments fear that the target of reducing maternal deaths would not be met without concerted efforts of all, including men. Women always wanted to use a family planning method which their husbands would not so easily noticed. They use injectables so that their husbands would not detect it. Women hide behind taking their babies for check-up, and then visit the clinic to get the injection. In Kenya, it was found that it is not only wives who are threatened.

Community health workers who seek to provide family planning education and distribute contraceptives have faced hostility from the men who accuse them of ruining families. Community health workers have been confronted several times by men who have threatened to teach them a bitter lesson if they continue to propagate the messages on family planning (Rao and Sinha, 2011; Rimal, 2013).

It could also be that, men's low acceptance and near rejection of family planning is due to numerous reasons. They reported that most men were reluctant to visit reproductive health clinics for advice on family planning because they viewed the facilities as a 'women's place', and did not want to mix with women for fear of being seen to be henpecked or considered effeminate.

Men's fertility preferences and attitudes towards family planning seem to influence their wives attitudes towards the use of modern family planning services. Therefore, programs that attempt to promote reproductive health through increasing the use of modern family planning services



need to target men specifically at all levels of the program. Their decision-making role should be taken into account in order to promote family planning method use.

From the results, it was showed that 54.6% respondents said their husband decided everything including the number of children they should have. It was even stated by the results that sometimes decisions concerning the number of children they should have was the sole right of the man. This finding supports the study done by Bawah, Akweongo and Phillips (2010) where women in Northern Ghana cited that the husbands decided how many children they should have. Although both men and women have responsibilities and interest in reproductive health and family planning, demographic studies on fertility and family planning have overwhelmingly focused on women.

In practice, the effect that men have on their own and on women's reproductive lives may be more varied. Perhaps most importantly, around the world many women and their partners would like to participate more fully in reproductive health counseling and services. In response to these factors, programmes are increasingly seeking ways to develop strategies that allow men's constructive involvement in family planning and other reproductive health services. Studying male involvement, therefore, is important to understand the multiplicity of forces shaping reproductive decisions among women and men.

Also from the results, 33.7% respondents said they had never discussed with their husbands concerning family planning methods before. This finding supports the study done by Bawah, Simmons and Phillips, (2013) where women in Northern Ghana stated that they had never discussed with their husbands concerning family planning services. Most of the women reported husband as the sole decision maker for family planning concerns. Women considerably have a



lower social status and autonomy and this seems to be associated with their lower control over fertility.

Spouse communication is positively associated with family planning use. Studies showed that the percentage of women using modern family planning is consistently higher in the group that had discussed family planning with their husbands in the year before the interview than in the group that had not. Because of lack of communication, many women do not know what their husbands think about family planning.

Many women think that their husbands disapprove of family planning, when in fact the husband approves. Nevertheless, the study also draw attention to factors which prevent women from using family planning services such as lack of knowledge about family planning, partner opposition, fear of side effects, and religious constraints.

The study also revealed that one way ANOVA showed that there was a statistical significant association in terms of education of respondents husband and being supportive of family planning services (ANOVA;  $p < 0.001$ ). This finding from the study is at variance with the study done by Beekle and McCabe (2013) and Bhattarai and Panta (2013) where women in Jimma, Ethiopia and Khotang respectively did not found any association between women husbands' educational status and using family planning methods.

Throughout the whole world, there has been a progress in the access to family planning services and products, but the unmet needs for family planning continue to remain high among women simply because of their partners' position on family planning information and services.

In the developing countries the number of individuals wishing to use family planning supplies and services but do not have access to modern family planning information and services still remain high (WHO, 2015). Most studies, it was discovered that most women said their husbands



were the only person who could determine whether a woman should go to do family planning or not whilst a relatively smaller number said it was the decision of both the man and the woman to agree before she could practice family planning (WHO, 2012).

The idea of unmet need for family planning is important for finding women who may want to use, but are not currently using, a method of contraception and the reduction of unmet need of family planning has significant outcome. Policy makers are normally concerned about unmet need for family planning because unmet need for family planning services normally leads to unintended pregnancies which in turn pose risks for women in general (WHO, 2015).

In Africa and other developing countries about 25% of pregnancies are unintended (unwanted or mistimed) and this leads to mostly unsafe abortions in the long run. In addition, unwanted births pose risks for children's health and wellbeing and contribute to rapid population growth in poor countries. In general, unmet need for family directly impacts on total fertility rate and if the countries can be able to completely eliminate the unmet need, the fertility rate would go down (WHO, 2012).

By reducing the TFR, mothers and women are assured of good health by preventing unwanted pregnancies and with decreasing unmet need reduce the maternal morbidity and mortality. Lack of reproductive health services is one of the reasons for unmet need and therefore the prevalence of unmet need gives a clear picture family planning program kept in place. As an evaluation tool for family planning services, identification of causes and the factors responsible for lack of services can be useful in the implementation of strategies that will improve family planning service and promoting the uptake of family planning methods.



## **5.6 Explaining the Theoretical framework of the study**

The study employed Kolcaba's Theory of Comfort (Kolcaba, 2015) to support the study. In the health setting, the specific comfort needs of a patient are actualized, the patient experiences comfort in the sense of relief. For example, a patient who receives pain medication in post-operative care is receiving relief comfort. The patient's anxieties are calmed. This comfort would assist the patient to rise above their challenges.

Kolcaba's Theory of Comfort (Kolcaba, 2015) describes comfort as existing in three forms; relief, ease and transcendence as well as the four contexts in which patient comfort can occur; physical, psycho spiritual, environmental and socio-cultural. For instance, a women who prefers to use Bilateral tubal ligation (BTL) would be a relief comfort for her who has high parity status and who needs a permanent method of family planning, since this method of family planning is a onetime procedure and does not demand recurrent visit to the hospital or change.

This way, women have no fear of unintended pregnancy and are free from sudden gynecological emergencies. Bilateral tubal ligation is a onetime procedure that is a very easy and safe method of family planning. With the procedure done, the woman is poised to have a very healthy and active reproductive life without the fear of pregnancy or possible side effects of other methods of family planning.

With the choice of using bilateral tubal ligation as a method of family planning, women are able to go about their lives, achieve their dreams and live a happy life. With the choice of bilateral tubal ligation as a family planning method, women with known gynecological problems are able to rise above their problems because of the benefits it proffers. For women to achieve comfort in their reproductive life, their bodies need to be healthy and free from any form of stress.





The body after child birth needs to heal and go back to its pre gravid state and for this to occur a good choice of family planning method needs to be adopted. The choice of a family planning method is usually made by the couples. This is so, because the couples enjoy the choice they have made and are not left out in the decision making process. Women would need to be guided through making the right choice. Women should be given thorough counseling and psychological support as this would strengthen them through the process and spouses should be involved in the process as this would strengthen the wife to go through the process.

Religious beliefs of women should not be ignored as this also plays a great role in a woman's decision to have family planning or not. An individual is a reflection of his environment, thus, a woman is more likely to adopt a method of family planning if there are women in her environment who have undergone the procedure and are happy using it. Also, she would adopt any family planning method if her spouse and other family members give her the necessary support. Society has always played a great role in individual decision making most times, it is a very strong determinant in decision making.

Women considering family planning methods may experience pressure from the society and culture may also influence her decisions. The above theory delineates the immediate social environment of the women role in using family planning service, emphasizing the lack of individual autonomy which goes beyond the individual women wish. Members of the extended joint family, for example, the mothers-in-law, elder sisters-in-law and peers influence the reproductive health decision-making of women play a significant part in that regards.

The health care workers, which include the medical officers of the primary health centre, the Nurses, the Midwife and Multi-Purpose Worker who are in direct contact with the couple through home to home visits, or during the couple's visits to the sub-centre or primary health



centre are the influencers who facilitate the implementation of the couple's choices and are therefore the next core group. The last group of 'indirect influencers' or the 'gatekeepers' constitute the village elders, and members of the local village health committee. This group is significant as they provide the necessary social direction and boundaries within which each community member has to live. All these people also played a key role in the decision of people to use family planning service or not.



## CHAPTER SIX

### SUMMARY, CONCLUSION AND RECOMMENDATIONS

#### 6.1 Introduction

In this chapter, a summary of the results from the study is presented and conclusion drawn from the research findings following which key recommendations made to assist policy makers interested in sexual and reproductive health issues especially as they relate to women in the study area and Ghana as a whole as they make efforts to address identified bottlenecks.

#### 6.2 Summary of findings

Family planning is known to prevent maternal deaths, but some social norms, limited supplies and inconsistent use makes this difficult to achieve in most low- and middle-income countries. In spite of the high fertility levels in most countries and the potential economic benefits of family planning, its patronage remains very low. The demographic profile of the respondents in this study showed that majority (55.9%) were in the age group (25 to 34) years old. There was a married preponderance of 78.2%.

The average age of marriage among the respondents was found to be 21.1years. The study showed that 18% respondents had at least some form of Senior Secondary School education (SHS) and 34.9% respondents had at least some form of Tertiary education. From the results, majority of them (83%) explained family planning in the context of controlling pregnancy.

Most 82 (44.3%) of the respondents who were using family planning services at the time of the research said they had used it between 1-2 years and 74 (40%) said they had used family planning service less than a year. It also showed that 49 (26.5%) respondents said family planning services can be used immediately after birth whilst 44 (23.8%) respondents said family



planning services can be used after birth between 4-5 months. The results from the study revealed that there was no statistical relationship between respondents occupational status and the use of family planning services ( $\chi^2= 36.70$ ;  $P = 1.104$ ).

Most 134 (39%) considered socio-cultural factors as hindrance to family planning services uptake whilst 210 (61%) did not consider it as a barrier to family planning uptake. The results further showed that 256 (74.4%) respondents considered affordability of family planning services as barrier to its uptake whilst 88 (25.6%) respondents did not consider it as such.

### **6.3 Conclusion**

The results demonstrate that good knowledge among respondents was observed concerning family planning services, yet the uptake of family planning among women was very low. The study revealed that mere physical access and awareness of family planning methods are not sufficient to ensure that family planning services needs are met. It is evident from this study that high knowledge on family planning services is not matched with the high family planning services use. This could be due to cultural and other barriers perceived by the women in the study institution.

Among reasons for not using family planning services, some respondents said they wanted to have a child and side effects of family planning services were given by respondents. It was also revealed that husbands had a role to play as whether to use or not to use family planning services among the respondents.

The decision to use or not is primarily influenced by others from within the social network, whose views and perceptions are often more important than an individual's own. Therefore, family planning campaigns should look beyond the individual woman to include other significant



social networks in order to drive demand and remove barriers affecting the uptake of family planning among women.

#### **6.4 Recommendations**

- **To the Bawku Municipal Health Directorate**

Culturally and socially appropriate outreach activities might be particularly effective for assisting some people in some areas in the Bawku and its environments in obtaining family planning information and services.

- **To the Presbyterian Hospital management team**

Service providers should plan educational programmes and counseling sessions for women who seek health care at the facility

- **To health workers in Bawku municipal**

The Bawku Municipal Health Directorate should sponsor the Mass media to raise awareness about the importance of male participations in family planning.

#### **6.5 Implications of the study and further research**

This study focused on assessing the knowledge and utilization of family planning among women 15-49 years attending Bawku Presbyterian Hospital in the Bawku municipality. This study would be very relevant to major stakeholders especially in the Bawku municipality as they would develop ways of enhancing women in their reproductive age use family planning methods. The findings of the study reflected adequate knowledge of family planning but low usage of family planning services.



Thus, major stakeholders such as, the Bawku municipal Health Directorate, hospitals and others health centres can use the information to design evidence based interventions for this category of respondents in their service areas. The study employed mainly quantitative study to collect the primary data, this method might not be good in collecting sensitive issues related to family planning among the women since they might not freely express themselves well.

The researcher therefore, suggests that more qualitative study should be conducted in the study area on barriers to uptake of family planning among women using mainly focus groups discussions involving men, women and health workers since the current study excluded these categories of respondents. The assumption is that the women may share similar stories regarding specific influences that affect their decision to use family planning services including contraception. By identifying specific needs for, or barriers to such services, focus groups can help inform the design of programs to make it easier for women to receive such services especially in the Bawku municipality and its environs.



## REFERENCES

- Adanu, R. Darko, R. and Rosemary, B. (2014). Contraceptive Use by Women in Accra, Ghana: Results from Accra Women's Health Survey. *African Journal of Reproductive Health*, Vol.11: pp 23-34.
- Adanu, R. Hill, A. and Rosemary, B. (2013). Contraceptive Use by Women in Accra, Ghana: Results from the 2003 Accra Women's Health Survey. *African Journal of Reproductive Health*, Vol.13: pp 29-30.
- Adjei, D. Sarfo, J. Asiedu, M. and Acheampong, I. (2014). Psychosocial factors affecting contraceptive usage. A case of unmet needs in Ghana: *European Scientific Journal*. Vol. 10, No. 15,p34.
- African Population and Health Research Center (2011). Report on family planning uptake among countries. p34
- Agarwala, S. (2013). Effect of a Rise in Female Marriage Age on Birth Rate in India. Paper Presented at United Nations World Population Conference Belgrade. p7.
- Aggarwal, P. Bhasin, S. and Rajoura, O. (2013). A new instrument (scale) for measuring the socioeconomic status of a family: Preliminary study. *Indian J Community Med*. Vol.30(4): pp 10-2.
- Alberta, G. (2008). Assessing the knowledge , attitude and perceptions of teenage girls on comprehensive abortion. p56.
- Albsoul-Younes, M. and Saleh, F. (2012). Perception of efficacy and safety as determinants for use and discontinuation of birth control methods in Muslim Jordanian women. *Eur J Contracept Reprod Health Care*. Vol. 8(3): pp 56-61.



- Andersch, B. (2012). The effect of various oral contraceptive combinations as pre-menstrual symptoms, international journal of gynecology and obstetrics. Vol. 20(6): pp 43-49.
- Andersen, R. A. (2009). Behavioural Model of Families" Use of Health Services. Research Series No. 25.
- Ansary, R. and Anisujjaman, M. (2012). Factors Determining Pattern of Unmet Need for Family Planning in Uttar Pradesh, India [online] International Research Journal of Social Sciences. Vol. 1(4): pp19-21.
- Aryeetey, R. and Hindin, M. (2010). Knowledge, Perceptions and Ever Use of Modern Contraception among Women in the Ga East District, Ghana. African Journal of Reproductive Health. Vol.14: pp 29-32.
- Aryeetey, R. Kotoh, A. and Hindin, M.J. (2010). Knowledge, Perceptions and Ever Use of Modern Contraception among Women in the Ga East District, Ghana. African Journal of Reproductive Health. Vol.14: pp 29-31.
- Asamoah, O. Agardh, A. and Per-Olof, Ö. (2013). Inequality in fertility rate and modern contraceptive use among Ghanaian women from 1988–2010. p34.
- Baumgartner, J. Johnson, L. and Nyamhanga, T. (2010). “Being Faithful” in a Sexual Relationship: Perceptions of Tanzanian Adolescents in the Context of HIV and Pregnancy Prevention. AIDS Care. Vol. 22: pp 53-5.
- Bawah, A. Akweongo, P. and Phillips, J. (2010). Women’s Fears and Men’s Anxieties: The Impact of Family Planning on Gender Relations in Northern Ghana. Studies in Family Planning, Vol.30: pp 59-62.





- Bawah, A. Simmons, R. and Phillips, J. (2013). Women's Fears and Men's Anxieties: The Impact of Family Planning on Gender Relations in Northern Ghana. *Studies in Family Planning*, Vol. 30: pp 58-60.
- Bawku Municipal Health Directorate Report (2014). Bawku Municipal Health Directorate Annual Health Report.
- Becker, M. Haefner, D. Kasl, S. Kirscht, J. Maiman, L and Rosenstock, I. (2009). Selected psychological models and correlates of individual health related behaviours. *Medical Care*. Vol.5: pp 27-46.
- Beekle, A. and McCabe, C. (2013). Awareness and determinants of family planning practice in Jimma, Ethiopia. *International Nursing Review*. Vol. 53: pp 69–72.
- Bertrand, J. Hardee, K. Magnani, J. and Angela, W. (2005). “Access, Quality of Care and Medical Barriers in Family Planning Programs”, *International Family Planning Perspectives*. Vol. 2(21): pp 64-694.
- Bhattarai, D. and Panta, O. (2013). Knowledge attitude and practice on contraception in village women in Khotang. *Journal of Nepal Health Research council*. Vol.11 (23): pp 40-43.
- Bongaarts, J. (2008). “Fertility Transitions in the Developing World: Progress or Stagnation?” *Studies in Family Planning*. Vol. 2 (39): pp 105-110.
- Bracken, M. and Farak, M. (2009). Contraception and pregnancy after dropping out of family planning clinics: A national interview survey in Jamaica. *Social Biology*. Vol. 23: pp 55-56.
- Brown, S. and Eisenberg, L. (2013). *The best intentions: Unintended pregnancy and the well-being of children and families*. Washington, D.C.: National Academy Press. p34.



- Bullough, V. L. and Bullough, B. (1987). *Women and Prostitution — A Social History*. Buffalo, NY: Prometheus Press.
- Caldwell, J. C. and Caldwell, C. P. (1999). The Cultural Context of High Fertility in Sub-Saharan Africa, *Pop Dev Rev*. Vol. 3 (13): pp 409-437.
- Caldwell, J. C. and Caldwell, C. P. (2002). Family Planning Programs in the Twenty-First Century Studies in Family Planning. Vol. 1 (33): pp76-86.
- Caldwell, P. and Caldwell, J. (1997). The role of marital sexual abstinence in determining fertility: A study of the yoruba in Nigeria population studies. Vol. 3(2): pp 193-217.
- Chacko, S. and Kabagambe, G. (2013). Knowledge of and Perceptions about Sexually Transmitted Diseases and Pregnancy: A Qualitative Study among Adolescent Students in Uganda. *Journal of Health, Population and Nutrition*. Vol. 25: pp 19-22.
- Chapagain, M. (2013). Masculine Interest behind High Prevalence of Female Contraceptive Methods in Rural Nepal. *Australian Journal of Rural Health*. Vol. 13: pp 35-42.
- Chetley, H. and Andrew, Y. (2007). “Improving Health, Connecting People: The Role of ICTs in the Health Sector of Developing Countries A Framework Paper.” Washington: infoDev. <http://www.infodiv.org/en/Document.84.pdf>.
- Clement, S. and Nyovani, S. (2004). Who Is Being Served Least by Family Planning Providers? A Study of Modern Contraceptive Use in Ghana, Tanzania and Zimbabwe, *African Journal of Reproductive Health*. Vol. 8, No. 2: pp124-136.
- Corker, J. and Ligne, V. (2010). Toll-Free Hotline: using cell phones to increase access to family planning information in the Democratic Republic of Congo. *Cases in Public Health Communication & Marketing*. Vol.4: pp23–37. [www.casesjournal.org](http://www.casesjournal.org)



- Coverdale, J. Turbott, S. and Roberts, H. (2014). Family planning needs and STD risk behaviors of female psychiatric outpatients. *British Journal of Psychiatry*. Vol. 171: pp 69-72.
- Creswell, J. W. (2005). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (2nd ed.). Upper Saddle River, NJ: Prentice- Hall.
- Critchlow, D. T. (1996). *The politics of abortion and birth control in historical perspective*. University Park, PA: The Pennsylvania State University Press
- DeClerque, J. Tsui, A.O. and Barcelona, D. (2014). Rumor, Misinformation and Oral Contraceptive Use in Egypt. *Social Science & Medicine*. Vol. 23: pp 83-92.
- Ebrahim, S. and Muhammed, N. (2011). Knowledge, Attitude and Practice of family planning among women in Basrah city South of Iraq. *MBU*. Vol. 29 (1,2): pp 70-72.
- Edwards, S. R. (2014). The role of men in contraceptive decision making: current knowledge and future implications, family planning perspectives. Vol. 26 (2): pp 79-82.
- Ekewmpu, C. C. (1990). The realities of VSC service at Zaria management, socio-cultural and medical issues. *Tropical Journal of Obstetrics and Gynecology*. pp 35-6.
- Foreman, A. and Mia, D. (2002). "Unmet Need for Contraception in the 21st Century: sub-Saharan Africa." 2002. [http://www.prcdc.org/files/Unmet\\_Need\\_Africa.pdf](http://www.prcdc.org/files/Unmet_Need_Africa.pdf) (accessed May 9, 2017).
- Foreman, A. and Mia, D. (2011) "The Challenges of Integrating Family Planning and Maternal/Child Health Services." The Population Reference Bureau. <http://www.prb.org/Articles/2015/family-planning-maternal-child-health-integration-programs.aspx> (accessed May 8, 2017).
- Freedman, H. L. (2014). Reproductive health on sexually adolescents, world health statistics 47. Vol. (1): pp 11-15.



- Fuse, K. (2010). Variations in attitudinal gender preferences for children across 50 less-developed countries *Demographic Research*. Vol. 23: pp 39–40.
- Gelaye, A. and Mekonen, T. (2014). Magnitude and risk factors of abortion among regular female students in Wolaita Sodo University, Ethiopia. *BMC Womens Health*. Vol. 14: p 1.
- Ghana Statistical Service (GSS). (2012). Population & Housing Census 2010. Summary Report of Final Results. Accra: GSS.
- Ghana Statistical Service, Ghana Health Service, and ICS Macro (2009). Ghana Demographic and Health Survey 2009. Accra.
- Ghana Statistical Services (2014). Ghana Demographic and Health Survey. Report. Accra, Ghana
- Gille, H. (2015). The world fertility survey: Policy implications for developing Countries, international family planning perspectives. Vol. II (1): pp7-9.
- Giusti, C, and Vignoli, D. (2012). Determinants of contraceptive use in Egypt: a multilevel approach. *Statistical Methods and Applications*. Vol. 15: pp 89–90.
- Gizaw, A. and Regassa, N. (2011). Family planning service utilization in Mojo town, Ethiopia: A population based study. *J Geogr Reg Plan*. Vol. 4: p55.
- Gordon-Maclean, C. and Rodriguez, M. I. 2014). The safety, efficacy and acceptability of task sharing tubal sterilization to midlevel providers: a systematic review, *Contraception*. Vol. 89 (6): pp 504-11.
- Gupta, V. Mohapatra, D. and Kumar, V. (2016). Family planning knowledge, attitude, and practices among the currently married women (aged 15-45 years) in an urban area of Rohtak district, Haryana. *Int J Med Sci Public Health*. Vol.5 (4): pp 27-32.



- Haggai, D. N. (2003). The Norplant experience in Zaria: A ten year review, *African Journal of Reproductive Health*. Vol. 7: pp 20-4.
- Hamid, S. and Stephenson, R. (2013). Provider and Health Facility Influences on Contraceptive Adoption in Urban Pakistan. *International Family Planning Perspectives*. Vol.32: pp 71-73.
- Hatcher, S. Sharon, V. Parag, D. and Collins, M. (2011). Problem-solving therapy for people who present to hospital with self-harm: Zelen randomised controlled trial, *The British Journal of Psychiatry*. Vol. 199 (4): pp310-316.
- Hausmann-Muela, S. Muela, R. and Nyamongo, I. (2013). Health-seeking behaviour and the health system response. *DCPP Working Paper no. 14*: p 23.
- Helzner, J. (2013). Gender equality remains the objective. *Planned Parenthood Challenges*. Vol. (2): pp 4-7.
- Ibrahim, M. T. and Sadiq, A.U. (1999). Knowledge, attitude, practices and beliefs about family planning among women attending primary health care clinics in Sokoto, Nigeria, *Nigerian Journal of Medicine*. Vol. 8: pp 154-8.
- Igberase, G. O. and Ebeigbe, P. N. (2007). Maternal mortality in a rural referral hospital in Niger Delta Nigeria, *J Obstet Gynaecol*.Vol. 27(3): pp 375-8.
- Igwegbe, A. Ugboaja, J. and Monago, E. (2009). Prevalence and determinants of unmet need for family planning in Nnewi, south-east Nigeria, *International Journal of Medicine and Medical Sciences*.Vol. 1: pp 325-29.
- Islam, M. Padmadas, S. and Smith, P. (2013). Men's approval of family planning in Bangladesh. *Journal of Biosocial Science*. Vol. 38 (2): pp 49-50.



- Jain, A. Visaria, L. and Visaria, P. (2013). Impact of family planning programme inputs on use of contraceptives in Gujarat state. Working Paper No. 43. Ahmedabad: Gujarat Institute of Development Research.
- Jaya, J. and Hindin, M. (2012). Premarital romantic partnerships: Attitudes and sexual experiences of youth in Delhi, India. *International Perspectives on Sexual and Reproductive Health*. Vol. 35: pp 102–105.
- Jaya, J. and Hindin, M. (2013). Non-consensual sexual experiences of adolescent in Urban India. *Journal of Adolescent Health*. Vol. 40: pp 59- 61.
- Jeffery, P. and Jeffery, R. (2014). population out of control? Myths about Muslim fertility in contemporary India. *World Dev*. Vol.30: pp 15-19.
- John, E. S. (2010). Family planning programme structure and performance in West African, family planning perspective. Vol. 25 (3): pp 14-19.
- Kabir, Z. Iliyasu, I. S. Abubakar, and Mage, B. S. (1990). The role of men in contraceptive decision making in Fashekara village, Northern Nigeria, *Tropical Journal of Obstetrics and Gynecology*. pp18-21.
- Kamal, I. (2012). Field experiences in involving men to promote safe motherhood: The Pakistan experience. Paper presented at the World Health Organization (WHO) meeting of regional health advisors on programming for male involvement in reproductive health, Washington, DC, Sept. pp 5–7.
- Kanitkar, T. and Kulkarni, S. (2012). Involvement of males in practice of contraception in Maharashtra. *Demography India*. Vol.31(1): p 11–15.



- Karra, M. Stark, N. and Wolf, J. (2013). Male involvement in family planning: a case study spanning five generations of a south Indian family. *Studies in Family Planning*. Vol.28(1): pp 24–34.
- Kats, G. (2013). Family planning and the religious issue. *Cairo Today*. Vol.4(1): pp 43-4.
- Kolcaba's, C. (2015). *Nursing Theories and Nursing Models, 2015* [Online], Available from: <http://www.nursing-theory.org/theories-and-models> [Accessed: 8/5/2017].
- Liston, L. (2014). Periodic Abstinence: How well do new approaches work? *Population reports*. Vol.3 (1): pp 13-15.
- Madhukumar, S. and Pavithra, M. (2015). A study about perceptions, attitude, and knowledge among men toward vasectomy in Bangalore rural population. *Int J Med Sci Public Health*. Vol. 4(8): pp 69-70.
- Mahaini, R. and Mahmoud, H. (2013). Maternal health in the Eastern Mediterranean Region of the World Health Organization. *Eastern Mediterranean Health Journal*. Vol.11: pp 32–38.
- Maudlin, W. (2011). Contraceptive use in the year 2010: *DHS world conference proceeding*. Vol. 2 (1): pp 13738-1381.
- Maudlin, W. P. (2015). Fertility studies: knowledge, attitude and practice studies. *Family planning perspective*. Vol. 73: pp 11-13.
- Mekonnen, W. and Worku, A. (2011). Determinants of low family planning use and high unmet need in Butajira District, South Central Ethiopia. *Reproductive health*. Vol. 8(1): pp 8-11.
- Mengistu, S. (2010). Assessment of level of awareness and utilization of emergency contraception, among college female students in Oromia Regional state, Arsi Zone, Asella town, South-East Ethiopia. Master's thesis. Addis Ababa: School of Public Health, Addis Ababa University.



- Muia, K. Blanchard, M. and Lukhando, J. (2012). Evaluation of an emergency contraception introduction project in Kenya. *Contraception*. Vol. 66: pp 255-260.
- Mutihir, J. T. and Pam, V. C. (2008). Overview of contraceptive use in Jos University Teaching Hospital North Central Nigeria, *Journal of Clinical Practice*. Vol.11: pp139-143.
- Najafi, F. Rahman, H. and Juni, M. (2011). Barriers to Modern contraceptive practices among selected married women in a public university in Malaysia. *Global Journal of Health Science*. Vol.3(2): p50. 56
- Najafi, F. Rahman, H. and Juni, M. (2011). Barriers to Modern contraceptive practices among selected married women in a public university in Malaysia. *Global Journal of Health Science*. Vol. 3(2): pp 50-56
- Nasir, T. (2010). Knowledge, attitude and practice of emergency contraception among graduating female students of Jimma University, Southwest Ethiopia. *Ethiop J Health Sci*. Vol. 20 (2): pp 91–97.
- Neville, H. and Golden, K. (2010). Emergency contraception: Pediatricians' knowledge, attitudes, and opinions. *Pediatrics*. Vol. 107 (2): pp 287-292.
- Neyaz, A. Ahmed, M. and Sahu, P. (2015). Contraceptive practices in Muslim-predominated slums of Aligarh, Uttar Pradesh. *Int J Med Sci Public Health*. Vol.4(12): pp 44-9.
- Nketiah-Amponsah, E. Arthur, E. and Abuosi, A. (2012). Correlates of Contraceptive use among Ghanaian women of Reproductive Age (15-49 Years). *African journal of reproductive health*. p 16 (3).
- Nuruzzaman, H. (2010). Unmet Need For Contraceptive: The Case Of Married Adolescent Women In Bangladesh *International Journal Of Current Research*. Vol. 9: pp 29–31.





- Obare, F. Keesbury, W. and Liambila, A. (2010). The provision of emergency contraceptives in private sector pharmacies in urban Kenya: Experiences of mystery clients. *African Population Studies*. Vol. p 24 (1).
- Odimegwu, C. O. (2013). Determinants of choice of traditional and modern methods of contraception unpublished manuscript, Department of Demography and Social Statistics, Obafemi Awolowo University, Ile-Ife, Nigeria. p23.
- Odimegwu, C. O. (2013). Family planning attitude and use in Nigeria: a factor analysis. *Family planning perspective*. Vol. 25: pp 89-91.
- Ogunjuyigbe, A. (2013). Spousal communication, changes in partner attitude and contraceptive use among the Yoruba's of southwest Nigeria. Department of Demography and Social Statistics, Obafemi Awolowo University, Ile-Ife, Nigeria.p 23.
- Ogunjuyigbe, P.O. Ojofeitimi, E. and Liasu, A. (2013). Spousal Communication, Changes in Partner Attitude, and Contraceptive Use among the Yorubas of Southwest Nigeria. *Indian Journal of Community Medicine: Official Publication of Indian Association of Preventive & Social Medicine*. Vol. 34: p 112.
- Ojule, J. D. and Macpepple, D. A. (2011). Family planning practice in a Tertiary Health Institution in Southern Nigeria, *West African Journal of Medicine*. Vol. 30 (3): p178.
- Okech, T.C. Wawire, N.W. and Mburu, T.K. (2011). Contraceptive Use among Women of Reproductive Age in Kenya's City Slums. *International Journal of Business and Social Science*. Vol.2: pp 22-43.
- Olakojo, O. A. (2012). Knowledge, attitude and practices of married women in Nigeria towards family planning. *journal of sociology, psychology and anthropology in practice*. Vol. 3 (4): p44.



- Oliver, R. (2015). Contraceptive Use in Ghana: The Role of Service Availability, Quality, and Price. World Bank, Washington DC. <http://dx.doi.org/10.1596/0-8213-3020-9>
- Omo-Aghoja, L. Omo-Aghoja, V. and Aghoja, C. (2012). Factors associated with the knowledge, practice and perceptions of contraception in rural southern Nigeria. *Ghana Medical Journal*. Vol.43: pp 119–120.
- Omole-Ohonsi, A. Ashimi, S. and Attah, R.A. (2010). A Review of family planning methods used in Kano, Nigeria. *Nigerian Journal of Clinical Medicine*. Vol. 2: pp 7-9.
- Otolorin, E. O. Falase, I. A. Olayinka, E.A. and Ladipo, O. A. (1990). Attitudes of Nigerians to voluntary sterilization: A Survey of an Urban Population, *Tropical Journal of Obstetrics and Gynecology*. Vol. 2: pp 18-21.
- Owusu-Agyei, S. Adda, R. and Mbacke, C. (2012). Demographic Patterns and Trends in Central Ghana: Baseline Indicators from the Kintampo Health and Demographic Surveillance System. *Global Health Action*. Vol. 5: pp 35-40.
- Oyedokun, O. (2007). Determinants of Contraceptive Usage: Lessons from Women in Osun State, Nigeria, *Journal of Humanities and Social Science*. Vol.2pp :1-3
- Parker, C. (2010). Adolescents and emergency contraceptive pills in developing countries. *Family Health International Working Paper Series WP05-01*. pp 1–18.
- Parr, N. (2013). Discontinuation of Contraceptive Use in Ghana. *Journal of Health, Population and Nutrition*. Vol. 21: pp 150-157.
- Parr, N. (2013). Discontinuation of Contraceptive Use in Ghana. *Journal of Health, Population and Nutrition*. Vol. 21: pp 50-52.
- Philips, J. (2015). The determinant of contraceptive choice in two rural sub-districts in bangladesh. *East west population institute*. Vol. 3(2): pp 19-21.



- Phipps, M. G. (2012). Characteristics of women who seek emergency contraception and family planning services. *American Journal of Obstetrics and Gynecology*. p34.
- Planned Parenthood Federation America (2012). *A History of Birth Control Methods*. New York, USA: Katharine Dexter McCormick Library.
- Postlethwaite, D. (2013). A comparison of contraceptive procurement pre- and post-benefit change. *Contraception*. Vol. 76: pp 36–43.
- Quraishi, S. (2013). Muslims’ low practice of family planning. India. Low levels of education, particularly among women, is one of the major reasons behind high fertility rates. *Integration*. Vol. 47: pp 25-7.
- Rajaretnam, T. and Deshpande, R. (2014). Factors inhibiting the use of reversible contraceptive methods in rural south India. *Studies in Family Planning*. Vol.25(2): pp 11–13.
- Raju, S. and Leonard, A. (2012a). Men as supportive partners in reproductive health – Moving from rhetoric to reality. Population Council, New York. p 23.
- Raju, S. and Leonard, A. (2013b). Non-governmental organizations pave the way. In: Raju S. and Leonard A. (Eds). *Men as supportive partners in reproductive health – Moving from rhetoric to reality*. Population Council, New York. p 34
- Rao, G. and Sinha, R. (2011). Male participation in family planning. An evaluation study of no-scalpel vasectomy project, Madhya Pradesh. *International Institute for Population Sciences*. Vol.6: p 47.
- Renjhen, P. (2013). A study of knowledge, attitude and practice of family planning among the women of reproductive age group in Sikkim. *The Journal of Obstetrics and Gynaecology in India*. Vol.58: pp 63-67.



- Rimal, G. (2013). Knowledge, Attitude and Use of Contraceptive among currently Married: A case Study of tamang community in samari VDC of Nuwakot District, in Central Department of Population Studies. Tribhuvan University: Kathmandu. p 23.
- Rutenberg, N. (2013). Knowledge and use of contraceptive, DHS comparative studies. Vol. 6(1): p 67.
- Samira M. E. and Nihad, K. M. (2011). Knowledge, attitude and practice of family planning among women in Basrah city south of Iraq. Medical journal Basrah University. Vol. 29, no. 1&2 pp :1-3
- Sargent, C. and Cordell, D. (2012). Polygamy, disrupted reproduction, and the state: Malian migrants in Paris, France. Soc Sci Med. Vol.56 (9): pp 69-72.
- Schoenmakers, R. (2013). The child spacing tradition and post partum tab taboo in African anthropological evidence. New York: Academic Press.
- Sedgh, G. Hussain, R. Bankole, A. and Singh, S. (2007). Occasional report No. 37. Women with an unmet need for contraception in developing countries and their reasons for not using a method. New York, USA: Guttmacher Institute. pp 5-9
- Sharma, V. Mohan, U. and Awasthi, S. (2012). Socio- demographic determinants and knowledge, attitude, practice: survey of family planning, Sharma. Journal of family medicine and primary care. Vol. 1: pp 43-46.
- Sonenstein, F. (2011). Sex and contraception among adolescent males, the Networks. Vol. 29 (3): pp 13-15.
- Srivastava, D. Goutam, P. Goutam, R. Gour, N. and Bansal, M. (2011). A study to assess the unmet need of family planning in Gwalior Division and to study the factors that helps in determining it. National Journal of Community Medicine. Vol. 2(1): pp 28-31.



- Sterley, K. (2011). Incidence of abortion worldwide: World health statistics. Vol.3(1): pp 22-36.
- Subhash, B. (2013). Socio-economic and Demographic Determinants of Unmet Need for Family Planning in India and its Consequences. Research on Humanities and Social Sciences. Vol.3, No.3 pp: 2-3
- Tafforeau, J. Damiba, A. and Maternowska, M. (2013). Changes in Chad: The results of a KAP survey. Biol Soc. Vol.7(4): pp 199-202.
- Tajure, N. and Pharm, B. (2010). Knowledge, attitude and practice of emergency contraception among graduating female students of Jimma University, Southwest Ethiopia. Ethiop J Health Sci. Vol. 20 (2): pp 91–97.
- Tamire, W. and Enqueselassie, F. (2010). Knowledge, attitude, and practice on emergency contraceptives among female university students in Addis Ababa, Ethiopia. Ethiop J Health Dev. Vol. 21 (2): pp 111–116.
- Tilahun, D. Assefa, T. and Belachew, T. (2010). Knowledge, attitude and practice of emergency contraceptives among Adama University female students. Ethiop J Health Sci. Vol.20(3): pp195–202.
- Tuladhar, H. and Marahatta, R. (2010). Awareness and Practice of Family Planning methods in women attending Gynecology OPD at Nepal Medical College Teaching Hospital. Vol.10: pp 89-90.
- United Nations Population Fund (2010). Improving Reproductive Health, UNFPA, New York, viewed 23 April 2010.
- UNPFA, (2010). State of the World Population 2010: From Conflict and Crisis to Renewal generations of change.



- Wablembo, M. Ntozi, J. and Kwagala, B. (2011). Does couple discussion influence unmet need for family planning in Uganda. p34.
- Waheeb, A. Zeid, W. and El Faky, A. (2005). Community and Service Providers' Attitudes about Tubal Ligation for Medical Reasons, The British Journal. p12.
- Westhoff, C. and Davies, A. (2000). Tubal Sterilization Focus on the US Experience, Fert. Steril. Vol. 23: pp 913-22.
- Westoff, C. F. and A. R. Cross (2006). The Stall in the Fertility Transition in Kenya, Measure/DHS.ORC Macro. United States Agency for International Development (USAID).
- Westoff, F. (2006). New estimate of unmet need and the demand for family planning. DHS comparative reports No. 14. Calverton, Maryland, USA: Marco International Inc; 2006.
- Woldemicael, G. and Beaujot, R. (2011). Currently married women with an unmet need for contraception in Eritrea: Profile and determinants. Canadian Studies in Population. Vol. 38 (1-2): pp 69-71.
- World Health Organisation (2012). Essential contraceptives Care: A report of Technical Working Group. Geneva
- World Health Organisation (WHO). (2011). Global consultation of friendly health services. A consensus statement. Department of Adolescent and Child Health and Development, Geneva.
- World Health Organisation (2012). Trends in Maternal Mortality 1990-2010. WHO, UNICEF, UNFPA and The World Bank Estimates.



World Health Organization (2010). Unsafe abortion. Global and regional estimates of the incidence of unsafe abortion in 2008. Sixth edition. WHO, Department of Reproductive Health and Research, World Health Organization. ISBN: 978 92 4 150111 8.

World Health Organization (2015). Family planning / contraception: Facts Sheet. Geneva: WHO Int. publication.

World Health Organization (WHO, 2005). Department of Reproductive Health and Research. Medical eligibility criteria for contraceptive use, fourth edition.

World Health Organization (1971). Family planning / contraception: Facts Sheet. Geneva. WHO.

Wubegzier, M. and Alemayehu, W. (2011). Determinants of low family planning use and high unmet need in Butajira Division, South Central Ethiopia. Mekonnen and Worku Reproductive Health. Vol. 8: p37



**APPENDIX I**

**UNIVERSITY FOR DEVELOPMENT STUDIES**

**SCHOOL OF ALLIED HEALTH**

**DEPARTMENT OF COMMUNITY HEALTH**

**Questionnaire**

**Informed consent**

This is an Mphil student at the Department of Community Health, School of Allied Health Sciences, of the University for Development Studies. I am conducting a study on the knowledge and practice of family planning among women (15-49years) attending Bawku Presbyterian Hospital. The purpose of the study is to help the Ghana Health Services/CHAG and other stakeholders in reproductive health to plan and provide family planning services that can best serve the needs of our clients. I would expect respondents to cooperate and help to make the study a success. Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. You can stop the survey at any time. All information provided would be strictly confidential and restricted to the research purpose only.

Please kindly, answer the questions below.

Thank you.

**Section a: Socio-demographic characteristics**

1. Age: I. 15-20 ( ) ii. 21-24 ( ) iii. 25-30 iv. 31-34 ( ) v. 35-40 ( ) vi. 41-44 ( ) vii 45-49 ( )
2. Age at first pregnancy.....years
3. Age at first marriage.....years
4. Parity: a. 0 [ ] b. 1 [ ] c. 2 [ ] d. 3 [ ] e. others (specify).....
5. What is your religion? a. Islam [ ] b. Christianity [ ] c. African traditional [ ]





d. (Others specify): .....

6. Ethnicity of respondent: a. Kusasi [ ] b. Mamprusi [ ] c. Bissa [ ] d. Mossi [ ]

e. (Others specify): .....

7. Educational level a. None [ ] b. Primary [ ] c. Middle/JHS [ ] d. SHS [ ] e. Tertiary [ ]

f. Others (specify).....

8. Form of Occupation: a. formal [ ] b. informal [ ]

9. Marital status: a. Single [ ] b. Married [ ] c. Divorced [ ] d. other (specify) .....

10. What is the age of your husband?

a. 18-25 [ ] b. 26-30 [ ] c. 31-35 [ ]

d. 36-40 [ ] e. 41-45 [ ] f. 46-50 [ ] g. 51 and above [ ]

11. Did your husband/partner ever attend school? a. yes [ ] b. no [ ]

12. If your answer to question 11 is yes, what was his highest level of school attended?

a. Primary [ ] b. secondary [ ] c. tertiary [ ] d. don't know [ ]

13. What is the occupation of your husband? .....

**Section b: Knowledge and practice**

14. Have you heard of contraceptives: a. yes [ ] b. no [ ]

15. If yes where.....

16. What is contraceptive? .....

17. Do you use it: a. yes [ ] b. no [ ]

18. If no why? .....

19. If yes to Q. 17, which contraceptive?



Multiple responses allowed, read from the list and mark all that apply

- i. Pills
- ii. Intrauterine device (IUCD)
- iii. Injectable (depo-provera)
- iv. Norplant (buried under skin)
- v. Condom
- vi. Spermicidal
- vii. Tubal ligation/female
- viii. sterilization
- ix. Vasectomy/male sterilization
- x. Periodic abstinence/calendar
- xi. Others specify .....

20. Are you currently using any FP method? a. Yes [ ] b. No [ ]

21. How long have you been using it?

a. Less than one year [ ] b. 1- 2 years [ ] c. 3 – 4 years [ ] d. 5 years and above [ ]

22. Do you have an idea about any natural method of family planning?

a. Yes [ ] b. No [ ]

23. If yes to the above (Q. 22), which of these do you know?

- i. Withdrawal method
- ii. Calendar method
- iii. SDM
- iv. Basal temperature
- v. Lactational amenorrhea



vi. Others specify.....

24. Do you use any of the above? a. Yes [ ] b. No [ ]

25. What is the reason for your answer to Q. 24?

.....  
.....

26. When do you use contraceptive after birth?

a. immediately after birth [ ]

b. Within 1-3 months [ ]

c. 4-5 months [ ]

d. Other specify.....

27. In your view how effective was the contraceptive method you were using:

a. very effective [ ] b. effective [ ] c. Moderate [ ] d. very moderate [ ]

28. Would you advice someone to use it: a. yes [ ] b. no [ ]

29. Give reason for your answer to Q. 28: .....

.....  
.....

30. Have you heard of emergency contraceptive: a. Yes [ ] b. No [ ]

31. If yes where: .....

32. What is emergency contraceptive? .....

.....

33. Have you ever use emergency contraceptive before: a. yes [ ] b. no [ ]

34. If yes to question 33 above, did the method failed to work? a. yes [ ] b. no [ ]

**Section c: Availability and extent of access**



35. Where can you receive family planning service in the hospital?

- i. Maternity ward
- ii. Family planning unit
- iii. ANC
- iv. PNC
- v. Child welfare clinic
- vi. Any other unit, please specify .....

36. In your view are there various family planning methods to choose from?

a. yes [ ] b. no [ ] c. no idea [ ]

37. What are the available methods of FP in the hospital? Multiple response allowed, read from the list and mark all that apply

- i. Pills
- ii. Intrauterine device (IUCD)
- iii. Injectable (depo-provera)
- iv. Norplant (buried under skin)
- v. Condom
- vi. Spermicidal
- vii. Tubal ligation/female
- viii. Sterilization
- ix. Vasectomy/male sterilization
- x. Periodic abstinence/calendar
- xi. Others specify .....

38. Are the methods readily available for use? a. yes [ ] b. no [ ] c. No idea [ ]



39. What are your impressions on access to family planning service?

- i. Excellent
- ii. Very good
- iii. Good
- iv. Bad
- v. Very bad

40. Do you walk or take transport to the facility?

- i. Walk
- ii. Take transport

41. Does distance affect utilization of the service?

- a. Yes [ ] b. No [ ]

42. If yes how? .....

.....

43. Do you know where a person could go for a FP method outside the hospital?

- a. Yes [ ] b. No [ ]

44. In your view is it easy to get access to FP service? a. Yes [ ] b. No [ ]

**Section d: Male involvement in family planning services**

45. How supportive is your partner towards the use of contraceptive:

- a. supportive [ ] b. not supportive [ ] c. partially supportive [ ]

46. Did you seek for consent from partner before attending FP clinic?

- a. No consent is sought [ ] b. Consent is sought [ ]

47. Does your husband approve the use of a contraceptive? a. Yes [ ] b. No [ ]

48. How often have you and your husband talked about family planning for the past year?



a. Once in 3 months [ ] b. Once in 6months [ ] c. Once a year [ ] d. Never [ ]

e. others specify.....

49. Have you and your husband ever discussed the number of children you would like to have?

a. Yes [ ] b. No [ ]

50. If yes to Q. 49 above, how many children have you decided or agreed to have? .....

51. Do you think your husband likes the same number of children you would like to give birth

to? a. Yes [ ] b. No [ ] c. no idea [ ]

52. How long do you space your birth: a. 1-2 years [ ] b. 3-4 years [ ] c. 5-6 years [ ]

d. 6 and above [ ]

53. In spacing your children do you plan with your partner: a. yes [ ] b. no [ ]

54. If no why: .....

**Section e: Unmet needs**

55. When you got pregnant, did you want to get pregnant at that time? a. Yes [ ] b. No [ ]

56. Give reason for your answer to Q. 55 .....

.....  
.....

57. Did you ever used anything or tried in every way to delay or avoid getting pregnant?

a. yes [ ] b. no [ ]

58. Give reason for your answer to Q. 57 .....

.....  
.....

59. When did you start your antenatal clinic session: a. 1st month [ ] b. 2nd month [ ]

c. 3rd month [ ] d. (other specify).....



60. After the child you are expecting now, would you like to have another child?

a. Yes [ ] b. No [ ]

61. Give reason to Q. 60.....  
.....  
.....

62. After the birth of the child you are expecting now, how long would you like to wait before the birth of another child? .....

**Section f: Barriers to family planning**

63. Which of these do you consider as a barrier to practice of family planning?

(Tick as many as possible)

- i. Socio-cultural factors
- ii. Physical access
- iii. Hours of opening and length of wait
- iv. Medical barriers
- v. Interpersonal relations
- vi. Competent providers
- vii. Affordability/cost
- viii. Religion
- ix. Others (specify).....

64. Explain your answer to any factor(s) selected in 63 above.  
.....  
.....

**Thanks for your time**

