UNIVERSITY FOR DEVELOPMENT STUDIES

DETERMINANTS OF UPTAKE OF FAMILY PLANNING SERVICES IN THE NINGOPRAMPRAM DISTRICT, GHANA

BERNARD BLESS AYELLAH (B.Ed. Health Sciences)

(UDS/CHD/0062/12)

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

FEBRUARY, 2017
DECLARATION

Student

I hereby declare that this thesis is the result of my own original work and that no part of it has been presented for another degree in this university or elsewhere:

Candidate’s signature........................................ Date........................................

Name: BERNARD BLESS AVELLAH

Supervisor’s

I hereby declare that the preparation and presentation of the dissertation were supervised in accordance with the guidelines on supervision of thesis laid down by the University for Development Studies:

Supervisor’s Signature:........................................ Date:........................................

Name: DR. BENSON KONLAAN (PhD)
ABSTRACT

Use of family planning services improves maternal and child health. This study was conducted in the Ningo-Prampram District to assess the determinants of the uptake of family planning services. A community-based cross-sectional analytical study was conducted. The sample included 30 family planning service providers and 415 women in the reproductive age group of (15 – 49 years). Both qualitative and quantitative methods were used in the data collection. Two-stage sampling procedure was used to select 30 communities in the district.

In each of the study communities, 15 women were interviewed using a structured questionnaire whilst 10 women who were not interviewed with a structured questionnaire were engaged in focus group discussion. The contraception prevalence rate (CPR) was 15.4%. Regression analysis showed that the uptake of modern family planning methods was associated with the ability of women to discuss their health issues with service providers (OR = 1.10, 95% CI: 1.9- 2.4, P < 0.001), household wealth index (OR = 2.70, CI: 1.7- 4.4, P < 0.001), number of daughters a woman have (OR= 0.471, 95% CI: 0.31-0.72, P < 0.001) and maternal autonomy (OR= 1.413, 95% CI: 1.09-1.83, P < 0.009). Education level of husbands had a more positive effect on the uptake of family planning services, compared to that of their wives. Women’s education, economic empowerment or autonomy were significant determinants of the uptake of family planning services in the study population.

It is recommended that family planning service providers should freely avail themselves to women and encourage them to feel confident to discuss their health needs with them. Family planning behaviour change communication (BCC) that target both women and men should be strengthened in the district.
ACKNOWLEDGEMENTS

To God be the glory and honour for giving me the strength to defy all the odds and come out with a project of this nature. I wish to express my heartfelt gratitude to my supervisor; Dr Benson Konlaan for guiding me to conduct this study. Indeed he has been a pillar behind this work.

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Also to the former Dean of the School of Allied Health Sciences; Dr. Robert Kuganab-Lem who had an oversight supervision of the programme in the entire duration of my study.

I am again grateful to the District Director of Health Services of the Ningo-Prampram District and all the staff of the District Health Directorate for their support and co-operation during my data collection.
DEDICATION

To my family
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>CBD</td>
<td>Community-based distribution</td>
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<td>CHAG</td>
<td>Christian Health Association of Ghana</td>
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<td>CSM</td>
<td>Contraceptive Social Marketing</td>
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<td>DHMT</td>
<td>District Health Management Team</td>
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<td>FP</td>
<td>Family planning</td>
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<td>FPHP</td>
<td>Family Planning and Health Programme</td>
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<td>GDHS</td>
<td>Ghana Demographic and Health Survey</td>
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<td>GHS</td>
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<td>HIV</td>
<td>Human immune-Deficiency Virus</td>
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<td>IEC</td>
<td>Information-education-communication</td>
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<td>IUD</td>
<td>Intrauterine device</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>NGO</td>
<td>Nongovernmental organisation</td>
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<td>PPAG</td>
<td>Planned Parenthood Association of Ghana</td>
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<td>QA</td>
<td>Quality Assurance</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<td>RCHU</td>
<td>Reproductive and Child Health Unit</td>
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<td>SAS</td>
<td>Situation Analysis Study</td>
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<td>SPSS</td>
<td>Statistical Package for Social Sciences</td>
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<td>STI</td>
<td>Sexually transmitted infection</td>
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<td>FP</td>
<td>Family Planning</td>
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OPERATIONAL DEFINITION OF KEY TERMS

**Family planning:** is the system in which married couples space and decide on the number of children they want to have.

**Provider:** health professionals who work in the family planning unit and provide services to clients.

**Unmet need:** this involves fertile married couples who do not want to get pregnant but are not currently not using any contraceptive.

**Empathy:** Caring and individualized attention provided to clients.

**Maternal care:** Care provided at a health facility during antenatal, labour and delivery and postnatal period.

**Responsiveness:** Willingness of the providers to help clients and provide prompt service.

**Tangibles:** Physical facilities, equipment and appearance of personnel.

**Quality of care:** The extent to which health service for populations increased the likelihood of desired health outcomes and is consistent with current professional knowledge.

**Structure of quality:** It comprises care delivery systems includes community, individual, and provider characteristics associated with the likelihood of providing high quality care.

**Process of quality:** The process of care focuses on the content and method by which health providers deliver services.

**Outcome of quality:** Outcome is final aspect of quality of the care, which can Include clinical status, functional status, and satisfaction with care.
CHAPTER ONE
INTRODUCTION TO STUDY

1.1 Background to the Study

The history of family planning (FP) could be traced back to the 1920's when the first birth control clinic was established in the United Kingdom in 1921 by Marie Stopes International (Family Planning Association, 2011). In the 1930's, five separate birth control societies were formed to open clinics throughout England to make birth control services accessible to people. The slogan of these societies was “Children by choice, not chance” (UK Ministry of Health, 2003). The Alma Alta Declaration on Primary Health Care identified FP as one of the key strategies to achieve a better quality of life for all people (WHO and UNICEF, 1978). When FP carried out effectively, it is one surest way of reducing the maternal mortality ratio, high rates of infant and child morbidity and mortality and ultimately promoting optimum wellbeing of the whole family. Singh (1974, p.6) as cited by Stephenson et al (2008) reported that “Development is the best contraceptive,” which highlighted a change of thinking and the need for a more balanced approach to population control.

In Africa, FP concept is not a new idea in most African cultures. All countries have FP programs that are being funded by donors and the governments. According to Seltzer, (2002), FP programs occupy an unusual space in the public policy arena yet, FP programs are persistently controversial as they center or focus on birth control which is a sensitive subject and stirs strong views from religious, political, cultural and sometimes scientific perspective.
West Africa has one of the most rapidly growing populations in the world, and on average, women here have 5.7 births during their lifetimes (World Health Organization, 2013). West African countries have different health systems, levels of political commitment to family planning, and numbers and types of health care providers—all of which can contribute to differences in family planning use (Awusabo-Asare, 2009). In West Africa, approximately 13% of married women use some form of family planning (International Planned Parenthood Association, 2014). In recognition of the importance of family planning in every society, ministers of health in Africa adopted a framework in 2005-2014 for accelerated action to reposition family planning on national agenda and in reproductive health services (WHO, 2005).

In Ghana, FP services have been available since 1960 with the advent of the Planned Parenthood Association of Ghana (PPAG) and the formation of the Ghana National Family Planning Programme (Ghana Ministry of Health, 2004). However, low uptake of modern family planning services is one of the biggest challenges maternal health programmes face. This is as a result of pressures being put on the limited resources that are available for carrying out these programmes (Ghana Health Service, 2013). Low uptake of FP services has a negative impact on the nation as a whole because it leads to high fertility rates and which has a cascading effect on every sector of the country. Awusabo-Asare, (2010) opined that traditional beliefs, religious barriers, lack of male involvement, poor funding for FP programs and the low quality of FP services provision have weakened family planning interventions in Ghana, as well as in many developing countries. The Ghana Demographic and Health Survey (2014) established that the contraceptive prevalence rate for married
women is 22% for modern methods; while at the national level, 30% of women have an unmet need for family planning.

A study by Stephenson et al., (2007) on the service quality of contraceptives intimated that the distribution system of contraceptives from the national, regional, district to the health facility level is a factor that affects the quality of service. Caldwell and Caldwell (2002) also reported that to enhance the quality of FP services in health facilities, there should be a source of reliable water supply in the health facility and a functioning latrine. When the above mentioned variables or factors are available to service providers and the health facilities, it will ultimately lead to clients' satisfaction.

Taking cognizance of the afore mentioned variables of FP services quality, this study sought to assess the quality of FP services in the Ningo-Prampram, District of Ghana.

1.2 Statement of the problem

The Ningo-Prampram District which is located in the Greater Accra reported Region reports that the key challenges facing its health sector include inadequate staffing and poor staff attitude to work, heavy workload of existing staff, inadequate equipment and logistics, inadequate workspace at Heath Centres, Clinics and CHPS compounds (Ningo-Prampram District Assembly, 2014). Inadequate staffing increases the workload of available staff which leads to fatigue and poor staff attitude towards clients. This could affect the quality of service provision and reduce the uptake of services by clients. Furthermore, inadequate logistics and equipment reduces the work output of staff which goes to affect service uptake among clients. There were reported cases of shortage of some contraceptives commodities
(Depo-provera, Norigynon and Pills) in the Ningo-Prampram District (District Directorate Annual Report, 2014). Shortage of commodities could lead to low uptake of FP services and increase unintended pregnancies. FP service quality requires that women are able to access any method of their choice at any time they need it. Due to the challenges of the health sector in the district, CPR has been decreasing in the past three successive years thus 2012, 2013, and 2014. The CPR in 2012 was 42.4% and 34.6% in 2013. However, it decreased to 27.8% in 2014. This study therefore aims at assessing the determinants of FP services in the district and the contributory factors to the declining CPR.

1.3 Study Objectives

The objectives of the study are categorized into two thus general and specific objectives;

1.3.1 General Objective

The general objective of the study was to assess the determinants of family planning services in Ningo-Prampram District.

1.3.2 Specific Objectives

The study specifically sought;

1. To assess clients’ satisfaction with family planning services in the Ningo-Prampram District

2. To assess the competence, skills and practices of providers (quality of FP) towards the provision of family planning services in the Ningo-Prampram District

3. To establish the relationship between women economic, educational and empowerment status and the uptake of family planning services in the Ningo-Prampram District
4. To identify the factors that influence the uptake of family planning services among women in the Ningo-Prampram District

1.4 Justification of the study

The relationship between fertility and economic development is complex and often reciprocal – that is each affects the other – research in developing countries has shown that reducing fertility can yield economic benefits both at the household and national levels. Development is therefore intricately linked to fertility rates of countries. Since fertility rates can be reduced through birth control methods which has family planning as its pivot, it is therefore prudent that family planning services are made accessible and of high quality to increase their patronage. Little is known about the quality of FP services in the Ningo-Prampram District due to the paucity of data on the quality of family planning services even though there are reported downward trend of CPR.

The Ningo – Prampram district has over the years recorded consistently poor performance in the area of family planning coupled with high teenage pregnancies and increased population. However there has not been any study to find out why family planning has had very low coverage in the district.

No specific study has been conducted in the district to find out health facilities readiness and the competence of service providers in the provision of family planning.

1.5 Significance of the Study

Measuring the determinants of family planning services and explicating the potential barriers to contraceptive use represents an important step in promoting the effectiveness of a
strategy for improving their use. Factors identified through this study could be fed into reproductive health programs and guide the development of policies and programs for improving quality in family planning services.

For academic purposes, findings of this study when published will contribute to knowledge and literature on FP and quality of health services.

The results will also form a baseline for improving the quality of family planning services in the Ningo-Prampram and subsequently leading to reduced maternal mortalities.

It will therefore help the district to get a baseline data that will help to monitor and improve the quality of family planning services leading to improved coverage, low pregnancies and abortions and an overall improvement in the maternal mortality.

1.6 Conceptual Model

The study was conducted being guided by a conceptual framework of quality of services and the barriers to the uptake of family planning services. Figure 1.1 below is the conceptual framework of the study.
Barriers to uptake of FP

Affordability of services
Access to health facility (Distance)
Service Provider
Nature of health facility

Determinants of Family planning services

Service Receiver/client
Attitude of health workers
Socio-cultural factors (Beliefs and practices)
Socio demographic characteristics
Satisfaction with service

Increased uptake of FP services

Fig 1.1: Conceptual framework of the study

Source: Author
Service providers: The study considered the family planning service providers. The providers in the various health facilities in the district were interviewed. The qualification of the providers, the skills, and in-service training sessions which they attended were recorded. Again, the workload of the providers was assessed. This was done by considering the number of days and hours they work in a week.

Access to FP services: Accessibility to FP services has an influence on their uptake. The study considered economic accessibility, social accessibility and geographical accessibility. The availability of contraceptives commodities in the health facilities was assessed. The cost of the commodities and the approximate distance that clients have to travel to access the services were assessed.

Barriers to the uptake of FP services: Barriers to the uptake of FP services were assessed by the study. Both quantitative and qualitative methods were used to elicit the views of respondents on the barriers to the uptake of the services.

Socio demographic variables: the socio demographic characteristics of the clients were assessed. Earlier studies and Demographic and Health Surveys have shown the influence of socio demographic factors on the use of family planning services. The study therefore assessed the relationship between the uptake of FP services and socio demographic variables.

Client’s satisfaction with FP services: When FP services are of high quality, it will improve the uptake of the services. The study therefore assessed the level of client satisfaction with the services they receive from the health facilities.
1.7 Organization of the Thesis

This thesis has been presented or organized into six chapters thus IMRaD (Introduction, Methodology, Results and Discussions) and conclusion and recommendations.

Chapter one includes the introduction to the study, background to the study, the problem statement, the study objectives, the significance of the study, conceptual framework and the operational definition of terms of the study.

The second chapter reviewed relevant literature in relation to the study. The methodology, which is made up of the study design, study type, study variables (independent and dependent variables), data collection instruments, sampling procedure and sample size, study population, sources of data, data collection methods, determination of educational level, determination of household wealth index, determination of maternal autonomy, quality control measures, some ethical considerations as well as plan for dissemination of results are captured in the third chapter.

Results and findings of the study are presented in chapter four whilst the discussion of the results and findings of the study is done in chapter five. The conclusion and recommendations of the study are also presented in chapter six.

The references that were cited in this work have been provided whilst the study questionnaire forms the appendices of the thesis report.
CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

Child bearing and raising a family is often times a very prideful event in the lives of women. However, a woman must survive her pregnancy first to become a mother. This is the point that has necessitated access and use of family planning services, a major priority for the promotion of better lives for mothers and their families.

The use of family planning services is influenced many factors including the quality of the services provided. This chapter therefore reviews on available literature on uptake of family planning services and the quality of the services provided in health facilities. The chapter contains a brief history of family planning in Ghana and the current rate of uptake of the services. Literature was also reviewed on the concept of quality of services and the dimensions of quality family planning services. Literature was also reviewed on the barriers to the uptake of family planning services.

2.1 An Overview of Family Planning and its Importance

To reduce the menace of maternal deaths attributed to unplanned pregnancies, Collumbien et al (2008) in their study stated that if women had only the number of pregnancies they wanted or planned and had these pregnancies at the intervals they wanted, and then maternal mortality would drop by about one-third. In emphasizing the importance or contribution of family planning services as recipe to lower or reduce maternal mortality, Agustinand Jose (2000) stated that women with birth-to-pregnancy intervals of less than five months experience a risk of maternal death that was 2.5 times higher than women with birth-to-
pregnancy intervals of 18 to 23 months. To achieve the desired birth-to-pregnancy intervals couples have to employ the use of contraceptives and family planning services. Family planning therefore remains one of the most cost-effective public health measures available in developing countries. Family planning and contraception has been given several definitions. However, all the definitions have the same central message of limiting, spacing births and prevention of unintended pregnancies which buttresses the slogan of the first birth control clinic that was established in the 1920s which said that “children by choice, not chance”.

Among the several definitions, the Ghana Health Service (2007) defined family planning services as methods and practices that are used to space births, limit family size and prevent unwanted pregnancies. According to the report, pregnancy by choice and not by chance is a basic requirement for women’s health. Mturi (1996) defined contraception as any deliberate practice or technique undertaken to reduce the risk of conception. Similarly, contraception is defined by Hennink (1997) as the deliberate employment of a technique or a device to prevent conception or pregnancy.

The use of family planning is associated with lower rates of maternal and infant mortality and can therefore influence economic growth. Beyond the health and survival implications of high levels of closely spaced and unintended births, high fertility rates accelerate population growth, undermining development efforts across all sectors not just the health sector (USAID, 2005)

Even though pregnancy or childbirth is seen as a blessing and welcomed by most women, yet the risks of illness and death associated with these events are very high in some parts of
the world. According to Rhonda et al (2009) in developing countries, a woman's life time risk of dying due to pregnancy and childbirth is 1 in 75, or almost 100 times higher than the 1 in 7,300 risk in developed countries. They further stated that the risk was higher in sub-Saharan Africa, where; a woman’s lifetime chance of dying from pregnancy or childbirth-related causes is 1 in 22. The World Health organization (WHO, 2004) reported that more than 500,000 women die every year due to pregnancy-related problems and that the use of methods for family planning reduces maternal mortality prevents unwanted and highly risky pregnancies and also prevents the need for safe and unsafe abortions.

Accordingly, it provides protection from sexually transmitted diseases. The report further stated that approximately 120 million couples in the world do not use contraception and 300 million are not satisfied with the method applied.

Again, the African Population and Health Research Center (2011) reported that, globally, 415,000 women die annually of pregnancy-related causes, and 75,000 die as a result of unsafe abortions (Grimes, 2000). He further stated that, failure or lack of contraceptive services is the cause of about 200,000 of these maternal deaths. The Center further reported that mothers who have unintended births tend to suffer non-psychotic or postpartum depression, feelings of powerlessness, increased time pressures, and a reduction in overall physical health. They also have poorer quality relationships with all their children, tending to physically abuse them more and spend less leisure time with them.

Governments of various countries especially developing countries are struggling to reduce fertility rates due to the pressure it poses on every sector of development. Bongarts et al (1994) in their study entitled the proximate determinants of fertility in sub Saharan Africa
stated that contraception is the most proximate determinant of fertility. It therefore stands to reason that governments and policy makers who want to check fertility rates should promote the use of contraceptives and working on the underpinning factors that influence contraceptives use. They again stated in their study that the proximate determinants of fertility are the biological and behavioural factors through which social, economic, and environmental variables affect fertility. These factors listed also affect the uptake of family planning services and contraceptives use. Demographers find the study of contraception as a crucial issue in demography since there is a strong association or relationship between contraception and fertility.

Alluding to this fact, Olivera et al (2006) stated that family planning in its broader meaning; is part of the entire demographical and population policy of each country and the planet as a whole. In almost every surroundings, the objectives of family planning commonly highlighted include unwanted pregnancy prevention, extensive population growth reduction, and health improvement of women, children and population as a whole. In 2001, Ntozi & Ahimbisibwe conducted a study in Uganda and postulated that the use of contraceptives has a significant impact on reducing a woman’s fertility level.

There are variations in the levels of contraceptives use in the world. There are different levels of use between continents and countries. Within countries, there are also regional and zonal differences in the use of contraceptives. According to Mturi & Hinde (2001), the differences in levels of contraceptive use accounts for or explain about 92 per cent of the variation in fertility and argued that where contraceptive use is widespread, fertility is expected to decline and birth spacing is equally widespread. Thus, contraceptives use is
Family planning and contraception has an array of benefits to the individual and the society. In estimating the importance or benefits of family planning and contraception, Moreland & Talbird (2006) made an analysis of the importance of contraceptives use and vis-a-vis its contribution to the achievement of the Millennium Development Goals (MDGs) which developing countries are striving to achieve. Their study in Kenya stated that the contribution of family planning to the MDGs showed that satisfying unmet family planning needs in Kenya could avert 14,040 maternal deaths and 434,306 child deaths by the MDG target date of 2015. In USAID/HPI (2007), it was noted that the cost savings in providing services to meet MDGs outweigh the additional costs of family planning by a factor of almost 4 to 1.

Cleland et al (2006) stated that promotion of family planning in countries with high birth rates has the potential of reducing poverty and hunger, while at the same time averting 32 percent of all maternal deaths and nearly 10 percent of child mortality. This would contribute substantially to women's empowerment, achievement of universal primary schooling or education and long term environmental sustainability. Other substantial economic benefits could include demographic bonus or dividends. Demographic bonus exists when there is a shrinking share of the population consisting of dependent children at the same time as a greater share consisting of working-age adults. According to David et al (2002), when this occurs, it boosts productivity and allows added savings or investment. They again observed that family planning helps to reduce the number of high-risk pregnancies that result in high levels of maternal and child illness and death.
Wawire (2006) noted that high population growth is associated with high illiteracy rates and low education level that make it difficult to implement government programmes, given their budgetary implications. According to World Bank (2003), the use of family planning services is an important issue for a developing country like Ghana. The World Bank (2003) noted that this was due to the benefits gained in terms of development through reductions in fertility levels. Furthermore, the uptake of family planning widened choices available to people, particularly women, by allowing individuals and society more opportunities for social and economic development. Singh et al (2004) revealed that a high fertility rate (which in many cases is attributed to low contraceptive prevalence rate) impedes economic growth. Singh et al (2004) observed that countries with high “population pressure” or with rapidly growing populations may not be able to meet the large education, labour, health, and infrastructure-related demands of the population.

Leisinger et al (2002) noted that population growth affects the environment and raises concerns about food security, safe drinking water and availability of arable land. Eastwood and Lipton (2001) observed that reducing fertility can help alleviate poverty and stimulate economic growth.

2.2 Brief History and Current State of Family Planning in Ghana

Family planning activities in Ghana started in 1961 when the Committee on Christian Marriage and Family Life of the Christian Council of Ghana opened the first family advice centre in Accra with the objective of offering advice to married couples on family planning and responsible parenthood (National Population Council, 1994). This was followed by the activities of the Planned Parenthood Association of Ghana (PPAG) and later the
establishment of the Ghana National Family Planning Programme in 1970 after the adoption of the Ghana Population Policy in March 1969 (Freedman and Berelson, 1976). Since then, family planning services have become an integral part of the health care delivery system as well as a means for the promotion of responsible parenthood in the country (Ghana Health Service, 2000).

Some of the policies and programmes that have focused on family planning in Ghana include the National Population Policy of 1969 which was revised in 1994, the National Reproductive Health Policy which among other things also covers safe motherhood and family planning, and the Adolescent Reproductive Health Policy which aims at promoting the rights of adolescents to sexual and reproductive health information and services in a caring and friendly atmosphere (NPC, 1997). The Ghana Health Service (2000) of the Ministry of Health and its partners is of the belief that the impact of population growth on the development of a nation is critical and worth noting. The GHS is therefore of the view that the growth of the population in should be in tune with economic growth which enables development to take place.

According to the NPC (2008) and the GHS (2010) without sufficient support for FP, the quality of the population will be compromised. Again, it states that without the support for FP, the achievements made in the TFR of Ghana will be lost as evidenced in the low uptake of FP services which has led to a low contraceptive prevalence rate.

Studies by the PPAG (2012) have shown that Family Planning (FP) reduces maternal deaths by between 20 and 30 per cent in Ghana. Again, a multi sentinel survey conducted in by the Ghana Health Service in 2011 revealed that the use of modern contraceptives stood at only
23 per cent. This shows that despite the almost universal knowledge about family planning (over 90 per cent), practice of contraception remains low in Ghana. According to the GDHS (2014), the contraceptive prevalence rate for married women is 22 per cent for modern methods; while at the national level, 30 per cent of women have an unmet need for family planning. This indicator refers to the percentage of women in their fertile years of age and sexually active but are not using any method of contraception. This indication to space or limit child bearing speaks volumes about women welfare and their freedom of choice to make their own reproductive health decisions. The high number of women who report not wanting any more children or seeking to delay the next child and yet not using contraceptives means more women are at risk of unintended pregnancies and its associated dangers.

There are variations in the use FP at the regional levels. The World Health Organization’s statistical profile on Ghana, also indicates that the total fertility rate (TFR) per woman is 3.9 as of 2014. The TFR of women in Ghana ranges from 2.5 births per woman in Greater Accra to 6.8 births per woman in the Northern Region.

Family planning is considered as the first pillar of safe motherhood and an essential component of primary health care. (WHO, 2005). The WHO further says that family planning plays a major role in reducing maternal deaths, which is currently at 380 per every 100,000 live births in the Ghana, and newborn morbidity and mortality, which also stands at 78 per every 1,000 live births.

The three main family planning methods used in Ghana are the short-term methods, which are the pills, condoms, injectables and spermicide; long term which are the Intrauterine
Device (IUD), implants and intrauterine system (IUS); and finally the permanent methods which include vasectomy and female sterilization (GHS & GSS, 2015).

2.3 Healthcare Service Quality as a Concept

According to the WHO (2002), the term health service refers to a wide array of services that affect health, including those for physical and mental illnesses. It includes services aimed at preventing disease and promoting health and well-being as well as acute, long-term, rehabilitative, and palliative care. Furthermore, the definition applies to many types of health care practitioners (example physicians, nurses, various other health care professionals) and to all settings of care (from hospitals and nursing homes to physicians' offices, community sites, and even private homes. Donabedian, (1980) defined healthcare quality as 'the application of medical science and technology in a manner that maximizes its benefit to health without correspondingly increasing the risk.' Quality, because of its subjective nature and intangible characteristics, is difficult to define. Healthcare service quality is even more difficult to define and measure than in other sector. Strauss et al, (1998) Zabada et al,(1998) Joss, (1995) McLaughlin et al, (2006) Mosadeghrad, (2003) admitted that the concepts such as intangibility, heterogeneity and simultaneity make it difficult to define and measure quality. Eiriz et al, (2005) Rohlin et al, (2002) Zabada et al (1998) reported the complex and broad nature of health care practices especially the existence of many participants with different interests in the healthcare delivery contributes to its quality measurement problems.
WHO, (2006) recommended that to measure the quality of the health care system the health system should seek to make improvements in six areas or dimensions of quality, which are effectiveness, efficiency, accessibility, acceptability and equity. Effectiveness in providing health care is an evidence base health care provision which results in improved health outcomes for individuals and communities, based on individual need. Efficiency in health care delivery is about the maximizing resources to reduce wastage. Accessibility in delivering health care is about providing health care in a timely, geographically reasonable setting and provided where skills and resources are appropriate to medical need of the people. Acceptable/patient-centered health care takes into account the preferences and aspirations of individual service users and the cultures of their communities. Equitable health service does not vary in quality and also does not discriminate because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status. Safe health care delivery minimizes risks and harm to service users.

Øvretveit, (1992) sees quality care as the provision of care that exceeds patient expectations and achieves the highest possible clinical outcomes with the resources available. Schuster et al, (1998) view quality as providing health care services to patients with appropriate technically competent manner supported by good communication, and cultural sensitivity. Leebov etal, (2003) considers quality healthcare as a care where by people entrusted with care provision doing the right things right for the first time in providing treatment and making continuous improvements. Lohr, (1991), said quality healthcare is the degree to which healthcare services for individuals and patients increases the likelihood of desired healthcare outcomes and is consistent with the current professional knowledge.
According to Øvretveit, (1992) three dimensions of care are essential for provision of quality care to patients; these dimensions have been grouped into professional, client, and management. Professional quality is based on professionals' views of whether professionally assessed consumer needs have been met using correct techniques and procedures. Client quality is whether or not direct beneficiaries feel they get what they want from the services. Management quality is ensuring that services are delivered in a resource-efficient way.

Joss et al., (1995) centered their quality argument on technical quality in health delivery as bases of improving quality care; they identified three main technical qualities such as technical, systemic, and generic quality. Technical quality is concerned with the professional content of work within a given area. Systemic quality refers to the quality of systems and processes that operate across the boundaries between areas of work. Generic quality refers to those aspects of quality which involve inter-personal relationships.

Grönroos, (1982) also reported two types of service quality: technical and functional quality. Technical quality refers to the delivery of the core service or outcome of the service (what is offered and received), while functional quality refers to the service delivery process, or the way in which the customer receives the service (how the service is offered and received).

Maxwell, (1984) said six dimensions of quality that could guarantee quality health care for patients include effectiveness, acceptability, efficiency, access, equity, and relevance.

Hulka et al., (1970) reported three dimensions important for assessing quality healthcare such as personal relationship of the care provider, convenience of treatment and professional competence or knowledge the care giver. According to department of human services (2009) observed quality care as doing the right things, for the right people, at the right time and
doing them right the first time. Thompson,(1983) Baker,(1990) agreed on seven dimensions for evaluating healthcare service quality they includes admission and discharge procedures visiting procedures and religious needs tangibles communications relationships between staff and patients and waiting time. Tomes et al, (2001) also reported using eight dimensions including empathy understanding of illness mutual respect, dignity of food physical environment and religious needs.


The institute of Medicine, (2001), listed six elements of quality to broaden the concept of quality of care; these elements include patient safety, effectiveness, patient centeredness, and timeliness

Clinical commissioning groups, (1999) suggested human dynamics in consultations as an important part of general practice and the community it serves these human dynamics incorporate the four basic principles of medical ethics, autonomy, justice, beneficence and non-malfeasance, suggests that what lies at the core of high quality care is greater than that which can be captured through measurable indicators.

2.3 Quality of Family Planning Services in Ghana

The WHO (2005) gave a report on the quality of family planning services and what contributes to quality family planning services. The report espoused five variables that contribute to the quality of the services which are qualification of service providers, in-service training sessions, clients educational materials on sexually transmitted infections (STIs) and types of FP methods, availability of STIs treatment services and contraceptive commodity security (thus availability). Another study by Stephenson et al. (2007) on the service quality of contraceptives intimated that the distribution system of contraceptives from the national, regional, district to the health facility level is a factor that affects the quality of service. Caldwell and Caldwell (2002) also reported that to enhance the quality of FP services in health facilities, there should be a source of reliable water supply in the health facility and a functioning latrine. When the above mentioned variables or factors are available to service providers and the health facilities, it will ultimately lead to clients' satisfaction.

In line with the WHO’s description of quality family planning services, an assessment of the quality of family planning services was done in Ghana. The Ghana Health Service (2008) found that the qualifications of providers of family planning services have remained essentially the same, with a small increase (from 2 percent in 2002 to 5 percent in 2008) in doctors providing the service. The study further stated that the proportion of family planning providers (primarily nurses) who have received in-service training on counseling for family planning during the past five years has increased significantly, from 38 percent in 2002 to 60 percent in 2008.
Another study by UNFPA (2009) found that client educational materials for STIs and HIV/AIDS are more available in health facilities in Ghana, increasing from 25 percent in 2002 to 37 percent in 2009. The study further stated that PPAG facilities have the greatest improvement, with 93 percent having any information-education-communication (IEC) materials for STIs or HIV/AIDS (2009). UNFPA further stated sexually transmitted infection (STI) service availability at any site in facilities offering family planning has increased substantially (from 42 percent in 2002 to 71 percent in 2008). In addition, 39 percent of facilities in 2002 indicated that STI services are also offered by family planning providers.

The Ghana Health Service (2012) did an assessment of its facilities. The results showed that the proportion of family planning providers (primarily nurses) who have received in-service training on counseling for family planning during the past four years has increased significantly, from 38 percent in 2008 to 60 percent in 2012. The study again said although there were no stock outs of contraceptives at the national level there were stock outs in the health facilities. The reasons for the gaps in supply of contraceptive methods need to be assessed, and interventions must be made to ensure consistent distribution. The new distribution system adopted by the Ministry of Health, which allows regions to directly supply service delivery points, bypassing districts, should be put into effect.

The Ministry of Health (2013) also gave guidelines for family planning services which requires that instructions should be included for the use of IEC material. The availability and use should then be supported through proper supply, training, and supervision. It also requires a source of water for all facilities is critical for infection control. Where piped water is not feasible, water must be made available in the service area, preferably in containers.
with a tap to allow running water. Facilities must ensure that there is a functioning latrine, which is critical to client comfort and infection prevention.

In 2008, the Ministry of Health also proposed that there should be an improved availability of essential equipment for family planning, the existing systems for maintenance and/or replacement of minor equipment should be reviewed, barriers to effective implementation should be addressed, and then changes should be made to rectify the problems.

Awoonor-Williams (2014) also proposed that cost free family planning would empower women and enhance their freedom to effectively take charge of their destinies. It is well known that knowledge and awareness about family planning methods in Ghana are almost at par with most developed societies, the rate of use however has been less than desirable. Yet policy statements from the Ministry of Health seeking to remove financial barrier, one of the major challenges limiting family planning uptake, are not backed by practical implementation plans.

2.4 Factors Influencing Contraceptives Use in Sub Saharan Africa

Factors influencing the uptake of contraceptives are both exogenous and endogenous. Studies of the determinants of contraceptive use, however, have focused on individual and household-level factors (National Research Council, 1993). For example, associations have been shown between modern contraceptive use and parity, (Clements and Madise, 2004) education, (Oliver, 1995) and household socio-economic status, (Mallucio & Thomas, 1995; Guilkey & Jayne, 1997). In buttressing Stephenson ‘s findings, Amin et al (2002) pointed out that many developing countries have substantial geographic variations in
contraceptive use although the factors shaping these variations were little or not properly understood. Previous studies by Tuoane (2003) suggested that variations in contraceptive use typically remain after accounting for individual and household factors.

Stephenson et al (2007) in their study on contextual influences on modern contraceptives use in sub Saharan Africa stated that it is unlikely that characteristics of the health services in a community alone account for all geographic variation in contraceptive use. For example, contraceptive use may be indirectly influenced by economic development, through a relationship with access to health services (Diez-Roux, 1998) or through its relationship with female autonomy and positive attitudes toward health service use (Alan, 1998).

Some studies have examined the effects of other characteristics of the community, including the influence of levels of community economic development (Adongo et al, 1995; Diez-Roux, 1998; Saha, 1998) levels of school participation (Chacko, 2001) economic roles of children, (Entwisle & Mason, 2002) and community fertility norms (Nsemuklia, 1999) on contraceptive use.

2.5 Cost of Family Planning Services

Family planning in the West African sub region is sponsored by donors. In 2010, the Ghana Health Service reported that there has been a change in donor interest in family planning over time. Initially, family planning activities were supported by private foundations in the United States of America. Later, the governments of the USA and of some European countries (Sweden, in particular) provided large-scale funding for family planning programmes in Ghana and other African countries. Also, the World Bank recognized that
rapid population growth is a major hindrance to development and provided assistance; and the United Nations Fund for Population Activities (UNFPA) supported family planning programmes. More recently, however, funding for population growth issues from the USA and other donor countries has decreased resulting in low funding of family planning programmes (GHS, 2010).

Global Doctors for Choice (GDC) Ghana advocated that the government should incorporate family planning services into the free maternal health care under the National Health Insurance Scheme (GDC, 2013). However, this has not been done because women are still paying for family planning services.

Awoonor-Williams (2010) also advocated for cost free family planning services. The proposal of Awoonor-Williams also stated that when family planning services are made free; health workers should no longer sit at health facilities and send messages to women that family planning has now been made free, expecting them to rush for the services. Instead, health workers should directly engage communities through durbars and talking to men and opinion leaders. They should educate communities on the importance of birth spacing, limiting birth and the dangers of early or late pregnancy.

The Ghana Health Service (2011) also intimated that ‘cost free’ family planning services is a major theme or issue being used to seek attention in communities in to talk about family planning and the misconceptions of side effects. Education messages on family planning have been designed to target everyone in the community, including men, and making sure that they understand that contraceptive use does not affect fertility, but rather provides an opportunity for women and men to space birth. The messages are tailored to the effect that
spacing births can help women stay healthier, stronger and more productive so they can better help their families grow. Community members are also sensitized on the fact that spacing births has been found to promote the survival of children.

In another dimension, Awoonor-Williams (2014) said that the money factor in family planning services is greatly affecting women chances of using family planning services because they serve as a source of internally generated funds (IGF) at district health facilities. Since providers are allowed to retain a percentage of the cost of devices after sales while returning the principal cost to the regional and national level, most providers often stock only devices with highest returns and therefore making some devices perpetually unavailable. This practice could affect the quality of family services because some clients may not get what they want from the facilities which can prevent them from using family planning services.

The direction and pathways of causality between contraceptives use and economic status remain debatable. According to Bryant (2007) socio-economic change of women is believed to modify the incentives to have children, diffuse new ideas about childbearing through society, and provide them with better access to contraceptive methods.

Benefo (2006) in a study in Ghana found that a woman’s socio-economic status as well as her life cycle stage affects her reproductive behavior. This relationship according to him is quite complicated and varies depending on the aspect of reproductive behavior examined. Neoclassical theory suggests that as investment in human capital increases and as more women participate in the labour market, the fertility behaviour of households is bound to change, in favour of fewer children (Singh, 1994).
Oyedokun (2007) in recounting the contribution of economic status to contraceptives use said that many developing economies are characterized by rapid population growth that is partly attributed to low contraceptive prevalence rate, high fertility rate, high birth rates accompanied by steady declines in death rates, and high but declining mortality rate.

2.6 Socio-Cultural Barriers to Family Planning

According to Adinma et al, (2009) it is difficult to convince people, both women and men, to use health services that are not familiar to them or that are different from their traditional approaches to medicine – cultural beliefs or folk methods may trump doctor’s orders.

Anrudth, (2011) conducted a study in rural parts of Mexico and found that some women give birth in a cement dome called a temazcal. Temazcal which is a heated “sweat lodge” or steam room used for giving birth, healing the sick, and purifying the body. If you were told by a foreign doctor that you were going to give birth in a temazcal.

“I’m sure you would not be ecstatic to hear the news, and at the very least you would have a lot of questions to ask. The same applies to some Mexican women who are being asked to give birth in a hospital”

Ali et al, (2011), said that often, individuals go without lifesaving medical treatment not only because of a lack of access, but sometimes because of a fear of the unfamiliar. In some countries such as Mexico there are some hospitals that have begun combining folk methods and western medicine to ensure the safest birth outcomes and create a familiar atmosphere for the women. In the case of family planning, the difficult part is not convincing an individual that the service will be beneficial to them – in most communities women want to
be able to plan their families. The difficulty lies in changing structures and systems that currently hinder women’s ability to access family planning services, and eliminating social stigma (Bertrand et al, 2004).

Chigbu et al, (2010) reported that cultural beliefs that prevent women from making their own decisions negatively impact the implementation of family planning services. Overcoming these barriers requires innovative approaches that are different from those implemented for other health care services.

The world view of women in developing and developed countries are different. According to D’Antona et al (2009) most women in developed countries have a plan regarding their education, career, marriage, and when they hope to start a family. These women want to be well prepared to give their families the best they possibly could. However, in many developing countries women do not have these choices, and conversely, having children may determine whether or not they can pursue an education or a career. In developing countries, women have increased risk of dying in childbirth, are controlled by their husbands, and their value can be determined by their fertility.

Natalie-Rico, (2011) posited that some socio-cultural barriers to family planning in many of the countries in sub-Saharan Africa are similar. Traditionally, having many children symbolized high social status in all the African countries. It is also noted adolescents are not considered adults until they have a child. Selby, (2009), also opined that payment of dowry suggest that women must bear many children as a way to repay it. Women become a man’s property after marriage, therefore having little say in family planning.
Strasburger et al, (2009) also said that in impoverished areas, women have few choices other than becoming a mother and wife. The role of wives is therefore limited to child bearing. Prior to 1960, the Belgian Congo provided financial incentives for large families Christian churches that are well established in Africa oppose the use of contraceptives (Omar et al, 2010). Reyes (2006) espoused some social factors that affect the use of family planning services. These include; social stigma, rumors and myths about contraceptives i.e. that condoms are only used to prevent STI transmission, lack of male involvement in family planning and familial pressure.

Removing cultural barriers is only one part of creating access to family planning services. There are numerous other issues to tackle in order to scale-up services such as providing accessible facilities, adequate staff and supplies, and providing clear information (Mkhwanazi, 2011).

2.7 Influence of Education Level of Women and their Spouses on Contraceptives Use

Education has long been associated with declining fertility and increasing contraceptive use since the publication of the results of the first World Fertility Survey in the mid-1970 (Charlie, 2011).

Findings from across the developing world show that the better educated a women is, the more likely she is to use contraceptives (Ainsworth et al, 1996; Rutenburg et al, 1991).

Education has been linked to the uptake of family planning services in different ways by different studies or authors. According to Rehan (2011), the education level of a woman affects her reproductive behaviors and desires in a number of ways. First, it typically delays
the age of cohabitation. Secondly, literate women can learn about and use of contraceptives more effectively than uneducated women, thus reducing the number of unanticipated or unexpected pregnancies. Thirdly, highly educated women are likely to be more effective in producing healthy children because they have knowledge on healthy child upbringing.

In another dimension, Bertrand et al (1993) and Caldwell (1982) sees education as a vehicle by which people learn more Western views about the family, which leads to a more child centered parenting approach, and to different definitions of acceptable child care. This may lead to a demand for fewer children, and consequently, the use of contraceptives to prevent or to space childbirth. Another important linkage of female education and fertility according to Ghulam & Naushin (2003) and Bbaale (2009) is the improved survivorship chances of their children.

Some demographers have propounded theories linking the influence of female education to the use of contraceptives. Diffusion theories emphasize the role of elite educated women in exposing other women to new ideas about fertility control. According to the theories, elite educated women develop a heightened awareness of the opportunity costs of childbearing, learn about western contraception and become empowered to adopt them (Johnson-Hanks 2003). These elite women then act as sources of information, social support and social pressure that diffuse their new lifestyles and ideas to other women (Montgomery and Casterline 1996; McNay et al 2003).

Other theories argue that the education of women in a community changes the institutional setting in ways that reduce the incentive to have many children. Some claim that the education of some women in a community initiates social and ideational changes that undermine traditional patriarchal power and reduce men's interest in having large numbers
of children as it becomes difficult for them to devolve the costs of childbearing onto their wives (McNay et al, 2003). Other versions of institutional theory suggest that women’s education makes female labor markets more competitive or increases women’s interest in educating their children. These social changes give rise to the idea that social mobility is incompatible with large family sizes (Kravdal, 2002). However it happens, these theories imply that individual women become interested in regulating their fertility and using contraception as other women in their community become educated.

Another prominent theory proposed to understand the effect of education on contraceptives use is the one proposed by Gary (1979) which is entitled the “New Household Economics.” This theory views education as a public good. According to the theory, members of a household unit seek to maximize income. In this formulation, it is assumed that women and men respond to economic incentive structures. Accordingly, the theory predicts that once education is provided as a public good and becomes widespread for women and men, an increase in education leads to an increase in contraceptives use to reduce fertility, all things being equal. According to Tuman et al (2007) the putative mechanism for this effect is the opportunity costs associated with caring for children as education increases. As women acquire skills that are useful in the marketplace with higher levels of educational attainment, they tend to command a higher wage, increasing the value of their time. One link of education to the use of contraceptives was proposed by Cristian& Columbia University (2005) which goes directly through the financial costs of contraceptives. They said that an educated woman has presumably more resources to afford costly birth control methods. Secondly, certain contraceptive methods might be associated with psychic costs that could be lower for educated women. As an example, the use of condoms or traditional methods,
such as the calendar method or the withdrawal method, might require the cooperation of the husband. An educated woman has potentially more bargaining power within the family and thus could be more successful at using these methods if other alternatives are not available. Alternatively, an educated person may have lower psychic cost of reducing sexual activity if access to birth control methods is limited. Again, they stated that educated women may be more efficient at using particular contraceptive methods, especially in settings where information about the proper use of a contraceptive technology is not readily available or where the only methods of birth control available have high failure rates and need to be used with extreme care, such as in the case of traditional methods.

Another potential explanation of the mechanisms behind the education-contraception link was proposed by Charlie (2011) which is knowledge of, and access to, family planning services by educated women and men.

2.8 Relationship between Women Empowerment and Use of Modern Contraceptives

According to Narayan et al (2002), there is considerable variation in the definition and conceptualization of women’s empowerment. There are different existing definitions for the term empowerment and people define it depending on what they want to measure. Nevertheless there are some commonalities in the widely known definitions for empowerment. Narayan et al (2002) stated that the World Bank defines empowerment as the “expansion of freedom of choice and action to shape one’s life.” Pradhan (2000) argued that this World Bank definition encompasses two features of women’s empowerment: process of change (through which a woman gains power in making decisions) and agency.
Kabeer (2000) defines women's empowerment as a "process by which those who have been denied the ability to make strategic life choices acquire such ability. Jejeebhoy and Sathar (2001) commenting on Kabeer's definition said it involves resources and achievements, in addition to process of change and agency, all of which are interrelated. They compared the World Bank's definition with that of Kabeer's and came out with a commonality which is the recognition that household and interfamilial relations are central aspects of women's empowerment.

Alsop et al (2006) reiterated that empirical research often incorporates analyses of empowerment that use data aggregated from individual and household levels or direct measures at the community and societal levels. According to them the measurement of women's empowerment is difficult: first, because it is a process; secondly, it is multi-dimensional; and thirdly, the concept operates at various levels. They again stated that until recently, women's empowerment was often measured by these three proxies, thus education, employment and knowledge. In their assessment, they said that these proxies or characteristics were important but conceptually distant, and they do not always reflect empowerment.

According to Lee-Rife and Edmeades (2011), Malhotra et al (2002) and Upadhyay & Hindin (2005) the body of research on women's empowerment has conceptualized and defined this construct in many ways and used different terms, often interchangeably, including "autonomy," "status" and "agency."

Other studies by Mason and Smith (2000) have examined other dimensions of women's empowerment, including decision making regarding household economy and family size, whether women need permission to go out, coercion or control of women by their spouse or
family, women’s political and legal awareness, and their participation in public protests and political campaigning.

Malhotra et al (2002) also showed different measures for the conceptualization of women empowerment. According to their study the proxies used to measure women’s autonomy include their participation in decision making in various household issues. This index represents women’s degree of control over their environment. They mentioned both major and minor decisions, while others include only major decisions, excluding day-to-day household decisions and those that are traditionally within the woman’s domain. Women’s empowerment encompasses many dimensions, including economic, socio-cultural, familial, interpersonal, legal, political, and psychological, which contributes to the wide variation in conceptualization of women’s empowerment.

Additionally, to measure empowerment at an individual level, Kishor and Subaiya (2008) stated that researchers must translate the amorphous constructs into a set of specific questions that population-based surveys can ask of individual respondents.

Cultural differences are also seen as a challenge in the measurement of empowerment. Ushma & Deborah (2010) stated that it is desirable to use standardized questions that enable cross-cultural comparisons of empowerment. Yet a measure that captures empowerment in one context may have limited relevance in another, as is the case with measures that assess mobility in a community where women’s free movement is the norm. It is still unknown whether the same dimensions of empowerment that were developed elsewhere are relevant in sub-Saharan Africa, where the gender environment is completely different than in other regions. In Africa, empowerment is likely to look different than elsewhere because of such differences as more working women who have control over their earnings, more polygamy,
more nuclear families (as opposed to extended families), and larger ideal family size, and because women's status is often tied to their fertility.

2.8 Health Systems and Available Family Planning Methods
According to Rhonda et al (2009) there is no "ideal method" of family planning, but there is a safe and effective method for every woman. They stated that family planning methods vary according to their convenience, cost, effectiveness, side effects, risks, and benefits for the individual. Family planning users are best able to evaluate the relative importance of these factors based on their preferences; their desired family size; stage of life; goals of delaying, spacing, or limiting future pregnancies; health status; relationship status; and living conditions.

Mona et al (2010) in considering the choices that people make in their contraceptives use they said that making a choice of a family planning method does not just depend on the users' preferences but also on health system characteristics prevailing in that environment. Strong family planning programs rely on effective family planning service delivery strategies, such as those that offer method choices tailored to the needs of users, provide family planning counseling and medical expertise for administering methods, and follow up on users' response to the method.

The National Statistical Office of Malawi & ORC Macro (2005); and Central Statistical Agency & ORC Macro (2006) asserted that countries in the African sub region with frail health systems are faced with the challenge of improving contraceptive method choice within existing constraints. Magadi & Curtis (2003) in their study said that broadening the
choice of contraceptive methods increases the overall contraceptive prevalence. According to them, the provision of a wide range of contraceptive methods increases the opportunity for individual couples to obtain a method that suits their needs.

It has been suggested by Caldwell and Caldwell (2002) that successful family planning program strategies in Africa must promote methods that are temporary, can be used covertly by women, and do not have to be stored at home. Catherine and Everd(2008) also said that given the low literacy level especially among women, their commonly weak domestic position in making decisions over childbearing and weak economic power, the injectable hormone is a very opportune method for them. Other artificial methods like oral pills, spermicides and condoms require overt actions that require the acceptance and cooperation of the partners.

2.9 Male Involvement in Family Planning

According to United Nations (2001), male involvement in population planning is defined as the ways in which men relate to reproductive health, problem, reproductive rights and reproductive behavior. Both men and women involvement on fertility and reproductive health was the key message in 1994 International Conference on Population and Development and 1995 Fourth World Conference on Women. Jamal (2002) listed two aspects of male’s involvement in family planning, first is that men accept and support their partner’s need, choices and rights in fertility regulations and second men have their own perceptions regarding contraceptive knowledge, approval, use and sexual behavior. However, the husband’s reasons for opposing or accepting family planning vary by their socio-economic characteristics, religious and societal norms.
According to the IPPF (2009), engaging men in family planning programs holds promise as a means to improve access and use of family planning and that addressing gender in family planning programs — for instance by engaging men — can improve program outcomes and increase gender equality.

Mustapha et al (2006) said that in a patriarchal society, with men having absolute power over certain family issues, it has been found that the wife has no say on family size. In a patriarchal society like Zaire children belong to the husband and an extension to his extended family or clan. The husband pays dowry in marriage to the bride’s family as a compensation for the loss of her services and expenses of upbringing. In return the woman is expected to contribute to the husband’s family in terms of labour and child bearing. For this reason a woman cannot cease child bearing voluntarily because it will be seen as a failure of the wife to fulfill her obligation.

Ria (2009) in citing Mohamad et al (1988) in their in Indonesia, found that a husband’s approval of contraception is the most significant factor in affecting contraceptive use, followed by the number of living children and the woman’s education. According to the study, a husband’s view on family planning has a substantial effect on contraceptive use and modern method usage. In their study they stated that, wives with the perception that their husbands approve of contraceptive use, are more likely to use contraceptives, and a modern method, than wives with the perception that their husbands disapproves contraception.

A study in Ghana by DeRose et al. (2002) has suggested that husbands' declining fertility desires are largely responsible for national-level reductions in infertility. Atenane (2002) in reporting on “male attitudes and behaviors concerning family planning and male initiatives
in Africa" indicated that men often have positive attitudes toward family planning, but women believe that their husband disapproves of family planning.

The Cairo declaration demands men's participation in family planning and reproductive health in terms of gender equality and fulfilling various reproductive responsibilities. It is argued that "men are partners in reproduction and sexuality and therefore it is logical that they equally share satisfying sexual lives and the burdens of preventing diseases and health complications" (Green, et al., 1995).

Khan & Bella (1997) proposed that; the broadening of the concept of 'male-involvement' to 'male-responsibility' demands changes in the strategies of educational campaigns and motivational efforts also where men and women need to be educated and informed about gender equality, their reproductive rights and responsibilities and not only about the adoption of contraception.

According to Alemayehu (2012), male involvement in family planning not only helps accepting a contraceptive, but also in its effective use and continuation. Men's knowledge, attitude and practice towards family planning also influence the behavior of their wives.

There are various factors that influence male participation in family planning. These include cultural norms and values, religious beliefs, socio-economic factors, psychological factors. These factors can act as barriers to male involvement (Kabwigu, 2001).

2.10 Conclusion on Literature Review

The literature review has shown that family planning plays a significant role in the development of the world. It is the pivot of development in every country. The literature
review also showed that uptake of family planning services is low in developing countries especially sub Saharan Africa. This has led to the under development in these countries due to high fertility rates. Poor maternal and child health is a problem in these countries leading to high maternal mortality rates. The available literature also showed that several factors affect the uptake of family planning services. Most of the studies conducted by other researchers found that factors such as maternal autonomy/empowerment, education level, economic status, age and religion affect the uptake of family planning services. Other factors that were cited include husband’s education, women exposure to media, husband’s occupation, parity and socio-economic status are the independent variables, which are assumed to have positive or negative association with the utilization of family planning services.

The studies however were silent on the quality of family planning services and its impact on the uptake of the services. This has therefore warranted the conduct of this study in the Ningo-Prampram district to assess the quality of family planning services and how it affects the uptake of the services.
CHAPTER THREE
METHODOLOGY

3.0 Introduction

This chapter presents the methodologies that were employed during the study. The data collection techniques and tools, the study population, data analysis, quality control measures and the limitations of the study are presented in this chapter.

3.1 Description of Study Area

Ningo Prampram District is one of the 17 districts in the Greater Region. It was established on 15th March 2021 through the local government Act 462 of 1993 as part of ongoing national decentralization efforts. The estimated population of 73,386 and was formed from the Ningo and Prampram sub-districts of the now defunct Dangme-West District. The district capital is Prampram 45 km east of Accra. The district is bounded on the north by the Shai-Osudoku District and the south by a 32.3 km long beach golf. On the west, Ningo-Prampram is bordered by the Kpone-Katamanso District. The western half of the district with communities like Afienya and Dawhenya is peri-urban and some areas like New Dawhenya, Mateheko and New Prampram are rapidly becoming urbanized with some sophistication. The eastern side is largely rural with scattered type population living in small settlements in communities like Lakpleku, Some, Dawa and Minya. The Ningo Prampram District falls within the Accra plains. The Djange Lagoon separates Old and New Ningo.

Residents engage in small and medium scale commercial fishing and farming activities including cattle rearing. Some residents (mainly fisher folk) engage in fish smoking as their
source of livelihood. The building construction industry is very vibrant in the district. This provides employment to manual and skilled labourers including carpenters, Masons, Painters, electricians and other construction workers. Some industries in the district located in the district fish processing factories, furniture makers and one that deals in yam exportation.

Natives of the Ningo-Prampram are GaDangmes and they constitute the principal ethnic group in the district. There are also persons from other ethnicities residents in the district: Ewe, Akan’s as well as persons of northern and foreign descent including Fulanis.

In all there are 126 schools from KG to JSS in the district with a total enrolment of 27,409. The teacher population at primary school level stands at 263. The two second cycle schools in the district are: Prampram and Ningo Senior High Schools. There are some technical and vocational schools as well. Central university is located in Miotso a community close to Prampram. Literacy rates are low, 39.5% compared to the national average of 67.3% (Ref. Ghana Service, Population and Housing Census 2010)

Roads and transport are important factors that influence health. The Ashaiman-Akosombo and the Tema-Aflao highways are major roads that pass through the Ningo-Prampram district. Dawehnya, Dawa and Nyigbenya are some of the communities along the Tema-Aflao highway. Mataheko and Afienya fall along the Ashaiman-Akosombo highway. Three major highway facilitate travel but also present potential for road traffic accidents. These are high police checkpoints are Nyigbenya (Tsopoli) and Afienya. Apart from the two major highways mentioned above and a few roads with in the Prampram township, the roads within the district are largely un tarred and in poor shape especially in the Ningo (eastern
parts) e.g. Bundase, Yoma, Some, and Lakpleku and even in the newly developed and developing areas on the west like Prampram, New Dawhenya and Mateheko. Often these roads are difficult to ply especially in the rainy season posing a challenge to outreach services and supervisory and support visits.

There are two Health Centres and 8 CHPS zones with 6 CHPS compounds. The total staff strength is 64 including 1 Medical Officer, 1 physician Assistant and 5 midwives. There is staff accommodation for 10 staff.

There are 6 CHPS compounds offering basic health services at household level and operating as community clinics as well. In addition, there are 2 CHPS zones operating on outreach basis.

The DHMT has created six sub-districts for the original two (Ningo and Prampram). The new sub-districts have been carved around existing health facilities to facilitate smooth health services delivery and administration at the district sub-structure level. Stakeholder consultations are ongoing to facilitate this.

There are 6 health facilities operating within the district. Several Non-governmental agencies (NGOs) in health operate within the district. Key among these are Behaviour change support (BCS) and Focus Region Health Project (FRHP). These are USADID supported organization that operate even beyond the Ningo-Prampram District. FRHP interventions re facility based and directed towards health workers. BCS on the hand focuses on behaviour change at community level. There are in all 34 active CBA’s actively supporting the support with various health related activities and programs including disease surveillance.
3.3 Study Design

The study design was a cross sectional analytical study. Cross sectional surveys are conducted at one point in time. They measure certain phenomena (events, behaviour, attitudes) in the population of interest (e.g. the uptake of family planning services, reported reasons the non-uptake of these services). These types of surveys are often descriptive surveys because the information is collected from a sample of the population of interest and descriptive measures or statistics are calculated. However, in exploring for the determinants of uptake analytical measures have been used. They are known as cross sectional because the data are collected from the field at one point in time. The respondents are generally asked to answer questions on events, feelings and behaviour retrospectively therefore the surveys are called retrospective studies. Cross sectional surveys are also sometimes referred to as correlation studies because it is not generally possible to draw conclusions about cause and effect from them.

3.5 Study Population

The study population comprised women in fertile Age (WIFA) of 15-49 years and who have given birth at least once. Information on barriers to contraception, supply of contraceptives, preferred family planning methods, and the quantities of contraceptives issued was sourced from the district public health Nurse (DPHN) in charge of reproductive health, the nurses and midwives in charge of reproductive health in the facilities of the study communities and licensed chemical sellers. The competence and qualification of service providers was also considered in the study by looking at the number of in-service trainings that have been given to service providers and whom/which department or agency carried out or organized the
training. Nurses at the Reproductive and Child Health (RCH) units of four (4) health centers were interviewed.

The DPHN in charge of distribution of contraceptives to all the health facilities in the district and also receives monthly reports on family planning services from all the health facilities was interviewed to assess the trend of family planning acceptance rate and quantities of contraceptives distributed.

3.7 Sample Size Determination and Sampling Procedures

The sample size was determined based on the formula for binomial probability exact methods for one sample tests as follows:

\[ n = \frac{p_0 (1-p_0) [z_\alpha + (z_{1-\beta}) \sqrt{p_1 (1-p_1)/p_0 (1-p_0)^2}]}{\alpha (z_{1-\beta})^2} \]

Where:

- \( p_0 \) = regional contraceptive prevalence rate as reported in the 2014 GDHS for the Greater Accra region which is 38%
- \( p_1 \) = the district contraceptive prevalence rate as reported in the 2014 District Health Directorate Annual Report which is 27.8%
- \( \alpha \) = probability of type I error and \( z_\alpha = 1.96 \) (at \( \alpha = 5\% \ 2\text{-tailed} \)
- \( \beta \) = probability of type II error and \( z_{1-\beta} = -0.157 \) (at 80% power 2-tailed) = 0.03 (sum of binomial probabilities for exact methods for one sample tests)

\[ n = \frac{0.38 (1-0.38) [1.96 + (-0.157) \sqrt{0.278 (1-0.278)/0.38 (1-0.38)^2}]}{0.05 (0.157)^2} \approx 415 \]

A final sample size of 415 was used in this study.
3.7.1 Selecting the Starting Household Using the EPI Method

The first household was selected from the centre of each cluster or community. In each community, the Community based health volunteer (CBHV) together with the interviewer chose a starting location by going to a central location in the cluster. At the centre of the cluster, a travel direction was selected at random by spinning a pen. The team then moved in a straight line in a chosen direction and counting all of the households until the end of the community was reached. The team then randomly chose a number between 1 and the number of houses counted as the starting point for the survey. The number randomly chosen therefore corresponded with the starting house.

3.7.2 Selection of Subsequent Households

The random-walk procedure was followed until such time that the required number of interviews was reached. Every third household from the previously selected household formed the basis of selecting respondents for interview. This approach of selecting households has been reported to reduce similarity in responses by the interviewees (that is, reduced homogeneity) (Bennett et al., 1994).

3.7.3 Procedure for Selecting Individual Survey Subjects

Women of reproductive age who had a child under 24 months old in the sampled households were eligible for interview. Only one eligible mother was randomly selected for interview in any particular sampled household where there were more than one woman eligible for the study or interview. In any chosen household where two women fit that description, the mother of the youngest child was interviewed.

3.8 Data Collection
Both quantitative and qualitative methodologies were used in the data collection. The qualitative design consisted of focus group discussions and in-depth interviews with identified individuals such as the DPHN, midwives and nurses to find out more about competence, attitude and skills in the provision of family planning services. A total 30 health professionals were interviewed.

Face-to-face interviews’ using structured questionnaires was used to collect primary data from the respondents including health service providers. The questionnaires consisted mainly of closed-ended questions. Information on the independent variables and dependent variables were collected.

3.8.1 Focus Group Discussion
A total of 6 focus group discussions were organized in the communities to gather information on societal perception of family planning services, benefits of family planning, and barriers to family planning.

3.8.2 Secondary Data
Information on the quantities of contraceptives issued to clients for the past three (3) years was taken from the District Health Directorate (DHD). Health personnel in-charge of health facilities in the communities of study were also contacted for the clients’ registers to get the average number of clients and their preferred methods.

3.9 Variables and Measurements
The independent and dependent variables are listed below:

**Independent variables**
• Availability of family planning services and contraceptives
• Maternal autonomy effect on FP utilization
• Socio-cultural barriers to uptake of family planning methods and contraceptives
• Attitude of family planning service providers
• Knowledge and awareness of contraception and family planning services among women
• Husbands' attitude or approval of contraception and family planning

**Dependent variable**

Family planning acceptor rate and the quality of the services were the principal outcome variables of the study.

### 3.10 Assessment of Maternal Autonomy

Autonomy has been defined as the control women have over their own lives, the extent to which they have an equal voice with their husbands in matters affecting themselves and their families, control over material and other resources, access to knowledge and information, the authority to make independent decisions, freedom from constraints on physical mobility and the ability to forge equitable power relationships within families (Jejeeboy and Sathar, 2001).

Maternal autonomy or the mother's status in the household indicates her decision-making power with respect to movement, finance, healthcare use, and other household activities. The dimension of women's autonomy that was investigated in this study related more to decision-making power, control over finances and ability to communicate with spouse or
health worker on her health. Maternal autonomy was determined by taking into consideration the ability of the woman to take some decisions including the following:

i. Woman takes part in decision making on household matters
ii. Woman decides how to spend her own money
iii. Woman makes the decision to buy her clothes
iv. Woman is involved in making decision to buy large household items/furniture
v. Woman makes the decision to work outside of the home
vi. Woman’s power to deny sex to the husband
vii. Woman’s freedom to travel
viii. Knowledge of where to find family planning services
ix. Ability to discuss family planning issues with spouse
x. Ability to communicate with service provider on health matters

In this study, women are considered to participate in decision making if they make decisions alone or jointly with their husband or someone else. A composite measure was created using the sums of equally weighted binary input variables. Women were scored 1 for answers to each factor that included her (alone or jointly) in decision making, otherwise they were scored 0. The index of decision making power contained ten factors, thus the respondents were scored from 0 to 10. A composite index of women autonomy (CIWA) was then constructed similar to that of Singh et al (2005). Two categories of CIWA viz. low and high were created on the basis of average value of index in the study sample. Thus a binary variable from CIWA was created to indicate women with high versus low autonomy. The high and low categories were created by dividing the sample indexes into approximately half. The women receiving less than the average score were classified as low autonomy
category. Women who scored at least the mean index value were classified as having relatively high autonomy.

3.11 Determination of Household Wealth Index

A household wealth index based on household assets and housing quality was used as a proxy indicator for socio-economic status (SES) of households. An absolute measure of household wealth (wealth index) used in this study is based on an earlier concept developed by Garenne & Hohmann (2003), whereby the sum of dummy variables created from information collected on housing quality (floor, walls, and roof material), availability of electricity, water and type of toilet facility, and ownership of household durable goods and livestock (e.g. bicycle, television, radio, motorcycle, sewing machine, telephone, cars, refrigerator, mattress, bed). These facilities or durable goods are often regarded as modern goods that have been shown to reflect household wealth. A household of zero index score for example means that household had not a single modern good. The scores were thus added up to give the proxy household wealth index. The index varied from 0-18. Households that had a wealth index score of 13 and below were classified as having a low wealth index score and those that had a wealth index score of 14 and above were classified as having a high wealth index score.

The main aim of creating the index was to categorize households into SES groupings in order that we could factor in socio-economic status in multiple regression analysis and to compare the difference in the uptake of family planning services between the groups of lowest and highest SES.
3.12 Determination of Educational Level

The educational level was based on the highest level attained according to the Ghanaian System where primary education consist of six years of formal education, the Junior High School (JHS) is nine years, Senior High School (SHS) is 13 years. An individual with tertiary level education spends at least 17 years acquiring formal education. This variable has three categories: no education, primary or junior secondary, senior secondary education or higher.

3.13 Data Processing and Analysis

Data from the structured questionnaires for service providers and the WIFA group were cleaned and analyzed using the Statistical Package for Social Sciences (SPSS) version 20.0. The data were analyzed using univariate and bivariate statistics where appropriate. Bivariate analysis was done to find association between the uptake of modern contraceptives and family planning methods with quantitative variables such as education level of mothers, distance to source of family planning service, age of the woman, and education level of husbands.

Chi square values for bivariate analysis were considered to be statistically significant with P <0.05 and a confidence level of 95%. Independent variables found to be statistically significant at the 0.1 level based upon the results of the bivariate tests, were entered as potential variables in the logistic regression models. Multiple logistic regression analysis was used because the main outcome variable was binary and it also allows for testing for confounding and independent contribution of potential factors that influence the uptake of
family planning services. This type of regression also gave the P-values together with the confidence intervals of the individual factors that were identified. This was helpful in determining factors that were statistically significant.

Multiple logistic regression analysis was done to find out the determinants of the uptake of family planning services. Factors that were included in the first step of the multiple logistic regression analysis included the maternal education level, wealth index, maternal autonomy and mothers' ability to discuss family planning issues with their spouses.

In the second stage of the multiple logistic regression analysis, factors that were included in the analysis were maternal autonomy, ability of mothers to discuss family planning issues with family planning service providers, maternal wealth, education level, and mothers' ability to discuss family planning issues with their spouses.

Statistical difference was considered significant if the P-value was less than 0.05 and 95% Confidence Intervals (CI) was calculated for all main outcome measures that met the normality and homogeneity criteria.

The focus group discussions were recorded with a voice recorder after which the recorded tapes were transcribed. A thematic analysis was then carried out for this qualitative data.

3.14 Quality Control Measures

> Training: There was a two-day training session held for the three nurses who assisted in the data collection to ensure that valid and reliable data were collected. The training gave the data collectors much insight into the questionnaires and what it sought to achieve.
➢ **Pre-testing of questionnaires:** There was a pilot survey to pre-test the questionnaires in order to refine and restructure the questions where necessary. The pre-testing was done in three communities in the Ada West District which shares boarder with the Ningo-Prampram District. The pre-testing helped to compare the responses with the objectives of the study.

➢ **Double entries of data:** Double entry of data was done after which the two data sets were compared at the analysis stage. This helped in identifying some omissions during the data entry.

### 3.15 Ethical Considerations

Ethical clearance was sought from the ethics committee of the Ghana Health Service before data was collected. Permission was also sought from the District Director of Health Services of the Ningo-Prampram District before embarking on the study. The questionnaires were approved by the District Director before they were administered.

An informed consent of the respondents was also sought and in the consent form, the objectives and significance of the study were clearly stated and explained to the prospective respondents. Respondents were given the free will to decide whether to partake in the study or not.

Anonymity and confidentiality of the actual source(s) of information obtained from the study was ensured by not indicating the names of facilities and individuals who took part in the study. Names were not provided on the data collection tools and therefore no clues were provided for someone to trace the source of information.
3.16 Limitations of the Study

These were the limitations or challenges to this study:

- Social barriers vary and difficult to measure since these are based on the individual’s perception and judgment.

The tape recordings of the focus group discussions were destroyed after transcription so that the voice recordings of those who took part in it are not recognized.
CHAPTER FOUR

RESULTS

4.0 Introduction

The results and findings of the study are presented in this chapter. The results of the quantitative arm of the study are presented in tables and graphs using descriptive statistics in the form of univariate, bivariate and regression analyses. The findings of the qualitative arm of the study are reported by presenting extracts from the focus group interviews. The themes are presented and supported with some direct quotations or statements from the discussants.

4.1 Characteristics of Family Planning Service Providers

Family planning service providers were selected from five health facilities in the Ningo-Prampram District. A total of 30 service providers were surveyed. Most of the providers surveyed 13 (43.3%) were from Prampram polyclinic, 8 (26.7%) were from Old Ningo while 4 (13.3%) were from New Ningo. Majority of the facilities in these communities, 21 (70%) were polyclinics, 6 (20%) were clinics with maternity units while only 1 was a postnatal ward. Majority of the providers 26 (86.7%) were females. Half of the providers (50%) were Community Health nurses and 13 (43.3%) were Health Assistants. Most of the providers 16 (53.3%) have served for 1-4 years, 26.7% for 5-9 years while 4 (13.3%) have served for more than 15 years.
Table 4.1 Distributions for demographic characteristics of providers

<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
<td>13.3</td>
</tr>
<tr>
<td>Female</td>
<td>26</td>
<td>86.7</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100</td>
</tr>
<tr>
<td>Qualification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Aide</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Health Assistant</td>
<td>13</td>
<td>43.3</td>
</tr>
<tr>
<td>Community Health Nurses</td>
<td>15</td>
<td>50.0</td>
</tr>
<tr>
<td>Public Health Nurse</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100</td>
</tr>
<tr>
<td>Length of Service (Years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-4</td>
<td>16</td>
<td>53.3</td>
</tr>
<tr>
<td>5-9</td>
<td>8</td>
<td>26.7</td>
</tr>
<tr>
<td>10-14</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td>≥ 15</td>
<td>4</td>
<td>13.3</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100</td>
</tr>
</tbody>
</table>

4.1.1 Assessment of basic education and in-service training

In table 4.2, less than half of the respondents reported having adequate in-service training in any of the methods. Close to half (46.7%) of the respondents reported having adequate training in short term methods and 43.3% in counseling. About a quarter (26.7%) of the providers reported inadequate training in long term methods.

4.1.2 Adequacy of in-service training

Table 4.2 Distributions for adequacy of in-service training

<table>
<thead>
<tr>
<th>Methods</th>
<th>Adequate training</th>
<th>Not adequate training</th>
<th>Can't tell</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long term methods</td>
<td>11 (36.7)</td>
<td>8 (26.7)</td>
<td>11 (36.7)</td>
</tr>
<tr>
<td>Short term methods</td>
<td>14 (46.7)</td>
<td>5 (16.7)</td>
<td>11 (36.7)</td>
</tr>
<tr>
<td>Counseling</td>
<td>13 (43.3)</td>
<td>6 (20.0)</td>
<td>11 (36.7)</td>
</tr>
<tr>
<td>Infection control</td>
<td>11 (36.7)</td>
<td>4 (13.3)</td>
<td>15 (50.0)</td>
</tr>
</tbody>
</table>
4.1.3 In-service training related to services provided

Less than half of the providers 12 (40%) reported they have had in-service training related to services provided.

![Graph showing distribution for the last time in-service training was organized]

**Figure 4.1 Distribution for the last time it was organized**

4.1.4 Supervision of health providers

Approximately half of the providers 15 (50%) reported that they have been supervised within the last 12 months. Majority of the providers 66.7% reported being supervised by Head of their units while only 6.6% reported supervised by an Outside institution. This is shown in figure 4.2
4.1.4 Reminders

4.1.4.1 Remind clients of up-coming visits

Majority of the providers 26 (86.7%) reported that they provide reminders for up-coming visits and follow-ups. Forty percent of the providers reported using verbal and other reminders such written reminders. None of the providers reported using mailing or telephone procedures.

<table>
<thead>
<tr>
<th>Reminders</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upcoming visits</td>
<td>26 (86.7)</td>
<td>4 (13.3)</td>
<td>30 (100)</td>
</tr>
<tr>
<td>Procedures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mailed</td>
<td>0 (0.0)</td>
<td>30 (100)</td>
<td>30 (100)</td>
</tr>
<tr>
<td>Telephone</td>
<td>0 (0.0)</td>
<td>30 (100)</td>
<td>30 (100)</td>
</tr>
<tr>
<td>Verbal</td>
<td>12 (40)</td>
<td>18 (60)</td>
<td>30 (100)</td>
</tr>
<tr>
<td>Others</td>
<td>12 (40)</td>
<td>18 (60)</td>
<td>30 (100)</td>
</tr>
</tbody>
</table>
4.1.4.2 Remind clients of follow-up on annual visits

Half (50%) of the providers reported providing reminders on missed appointments. Only 10% of the providers reported using Telephone and 6.7% reported using verbal procedures. However, 33.3% reported using other procedures such as written reminders.

Table 4.4 Distributions for responses to follow-up on annual visits

<table>
<thead>
<tr>
<th>Reminders</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow up on missed appointments</td>
<td>15 (50.0)</td>
<td>15 (50.0)</td>
<td>30 (100)</td>
</tr>
<tr>
<td><strong>Procedures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mailed</td>
<td>0 (0.0)</td>
<td>30 (100)</td>
<td>30 (100)</td>
</tr>
<tr>
<td>Telephone</td>
<td>3 (10.0)</td>
<td>27 (90.0)</td>
<td>30 (100)</td>
</tr>
<tr>
<td>Verbal</td>
<td>2 (6.7)</td>
<td>28 (93.3)</td>
<td>30 (100)</td>
</tr>
<tr>
<td>Others</td>
<td>10 (33.3)</td>
<td>20 (66.7)</td>
<td>30 (100)</td>
</tr>
</tbody>
</table>

4.1.5 Correlation between level of implementation score and Global Client Satisfaction

The level of competencies and skills of service providers correlated positively with the key components as well as the general (global) satisfaction of in-patients (Table 4).
Table 4.5: Correlation between the competencies and the key components of the general (global) satisfaction of clients

<table>
<thead>
<tr>
<th></th>
<th>Competence of service providers</th>
<th>Interperson</th>
<th>Adequacy of contraceptives</th>
<th>Score for overall satisfaction with care</th>
<th>General satisfaction of clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competence of service providers</td>
<td>Pearson Correlation Sig.</td>
<td>1</td>
<td>0.21**</td>
<td>0.40**</td>
<td>0.09</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>104</td>
<td>0.001</td>
<td>&lt;0.001</td>
<td>104</td>
</tr>
<tr>
<td>Interpersonal communication</td>
<td>Pearson Correlation Sig.</td>
<td>0.21**</td>
<td>1</td>
<td>0.45**</td>
<td>-0.042</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>104</td>
<td>0.001</td>
<td>&lt;0.001</td>
<td>104</td>
</tr>
<tr>
<td>Adequacy of contraceptives</td>
<td>Pearson Correlation Sig.</td>
<td>0.40**</td>
<td>0.45**</td>
<td>1</td>
<td>0.32**</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>104</td>
<td>&lt;0.001</td>
<td>104</td>
<td>104</td>
</tr>
<tr>
<td>Score for overall satisfaction with care</td>
<td>Pearson Correlation Sig.</td>
<td>0.094</td>
<td>-0.042</td>
<td>0.32**</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>104</td>
<td>0.132</td>
<td>&lt;0.001</td>
<td>104</td>
</tr>
<tr>
<td>General satisfaction of clients</td>
<td>Pearson Correlation Sig.</td>
<td>0.33**</td>
<td>0.87**</td>
<td>0.78**</td>
<td>0.21**</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>104</td>
<td>&lt;0.001</td>
<td>104</td>
<td>104</td>
</tr>
</tbody>
</table>

**. Correlation is significant at the 0.01 level (2-tailed).

4.2 Socio-Demographic Characteristics of WIFA Respondents

The mean age of the WIFA respondents was 26.83 ± 6.47 (mean ± SD) with a range of 15-49 years. Majority of the respondents were within the age group of 25-29 and formed 29.3% (117) of the study population. The results showed that 3.8% (16) of the respondents were within the age group of 45-49 years

Christians formed the majority of the study sample and represented 62.4% (259) whilst African Traditional religion believers formed 29.2% (122) of the study sample. The
dominant ethnic or tribal group of the study was Ga who formed 59.3% (237) of the study sample. About 88.8% (355) were married with 9.3% (37) being single. There was also 1.8% (7) who was divorced.

On the level of formal education attained by the respondents, only 4.5% (18) were educated to the tertiary level whilst 20.8% (83) were educated to the JHS level. Those who ended their education at the primary school level were 21.0% (84). Majority of the respondents representing 43.3% (173) of the study sample did not have any formal education. Majority of the respondents forming 34.5% (138) of the study sample were housewives and unemployed whilst 18.3% (73) were farmers. Civil servants formed 23.0% (92) of the respondents. Table 4.6 below shows the socio demographic characteristics of the respondents.
Table 4.6: Socio-demographic characteristics of respondents

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency (n=415)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19</td>
<td>25</td>
<td>6.0</td>
</tr>
<tr>
<td>20-24</td>
<td>95</td>
<td>22.8</td>
</tr>
<tr>
<td>25-29</td>
<td>117</td>
<td>28.1</td>
</tr>
<tr>
<td>30-34</td>
<td>107</td>
<td>25.7</td>
</tr>
<tr>
<td>35-39</td>
<td>47</td>
<td>11.3</td>
</tr>
<tr>
<td>40-44</td>
<td>8</td>
<td>1.9</td>
</tr>
<tr>
<td>45-49</td>
<td>16</td>
<td>3.8</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ATR</td>
<td>122</td>
<td>29.4</td>
</tr>
<tr>
<td>Islam</td>
<td>34</td>
<td>8.2</td>
</tr>
<tr>
<td>Christianity</td>
<td>259</td>
<td>62.4</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dangbe</td>
<td>238</td>
<td>57.3</td>
</tr>
<tr>
<td>Ewe</td>
<td>37</td>
<td>8.9</td>
</tr>
<tr>
<td>Ga</td>
<td>76</td>
<td>18.3</td>
</tr>
<tr>
<td>Twi</td>
<td>29</td>
<td>6.9</td>
</tr>
<tr>
<td>Others</td>
<td>35</td>
<td>8.4</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>40</td>
<td>9.6</td>
</tr>
<tr>
<td>Married</td>
<td>299</td>
<td>72.0</td>
</tr>
<tr>
<td>Consensual relationship</td>
<td>58</td>
<td>14.0</td>
</tr>
<tr>
<td>Divorced</td>
<td>18</td>
<td>4.3</td>
</tr>
<tr>
<td><strong>Educational status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic</td>
<td>170</td>
<td>40.9</td>
</tr>
<tr>
<td>SHS</td>
<td>47</td>
<td>11.3</td>
</tr>
<tr>
<td>Tertiary</td>
<td>20</td>
<td>4.8</td>
</tr>
<tr>
<td>None</td>
<td>178</td>
<td>42.8</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housewife</td>
<td>24</td>
<td>5.8</td>
</tr>
<tr>
<td>Trader</td>
<td>80</td>
<td>19.3</td>
</tr>
<tr>
<td>Civil service</td>
<td>95</td>
<td>22.9</td>
</tr>
<tr>
<td>Fish mongers</td>
<td>137</td>
<td>33.0</td>
</tr>
<tr>
<td>Craftsmanship/Artisan</td>
<td>79</td>
<td>19.0</td>
</tr>
</tbody>
</table>
4.3 Uptake of Family Planning Services

The results show that 25.1% (104) of the respondents have ever used family planning services whilst majority who formed 74.9% (311) said that they have never used any method of family planning. However, the proportion of the women who were currently using family planning was 15.4% (64) as shown in table 4.7 below.

Table 4.7: Use of family planning services

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency (n)</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever used FP method</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>104</td>
<td>25.1</td>
</tr>
<tr>
<td>No</td>
<td>311</td>
<td>74.9</td>
</tr>
<tr>
<td>Currently on FP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>64</td>
<td>15.4</td>
</tr>
<tr>
<td>No</td>
<td>40</td>
<td>9.6</td>
</tr>
<tr>
<td>Not applicable</td>
<td>311</td>
<td></td>
</tr>
<tr>
<td>Will continue to use FP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>48</td>
<td>46.1</td>
</tr>
<tr>
<td>No</td>
<td>20</td>
<td>19.2</td>
</tr>
<tr>
<td>Can’t tell</td>
<td>36</td>
<td>34.6</td>
</tr>
<tr>
<td>Not applicable</td>
<td>311</td>
<td></td>
</tr>
</tbody>
</table>

4.3.1 Bivariate Analysis of Socio-demographic Characteristics of the Mother and Uptake of Family Planning Services

More educated women were using modern contraceptives; compared to illiterate women. This was shown in bivariate analysis (Table 4.8). Educational level of women correlated positively with the uptake of contraceptives and family planning services. As the level of
education increases, the uptake of contraceptives and family planning services also increase. This association produced a Chi-square ($\chi^2 = 189.373, P < 0.001$). Also, as the level of spousal education increases, the approval of the uptake of contraceptives increases. Husbands who are highly educated tend to approve the use of contraceptives by their wives (Table 4.8). This association produced a Chi-square ($\chi^2 = 90.434$ with $P < 0.001$).

Of all the religious dominations, the Pentecostal/Charismatic group was the highest users of modern contraceptives whilst the lowest users came from Islam.

In bivariate analysis, there was a significant inverse association between the distance travelled and the uptake of family planning services though the association was not sustained in multivariable logistic regression analysis. Women who stayed closer to a health centre patronize modern family planning services more than their colleagues who had to travel over 25Km to access the services ($\chi = 14.6, P = 0.002$).

The uptake of family planning services was high among women who were economically empowered and have their own financial savings and it is low among women who do not have savings at all and those whose partners only have savings. There is a stronger relationship between women economic status and uptake of family planning services ($\chi^2 = 96.15, P < 0.001$). Also, the wealth index of women who were using one form of modern contraceptive was significantly higher than women who did not use any ($3.0 \pm 1.05$ versus $2.5 \pm 1.01$) $F(1,599) = 25.6, P < 0.001$.

Access to media also had a significant influence on the uptake of family planning services as women who watched TV frequently were more likely to use FP as shown in (Table 4.8). This association produced a Chi = 67.0 $P < 0.001$. However, this association was not significant.
in multiple regression analysis ($P < 0.09$, $\chi^2 = 4.3$). Also, frequent listening to radio was positively and significantly associated with uptake of FP services ($\chi^2 = 1.7$, $P < 0.001$). The association was not significant in the regression model.

There was a stronger relationship between spousal approval of the uptake of contraceptives and their current uptake by their wives or partners as shown by a Chi square value of $107.415$ and $P < 0.001$ (table 4.8)

Uptake of contraceptives was higher 70.3% (26) among women in the civil service or government agencies and lowest 0.6 % (2) among women were farmers or in the agricultural sector. Among the respondents who were traders 50.9 % (89) were using modern contraceptives. The chi square value of $243.815$ and $P < 0.001$ (Table 4.8 below shows a stronger association or relationship between the occupation of a woman and uptake of contraceptives or family planning services.

The uptake of contraceptives and family planning services was low among teenagers and women who were above thirty years but uptake was relatively high among women in their twenties. A chi square value of $19.810$ and $P < 0.001$ shows that there is a stronger association between age and the uptake of contraceptives among women (Table 4.8.)
Table 4.8: Bivariate analysis of socio-demographic characteristics, economic status and the uptake of family planning services.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Currently using contraceptive</th>
<th>Test Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-24</td>
<td>68(84.0)</td>
<td>13(16.0)</td>
</tr>
<tr>
<td>25-34</td>
<td>113(73.4)</td>
<td>41(26.6)</td>
</tr>
<tr>
<td>35-44</td>
<td>149(74.1)</td>
<td>52(25.9)</td>
</tr>
<tr>
<td>45-49</td>
<td>148(90.2)</td>
<td>16(9.8)</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>92(78.0)</td>
<td>26(22)</td>
</tr>
<tr>
<td>Orthodox</td>
<td>44(73.3)</td>
<td>16(26.7)</td>
</tr>
<tr>
<td>Pentecostal/Charismatic</td>
<td>32(57.1)</td>
<td>24(42.9)</td>
</tr>
<tr>
<td>Islam</td>
<td>309(84.7)</td>
<td>56(15.3)</td>
</tr>
<tr>
<td>ATR</td>
<td>1(100.0)</td>
<td>0(0.0)</td>
</tr>
<tr>
<td>Education Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>340(94.7)</td>
<td>19(5.3)</td>
</tr>
<tr>
<td>Low</td>
<td>126(65.3)</td>
<td>67(34.7)</td>
</tr>
<tr>
<td>High</td>
<td>12(25.0)</td>
<td>36(75.0)</td>
</tr>
<tr>
<td>Distance to Health Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.5-5Km</td>
<td>189(73.0)</td>
<td>70(27.0)</td>
</tr>
<tr>
<td>6-11Km</td>
<td>114(81.4)</td>
<td>26(18.6)</td>
</tr>
<tr>
<td>12-17Km</td>
<td>68(85.0)</td>
<td>12(15.0)</td>
</tr>
<tr>
<td>18-25Km</td>
<td>107(88.4)</td>
<td>14(11.6)</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Civil Service</td>
<td>11(29.7)</td>
<td>26(70.3)</td>
</tr>
<tr>
<td>Trading</td>
<td>86(49.1)</td>
<td>89(50.9)</td>
</tr>
<tr>
<td>Farming</td>
<td>353(99.4)</td>
<td>2(0.6)</td>
</tr>
<tr>
<td>Unemployed</td>
<td>28(84.8)</td>
<td>5(15.2)</td>
</tr>
<tr>
<td>Spousal Approval</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>29(36.3)</td>
<td>51(63.8)</td>
</tr>
<tr>
<td>No</td>
<td>449(86.3)</td>
<td>71(13.7)</td>
</tr>
<tr>
<td>Savings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, partner's savings</td>
<td>25(89.3)</td>
<td>3(10.7)</td>
</tr>
<tr>
<td>Yes, mine and partner's savings</td>
<td>18(60.0)</td>
<td>12(40.0)</td>
</tr>
<tr>
<td>Yes, self savings</td>
<td>49(47.1)</td>
<td>55(52.9)</td>
</tr>
<tr>
<td>No, we don't have savings</td>
<td>386(88.1)</td>
<td>52(11.9)</td>
</tr>
<tr>
<td>Not at all</td>
<td>338(97.4)</td>
<td>9(2.6)</td>
</tr>
</tbody>
</table>
4.4 Educational Level and Choice of Contraceptive Method

The majority of the respondents, 79.7% (478/415) were not using any form of modern contraceptive. However, the most popular method was injectable Depo Provera (Table 4.9).

4.4.1 Contraception Prevalence Rate in District

The number of women or respondents using modern family planning methods was 64 giving the contraception prevalence rate was 15.4% (64/415).

Table 4.9: FP methods used according to respondents' education level

<table>
<thead>
<tr>
<th>Educational level of mother</th>
<th>Preferred family planning method</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never used</td>
</tr>
<tr>
<td>None Count</td>
<td>331</td>
</tr>
<tr>
<td>%</td>
<td>92.2%</td>
</tr>
<tr>
<td>Low Count</td>
<td>107</td>
</tr>
<tr>
<td>%</td>
<td>55.4%</td>
</tr>
<tr>
<td>High Count</td>
<td>8</td>
</tr>
<tr>
<td>%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Total Count</td>
<td>446</td>
</tr>
<tr>
<td>%</td>
<td>74.3%</td>
</tr>
</tbody>
</table>

4.5 Spousal Approval of Contraceptives Usage

Spousal approval of contraception was assessed among the respondents. 13.7% (82) of the respondents said that their husbands approve of the uptake of contraceptives whilst 86.3% (518) said that their husbands were against the uptake of contraceptives below.

A total of 122 (20.3%) women were using contraceptives as against 478 (79.7%) of the respondents who were not using. A total of 45 (7.5%) of the respondents who were using contraceptives sought the consent of their spouses whilst 77 (12.8%) of them did not seek approval from their husbands. This is shown in table 4.10.
Table 4.10: Husbands educational level *Approval of contraceptives usage

<table>
<thead>
<tr>
<th>Husband's educational level</th>
<th>Approves contraceptives uptake</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>None</td>
<td>16</td>
<td>312</td>
</tr>
<tr>
<td></td>
<td>4.9%</td>
<td>95.1%</td>
</tr>
<tr>
<td>JHS</td>
<td>18</td>
<td>121</td>
</tr>
<tr>
<td></td>
<td>12.9%</td>
<td>87.1%</td>
</tr>
<tr>
<td>SHS</td>
<td>28</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>34.1%</td>
<td>65.9%</td>
</tr>
<tr>
<td>Voc/Tech</td>
<td>8</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>22.2%</td>
<td>77.8%</td>
</tr>
<tr>
<td>Tertiary</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>66.7%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Total</td>
<td>80</td>
<td>335</td>
</tr>
<tr>
<td></td>
<td>13.3%</td>
<td>86.7%</td>
</tr>
</tbody>
</table>

4.6 Knowledge and Use of Modern Family Planning Methods

Of the 415 women interviewed, 15.2 % (91/415) heard of family planning prior to the study. Most respondents had information about modern family planning methods than about natural family planning methods. More than half of the respondents 58.2 % (349) knew of modern family planning methods, 36 % (216) had no knowledge of modern methods and only 5.8 % (35) knew of natural family planning methods. The results show that there is a strong association between family planning knowledge and utilization. The more knowledge a woman has, the greater the chance of utilizing a modern family planning method (Likelihood ratio = 154.3, P< 0.001)
The knowledge level of the specific contraceptives and family planning methods is shown in Fig 4.3 below.

**Fig. 4.3: Knowledge level of modern contraceptives methods among respondents**

4.6.1 Source of Family Planning Information

The respondents reported their sources of family planning information and the clinic/health centre was the main one cited (Table 4.11)
Table 4.11: Sources of information about FP methods in the last month

<table>
<thead>
<tr>
<th>Source of FP messages</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never Heard</td>
<td>519</td>
<td>86.5</td>
</tr>
<tr>
<td>Clinic</td>
<td>74</td>
<td>12.3</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>3</td>
<td>0.5</td>
</tr>
<tr>
<td>Friends</td>
<td>3</td>
<td>0.5</td>
</tr>
<tr>
<td>Media</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>Total</td>
<td>415</td>
<td>100</td>
</tr>
</tbody>
</table>

4.7 Quality of Family Planning Services at Health Institutions

The quality factors investigated were staff attitude, waiting time, privacy during consultation, communication between service providers and clients, staff qualification, in-service training for staff, and number of days family planning services were available. Out of the women who have ever used family planning services, most of them 97.4% (148/152) reported the attitude of health staff was satisfactory. Privacy at the health facilities was generally considered to be adequate 98.1% (151/152).

The number of days family planning services were offered in a week were in the range of 5-6 days (Table 4.12).
Table 4.12 Number of days family planning services are offered in a week

<table>
<thead>
<tr>
<th>Number of working days</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 2 days</td>
<td>22</td>
<td>3.7</td>
</tr>
<tr>
<td>3 to 4 days</td>
<td>2</td>
<td>0.3</td>
</tr>
<tr>
<td>5 to 6 days</td>
<td>99</td>
<td>16.5</td>
</tr>
<tr>
<td>throughout the week</td>
<td>10</td>
<td>1.7</td>
</tr>
<tr>
<td>Total</td>
<td>133</td>
<td>22.2</td>
</tr>
<tr>
<td>Missing(Not Applicable)</td>
<td>311</td>
<td>77.8</td>
</tr>
<tr>
<td>Total</td>
<td>415</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Of the quality factors considered, free or interpersonal communication between clients and service providers was the only significant determinant of uptake of family planning services (chi² = 4.2, P< 0.001) and clients' ability to communicate with the service providers was strongly associated with the educational level of the mother (Table 4.13)

Table 4.13: Relationship between uptake of FP and ability to communicate with service providers

<table>
<thead>
<tr>
<th>Ability to communicate with service provider on health matters</th>
<th>No</th>
<th>Yes</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational level of None mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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4.8 Barriers to the Uptake of Contraceptives and family planning services

The socio-cultural barriers to the uptake of contraceptives and family planning services in the communities as reported by service providers are presented in Fig 4.4 below.

![Barriers to the use of modern contraceptives](image)

**Fig 4.4**: Socio-cultural barriers to the uptake of family planning services among respondents

4.9 Maternal Autonomy and its Influence on Uptake of FP services

Maternal autonomy or the mother's status in the household indicates her decision-making power with respect to movement, finance, healthcare use, and other household activities. Evidence suggests that autonomy of the mother is significantly associated with uptake of FP services and contraceptives use (Table 4.19). Women who use modern contraceptives had significantly higher maternal autonomy score, compared with women who were not using any kind of modern contraceptives (7.4 versus 2.1) F (1,599) = 490.6, P < 0.001. This
association remained significant even in a multiple regression analysis (P< 0.009, CI = 1.09-1.83) (Table 4.10)

Table 4.14 Composite index of women autonomy (CIWA) and uptake of modern family planning methods

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
<th>95% Confidence Interval for Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lower Bound</td>
</tr>
<tr>
<td>No</td>
<td>293</td>
<td>2.1381</td>
<td>2.45585</td>
<td>0.11233</td>
<td>1.9174</td>
</tr>
<tr>
<td>Yes</td>
<td>122</td>
<td>7.3034</td>
<td>1.80704</td>
<td>0.16360</td>
<td>7.0695</td>
</tr>
<tr>
<td>Total</td>
<td>415</td>
<td>3.2067</td>
<td>3.15339</td>
<td>0.12874</td>
<td>2.9538</td>
</tr>
</tbody>
</table>

4.10 Role of Maternal Autonomy, Education and Economic Status in the Uptake of Modern Family Planning Methods

The analysis showed that maternal education was consistently related to maternal autonomy in the study sample. Women who attained higher education had greater autonomy in taking critical decisions that affect their welfare, compared to their illiterate colleagues (7.3 versus 1.9) F (2,599) = 133.9, P< 0.001 (Table 4.15)
Table 4.15: Maternal autonomy and maternal educational level

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
<th>95% Confidence Interval for Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lower Bound</td>
</tr>
<tr>
<td>None</td>
<td>174</td>
<td>1.8830</td>
<td>2.25664</td>
<td>0.11910</td>
<td>1.6488</td>
</tr>
<tr>
<td>Low</td>
<td>193</td>
<td>4.6425</td>
<td>3.28057</td>
<td>0.23614</td>
<td>4.1767</td>
</tr>
<tr>
<td>High</td>
<td>48</td>
<td>7.3333</td>
<td>2.17660</td>
<td>0.31417</td>
<td>6.7013</td>
</tr>
<tr>
<td>Total</td>
<td>415</td>
<td>3.2067</td>
<td>3.15339</td>
<td>0.12874</td>
<td>2.9538</td>
</tr>
</tbody>
</table>

4.11 Determinants of Uptake of Family Planning Services

Results of logistic regression analysis in Table 4.15 showed that educational level of the spouse has positive and highly significant effect on the uptake of family planning services. Compared to women whose husbands had no education, women whose husbands attained secondary or higher education had significantly greater odds of utilizing a family planning service (AOR = 3.7, CI: 1.4-9.5, p=0.01).

These results also show that uptake of family planning services in the study sample is significantly related to many other factors including ability of the woman to communicate with health service provider on health matters, household wealth index of mother (access to resources), and maternal autonomy (that is, empowerment to make key decisions). The greater the number of daughters a woman has, the lesser her chances of patronizing family planning services.
The educational level of the mother and her/husband remains an important determinant of uptake of family planning methods but the effect of education becomes irrelevant or the effect is reduced with the inclusion of the variable that takes care of maternal ability to communicate with health service provider on health matters variable. The ability of the woman to discuss health matters with the service provider makes irrelevant the contribution of maternal autonomy in the uptake of family planning services (Table 4.15). Maternal education up to the JSS level also had no significant explanatory power on the use of family planning methods when the ability of the woman to discuss health matters with service providers is taken into consideration in the multivariable logistic regression model (Table 4.15). This, then, suggests that the ability of the woman to discuss health matters including family planning is mediated through education whereby women educated up to SHS level have greater opportunities to take decision on their own health, compared to her illiterate colleagues. Inclusion of the woman’s ability to communicate with health provider on health matters increased Nagelkerke R Square from 73.5% to 81.7%. This means that variable alone accounted for 8.2% of the variance in the uptake of family planning services. A woman who is able to discuss health matters with the service provider was 148 times more likely to use a modern contraceptive (adjusted odds ratio = 148, CI: 30.5-726).
Table 4.16: Determinants of the uptake of family planning methods (Model 2)

<table>
<thead>
<tr>
<th>Determinant</th>
<th>B</th>
<th>Wald</th>
<th>P-value</th>
<th>Exp (B)</th>
<th>95.0% CI for EXP(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of daughters alive</td>
<td>-0.754</td>
<td>12.035</td>
<td>0.001</td>
<td>0.47</td>
<td>(0.31, 0.72)</td>
</tr>
<tr>
<td>Household wealth index</td>
<td>0.995</td>
<td>16.552</td>
<td>0.000</td>
<td>2.70</td>
<td>(1.7, 4.4)</td>
</tr>
<tr>
<td>Maternal autonomy</td>
<td>0.346</td>
<td>6.887</td>
<td>0.009</td>
<td>1.41</td>
<td>(1.09, 1.83)</td>
</tr>
<tr>
<td>Ability of the woman to communicate with health service provider</td>
<td>4.703</td>
<td>28.454</td>
<td>0.000</td>
<td>1.10</td>
<td>(1.9, 2.4)</td>
</tr>
<tr>
<td>Planned number of children to have</td>
<td>0.909</td>
<td>4.673</td>
<td>0.031</td>
<td>2.5</td>
<td>(1.1, 5.7)</td>
</tr>
<tr>
<td>Constant</td>
<td>-8.494</td>
<td>44.438</td>
<td>0.000</td>
<td>0.000</td>
<td></td>
</tr>
</tbody>
</table>

4.12 Results of Qualitative Study

The qualitative data was gathered according to selected topics of interest which include fertility preference of the men and women who took part in the discussions, factors influencing the fertility preference of wives and husbands, barriers to the use of modern contraceptives among couples, benefits of family planning, ways to improve uptake of modern contraceptives, roles of men and women in the use of contraceptives, and the sexual rights of women. The results or findings of the focus group discussions were arranged according to the themes or areas of interest and the themes were linked to the results of the quantitative analysis.
4.12.1 Determinants of the Uptake of Family Planning Services and Modern Contraceptives

Although the women displayed some level of awareness and knowledge of family planning services and also some level of use of contraceptives, majority of them reported that they have never used any modern contraceptive. Few of them reported that they have ever used modern contraceptives but are currently not using them. This was consistent with the quantitative data where those who have ever used contraceptives were more than those who were currently using them.

In probing to find out the factors or determinants of the use of contraceptives there were some factors that were mentioned which kept recurring in the discussions in all the study communities. These factors include:

**Economic status of the women:** From the focus group discussions organized it was realized that the economic status of a woman has an influence on her ability or propensity to use modern contraceptives just as it was observed in the bivariate analysis of the quantitative study. This became clearer when women made statements such as;

"my husband is the one who controls the money we get from our farm produce and he is the one who married me so he takes care of our children. He decides on the number of children he can take care of and I have to obey him"...........

"I don’t go to the hospital alone; I always go to the hospital with my husband. He takes me on his bicycle to the hospital and pay my hospital bills so he knows what I go to the hospital to do. He will not pay for me to go for family planning because he does not need it, but I cannot also get up and go to the hospital by myself without his knowledge"...........
you know that most women here do not have work on their so they don’t have any control over their reproductive health choices. It is your husband who is having all the money and will not give you some to be working because he thinks that when a woman is rich she will not respect her husband. This is why some women don’t do family planning”......

**Empowerment status of women:** The level of involvement of women in household decision making and the level of respect and dignity that their husbands attach to them was seen to have an influence on their uptake of contraceptives. Women who reported that they were using modern contraceptives had to decide with their husbands or went for it on their own volition because their husbands did not agree to their decision. Some of the excerpts from the women include:

.........“my husband is married to me and I am also married to him so I respect him and he should also respect me. I discussed it with him that I wanted to go for family planning, and he asked me my reasons which I explained to him and he agreed”......

.... “I am a civil servant and I take salary at the end of the month. I also know my rights so my husband respects me and I also respect. Anytime I want to go to the hospital I just inform him and sometimes he gives me money and other times he doesn’t and I am okay with it. I am using Depo provera and he is aware but he has not complained”.........

......... “We women are such that men don’t respect us. So they don’t want to take our advice and always want us to do what they want. That is why they don’t allow us to do family planning”.........
**Number of children alive:** From the discussions in the focus groups, it was seen that the number of children alive has an influence on the use of modern contraceptives either to space or limit births. Women who had five or more children showed some interest in using contraceptives as compared to those who had lesser number of children. Again, women who have suffered child mortalities showed apathy towards modern contraceptives. These are some statements made by some of the discussants:

"for me nature or God have done family planning for me because I have given birth to six children but as of now, only three of them are alive. I have divided them with death. What do you think will happen if I were using modern contraceptives then I wouldn’t have a child by now"..........

"I have only one child why should I use modern contraceptives? Those who have more children should be using them “..........

"I will only use contraceptives when I become an old lady and decide not to give birth again “..........

**Education level:** An interaction with the women in the focus group discussions showed that family planning is considered to be the preserve of the elites or educated couples. Some of the statements that exemplify this notion include:

"family planning is the white man’s ideology, so it should be used by those who have gone to school but not for us farmers. The food we eat is different from what the white man eats......"
Ability to freely discuss their health needs: The ability of women to discuss their health needs with health professionals and also their friends was seen to have a positive association with their uptake of family planning services. The following statements are excerpts to buttress the association:

"the women whom I have heard of and those I have seen using family planning methods are those who have gone to high schools and those women who have money".............

"when I gave birth to my second child and went for postnatal care, I talked to one of the nurses about how I can prevent early pregnancy. She taught me the various methods so I went for Jadelle which I am still using"............... 

"it was my friend who told me about the Depoprovera when we were in a bus going to the market. I told her that I didn’t want to give birth in the next three years but didn’t know any contraceptive method. So the following week I went to the health center for Depoprovera".........

Occupation of the couples: The type of occupation of the respondents was also seen to have an association with the use of modern contraceptives as it shown by bivariate analysis in the quantitative data. Majority of the women and men who reported that they were using modern contraceptives were in the civil service and commerce. This relationship was linked to the assertion that these categories of people (civil servants and traders) had enough time for their health matters or issues. Also, most of the discussants who were farmers recounted the importance of large family size to their occupation in terms of provision of free labour.

4.12.2 Knowledge Level of Modern Contraceptives

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The knowledge level of contraceptives among discussants varied greatly especially in the lines of education level and their place of residence (urban, peri-urban and rural). The knowledge level also differed with regards to the various methods which is similar to the results of the quantitative study. Majority of the women and men had knowledge of the male condom and the injectables. Knowledge of the male condom was almost universal among the male discussants with the female condom least heard of, as majority of the male and female discussants said they have never seen it before. Male vasectomy and female sterilization were known mostly among the women and men with a secondary and post-secondary education. Those who were in the urban and peri-urban areas had more knowledge of different modern contraceptives method. Some of the statements that were made by the discussants with regards to their knowledge of the family planning methods are;

"I have never heard of female condom before, I know the male condom and my husband have ever used it"............

"we know of the male condoms, the injectables and the pills but I have never used any of them before".............

"it is the women who know the family planning methods because they use them, as for we the men we don't use them so we don't even look for these things"..............

4.12.3 Preferred Family Planning Method among Discussants

Although the women were using different modern contraception methods, the use of Depo provera was more prevalent among the women who were currently or had ever used modern contraceptives just as the quantitative study revealed. These were some statements made by some of the women to support this point;
..."I use Depo provera because my husband doesn’t see it and will not know that I am using it".....

......... "the reason why most of us use Depo provera is that it makes you grow fat and you develop a good shape around your pelvis so that you look attractive to your husband"......

......... "Depo provera is good because it is an injection which will last for three months. You can go for it and be roaming with it, however with the pills you have to be taking it every day in a month and you can forget which will create problem or trouble for you. But when you are using Depoprovera you will not forget so it is safe".......... 

......... "initially I was using the pills and my husband saw it and threw them away, so this time I am using Depoprovera which he cannot see and he can’t ask me why I am not pregnant. If he asks why I am not pregnant, I will only tell him that I am not God"..........

4.12.4 Barriers to the use of contraceptives

Even though the knowledge level of modern contraception methods was very high especially among both men and women; the use of contraceptives was faced with some obstacles. In probing to find out why majority of the women and men were not using contraceptives the following reasons were given with some of their quotations.

Fear of side effects of modern contraceptives: Majority of the women and men gave the fear of side effects of modern contraceptives as one of the reasons for not using them. These are some statements made by some of the women:

......... "I am a woman with four children, and I safely gave birth to three of my children in the house without the help of a doctor or a nurse. A friend advised me to go for Depo provera
which I wholeheartedly did. Later when I became pregnant and was in labour, it was very 
serious and was at the crossroad of death and life. I became unconscious and was rushed to 
the hospital for a caesarian session. It was because of the family planning method that is 
why I didn’t deliver safely at home so I have stopped using it and I have advised my friends 
and relatives never to use contraceptives.” .........

A lot of the women in all the communities who took part in the focus group reported 
irregular menses as one of the problems with contraceptives especially Depo provera, 
Norigynon and Jadelle. These are some excerpts:

............“I used Depo provera when I gave birth to my third child but I realized that I was 
not having my menses again for about 6 months. I thought I was pregnant but my belly was 
not growing bigger. I was having some weird feelings in body so I went to hospital for a 
pregnancy test which proved negative. I was then given some drugs but as of now I am still 
not having my normal menses. It is therefore a problem for me so it not good to use family 
planning especially injectables.” .......

Some of the women complained of a complete cessation of their menses when they used 
modern family planning methods. This is what one woman said;

............“I have not menstruated for fourteen months. It all started the very month I used 
Depoprovera up to this time I don’t menstruate so am I a woman? Nurses deceive us to use 
family planning methods which create big problems for us. As for me I will not advise 
anybody to use contraceptives.” .......

Other women also complained of an overflow during their menses when they use injectables 
and Jadelle. Some of the excerpts are;
"my husband and I decided that I should go for Jadelle for about a year now but anytime I have my menses it lasts for about one week and sometimes more than that. It makes me feel uncomfortable because in Islam anytime you are menstruating you can’t go to the mosque and pray." ......

"When I went for Depo provera, I was always having an overflow in my menses. I contacted a nurse and they told me it will become normal again but it didn’t so I have stopped." ......

Some of the women in all the groups who have never used any of the methods built their argument on the experiences of others who have used them and had some complications. These are some of the statements that were made:

"Some people say that when you do family planning you will not have your menses again"

"I have heard from my friends who went for Depoprovera that it is not good to do family planning because you will be menstruating by heart. All the time you will be menstruating." ......

Another issue that was raised by about 75% of the women was the issue of family planning methods or contraceptives making it difficult for a woman to become pregnant again when she wants to. These are some statements to exemplify their claims:

"when I gave birth to my first child I decided to go for Jadelle. Later I went to the Health Centre and had it removed, since then, I have struggled to become pregnant again but to no avail. Some of my friends are saying it is because of the Jadelle and I think it is true." ......

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"Since I stopped using Depoprovera for the past three years, I have struggled to become pregnant but it has not been successful so my husband have given me up to the end of this year that if don't become pregnant, then he would go for another woman. I have given birth to two children and decided to be use contraceptives which has created this problem for me."......

Spousal opposition or disapproval of contraceptives use: This was seen as a barrier to the use of modern contraceptives among the women as it was also cited in the quantitative data. Most of the women said that their husbands do not accept or approve of modern contraceptives use. Some of the women stated this in the following statements;

"my husband told me that if I go for a modern family planning method, then he will marry another woman because he wants more children"......

"we the women don't have problem in using modern contraceptives, it is rather our husbands who don't want us to use them. As Muslims we can't disobey our husbands so it is better you talk to our husbands"......

"when you tell your husband to use condom he will tell you that you don't trust him or you think he has HIV/AIDS"......

"my husband told me that he is the one who is going to take care of the children so I have to give birth to all the children in my womb. He said he will divorce when she sees me using a modern contraceptive"......

Knowledge/information gap: The use of modern contraceptives was also impeded by the knowledge or information gap especially among those with lower or no formal education. It
was also observed among women and men who were staying in rural areas. Some of the excerpts are:

............"we don't know of the methods of family planning apart from the condom. So they should teach we the women and our husbands"...........

............"we heard that when you use modern contraceptives you cannot become pregnant again".....

**Poor physical or geographical accessibility:** Poor accessibility to modern contraceptives was stated as one of the reasons why some men and women were using contraceptives. Some of the women and men blame the inability to get easy access to the contraceptives for their non-use. This was also realized in a bivariate analysis of quantitative variables that as the distance to the source of family increases, the uptake of family planning services decreased. Some of the people made the following statements to that effect

............"they don't sell condoms in this village so if I want to have sex with a woman I cannot take the bicycle to travel 15 miles to buy a condom. I will therefore do it like that and face the consequences"...........

............"I went for Depoprovera in Tamale, but the distance is very far and it is difficult to get a car to that place."............

............"even when our children are sick we find it difficult to get a car to the hospital or health centre. At times we rely on herbal medicines so we don't see it necessary to go to the hospital or health center for just a family planning injection"............

4.12.5 Benefits of Family Planning
Although the contraception prevalence rate respondents were not too encouraging, they knew some benefits of family planning. During the focus group discussions, the discussants mentioned some of the benefits of family planning as follows;

**Family planning improves maternal and child health:** In all the focus groups, it was mentioned that family planning helps to improve the health of mothers and children. Some of the statements to this effect include;

"any woman who is always nursing a child or who gives birth at short intervals looks filthy and smelly. Because the child will vomit, go to toilet and also breastfeed. These are the things that make mothers to smell. It is good that women will space their births and becomes very neat"...........

"when you become pregnant and your child is still crawling, the pregnancy affects the health of the child and he/she will develop kwashiorkor"...........

**Family planning improves financial status of households:** Some of the discussants mentioned that family planning improves the economic status of couples. Some of the excerpts are;

"when your children are few, you can take good care of them in their education and the provision of food. This is because you will share the household money among few people"......

"a woman with few children always wear new clothes because she will have excess money for herself. But a woman with so many children always dresses shabbily because the children require money for their clothes"............
Family planning promotes unity among couples in their sexual life: This point was reiterated among the female discussants. They said that with family planning couples do not fight over sexual rights. These are some of their statements;

"when I gave birth to my two children within two years, I started to deny my husband his sex request. We were always having confrontations because of that so I was advised to go for family planning. So now we don’t fight or argue over sexual issues again because I know I am protected from becoming pregnant”

"as a woman if you are always nursing a child your husband will use that as an excuse to go for other women. In this community anytime you give birth you have to leave your husband’s house and go to your mother. Before you return, your husband will go for another woman because of sex”

Family planning young people to reach their life’s aspirations: Some teenagers and young men and women in their twenties asserted that family planning helps the youth to reach their aspirations in life by preventing early parenthood.

Some of their statements include;

"I have regretted giving birth at a tender age of 16 because now when I compare myself to my classmates who didn’t give birth early, I feel embarrassed because I don’t have a work and don’t even know what I will achieve in my life”
“we the young men who gave birth early have regretted for becoming fathers at such early ages. Now we have forcibly become old men because you are always under pressure to care for your children and wife. If you are not careful too, your child will become useless in life because you couldn’t take good care of them. So they will grow and become like us which is bad”

4.12.6 Ways to Improve the Uptake of Family Planning Services

In probing to find out the ways by which the uptake of family planning services could be improved among women and men in the district the discussants suggested the following ways:

Men should be deeply involved in matters of family planning: The involvement of men in matters of family planning was seen to be crucial in improving the uptake of family planning services. These are some statements to support this assertion;

“in our societies it is believed that men are the main stakeholders in making decisions about fertility in marriages. If women can go for family planning then it will depend on what their husbands decide”

“as for we the women, we don't have much problem with using contraceptives rather it is the men who always want to prevent us from using them. So you have to talk to our husbands”

“there should be more male controlled family planning methods the women apart from the condom. If there were pills for men like we the women will sneak and put it inside their foods so that they will not notice it. This will prevent them from impregnating us. But here is the case we don’t have pills for males”
5.0 Introduction

This chapter discusses the findings of the study in relation to other existing literature. The chapter is divided into two sections to look at the findings of the quantitative and qualitative data. The information in the qualitative data was gathered from focus group discussions that were organized.

5.1 Client satisfaction with utilization of healthcare services

Owusu, (2007) commended the GHS for introducing the quality assurance checklist because it will increase the quality of health care services in Ghana. The primary purpose of this study was to gain an understanding of the quality of FP services and the determinants of the uptake of these services. Level of skills and competencies of the service providers was quantified by including eight aspects: level of skills training, qualification of the service provider, and communication skills.

Some researchers have argued that it is entirely desirable and proper that the views of patients should be sought on their experiences and expectations of health care (Ramez, 2012; Yousapronipaiboon and Johnson, 2013). This has called the attention of most hospitals in Ghana to modify their services to achieve patient satisfaction, in view of this, the hospital has to develop itself technologically (Naidu, 2009), as well as become more service-oriented (Laroche et al., 2004), to understand the fact that patients do not flock to a hospital just because its services are cheap, but because of its good customer service.
delivery. In this view, Alrubaiee and Alkaa’ida (2011) argued that it is necessary for hospitals to become organizations permanently controlled by the patients’ interest. They again reported that today’s clients of hospitals in Ghana are tougher, more informed and also sensitive to poor services, which makes them often walk away and never come back for repeated services. Therefore, the quality of service still remains a key factor to address in the healthcare delivery in all hospitals in Ghana. In this study, out of the 415 women interviewed, 26.8 % considered the level of competence and skills to be high which is consistent with that of Atinga and Gordon (2009) and Turckson (2009) who found that Patients Charter was not implemented in health facilities in Ghana.

5.2 Socio-Demographic Characteristics of the Women

The women in their fertile age (WIFA) who were interviewed were from the ages of 15 to 49 years and who were either married or in an informal sexual relationship. There were some teenagers who were already mothers and this is consistent with the findings of the GHS & GSS (2008) in the Ghana Demographic and Health Survey that 13% of teenagers in Ghana are already mothers or are pregnant with their first child. The findings are however not consistent with the assertion by the GDHS that a higher percentage of teenagers in the Northern region are already mothers or pregnant with their first child.

With regards to the religious distribution of the women, majority of the respondents were Muslims while the rest belonged to different Christian and religious denominations with Catholics forming higher proportion of the Christians group. These results confirm the report of the (GSS, 2001) in the 2000 Population and Housing Census which stated that the Ningo-Prampram district comprises of about 60 %. The results however differ from the 30
% composition of African Traditional believers. This could be attributed to the smaller number of the sample size as compared to that of the Population and Housing Census which involved everybody in the district.

The results showed that majority of the respondents did not have any formal education. The percentage of women without formal education was almost three times higher than that of the national average of 21% provided by the Ghana Demographic and Health Survey of 2008. However, the findings are consistent with GDHS assertion that two-thirds of women in the Northern region of Ghana have no formal education. The results were consistent with the findings by the GDHS that 4% of women in Ghana were educated to the tertiary level. The level of formal education attained by their husbands was higher that of the women even though men without formal higher education formed the majority. Men who attained tertiary education were slightly higher than the women. This finding agrees with the findings of the GDHS (2008) and the Ethiopian Demographic and Health Survey (2005) that men attain higher formal education than women.

5.2.1 Socio-Demographic Characteristics and Uptake of Family Planning Services

The results showed that the uptake of family planning services increases with an increasing level of the mother’s education. Women who had no formal education tend to have lower level of contraceptives use as compared to women with formal education. The level of modern contraceptives use was high among mothers with a secondary school and post secondary (Tertiary) education. This implies that more educated women were using modern contraceptives, compared to illiterate women. As the level of education increases the uptake of contraceptives and family planning services also increase. The finding is consistent with the results of the GDHS of 2008 which stated that modern contraceptive use increases with
women's education; nineteen percent of married women with more than secondary or higher education use modern methods compared with 11% of women with no education.

The gap between those who were educated to the primary and JHS level and those who did not have any formal education was not significant. Thus female education to the JHS and primary school level did not have influence on their uptake of modern family planning services as was earlier on established by Oliver (1995) and Chacko (2001).

These findings have also been replicated in studies in different countries across the developing world showing a positive association between women's education and the uptake of contraceptives and family planning service. Studies by Beekle and McCabe (2006) and Korra (2002) in Ethiopia, Zaheer et al (2011), and Rehan et al (2011) in Pakistan reported of a similar trend. The positive association between maternal education and the uptake of modern family planning services has also been reported by Sylvia (2004), in Nigeria, also by (Measure DHS Marco International Demographic and Health Surveys, 2006) using the Demographic and Health Survey (DHS) (2006) of Nepal, and Dang (2002) in Vietnam. Husband's education level has an effect on the use of modern contraceptives either by the woman (wife) or by himself. The results showed that over 80% of men without any formal education do not approve of the use of modern contraceptives whilst all the men with tertiary education approved of the use of modern contraceptives. The results showed a trend that as the level of education of husband (spouse) increases, the approval of the uptake of contraceptives also increases thus husbands who are highly educated tend to approve the use of modern contraceptives by their wives or by themselves. This finding that husbands' education level has a positive association or relationship with the approval and use of
modern contraceptives is consistent with the work of Ria (2009) and Mohamad et al (1988) in a study in Indonesia. Again the findings of Gereltuya et al (2007) in Kenya are similar with the findings of this study. They stated that wives’ education levels were an important influence on the types of contraceptive method used but husbands’ education levels has more influence on the use of modern contraceptives. Dang (2002) using data from the Vietnam DHS, also argued that husbands’ education level has a greater influence on contraceptive use than did wives’ education level.

This finding was also supported by the study conducted by Bina (2009) which stated that the husband’s education level has more influence on the use of particular contraception method especially male-controlled methods of modern contraception. He argued that men with any secondary or higher education are more likely than those with none to rely on either of these methods. Furthermore, Chapagain (2005) argued that husbands education level play a significant role in influencing their wives to use contraceptives especially female controlled methods.

Educational level also has an influence on the choice of method of modern contraception. The results showed that the use of Depoprovera was high among women with a higher educational level (Secondary or tertiary) compared to those with no formal education. The use of Jadelle was low among women with tertiary education. These results do not conform or support the findings of Nguyen (2012) that educated women tend to use more traditional methods of family planning like the calendar method than the pills and injectables.
5.3 Preferred Method of Family Planning

The study revealed that different methods of modern contraception were being used by the respondent. Depoprovera was the preferred family planning method among current users of family planning methods. Five methods namely spermicides, female condoms, IUCD, tubal ligation and male vasectomy had zero uptake among the respondents. The results do not agree with the findings of the GDHS of 2008 that the use of any modern contraceptives method such as emergency contraceptives, Jadelle etc has the highest uptake among Ghanaian women. The findings however buttress the results of the study by Gyapong et al (2003) that the trends in IUD use in Ghana has stagnated and people are not using it. IUD use among respondents was there zero percent.

Some of the reasons given for the low use of IUD came out during the focus group discussions and these included the fear of side effects of IUD as some of the women said they were afraid of inserting IUD because it could cause cancer. Others also said their husbands expressed the fear that it would obstruct sexual intercourse by blocking the vagina. There were others who also expressed the fear that because IUD is made of metal it could corrode and cause other medical complications for them.

5.4 Relationship between Religious Affiliation and the Use of Modern Contraceptives

The use of modern contraceptives was also influenced by the religious affiliation of respondents. Members of the Pentecostal/Charismatic churches were highest users of modern contraceptives whilst those in Islam recorded the lowest use. There is a positive association between religious affiliation of women and the use of modern contraceptives. These findings are consistent with results of earlier studies by Ria (2009) and
Vinod (2004) when they found that Muslim women were less likely to use modern contraceptives. According to Vinod (2004) Christian women are more likely (about four times) to use modern contraceptives than Muslim women.

5.5 Knowledge and Use of Modern Family Planning Methods

The results showed that there is a strong association between family planning knowledge and utilization. The more knowledge a woman has, the greater the chance of utilizing a modern (artificial) family planning method and this is consistent with the findings of Charlie (2011) that knowledge of modern contraceptives and family planning methods has a strong influence on their use. This was further supported by the findings of Hemmings et al (2008) in a qualitative study in Ethiopia which suggested that woman’s education impacts upon their level of knowledge of modern contraceptives and their use. The findings are again consistent with that of the GDHS of 2008 which reported that, the use of modern contraceptives increases with increasing knowledge.

Again, the level of use of modern contraceptives increases with increasing knowledge through a high level of understanding and demystification of the fears of side effects which encourages knowledgeable women to use contraceptives. This is supported by the findings of Abu et al (2003) and Okwero et al (1994) that proper understanding of the various modern methods of family planning allays the fears of women and encourages them to use these contraceptives.

The findings are inconsistent with the findings of the GDHS of 2008 which stated that the knowledge of family planning was universal among men and women in Ghana. However,
the knowledge of traditional method found by this study was almost the same as that stated by the GDHS of 2008.

These findings were also consistent with the findings of the GDHS of 2008 that the male condoms and injectables were the widely known methods of modern contraceptives among Ghanaians and male and female sterilizations were the least known methods.

The study also found that the respondents heard messages of family planning from different sources a month prior to the study. Some of them heard family planning methods from the media (both printed and electronic). The results showed that women who were exposed to family planning messages were using modern contraceptives than those who were not exposed to these messages. This supports the findings of Okezie et al (2010) and Antenane (2002) who stated that exposure to messages, either through hearing family message on radio or seeing advertisement about AIDS, or being visited by a family planning service provider; appears to be highly correlated with the use of modern contraceptives. The implication is that the use of contraceptive methods will increase with access to messages on contraceptive information.

5.6 Physical and Economic Accessibility and Uptake of Family Planning Services

In bivariate analysis, there was an inverse association between the distance travelled and the uptake of family planning services though the association was not sustained in multivariable logistic regression analysis. Women who stayed closer to a health centre patronize modern family planning services more than their colleagues who had to travel over 20 miles to access the services. This is consistent with the findings by USAID (2005), Timothy et al (2011) and Benefo (2006), that long distances that women have to travel before gaining access to family planning services, community access to motorable roads together with lack
of transportation and limited access to travel to services are some of the barriers to the uptake of modern family planning services.

The uptake of contraceptives and family planning services was high among women who were economically empowered and have their own financial savings and it was low among women who did not have savings at all and those whose partners only have savings. There is therefore a stronger relationship between women economic status and uptake of family planning services considering the Pearson Chi square value and P-value ($\chi^2 = 96.15$, $P < 0.001$). This association has been established by several studies in different countries and places. The GDHS of 2008 reported that the use of modern contraception methods increases with women economic status. Furthermore, Schoemaker (2005), Oliveras (2006), Benefo(2006), Eloundou-Enyegue (2010) and Ria (2009) found that wealthier women were more likely to approve of family planning and to use modern contraceptives than poor women. Most of them stated that economically empowered women more often consult their doctor about family planning than unemployed women and were also able to pay for family planning services. Also, the wealth index of women who were using one form of modern contraceptive was significantly higher than women who did not use any. The GDHS of 2008 reported that 12 percent of women in the poorest households use a modern method of family planning compared with 21 percent of women in the wealthiest households. The results are also consistent with the findings of Ria (2009) and Jayaraman (1995) that couples financial position has a significant association with the use of modern contraceptives.
5.7 Quality of Family Planning Services at Health Institutions

On the assessment of the quality of family planning services in the district the findings were inconsistent with the USAID (2005) findings citing family planning service provider’s attitude and bias as one of the barriers to the uptake of family planning services. However, the results support the findings of GDHS of 2008 that more than half of women who went for family planning were educated on the side effects of the contraceptives and they were satisfied with the services provided.

Of the quality factors considered, free communication between clients and service providers was the only significant determinant of uptake of family planning services. Mothers’ ability to communicate with the service providers was strongly associated with the educational level of the mother. Among the respondents, women with a secondary or post secondary education were able to communicate or discuss their health issues (including family planning issues) with health professionals or service providers. This strong association between women’s ability to discuss family planning issues with service providers or health professionals and the uptake or use of modern contraceptives was also found by studies conducted by Ghulam & Naushin (2003) and Bbaale (2009). The ability of women to discuss family planning issues with service providers makes it possible for them to know the different types of contraceptives and family planning methods that are available for them to use. It may also help them to discuss the side effects that they may encounter in the course of using any method.
5.8 Access to media and uptake of Family Planning services

The study revealed that women who watched television daily were more likely to use modern contraceptives than those who did not watch television at least once a week. Bivariate analysis also showed frequent listening to radio was positively and significantly associated with uptake of family planning services. The associations between modern contraceptives usage and frequency of watching television and listening to radio were however not significant in the multivariable regression model.

These findings are consistent with the results of a research conducted by Okezie et al (2010) in Nigeria in which they found that exposure to mass media messages on family planning had an influence on the use of modern contraceptives. Women who were more exposed to these messages had the propensity to use contraceptives more than those who did not have that exposure.

5.9 Contraception Prevalence Rate

The contraception prevalence rate was 20.3 % (122/415) which is much higher than the figure (1.5 %) that was reported by the District health Directorate Annual Report (2010). This may be attributable to an improvement in the uptake of family planning services over the years or under reporting of the users of contraceptives.

5.10 Available Family Planning Methods at the Facilities

The number of family planning methods available in the facilities ranged from 2 to 6 different methods. The facility with the highest number of family planning methods had 6 different methods whilst the one with the lowest had two methods. Some methods were
totally absent or not offered in the districts or in the facilities e.g. IUD, vasectomy, tubal ligation, female condoms and spermicides. These methods had zero percent uptakes among the respondents. The results portray the GDHS of 2008 report that female sterilization had only 2% in Ghana. The findings were also consistent with Magadi et al. (2001) proposition that broadening the choice of contraceptive methods increases the overall contraceptive prevalence. According to them, the provision of a wide range of contraceptive methods increases the opportunity for individual couples to obtain a method that suits their needs.

5.11 Spousal Approval and Consent and its Effect on Use of Modern Contraceptives

Spousal approval of contraception was assessed among the respondents which revealed that there was a stronger relationship between spousal approval of the uptake of contraceptives and their current uptake by their wives or partners. Women whose husbands approved of family planning had a propensity to use modern contraceptives than women whose husbands do not approve of the use of modern contraceptives. These findings were in agreement with that of Ria (2009) and Mohamad et al. (1988) who found in Indonesia, that a husband’s approval of contraception is the most significant factor affecting the use of modern contraceptives.

The results were also consistent with the findings by Casterline and Sinding (2000); Shah et al. (2004) who asserted that a woman’s perception of her husband’s opinion about contraceptive use had a significant influence on her contraception practice, therefore it seemed that a husband’s attitudes acted as a serious obstacle to a woman’s contraceptive use.
5.12 Relationship between Occupation and use of Contraceptives among Women

Bivariate analysis between the occupation of women and the use of modern contraceptives showed a stronger association between the occupation of a woman and uptake of contraceptives and family planning services. Women who were in the civil service and those in commercial or trading activities were more likely to use modern contraceptives. Women in civil service were strongly associated with the uptake of family planning services. The least uptake of family planning services was found among women who were farmers. The findings support the results of the study conducted by Wubegzier and Alemayehu (2011) who stated that none use of modern contraceptives was identified with agricultural households whose livelihoods depend on petty mixed farming which require involvement of many household members including children who work on laborious farms free of pay. In such situation, large family size has been an accepted norm in to divide demanding farm workload among family members.

The findings also agrees with that of Eloundou-Enyegue (2010) who stated that women holding good jobs or good employment prospects face higher opportunity costs for childbearing. Those working outside of the home are further exposed to new ideas that can shape preferences, including their propensity to trade high fertility for child schooling. Furthermore, they are in a better position to meet the economic and social costs of contraception, and to overcome resistance by husbands.
5.13 Barriers to the Uptake of Contraceptives in the Communities

The study revealed some barriers to the use of modern contraceptives among respondents.

Opposition from husbands with regards to modern contraceptives usage was stated as a barrier to contraceptives use which was also identified Mustapha et al (2006) who stressed that the role of men in making family planning decision was becoming significant especially in sub Saharan Africa.

Some women who were not using modern contraceptives cited their beliefs system which were the high premium placed on child bearing, women do not have the power to take decisions with regards to their fertility, and barrenness or childlessness of a woman at some age especially from 25 years upwards is seen as a curse in the communities as barriers to the uptake of family planning services. These findings support the earlier findings of Ayoub (2005), who identified cultural traits as one of the impediments to the uptake of contraceptives.

5.14 Relationship between Socio-demographic characteristics and the Uptake of Contraceptives

The results of the study showed variation in the uptake of contraceptives and family planning among the various age groups. The uptake of contraceptives was high among women within the age group of 21-30 and low among teenagers and women who were more than 30 years. The results were not consistent with the findings of Nguyen (2012) that teenagers have the highest uptake of contraceptives because of their frequent indulgence in sexual acts. The results are however consistent with the findings of Jejeebhoy (2004) who
examined the differential in the use of contraceptives by putting three age groups thus 15 - 24, 25 - 39, and 40 - 49. The youngest group thus 15–24 is in the period of building family, the mid-group 25 -39 is practicing fertility and the oldest group 40-49 has finished their target of childbirth. Hence, the use of contraceptive methods is lowest for the first group of age, then it rises to the top for the second age group and it is likely to decline for the third group.

The results also agrees with the findings of Nauru Demographic and Health Survey (2007) which reported that most teenagers were not using modern contraceptives because they have not discussed family planning with a health or field worker which was attributable to the fact that majority of women aged between 15 and 19 have not been exposed to any family planning messages via the media and also feel shy to visit health facilities for education on family planning, which creates a considerable knowledge void.

5.16 Maternal Autonomy

Maternal autonomy, which indicates her decision-making power with respect to movement, finance, healthcare use, and other household activities were assessed. The indices that were used to measure maternal autonomy or empowerment included; her taking part in decision making on household matters, household matters decided together with partner, deciding how to spend her own money, decision to buy her clothes, decision to buy large household items/furniture, decision to send sick child to hospital, decision to work outside of the home, her involvement in making decision to spend the families income and her involvement in decision to obtain health care for herself. These same indices were used to assess the empowerment or autonomy of a mother by the Ethiopian Society of Population Studies.

The results showed that autonomy of the mother is significantly associated with uptake of family planning services and contraceptives use. Women who use modern contraceptives had significantly higher maternal autonomy score, compared with women who were not using any kind of modern contraceptives (7.4 versus 2.1) $F (1,599) = 490.6$, $p < 0.001$. This association remained significant even in a multiple logistic regression analysis. The finding is consistent with studies conducted by different researchers in different parts of the world. In Asian countries, women autonomy had been reported to be associated with contraceptive use, lower fertility, and longer birth intervals (Ushma & Deborah, 2010).

The findings also agree with the proposition by Malhotra et al (2002), Woldemicael (2009) and Shabana & Bobak (2005) that women empowerment or autonomy is associated with contraceptives use as empowered women use modern contraceptives more than their counterparts who are not empowered.

A survey in Ghana conducted by Mai Do and Kurimoto (2012) stated that, more than three-quarters of autonomous women in Ghana were using a contraception method. Their study found that empowerment of women was associated with the use of female contraceptive methods through the existence of a better negotiation for sexual activity rather than using no method of family planning.
5.16 Role of Maternal Autonomy, Education and Economic Status in the Uptake of Modern Family Planning Methods

Kabeer (2000) defines women’s empowerment or autonomy as a “process by which those who have been denied the ability to make strategic life choices acquire such ability. Narayan et al (2002) also sees women autonomy as expansion of freedom of choice and action to shape one’s life. The results of this study showed that maternal education was consistently related to maternal autonomy in the study sample. Women who attained higher education had greater autonomy in taking critical decisions that affect their welfare, compared to their illiterate colleagues (7.3 versus 1.9) F (2,599) = 133.9, P < 0.001. This is consistent with the findings of Krista (2000) who found female education as a proximate to increase their autonomy or decision making with regards to their sexual or reproductive life. He argued that female education influences the distribution of authority within households, whereby women may increase their authority with husbands, and affect fertility and use of family planning or contraceptives.

A study by Zaheer et al (2011) in Pakistan supported this finding that female education affect the social life of women by increasing their desire for higher living standards and by providing improved perception of the reproductive means, and easy access to up to date and efficient contraceptive methods. Again, his study stated education pays in economic terms for women, by allowing them going out of their houses and work in different sectors of the country. The working women desire small family so they can easily handle the family matters as well as the official matters.

One link of education to the use of contraceptives was proposed by Cristian& Columbia University (2005) which supports the finding of this study that educated women have
potentially more bargaining power (7.3 versus 1.9 as in this study) within the family and thus could be more successful at using modern family planning methods if other alternatives are not available.

Blanc and Wolf (2001) also demonstrated the influence of women’s empowerment on the use of contraceptives through the dynamics of marital relationships and focused primarily on spousal communication of family planning. According to their study spousal communication is considered a strong indicator of power relations between couples and this has also been closely associated with educational background of the woman.

5.17 Determinants of Uptake for Family Planning Services

Results of logistic regression analysis showed that maternal educational level has positive and highly significant effect on the uptake of family planning methods. This is consistent with the findings of several studies conducted in different areas. Some of these include studies conducted by Wong (2000) in Zimbabwe, Bolivia and the Philippines. Also studies conducted by Gereltuya et al (2007) in Kenya, Agarwal (2000) in India, Ria (2009) in Indonesia and Benefo (2006) in Ghana showed similar results.

The results of the study further show that the uptake of family planning services in the study sample is significantly related to many other factors including ability of the woman to communicate with health service provider on health matters, which was also found by Ghulam & Naushin (2003) and Bbaale (2009) that ability of women to discuss family planning issues with service providers makes it possible for them to know the different types of contraceptives and family planning methods that are available for them to use. It may also
help them to discuss the side effects that they may encounter in the course of using any method.

Household wealth index of mother (access to resources) was also found to affect the uptake of contraceptives and modern family planning services, which supports the findings of Ria (2009) and Hull & Mosley (2008) that women with better economic status or wealthier women are more likely to use contraceptives and to use a modern method than those who were in the middle and lower classes. According to her wealthier women were more likely to use a long-term contraception method which was attributed to their capacity or ability to pay private practitioners for a long-term contraceptive.

Maternal autonomy (that is, empowerment to make key decisions) was also found to be one of the determinants of the uptake of family planning services. This was earlier on identified by studies conducted by (Ushma & Deborah 2010), Malhotra et al (2002), Woldemicael, (2009) and Shabana & Bobak (2005) that women empowerment or autonomy is associated with the uptake of contraceptives and family planning services. In Ghana, this finding was replicated by Mai Do and Kurimoto (2012) who stated that, more than three-quarters of autonomous women in the Ghana were using a modern contraception method.

From the results of this study, the educational level of the mother remained an important determinant of uptake of family planning methods but its effect was reduced with the inclusion of the variable that takes care of maternal ability to communicate with health service provider on health matters variable. The ability of the woman to discuss health matters with the service provider makes irrelevant the contribution of maternal autonomy in the uptake of family planning services. Maternal education up to the JHS level also had no significant explanatory power on the use of family planning methods when the ability of the
woman to discuss health matters with service providers is taken into consideration in the multivariable logistic regression model. This then suggests that the ability of the woman to discuss health matters including family planning is mediated through education whereby women educated up to SHS level has greater opportunities to take decision on their own health, compared to her illiterate colleagues. This is supported by the findings of the GDHS of 2008 that the use of modern contraceptives increases with increasing education of a woman and also studies by Cristian & Columbia University (2005) which supports the finding of this study that women with secondary and post-secondary education consult their doctors on health issues and have potentially more bargaining power than the least educated or none educated women.

Inclusion of the woman's ability to communicate with health provider on health matters increased Nagelkerke R Square from 73.5 % to 81.7 %. This means that variable alone accounts for 8.2 % of the variance in the uptake of family planning services. A woman who is able to discuss health matters with the service provider was 110 times more likely to use a modern contraceptive (OR = 110.2, 95 % CI: 19.6- 620.4).
CHAPTER SIX
CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction

The summary of findings, conclusions and recommendations are presented in this chapter.

6.1 Summary of Main Findings

The main aim of the study was to investigate factors that contribute to the low uptake of family planning services in the Ningo-Prampram District. The CPR that was found in this study was higher than what was reported in the 2010 Annual report of the District Health Directorate (20.3% versus 1.5%).

Majority of the women in the district had no formal education however, their knowledge of modern family planning methods was high. The male condom and injectables were widely known among the women and the men but this did not translate to their use. It was found that having knowledge of family planning services did not wholly translate into the use of the services. Although maternal educational level was found to be significantly associated with the use of modern contraceptives, the education level of the husband was found to be more influential to use of modern contraceptives.

The study revealed that the use of modern contraceptives was significantly associated with educational level of couples, economic status of women, women autonomy or empowerment, and the ability of women to discuss their health needs with service providers.

It was also found that the number of daughters that a woman had was a determinant to the uptake of family planning services. Women who had more daughters had fewer propensities
to use modern contraceptives as compared to their counterparts with less number of daughters.

The socio-cultural barriers to the uptake of family planning services that were identified in the study were fear of side effects of modern contraceptives, husbands’ opposition to the use of family planning services and the beliefs system and values of the communities. Most of the husbands did not approve of the uptake of family planning services. Male involvement in family planning is very crucial if women in the district are to improve their uptake of these services.

6.2 Conclusions and Recommendations

The uptake of modern family planning services is low in the district. Women’s education, economic and maternal empowerment or autonomy were significant determinants of the uptake of family planning services in the study population.

Generally, women were satisfied with the family planning care, however the uptake of family planning services in the Ningo-Prampram District is influenced by factors such as the educational level of the couples especially that of the husband, the ability of the woman to discuss her reproductive health matters or needs with a health service provider, the level of autonomy or empowerment of the woman and the number of daughters that a married couple has given birth to.

Coverage of family planning programmes was unsatisfactory owing to the fact that the couple year of protection reduced gradually over the years.
Based on the findings of this study, the following recommendations are made to stakeholders and future researchers;

- Health service providers should intensify their health education and encourage women to feel confident in discussing their health needs with them. The health education should not be targeted at the women since men have a greater influence on family planning decisions of their wives.

- The importance of female education cannot be overemphasized although it is a long term measure. The district education directorate and the non-formal education department must be encouraged to sensitise the communities on family planning.

- It is also recommended that further research should be conducted to investigate the causes of low male involvement in use of modern contraceptives in Ningo-Prampram District. This is warranted because most of the women reported that their husbands do not approve the use of modern contraceptives.
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APPENDIX A: QUESTIONNAIRE FOR WOMEN IN FERTILE AGE (WIFA) GROUP

Informed Consent

Hello, my name is Bernard Bless and I am a student of the University for Development Studies offering a masters degree programme in community Health and Development. I am conducting a study on “Quality of family planning services”. The Ningo-Prampram District is my case study area. I would very much appreciate your participation in this study. This information will help the District Health directorate, private agencies, the community and other decision making bodies to plan how to make modern contraceptives and family planning services more accessible to everybody irrespective of your location.

The interview would last between 30 to 45 minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to any other than the District Health Directorate and the University.

Participation in this survey is voluntary, and if we should come to any question you don’t want to answer, just let me know and I will go to the next question; or you can stop the interview at any time. However I hope that you will participate in this study since your views are important.

At this time do you want to ask me anything of this study? May I begin the interview now?

Signature of interviewer ----------------------- Date-----------------------

Respondent agrees (A) Yes (B) No Record the time ---------------
Instruction for Data Collectors

✓ Make sure that you interview women in age group 15-49 years.

SECTION A - IDENTIFICATION

Locality name -----------------------------

Name of household head-------------------

Household number ------------------------

Language of interview ---------------------

Translator used (A) Yes (B) No

Code of respondent -----------------------

SECTION B: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE MOTHER

1. In what month and year were you born? --------------------------------------------

2. How old were you at your last birthday? ----------------------------------------

3. Have you ever attended school? (A) Yes (B) No

4. What is the highest level of school you attended? (A) Primary (B) JHS/Middle (C) SHS/Voc/ Tech (D) Tertiary

5. Can you read and write? (A) Yes (B) No If No, Go to Q7

6. Now I would like you to read this sentence to me.

Respondent (A) cannot read (B) Able to read whole sentence (C) Able to read part of sentence

7. Have you ever participated in a literacy programme that or any other programme that involves learning to read and write? (A) Yes (B) No

8. Type of residence, (A) compound house (B), semi-detached house,(C) detached house
9. Residential status, (A) own residence, (B) rented house, (C) family house, (D) others

10. Household head, (A) self, (B) spouse (C) grandfather, (D) in-law

11. Number of households living in the house ------------------------

12. To which ethnic group do you belong? (A) Gonja (B) Dagomba (C) Hanga (D) Ewe (E) other

13. What is your religion? (A) Catholic (B) orthodox (Anglican, Presbyterian, Methodist) (C) Pentecostal/Charismatic (D) Islam (E) ATR (F) No religion

14. What religion or religious denomination were you brought up in? (A) Islam (B) Pentecostal/charismatic (C) Orthodox (D) ATR

15. Does your religion support family planning? (A) Yes, (B) No (C) don’t know

SECTION C: ACCESSIBILITY TO FAMILY PLANNING SERVICES

16. How many miles will you approximately travel to access FP service and other health care services? ------------------------

17. How do you mainly or usually travel to the place of health care and FP service? (A) Foot, (B) bicycle,(C) motorbike,(D) passenger car, (E) others

18. How much time did you wait for the service provider to attend to you? ------------------------

19. Ability to discuss your health needs or problems with the service provider (A) Very well (B) Not well (C) Poorly

20. Privacy to prevent people from seeing your examination and listen to your consultation discussion (A) good privacy (B) No privacy (C) Averagely

21. What was the attitude of the staff towards you? (A) Satisfactory (B) Unsatisfactory (C) Bad
22. Cost for service or treatment --------------------

23. Number of days family planning services are offered in a week (A) 1-2 (B) 3-4 (C) 5-6 (D) throughout the week

24. Seeking of consent from partner before providing service (A) No consent is sought (B) consent is sought

25. Does your husband approve the use of a contraceptive? (A) Yes (B) No

26. How often have you and your husband talked about family planning for the past year? (A) Once in 3 months (B) Once in 6 months (C) Once a year (D) Never

27. Have you and your husband ever discussed the number of children you would like to have? (A) Yes (B) No

28. How many children have you decided or agreed to have? -----------------

29. Do you think your husband likes the same number of children you would like to give birth to? (A) Yes (B) No

30. Do you know where a person could go for an FP method? (A) Yes (B) No

31. In your view is it easy to get access to an FP service? (A) Yes (B) No

PARITY

32. At what age did you first marry? (A) Below 16, (B) 16-18 (C) above 18

33. Number of children ever born ------------------

34. Do you have any sons or daughters to whom you have given birth who are now living with you? (A) Yes (B) No

35. How many sons live with you? ------------------

36. How many daughters live with you? ---------------
37. Do you have any sons or daughters to whom you have given birth to who are alive but do not live with you? (A) Yes (B) No

38. How many daughters are alive who are not living with you? ------

39. How many sons are alive who are not living with you? ------

40. What is your fertility preference or do you desire for more children? (A) Want others (B) want no more (C) undecided

If no

41. How are you going to prevent having more children? (A) Abstinence (B) Use of traditional methods of FP (C) Use of modern FP methods (D) Don’t know

42. At what age did you have your first child? --------------

43. Did you intend having a child at that age? (A) Yes (B) No

44. What is your ideal number of children? (A) 0, (B) 1 or 2, (C) 3 or 4, (D) 5 or 6, (E) 7+, (F) non-numeric response

KNOWLEDGE ON FAMILY PLANNING

45. Have you ever heard of family planning or methods used to delay or avoid pregnancy? A. Yes B. No

46. In the last month have heard any message on FP? (A) Yes (B) No

If yes

Where? --------------

If no
47. What FP method(s) do you know? (A) Knows no method, (B) knows traditional methods only, (C) knows modern methods

48. Have you ever used any modern contraceptive method? (A) Yes (B) No
If yes, (proceed to the next question)
If no (go to Q 61)

49. Which method did you use? 

50. Which method is your preferred method? 

51. Why do you prefer that method? (A) Safety (B) Easy to use (C) Only available method (D) No side effects (E) Dual purpose

52. Are you currently using an FP method? (A) Yes (B) No
If no go to Q 

53. Which FP method are you currently using? 

54. Do you intend using any?

55. Which type of contraceptive methods do you know? /multiple response allowed read from the list and mark all that apply/
   I. Pills
   II. Intrauterine device (IUCD)
   III. Injectable (depo-provera)
   IV. Norplant (buried under skin)
   V. Condom
   VI. Spermicides
   VII. Tubal ligation/female
   VIII. sterilization
   IX. Vasectomy/male sterilization
   X. Periodic abstinence/calendar
   XI. Others [specify __________________________]

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56. Do you use any contraceptive methods currently? A. Yes B. No (Go to Q 58)

57. Which type of contraceptive methods are you using?
   I. Pills
   II. Intrauterine device (IUCD)
   III. Injectable (dep-o-provera)
   IV. Norplant (buried under skin)
   V. Condom
   VI. Spermicides
   VII. Tubal ligation/female
   VIII. sterilization
   IX. Vasectomy/male sterilization
   X. Periodic abstinence
   XI. Others

Economic Status, Education Status and Level of Empowerment

58. How many rooms are available for use only by this household? ---------------

59. What type of fuel do you use in cooking? (A) Charcoal (B) Firewood (C) Gas (D) Others

60. Is there electricity in the house? (A) Yes (B) No

61. Do you have access to the media? (A) Yes (B) No

62. Do you read a newspaper at least once a week?

63. Do you listen to radio? (A) Almost every day (B) At least once a week (C) Less than once a week (D) Not at all

64. Do you watch television? (A) Almost every day (B) At least once a week (C) Less than once a week (D) Not

65. Which of the following do you own? (A) Radio, (B) television
66. What is the educational level of your husband? (A) None (B) JHS (C) SHS (D) Vocational/Technical (E) Tertiary

67. Did you drop out of school? (A) No (B) Yes

68. Why did you drop out? (A) Parental neglect, (B) early marriage, (C) poverty, (D) living in rural areas, (E) others

69. What is your occupation? (A) Unemployed (B) trader, (C) civil servant (D) Farmer

70. Which household resources do you control? (A) Financial, (B) food materials,

71. Do you have access to resources like land, cattle, ownership of a house? (A) Yes (B) No

72. Do you decide with your husband on how to spend his income? (A) Yes (B) No

73. Is wife beating acceptable in this community? (A) Yes (B) No

74. When is your partner justified to beat you? (A) when you burn the food, (B) argue with him, (C) you go out of the house without telling him, (D) refuse him sex

75. When are you justified to refuse your partner sex? (A) When you know he has an STD, (B) sleeps with other women,(C) you are tired, (D) not in the mood

76. Employment status in the last 12 months? (A) Not employed, (B) employed

If you are employed

77. What is your occupation? (A) Professional/technical/managerial, (B) sales and services/clerical, (C) agricultural, (D) skilled manual, (E) unskilled manual

78. What type of earning do you earn for your employment? (A) Unpaid, (B) cash only or partly on kind, (C) In kind only

79. In what sector is respondent mainly working? (A) Public (government), (B) private formal, (C) private informal
80. What is the age gap between you and your partner? (A) Up to 5 years, (B) 6 to 10, (C) above ten

81. Do you have access to the media? (A) No, (B) frequent access, (C) infrequent access

82. Which medium do you have access to? (A) Newspaper/magazine, (B) radio, (C) television

83. How many times in a week do you have access to this medium? ---------

84. Have you heard of family planning messages in the media? (A) Yes (B) No

85. Do you have the freedom to move or travel? (A) Yes (B) No

86. Do you earn more than your partner? (A) Yes (B) No

**FAMILY HISTORY/BACKGROUND**

87. How many children did your parents give birth to? ---------

88. How many are alive? -----------------------

89. How many are females? ---------------------

90. How many are males? ----------------------

91. How many were educated at least to the secondary school level? -------------------

92. How many of them are males? ----------------

93. How many are females? ---------------------

94. How many of the women dropped out of school to marry? -------------------
Women Autonomy Status/Empowerment Questions

95. Do you have the power to negotiate safer sex with your partner if your partner has an STD? (A) Yes (B) No

96. Do you have the power to refuse sex? (A) Yes (B) No

97. In which conditions do you refuse sex? (A) Tiredness, (B) menstrual period, (C) ill-health, (D) not being in the mood

98. What is your family’s main source of income?
   A. Husband’s earnings
   B. Own earnings
   C. Yours and husband’s earnings
   D. Others
   E. (specify) ______________________

99. Do you earn monthly income by your own? A. Yes B. No

100. How often do you have money that you alone can decide how to spend?
    A. Always
    B. Often
    C. Sometimes
    D. Never

101. Do you currently have any type of savings Scheme?
    A. Yes, partner’s savings
    B. Yes, mine and partner’s savings
    C. Yes, self savings
    D. No, we don’t have any savings
House Hold Decision Making Questions

102. Do you take part in decision making on household matters? (A) No (B) Yes

If yes

103. Which household matters do you decide together with your partner? (A) Own Health care, (B) large household purchases, (C) daily purchase, (D) children’s education, (E) household expenditure

104. Do you have the right to decide how to spend your own money? (A) Yes (B) No

105. Who makes the decision if you need to buy clothes for you and the family?
   A. Your Husband/partner
   B. You and husband
   C. Spouse/myself

106. Who makes the decision if you need to buy large household items/furniture?
   A. Your Husband/partner
   B. You and husband
   C. Spouse/myself

107. Who makes the decision whether a child is sick enough to go for treatment?
   A. Your Husband/partner
   B. You and husband
   C. Spouse/myself
108. Who makes the decision whether you should work outside of the home?
   A. Your Husband/partner
   B. You and husband
   C. Spouse/myself

109. Who makes the decision when your children have stationeries /school needs to be addressed?
   A. Your Husband/partner
   B. You and husband
   C. Spouse/myself

110. Who makes the decision on how to spend the family's income?
   A. Your Husband/partner
   B. You and husband
   C. Spouse/myself
APPENDIX B : QUESTIONNAIRE FOR FAMILY PLANNING SERVICE PROVIDERS

1. Facility type (A) public (B) Private

2. How long has this facility being in this community? .......

3. Hours of service at this facility .......

4. Seeking of consent from partner before providing service (A) No consent is sought (B) consent is sought

5. How many family planning methods do you offer in this facility? ------------

6. Names of the FP methods in this facility ---------------

7. Which method do clients prefer or mostly take? ..............

8. Which method is the least expensive? ---------------

9. Which method is the most expensive? ............

10. What is the cost or price of the least expensive method? .................

11. What is the cost/price of the most expensive method? ............... 

12. How many days in a week do you provide family planning service? .............

13. Which methods are you not able to provide in this facility? .................

14. How many staff members in this facility provide FP service? ............... 

15. What is the qualification of these staff members? ............

16. What is the average age of these staff members who provide FP service?.........

17. Do you carry out IEC activities on FP in the community? (A) Yes (B) No

   If yes

18. How many times do you carry out these activities? ...............
19. What is your assessment of the uptake of FP services in this facility or community?
(A) Satisfactory (B) Unsatisfactory (C) Extremely low

20. Why this answer to the question above? ..................................................

21. What barriers have identified to the uptake of FP services in this community? ....

22. How can the uptake of FP services be promoted in this community? ............

23. Do you sometimes get out of stock of contraceptives? (A) Yes (B) No

24. Which periods of the year? ..............

25. Where do you get your contraceptives supply? .........................

26. Is it so easy to get your contraceptives supply? (A) Yes (B) No

27. What difficulties do you face in getting your contraceptives stock? .................

28. Does your facility have the maximum privacy and confidentiality for clients? (A) Yes (B) No

29. Do clients complain about the attitude of your service providers? (A) Yes (B) No

30. Is there any other service provider in the community apart from your facility? (A) Yes (B) No

31. Is there a place purposely for FP services in this facility? (A) No (B) Yes

*If yes*

Can I have a look at the place?

*Make my assessment of the following*

Availability of electricity ............... 
Availability of water .................... 
Cleanliness of the place ...............
32. Do you have the equipment for FP services? (A) Yes (B) No
33. Do you have emergency contraceptives? (A) Yes (B) No

If yes,

34. Which brand or type of emergency contraceptives do you have? ----------

35. Stock of contraceptives and quantities issued.

<table>
<thead>
<tr>
<th>Contraceptive</th>
<th>Stock</th>
<th>Quantities issued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male condoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female condom</td>
<td></td>
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<tr>
<td>Norigynon</td>
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<tr>
<td>Depoprovera</td>
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<td>IUCD</td>
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<td>Emergency cont.</td>
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APPENDIX C: FOCUS GROUP DISCUSSION FORM FOR WOMEN

QUESTIONS

1. What are the benefits of family planning to you the women and your children?

2. What prevents you the women from taking family planning services?

3. What can we do to improve the uptake of family planning services in this community and the district at large?

4. What are the factors that determine the higher fertility rate in rural communities?

5. Which family planning methods have heard about or know? Which method will you go for or encourage your friends to go for? Why?

6. Do you use any family planning method? Do you support family planning? Why do you or do not support it?

7. Do you discuss family planning issues with your spouse? How often do you discuss with her?

8. What role can men play in the uptake of family planning services by their wives?

9. What is your fertility preference? What is your ideal number of children?

10. Do you have the right to refuse your spouse sex? Under what conditions will you refuse sex with your husband?

11. Are you involved in decision making in your marriage or family? Which decisions do you take independently?

12. Why are women usually withdrawn from school unlike their male counterparts to start their families?