ASSESSING THE FACTORS INFLUENCING UTILIZATION OF FAMILY PLANNING SERVICES AT THE COMMUNITY-BASED HEALTH PLANNING SERVICES (CHPS) IN THE BONGO DISTRICT OF THE UPPER EAST REGION OF GHANA.

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2017
UNIVERSITY FOR DEVELOPMENT STUDIES

ASSESSING THE FACTORS INFLUENCING UTILIZATION OF FAMILY PLANNING SERVICES AT THE COMMUNITY-BASED HEALTH PLANNING SERVICES (CHPS) IN THE BONGO DISTRICT OF THE UPPER EAST REGION OF GHANA.

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UDS/CHD/0151/13

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

SEPTEMBER, 2017
DECLARATION

This thesis has been composed and documents the original work carried out by Irene Ngeh.

All data were originally gathered and analyzed by the author of this thesis unless explicitly stated otherwise in the text.

This thesis does not incorporate, without due acknowledgement, any material previously submitted for a diploma or degree in any institution or university.

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Dr. Ziblim Shamsu-Deen Date
The experimentation and final adaptation of the Community –based Health Planning and Service (CHPS) as a policy option to address the concerns of access to healthcare is perhaps one of the innovative outcomes made to confront the myriad of developmental challenges facing access to healthcare in sub Saharan African including Ghana. Several studies that have so far been conducted on the CHPS strategy gives premium to the CHPS strategy by concentrating on Immunization with only a cursory remarks made on their core mandate. This study therefore examines how the inception of CHPS has affected the patronage of family planning at the communities where they are established in the Bongo District.

Employing both qualitative and quantitative (mix method) methods of data collection using tools such as questionnaires, focus group discussion guides, key informant interviews guides, this study provide both empirical and theoretical clarifications on the services rendered at the CHPS especially family planning services. The study found out that majority of the people in the Bongo district who use the services of the CHPS were women in their reproductive age group. The study also revealed that majority of the men in the selected communities for the study did not use and practice family planning methods this they attributed to traditional and religious beliefs and to them is a taboo to practice family planning. The study further revealed that the Community Health Officers working in the various CHPS are accommodative and that they understand their problems very well. The study indicated that the CHPS faces series of challenges such as lack of logistics, poor accommodation for health staff, lack of electricity and difficult in maintaining the cold chain. This study therefore recommend that logistics should be provided for effective running of CHPS.
ACKNOWLEDGEMENTS

After three years of hard work, I realized now that obtaining an MPhil degree is not one person’s effort. For this reason, I will like to publicly acknowledge the contribution and sacrifices from many people who have played a crucial role in the completion of this thesis.

I extend my sincere appreciation to the God Almighty for his favor of life and for guiding and seeing me through this course successfully.

I am highly indebted with heartfelt gratitude and thanks to my inspiring supervisor Dr. Ziblim Shamsu-Deen for the guidance, encouragement and insightful inputs into my work. This thesis would not have been completed without his encouragement and support.

I would wish to extend my heartfelt gratitude to the chief and people of Bongo district, the district director and the entire staff of the DHMT for their support and benevolence.

I am sincerely grateful to my colleague tutors of Nursing training college, Bolga, Mr. Williams Sebil, Mr. Edward Atiim, Mr. George Apee, Mr. Moses Laar, Mr. Mathias Gnasin, kampitib Mathew, Mama Margaret Azusiyinne and my former principal Mr. Mac-Moon Musah for their endless motivation and support throughout my study. I also register my heartfelt gratitude to Dr. Robert Kuganab and wife, Dr. Thomas Azongo, Dr. Vida Yakong and Mr. Mustapha Issahaku for their discerning and useful criticisms and comments.

My deepest appreciation goes to my beloved and sweet mother and paramount Queen mother of Bongo traditional area, Napoka Christiana Asindikye Ngeh for her love, care, sacrifice, encouragement and support during my studies. I am short of words to describe your commitment and contribution to my life.
DEDICATION

This work is dedicated to my lovely husband Albert Zoogah, children (Anbella, Zephaniah and Reagan-Daniel Zoogah) and my Mother for their immerse support and prayers.
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CHAPTER ONE

1.1 Background of the Study

In 1997, after a decade of institutional development, the Ministry of Health, Ghana, launched a Health Sector Reform (HSR) process with the aim of improving both geographical and financial access to basic health care services, improving the quality of the services provided, ensuring efficiency in the services being provided, improving inter-sectoral action for service provision and increasing financial resources of the sector. The reforms also build on a reorganization of the MOH that began in 1993, which was explicitly designed to set the stage for the creation of the Ghana Health Service (GHS). In 1998, the Ministry of Health/GHS in Ghana, using the research findings of the Navrongo Health Research Centre (NHRC) in the Upper East Region of Ghana, initiated a strategy designed to improve access, equity, quality, and efficiency of Primary Health Care (PHC) in support of the objectives of health sector reforms at the community level. This initiative known as the Community-based Health Planning and Services (CHPS) Initiative seeks to develop community-based service delivery points and improve partnerships with community leaders and social groups in all the districts of Ghana. In the CHPS strategy, family planning was an initial component of the programme.

CHPS is the Ministry of Health’s plan to shorten the gap between health access for the increasingly urbanized south and the agrarian north. Even within districts, there is often a spectrum between urbanized areas and remote communities. The CHPS system decentralizes Ghana’s health system by locating more resources directly into communities and involving communities in important health decisions. This
empowers communities with choices about health care and gives individuals the opportunity to receive quality and prompt treatment from the health system. The CHPS system is the system of the present and the future for Ghana; it represents an opportunity for the country to provide quality health care for all of its citizens, a goal which has long been sought by the government and a crucial step for Ghana’s development.

Reproductive health and Family Planning (FP) issues and services have been of concern to both the developed and the developing world. It is therefore said to be of global concern especially in Africa and other third world countries where fertility rates are high. Family Planning services had always targeted females in the urban communities as a result of inadequate staff in the health sector in the developing world including Ghana.

The CHPS programme is a scale-up of the “Navrongo experiment” that was initiated and piloted in Northern Ghana over a decade ago. Thus, The Ghana Health Service adopted this model of delivering Primary Health Care (PHC) services as it has the potential of extending health services to poorly deprived communities in Ghana (Nyonator, Akosua, Awoonor, 2005)

The delivery of family planning services is one of the key activities that CHPS strategies emphases. This is a door-to-door strategy of providing health information on family planning that targets both women and men. These messages are aimed at changing the perception of men about family planning and contraceptive use. This is particularly relevant, as most men in developing countries tend to oppose family planning and contraceptive use (Miskik, Nacar, Mazicioghu, Cetinkaya, 2003). The patriarchal nature
of most African societies often put men in a Dominance position over women. This
domineering attitude is also transferred across all spheres of life including maternal and
reproductive health decisions. Globally, use of modern contraceptives has risen slightly,
from 54% in 1990 to 57% in 2012. For instance, Contraceptive use has increased in many
parts of the world, especially in Asia and Latin America, but continues to be low in sub-
Saharan Africa (WHO, 2013). Regionally, the proportion of women aged 15–49 reporting
use of a modern contraceptive method has raised minimally or plateau between 2008 and
2012. In Africa it went from 23% to 24%, in Asia it has remained at 62%, and in Latin
America and the Caribbean it rose slightly from 64% and 67%. There is significant
variation among countries in these regions (Kamal, 2000).

The implementation of CHPS at the local level requires the cooperation of the health
sector and communities as it involves systematic planning and negotiation with all
stakeholders; local authority, political establishment and the community members
through community mobilization and effective participation. In this system of health care
delivery, the health sector provides additional training on preventive health care services
in areas such as immunizations, family planning, supervisory delivery, antenatal/postnatal
care, treatment of minor ailments and refresher training to community health nurses after
are relocated to the various communities to provide Door-to-Door services after the
training (Binka, Nazzar, Phillips, 2005).

In addition, the communities in consultation with the health sector select community
volunteers to support the work of the Community Health Officers (CHOS) in the area of
community mobilization and participation, recording vital community statistics and
maintaining other essential activities. As a strategy to improve health services delivery,
some donor agencies and collaborators, provide assistance to regions to initiate and implement the CHPS strategy (GHS 2005). The Population Council through a USAID grant has been in the forefront of implementing CHPS in mainly in the Northern sector of Ghana. Also WHO, the brain behind this concept has been a pillar of support to the CHPS concept in the most countries including Ghana (Beckman, 2002).

In most African communities and in Ghana in particular, due to certain cultural norms and misconceptions, women are forced to conform to men when it comes to matters affecting their reproductive rights and their ability to take decisions on contraceptive use and birth control (Adongo, Philips & Baymes, 2013). Hence, most family planning programmes over the years have viewed men as an obstacle to women’s ability to control their reproductive rights and therefore concentrating on providing the family planning programmes to women. Family planning programmes have focused attention primarily on women, with the intention to free them from excessive childbirth, and to reduce maternal and child mortality through the use of contraceptives. For this reason, family planning services were offered within maternal and child health centre, whereas research and information campaigns were tailored to the needs of women with the hope that family planning services targeting women will help them to achieve a sustainable socio-economic development and protect their health. Based on this assertion, the CHPS concept was introduced to draw service closer to women so as to help space their children and also allow internal healing to take after birth. However, evidence suggests that the programme that involved men and encouraged the use of male methods have led to a drop in fertility and the overall development of women. Men are able to better place their
reproductive intentions, promote good decisions for the benefit of their wives when they are made active participants in service delivery programme (Kamal, 2000).

Socially, contraceptives have been perceived as a liberating strategy for women as it has the potential of providing ability to control fertility. Most men see this as empowering women and a strategy that undermine their authority. In addition, men perceive the use of contraceptives as an opportunity for women to become unfaithful and promiscuous. The desire for large family size, religious considerations, and socio-cultural factors explains the lack of enthusiasm for community involvement in family planning programmes. However, carefully designed programmes that have used available local networks to deliver information and activities have proven to reduce social tension thereby improving total community involvement in family planning activities (Miskik, Nacar, Maziciogh, Centinkaya, 2003).

Inter-spousal communication has been identified as an important consideration in encouraging couples to accept family planning and adhere to contraceptive use. Studies have shown that women whose partners approve the use of contraceptives are more likely to use contraceptives as compared to women whose partners’ disapprove contraceptive use. This evidence suggests that couples who frequently discuss contraceptive methods are more likely to try other methods when they experience discomfort with a particular contraceptive method. Previous studies also revealed that where both partners approve of the use of contraception, there is high intention and likelihood of future contraceptive use as compared to the likelihood of contraceptive use among partners who object to contraceptive use (Beckman, 2002).
Availability and access to family planning commodities is very essential in facilitating family planning acceptance and use as they are closely linked to the strength and extent of programme coverage. The availability of accurate family planning information, quality of service and adequate supplies are crucial determinants in the acceptance and participation in reproductive health programmes (Bateman, 1994). Low programmes coverage and poor quality family planning services have the tendency to discourage both men and women from family planning uptake. The availability of wide range of contraceptive method-mix provides the opportunity for both men and women to make informed choices. Accessibility and client-focused services are a hallmark of high-quality patronage of reproductive health [family planning] services. Reliable information, education, sensitization, effective communication and proper counseling provided through primary health care systems have the potential to increase access to the family planning client services. In view of this, i decided to investigate the contribution of CHPS, which is an integral part of Ghana’s primary health care system on the impact of the CHPS concept on family planning services in the Bongo district.

1.2 Problem Statement

Globally, the current world’s population growth stands at 7 billion in 2013. Although population growth has been slowing, projections still place the world’s population between 9 billion and 10 billion by 2100. (UNDP, 2014).

Population growth is one of the key factors for nations to consider if they are to address major issues such as climate change, hunger, the disparity between rich and poor as well as economic crisis.
Population experts are concerned that developing countries, particularly those in sub-Saharan Africa, where fertility continues to be high and shortage of food and water are worsening, will face more deteriorating conditions if family sizes do not shrink.

Not only do higher birth rates have an impact on a sustainable future, they also present devastating impact on the lives of mothers and their children. In sub-Saharan Africa, up to a quarter of girls drop out of school due to unintended pregnancies, “stifling their potentials to improve their lives and their children’s lives. (WHO, 2013).

It seems clear that global access to free voluntary family planning, including effective contraception, is necessary to reduce maternal and newborn infant deaths, improve women’s and their children’s lives, and to achieve a population level that ensures economic and environmental sustainability.

An estimated 225 million women in developing countries would like to delay or stop childbearing but are not using any method of contraception. Reasons for this include: limited choice of methods, limited access to contraception, particularly among young people, poorer segments of populations, or unmarried people; fear or experience of side-effects, cultural or religious opposition; poor quality and available services; users and providers bias, gender-based barriers. (WHO 2013).

In the sub-Saharan, Most of the countries with lowest rates of contraceptive use, Experience high maternal, infant, and child mortality rates, (Buor 2004). Only about 30% of all women use birth control, although, over half of all African women would like to use birth control if it was available. The main problems preventing access to and use of birth control are unavailability, poor health care services, spousal disapproval, religious
concerns, and misinformation about the effects of birth control and attitude of some health care givers. (Adongo, Philips and Baymes, 2013).

In an attempt to provide effective family planning care services to the rural folks in Ghana, as a positive step to control population growth and its negative percussions, it was imperative to adopt the Door to Door delivery of services Known as the Ghana Community-based Health Planning and Services (CHPS) Initiative, the program translates innovations from an experimental study of the Navrongo Health Research Centre (NHRC) into a national community health care program. The Navrongo experiment has demonstrated service strategies that improved the quantity, efficiency or quality of health and family planning care (Binka et al. 1995, Debpuur et al. 2002), CHPS represents a process of organizational change that bridges the gap between research results and health sector reform.

The main purpose was to bridge access to health services by the rural communities in Ghana which would encourage people to go in for health care services without constrains. Although the CHPS concept was started at Navrongo but it was later adopted by all the 14 districts in the UER of which Bongo district is part. However, according to Bongo District 2013 revealed that there has been a decline in the acceptance and use of family planning services, also records reveals that the district still records a high growth density of 2.8% for the 2010 census, and high child streetism and this pose a big question on their FP services Bongo District Annual Report, (2013).

There have been several complains from the CHPS centers in the upper east region and the Bongo district in particular which has led to low patronage in a declined in family planning services in the area (RHMTTP, 2014). A studies conducted by Yakong, (2008)
revealed that inadequate health personnel and poor attitudes of health workers, low male involvement in Family planning services, distance, sociocultural factors are the major factors hindering the uptake of family planning services in some rural communities in the Upper East region of Ghana. Issues of reproductive health especially family planning is a bedrock of the sustainable development goals 4 and 5. To achieve these goals attention and concentration should be on the CHPS strategy in all the communities where there are built (Ziblim, 2014). In address this problem the following research questions are posed:

1.3. Objectives of the study

The general objective of the study was to examine the role of the CHPS in family Planning and to ascertain how effective the implementation of the CHPS in health education in the Bongo district of the Upper East Region of Ghana. Specifically, the study aimed at achieving the following objectives:

1. To ascertain the services delivered by the CHPS
2. To examine the attitude of health workers and their competencies in delivery family planning services.
3. To also investigate the financial and the geographical accessibility of the CHPS strategy in the entire Bongo district.
4. To investigate the involvement of the people both men and women in family planning service at the CHPS compounds.
5. To examine the challenges faced by the CHPS in the effective and efficient delivery of their mandate particularly family planning services.
1.4.1 Purpose of the Study

Purpose of this study is to explore the patron of Family planning services at the CHPS in Bongo District. The study tries to investigate the activities of the CHPS in the Bongo district and to find out if indeed they are up to the tasks given them. There is the notion that the CHPS are white elephants in the various communities and that they are not really up to the task of which they were established. Another school of thought is of the view that the CHPS strategy has help in sending health care to the door steps of the people especially in the hinterlands. This study focused on an aspect of the service delivered by CHPS which is family planning services and this is as a result of the time and resource constrains.

1.5 Significance/Relevance of the Study

The study when completed will serve as a stock of knowledge to researchers and professional in the health delivery system in Ghana and beyond. It also will help policy makers in the formulation of health policies especially in the bit to decentralize health facilities in all communities in Ghana so that those in the rural areas can have access to health care.

The study will as well help in unveiling the gaps and the challenges in the implementation of the CHPS strategy.

1.6 Conceptual Framework

A Conceptual framework broadly presents an understanding of a phenomenon of interest of a study and reflects the assumptions and philosophic views of the model’s designer (Polit & Beck, 2008). A model “is frequently described as a symbolic depiction of reality.
It provides a schematic representation of certain relationships among phenomena, and it uses symbols, words or diagrams to represent an idea” (Brink et al, 2006). The phenomena under study is assessing the impact of the CHPS concept on family planning services. The conceptual framework enables the researcher to discover what was known or not known about the topic of interest in order to conduct research that adds to the body of knowledge and also lays the foundation of the study (Polit& Beck 2006).
CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature on the activities of CHPS and its related challenges in Ghana. It also reviews literature on issues relating to family planning and reproductive health as well as maternal and child health. This is so because those areas have a direct link with the mandate of CHPS administration.

This chapter looks at the literature review of family planning services and the CHPS concept. It begins with a general overview of family planning and the CHPS concept, it has been organized according the following themes derived from the research objectives; community understanding and participation of CHPS activities, physical, geographical and socio-cultural barriers affecting patronage of family planning services, attitudes of male towards family planning services and patronage, and the attitudes of health workers toward clients patronizing family planning services, as well as training, monitoring, supervision and evaluation of family planning services by the District Health Management Team (DHMT).

2.2 Overview of Family planning

Family Planning as a Universal Human Right

The World Health Organization (WHO 2013) defines family planning as the means to allow people to attain their desired number of children and determine the spacing of pregnancies. Through family planning the general well-being and autonomy of women is improved, while simultaneously strengthening communities and nations by
means of a multiplicity of benefits. First of all, family planning prevents pregnancy related-health risks in women, particularly adolescent girls and older women that face the greatest dangers in pregnancy, by allowing them to space or limit births if necessary. In addition, the power to space or limit births reduces the need for the unsafe and often deadly abortions that commonly occur in developing countries.

Secondly, family planning helps slow the spread of HIV/AIDS by preventing unintended pregnancies, and thus mother to child transmission of HIV/AIDS. Condoms, a family planning method, additionally reduce the spread of HIV/AIDS by preventing unintended pregnancies while simultaneously preventing the transmission of HIV and other STI’s. Thirdly, family planning combats infant and maternal mortality by preventing ill-timed pregnancies and births. Fourthly family planning slows unsustainable population growth, and thereby lessens negative stress on environments, communities, and nations. (WHO 2013) These benefits of family planning to women’s health and to the well-being of nations are reasons why nations have over the years advocated for its use.

However, to truly understand its significance and necessity, one must also consider the ways that women’s lives are changed when they are able to control the number of children they have throughout their lifetime. The most immediate adversity caused by a high rate of population growth lies in the loss of freedom that women suffer when they are shackled by persistent bearing and rearing of children, (Amartya Sen 2001) When women have many children against their wishes they are less likely to realize other opportunities outside childcare and home management, and in this way their
livelihoods suffer. But when women, and their partners, make informed choices about their health and families through family planning their lives are profoundly changed. Women have greater prospects of participation in public life, including paid employment, self-employment and enhanced education. Family planning also benefits families as a whole as fewer children allow parents to invest more in each child, thus increasing their likelihood of staying in school longer (WHO 1998).

The recognition of family planning, as a universal human right is dated back since 1948, many years ago. The fundamental right to health was first recognized by the Universal Declaration of Human Rights of the UN General Assembly in 1948, (UN 1948) with the right to Choice in reproduction, following 20 years later, at the World Conference on Human Rights in Tehran, Iran in 1968. It was not until the 1994 International Conference on Population and Development in Cairo, Egypt that family planning was recognized as a universal human right. It was decreed that, “the aim of family planning programmes must be to enable 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,” (UN 2004).

The right to family planning is a crucial aspect of reproductive rights and is essential in and of it, but it is also significant in that it permits the attainment of other rights, including rights to health, education, and the achievement of a life with dignity. (UN 2004).

Birth control (family planning) is a technique used to prevent unwanted pregnancy. There is a range of contraceptive methods, each with unique advantages and
disadvantages. Any of the widely recognized methods of birth control is much more effective. Behavioral methods that include intercourse, such as withdrawal and calendar-based methods have little upfront cost and are readily available, but are much less effective in typical use than most other methods. Long-acting reversible contraceptive methods, such as intrauterine device (IUD) and implant are highly effective and convenient, requiring little user action. When cost of failure is included, IUDs and vasectomy are much less costly than other methods. In addition to providing birth control, male or female condoms protect against sexually transmitted diseases (STD). Condoms may be used alone, or in addition to other methods, as backup or to prevent STD. Surgical methods (tubal ligation, vasectomy) provide long-term contraception for those who have completed their families (WHO 2008).

Family planning is among the most cost-effective of all health interventions. "The cost savings stem from a reduction in unintended pregnancy, as well as a reduction in transmission of sexually transmitted infections, including HIV, maternal morbidity and mortality it also allows the woman system to rest adequately so as to prepare her for another pregnancy. (WHO 2010).

Childbirth and prenatal health care cost averaged $7,090 for normal delivery in the United States in 1996. U.S. Department of Agriculture estimates that for a child born in 2007, a U.S. family will spend an average of $11,000 to $23,000 per year for the first 17 years of the child's life. (Total inflation-adjusted estimated expenditure: $196,000 to $393,000, depending on household income (USAID 1998).
The world's largest international source of funding for population and reproductive health programs is the United Nations Population Fund (UNPF). The main goal of the International Conference on Population and Development Program of Action are:

- Universal access to reproductive health services by 2015,
- Universal primary education and closing the gender gap in education by 2015,
- Reducing maternal mortality by 75% by 2015,
- Reducing infant mortality,
- Increasing life expectancy,
- Reducing HIV infection rates in persons aged 15–24 years by 25% in the most-affected countries by 2010, and by 25% globally by 2015. (UNPF 2008).

The World Health Organization (WHO) and World Bank estimate that $3 per person per year would provide basic family planning, maternal and neonatal health care of women in developing countries. This would include contraception, prenatal, delivery, and post-natal care in addition to postpartum, family planning and the promotion of condoms to prevent sexually transmitted infections. (WORLD BANK; 2008).

Most of the countries with lowest rates of contraceptive use, highest maternal, infant, and child mortality rates, and highest fertility rates are in Africa. Only about 30% of all women use birth control, although over half of all African women would have liked to use birth control if it was available.

CONCLUSION

The major problems preventing access and patronage of family planning methods (contraceptives) are; unavailability of varied methods, poor health care delivery services, spousal disapproval, religious and cultural doctrines, taboos, and
misinformation or poor counseling about the side effects of birth control methods. The most available type of birth control is condom. Sub-Saharan Africa is faced with an increase in population if not handled carefully, could result into excessive population growth, high prevalence of preventable diseases with devastating adverse effects on the economy and general wellbeing of people.

2.3 Historical Perspectives of the Community –Based Health Planning Services (CHPS)

Community-based programs providing family planning services and information began to appear in rural areas to complement facility-based services in the 1950s and included community-based distribution (CBD) of family planning, as well as CHWs. Contraceptive CBD first appeared in India and other Asian countries in the late 1950s, and spread by the late 1960s to Africa and Latin America (Foreit and Frejka 1998). These programs used either non-professional health workers, such as auxiliary nurses, or non-health workers, such as community volunteers, to provide family planning information and a limited range of contraceptives. In addition, CHWs provided a wide variety of maternal, child health and other types of preventive and primary care services.

Ghana’s large-scale Community-based Health Planning and Services (CHPS) is a well-known Community health program introduced into the country in 1994 with the aim of moving health services to the door steps of the people. Most of Ghana’s impoverished individuals live in remote villages, where it is particularly difficult for people to receive proper and timely medical attention. About 60% of Ghanaian’s participate in subsistence farming and an astounding 80% work in the informal sector.
as farmers, fishermen, or roadside vendors these activities only yield small income which is unable to meet their needs. Hence, Ghana adopted the Community-based Health and Planning Services system to increase access to and use of health services in remote communities (GHS 2006). This revolutionary system brings trained health care workers directly into the communities and rallies community support behind them to ensure the system’s acceptability and sustainability. CHPS offers the best opportunity for more effective and efficient health care in rural communities in Ghana. (MOH 2008).

From 1998 to 2008, in some CHPS program areas, under-five mortality declined from 108 per 1,000 live births to 80, and total fertility rate (TFR) declined from 4.6 children per woman to 4.0 (CHPS Project 2010; Nyonator, Awoonor-Williams, Phillips, Jones and Miller 2005; Phillips, Bawah and Binka 2006). Ghana’s CHPS program was originally based on the Community Health and Family planning (CHFP) project, launched in Northern Ghana by the Navrongo Health Research Centre for determining what works, and what does not when health services are removed from clinic settings and converted to community-based programs.

Transforming clinic-based operations to community-based programs involved multiple steps, over time. Under CHPS, District Health Management Teams (DHMTs) are encouraged to define implementation zones for the initiative, recognizing that not all CHPS elements can be instituted at once and that resources for sustaining the process are typically available for only a few work zones each year.
CHPS begins with a planning process, identifying locations in districts where health care access is low, and then maps work areas for nurse relocations, and corresponding catchment areas for CHC construction, within those identified areas. Once ‘zones’ are clarified, DHMTS then introduce the program to chiefs, elders, leaders, and community members through community durbars, through a coordinated program consistent with local resources, staff, and Geographic conditions. Community health officers are retrained to work as community resident paramedics, including nurses not designated for community posting. In cases where transportation is both needed and not easily available, each nurse is supplied with a motorbike and trained to operate it.

Community diplomacy is directed towards fostering CHPS construction, by utilizing volunteer labor and community resources. Once constructed, CHPS compounds serve as both nurses’ homes and places for delivering primary health care. Each community is required to constitute a health committee, and Community health volunteers are recruited, trained, and equipped for basic health care and referral. Altogether, these components comprise the set of activities or steps in instituting the CHPS system in each location. Community health volunteers conduct disease surveillance and identify cases, as well as providing condoms and family planning information, and refer clients to community health officers for disease treatment and other family planning services. Although Community health volunteers’ roles in health delivery are varied, they are usually categorized by two roles: home visits and also assisting community health officers in their work that is translation case tracing, identifying defaulters’ distribution of condoms, dissemination of health information etc. (MOH/GHS 2009).
Almost all DHMTS in Ghana are involved in CHPS implementation. Donors and development partners also contribute in various ways: private, voluntary agencies such as population council engender health, USAID, and Japanese international cooperation agency (JICA) all sustain activities and programs contributing to CHPS success. Available statistics from “advanced” (with successful implementation for several years) CHPS zones show great improvements in child and maternal mortality, but with little impact on family planning Services and contraceptive prevalence rates, however, this is a challenge in implementing the original CHPS model. (GHS 2004).

2.3.1 KEY PLAYERS OF THE CHPS PROCESS

According to the Ministry of Health (1999) the key players of the CHPS process are as follows;

The Community; this is made up of the following;

(1) The Community Members and Leadership including the opinion Leaders.

(2) The Community Health Committee. (CHC)

3. The Community Health Volunteers. (CHVS)

The Ministry of health

(1) District Director of Health Services (DDHS)

(2) The District Health Management Team (including the health Workers-Medical Officers and other health personnel in the hospital the clinics. (DHMT)
(3) The sub District Health Team.

(4) The community Health Officers. (CHO)

The District Assembly

(1) The District Chief Executive (DCE)

(2) The Social Services Sub Committee of the District Assembly.

ROLES AND RESPONSIBILITY OF THE KEY INSTITUTIONS AND OFFICIALS

(a) The community Health committee

The following are the roles and responsibilities of the key institutions and officials of the CHPS program; Settling of disputes concerning work of the Community Health Volunteers. Organizing communal labour activities in support of the programme, Advocating community health and family planning activities financial management of medical account. As well as managing Community Health Volunteers stock of drug and family planning materials; and Supervising bicycle maintenance for Community Health Volunteers.
The community health volunteers

Provide preventive and curative services for malaria and diarrhea; provide family planning (distribution of condoms) and counseling; refer serious cases to community health officers and clinics; identify children for immunization; notify disease appearance to community health officers.

The district health management team (DHMT)

While the district director of health services (DDHS) is responsible for overall program management, providing guidance and technical assistance, planning and budgeting, the District health management team members:

Assist in overall program management;

Provide guidance and technical assistance to sub District Health Team;

Plan and budget program activities;

Serve as liaison and organize meetings between district health management team and SDHT;

Supply essential medical supply to SDHT; and Supervise SDHT activities.

(e) The sub district health team (SDHT)

Holding management meetings with community health committees and community health officers;
- collecting data on community health officers and volunteer programs for the district health management team;
- Managing supply and monitoring usage of drugs and family planning materials by community health officers and volunteers; and
- Writing progress report to the District Health Management Team.

**The community health officers (CHO)**

- community and compound level education on primary health care and family planning, immunizing and providing pre and post-natal care
- supervising and monitoring sanitation efforts;
- provision of nutrition education and care;
- primary care for simple cases like diarrhea, malaria, acute respiratory diseases, wound and skin diseases;
- providing referrals for more serious conditions

**The district chief executive and the district assembly**

The district chief executive as the head of government machinery at the district level serves as the link between the CHPS process and other social services development program in the district. The district chief executive and the district assembly through the social services subcommittee is responsible for:

- working with the district health management team in the selection and prioritization of communities for participation in the CHPS process
• provision of funding and other material support operating the CHPS process particularly for the construction of community health compounds and motivation and encouraging members of parliament in the district, as well as NGOS to advocate for the CHPS process and provide material support for its implementation.

• empowering district assembly, area council and unit committee members to provide active organizational and material support to the development of CHPS program in their communities and

• Receiving quarterly progress report on implementation of the CHPS process in the district from the district health management team and recommending or initiating necessary action.

Organizational structure for implementing the CHPS process by the district health management teams

There are three inter-related components of this structure:

• The community with its operational units, the chiefs and elders, the community health committees, the community health volunteers and the community members.

• The ministry of health; comprising the district health management team, the sub-district health team and the community health officer,

• The district political authority made up of the; district chief executive, administrative staff and the district assembly at large.
2.4 Community Participation in the CHPS Programme

Community involvement enhances community acceptance and participation of CHPS activities as community would own the CHPS and embrace the importance of its existence. Community entry moves the planning process from the district to the community level. Newly recruited CHOS should be acquainted with the socio-cultural and behavioral patterns of community members in relation to family planning issues. Hence they should be proficient in the local language. They shall be engaged in consultation with the leadership of the community such as chiefs, queen mothers, Members of Parliament and local opinion leaders. The program shall follow proper and appropriate community entry procedures for each community; this involves developing community health leadership and initiate participation in the programme through dialogue with community leaders and residents. Community ‘durbars’ are traditional gatherings comprised of drumming, dancing, speechmaking and public debate. In the community entry process, this tradition is marshaled to foster Open discussion of CHPS activities. (J. A Williams et al 2005).

This strengthens the working relationship between community health officers and community health volunteers. Communities develop and manage a local (under a sub district) health governance system through a community health committee overseeing and supporting the network of community health volunteers. Health committees maintain CHPS centers, organize durbars (community meetings) for health education activities, mobilize emergency service transportation, and mediate conflicts between community health volunteers, or the community health officers. Community health committees also monitor and supervise community health volunteers and support
community health officers with regular monthly meetings, involving both, that address health-related issues. If these coordination structures are weak, health committees and community members would not fully get involved in CHPS activities, hence its purpose would be defeated. (F.N. Nyonator, J.A. Williams, J.F. Phillips et al 2005)

The unique relationship CHPS nurtures with communities permit a level of mutual trust between nurses and families that contributes to health-seeking behavior. People are more likely to seek care from a community provider than the culturally remote clinical workers at the sub-district. Moreover, when trust is well grounded, its impact on health seeking is enhanced by informal payment arrangements. While clinic patients must pay for care at the time that service is provided, CHPS clients typically defer the timing of payment an arrangement that is possible because nurses can trust extended families to honor payment obligations.

If community members are involved in the CHPS implementation process they turn to appreciate this new relationship with the health care system and view CHPS as a form of health insurance since deferment of payment provides time for patients to seek emergency funded support from extended families and kin. Thus, while the immediate cost of health care constrained health seeking behavior in the past, CHPS uses an informal mutual trust system which martials the social resources of traditional health insurance for Western health care (I.A Agyepong, C.Marfo 1999). Community ownership of the health care system through community engagement and Community
mobilization has important implications for the roles of various levels of the GHS hierarchy.

Community ownership of CHPS in the advanced program area is grounded in the climate of commitments resulting from community involvement in communal labor for CHC construction which is clearly more important to CHPS than the building of a CHC. Community engagement with CHC construction tasks can lead to lasting teamwork and organizational arrangements, community ownership perceptions, and leadership that means much more to sustaining CHPS than just the standing facility that communities construct. It is reasonable to conclude that the use of external contractors for the construction of these compounds would bypass the community engagement with construction and weaken community participation in CHPS.

Ownership is instilled by the volunteerism process, and community ownership of the program turns the authority structure of health and other public sector bureaucracies on end: Community cohesion and grass roots political clout become the focus of worker accountability and supervision; supervisors, in turn, are expected to provide support, the district authorities, in turn, are expected to make the initiative work by removing barriers and providing resources (B. Pence et al 2000).

Thus the process of convincing community health committees and fostering volunteerism generates a climate of accountability for service quality that respondents perceived was lacking in clinical care in the past. Apprehension about resident community nurse services was evident where CHPS has not yet started.
Community members doubt that accommodations they provide in their rural and isolated villages might not be accepted by nurses accustomed to living in sub-district health centers. Leaders and community members normally express concerns about how practical management problems, such as leave coverage, the range of drugs available, and the cost of services for volunteer support, will be sustained.

Community education on the importance of CHPS and motivation that launches CHPS must continue to foster sustained support for the program. Tangible benefits for the program must be communicated to communities continuously to sustain social support. Moreover, rampant misinformation about appropriate treatment and misunderstanding about the level of service that a nurse can competently provide requires communication focused not only on what a nurse can do, but also on types of services that a nurse should not provide (C. Depuur, J. E. Philips, and E. F. Jackson et al., 2002).

In general, the concept of referral is not well understood, indicating that service operations must be continuously be defined and that community entry diplomacy must be sustained even after CHPS operations are established. Community leaders and members sometimes indicate that numerous political, organizational, and economic difficulties has to be overcome in initiating the CHPS program. As Sectorial coordination is vital in sustaining the CHPS as a multisectoral program, with political involvement and district leadership involvement contributing to coordinated action. Pursuing CHPS as solely a health initiative can lead to misunderstandings with staff assigned to community roles by other ministries (MOH 2000).
A study conducted at Nkwanta revealed that community members demonstrated with placards against the Forestry Department at Nkwanta, and discord continued until the district health management team and an NGO coordinated community outreach to address the problem (Nyonator 2005).

For communities to totally embrace CHPS the chiefs, elders, and opinion leaders should be deeply involved at the grass root level ensure that responsibilities are assigned to the different clans comprising the community. Initiating the CHPS Program in communities, especially the construction of a CHC, would involve considerable community problem solving. While traditional community structure provides mechanisms for solving problems, achievement of advanced stage of the CHPS program implementation will not be accomplished without external catalytic support from NGOs and the assembly (Nyonator 2005).

For effective community ownership of the CHPS programme, effective stakeholder consultations are needed. The Chiefs and Elders of the community must be engaged in consultative meetings with community members to afford them the opportunity to understand and endorse the Campaign, to seek their participation directly and to get them involved in the whole process. The community will be mobilized in this process to actively participate and support the CHW through shared health knowledge, health campaign planning, quality oversight, and a commitment to collaborate with health services. Mobilized communities establish the CHMCs to support the selected CHO from the health sector, provide local legitimacy to the CHWs’ role, support CHWs’ household and community outreach tasks, provide additional intrinsic and extrinsic
incentives as motivators, guide health delivery interventions, problem-solve, and hold service providers accountable.

When health systems are weak and mortality is high, a fully developed community approach will offer significant contributions to the health system. Community engagement also includes surveying and partnering with existing community-based organizations, non-government organizations, faith-based organizations, leaders and the private sector to support the CHW program. For example, peer support groups have been effective at reducing stigma, supporting home care, and overcoming obstacles to care-seeking and practice of key behaviors. Participatory women’s groups, in particular, have been cited for their effect on women’s empowerment leading to positive health outcomes, especially when linked to savings and loan programs. Local multi-agency, cross-sectoral coordination committees can address determinants of health, contributing to sustainable cause-specific reductions in mortality. Furthermore, the active involvement of the local assemblymen in the functions of the CHWs and CHMCs will create sustainability for this community health system.

Conclusion

Sensitization of the District Assembly (District Chief Executive and the Assemblymen) community members and leadership would create a buy-in from the local government structure which ultimately links the community health system to the local government structure and open up avenues for resource mobilization for sustainable health development at the community level. Community buy-in results
into acceptance and ownership of the CHPS program leading to patronage. As each community is a reflection of its local culture, history, politics and interacts with the health system, will reveal the uniqueness in each local context with its unique challenges to standardized health care services. There is the need to develop different approaches in addressing these challenges within the cultural context of the people. Often a community is a variety of groups of people bounded by common cultural beliefs, values and norm. Community engagement strategy is employed to guide sub-district level implementation of the CHPS activities through community participation. This will further foster community acceptance, buy in and patronage of FP at the CHPS through proper community entry and dialogue.

2.5 Attitudes of health workers towards family planning (FP) service delivery

Community participation is not always easy to achieve and may be opposed by entrenched interests. The Colombian government established two mechanisms to increase user participation of health services: user associations and consumer care services. A study of the initiatives’ impact found that despite some increased consumer perceptions of potential empowerment, consumer apathy, fear and life style modification limited community participation in health related programmes (Mosquera et al. 2001). Also, consumers viewed the user associations as politicized hence would show no interest. A study of an initiative to promote participation in the provision of primary health care in Family planning services in Uganda found that local people were not interested in participating in public affairs (Golooba-Mutebi 2005). In the case of Peru, regional officials feared losing control over health finances, leading to poor relationships between the committees and regional

In Mexico, the Ministry of Health co-opted resources from local community participation groups, using mobilization not to enhance provider responsiveness but as a means to support its own agenda (Zakus 1998). Some evidence indicates that another oversight mechanism—provider performance reports—have the potential to enhance responsiveness to consumers, although their effectiveness depends on design. There are few examples in published scholarship concerning low-income countries; however, one study of a programme in Uganda showed evidence of enhanced consumer responsiveness. The Uganda programme included frequent evaluating indicators that included not just technical but also interpersonal performance (McNamara 2006). On the other hand, a review of 32 evaluations report card systems in the United States concluded that consumers’ failure to utilize the services was due to inadequate information on FP methods. (Schauffler and Mordavsky 2001). Another review showed that public disclosure of information about the quality of health care provision especially FP methods improved some outcomes of care but did not lead to the strong influence of consumer choice. The review attributed this partly to design flaws in the reports, as consumers faced difficulties interpreting and utilizing the complex information (Schneider and Lieberman 2001).
An overlooked factor is the match between measures of performance and the actors whose desires are being encouraged. Consumer perceptions of quality differ significantly from those of other actors (Haddad et al. 1998; Blendon et al. 2001). For instance, focus group discussions in Guinea identified factors used by consumers to judge quality of service, including how service was rendered, availability of choices, manner of reception, and ease of access to facility, and extensiveness of examination or education on service (Haddad et al. 1998). Unlike professional evaluations of quality emphasizing on process and structure, consumers appeared more concerned with the quality of interaction and their individual outcomes (Haddad et al. 1998). Research from developed countries echoes these findings. In a study of citizens in eight developed countries, client had markedly different priorities than providers, emphasizing access to service, availability of choices, information and quality of client–provider relationship (Grol et al. 1999). Another study found that consumers focused on the delivery of service, while experts emphasize broader public health issues (Blendon et al. 2001).

Another health system influence on patronage of service is the cost of services. In principle, we would expect providers to demonstrate accountability toward the actors that serve as their primary sources of financial support. If that source is a government or donor, providers may pay less attention to consumer preferences; if patients pay for services out-of-pocket, health care providers may be more responsive. On the other hand, one might expect that such payments would enhance accountability only for that subset of the population that can afford these fees, and with the introduction of such payments access might decrease for the very poor. Evidence from studies on
fees generally demonstrates a causal connection between fee introductions on the one hand, and improved quality of service but reduced access on the other. A longitudinal study of a rural community in Zaire showed that after the introduction of fees, over a 5-year period quality improved but the utilization of health services decreased by 40%, with 18–32% of this decrease explained by rising costs (Haddad and Fournier 1995). In reforms involving the initiation of fees for services in Zimbabwe, some aspects of the quality of care may have improved; however, access to care decreased (Basset et al. 1997). Other studies have shown that out of pocket expenses for health care are highly regressive (Gilson and McIntyre 2005; James et al. 2006) and can result in catastrophic expenses for consumers (Xu et al. 2006), but that these effects are partially offset by improvements in the quality of services (James et al. 2006).

Consumers often lack the power and information to influence health care provider’s behavior. (Brinkerhoff 2004) observes that ‘health services are characterized by strong asymmetries among service providers, users and oversight bodies in terms of information, expertise and access to services’. These asymmetries prevent market forces from ensuring that consumers are able to influence providers’ behavior (Segal 1998; Brinkerhoff 2004). Reforms addressing information and power asymmetries may be necessary even in the presence of other reforms to ensure that consumers actively take ownership of their own health care. Rifkin states that ‘accountability is only possible when those affected by decisions have ways to ensure that their needs and concerns are dealt with fairly’ (Riftin 2003). This statement echoes a call by several researchers that focusing on the supply side reforms in the health system may be insufficient to bring about better health behaviors outcomes. Demand-side
interventions that address consumer power are also necessary (Segal 1998; Rifkin 2003; Ensor and Cooper 2004; Laverack 2006).

Among the potentially promising mechanisms researchers have investigated are increasing consumer access to information about family services and facilitating collective action at the community level. A number of studies provide evidence of enhanced provider accountability when consumers gain greater access to information on the various FP methods for consumers to make informed choices. In a controlled experiment in the state of Uttar Pradesh in India, meetings, posters and handouts conveyed information to poor villagers about the right to access government build health facilities for FP services and mechanisms for communicating grievances (Pandey et al. 2007). Communities receiving the information fared significantly better than control communities, as nurses increased the number of clients they attended to per visit in communities, and village councils, with households of all castes reporting noticeable improvement in services. Focus groups revealed that a quarter of members raised service issues directly with health care providers and 40% discussed the information with others. Another project in India providing information by health care providers to consumers showed better breastfeeding behaviors and lower diarrheal prevalence among infants in intervention than in control communities (Bhandari et al. 2003). A study on participatory malaria control in western Kenya indicated that improved information and knowledge on health service by health provider enabled consumers to enhance preventative behaviors (Opiyo et al. 2007).
An analysis of pooled data from 70 countries demonstrated that where information and communication networks were strongest among communities, there was a reduced probability of deaths of people clinically identified as infected with malaria (Mozunder and Marathe, 2007). Individuals in tight networks identified symptoms earlier, and had higher quality home treatment, resulting in improved health outcomes. A review of studies on information provision to consumers indicates that the form of information is critical: consumers ignore raw data and must be presented with information in ways that are relevant, comprehensive and credible (Sangl and Wolf 1996). Several studies also show the power of community collective action (full participation) to shape health service in provision of family planning services.

In Bangladesh, an NGO health care and insurance provider that cultivated community social mobilization showed lower levels of insurance non-renewal than another NGO that did not emphasize on mobilization (Desmet et al. 1999). In Mawkanpur district- Nepal, a community-based participatory intervention resulted in reduced neonatal mortality in control areas (Mandandhar et al. 2004). A female facilitator convened women’s groups and facilitated their capacity to identify perinatal problems and develop strategies to address them. In a village in Chiang Mai Province, Thailand, an empowerment programme facilitated a women’s group to address patronage of FP services, enabling the group to develop family protection plans, to provide FP education to the community and to scale-up the use of FP methods (Geounuppakul et al. 2007). That village showed increased levels of FP patronage behaviors compared with a control village, and participating women reported improved levels of self-esteem and self-confidence.
Health care Provider attitudes toward consumers may also contribute to a lack of responsiveness. Gilson (2003) suggests that provider beliefs may influence the quality of consumer–provider interactions, arguing that, ‘health systems are inherently relational and so many of the most critical challenges for health systems are relationship problems’. The influence of professional and social norms upon providers is especially important in health care because consumers view respectful interactions as significant elements of quality of care (Haddad et al. 1998; Grol et al. 1999; D’Amburoso et al. 2005) and because patients may be unwilling to demand better provider behavior for fear of not receiving necessary care. Research indicates that many providers look down upon the poor.

In Uganda (McPake et al. 1999) and Zaire (Haddad and Fournier 1995), for instance, providers failed to lower or set aside user charges for poor consumers despite government policies that allowed for such waivers. A number of studies indicated that provider attitudes toward service delivery of the poor is one reason why consumers would fail to access health care, those from low socio-economic classes are less likely to seek health care than individuals who are better off (Matthews and Diamond 1997; Makinen et al. 2000; Chowdbury et al. 2006; Anwar et al. 2008; Thuan et al. 2008). Several studies also demonstrate provider gender biases. Sen (2009) argues that such attitudes lead providers to offer lower quality care to female clients and to treat women with disrespect. Health care Providers of both genders may be judgmental of women who transgress gender norms (Govender and Penn-Kekana 2007). Studies show that some male health care providers hold beliefs that accept violence against women as justifiable (Kim and Motsei 2002), and even female health care providers
in frontline positions act with hostility toward women. Studies in Ghana and South Africa found that female nurses abused patients from lower socio-economic classes (Jewkes et al. 1998; Abrahams et al. 2001; D’Ambruoso et al. 2005).

In the South African study, nurses in a maternity service used violence against women as a means of asserting their professional and middle-class identity, and their social superiority to their patients (Abrahams et al. 2001). Norms in society also hamper quality of health care services to women, including restrictions on travel, prohibitions against care outside the home, male domination on decisions and preferential treatment of men (Ensor and Cooper 2004). A study of a rural community in West Bengal, India, for instance, showed that parents were willing to travel longer distances and were more likely to seek care for their sons than their daughters for treatment of diarrhea, acute respiratory infections and fever (Pandey et al. 2002).

Health care Providers may be part of the problem: instead of seeking to overcome these disparities, they frequently subscribe to and reinforce them. Aside from class and gender biases, professional norms may lead to information exchanges that favor health care providers over consumers. Studies from Mexico, for instance, found that only a third of physicians provided explicit information to patients (Lazcano-Ponce et al. 2004) and doctors on average spent only 2.1 minutes in information-giving, asking 27.3 minutes on questions while allowing patients only 1.5 minutes to respond (Waitzkin et al. 1996). Twaddle (1996) argues that over time, consumers have become less involved in the process of health care delivery due in part to the increasingly technical nature of medical knowledge.
While decentralization of control of health care services alone has had ambiguous results, government facilitated community involvement in health care services under decentralization seems to have had positive effects on health care provider behavior in a number of low-income countries, including Peru, Ghana and the Philippines (Ramiro et al. 2006). Speculate on the following reasons: perhaps decentralization facilitates local official responsiveness to consumer demands, but it alone is insufficient. Second related to the first point, is community collective action— independently generated or facilitated by NGOs or donors this has led to improved health behavior on the part of local citizens and may have resulted in more responsive health providers. (Manandhar et al. 2004; Fitzpatrick et al. 2007; Geounuppakul et al. 2007). Again the reasons may lie in communities transcending traditional passivity on health care issues to take responsibility for health outcomes and to place pressure on normally complacent providers to improve performance.

Thirdly, several studies from India and Kenya and analysis of pooled data from multiple countries indicate that consumers armed with information are better capable of influencing providers behavior (Sangl and Wolf 1996; Bhandari et al. 2003; Mozounder and Marathe 2007; Opiyo et al. 2007; Pandey et al. 2007). Studies show that information asymmetries between providers and consumers are a defining feature of health care services, and as these asymmetries diminish, the ability of consumers to make their voices heard may rise.

Fourth, numerous studies from Africa, Asia and Latin America provide evidence that well-designed contracts to nongovernmental organizations for health care provision
have positive effects on equity and quality of care for the poor, particularly in comparison with the performance of for-profit and public institutions (Loevinsohn and Harding 2005; Liu et al. 2007; Anwar et al. 2008).

The effects of improvements in health care provider working conditions, such as better pay or facilities, accommodation, lack of social amenities, poor road infrastructure, and lack of motivation are some factors that frustrate CHWs to exhibit bad attitudes towards service delivery. Some evidence drawing upon health care provider perceptions reveals impacts of poor working conditions upon attitudes toward patients and provider beliefs in their ability to provide quality care to all could also reflect on health worker attitude (Jewkes et al. 1998; Gilson et al. 2005).

The central government devolved control of financial resources, providing central funding and assigning rights to keep and use drugs and user fees to the community health committees. The reform raised consumer satisfaction and increased access to care for women and disadvantaged groups. In Ghana, a project to allocate nurses in communities rather than regional health centers (CHPS), involved community leaders and local volunteers extensively in planning has resulted into community patronage of health services (Nyonator et al. 2005).

Supervision and Monitoring of CHPS programmes is very vital in the CHPS concept in order to achieve the main objectives of the program, this is done periodically to assess the level of CHO’s and CHW’s commitment and utilization of CHPS centers by community members especially FP services, it also unveils the resources available, and weather more resources should be provided as well as
problems encountered by the health team, Decentralization of planning and budgeting is down to the district and sub-district levels.

Here, there is monthly performance data consolidation and validation meetings at the SDHT level before data is submitted to the DHMT. There is also Peer performance review every quarter at the district level attended by Regional and National Level observers as well as Development Partners. Both process and impact evaluations are done;

Process evaluations explain why interventions may have the effect that they have, and these Evaluations can identify what should be done to improve the processes in the system or its structure through analysis of both health indicators as well as the effectiveness of specific program design elements. In addition, real-time monitoring systems via mobile technology can provide more regular feedback to inform active management and adaptation of program design and deployment for optimal outcomes.

Impact evaluations are utilized to determine the effect that the program and its interventions have on end outcomes such as health status and access to service delivery. They can assess changes in coverage, access to care and use of key interventions, quality of service, program cost, and lives saved. Impact evaluations generate knowledge about whether a program achieved its basic aims, and can contribute to the international knowledge base about CHO interventions and operational design effectiveness. Process evaluations, impact evaluations, and other traditional M&E approaches are designed to provide and disseminate findings as rapidly as possible to improve program development through feedback to all levels of
service provision. In order to maximize an M&E programs’ potential, it should be integrated into an active management system enabled by the use of mobile technology. (MOH/GHS 2004)

**CONCLUSION**

Challenges like poor working conditions; such insufficient salaries, lack of accommodation, lack of social amenities, poor road infrastructure, inadequate resources and logistics, and lack of motivation are some of the factors lead to frustrations community health workers making them exhibit bad attitudes towards clients who visits CHPS centers to obtain family planning services.

Decentralization of CHPS related programmes especially family planning could foster local official responsiveness to client demands, this will help boost community collective action— to support and buy into the program which could lead to improved health behavior on the part of local citizens to result in positive attitude toward health and family planning services.

2.5.1 **Barriers to family planning service, access and usage**

The influence of physical access on the utilization of family planning services is well founded, with many studies demonstrating the greater use of services among women who live in relative proximity to a service (Toure 1992). research into the barriers faced in accessing reproductive health services, however, now recognizes that problems of access extend beyond physical access to services, and include issues of economic, administrative, cognitive and psychosocial access (Bertrand et al 1995;
Furthermore, the barriers to family planning service use are seen as extending beyond factors operating at the individual and household levels, to include characteristics of the social and cultural environment and the health service infrastructure. This view of access recognizes the importance of attributes of the health system in shaping an individual’s ability to seek health care, highlighting the importance of the supply environment on health care utilization, this conceptualization of access incorporates factors operating at the individual, household and community level to influence an individual’s ability to utilize a health service, thus framing an individual’s access to services in terms of the socioeconomic, cultural and service supply context in which they live.

Previous studies on the use of reproductive health services have largely focused on factors operating at the individual and household levels, broadly categorized as demographic, socioeconomic, and cultural and health experience factors. Demographic factors that have been shown to increase the likelihood of using reproductive health services are; low parity (Magadi, Madise, and Rodrigues 2000; Kavitha and Audinarayana 1997) and younger maternal age (Bhatia and Cleland 1995). Socioeconomic factors, however, have been shown to be of greater importance in determining health service utilization than demographic factors (Obermeyer and Potter 1991). Whilst demographic factors may shape the desire to use services (e.g. younger women may have more modern attitudes towards health care use) the socioeconomic status of an individual and the household in which they live determines the economic ability to utilize health services (Foreit et al’s (1978) , in terms of socioeconomic factors, the most consistently found determinant of
reproductive health service utilization is a woman’s level of educational attainment (Addai 1998; Magadi, Madise, and Rodrigues 2000; Nuwaha and Amooti-Kaguna 1999; Obermeyer 1993).

It is thought that increased educational attainment operates through a multitude of mechanisms in order to influence service use, including increasing female decision-making power, increasing awareness of health services, changing marriage patterns and creating shifts in household dynamics (Obermeyer 1993). Cost has often been proven to be a barrier to service utilization (Griffiths and Stephenson 2001; Bloom, Lippeveld and Wypij 1999). Socioeconomic indicators such as urban residence (Addai 1998), household living conditions (Magadi, Madise, and Rodrigues 2000; bloom, Lippeveld and Wypij 1999), household income (Kavitha and Audinarayana 1997) women’s employment in skilled work outside the home (Addai 1998), high levels of husband’s education and occupational status (Nuwaha and Amooti-Kaguna 1999) have also proven to be strong predictors of a woman’s likelihood of utilizing reproductive health services, both demographic and socioeconomic determinants of reproductive health service utilization are mediated by cultural influences on health service behavior (Basu 1990; Goodburn, Gazi and Hury 1995).

The health behavior of individuals is often mediated by community beliefs and norms, such that individual behavior is influenced by community perceptions and beliefs about family planning use as well as the psychosocial aspect of access (Rutenberg and Watkins 1997), although individual demographic and socioeconomic factors may shape an individual’s desire and ability to use a service, the cultural
environment in which an individual lives exerts a strong influence on the extent to which these factors actually lead to family planning service utilization. A study conducted by Obermeyer revealed that the most evident psychosocial influences on family planning service use amongst women in Pakistan are the behavioral norms that relate to residence in an Islamic society, the prevailing value systems of purdah and izzat encourage the segregation of the sexes and the confinement of women to the family home, reducing women’s mobility and access to services. Family planning services with male practitioners, or those located in areas where there may be only males present a barrier to the use of family planning methods by women observing purdah.

Women may need permission from their husband or household elders to seek health care. Additionally, the doctrine of Islam has often been interpreted to forbid the use of family planning methods (Obermeyer 1994: Underwood 2000). The absence of a central authority or hierarchically organized clergy in Islam results in the lack of a single interpretation of the Koran (Obermeyer 1994) and thus the interpretation of the Koran’s position on family planning is open to wide variations (Obermeyer 1994: Underwood 2000). The ambiguity of the Koran towards family planning means that attitudes towards family planning in Muslim communities are often shaped by local consensus of opinion (Amin, Diamond and Steele 1997). Hence women’s use of family planning services is often shaped by the prevailing religious attitudes of those in their community. Therefore, family planning services may be physically accessible in the local community, but cultural influences may mean that they may not be socially accessible. In addition to individual, household and community barriers to
family planning service use, previous studies have highlighted the influence of the supply environment on an individual’s ability to utilize services (Foreit et al’s 1978) administrative aspect of access).

Numerous studies have demonstrated an association between service quality (or perceived quality) and an increased use of family planning services (Koenig, Hossain and Whittaker 1997; Magnani et al 1999; Mensch, Arends-Kuenning and Jain 1996). In the conceptualization of the five dimensions of access, Foreit et al (1978) noted the importance of medical barriers (e.g. regulations that inhibit contraceptive method) and service quality (e.g. long waiting times or limited supply of methods) as potential inhibitors to the use of family planning services.

A study on family planning service provision in Tanzania, (Speizer et al 2000) found that provider bias in method promotion and age restrictions to the use of some contraceptive methods lead to the creation of restrictive barriers to contraceptive adoption. Similarly, Williams, Schutt Aine and Cuca (2000) demonstrate high levels of dissatisfaction with family planning services in their analysis of exit interview data from eight Latin America countries, with long waiting times and cost of services highlighted as the main areas of dissatisfaction. Thus, the characteristics of family planning services themselves may act as a barrier to service use. The influence on service patronage may also be influenced by a woman’s past experience of service provision. Previous contact with health professionals creates both confidence and familiarity in patronage of health services, making a woman more likely to continue using reproductive health services. A woman’s previous exposure to health services
has been shown to be a strong predictor of her propensity to utilize reproductive health services (Basu 1990; Bloom, Lippeveld and Wypij 1999).

The rural communities in developing countries are expected to increase significantly in number over the next 25 years, such that the balance of population in developing countries will shift from predominantly rural to mostly urban (PUPD 2003; Hinrichsen et al 2002). The greatest increases will occur in Asia and Africa, with the most significant increases in urban growth in the smaller, secondary cities rather than large urban centers. The World Bank estimates that worldwide 30% of poor people live in urban areas, by 2020 the proportion is projected to reach 40% and by 2035 half of the world’s poor people are projected to live in urban areas (Ravallion 2001). The rural communities face health penalties that may outweigh the urban health advantage. Generally urban residents have higher standards of living and better reproductive health than rural residents, however, the spatially concentrated rural communities, show levels of health that are significantly worse than their urban counterparts (PUPD 2003; Harpham et al 1995; APHRC 2002).

In addition, the reproductive health of the rural communities can be worse: unmet need for family planning is 25% in cities with less than 100,000 inhabitants, and 15% in cities with a population between 500,000 to 1 million (PUPD 2003). While urban areas have a marked advantage in the provision of amenities and services, the rural areas are significantly underserved. The rural communities are in a distinctly inferior position relative to other urban residents in terms of access to basic amenities (electricity, clean water, sanitation and adequate health care). They are also
underserved in terms of access to reproductive health services compared with their counterparts living in larger cities (PUPD 2003). Given that the greatest increase in population is expected to occur in the rural cities of developing countries, due to increased poverty rates and obstacles impeding reproductive health and family planning services makes life generally difficult and unbearable to rural communities of developing countries.

In Sub-Saharan Africa, significant resources have been allocated for family planning programs, ranging from service improvement to policy advocacy activities, from mass media campaigns to peer education, and from strengthening contraceptive supply chains to expanding contraceptive methods and also training of community health officers on service provision. Yet, family planning patronage and sustained family planning use remains elusive. A study conducted in Benin, revealed that there is low patronage of family planning services despite a USAID funded five-year project aimed at increasing family planning patronage and also to reduce unmet need for family planning in Benin through social network interventions. Community mobilization could lead to community actions to address social issues, mostly tend to focus on communicating family planning facts rather than engaging communities in reflective dialogue on the social and structural barriers related to low family planning patronage. In addition, most current initiatives are not scalable; since they appear too expensive to achieve widespread impact (Tekponon Jikuagou 2013).

The results of a baseline survey conducted in 2013 by Tekponon Jikuagou in the Mono Couffo Department of Benin revealed the importance of social barriers to
family planning use. In fact, most women reported that it was not acceptable to talk about family planning in public. Gender norms often underlie negative attitudes towards family planning; for example, most men believe that women who use family planning are promiscuous. According to the baseline findings, a few women reported discussing family planning with their husbands in the last year and few reported that they had taken action to obtain family planning (e.g. talking with a health agent) during the last year. Multiple government and non-governmental efforts to increase access to family planning information and services still has not been so successful.

Clearly other factors also interplay to compound under patronage of family planning services, particularly social factors and cultural norms create barriers to family planning use. Women and men’s perceptions of pregnancy risk, whether accurate or not, shape decisions related to family planning use. These perceptions influence their decision to use family planning—that is women and men who wish to avoid pregnancy but are not using a family planning method, including those who erroneously believe they are unlikely to become pregnant and therefore are not seeking family planning services or information.

To address these barriers, as stated in Tékponon Jikuagou,s study, intervening through social networks, applying network theory and analysis to move beyond a view of women and men as individuals, to an understanding of them as members of formal and informal social networks. An approach with proven results, social network analysis (SNA) has been used to design effective HIV prevention interventions, and family planning services.
Findings generated from Tékponon Jikuagou study have informed the development of a package of social network activities designed to catalyze strategically-selected community groups and individuals to address gender and other social factors that silence discussions of family planning use. The baseline results suggested the importance of understanding family planning decisions from the point of individual women and men, as well as the perspective of the family planning program as the way forward. (Tekponon Jikuagou 2013).

A similar study conducted by Aasha Jackson in 2013 in Cameroun on barriers to contraceptive use by women, revealed that one of the reasons why most women did not patronize family planning services in Cameroun was that they knew someone who had a bad experience with family planning or that they were advised by someone against it. The women explained that such person experienced or spoke of the side effects of contraceptives, such as weight gain, heavy bleeding, or trouble conceiving as a result of family planning, and for these reasons they were not interested in using contraceptives. Many women do experience side effects as a result of family planning methods, but this is why family planning consultations with professional are so valuable. At the consultation, community health officers go over the patient’s medical history to determine which method would work best as each has unique advantages and disadvantages. “With the provider’s help, the client considers how these advantages apply to his or her own situation. Then the client can make an informed choice about whether the method meets his or her needs,” however, many women relied on information provided by others and were discouraged by it. Fear of weight gain, infertility, and other side effects based on rumors thus presented a
serious barrier to family planning among women in the study, “while it is true that certain contraceptives usage could result in weight gain, if that is the greatest concern, the community health officers should have adequate knowledge in family planning methods so as to give good counseling and education on family planning method.

However, it seems as though women don’t seek professional medical advice once they learn about the potential negative side effects of family planning, the fear to practice it. Thus family planning hears say discourages women from seeking factual family planning information, infertility is perhaps the greatest fear encountered among the women in the study. The spread of misconceptions about family planning is a serious issue because it creates and perpetuates a negative image of family planning. As more women learn this false information and circulate it, more women have erroneous ideas about family planning and are further discouraged from using it (Aasha Jackson 2013).

According to MOH statistics, 8 in 10 married women in sub Saharan Africa wanted to delay the next birth for at least 2 years, yet a sizeable proportion did not use contraception also, more than half the women intended to use family planning but were unable to do so as a result of; spousal refusal, lack of finance, cultural norms etc.( Menufia Governorate, 2009), in his study, the majority of the non-users of family planning and the women who had discontinued usage said they intended to have children and intended to use family planning methods in the future. These findings presented a discrepancy between what the women want and what they really do. This could be because many Africa women want to have greater control over reproductive
decisions, but they lack the knowledge and need proper counseling. It has been reported that behavior change goes through the following stages: knowledge, approval, intention, use, and advocacy. Such findings could explain that women’s intention reflects their ability to respond to health education sessions about contraception.

Menufia Governorate, (2009) explored the various types of reported barriers for both the discontinued group and the non-users of family planning in Egypt revealed that cognitive, cultural and demographic barriers were the main barriers that lead to non-usage or discontinuation of family planning methods followed by barriers related to the method itself. The administrative and physical barriers were the least reported, this contradicts findings from studies in Nepal and in Jordan, where the researchers related the hesitation to seek out family planning services to administrative barriers, which included problems in the health-care delivery system and perceived knowledge of health-care providers, especially their family planning counseling skills in addition, a study in Pakistan found that half of all rural communities women identified psychosocial reasons as the primary barrier to not using family planning services.

Administrative barriers were the second most commonly reported barrier, with few women reporting cognitive and physical barriers to family planning service use, this was attributed to subjective perceptions about the barriers which varied from person to person, according to; cultural beliefs, personal characteristics and the quality of service itself. The majority of women in both groups in the study believed that family
planning was good for a woman’s health. However, about half had not heard or seen any advertisement about family planning in the community. This reported lack of awareness about contraceptive methods as a reason for not using contraception among most women.

This is supported by a survey in sub-Saharan Africa which indicated lack of media exposure as a prominent reason, cited by most of the women interviewed in the survey, a large proportion of women in the study disclosed that they would refuse to discuss sexual behavior and problems with a male health officer. This means that most Egyptian women preferred a female health officer due to their religious norms, in Islam it is a taboo (haram) for a man who is not your husband to see the nakedness of another man’s wife.

CONCLUSION

The review of literature Concerning barriers of family planning methods revealed that there are several reasons why most women and men do not patronize family methods, this ranged from factors related to the method itself, poor counseling and education on family methods by service provider due to lack of requisite knowledge on family planning methods, the presence of side-effects experienced by some women using contraceptives as well as belief systems and spousal disapproval affect the patronage of family planning methods.

From this it is an undoubted fact that socio cultural barriers interlaced with other physical barriers imperatively affect the patronage of family planning services.
2.6 Attitude of male towards family planning services and use

2.6.1 Introduction

Male involvement in family planning is another key concern of this literature review. Family planning and reproductive health have generally targeted women, having been initially conceived to alleviate the burden of childbearing on women. Hence throughout history, family planning has been regarded as a female preserve. Owing to recognition of the role of men in RH, there is a justification for involving men at wider level; not just as consumers of family planning products. This study also highlights areas that illustrate low male involvement centered on the way couples communicate regarding family planning and the level of knowledge of the different methods and types of female contraceptives and their application to the man. (WHO 2005).

History reveals that RH and family planning services has focused exclusively on women and more specifically on their fertility and reproductive lives, very little information has been collected on men as a result, few reproductive health services programs reflect the specific needs and perspectives of men (WHO 2005). In recent times, the most common means by which couples regulate fertility have changed from methods requiring control or cooperation by men, e.g., condoms, withdrawal and periodic abstinence, to those for which women bear primary responsibility e.g., virtually all-reversible modern methods (Ringheim 1996). Family planning programs focused attention primarily on women because of the need to free women from excessive child-bearing; and to reduce maternal and infant morbidity and mortality rates through the use of modern methods of contraception. Most family planning
services were offered within maternal and child health (MCH) centers. 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 affair thing, with a man playing a peripheral role (Toure.1996). According to Toure (1996), 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 partners and their peers to use family planning and who influence the policy environment to be more conducive to developing male-related programmes. in this context, male involvement should be understood in a much broader sense than male contraception; and should refer to all organizational activities aimed at men as a discrete group which have the objective of increasing the acceptability and prevalence of family planning practice of either sex, ‘male involvement is more than just increasing the number of men using condoms.

2.6.2 Recognition of male involvement in the FP policy framework

At global level, the 1994 Cairo international conference on population and development is clear in its call for countries to promote men’s support in the struggle for gender equality and encourage their involvement and shared responsibility in family planning programmes (WHO, 2005). The programme of action recognizes that ‘men need to take responsibility for their own sexual behavior as well as respect and support the rights and health of their partners’. It urged that: special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior including family planning; prenatal, maternal child health; prevention of sexually transmitted diseases,
including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; recognition and promotion of the equal value of children of both sexes.

Male responsibilities in family life must be included in the education of children from the earliest ages. In Uganda, male involvement in FP has been identified as a key strategy in all the government policies and plans to address FP in Uganda. For example, one of the key strategies under promoting positive health seeking behavior is to encourage male involvement in RH /FP; and to promote awareness among men, women and communities on their roles and responsibilities in sexual and reproductive health and rights (WHO, 2008). However, some studies have shown that male involvement in family planning is still lacking, or in some cases counterproductive. Hence, couple communication regarding family planning and the level of male knowledge of family planning methods used by women is the right path of ensuring family planning patronage among couples. (MOH 2008)

2.6.3 Rationale for male involvement in family planning

The CSA (2008) study makes a case for male involvement in family planning, that there is need to increase better understanding of men’s central roles in determining women’s health. Although, men often dominate reproductive health decisions, however, men generally have little access to information and resources for communication with and supporting their sexual partners. Some barriers to male involvement include; lack or inadequate knowledge on family planning services, socio –cultural issues, misconceptions and myths related to family planning services.
family planning methods seems to be narrowed to only women which makes its services unattractive for men, since men have condoms as the only option and they sometimes feel override my women. (CSA 2008).

CONCLUSION

There are several overlooked barriers that contribute to poor male involvement and patronage of FP methods which include; lack or inadequate knowledge on family planning services, socio-cultural factors like taboos, social norms, beliefs, misconceptions and myths related to family planning services. Moreover, family planning methods seems to be narrowed to women only, which makes its service unattractive to men, majority of men see FP as a means of giving power and authority to women to override them.
CHAPTER THREE

3.0 STUDY AREA AND RESEARCH METHODOLOGY

3.1 Introduction

This chapter is devoted to the study area and the methodology employed in conducting the study.

It gives a detailed discretion of the study area so that reader will have an idea of the study settings and the challenges posed by the people in the area. The second section deals with the methodology adopted in carrying out the study.

3.2 Location and Size

The Bongo District is one of the fourteen Districts in the Upper East Region and shares boundaries with Burkina Faso to the North and East, Kassena-Nankana West and East Districts to the West and Bolgatanga District to the South. The study will be conducted in the Bongo district of the UER of Ghana. The 2010 Population and Housing Census put the populations of this district at 99,890. The district is predominantly rural with over 80% of the inhabitants living in areas classified as rural. It is fairly homogeneous with the Boosi and Gursu ethnic group forming about 80% of the population.

It lies between longitudes 0.45° W and latitude 10.50° N to 11.09 and has an area of 459.5 square kilometres. It lies within the Onchocerciasis-freed zone.
The location and size of the district has implications for development, especially in a situation where the district share borders with Burkina Faso. Thus amongst others it has the potential of enhancing economic activities between the district and its neighbors in Burkina Faso.

On the other hand, it also poses some health risk on the people of the district and beyond with regard to the spread of HIV/AIDS and other communicable diseases. There is also pressure on the few health and educational facilities in the district
because people come from the Burkina side to access these facilities in the district more.

The district has also been under siege by Fulani herdsmen who come to the district through the border with Burkina Faso which has resulted into so many vices such as cattle rustling, armed robbery as well as rape.

3.2.1 Climate and Vegetation

The climate of the district is similar to the ones experienced in other parts of the Upper East Region as well as the Upper West Region. Mean monthly temperature is about 21°C. Very high temperatures of up to 40°C occur just before the onset of the single rainy season in March. Low temperature of 12°C can be experienced in December when desiccating winds from the Sahara dry up the vegetation. The district has an average rainfall ranging between 600mm and 1400mm. The high temperatures in the dry season especially in March are a good source of energy for the district which is presently underutilized due to the lack of appropriate technology.

3.2.2 Ecological Zone

The district lies within the Northern Savannah Zone with one rainy season in a year. The amount of rainfall in the district is offset by the intense drought that precedes the rain and by the very high rate of evaporation that is estimated at 168 cm per annum. The vegetation is that of the Guinea Savannah type. Rivers and streams dry up during the dry season and the vegetation withers. Farming activities are halted and livestock starved culminating into severe loss of animal weight, which in turn affects household income.
3.3 Demographic Characteristics

The Bongo District is predominantly rural and it is characterized by large household sizes, high population density, and high fertility rates as found in other parts of the region.

3.3.1 Growth and Size

The 2000 Population and Housing Census put the population of the district at 77,885. A calculation by the Planning Team indicated that the District has a growth rate of 2.8%. This put the population of the District at 99,890 in 2009. Data available in the district shows that there is no significant in-migration of population. It is therefore presumed that the high growth rate is as a result of high birth rate.

3.3.2 Spatial Distribution of Population

The settlement pattern of the district exhibits rural characteristics. Apart from the district capital, Bongo, all the other communities are made up of small farm settlements scattered around the district. The district is characterized by dispersed settlements which sometimes make accessibility to some settlements difficult. According to the projected population for 2006, Bongo Township and its environment had a population of about 17,008 which accounts for about 18% of the entire population of the district. Other relatively larger settlements like Namoo, Soe, Zorko Kanga, Beo exhibits similar characteristics.
3.3.3 Population Density

In 2000, the population density for the district was 169 persons per sq. km. Projections made in 2009 put the population density at 217 persons per sq. km with the land size of 459.5 sq. km.

The trend of increase in population density points to the fact that there is increasing pressure on land for farming and other human activities by rocks. Thus the land carrying capacity keeps on dwindling with the increase in population. Conscious efforts should be made to reduce the birth rate in the district and develop alternative means of livelihood rather than depending solely on the land for farming which is the main economic activity in the district.

3.4 Religious Composition

The major religion in the district is traditional worship. The Traditionalist form about 53.6% followed by Christianity, which constitute 28.3%. Within the Christian religion, the Catholics are in the majority, constituting 69%. Islam forms about 6.4 percent of the population.

3.5 Ethnic Groups

There are many ethnic groups in the Upper East Region and in the Bongo District two main ethnic groups exist. The Bossis and the Gurunsis constitute about 94.2% of the total population. However, there are settler ethnic groups like the Kusasi, Nankani, Builsas, Kasena, Dargarte among others. These two major ethnic groups co-exist peacefully ostensibly because most of them trace their ancestors to the same family root.
3.6 Labour Force

According to the Report of the 2010 Population and Housing Census, 67.4% of the active labour force in the district is employed in various sectors of the district economy. This is made up of 67.7 female and 64.7 males. The above picture shows that females who are employed are more than the males.

The unemployment rate in the district is 26% which is more than twice the National average of 10.4%. It is also higher than the Regional average of 20.1%. Bongo District has the second unemployment rate in the Region apart from Bawku West which is 27.4%.

3.6.1 Child Labor/Working Children

Working children or child labor may be defined as children of school going age (7–14) engaged in economic activity. The Convention on the Rights of the Child, specifically Article 32, the MDGs as well as the 1992 Constitution of Ghana and the Children’s Act, all abhors any form of child labour. It is said that 33% of children in the Upper East Region are engaged in Child Labour while in the Bongo District, 30% of children are engaged in child labour (MICS, 2007-2008). It has also been revealed that engagement in child labour is much higher for children from poorer families, about 34% than for children from richer families who constitute about 25%. (HIRD Survey, 2007-2010).

It has also been revealed that 85% of child laborers in the Bongo District are also attending school. This is very dangerous for the district considering the fact that its future leaders dreams of one day holding leadership positions in the district is been
jeopardized and this can lead to a dead end situation for the district. The health of these young ones is also in danger since they are not matured enough to do the kind of work they are doing. Their education is also compromised for economic gains and this affects performance of school children.

### 3.6.2 Culture

Historically, the people of Bongo trace their roots to the Mamprugu Kingdom in the Northern Region of Ghana especially those entitled to the royal skin, which is the paramount seat.

The district is a multi-ethnic one with two major ethnic groups dominating that is the Bossi’s who are from the Bongo Central and some parts of the district and the Gurunsi’s.

The Bossi’s are heirs to the Paramountcy and are enskinned by the Nayiri the overlord of the Mamprugu Kingdom. There are also Tindaanas who hail from Zorko, Namoo and other settlements. Two major languages are spoken in the district that is Bonni which is spoken by the Bossi’s and Guruni which is spoken by the Gurunsi’s.

Due to the rural nature of the district, communal spirit among the people is high because they live in communities and see themselves as one. However, their level of communal spirit should be translated into development activities such as communal labour for development projects.
3.6.3 Festivals

The district has only one major festival known as “Azambene” which literally means the Fire Festival. This festival is also celebrated by the Mamprusi’s, Dagomba’s and Moshie’s. This goes to confirm that the people from the Bongo district trace their roots to Mamprugu.

During the festival, there is merry-making as well as drumming and dancing. There is also traditional pomp and pageantry and both the young and old participate in this festival.

The traditional council currently celebrates this festival every year and a grand durbar of chiefs and people of the traditional area is usually held. The durbar serves as a platform for discussing developmental issues confronting the traditional area and an educational endowment fund has been established by the Paramount Chief through the festival. The festival has also annually brought together politicians, technocrats and even diplomats who contribute in diverse ways to the development of the district.

3.6.4 Negative Cultural Practices

The district is abounding with some negative cultural practices that impede development in the district especially women and children particularly the girl-child. There are bad practices such as dehumanizing widowhood rites that infringe on the rights and freedom of women. Child betrothal is still practiced in the district as well as early marriages. This has affected children and those who are already in school. The practice also accounts for high drop-out rate especially among the girl-child.
Another practice that affects the development of the girl-child and children in general is the practice of “tanzaba” which literally means “Sister-in-bed.” This is a practice where a young man can flirt with a relative who is a sister and give birth but cannot marry her.

This practice has affected a lot of young girls and women in the district. It is noted as the principal cause of teenage pregnancies in the district. The practice is also responsible for some form of streetism in the district since children born out of this relationship are usually left to the care of the unfortunate young girls and women. It is important that educational programmes are embarked upon to educate all and sundry on these negative cultural practices which can derail the future of our young women and girls in the district.

The posting of additional personnel to cover the entire district. Currently, the police-citizen ratio which stands at 1 police officer to over 3,699 citizens is not the best.

3.7 Major Economic Activities

Farming is the major economic activity in the district. It employs little over 90% of the population and both men and women participate in this activity. Majority of the farmers are subsistence farmers while a few are into medium scale commercial farming. Major crops cultivated in the district are millet, sorghum, groundnuts, rice, soya beans while a few of them grow maize. Farmers who are close to the Vea Irrigation dam and other small dams also grow tomatoes and leafy vegetables.

The Vea dam is said to have 850 hectares of land which is used by 2000 small farmers. Major crops grown at the irrigable area include onions, tomatoes, beans,
vegetables and rice. Farming in the district is mostly done alongside livestock and poultry rearing. The system of rearing is mostly free ranging especially for guinea fowls and this has increased the mortality rates of the guinea fowl. Livestock and poultry is a store of wealth in the district and people prefer to keep watch over them instead of disposing some of them to meet basic needs such as food and payment of school fees and sometimes even medical bills.

The revenue of the Bongo District Assembly is mobilized through the following: rates, fees, fines, licenses and rent.

3.8 Study Methodology

This study used both secondary and primary data. The secondary data for the study was gotten from books, reports, journal articles on the activities of the CHPS in Ghana, particularly in the Upper East Region. Also, district assembly documents were accessed for the purposes of understanding the area. The primary data was sourced from the respondents using questionnaire, observation, focus group discussion and In-depth interviews.

Mixed methods have several advantages. It helps the researcher compensate for the apparent limitations of each individual method; that is quantitative and qualitative (Barbour, 2008). The study made use of the quantitative and qualitative methods. A questionnaire was designed in line with the study objectives and research questions and using the literature on the issues under investigation (CHPS), which helped to capture a lot of information including characteristics of the respondents and to locate the various CHPS compounds in the Bongo district of the upper east region of Ghana. There were also qualitative questions in which respondents were made to speak their
minds on the issues of family planning and their understanding of the CHPS activities and the services rendered at the various CHPS. Quantitative techniques help one to easily generalize and obtain patterns about a sample population (Barbour, 2008). The weakness of this method, however, is that it does not give detail understanding of the issues or even fails in some cases to point or give clues about this likely causes (Thagaard, 2003). This study compensated for the weaknesses of the quantitative method by adding a qualitative portion.

Qualitative methods in social research have many advantages that make them suitable for use together with quantitative methods. Some of the most important differences from quantitative methodology are according to Thagaard (2003) that qualitative method uses analysis of text instead of numbers, it includes proximity and closeness to the informants as opposed to distance to respondents, and one has small (and often carefully chosen) selections of informants or object of study. While quantitative studies often have a linear process, qualitative methodology often goes in a cyclical process. Analysis and interpretation are activities that are on-going throughout the research process, because the researcher will reflect and interpret the data while trying to get the overview. The research moves through different phases, and these overlap to a certain extent. The flexibility that lies in the qualitative research process can also give the researcher possibilities to change strategy during the process, and the process itself goes back and forth between theory, methodology and data (Thagaard, 2003).

There is no single accepted way of doing qualitative research. The researcher’s view on ontology, epistemology, goal of research, the research participants and audience for the research are amongst the factors that influence the research that is carried out.
In terms of the characteristics of this method, there is a consensus that qualitative research is a naturalistic, interpretive approach concerned with the meanings which people attach to phenomena within their social worlds (Snape and Spencer, 2003). Certain data collection methods have also been associated with this type of research, such as observation, in depth interviewing, focus group discussion and narratives. It also involves using methods of data generation that which are flexible and sensitive to the social context in which the data are produced. Close contact between the researcher and the people being studied is also a key element in the nature of the data generation. In terms of outcomes, or nature of outputs, there are several important elements. Producing detailed descriptions based on or an interpretation of the perspectives of 50 the participants in the social setting is one aspect, while answering ‘how’, ‘why’ and ‘what is’ is another. Particularly important for my research is also consideration of the influence of the researcher’s perspective. In sum, the aim of qualitative research is generally to provide an in depth and interpreted understanding of the social world, by learning about people’s social and material circumstances, experiences, histories and perspectives (Snape and Spencer, 2003).

According to Antwi Bosiakoh (2009), in-depth interviews give an advantage of helping us enter the thoughts of the respondents and experience the world just like they do. It is appropriate for addressing sensitive issues which respondents may not feel free to discuss in public settings. Also the interviewer can observe the physical environs and also use non-verbal cues like grimaces (Neuman, 1997). The demerits of this technique include interviewer bias. For instance, the tone of voice or wording of questions can affect the respondent. In-depth interviews are appropriate for this study
because after dealing with views of women in the reproductive age as a group, the study finds it proper to isolate various cases which tell the stories of resilient adolescents from the perspective of individual adolescents. The use of this technique will ensure that the views of those respondents are highlighted and that access is gained to certain sensitive but important information which respondents will otherwise not share.

3.9 Study Design

The study was descriptive cross-sectional in design with both quantitative and qualitative data collected using structured questionnaire, interview guide and focused group discussion guide. The Data collected included socio-demographic characteristics of the respondents, socio-cultural factors that hinder effective utilization of the CHPS, attitude of health workers at the various CHPS, challenges in effective implementation of the CHPS and the core as well as the services rendered at the CHPS compound in the Bongo district of the upper east region of Ghana.

3.9.1 Sources of data

Two sources of data were used to collect data for this study; these were both primary and secondary sources. In the collection of the primary data both quantitative and qualitative methods of data collection were employed. The quantitative data were collected by the use of structured questionnaires. These were categorized into sections that will enable the researcher achieve her objectives. They were then sectioned according to the stated objectives.
The qualitative method involved the use of Focus Group Discussions (FGDs) among women in their reproductive age groups and young girls who were not married but were noted to be sexually active in the study community. The FGDs and interviews were organized to elicit information on the factors that influence the occurrence of teenage pregnancies. The knowledge of the discussants on the consequences of teenage pregnancies was also discussed.

3.9.2 Primary data

Primary data was sourced using the following tools: questionnaire, focus group discussions, observations, key informant interviews and photographs as data.

3.10 Tools for data collection

3.10.1 Questionnaire

Questionnaire was the main tool employed to collect the quantitative data. The questionnaire was made up of four sections. Apart from the demographic characteristics of the respondents, the questionnaire was section in line with the study objectives. This when well administered will help achieve those stated objectives.

The questionnaire method was deemed relevant for this study because it was the most convenient and effective way of reaching the target population, which were scattered their various geographical dispersed locations in the study area (Couper, 2000). The questionnaire was a quantitative instrument used in collecting data from the respondents at their various communities selected for the study. This allowed for the collection of data using both pre-coded responses categories and also a narrative approach when discussing sensitive issues related to family planning and other related
health issues (Edmeades et al, 2010). In conducting the survey, two hundred and sixty-three (263) questionnaires were administered to two hundred and sixty three (263) respondents in different location in the Bongo district. The questions in the questionnaire were such that they covered almost every objective of the study. The questionnaire was divided into five sections; namely; the socio demographic characteristics of respondents, all the questions were designed in such a way that they have link with the topic under investigation.

3.10.2 Key informant interviews

A key informant interview is a standard anthropological method that is widely used in health related research and other social development enquiries. It is one of the methods used in rapid assessment for gathering information from the affected people or community. The term key informant refers to anyone who can provide detailed information and opinion based on his or her knowledge on a particular issue or subject of investigation. A key informant interview seeks qualitative information that can be narrated and cross-examined with quantitative data. This is done through triangulation. In this case the interviewer has to remain neutral and must refrain from asking biased or leading questions during the interview (Kearns, 2000).

With regard to this study, seven key informants were selected to share their opinions about the CHPS strategy, the type of services they provide and family planning issues as a component of the CHPS strategy and other health related activities conducted in the various CHPS in the study district. The key informants selected were five women and two men from the Ghana health service. They were the district health director, the
in charge of the various selected CHPS for the study. These people were selected because they have adequate knowledge of the CHPS strategy.

3.10.3 Observation

Apart from the research instruments mentioned above, observation was employed to complement data collected through questionnaire administration, focus group discussions and key informant interviews. Observation was used in this study to capture speculations, feelings, ideas, problems, impressions and prejudices that may not have come out during the survey, the in-depth interview and the focus group discussion, (Creswell, 2009). Observation is described as the fundamental base of all research methods in social science. It is essential as it enables the interviewer to note the body language of the interviewee to obtain a complete picture of the situation, especially in studies that are mainly uses interview as a basic data collection technique (Alder and Alder, 1994). Social scientists observe human activities and behaviour as well as social settings in which they take place (Angrosino, 2005). Observation was an on-going process that continued throughout the research process. The researcher was both an active and passive participant in various social interactions (Malufashi, 2006). The observation conducted during the field work was observing the CHPS building and where they are located and items in them. According to Cook (2008), observation helps to produce a rich account of the phenomenon being studied.
3.10.4 Focus Group Discussions (FGDs)

Focused groups discussion were employed to provide a wider range of experience from the respondents and also to complement the data collected through the survey and the individual in-depth interviews (Bazeley, 2002; Johnson and Onwuegbuzie, 2004). Focus group allowed the individual respondent to express their personal views, knowledge and experiences in an informal way. In this study six focus groups discussions were conducted in all the six CHPS locations in the district which lasted for two (2) hours each. Each focus group discussion was made up of six people; a moderator, and a secretary, mostly dominated by women of reproductive age groups who patronise the CHPS compound in the various selected areas for the study. Also two men groups were also selected in 2 communities to find out the attitude of the men with regards to the utilization of family planning at the CHPS and also to find out their role in discussion family planning issues with their spouses in the study.

3.11 Sampling Methods

Sampling is very important in both quantitative and qualitative research; it is used when it is not possible to include the whole of population in research projects (Williamson, 2002). A multi stage sampling technique was employed to select respondents for the survey. In the first stage, purposive sampling method was employed to select the study communities in the study district of in the upper east region. This was done by selecting communities with CHPS facilities. After that simple random sample technique was adopted in selecting the respondents at their various communities. This was done by first contacting the assemblymen of the various communities who provided the house numbers of the communities. On the
day of the selection, I went to selected study communities and I wrote number 1 to 6 on the least of houses and any house number assigned with the number 4 had the chance of being selected. The population of the various selected areas informed the choice of respondents. That is why Anafobisi had the highest number of respondents.

### Table 3.1 Sample Communities in Bongo district and Number of Respondents.

<table>
<thead>
<tr>
<th>Communities Selected</th>
<th>Number of Respondents (women at their reproductive age)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anafobisi</td>
<td>60</td>
</tr>
<tr>
<td>Namoo</td>
<td>50</td>
</tr>
<tr>
<td>Soe</td>
<td>50</td>
</tr>
<tr>
<td>Zorko</td>
<td>43</td>
</tr>
<tr>
<td>Beo</td>
<td>30</td>
</tr>
<tr>
<td>Vea</td>
<td>30</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>263</strong></td>
</tr>
</tbody>
</table>

Source: field survey, 2016

#### 3.12 Sample Size Determination

The sample size of the study was determined using the following statistical formula for sample size determination $N = \frac{z^2pq}{d^2}$ (Snedecor and Cochran, 1989), where $N$ is the required sample size, $z$ is the z-score corresponding to a 95% confidence level which is estimated to be 1.96, $p$ is the prevalence rate of CHPS utilization in the study area = 15% (0.15) (Bongo District Health Directorate’s Report, 2014), $q$ is the
proportion of women who are not utilizing the CHPS = 1-p = 1-0.15 =0.85, d is the precision or margin of error = 5% (0.05).

\[ N = (1.96)^2 \times (0.15)(0.85) \]

\[ (0.05)^2 \]

\[ N = 3.8416 \times 0.127 \]

\[ 0.0025 \]

\[ N = 265.28 = 263 \]

Therefore, a final sample size of Two Hundred and Sixty-Three (263) was used in the study.

3.12.1 Sampling Technique

Cluster sampling was used to sample six communities with CHPS and simple random sampling method was used to enroll 263 women in their reproductive age group into the study. Employing simple random sampling, the houses in selected communities were giving numbers one (1) up to six and every 4\textsuperscript{th} number house was selected, afterwards purpose sampling was used to select respondents for the study.

3.12.2 Data Processing/Analysis

Quantitative data collected was entered into SPSS version 21.0 and analyzed in order to draw valid and reliable conclusions. The data collected were coded before entering them into the SPSS software.
Simple frequencies were established or found for socio demographic characteristics, parental information, and knowledge of contraceptives and use of contraceptives. Bivariate analyses or cross tabulation were performed for the quantitative data. Chi square values of these bivariate analyses were considered to be statistically significant with P < 0.05 and a confidence level of 95%. The essence of the cross tabulation was to determine the factors that are significant contributors to utilization of CHPS.

The qualitative data was analyzed by transcribing the recorded tapes of the FGDs. Thematic and content analyses were performed by extracting the main themes of the discussions and supported with some directed quotations from the discussants.

3.13 Quality Control Measures

To ensure the quality and genuineness of the data, the questionnaires were self-administered by the lead/principal investigator. This made the questioning to be uniformed. The questionnaires were pre-tested in two facilities before the final administration. Ten people were interviewed during the pre-testing and it helped in re-structuring the questionnaires.

Research Ethics

An introductory letter was obtained from the school (University for Development Study) the department of allied health sciences and delivered to the Bongo DHMT through the Director of Health Services of Upper East Region-Bolga (Ghana Health Service). All the respondents in this study were provided written or oral informed consent before taking part in this study, which was approved as part of the protocol for the study. To those who gave oral consent, the consent form was translated into
the local language by the interviewer. There was no name indicated during the IDIS and FGDS process, also respondents who refused to consent did not participate in the process it was only those who consented that took part in the study. They were assured of confidentiality. Personal identifier information was not collected, and any identifying information accidentally mentioned was removed from the text prior to analysis. Participants were approached individually and the research project, explained to them fully. Prior to the commencement of data collection, all participants were provided with detailed information (verbal and written) about the purpose of the study and individual consent was obtained either by signing or thumbs printing.

Participants were told that participation was voluntary; and they did not have to complete the interview and could stop at any point in time if they so wished. It was not anticipated that participants would face any harm by participating in this study, however, participants may experience some emotional discomforts as participants told their stories and their experiences with family planning services. When a participant became uncomfortable with a question, the interview was suspended immediately and the question framed or passed over.

The researcher ensured anonymity and confidentiality of the participants by using code numbers/letters or pseudonyms for the audiotapes and transcripts. The individuality of the participants was maintained by respecting each participant’s answer and not being judgmental. Any information that represents participants’ identities was coded and kept confidential. Data gathered were stored in locked files, to which only the researcher can have access to. The audiotapes and transcripts will
be kept secured by the researcher for a period of two years after the study after which they will be destroyed.
CHAPTER FOUR

4.0 PRESENTATION OF RESULTS

4.1 Introduction

The chapter presents the results of the data collected from the field. It presents the analysis of the data on the socio-demographic characteristics of the respondents as well as given a vivid analysis of the stated objectives of the study. It also presents some qualitative analysis to support the quantitative data.

4.2 Socio-Demographic Characteristics of Respondents

The socio-demographic characteristics such as sex, age, educational level and occupation of the respondents are presented and discuss. These characteristics give a well-defined description of respondents and how their differences influence the overall objectives of this study. The study sampled 263 respondents from the Bongo District of the Upper East Region. The results revealed that a higher percentage (34%) of the respondents were between the ages of 24-31 years. However, the average age of respondents was 32 years. With regards to marital status, majority (63%) of the respondents were married, while 11% were single. Also, 18% and 7% were divorced and widowed. The educational level of the respondents was generally low, as 38% of the respondent had no formal education. Twenty-eight percent (28%) of the sampled women had primary education. About 11% of the respondents attained tertiary education. However, the study revealed that, majority (66%) of the respondents were women and the remaining 34% were men. Female were dominated in the study because the subject under discussing is mostly dominated by women with men sometimes playing a vital role when it comes to decision in accessing health care.
Table 4.1 Socio-Demographic Characteristics and Awareness of CHPS

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age category</strong></td>
<td></td>
</tr>
<tr>
<td>18-24</td>
<td>42 (15.9%)</td>
</tr>
<tr>
<td>24-31</td>
<td>89 (33.8%)</td>
</tr>
<tr>
<td>32-38</td>
<td>71 (26.9%)</td>
</tr>
<tr>
<td>39-45</td>
<td>61 (23.4%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>263 (100%)</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>169 (64.3%)</td>
</tr>
<tr>
<td>Single</td>
<td>28 (10.6%)</td>
</tr>
<tr>
<td>Divorced</td>
<td>47 (17.9%)</td>
</tr>
<tr>
<td>Widowed</td>
<td>19 (7.2%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>263 (100%)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
</tr>
<tr>
<td>No formal</td>
<td>101 (38.4%)</td>
</tr>
<tr>
<td>Primary</td>
<td>62 (23.6%)</td>
</tr>
<tr>
<td>JHS</td>
<td>34 (12.9%)</td>
</tr>
<tr>
<td>SHS</td>
<td>37 (14.1%)</td>
</tr>
<tr>
<td>Tertiary</td>
<td>29 (11.0%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>263 (100%)</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>173 (65.8%)</td>
</tr>
<tr>
<td>Male</td>
<td>90 (34.2%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>263 (100%)</td>
</tr>
</tbody>
</table>

Source field work 2016
4.2.1 Religion

The study found that Christians where more dominated in the district representing about 63% followed by Muslims, 27% and Traditionalists 10%. This results is not surprising because the Upper East Region is dominated by Christians. Personal observation revealed that some of the respondents were also practicing traditional religion alongside with Christianity.

**Figure 4.1 Distribution of religious affiliation.**

Source: field work 2016.

4.2.2 Years of marriage

A higher proportion (about 75%) of the respondents had married for 11 years and above, with about 8% married for less than 5 years. The null represents those who have never married who constitute about 11%.
4.2.3 Household size

The mean household was 9 people per house. Proportionately, majority (51%) of the respondents had household size ranging between 6-10 people.
4.2.4 Major occupation

Majority (26%) of the respondents were traders, followed by farmers who constitute 19%. Only about 6% were students.
4.2.5 Household marital arrangement

The study found that, polygamous-type marriage were common among the respondents. Thus, about 57% of the respondents were into polygamous-type marriage, and the remaining 43% were into monogamous-type of marriage.
Figure 4.5 Distribution marital arrangement.

Source: fieldwork 2016

Physical, geographical and socio cultural factors that affect utilization to family planning services.

The study investigate and presents the analysis on the factors influencing utilization of family planning services. The dependent variable was family planning measured as dummy coded 1 for users and 0 for non-users. The independent variables were marital status, age, sex, education, number of children, maternal disorder, religion, marriage type, awareness of CHPS, external family ideology and work arrangement. Out of these variables, marital status, maternal disorder, marriage type, awareness of CHPS, external family ideology and work arrangement significantly influence utilization of family planning services. Also, the model fit diagnosis revealed a LR chi-square of $= 172.8$ (p<0.01) which implies that the joint effect of the independent variables are significantly different from zero. Statistically, this means that at least one of the
independent variables significantly influence the probability of utilizing family planning services. The pseudo R-square of 0.5052 (51%) implies that about 51% of the probability of utilizing family planning services was explained by all the independent variables and the remaining 49% was unaccounted for.

Table 4.2 Maximum likelihood estimation of the logistic regression model

| Variable            | Odds ratio | Coefficient | Std. Err. | P>|z|
|---------------------|------------|-------------|-----------|------|
| Marital status      | 0.6495     | -0.432***   | 0.106     | 0.000|
| Age                 | 1.001476   | 0.001       | 0.001     | 0.241|
| Sex                 | 0.654745   | -0.424      | 0.451     | 0.347|
| Education           | 0.905205   | -0.100      | 0.178     | 0.575|
| Number of children  | 0.996684   | -0.003      | 0.067     | 0.960|
| Maternal disorder   | 0.757723   | -0.277**    | 0.124     | 0.025|
| Religion            | 1.12853    | 0.121       | 0.132     | 0.360|
| Marriage type       | 1.000205   | 0.005**     | 0.002     | 0.028|
| Awareness to CHPS services | 1.007592 | 0.008*  | 0.004  | 0.058|
| External family ideology | 1.007098 | 0.007*** | 0.002   | 0.000|
| Work arrangement    | 1.515971   | 0.416*      | 0.243     | 0.087|
| Constant            | 0.833223   | -0.182      | 2.058     | 0.929|

Number of observation = 262; LR chi^2 = 172.8; Prob>chi^2 = 0.000; Pseudo R2 = 0.5052

Source: fieldwork, 2016.

Marital status coded 1 for married and 0 for single was significant (p<0.01) and negative. The negative sign connotes to respondents who were single. Based on the coefficient of marital status, it implies that respondents who are single had higher probability of utilizing family planning services than their counterparts who are married. With regards to the odds ratio of 0.65 approximately, means that respondents who are married are 0.65 less likely to utilize family planning services. The study also revealed significant positive relationship between family planning services utilization and maternal abnormalities (p<0.05). Maternal abnormalities coded 0 for absence of maternal problems and 1 presence of maternal health. Therefore, this results connote
to respondents who experienced no maternal problems implies that in the absence of maternal health problems, individuals are more likely to utilize family planning services. Respondents who were aware of CHPS have higher probability of utilizing family planning services. Also, external family ideology on child bearing was found to be significant and positive. This means that category of the response coded 1 which connotes to families who want less children in this case. It implies that if the family ideology is the desire for more children, the likelihood that they would patronize family planning services reduces. The odds of external family ideology is 1 which means that, families who aim for less children are 1 time more likely to patronize family services than their counterparts. Work arrangement also had a positive significant influence on the use of family planning services. This implies that respondents who have busy schedules with the work, coded 1 in the analysis have higher probability of utilizing family planning services compared to those who are less busy with their work.

4.3 Attitudes of CHPS workers to family planning

With regards to the attitudes of CHPS workers towards family planning, the response was generally good. In terms of CHPS workers the study revealed that the workers at the selected CHPS compounds have respect for privacy during service delivery and opportunity for choosing one’s own family planning method (s). The study further revealed that, more than 90% of the respondents agreed that the methods employed at the CHPS was favorable. About 55% said that CHPS workers delivery of family planning services was on time. A higher percentage (70%) also agreed that overall
participation in family planning delivery was high. Also, 64% of them indicated that, the message or advice provided by CHPS workers was adequate and very relevant, and 51% stated that CHPS workers ask for feedback on family planning services. In terms of friendliness, majority (88%) of the respondents said that CHPS workers were friendly. Lastly, a greater percentage (98%) of the respondents stated that CHPS workers were non-discriminatory.

**Table 4.3 Attitudes of CHPS workers to family planning**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely delivery of services</td>
<td>55.1%</td>
<td>44.9%</td>
</tr>
<tr>
<td>Respect for privacy</td>
<td>92.0%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Overall participation</td>
<td>70.0%</td>
<td>30.0%</td>
</tr>
<tr>
<td>Adequacy and usefulness of message/advice</td>
<td>63.5%</td>
<td>36.5%</td>
</tr>
<tr>
<td>Opportunity for selecting your own service</td>
<td>98%</td>
<td>2%</td>
</tr>
<tr>
<td>Provides feedback</td>
<td>51.1%</td>
<td>49.9%</td>
</tr>
<tr>
<td>Friendliness</td>
<td>88.2%</td>
<td>11.8%</td>
</tr>
<tr>
<td>Non-discrimination</td>
<td>97.5%</td>
<td>2.5%</td>
</tr>
</tbody>
</table>

**Source:** fieldwork, 2016

**4.4 Attitudes of men workers to family planning**

Approximately 45% of women indicated that they had once or more been assaulted by their husbands for discussing family planning issues. Also, more than one quarter (about 30%) of the women said their husbands refused family planning uprightly when they discussed it with them. Only about 5% said that their husbands do not engaged them in decision-making process regarding family planning (see figure 4.6).
Figure 4.6 Attitudes of men towards family planning.

Source: fieldwork, 2016

In an individual interview with one of the respondent in one of the communities narrated as shown below.

“In my community it is a taboo to do FP because it is believed that it is only promiscuous women who uses FP so that they do not get pregnant; it is belief that if a married woman conceives with another man, she will not be able to give birth unless she confesses hence most women nowadays use the FP to cover up their promiscuity”
(MR tee an elder during a FGD session)

“The contraceptive that are inserted into the vagina can travel to the brain to give you headache and other discomfort like numbness” - (Madam Weea.).

4.5 Awareness of CHPS by socio-demographic characteristics

Majority (42%) of the respondents who were very much aware of CHPS compound were between the ages of 24-31 years. Also, 61% of respondents who were aware of
CHPS compound were married. A higher proportion of respondents who were aware of CHPS compounds were educated.

Table 4.4 Awareness of CHPS by socio-demographic characteristics

<table>
<thead>
<tr>
<th>Age category</th>
<th>Aware of CHPS</th>
<th>Not aware of CHPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>23 (17.0%)</td>
<td>19 (14.8%)</td>
</tr>
<tr>
<td>24-31</td>
<td>57 (42.3%)</td>
<td>32 (25.0%)</td>
</tr>
<tr>
<td>32-38</td>
<td>25 (18.5%)</td>
<td>36 (28.2%)</td>
</tr>
<tr>
<td>39-45</td>
<td>30 (22.2%)</td>
<td>41 (32.0%)</td>
</tr>
</tbody>
</table>

**Marital status**

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Aware of CHPS</th>
<th>Not aware of CHPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>103 (61%)</td>
<td>66 (39%)</td>
</tr>
<tr>
<td>Single</td>
<td>5 (17.9%)</td>
<td>23 (82.1%)</td>
</tr>
<tr>
<td>Divorced</td>
<td>32 (68.1%)</td>
<td>15 (31.9%)</td>
</tr>
<tr>
<td>Widowed</td>
<td>14 (73.7%)</td>
<td>5 (26.3%)</td>
</tr>
</tbody>
</table>

**Education**

<table>
<thead>
<tr>
<th>Education</th>
<th>Aware of CHPS</th>
<th>Not aware of CHPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>No formal</td>
<td>35 (31.1%)</td>
<td>66 (42.1%)</td>
</tr>
<tr>
<td>Primary</td>
<td>23 (17.1%)</td>
<td>39 (22.2%)</td>
</tr>
<tr>
<td>JHS</td>
<td>13 (13.6%)</td>
<td>21 (13.2%)</td>
</tr>
<tr>
<td>SHS</td>
<td>30 (21.1%)</td>
<td>7 (9.3%)</td>
</tr>
<tr>
<td>Tertiary</td>
<td>20 (17.1%)</td>
<td>9 (13.1%)</td>
</tr>
</tbody>
</table>

**Total**

**Sex**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Aware of CHPS</th>
<th>Not aware of CHPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>201 (70.1%)</td>
<td>38 (29.8%)</td>
</tr>
<tr>
<td>Male</td>
<td>62 (29.9%)</td>
<td>56 (70.2%)</td>
</tr>
</tbody>
</table>

**Source:** fieldwork, 2016
4.6 Source of information on awareness of CHPS

The study revealed that, a higher proportion (37%) of the respondents had heard about CHPS through community health officers (CHO); community health nurses or community health volunteers, followed by radio (17%) and District Assembly (14%). Also, about 13% of the respondents indicated that they were aware of the CHPS through non-governmental organizations (NGOs) and family member respectively. About 4% and 2% were aware of CHPS through friends and television programs.

<table>
<thead>
<tr>
<th>Source</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHO/CHN/CHV</td>
<td>96 (36.5%)</td>
</tr>
<tr>
<td>Radio</td>
<td>45 (17.1%)</td>
</tr>
<tr>
<td>Television</td>
<td>5 (1.9%)</td>
</tr>
<tr>
<td>District Assembly</td>
<td>36 (13.7%)</td>
</tr>
<tr>
<td>Family member</td>
<td>35 (13.3%)</td>
</tr>
<tr>
<td>Friend</td>
<td>11 (4.2%)</td>
</tr>
<tr>
<td>NGO</td>
<td>35 (13.3%)</td>
</tr>
<tr>
<td>Total</td>
<td>263 (100%)</td>
</tr>
</tbody>
</table>

Source: fieldwork, 2016.

4.6.1 Appropriate medium of CHPS information Delivery

Based on the respondents’ source of awareness on CHPS, they were asked to rate the appropriate medium of information delivery by CHPS. A greater proportion (37%) said that they are comfortable hearing information from CHO/CHN or CHV. This was followed by family members (19%), friends (18%) and NGOs (16%). The least
of the respondents said that they want to receive CHPS information through the television.

**Table 4.5 Appropriate medium of CHPS information Delivery**

<table>
<thead>
<tr>
<th>Source</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHO/CHN/CHV</td>
<td>36.6</td>
</tr>
<tr>
<td>Family member</td>
<td>19.2</td>
</tr>
<tr>
<td>Friend</td>
<td>18.7</td>
</tr>
<tr>
<td>NGO</td>
<td>15.9</td>
</tr>
<tr>
<td>Radio</td>
<td>4.8</td>
</tr>
<tr>
<td>District Assembly</td>
<td>3.5</td>
</tr>
<tr>
<td>Television</td>
<td>1.9</td>
</tr>
</tbody>
</table>

Source: fieldwork, 2016.

**4.7 Awareness of CHPS Services**

When the respondents were asked to mention the types of services provided by CHPS, 76% out of 263 respondents said that CHPS provides primary health care. About 75% stated that CHPS provides skill birth attendants. Twenty-six percent listed provision of education on nutrition. Also, the provision of family planning services was mentioned by about 64% of the respondents. About 22% and 21% said that CHPS educates people on primary health care and nutrition respectively.
Table 4.6 Awareness of CHPS services

<table>
<thead>
<tr>
<th>Services</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of primary healthcare</td>
<td>53 (17.1%)</td>
</tr>
<tr>
<td>Provision of education on primary healthcare &amp; STIs</td>
<td>22 (7.1%)</td>
</tr>
<tr>
<td>Provision of education on nutrition</td>
<td>36 (13.5%)</td>
</tr>
<tr>
<td>Provision of skilled birth attendant</td>
<td>68 (31.9%)</td>
</tr>
<tr>
<td>Education on sanitation</td>
<td>26 (10.5%)</td>
</tr>
<tr>
<td>Provision of family planning services</td>
<td>58 (19.9%)</td>
</tr>
</tbody>
</table>

4.8 Access to CHPS Services

The study found that, majority (54%) of the respondents had access at least one CHPS services and 46% had not.

Figure 4.7 Access to CHPS Services.

Source: fieldwork, 2016
In a focus group discussion with women who access the services of the CHPs in the communities, the following was what one of the respondents reported.

“The CHPs has brought health care services closer to us. When the CHP compound was not in this community we used to travel to the district capital or Beo Walega to access the health care service but with the introduction of the CHPs we now know much about health issues through health education”. Source: (Atipaga, a 26 years old mother of three in Beo.)

When respondents were asked the challenges the face in accessing the CHIP with regards to geographical and financial accessibility almost 80% indicated that the major challenge is the geographical accessibility. They reported that they have to travel about 4 or more kilo meters before accessing the facility. About 19% reported financial challenge was there major setback. When they were asked further as to whether they pay money at the facility, they indicated that they don’t pay anything. It was revealed at the focus group discussion that transportation cost to the facility was what they reported as a financial barrier. The about 5% percent who indicated that they were another factors that influenced their access to the facility reported traditional beliefs and the refusal of their spouse to attend the facility.

Table 4.7. Percentage Distribution of Accessibility to CHPs

<table>
<thead>
<tr>
<th>ACCESS</th>
<th>FREQUENCY</th>
<th>PERCENTAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographical</td>
<td>210</td>
<td>76.3</td>
</tr>
<tr>
<td>Financial</td>
<td>50</td>
<td>19.0</td>
</tr>
<tr>
<td>Others</td>
<td>13</td>
<td>4.7</td>
</tr>
</tbody>
</table>
Totals 263 100.0

Source: Field work, 2016.

In an individual interview with sister Faustina she illustrated as follows:

“Hmmm! Is good to always visit the CHP compound, but the location of the facility to this village is not a small distance. I have to travel not less than 4 km before getting there and coming back is always a problem especially on a sunny days when the sun is too high”.

Another person reported as follows:

My husband is not always happy when I visit the facility. He always wants me to resort to traditional herbs. When you tell him about family planning then you are in trouble. He holds the view that children are his assets especially the girl child because of the pride price system in this our traditional set up. He what to have more female children to get more cattle.

The researcher also had a personal interview with some of the health workers at the selected CHPS compound and the following were some of what they reported:

“You have to pay for the contraceptive but not everybody who wants to use them has the money. I met a woman who was interested in doing FP but complained that she did not have money. It is not very expensive but it is not everybody who can afford it; some people do not have money so it becomes a hindrance to accessing the service” - (Mr. Veal a Senior Health Manager in an IDI).
“Sometime we do run out of stock of contraceptives and clients gets so disappointed in that situation but we could easily borrow from the nearby center” (Madam Egre, a CHO in a FGD).

“The supply to our compound interns of drugs, logistics and other resources are sometimes woefully inadequate which can make service delivery difficult for us, in that clients come and we have no options than return them back politely” “Sometimes when we visit the clinic to purchase contraceptives, and what we are told by the nurses is that it is finished, since we need it urgently we decide to purchase it at the drug store. We are also not well enlightened about the pills, especially the side effects, so the stories we hear outside scare us from using the contraceptives” (Miss keer, a CHO in an IDI).

4.9 Knowledge of Family Planning

A higher percentage (89%) of the respondents maintained that family planning denotes spacing of children. 44% mentioned that limiting and treating fertility can also be used to mean family planning and about 38% said family planning is used to correct maternal health abnormalities
Source: fieldwork 2016.

4.9.1 Source of Information on Awareness of Family Planning

Analyzing the respondents’ awareness of family planning services, the distribution shows that the majority (44%) of the respondents indicated that they knew family planning through CHPS.
Figure 4.9 Source of Information on Awareness of Family Planning.

Source: fieldwork 2016

4.10 Utilization of Family Planning Services

Table 4.7 Utilization of Family Planning Services

<table>
<thead>
<tr>
<th>Use of family planning</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>101 (38.4%)</td>
</tr>
<tr>
<td>No</td>
<td>162 (61.6%)</td>
</tr>
<tr>
<td>Total</td>
<td>263 (100%)</td>
</tr>
</tbody>
</table>

Source: fieldwork, 2016.

4.10.1 Reasons for Patronizing Family Planning

Approximately 32% of participants reported that their choice of family planning utilization was because they were getting older. About 24% and 25% of the respondents used family planning services as a result of peer and family influence.
4.10.2 Reasons for Not Patronizing Family Planning

A higher percentage (31%) of those who revealed that they do not utilize family planning services indicated that, children are God’s blessings and that children comes from God, therefore, they are not prepared to restrain them from coming. About 22% said that they are still young to give birth. Complain's from other colleagues who have utilized the family planning services had influence on about 17% of the respondents.
4.10.3 Type of Family Planning Services Utilized

A lot of women (40%) turn-out to utilize injectable. Also, about thirty-five (35%) of the women used pills as a family planning. A number of them, about 13% and 9% said they used condoms during sex or better still abstain from sex. Only about 0.7% practiced Diaphragm.
Figure 4.12 Type of Family Planning Services Utilized

4.10.4 Level of satisfaction of family planning services for respondents

The study revealed that majority (45%) of the respondents stated that they were satisfied with the family planning services. Only 9% said that they were not satisfied with the family planning services.
During a focus group discussion of some of the participants in the study area one of the respondents reported as follow:

“I am satisfied with the family planning services rendered at the CHIP because I never knew that family planning was a good method in poverty alleviation but as a result of the education at the CHPS I got to realized that planning your family well through birth spacing as help reduce poverty. Thanks to Madam Agnes”. Source :(Madam Atipoga 36 year old woman at Bongo)

Another participant in a different focus group discussion disclosed that:

“The nurses in the community talk about FP and its benefits a lot. If you go to the CHPS compound, the (CHO) talks to you about FP. They sometimes come to talk about FP through durbars in the community “. Source: (Madam Reer, a 31 year old woman CHPS center). She also indicated as follows:
“When we go for child welfare clinic, the nurses educate us that when we breast feed the children, the breast milk contains nutrients and water, so we should do exclusive breastfeeding for six (6) months which is also a form of natural FP for the mother.”

This finding supported that of Ziblim, (2014) that the CHPS have played a vital role in educating women in most rural communities in Ghana especially with regards to maternal and child health and family planning related issues.

4.11 Knowledge of family planning

The participants elaborated some benefits of family planning through the knowledge they have acquired.

“FP has helped us to space our children and also provide them with quality education. It has also improved our productivity since we get time to do our work on time, so it is good”- (A woman, FGD in a community with CHPS).

“For me, I gave birth to three children and became pregnant in less than two years. I later discussed with my husband about FP. He embraced the idea and went to the clinic with me. In the clinic, we were given many options, we were also enlightened on their positives and negatives, and we told her we wanted one that would be for a long time hence, we finally chose the Norplant for 5 years. We wanted another boy so I went to remove it and I got pregnant. Even though I was scared that something could happen to me but nothing happened, the only thing is that I kept on some small weight, which made me look very nice and God being so good I had my baby boy. After giving birth to that boy we just told the doctor that we have 5 children so he
should ‘cut me’ (tubal ligation) so I wouldn’t make any more babies again which he did” - (Madam Gee, FGD in a community with CHPS).

4.12 Physical, geographical and sociocultural Barriers to FP services and patronage

From the focus group discussion, a lot of factors that hinders patronage of family planning emerged. These were grouped under socio-cultural barriers, geographic and physical barriers.

4.12.1 Socio-cultural barriers

It is believed that certain cultural beliefs and norms prevent couples from utilizing family planning services. From the focus group discussion, misconceptions about family planning and its side effects of contraceptives were identified as barriers to family planning patronage.

“I know of a woman who did it (FP) and stopped menstruating, later on it developed into fibroid and ended up in surgery” - (Mr. Tooa, FGD in a community).

“Every drug has its way of working, but my observation is that majority of the clients do not get their monthly menstrual flow due to the mechanism of action of the drugs. The women therefore feel that the lack of monthly menses can cause fibroid or block their tubes and prevent them from having children in future” - (A male CHO, IDI in a community CHPS).

“My elder sister went to do the implant and she changed drastically, that is, first, she was fat but after doing the FP, she grew very lean. Because of what happened, my mother asked her to stop the FP and as soon as she stopped the FP, she gained her weight back” - (Miss ier, FGD).
4.12.1 Physical Barriers

Majority of the participants relates the low patronage to cost of the family planning services. Inadequate counseling, correct method used and failure to differentiate between myths and facts on family planning, shortage of family planning methods was elaborated as one of the barriers to family planning patronage.

“I went to the clinic one day with my husband to enquire about the family planning services rendered in the clinic and their side effect. Then, it was a big problem, because the CHO could not speak my language and I did not also trust the translation made by the CHV, since I know very well that he only dropped out of school at the JHS, and because of that we went back home without using any of the family planning methods” (Madam Vee, fGD)

4.12.2 Side effects of FP methods

Just as we have for other medications, hormonal based contraceptives have some adverse reactions when taken by some individuals but this was often over generalized. This was reported as one of factors preventing most women from using contraceptives. Some of the common side effects that respondents reported were headache (margarine), excessive bleeding (menorrhagia), palpitations and dizziness. In principle, not every woman who uses the hormonal contraceptive methods experience these adverse reactions instigated a general perception in the community that all contraceptives except condoms have side effects.

“My wife tried the pills and it affected her seriously, she complained about heart (palpitation) and waist problems, so many people are scared” (Mr. Paul a 43 year old farmer in Bongo).
“In fact, my friend’s wife who was on FP also complained that anytime she takes the pills she gets palpitations. So she stopped taking the pills and went back after 2 years but still she feels very weak and complains of heartaches, so I have decided that I would let her give birth to another child after which we would go in for a permanent method through surgery”- (Mr. Jeea, FGD in a community with functioning CHPS).

“I know someone who has done FP before and after she stopped using it, she is struggling to become pregnant again”- (Madam Leeg, FGD in a community with no CHPS).

“In fact, as for the condom we should not talk about it because when I use it I don’t enjoy the sex as going raw, it is a rubber. The condom is not nice at all for sex”- (Mr. Neer, FGD in a CHPS).

Hmm nurse, I don’t know what is happening to me sometimes when I swallow the pills I feel like vomiting, and this makes me uncomfortable, hence I feel like discontinuing it. (Madam Aeey in an IDI).

4.13 Attitude of CHO\'s and CHVS towards People Who go to CHPS Center for FP Services

This section of the results was purely qualitative, here in-depth interviews were held with the Community Health Officers and the various Community Health Volunteers in the various selected CHPS to ascertain their views or otherwise of their attitude towards their clients at the facility. This was done to cross check the responses the people gave especially the women who attend the CHPS for their health needs.
“Hmm, as for me, I like the nurse and the way she does her things, she shows us respect and make us feel like human beings, she advices us on how to live a healthy life to prevent illness and also treat us well when we are sick” (Madam Udeeo in an IDI).

“I know it is for our health sake that this clinic is in existence, but what I don’t understand is how the nurse treats us, in fact, she does not regard us as human beings and because of this we find it difficult to approach her for family planning services” (Madam lwoo in a FGD).

“I think the nurse is so nice, she visits us at home, and when she comes she eats whatever we eat, in fact she love children a lot” (Mr Neer in an IDI).

“I don’t know if the volunteer is a nurse, but I think he is doing well, she normally educate us on issues like child welfare clinic, immunizations, family planning etc, and do visit us in our homes to encourage us to wash our hands well before eating” (Madam Q in a FGD).

“The clinic is good for us, it is near us and we can even go there, but why should they put only females there, sometimes we the men find it difficult to discuss sexuality issues with the female nurses” (Mr Jeea in a FGD).
“Language barrier affects the patronage of family planning services at the CHPS, CHO's who are proficient in the local (Gurene/booni) dialect have an upper hand of educating and counseling couples on family planning methods and their side effects better than CHO's who are not proficient in the local dialect.” (MR FEER a CHV IN AN IDI).

4.14 Male involvement in family planning

The focus group discussion with women outlined varied views on the level of male involvement and participation in family planning programmes. Some women indicated that their husbands have embraced family planning, while others stated that their husbands despise family planning. Generally, women from communities with functioning CHPS indicated that their men were becoming more aware of family planning and approving of family planning use than their counterparts from communities without functioning CHPS.

“My husband is 100% support of me to do FP, and I have used FP for almost four years now and he has even advised that I should go in for a 10 years long method if any”—(Madam teer, FGD in community with functioning CHPS).

“Before I started using FP I went to the clinic with my husband and the nurse educated us on the different FP methods for us to choose that we thought would be convenient for us and since that time, he has been encouraging me”—(Madam Cooa, FGD in a community with functioning CHPS).
“My husband keeps reminding me about review dates when I forget and any time we think I am not safe because I have missed a pill, we do use a condom or abstain” - (A woman, FGD in a community with functioning CHPS).

“I think we men are beginning to appreciate the importance of FP we those who practice it are now more than those who do not like it. More men are beginning to like FP now because they, say that life is difficult, hence many would like to space their children as well as give birth to less children” - (Mr. sheer, FGD in a community with CHPS).

“The men who have knowledge on FP are very helpful, if you have FP knowledge and you do not educate others on what you know, it is not good. In fact, one family should not have more than three children in one room because when the room is too congested, it can bring about diseases. In my area, those who have knowledge on FP tend to be very helpful, sometimes they bring teachers and midwives/nurses to the churches to give us health education on the benefits of FP” - (Mr Vooa, FGD in a community with functioning CHPS).

I and my wife had five (5) children 3girls and 2 boys, in fact I had wanted another boy but unfortunately my wife gave birth to another girl who died after one month, I later thought of it concerning the children upkeep and then, I sat with my wife and had a discussion with her on the need for FP to preserve our strength to take care of the children we already have. This is important so that our children would grow to
become better than us. So that was how I supported my wife”- (Mr. Young, FGD in a community with CHPS).

“Most of the men think FP is not their responsibility to do, but it is only for women that is why many do not get involved”- (Madam Zeek, FGD in a community without CHPS).

“The men feel they are the head and decision makers and see us women as inferior to them, so you cannot tell them what is good for them”- (Madam, Fooa, GD in community with less functioning CHPS).

4.15 Community reaction and cohesion between men and women as a result of Family Planning patronage

Participants indicated that some community members disrespect and ridicule men who patronize FP. In order to avoid this humiliation, some couples are compelled to either do FP in secret or stay away from it.

“In my community they like to gossip especially about people who are using FP methods, especially men who allow their wives to use family planning they say they are not men enough. low self-esteem is also a challenge since some shy away from accessing family planning at the service centers because they would be seen by their neighbors, some hide their cards from their spouse and family to avoid gossips”- (Mr Deo, A male CHV).
“We the men in our community are of the opinion that endorsing the use of family planning methods was a slap to our authority, as this amounts to giving power to our wives, retorted” (Mr Aao a male respondent).

“In fact, I think we need more education on FP, as custodians of the land think the government is trying to make women dictate to us on the number of children to have (Chief).

“Women who use contraceptives become promiscuous because when you go and have sex with another man, they will not become pregnant. So if you encourage your wife to do FP you are encouraging her to become promiscuous which is a taboo in our culture”- (Mr Ceo, FGD in community without CHPS).
CHAPTER FIVE

5.0 DISCUSSION OF THE STUDY RESULTS

5.1 Introduction

This chapter further discusses the study results presented in chapter four. It gives a detailed and vivid explanation of the study results. The discussions were done in line with the socio-demographic characteristics and the study objectives.

5.2 Age distribution

Table 4.1 presents the socio-demographic characteristics such as age, education, marital status, sex, religious background and all the things that influences health seeking behavior. Age distribution of respondents. The highest age group captured from the results was found to be in 24-31 years age bracket, this is so because out of 263 respondents, 89 of them were between the ages of 24 and 3. This was not surprising as the topic was dealing with people in the reproductive age group. However, the average age of respondents was 32 years.

5.3 Sex Distribution

The results revealed that, majority of the respondents were women, this was so because in matters of health issues women dominates taking into accounts their biological make up and for the fact that they take care of children in most rural setting. It was clear from the study that most women in the study district visit the health facility for several seasons. Some of them reported that they visit the CHPs for the following: antenatal, child welfare, family planning related issues and to them this
is mostly done by the women. This finding support that of Ziblim (2014) that women patronize visiting health facility as compare to their male counterparts.

It was also revealed in an individual interview with Madam Tani the in charge of the CHPS in one of the communities. She reported as follows:

_In this community men fell reluctant to visit the facility. They are more into traditional medicine than that of the orthodox it is only the women who patronesses the facility. Even when I ask the women to come with their husbands for family planning counselling the men always refused. Hmmm for our men the least we stop talking about them the better._

### 5.4 Marital status of respondents

The study found that, polygamous type of marriage was common among the respondents. Thus, about 57% of the respondents were into polygamous-type marriage, and the remaining 43% were into monogamous-type of marriage. The study observed that majority of the men married more than one wives because of their beliefs systems. Also some of the men held the view that women serve as their farm hands and for that matter if you have only one wife you will have a limited farm labour and that there will be much pressure on you during the farming season.

_As reported by Mr. Stephen, I have three wives. I married them so that they can help me in my farming activities. My brother, all their children are helping me in the farm and their mother too are always with me in the farm. Is that not good._

This finding resonate the study by Awudobar, (2004) that polygamy is good for the people in the hinterland because the women serves as farm hands to their husbands.
5.5 Educational background of respondents

Education is play an important role when it comes to health issues especially visiting health facilities for health check and family planning related issues. The study found out that majority (38.4) of the respondents were not having even the basic primary education. This has a serious implication on the health seeking behavior of the people. This finding resonates in Ziblim (2015) which states that education has a great influence on the health seeking behavior of people. The study also revealed that people with basic education turns to go to the facility for family planning counseling as compare to those without basic education.

In an individual interview with the charge of the Dua CHPS she reported as follows:

Almost all those who come to this facility for family planning have some level of formal education at least JHS leavers. They understand the important of population pressure and they want to give their children the best education, in achieving this they turn to reduce the number of children and rather invest on the education of the few that they have. Source: (Madam Asibi, the in charge of Dua CHPS in the Bongo District)

The finding also supports that of Rodrigues el at (2000) that the most consistently found determinant of reproductive health service utilization is a woman’s level of educational attainment.

With regards to religious affiliation, the study found out that Christians formed the majority (63%) and Muslims (27) and traditionalist (10). The study also found out that most of the people were combining traditional religion with that of Christianity.
and Islam. The study also found that the few Muslims do not adhere to the use of family planning. When asked they reported that is against their religious beliefs. In a focus group discussion one of the participants indicated as follows: I am a Muslim. And it is against my religion to practice and use family planning. We see children as gift from Allah (God) so there is no need to prevent yourself from a gift from Allah. For this reason, we do not even discuss family planning issues in our home. Source: (Fati a 32 year old Muslim woman from Zorko).

In an individual interview with Mr. Atinga an elder of the Catholic Church at Banaa also reported a similar thing. He reported that, it is a big sin to a catholic to use or practice family planning. To him practicing family planning is equal to committing abortion. Source : ( Mr. Atinga an elder of the Catholic Church). This study supported that of Sirina (2016) that family planning is a sin to Muslims and that who so ever practice it is not a believer.

5.6 Service Delivered by CHPS

The CHPS play an important role in delivering effective and efficient health services to the people especially those in the hinterlands. The basic services delivered by the CHPS include the following. Family planning services, immunization, ante natal services, health education, treatment of minor illnesses, case detection and referrals and education on nutritional status especially children and pregnant mothers.

For the various services rendered by the CHPS, this study focus much on the family planning because literature revealed that population growth is very high in the upper east region as compare to the other regions and the Bongo district is one of the district
with high population growth, GDHS, (2008). This study therefore tries to find out if
the family planning component is well executed in the various CHPS in the Bongo
district and if not what are the challenges militating against their effective and
efficient execution of their core mandate especially with that of the family planning.

The study revealed that the CHPS are more into ante natal and child welfare service
delivery and less attention is given to family planning issues. The records at the
selected CHPS revealed that out of the total attendance to the facility about 68% of
the clients are visiting the facility for ante natal and child welfare services, while only
13 % visit the facility for family planning, 10 % for case detection and 9 % for health
education.

The study further found out that the people are not interested in family planning
services as some of them attributed it to religious beliefs as indicated in chapter four
on the link between religion and family planning utilization on the socio demographic
characteristics of the respondents.

During a focus group discussion on of the participants indicated as follows:

“*My children are my wealth, for that reason if family planning is about me having*
*more children then I will be the first person to go in for that but to help me reduce the*
*number children that I have I will never go in for it. That is why most of us hear do*
*not want to hear the name family planning.*” (Agamolga, a 32-year-old woman at
Dua in the Bongo district).
5.7 Attitude of the Health Workers at the Various CHPS

The study revealed that the health workers at the various CHPS are doing very well. Their attitudes towards their clients are good. The respondents reported that the health workers at the selected CHPS are doing very well in improving the health status of the people. They indicated that they accommodative, patience and above all God fearing people. Some of the respondents indicated that the nurses at the facilities are respectful that they always advise them on how to live a healthy lives and also make their environment clean.

In a focus group discussion one of the participant reported as follows:

“The nurses at the CHPS are specially trained. They do not behave like those at the Bongo clinic who always insult pregnant women. Especially when your dress is not neat. At the CHPS even if you make a mistake the nurses there will know how to put it. I will have wish the same training should be given to those at the clinics. Those at the CHPS are very good. They treat us as if we are their own sisters or mother. Their attitudes always encouraged me to attend the facility when is due for me to attend. They are wonderful”.

This finding resonate the findings of Ziblim (2014) that pregnant women prefer to be attended to by traditional birth attendants to the skill attendants due the fact that the nurses at the modern health facilities insults and sometime beat the up when they are in labor.

5.8 Financial and Geographical Accessibility of the CHPS

Access is an important indicator when it comes to the health needs of the people especially the in rural areas of Ghana. It is therefore important that in order to achieve
the Sustainable Development Goals (SDGs) on health access to health facility should be an important indicator.

Even though the CHPS have help in bringing health care to the door steps of the people as indicated by Ziblim (2014), people are still facing the problem with distance. The study indicated that some people travel more than 3 km to access the CHPS. The respondents reported that the facility is good but walking for such a distance is a big challenge to them.

With regards to financial accessibility the respondent did not face much challenge as they indicated that most of the services rendered at the CHPS are mostly free. But they were quick to mention that some of them face the problem of transportation cost.

5.9 Attitudes of men to family planning

Family planning is not a one person’s decision especially when dealing with marriage couples. It is a joint decision between the man and the woman. It will not be the best if one of them accepted to use family planning whiles the other refuses. This study therefore tries to also find out the involvement of men or husbands in family planning decision making and also to find out if men approves the use or the practice of family planning by their wives.

Some studies have shown that majority of men in the northern region of Ghana do not approve the use of family planning by their wives. Example Sirina, (2016) indicated most men are not ready to accept family planning practice by their wives.
This study revealed that some men support and approve the use of family planning methods by their wives, but majority of the men does not approve the use of family planning. Some of the men will not even want to hear the term family planning let alone to practice it. To them it is against their religious beliefs. The study also indicated that most men will not want their spouse to use family planning because the children are their assets and farm hands.

5.10 Challenges the CHPS Face in Carrying out their Mandate.

The study also tried to find out the challenges that the CHPS compounds were facing in the district that hinder their ability to conduct their work effectively. The following challenges stemmed out from the study:

The nurses in some of the CHPS reported that electricity was one of their major problem. It was indicated in the strategy for the CHPS that water, electricity and motor bikes were part of the logistics plan before the commencement of any CHPS compound but the reality on the ground is that some of the CHPS do not have electricity. This according to the health worker is a big hindrance to their work. Some of the community health nurses even reported that they are compelled to use flashlight for delivery.

Another important challenge mentioned by the health workers was water. Most of the CHPS visited during the study were lacking good and clean drinking water. To them water is live and since they cannot access it, it makes their work very difficult. That pregnant women during labour have forced to visit the facility with water.
The changes in almost all the facilities visited reported that they did not have cold chain facility where drugs for treatment could be preserved. To them it is a challenge in preserving their drugs. They reported that lack of cold chain facility leads to a lot of losses in the system. In an individual interview with Madam Tani she reported as follows:

*My biggest problem in this facility is lack of cold chain where we can preserve drugs in the facility meant for treatment. Hmm! I am worried especially any time drugs are given to me. In this community there is no electricity, no water and above all there is no accommodation for the staff. During the rainy reason we face a lot of problems that has even made some of the staff to be staying far from the facility. I cannot blame them because their health too is important. We need a good place to sleep so that we can work effectively.*

The fact that these facilities are not available in most of the CHPS is an indication of a failure on the part of those implementing it. If you read the strategies for the implementation of the CHPS all these are to be provided.

Another important problem the study came out with was that some of the facilities were lacking skill delivery personnel. Some of the nurses were not skillful enough to conduct skill delivery.

Also there study revealed that almost all the facilities selected for the study were constrained financially. This was as a result of the fact that they were not having their own independent budget as stated in the strategic plan for the implementation of the CHPS strategy.
CHAPTER SIX

6.0 Conclusion and Recommendation

6.1 Introduction.

This chapter presents summary of the key findings, conclusion and policy recommendation that will enhance effective and efficient operation of the CHPs in the Bongo district and beyond.

This thesis aimed at contributing to the emerging body of knowledge about the activities of the CHPS and their relationship to family planning services in the Bongo district of the upper east region of Ghana. Several studies for example Ziblim, (2014), SEND GHANA, (2013,) have so far given attention primarily to the contribution of the CHPS to health delivery system in Ghana.

The introduction of the CHPS by the Ghana health services has received a lot of attention and commendation by all governments, Traditional authorities, and stakeholders as well as health policy planners in Ghana and beyond. It has been envisage as a measure to bridge the health gap between the hinterland and the urban areas. The strategy since its commencement has increased access to healthcare and has improved health outcomes. There are several empirical evidence indicating that where the CHPS programme has properly been manage and implemented family planning issue have been improved and that of infant and maternal mortality have reduced drastically. Also the implementation of the CHPS has contributed tremendously to improve the life of the rural people especially with regard to their health issues, especially in the field of preventive health care and family planning related issues as well as health education.
For the CHPS to achieve its stated mandate, there is the need to give practical meaning to the policy strategies and objectives. The mere establishing of CHPS compound in communities without the corresponding provisions of the needed logistics, motivations, and the skills require for an effective and efficient healthcare delivery system that addresses demand side constrains will likely lead to regressive health outcomes.

6.2 Summary of Key Findings

The study revealed the following key finding:

The study revealed that majority of people in Bongo district who patronize family services at the CHPS were women in their reproductive age group.

The findings also showed that 64% were married while few of them were single. This is in accordance with Awedoba, (2009) that young girls in most rural communities in the upper east region marry at a very young age.

It was envisaged from the study that majority of men in the selected communities did not support and practice family planning due to cultural and religious beliefs and that it is a taboo to practice family planning. This study resonates that of Ziblim (2014) which states that traditional religion practice taboos the use and practice of family planning.

The study indicated that the community health officers working at the various CHPS are accommodative and understand problems of the community members. some of the respondents concluded that they the CHO in the CHPS are far better than those at
the clinic in the district capital. They reported that the CHOs are accommodative and very helpful as compare to those at the clinics.

With regards to the educational status of the respondents, the study reported that 38% of the respondents had no basic education, 23% had primary education whiles 12% completed JHS. This illustrate why majority of the people did not have idea about family planning and modern contraceptives. Because the topic had to do with family planning of which women are directly involved, for this reason majority of the respondents were women.

According to the respondents, they had information about family planning at the CHPS compounds and few of them heard of it from the radio and some from the NGOs operating in the areas. It was also revealed that the people could not tell the actual services rendered by the CHPS some of them said the facility was their hospital and could not decipher CHPS from hospital.

The challenges according to some of the respondents was about the distance they walk before accessing the CHPS. Some of them reported that they travelled more than 5 km before they can have access to the facility.

The study also indicated the CHPS face series of challenges such as, lack of logistics, poor accommodation for health staff, lack of electricity and lack of the cold chain system. Also, ignorance was said to be an important challenge in accessing CHPS as some of the respondents held the view that they need to pay before accessing family planning education and any related services at the CHPS.
The study further revealed that respondent’s knowledge about family planning was limited and some were very low. This therefore presuppose that much education on family planning and the activities of the CHPS need to be intensify.

6.3 RECOMMENDATION

The findings of the study have policy implications and therefore the thesis came out with the following recommendations for policy formulation that when implemented will help improve the activities of the CHPS in the Bongo district and Ghana as a whole:

The community health workers (CHOs) who do not have midwifery skills be trained by the Ghana health Service to enable them to perform emergency delivery when the need arises. This will help pregnant women travelling to the district capital to access the delivery service. This in addition will help in the supervision of traditional birth attendants (TBAs) when the CHO has the required skills to do so. This can be done through in-service training and attachment to other midwives.

Men in the district should be encourage to take part in family planning education. This can be done with the help of the district assembly with the help of the Ghana health service. The men should be educated to know that family planning is not for the women alone but rather is a joint and collective action and decision by both men and the women.

Also, government as a matter of urgency should increase the budgetary allocation and disbursement to the health sector and also ensure that funds are transferred to the various districts as well as the Sub District Health Management Teams (SDHMT).
The Ghana Health Service should ensure that they take a second look at the issue of management of impress and address the challenges of capacity constraints rather than discontinuing with the practice of advancing impress to community health officers (CHOs).

Family planning education should be an important component of the CHPS strategy. In doing this, traditional rulers and all opinion leaders in the area should be actively involved so that issues with traditional beliefs systems that prevent the people from practicing family planning will be tabled and address. This is so because in spite of the strong community participation, there is still the need GHS and the community to motivate community health volunteers in the form of logistics and encouragement. Also the GHS should introduce a reword system to couple who patronize and accept family planning as a developmental issue in their homes.

Furthermore, the GHS in collaboration of the various district assemblies should see to be that the communities where the CHPS are allocated cold chain facilities should be provided to prevent CHO travelling to the district capital for medication especially for immunization.

Government should also see to it that the CHPS compound are evenly distributed to address the issue of geographical accessibility. The fact that people travel for more than five kilometers to access basic health services serve as a challenge in achieving the sustainable development goals four and five. Then also more education should be given to the people especially those in the rural areas that the family planning services are free and not for a fee.
Motivation should be given to the health workers who accept posting the CHPS facilities. This the government can do by proving an enabling environment for them to live comfortably and work effectively.

This study realized that most of the health officers at the CHPS are working under very poor conditions which made most of them to run to the district capital thereby vacating the CHPS. If this is done the workers will be compelled to stay with the people thereby understanding them and their customs and tradition and hence help to conduct an effective and efficient health education to the people.
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LIST OF APPENDICE

APPENIX A: QUESTIONNAIRE

UNIVERSITY FOR DEVELOPMENT STUDIES

QUESTIONNAIRE ON

Assessing the impact of Community-based health planning services (CHPS) and family planning services in the Bongo District of the Upper East Region-Ghana.

Introduction

My Name is Irene Ngeh, a student from the University of Development Studies (UDS)-Tamale, is currently conducting a research on “Assessing the patronage of family planning services at the community-based health planning services (CHPS) in the Bongo District of the Upper East Region-Ghana”. This questionnaire is designed as part of my research work in partial fulfillment for the award of Master of Philosophy Degree in community health and development. All information in this questionnaire will be treated strictly confidential and would be used for scientific purposes only. Your participation is voluntary but I would be grateful if you could allow 15-20 minutes of your time to complete this questionnaire.
SECTION A: Respondent’s Socio-Demographic Characteristics

1. How old are you? ..................................................

2. Sex distribution
   a. Male
   b. Female

3. What is your current marital status?
   a. Single
   b. Married
   c. Divorced
   d. Widowed

4. If married, how many years have you been married? ----------------

5. Number of people in the household:-----------

6. Level of education:
   a. No formal education
   b. Primary c. Middle school/JHS
   c. Vocational/Technical/SHS/O’level/A’level
7. Ethnicity: .............................

8. What is your religious affiliation? ..............................................

9. What is your main occupation? ..........................

10. What is your monthly income?

11. How many women are you or your spouse married to?

12. At what age did you give birth to your first child? .................

13. How many children do you have?

14. What is the spacing in terms of age difference between your children?

............................

(1) What is the ideology of you or your spouse extended family on child bearing?

a. They need more children [ ] b. They need few children [ ] c. Others (specify)

.........................

SECTION B: The CHPS concept

15. Have you ever heard of CHPS? a. Yes [ ] b. No [ ]

16. If yes, from which source of information have you heard of CHPS?

a. Community Health Officers/nurse [ ] b. NGO [ ] c. Radio [ ] d.
Television [ ] d. District Assembly [ ] e. Community Health Volunteer [ ]

f. Family member [ ] g. Friend [ ] h. Others (specify)…………………………

17. For how many years have you known CHPS in your community? -------

18. Are you aware of the services that CHPS provides? a. Yes [ ] b. No [ ]

19. If yes, please list some of them:

a. Provision of Primary Health care [ ]

b. Detect early cases of sickness [ ]

c. Provision of education on nutrition [ ]

d. Provision of education on primary health care [ ]

e. Provision of education on STIs [ ]

f. Provision of Skilled Birth Attendant [ ]

g. Sanitation [ ]

h. Family planning [ ]

20. In the past few years, have you or any member of your household visited CHPS for any services?

a. Yes [ ] b. No [ ]
21. If yes, what type of service (s) did you or any member of your household received?

........................................................................................................................................

........................................................................................................................................

SECTION C: Challenges of the CHPS

22. Indicate how the following problems affect you. Rank 1 = not severe 2 = severe 3 =

Extremely severe

Challenges Rank

Undemocratic decision making processes

Community not involved

Only a few people are consulted in the community

The programs are designed outside the community

The community meetings are limited to a few people

Low female representation in committee

Lack of external support
SECTION D: Family Planning and Health

23. Have you heard about family planning? a. Yes [ ] b. No [ ]

24. When we say family planning, what do we mean?

a. For spacing children [ ] b. Limiting and treating infertility [ ] c. Others (specify)

……………………………………………………………………..

25. Where did you hear about family planning?

a. CHPS health worker [ ] b. Radio [ ] c. Television [ ] d. Work place [ ]

e. Community forum [ ] f. Friend [ ] g. Family member [ ]

26. Do you have knowledge on family planning methods? a. Yes [ ] b. No [ ]

27. Have you ever patronized family planning services? a. Yes [ ] b. No [ ]

28. Are you currently using any family planning services? a. Yes [ ] b. No [ ]

29. If yes, why did you patronize family planning?

a. Busy doing work [ ]

b. I’m getting old to give birth [ ]

c. I have maternal health problems [ ]
d. Pressure from the extended family [ ]

e. My age mates were all doing some [ ]

f. Others (specify)

…………………………………………………………………………………………………………………………

30. If no, why have you not patronized family planning?

a. It’s a waste of time [ ]

b. It’s expensive [ ]

c. I think it’s not safe for me [ ]

d. More children are God’s blessing for my family [ ]

e. My other colleagues who have accessed some are complaining that it’s not good for them [ ]

f. I’m still young to give birth [ ]

g. I know of many women who have many children but did not do family planning [ ]

h. Some people does family planning and stop menstruating [ ]

i. I think if I stop using family planning I would not be able to give birth again [ ]
j. Others (Specify)……………………………………

31. What type of family planning services did you accessed?

a. Injectable [ ] b. Pill [ ] c. Diaphragm [ ] d. Vasectomy [ ]

e. Condoms [ ] f. Periodic abstinence g.

Please list as many for the respondents

32. For how long have you been accessing the family planning services?

………………………………

33. Who influenced you to patronize family planning?

a. CHO/nurse/volunteer [ ] b. Spouse [ ] c. Family member [ ] d. NGO [ ]

e. Myself [ ] f. Friend [ ] g. Others (specify)………………………………

34. What is your spouse opinion about family planning?

…………………………………………………………………………………………

35. Who takes decisions in the home especially pertaining to the number of children to have, when to have them and at what interval?

a. Men and family head [ ]

b. Women
C. other specify

36. Please tell me, what happens if only men take decisions alone in the family?

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

37. Does your spouse think family planning is his/her responsibility? a. Yes [ ] b. No [ ]

38. What do you think is ideal family size? Why?

a. Based on financial reason [ ]……. …......................

b. Social reasons [ ].................................

c. Economic status [ ].................................

d. Religious ideology [ ].................................

39. What role (s) does your spouse play in family planning?

→ Visit the community nurse together for advice [ ]

→ Remind me of the date/time that my family planning is due [ ]

→ Others (specify) .................................................................

40. Please rate the satisfaction in terms of the family planning services you are using:
SECTION C: CHPS Workers Attitudes towards people in accessing family planning services

41. Did you receive the health care services that you went for? a. Yes [ ] b. No [ ]

42. Did you waited a reasonable time before you were attended to by the health workers? 
   a. Yes [ ] b. No [ ]

43. Was the service provider friendly to you? a. Yes [ ] b. No [ ]

44. Are the health workers non-discriminatory? a. Yes [ ] b. No [ ]

45. Have you been assaulted verbally or physically by a CHPS worker in accessing family planning? 
   a. Yes [ ] b. No [ ]

46. Was the information given by the CHPS worker on family planning during your visit adequate and clear? 
   a. Yes [ ] b. No [ ]

47. Did the CHPS worker respect your privacy during your visit for the family planning? a. Yes [ ]
48. Have you ever been denied access to any health care services by a CHPS worker?
   a. Yes [ ] b. No [ ]

49. Overall, did you feel you were part of the discussion on family planning? a. Yes [ ] b. No [ ]

50. How would rate the effectiveness of the services of CHPS health providers
   a. Very effective [ ] b. Effective [ ] c. moderately effective [ ] d. Not effective [ ]

SECTION E: Attitudes of Men towards family planning

51. Does your husband support family planning? a. Yes [ ] b. No [ ]

52. Have you ever been insulted or beaten by husband on your plans to access family planning?
   a. Yes [ ] b. No [ ]

53. Has your husband ever reported you to any person on your plans to access family planning?
   a. Yes [ ] b. No [ ]

54. If yes, whom did your husband report you to? ………………………………….
56. Has your husband ever said he will divorce you when you ever patronize family planning?

a. Yes [ ] b. No [ ]

57. What are some of the challenges you face in accessing family planning? Indicate which one is challenge to you.

**Challenges of Family planning**

- Inadequate method-mix
- Disapprove by spouse
- Lack of information about family planning
- Inadequate counseling
- The cost of the methods
- Shortages of methods
- Others (specify)
APPENDIX B. FOCUS GROUP DISCUSSION GUIDE

FGD Interview Guide:

1. Are you aware of the CHPS if yes what services are they rendering in this community?
2. How did you learn about CHPS?
3. What are your views about the CHPS programme?
4. What is good about the CHPS programme?
5. How has the CHPS programme affected your access to health?
6. Do you know the kind of services provided by the CHPS?
7. Is family planning part of the services rendered by the CHPS?
8. Do you think family planning is good for your community people?
9. What in your own opinion are some of the factors that prevent people from patronising family planning?
10. What do you think can be done to motivate people to patronise family planning services?
11. Are you well received when you visit the CHPS to obtain health care services?
12. Do you get satisfied with the service delivered to you?
13. What are the common complains or reasons as to why people do not visit the CHPS for family planning services?
14. Can you please enumerate the challenges the CHPS are facing in this community?
APPENDIX C: INDIVIDUAL INTERVIEW GUIDE

Interview Guide for men and women who have utilized family planning

1. Can you please explain your experience visiting the CHPS for health care delivery especially family planning services?

2. Where you treated well?

3. Did the nurses explain in details to your understanding the various types of family planning services available

4. What is your spouse reaction to your usage of family planning services?

5. How do you feel when you use family planning products

6. At the CHPS, did you have the opportunity to choose from variety of family planning services

7. In your community, do you have any taboos against family planning?

8. How have your friends influenced your decision to practice family planning

9. Do you think the CHPS compound is beneficial to your community?

10. What is the benefit of family planning to you and your community?

11. What do you suggest can be done to improve family planning services in the community?