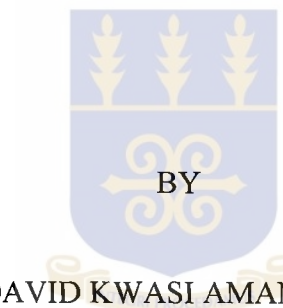
A STUDY OF FACTORS ACCOUNTING FOR THE LOW ACCEPTOR RATE OF FAMILY PLANNING IN THE NKWANTA DISTRICT OF THE VOLTA REGION



BY

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DECLARATION

I declare that, this is an original work based on my own research, and that it has not been submitted towards any other degree.

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DEDICATION

I dedicate this work to my beloved wife,Jennifer Amankwa and my three lovely daughters, Nana Ama Dapaah Amankwa, Maame Yaa Dankwa Amankwa and Maame Afua Mansah Amankwa.

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LIST OF ABBREVIATIONS

MOH	Ministry of Health
FP	Family Planning
MCH	Maternal and Child Health
IUCD	Intra-Uterine Contraceptive Device
CWC	Child Welfare Clinic
GDHS	Ghana Demographic Health Survey
FGD	Focus Group Discussion
HIV	Human Immuno-Virus
AIDS	Acquired Immune Deficiency Syndrome
STD	Sexually Transmitted disease
PHC	Primary Health Care
DHMT	District Health Management Team
IE&C	Information Education&Communication
IPPF	International Planned Parenthood
JSS	Junior Secondary School
SSS	Senior Secondary School
GPRTU	Ghana Private Road Transport Union

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ABSTRACT

The family planning acceptor rate in the Nkwanta District is generally very low - 3.0% as compared to the National figure of 16.8%. This is against the background of the fact that the district is a deprived one in its' early stages of development, a fact which makes population control very crucial if the new development is not outstripped by an unregulated population growth.

This study which was a descriptive qualitative and quantitative cross-sectional one, was designed with the objectives of finding out the possible factors accounting for the low family planning acceptor rate. FGD's were held in three of the five sub districts conveniently sampled and supplemented by a structured questionnaire administered systematically to a sample of 150 women in their reproductive age (15 49 years) attending MCH/FP clinics in the district. The questions were to respectively unearth the knowledge, perceptions, attitudes, beliefs and practices towards family planning and to help identify other factors which might influence utilization of family planning by women in the district.

The study, which lasted a period of six weeks revealed that among other factors, the main factors accounting for the very low family planning acceptance rate in the Nkwanta District were socio-cultural factors that lead to the desire for many children, including those that limit the right of women to take decisions concerning their reproductive health issues as well as marriage and religion.

There was however an insignificant relationship between education, age and the utilization of contraceptives, even though studies done elsewhere showed the contrary.

Underpinning these barriers are the attitude of men. In this connection, it is recommended that family planning educational programmes should concentrate on couples and men instead of on women alone, so as to win the support of the men for family planning. Efforts should also be made to raise the status of women to enhance their assertiveness to their reproductive rights. Culturally acceptable IE&C messages should be used to address the misconceptions unearthed by the FGDs.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

Family planning has been acclaimed, worldwide, as a very effective yet inexpensive tool for preventing the deaths of infants, children and mothers (3). It does this by allowing women of childbearing age bear their children during the healthiest times for both mother and baby. Worldwide studies demonstrate that spacing births two or more years apart significantly reduces the risk of death for a newborn infant and its next eldest sibling (3). It was estimated that in 1986, but for family planning, 14.7 million children under the age of five years, and 500,000 mothers, would have died of maternity-related causes (3). Family planning did not prevent all these deaths but reduced it considerably.

With this knowledge, many developing countries including Ghana which were yet to benefit from the full impact of the laudable programme have, since the late 1960's, embarked on family planning to improve maternal and child health, and also as a tool for socio-economic development (4). That is making sure, that the rate of socio-economic development is not outstripped by the rate of population growth having regard to the fact that population issues in Ghana concern the rate of growth as well as the number of people (4).

Notwithstanding the above, the use of modern family planning methods in Ghana is low, with an acceptor rate of 16.8 %(2). This means that Ghana as a country is missing the real opportunity of what family planning utilization can bring, in terms of socio-economic

development. The government is very concerned and considers it a priority, therefore to initiate programmes aimed at improving the acceptor rate of Family Planning.These measures have resulted in a gradual but steady increase in the family planning acceptance and use in the nation, over the past few years. However the same cannot be said of the trend in the Nkwanta District of the Volta Region.

Trends in National Acceptor Rates-1990-1998.

1.2 Problem Statement

The family planning acceptor rate in the Nkwanta District is generally very low – 3.0% as against a National figure of 16.8%. It is believed that if this acceptor rate is not improved the consequential increase in population growth rate, all things being equal, would over stretch the few available social amenities in a district as poor as Nkwanta and thus adversely affect the standard of living of the people which is already very low. Also not-withstanding MCH/FP service availability in the district, the unmet needs for family planning amongst married couples remain high.

Detailed information as to why there is the persistence of low utilization of family planning methods in spite considerable efforts into the provision of these services is still lacking. It is anticipated that information obtained from this study would be used to design an action plan as an intervention to improve the knowledge of family planning and highlight its advantages to eventually improve the acceptor rate in the district.

1.3 The Nkwanta District

The Nkwanta District is one of the twelve administrative districts in the Volta Region and occupies the whole north-eastern part of the Region. The district is the largest in the region, yet the most deprived in terms of social amenities and infrastructural development.

It is bordered by the Republic of Togo on the east, the Northern Region on the north, on the west by the Volta Lake, and the Kete-Krachi and the Kadjebi Districts in the south. The district is situated in the semi-equatorial climatic region. The climate is characterized by a rainy season with mostly southern winds from May to September and dry season from November to February.

Using projections from the 1984 population census the district currently has an estimated population of 142,397 with an average growth rate of 3.1. About 20% of the population is comprised of children under 5 years of age.

The following is the service target population for the district:

Total population	142,397
Children 0-11 months(4%)	5,696
Children 0-23 months(8%)	11,416
Children 0-5 years(20%)	28,479
Women(WIFA)(15-49)(20%)	28,479
Expected Pregnancies	5,696
Annual Population growth rate	3.1%

Sub-district population of the Nkwanta District.1998

Sub-District	Population	% of Total Population
Nkwanta	33,073	23.2%
Tutukpene	14,288	10.0%
Brewaniase	22,023	15.5%
Kpassa	44,946	31.6%
Damanko	28,067	19.7%
Total	142,397	100%

Source: Nkwanta DHMT 1998 Annual Report.

The district is predominantly rural with farming and trading as the main occupation of the inhabitants.There are several tribal and ethnic groupings i – Adeles, Achodes, Kotokoris, Ntrobos, Konkombas (major ethnic group) ewes and Akans – each claiming supremacy and ownership of the area. This situation, sometimes, makes the organisation of health programmes and activities very difficult. Nkwanta District is divided into five health sub-districts. These are Damanko, Kpassa, Nkwanta, Tusukpene/Kecheibi and Brewawase.

Each of these sub-districts has functional health centres and clinics manned by either a medical assistant, a senior nursing officer or nurse/midwife.

The Health Delivery System.

The health services are administered by a District Health Management Team based at the district capital,Nkwanta.The health services delivery in the district is based on the MOH's 3-tier Primary Health Care (PHC)concept of curative, preventive and promotive

health services which should be acceptably accessible and affordable to the communities, at all the three levels (Levels A,B and C) of health care provision

Level A(Community-Based) Health Services

These are carried out by community Health Workers, who have been trained as Health Educators and compilers of community registers. They assist the MOH workers in educating the communities in health promotion and disease prevention particularly Guinea Worm disease. Services at this level are also provided by Traditional Birth Attendants(TBA's),most of whom have been trained by the DHMT.

Level B(Subdistrict) Health Services

There are four Health Centres and two Health Posts which provide services at Level B. At this level minor ailments are treated while serious and complicated cases are referred to higher levels. The programmes carried out at level B facilities are, Immunization Health Education, Disease Control, Ante-natal and Post-natal care services, Maternity and Child Health services such as growth monitoring immunization etc, General Medical care and supervision of Level A Workers.

The Nkwanta District Hospital.

.The Nkwanta District Hospital serves as level C(Referral point) health facility where emergencies in Surgery, Obstetric and Gynaecology as well as medicine are handled.

Health Facilities/Providers.

There are (12) health facilities in the district out of which 6 are Government run and the 6 are mission and privately run.

Government Health Facilities are:

1.Nkwanta District Hospital

2.Tutukpene Health Centre

3.Kecheibi Clinic

4.Brewaniase Clinic

5.Kpassa Health Centre

6.Damanko Health Centre

Mission and Private run Clinics are:

1.St.Joseph's R.C.Clinic Nkwanta.

2.Church of Pentecost clinic Kpassa

3.Private Maternity home Kpassa.

4.Private Maternity home Sibi.

5.FAME clinic Obanda.

6.E.P.clinic Pusupu

Generally there is limited access to health care in terms of location, service provision, in terms of range of services and financial ability to pay.

In spite of the considerable number of health facilities, a large number of communities do not have access to health care, due to the fact that most communities are relatively very far from the nearest health facility and roads in the district are very bad.

Ability to pay for service charges by the people is very low. The people in the district are mostly farmers and are generally very poor. The district happens to be the most deprived in terms of socio-economic status in the whole of Volta Region.

Common Diseases in the district.

The top ten diseases in the district are malaria, diarrhoeal diseases, hernia, pregnancy related complications, snakebite, anaemia, upper respiratory tract infections, gyneacological disorders, intestinal worms and diseases of the skin including ulcers(21). Malaria remains the commonest cause of morbidity accounting for 48% of all cases. Onchocerciasis and Guinea worm are also prevalent. Cases of HIV/AIDS are also on the increase.

The Maternal Child Health and Family Planning Services

The Nkwanta district has Maternal and Child Health Unit that is concerned with:

(i) making maternal and child health services more accessible to women and children below 5years in the district;

(ii) reducing maternal and child morbidity and mortality;

(iii) Increasing birth interval of mothers to an average of 2 years through family planning services.

(iv) Increasing immunization coverage .

Unfortunately, as indicated earlier, the family planning acceptor rate is very low (3.0%) even though there is considerable access to family planning services and devices courtesy community-based distributors, drug stores which stock some of the family planning devices and the availability of maternity homes and health facilities which offer these services.

CHAPTER TWO

2.0 LITERATURE REVIEW AND STUDY OBJECTIVES

2.1 Literature Review

Available documents show that fertility regulation has been known and practised, many years ago. Greek philosophers discussed fertility control over 2000 years ago, with the aim to prevent frequent pregnancies (5). Nevertheless, for Africa and many developing countries the last quarter of the 20th century represents a dramatic turn in their attention to population issues, with particular reference to family planning vis-à-vis the various methods and techniques available.

Africa and Contraceptive Use

Despite all these, available literature shows that for most developing countries particularly sub-Sahara Africa, contraceptive use is much lower than expected. Studies have shown varied reasons. According to Tsui (1989) in most countries contraception is typically first made available to and used by older, usually married women to end their childbearing career(6). In some countries, even though contraceptives have recently been made available to younger women, yet lack of proper knowledge and limited access still make use difficult.

In Africa and many other developing countries, studies have shown that the rate of use of modern contraceptive methods is low, These studies have given reasons such as ignorance, misinformation about reproductive biology and contraception, difficulty in obtaining contraceptives, infrequent or unplanned sexual activity, opposition from partner, and religious proscription (Lema 1990; Ajayi et.al 1991; Boohene et.al, World Bank Report 1991). The Latin America and Caribbean Demographic and Health Surveys (DHS), found that young women had not expected to have intercourse and did not know about contraception.

Social, Demographic Characteristics and Contraceptive Use

A Bangkok study showed that the principal reasons for non use of contraceptives in order of importance, were little concern for pregnancy, poor knowledge of contraception, partners unwillingness, fear of contraceptives, and lack of preparedness (6).

A study in Italy in 1989 has shown that the young, the non-educated and the nulliparous women are least likely to use modern contraceptives, citing fear of side effects and ignorance as the main reason for non-use.(11) What is worse, however, is that such a situation always lead to an increased incidence of illegal abortion(14)

Education is positively associated with contraceptive use. A survey in Guatemela city found that only 4.5% of those who had received no education used a contraceptive method at first premarital intercourse compared with 25.6% who had education (CPO 1992b).

Knowledge, Awareness and Contraceptive Use

Studies have shown that there is a greater variability in the levels of knowledge of family planning among adolescents in Sub-Saharan Africa than in other regions. Levels are lowest in Madagascar and Nigeria where fewer than half of adolescents know about any method, and highest in Kenya, Rwanda and Zimbabwe, where at least 90% of adolescents are familiar with some contraceptive method (8).

Studies in Ghana show that knowledge about contraceptives is widespread among Ghanaian youth. About 86% of adolescents know at least one modern method of family planning (8). The two methods most commonly known are the condom and the pill. Although most adolescents can name modern methods of family planning, few know how to use them or where to get them from. Particularly in the Northern part of the country adults discourage adolescents from seeking information or asking questions about family planning.(7)

Knowledge of new methods of contraceptive technologies has great potential as it improves acceptability,continuity and satisfaction and thus lower failure rate(15). Three decades of experience worldwide have shown that in practice, the benefits of new methods of contraceptive technologies have not always materialized. Studies have shown that the introduction and knowledge of new family planning methods will not expand use unless the existing constraints faced by programmes in delivering adequate services are addressed (8)

Socio-cultural Practices, norms and Contraceptive Use

Socio-cultural practices and norms in many developing countries encourage large families and thus reduce motivation for couples to use contraceptives. Due to the perceived socio-economic benefit of having many children in some African societies, infertility in a wife is considered a taboo. Men are even encouraged to show prove of the fertility of the wife to be, prior to the marriage ceremony – practices which encourage couples to have many children. Studies carried out in other parts of the world have indicated that infertility is blamed on modern contraception and as a result; couples avoid the use of contraceptives for the fear of infertility (10). Poverty and poor living conditions also affect women's ability and freedom to practice family planning. In many African societies husbands disapprove of their wives use of contraception for fear that they would be promiscuous.

In Ghana, studies have identified the following as some of the important cultural factors which influence contraceptive use:

(i) the linking of social status and influence with the number of children one brings forth ,

(ii) in polygamous marriages, wives compete with rivals to out do each other in the number of children they bear to please their husbands and win their love;

(iii) most decisions affecting the family, including the fertility of women are taken by men;

(iv) culturally, Ghanaians are pro-natalist and believe that children are gifts from God; and

(v) some in-laws dictate the number of children a family should have.

The sex composition of living children, according to a Bangladesh study is systematically related to fertility preferences and behaviour, with a higher number of sons at each family size associated with a higher percentage of women wanting no more children and therefore using contraceptives (16).

Service-related Factors and Contraceptive Use

Studies have shown that family planning acceptor rate can improve dramatically amongst illiterate urban slum dwellers who like illiterate village dwellers are

globally recognised as presenting the greatest challenge to family planning programmes, if appropriate service delivery methods are provided. In 1987, the contraceptive prevalence rate of the Vadaj and Saharmati slums in India was only 12.4%, but after 4 years of culturally appropriate Information, Education and Communication(IE&C) strategies, the prevalence rate increased to 60.9% in 1991, comparing favourably with those in the cities (9).

Also attention to the quality of care which aims at fulfilling the rights of clients,has been found to greatly improve coverage.According to the International Planned Parenthood Federation (IPPF),there are ten rights family planning clients should have.These are the right to:
information,access,choice,safety,privacy,confidentiality,dignity,comfort, continuity and opinion ,which would greatly improve coverage(12).

Male role in Contraceptive Use

Although numerous studies have been carried out in Africa and most developing countries on the knowledge, attitudes and behaviour of women who use contraceptives, there is limited data on the characteristics of men and their perception about contraception. According to a pilot study conducted on men's involvement in family planning in Pakistan, Zimbabwe and Columbia, it was found that lack of useful information and services, rather than lack of interest have kept men form taking a more active role in family planning (10). A study in

Kenya has shown that most African men associate Family Planning only with the use of condoms and not other methods such as the pill or the IUCD.(13).

This study hopefully would unearth men's perception about family planning in addition to that of women. This is important because studies have shown that male perception of family planning has an influence on its use(17). This is confirmed by another study which shows that women living with their husbands are less likely to use contraceptives than those staying alone.(18)Another important finding according to another study in Bangladesh is that working women have a greater say in decisions relating to contraceptive use(19)

2.2 **Objectives of the Study**

Generally, the study has been designed to identify factors which account for low utilization of family planning services in the Nkwanta district of the Volta Region,from the point of view of potential consumers.

Specifically, the study would attempt the following:

(i) Determine and describe the knowledge about family planning for males (above 15 years) and females (in their reproductive age) and their perception about family planning.

(ii) Identify and describe other factors that might influence the use of family planning by women in the Nkwanta district.

(iii) Make recommendations based on the results of the study to appropriate authorities, on measures to increase family use by women in the district.

CHAPTER THREE

3.0 METHODOLOGY

3.1 The Study Design

A descriptive study, using qualitative and quantitative methods, to determine the factors that may prevent men and women from utilizing family planning services and methods.

Sample Size and Sampling Procedure

This study initially planned to interview ten to twenty five percent (10-25%) of the total number of women who would attend MCH/FP facilities in the district. Based on the 1998 attendance of five thousand (5000) attendants, a minimum sample size of five hundred (500) women should have been interviewed. However due to limited resources including time constraint this was reduced to two hundred (200). Through systematic sampling of every third woman who attended an MCH/FP facility in any of the subdistrict, a total of about 150 women in their reproductive age were interviewed. For the Focus Group Discussions participants were selected on the basis of sex (both sexes), ethnicity, age and socio-economic status. The FGD was used to determine and describe the knowledge and perception that people in the district have about family planning.

3.2 Data Collection Method

Focus Group Discussions

A total of nine (9) Focus Group Discussions were carried out in three of the five subdistricts-Nkwanta, Kpassa and Tutukpene purposively sampled as one of the data

collection methods This was supplemented by the survey questionnaire administered to women attending MCH/FP clinic. A total of seventy two people made up of twenty four (24) young women aged fifteen to twenty nine years, twenty four (24) young men aged fifteen to forty years twelve (12) women aged thirty to forty nine years and another twelve men aged forty years and above were selected taking into consideration their ethnic background, educational level, occupation, religion and marital status to ensure a balance in the Socio-Economic and Demographic background of participants. The young women and men were dealt with separately. In the case of the older men and women, two FGD were held with them separately whilst one had them together.

Questionnaire-based Data Collection

A structured questionnaire was administered to women in their reproductive age, (15-49 years) attending MCH/FP clinic in the district. Answers to questions seeking information about their socio-economic and demographic background as well as their opinion, perception and use either before or now family planning methods and also their intentions with respect to future use were solicited. This was done taking the privacy and comfort of the respondents into consideration.

4.2 **Variables**

4.3 Independent variables;

(i) Age

(ii) Marital status

(iii) Educational level

(vii) Knowledge of family planning.

(viii) Accessibility (Geographic).

(iv) Religion

(v) Parity

(vi) Ethnicity

Dependent variable;

Current use or intention to use contraceptives in the future.

Variables such as the availability of IE/C methods for health education, adequate and well trained staff and the lack of consistent supply of all the devices for the various methods of family planning are known to affect the use of contraceptives, and could be measured using a check list. However, due to the time constraint of only 2 months, and other limitations, this study focused only on the consumer-related variables, as stated above.

Assumptions underlying the Study:

A woman's use of contraceptives would be influenced by the following:

(i) Her socio-demographic profile, ie age, marital status, educational level, religion, ethnicity and parity.

(ii) Knowledge of family planning.

(iii) Accessibility of family planning services(distance to service point).

Data Analysis:

Analysis of the data collected is guided by the following assumptions

That a woman's current use of contraceptives or intention to use contraceptives would be influenced by:her socio-demographic profile,and accessibility of family planning services as stated above.

The SPSS Statistical Software was used to analyze all the data one hundred and fifty questionnaires,for simple frequences,crosstabulations at 5%(0.05) significant levels to determine associations.

Limitation to the study

In the Focus Group Discussion some respondents spoke in languages that needed interpretation for the principal investigator, and possibility of distortion of the original message could not be ruled out.

Sampling of women aged 15-49years attending MCH/FP clinics could introduce a bias. Therefore the results may not necessarily apply to the entire population of women 15-49 years of age in the district.A sample of all women aged 15-49years in the district would have necessitated a household survey and this was clearly beyond the resources available for the study.

Ethical Considerations

The objectives and purpose of the study were clearly explained to respondents. In the Focus Group Discussions, respondents were told of the need to record what ever they say, whilst at the same time they were assured that they would not be quoted by name. They were also told of their right to opt out, at any time they so wish.

CHAPTER FOUR

4.0 RESULTS AND OBSERVATIONS

This chapter presents findings based on the interviews and the FGDs described in the earlier chapter

The table below shows the Socio-Economic and demographic profile of the sampled women.

4.1 Findings based on Interviews

Table 4.1: **Distribution of women by Age, Marital Status, Educational level, Occupation, Religion and Ethnicity**

Characteristics	Frequency	Percentage
Age		
15 - 29	89	59.3
30 - 49	61	40.7
Marital Status		
Married	116	77.3
Single	28	18.7
Divorced/separated	6	4.0
Educational Status		
Nil	75	50.0
Primary	25	16.7
JSS/SSS	47	31.3
Tertiary	3	2.0
Religion		
Christian	102	77.3
Moslem	23	15.3
Traditional	23	15.3
	2	1.3
Occupation		
Farmer	62	41.3
Civil Servant	4	2.7
Unemployed	16	10.7
Trader	68	45.3
Ethnic Group		
Ewe	35	23.3
Kokonba	28	18.7
Basari	13	8.7
Kotokoli	18	12.0
Nbubo	11	7.3
Achode	10	6.7
Adele	7	4.7
Akan	6	4.0
Others	22	14.7

Source: Field Data

A total of 150 women were interviewed. Out of this 59.3% fell within the age group 15-29 years, a group which has the potential for many more births, if nothing is done.

(i) **Marital Status**

The majority of the respondents were currently in a stable marriage.

(ii) Educational Level

As much as 50% of the respondents had never had any form of formal education before. This is an indication of the rate of illiteracy particularly amongst women in the district. This was expected to negatively influence the utilization of family planning methods. Only 3 (2%) of the respondents have had a tertiary form of education with 48% having primary to senior secondary school level of education. This distribution by educational level should give an idea of how IE & C messages on family planning could be organised.

(iii) **Religion**

Christianity was the most popular religion with 77.3% of the respondents being Christians. 15.3% each was Moslems and traditionalist with 2 (1.3%) claiming not to belong to any form of religion. Attempts could be made to reach most women with family planning messages through the churches mosques and traditional religious leaders.

(iv) **Occupation**

Respondents were mostly farmers and traders - 41.3% and 45.3% respectively with 10.7% and 2.7% being unemployed and civil servants, respectively.

(v) **Ethnicity**

The multi-ethnic nature of the Nkwanta district was reflected in the distribution of respondents by ethnic background. One could count as many as about 20 different ethnic groupings in the district. However, the major ethnic groups as represented by respondents were Ewe 23.3%, Kokonba 18.7% Kotokoli 12.0% and Basaris 8.7%.

Table 4.2: **Distribution of respondents by contraceptive usage.**

	Frequency	**Percentage**
Ever used contraceptive N = 150		
Yes	55	36.7
No	95	63.3
Current use N = 150		
Yes	50	33.3
No	100	66.7
Future use N = 150		
Yes	66	44.0
No	41	27.3
NA(Not Applicable)	43	28.7

Source: Field Data

From the Table 4.2,it is observed that whilst 36.7% of respondents claimed to have used contraceptives before only 33.3% are currently using it.

However 44.0% have the intention of using contraceptives in future.

Table 4.3a: **Distribution of Respondents by contraceptive method used: for those who have ever used contraceptive .**

Method	Frequency	Percentage
Pill	19	34.5
IUCD	4	7.3
Injectable	25	45.5
Condom	4	7.3
Periodic Abstenance	1	1.8
Tubal Ligation	1	1.8
Others	1	1.8

Source: Field data

Table 4.3b: **For those currently using contraceptives**

Method	Frequency	Percentage
Pill	17	34.7
Injectable	28	57.1
Condom	2	4.1
Tubal Ligation	2	4.1

Source: Field Data

From Tables 4.3a and 4.3b it can be seen that, the injectable is the most popular method of contraception. This finding is very consistent with information obtained from the Focus Group Discussion, where most of the respondents said they like the injectable, because:

(i) It can be given secretly without your husband knowing about it, and also

(ii) It is always given by a qualified person, so the fear of having the side effects of the drug is always minimal as compared to the others.

Table 4.4: Distribution **of respondents by reasons for non use of contraceptives.**

Method	Frequency	Percentage
Missing cases	3	7.3
Want children	21	51.2
Side effects	8	19.5
Infrequent sex	2	4.9
Lack of knowledge	7	17.1

Source: Field Data

For those women who do not intend to use contraceptives; the main reasons cited were want of children (51.2%); side effects of contraceptives (19.5%) and lack of knowledge (17.1%) about family planning. However, the focus group discussions gave the main reason for the non use of contraceptives as the fear of side effect, even though reason like lack of knowledge of use and want of more children as "given don't know how many born would die or care for you" were mentioned.

Table 4.5: **Distribution of respondents by source of information on family Planning**

Source of information	Frequency	Percentage
Radio	17	11.4
Television	1	0.7
Newspaper	1	0.7
Posters	1	0.7
Husband	8	5.3
Health worker	100	66.7
Relative	12	8.0
Friends	4	2.7
Missing Cases	4	2.7

Source: Field Data

An overwhelming number of respondents 100 (66.7%) indicated that they received family planning messages from health workers. Other sources of information mentioned

were-radio by 17 (11.4%) of respondents, relatives 12 (8.0%) of respondents and 8(5.3%) of respondents received their messages of FP from husbands, with the other sources contributing insignificantly.The fact that very few respondents depend on Posters ,TV,and Newspapers confirms the very high illiteracy rate of 50%.

The widening of the activities of health workers to improve coverage of IE&C messages on FP is very significant to the improvement of family planning acceptance, since it has been found out that, most women in the district depend on the health worker or health facility for that matter for such information.

Table 4.6: Distribution of Respondents by distance to a Family Planning service point.

Distance	Frequency	Percentage
Within 2 km	86	57
Between 2 - 5 km	28	18.7
More than 5 km	30	20.0
Missing cases	6	4.0

Source: Field Data

Based on the assumptions guiding the analysis of the study, the following sections will present any relations found between variables.

For ease of reference, the assumptions are among other things, a woman's use of contraceptives would be influenced by:

- Her socio-demographic profile (i.e. age, marital status, educational level, religion, ethnic background and parity)and
- Accessibility of FP services (distance to service point),

The following CROSS TABULATIONS were to enable the investigator test the assumptions using the Nkwanta district data.

Table 4.1A **Distribution of Respondents by current contraceptive use and by age.**

	15 - 29	**30 - 49**	**Row Total**
Yes	30 33.7%	20 32.8%	50
No	59 66.3%	41 67.2%	100
Column Total	89	61	150

P - value = 0.90

Roughly equal proportions 33.7% and 32.8% of women in the two age groups 15-29 and 30-49 years were currently using contraceptives. At the 5% (0.05) significance level , the variation of current contraceptive use by the specified age group is insignificant and occurred just by chance.

Table 4.2A **Percentage distribution of future use by age**

	15 - 29	**30 - 49**	**Row Total**
Yes	45 70.3%	21 48.8%	66
No	19 29.7%	22 51.2%	41
Column Total	64	43	107

P - value = 0.025

Since $p<0.05$, it means that, the variation of age with future usage of contraceptives at the 5% significant level, is significant and not just by chance. This is supported by the strong desire of the young participants in the FGD to learn more about family planning. One may conclude that when provided with adequate information on family planning, acceptance is likely to increase.

Table 4.3A: **Distribution of Respondents current use of contraceptives by marital status.**

	Married	Single	Divorced	R. total
Yes	30	17	3	50
	25.9%	60.7%	50.0%	
No	86	11	3	100
	74.1%	39.3%	50.0%	
Column total	116	28	6	150

P-value=0.0014

Only 25.9% of married women were currently using contraceptives whilst 60.7% of single women were currently using it.The variation of current contraceptive use with marital status is very significant and not just by chance. This finding is also consistent with that of the FGD, where most married women claimed, are not allowed to use contraceptives by their husbands.

Table 4.4A: **Distribution of current use of contraceptives by educational level of Respondents.**

	Nil	Primary	JSS/SSS	Tertiary	Row Total
Yes	25 33.3%	9 36.0%	14 29.8%	2 66.7%	50
No	50 66.7%	16 64.0%	33 70.2%	1 33.3%	100
Column Total	**75**	**25**	**47**	**3**	**150**

P - value = 0.6.

Roughly equal proportion of women with no education,primary education JSS/SSS education were currently using contraceptives.Out of three women with tertiary education two(66.7%) were currently using contraceptives.However,this variation of current use by level of education was not significant.This could be attributed to the small number of women with tertiry education

Table 4.5A: **Distribution of current use of contraceptives by the religion of Respondents.**

	Others	Christian	Moslem	Traditional	Row Total
Yes	1 50.0%	42 41.2%	6 26.1%	6 26.1%	55
No	1 50.0%	60 58.8%	17 73.9%	17 73.9%	95
Column Total	**2**	**102**	**23**	**3**	**150**

P - value = 0.35

Since P>0.05,therefore it means the variation of contraceptive usage with religion at the 5% significance level is insignificant. Similarly there was an insignificant relationship between current and future use of contraceptive and religion. This finding makes social sense, since usually it is the older conservative Moslem males who object to family planning on religious grounds. In this case, all respondents were women and as confirmed by the FGDs, women participants did not see family planning as in conflict with their religion.

Table4.6A: **Percentage distribution of current use of contraceptives by ethnic background of respondents**

	Ewe	Kokonba	Basari	Kotokoli	Ntrubo	Achole	Adele	Akan	Others	R.Total
Yes	13	13	6	5	1	1	2	1	8	50
	37.1%	46.4%	46.2%	27.8	9.1%	9.1%	28.6%	16.7%	36.4%	
No	22	15	7	13	10	10	5	5	14	100
	62.9%	53.6%	53.8%	72.2%	90.9%	90.9%	71.4%	83.3%	63.6%	
C.T.	35	28	13	18	11	11	7	7	22	150

P - value = 0.27

Since p >0.05, therefore it means that, the variation of contraceptive use with ethnicity is insignificant and occurred just by chance. This result is inconsistent with the findings of the FGD, in which it was found that the Kokonba and the Basari ethnic groups seem to have very strong opinions against family planning than the other tribes. This inconsistency could be explained by fact that, notwithstanding this opposition which is mainly coming from the men, the women may be using the contraceptives secretly, as some of the women themselves confided in the investigator. This being the reason for women preferring the injectable contraceptives to the other ones.

Table 4.7A: **Distribution of Respondents use of contraceptives by distance from health facility.**

	Unknown distance	Within 2 km	Between 2-5 km	> 8 km	Row Total
Yes	1 16.7%	30 34.9%	11 39.3%	8 26.7%	50
No	5 83.3%	56 65.1%	17 60.7%	22 73.3%	100
Column Total	**6**	**86**	**28**	**30**	**150**

P - value = 0.59.

Since $p > 0.05$, it means therefore that the variation of contraceptive usage with distance by respondent is insignificant and occurred just by chance.

This could be explained by the fact that most respondents, 76% live within the reasonable acceptable distance of 5 km from a health facility.

4.2 Findings From The FGDS

The major purpose of the Focus Group Discussion was to unearth and examine factors that prevent couples from using family planning methods, the specific anxieties or attitudes that interfere with the acceptance and use of modern contraceptives.

As indicated in the methodology a total of nine focus group discussions were conducted in the 2 sub-districts among 2 age groups - 15 - 29 years and 30 - 45 years for women and 15 - 35 and 36 and above for men. Men and women were dealt with separately.

.. Most participants know of family planning but few practice it

Except some of the young women in Bonakye, all participants interviewed had heard of family planning, although not all could explain its meaning.

Abstinence and the injectables are the preferred means of contraception. Reasons given were *"with the injectable we are properly examined before given, so there are no side effect or failure like the others," "We can also take it secretly without our husbands knowing of it"*. Even though abstinence is used both men and women are frustrated with it. As one young woman put it, *"we want to space our births without having to refuse our husbands*".

.. Large families are an economic liability

The FGD showed that both men and women recognized the economic implications of having many children against the background of rising cost of living.

One old man remarked; *"Gone are the days when it was prestigious to have many children, now many children means more worries"*

•• **Women are aware and concerned about the health implications of excessive Child bearing**

Whilst few of the men agreed that, it is not healthy on the part of the mother and baby to have frequent and excessive number of children, all the women knew that it was not healthy. Most participants suggested 4 children as ideal for a couple now and also suggested a birth interval of 3 or 4 years with most suggesting 4 years. With reasons like "*this would make the older child independent and you can even send him or her*".

•• **Reasons why people do not use contraceptives**

The main reasons participants cited for not using contraceptives are the fear of side effects which some gave as, headache, obesity, infertility, weight loss, fever etc.

Also women fear being branded promiscuous by their husbands and even other women. This was confirmed by one man who retorted; *"it is only those women who want to go behind their husbands who like family planning"* Others cited, lack of understanding of use, as the reason for non-use. Some also cited the need to bring forth many children as the reason for non-use. This view was shared by older men and women and some few young women. They cited reasons such as you don't know how many children born would die or look after you, so if you bring forth more, say about seven, and some die, by all means some would remain. "*While those who bring forth two or three children could end up losing all of them through death*".

•• Opposition comes mainly from older, religious (particularly moslems) and Konkoma men and also women in polygamous marriages

Older, religious men from the predominantly Islamic area of Bonakye and also Konkonma men voiced the greatest opposition to family planning on religious and cultural grounds respectively. Some called it a '*crime*" or a *"sacrilege*".

Youths and young adults both expressed more moderate attitudes than older opinion leaders. In contrast, most women said that family planning does not conflict with their religion. Konkonma men see family planning as a taboo. They also do not see any need for it, since to them the availability of food is not a problem.

Some women strongly oppose the idea of family planning because of competition with rivals for the number of children one brings forth.

•• Couples don't share ideas on family planning

Participants indicated that they rarely shared their childbearing concerns with their spouses. The women claimed their husband could even beat them if they dared talk about family planning to them. Those women on contraceptives claim they do it secretly. One Konkonma woman remarked, "*it is not our custom to talk to our husbands about the number of children we desire*".

•• Some people want more information on family planning

Young participants expressed a strong interest in hearing more about family planning. This they believe would help them enjoy a better life. '*We want advice about family planning so we can better care for our children*', declared some women.

.. Some men do not want women talk to them about family planning

Some older men claimed they also wanted more information on family planning but "*certainly not from a woman*" one elderly-man retorted. "*How can a woman tell me what to do*" another chipped in.

CHAPTER FIVE

5.0 DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

The study assumed that the family planning acceptor rate in the Nkwanta district is low because there are some underlying factors which prevent women from using the available family planning services.

Consequently, the investigator attempted to identify factors which affect utilization of contraceptives in the district, from the consumers and potential consumers point of view, opinion, knowledge and perception about family planning and also the socio-demographic of women 15-49 years, that is expected to impact on the utilization of contraceptives, based on studies done elsewhere to that effect.

Most of the findings of the study were consistent with findings of studies done in many developing countries, socio-cultural practices and norms constitute major hindrance to the use of contraceptives. Amongst the socio-cultural factors identified, is the general desire for a large number of children due to its perceived socio-economic benefit. This was particularly so amongst two of the three major ethnic groups Kokonmas and Basaris. These groups of people are mainly farmers who have access to a vast expanse of arable lands and need a lot of hands to help them. For these groups of people, the caring of a child is just getting him food to eat, and since there is always the availability of food thanks to the vast fields of arable land and their own industry, why worry about family

planning? Also, competition amongst women in polygamous marriages to outstage their rivals in the number of children they bring forth is a contributing factor.

On the knowledge of family planning, it was found that, for a fairly illiterate community like Nkwanta, their general knowledge was quite impressive, therefore the reason for non-use could not be directly due to lack of knowledge. Whilst most women desire to use contraceptives, the socio-cultural factors notwithstanding, the men who are the custodians of these socio-cultural values present a formidable barrier. This is made worse by the fact that, family planning messages are usually given by women - public and community health nurses - something which the majority ethnic groups like the Kokonmas and Basaris in particular do not welcome.

Among the socio-cultural factors, it was also found that, socio-demographic factors like marital status of a woman in the district significantly influences her use of contraceptives.

Women in a form of a union are less likely to use contraceptives than single women. This contradicts findings in many areas where contraception is typically first made available to and used by older, usually married women to end their child bearing career, according to Tsui (1989) as quoted in a World Bank discussion paper; 272. This finding shows and underscores the barrier men pose to family planning utilization in the Nkwanta district. Also contrary to findings in studies done elsewhere particularly one done by Benneh G, Nabila J. et al in 1989 (20) and another in Guatemala which showed a significant variation between contraceptive utilization and education in favour of education, the

Nkwanta study showed an insignificant variation between the two variables (p-value = 0.6).

Whilst there was no significant variation between contraceptive utilization and age (p = 0.90), there was a strong association between intention to use contraceptives in future and age in favour of the young age group (15-29). It can be inferred here that this intention is not actualised due to socio-cultural barriers imposed by marriage as the young women grow older and get married.

Distance to health facilities was not found to be a barrier to family planning utilization (p = 0.59), since a respectable proportion (76%) of the women live within 5 km from a family planning service delivery facility.

CONCLUSION

The Nkwanta district being a new one is relatively very undeveloped lacking many social amenities. However strenuous efforts are being made by the people led by their District Assembly to catch up with the rest of the region. In this connection it is the desire of the district health authorities to improve the current family planning acceptor rate which is rather low if this anticipated development is not to be outstripped by unregulated population growth.

In this study which concentrated on the consumer factors accounting for low family planning acceptor rate; it was found that, socio-cultural factors that lead to the desire for

many children and socio-demographic characteristics like marital status, of a woman are the main hinderances to the utilization of family planning in the Nkwanta district.

RECOMMENDATIONS

Strongly behind the factors contributing to the low family planning acceptor rate is the attitude of men. In this wise, family planning programmes should seriously address the involvement of men. IE&C programmes in the district should move away from centering on women to couples.

Family planning educational programmes could be drawn for predominantly men's group such as the GPRTU, Men's Fellowship and other associations in churches and communities aimed at changing their perceptions about it. The difficulty of this task would require the active involvement of chiefs, queen mothers and other opinion leaders like pastors, fetish priest and moslem leaders.

The outreach programmes in the district, which are usually CWC - centered should have family planning services well integrated into it to improve coverage in an attempt to increase acceptance.

Community health nurses should be given periodic in-service training to enable them to give the right contraception information. Male community volunteers (herbalists, mallams, etc could be recruited and trained as FP motivators in the communities.

In the long term, measures or efforts to improve the status of women by way of ensuring female education, employment opportunities, community participation would enhance their reproductive decision making rights which would enable them to take favourable decisions towards family planning on their own.

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Appendix I

Focus Group Discussion Guide:For men(Age;15years and above) and women (Age;15-49years)

1. Introduction, greetings and familiarization.
2. Participants should be told the purpose of the discussion and explained to how the information are going to be solicited for and used.

Questions to unearth the knowledge, perceptions, attitudes, beliefs and practices of participants towards family Planning.

(i) What do you know about family planning/contraceptives?

(ii) When did you first hear of it, and where do people seek information on family planning/contraceptive?

(iii) Can people easily get family planning services in this community, who decide the need for family planning?

(iv) Do you know of any problems which are caused by contraceptives? What are these problems and which contraceptives cause them?

(v) How many children do you think a couple should have and why?

(vi) What do you think should be the normal intervals between births for mothers and why?

(vii) What do women in this community do to avoid becoming pregnant and what do you think about them?

(viii) Which of them in your opinion do you think is the best and why?

(ix) What factors prevent couples in this community from using contraceptives or family planning services.

Appendix II

QUESTIONNAIRE

Title: A Study of the reasons for how family planning acceptor rate in the Nkwanta district of the Volta Region.

Date of interview .....

Location .....

Respondent No. .....

Name of Interviewer .....

1. Name of Respondent .....
2. Age .....
3. Sex .....
4. Marital Status [] Married [] Single [] Divorced
5. Educational Level [] Nil [] Primary [] J. JSS/SSS
   [] J Tertiary
6. Occupation [] Farmer [] Civil Servant [] Unemployed
   [] Trader
7. Religion: Christian (specify .....) [] Moslem, Traditional
   Others (specify .....)
8. Ethnic group: .....
9. Total number of children ..... Males [] Females []
10. Which sex do you prefer?
11. Have you ever used contraceptives before? [] Yes [] No

If yes, which one, pill, IUCD, injection, condoms, Tubal ligition, periodic abstinence, other methods (specify.....).

12. Are you currently using a contraceptive method? [] Yes [] No

If yes which method? .....

13. Where do you get your contraceptives from?

14. For how many months have you been using the method? .....

15. If not currently using a contraceptive method, do you intend to use a method to delay or avoid pregnancy at any time in future? [] Yes [] No

16. If no, what is the main reason for not wanting to use form of contraception?

[] wants children [] Lack of knowledge [] Too expensive

[] Side effects [] Opposition [] Hard to get methods

[] Infrequent sex [] Menopause [] Other reasons .....

17. How did you first hear about family planning?

[] Radio [] T.V. [] Newspapers [] Posters [] Husband

[] Health workers/clinic [] Relatives [] Others .....

18. How far is the MCH/FP delivery point form your village?

[] Within 2km [] Between 2-5km [] More than 5-8 km

19. How do you get to the MCH/FP delivery point?

[] Walk [] Transport

How much does it cost, if transport? .....

20. What are general feeling about contraceptives? .....

.....