UNIVERSITY OF GHANA

SCHOOL OF PUBLIC HEALTH

COLLEGE OF HEALTH SCIENCES

ACCESS TO FAMILY PLANNING SERVICES AMONG WOMEN ATTENDING HEALTH FACILITIES IN THE GA SOUTH MUNICIPALITY, GREATER ACCRA REGION

BY

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THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF MASTER OF PUBLIC HEALTH DEGREE

JULY, 2018

DECLARATION

I, Gloria Korkor Amedalor, declare that this thesis/dissertation is my own hand work. Where other people's materials have been used, these have been cited accordingly.

…… ……..

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(Student)

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Dr Augustine Adomah-Afari Date

(Supervisor)

DEDICATION

I dedicate this book to God almighty, my parents Mr & Mrs Amedalor, my siblings and my dearest Dr Benjamine Ansah Dortey.

ACKNOWLEDGEMENT

I wish to offer my profound gratitude to the Almighty God for bestowing His able hands on me in completing this research successfully. My deepest gratitude goes to my supervisor Dr. Augustine Adomah-Afari as well as Dr. Chris Guure for their advice, patience, guidance, and readiness to help me complete this research. I really appreciate everything. Yakubu, I am so grateful for your contribution to this work. God richly bless you. Special thanks go to Dr. Benjamin Ansah Dortey, my soul mate for his encouragement, love and support throughout the program. To Emmanuel Anaba, for your great contribution to this work, and to Emmanuel Korankye, and Tressure who assisted me with the data collection, I say thank you.

ABSTRACT

Background: The importance of family planning as a tool and the means to achieving development has been espoused by several studies. However, in Sub-Saharan African, reports show low use of family planning methods, a high unmet need for family planning and subsequently, high fertility rate. Usage of family planning services in developing countries has been found to avert unintended pregnancies and reduce maternal and child mortality.

Objective: The study aimed to evaluate access to family planning in the Ga South Municipal Assembly area in the Greater Accra Region of Ghana.

Methods: Descriptive cross sectional design using quantitative methods was employed to collect data for the study. The study recruited women within the reproductive age (WIFA) of 15-49 years attending selected health facilities at the time of the study. A systematic sampling method was used to select 270 with a 10% (27) to cater for non-response, which was run up to give a total sample size of 300. A structured questionnaire with close-ended questions was designed to collect responses covering: the range (types) of family planning services provided, predisposing (client) factors, enabling (health provider) factors, and the need (community) factors influencing access to Family planning services at these health facilities. All answered questionnaires were checked, entered and analysed with STATA version 15. Results were presented in frequencies and percentages. Bivariate analysis was used to determine the association between the dependent and independent variables. Multivariable analysis was used to determine the strength of associations between the factors influencing family planning and the level of significance was set at $p<0.05$.

Results: Of the 300 respondents, 31.7% had used a family planning method before. About 95 (31.6%) of the respondents had accessed family planning method in the facilities. About 70 (69.3%) of the respondents who had used family planning method were currently on a family planning method, 30.3% of them had used a family planning method in less than a year, and about 21.2% of them last used a family planning method in 5 to 10 years, and more than 10 years each. The most used family planning method was condom (30.5%) among the respondents who had had access to family planning method while the least used family planning method among this group was morning pills. This implies that condoms were the frequently used family planning methods.

Conclusion: The findings of the study revealed that, women in the municipality had access to family planning methods such as: injectable, condoms, and pills among other. In addition, the women who were on family planning had children; perceived provider-level factors as acceptable and encountered little or no restrictions from their partners, culture, religion and community. The study concluded that access to family planning services could be influenced by client, provider and community level factors grouped under predisposing, enabling and need factors. These findings to some extent were consistent with existing literature.

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AHUM	-	Andersen's healthcare utilization model
AOR	-	Adjusted odds ratio
CHIPS	-	Community based health planning and services
FP	-	Family planning
GAR	-	Greater Accra region
GSMA	-	Ga South Municipal Assembly
IUD	-	Intrauterine Device
MDGs	-	Millennium development goals
NGO	-	None governmental organization
PMTCT	-	Prevention of mother-to-child transmission
RTIs	-	Reproductive tract infection
SDGs	-	Sustainable development goal
STI	-	Sexually transmitted infections
STD	-	Sexually transmitted disease
UOR	-	Unadjusted odds ratio

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Generally, family planning (FP) is acknowledged as a vital intervention to the achievement of development (Gutierrez, 2013). Family planning encompasses the services, policies, information, attitudes, practices and commodities, including contraceptives that give women, men, couples and adolescents the ability to avoid unwanted pregnancy and choose whether and/or when to have a child (Starbird, Norton & Marcus, 2016).

The benefits of family planning have become increasingly recognised worldwide, including improved health, economic, and social outcomes for women and families, as well as public health, economic, and environmental benefits at the population-level (Singh, Darroch, Ashford, & Vlassoff, 2009). At the individual-level, the health benefits for women and infants include; the prevention of pregnancy related health risks and deaths in women, reductions in infant mortality and the rate of unsafe abortions, the prevention of the transmission of HIV/AIDS from mother-to-child (PMTCT), and prevention of sexual transmission of HIV and sexually transmitted infections (STI) between partners (WHO, 2013). Family planning also has been found to promote gender equality as well as promote educational and economic empowerment for women (Apanaga & Adam.2015).

The cost effectiveness of family planning in poverty reduction and socioeconomic development, especially in the developing world with very limited resources cannot be disputed based on evidence from countries like Bangladesh and Thailand (Eliason, 2014). Eliason (2014), reported further evidence that every dollar spent on family planning services

saved at least, US$4 that could have been spent treating complications from unintended pregnancies and saved governments up to US$31 in health care, water, education, housing, sewers, and many more. Other analysts argue that family planning is touted as the single most important cross sectorial, socioeconomic intervention that can accelerate progress in achieving the sustainable development goals (SDGs) (Starbird, Norton & Marcus 2016).

In summary, family planning services involve the following (CDC, 2014):

1. Providing contraception to help women and men plan and space births, prevent unintended pregnancies, and reduce the number of abortions;
2. Offering pregnancy testing and counseling;
3. Helping clients who want to conceive;
4. Providing basic infertility services;
5. Providing preconception health services to improve infant and maternal outcomes and improve women's and men's health; and
6. Providing sexually transmitted disease (STD) screening and treatment services to prevent tubal infertility and improve the health of women, men, and infants.

It has been documented that over 200 million women in developing countries have an unmet need for contraception (Singh, Sedgh, & Hussain, 2010). The concept of unmet need reflects the gap between childbearing desires and contraceptive use (Wolff, Blanc, & Ssekamatte-Ssebuliba, 2000).). It is reported that meeting the unmet need for family planning and maternal and newborn health care in Sub-Saharan Africa is estimated to result in a 69 percent reduction in maternal deaths and 57 percent drop in newborn deaths (Guttmacher Institute, 2010). Notably, women in developing nations are disproportionately affected by an unmet need for family planning, with the highest need in Sub-Saharan Africa (Guttmacher Institute, 2010). Studies have grouped the reasons for non-use of contraceptives into four categories:

fertility-related reasons, method-related reasons, opposition to use, and lack of knowledge (Adebowale, & Palamuleni, 2014).). The argument is that an important method-related factor contributing to unmet needs, especially in Sub-Saharan Africa is access to family planning services (Seigh, Ashford & Hussain, 2016).

Efforts have been made by the Government of Ghana and non-governmental organizations (NGOs) through the implementation of various programmes to improve the coverage of family planning services in the country (Apanga & Adam, 2015). Apanga and Adam (2015), argue however, that the unmet need for family planning services still remains high even though there has been increased awareness. Therefore, addressing factors that limit access to family planning may thus reduce the unmet need for family planning services. This forms the motivation for this study.

1.2 Problem Statement

In Ghana, family planning services have been supported by the government, international actors like the World Health Organization (WHO) and other non-state actors (WHO, 2005). When it comes to Ghana and other African countries, family planning is integrated into the reproductive and child health services at all levels of the health delivery system (Addai, 2000). Family planning and other health service delivery in Ghana follow a three-tier structure. They are: primary, secondary and tertiary arrangements (Currie *et al*., 2012). Evidence adduced so far indicates that there are enormous benefits of family planning services to both the individuals and the country as a whole (Singh, & Darroch, 2009). However, one critical factor limiting uptake of family planning services is access to the services and this can be examined from the perspectives of the client, facility and community.

Currie *et al*. (2012), explain that the primary level of family planning incorporates a Community Based Health Planning and Service (CHIPS) system that ensures that family planning is provided at the door step of the people. Available statistics show that despite efforts being made by the Ghana Health Service and other non-governmental organizations to improve coverage of family planning services, about 30% of currently married women have an unmet need for family planning services due to the different range of services provided at different level of care (GDHS, 2014).

Reports show that knowledge and awareness of family planning services is over 90% (Gizaw, & Regassa, 2011). Thus, the lack of knowledge of family planning services cannot be an important contributor to Ghana's high unmet need for family planning. However, it is anticipated that improving access to family planning services has the potential to reducing the high unmet need for family planning services. This will have to consider the client factors such as the socio-demographic characteristics (age, education, income, religion, marital status). Early research in this area focused mainly on individual-level determinants of contraceptive uptake, including individual characteristics, such as socioeconomic and demographic factors as being the reasons why women of reproductive age are not accessing family planning (Stephenson *et al*., 2007).

However, this study will look at the factors influencing access to family planning services at three levels – these are the individual, the community and the health provider levels. This is because these three main factors have an influence on how women refuse to access family planning (d'Ambruoso, Abbey, & Hussein, 2005). For instance, it has been observed that effective interventions to promote maternal health service utilization should target the

underlying individual, household, community and policy-level factors - the interventions should reflect the relative roles of the various underlying factors (Babalola, & Fatusi, 2009).

The private sector (private health facilities) is recognised as an important partner in increasing access to health services generally in the low/middle income countries (Brugha & Zwi, 1998; Hanson *et al*., 2001, Harvey 2008). Although some women may decide to access family planning services from private health providers, the conditions of these providers (since they charge, especially those that are private-for-profit) may deprive these women from accessing FP accordingly. On the other hand, in the public health facilities where usually the services are free, clients seem to complain of staff attitude, waiting time, non-availability of supplies, among others (Sohail, 2005). Sohail (2005), reports that clients were dissatisfied with such aspects of care as waiting time, cleanliness and privacy of treatment and the expressed serious concern about the quality of inpatient food, non-availability of prescribed drugs and medical supplies at the primary health centres in Bangladesh.

Community factors have been assumed to be creating challenges for access to FP services in communities in Sub-Saharan Africa (Warfield, 2012). Evidence suggest that demand barriers may be as important factors in deterring patients from obtaining access to family planning services. Yet relatively little attention is given, either by policy makers or researchers, to minimizing their effect. These barriers are likely to be more important to the poor and other vulnerable groups where the cost of access, lack of information and cultural barriers impede them from benefiting from the public health facilities (Ensor & Cooper, (2004). There are certain cultures, traditions and beliefs that either prevent or encourage women from accessing orthodox health care. For example, in some communities, the culture, traditions and belief

systems can influence how women access family planning services (Cleland, & Bernstein, 2006).

The Ga South Municipal Assembly (GSMA) has eight (8) public health facilities and 27 private health facilities (GSMA, 2016). It will therefore, be difficult to improve access to family planning services without contributions from the private health facilities in the municipality. This study will also seek to evaluate the contributions of private health facilities towards improving access to family planning in the municipality. This study therefore, seeks to identify factors that impact (hinder or promote) on access to family planning in order to help address the high unmet need**.**

1.3. Significance/Justification of Study

Identifying factors that promote or limit access to family planning services will help inform health authorities, especially in the study area to put in place appropriate measures needed to improve uptake of family planning services. Patronage in family planning services depends on the range of services available (Smith, 2003). Although this factor is important to how women access family planning, it appears that few studies have looked at it in-depth (Glasier & Innis, 2006).

It is important to observe that access to family planning services will to a large extent depend on client factors or socio-demographic characteristics of the women in the area of service. Even as these factors are relevant to determine what policies to put in place regarding the provision of family planning in the GSMA, it looks like no particular study has examined these factors (Glasier & Innis, 2006). This study will endeavor to investigate how client

factors/socio-demographic characteristics of women have an influence on their access to family planning in the area.

Arguably, the provision of the family planning services by either the public or private health providers will encourage or discourage women from accessing them. For instance, it could be argued that there is paucity of research with respect to the contribution of private health facilities to the provision of family planning services in Ghana. This study will seek to evaluate the different contributions that both the public and private health care facilities make towards encouraging access to FP amongst women in the GSMA. (Glasier & Innis, 2006).

The composition and relevance of community-related factors toward enhancing women's access to healthcare services in Ghana in particular and Sub-Saharan Africa in general, cannot be overlooked (Maurer & Smith, 2013). There are certain cultures, traditions and beliefs that either prevent or encourage women from accessing orthodox health care (Maurer & Smith 2013). Nevertheless, it looks like these community factors have been minimally examined in earlier studies (Maurer & Smith, 2013).

The cosmopolitan nature of the study area and for that matter the cosmopolitan nature of most of Ghana's population will make the findings of this study essential and probably contribute to information on a national policy to help improve uptake of family planning services. The study may also serve as a reference material for future studies aimed at reducing the level of unmet need for family planning services.

The increasing need for such a study was motivated by the researcher's own background as a health care professional working in the health sector of the country. Having gained considerable years of working experience, the researcher will be able to throw more light on the issues under consideration. This will contribute to finding a lasting solution to address the challenges women face in accessing family planning services.

1.4. Objectives of the Study

The objectives of the study are categorised into general and specific as shown below.

1.4.1. General objectives

The general objective of the study is to evaluate access to family planning services among women attending health facilities in the GSMA, GAR.

1.4.2. Specific Objectives of the Study

The specific objectives of the study are:

1. To assess the range (types) of family planning services provided at health facilities in the GSMA, GAR.
2. To evaluate how predisposing (client) factors influence access to FP services at health facilities in the GSMA, GAR.
3. To examine how enabling (health provider) factors influence access to FP services at health facilities in the GSMA, GAR.
4. To evaluate how need (community) factors influence access to FP services at health facilities in the GSMA, GAR.

1.4.3. Research Questions

The following questions will help to find answers to address the objectives:

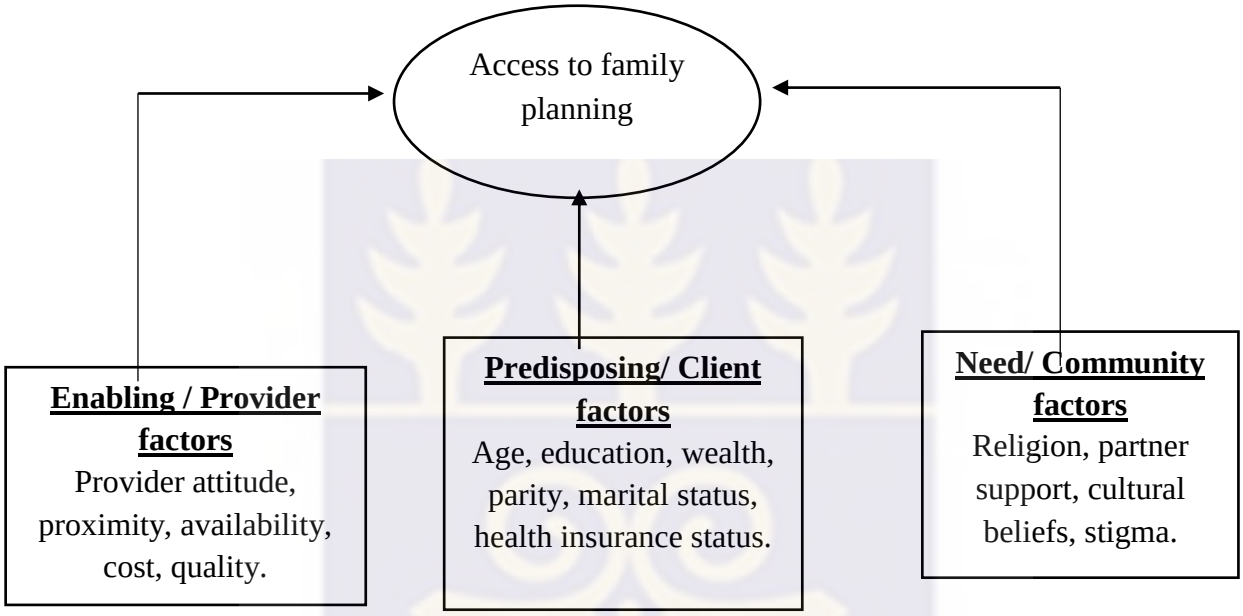
1. What is the range (types) of family planning services provided at health facilities in the GSMA, GAR?
2. How do predisposing (client) factors influence access to FP services at health facilities in the GSMA, GAR?
3. How do enabling (health provider) factors influence access to FP services at health facilities in the GSMA, GAR?
4. How do need (community) factors influence access to FP services at health facilities in the GSMA, GAR?

1.5. Conceptual Framework for Access to Family Planning

Figure 1.1 below is the conceptual framework for the study. In the framework, the researcher argues that three main factors come together to determine access or non-access to family planning. These are predisposing (client level), enabling (health care provider level) and need (community level) factors. The predisposing (client level) factors include the age, education and wealth quintiles of the potential client. The enabling (provider level) factors comprise of the attitude of health providers, their skills, the quality of services and proximity to the provider. And the need (community level) factors include religion, spouse's support, among others.

The conceptual framework was based on adaptation of the Anderson's (1960) model and previous studies (Carlos dos Reis *et al.*, 2010). Carlos dos Reis *et al.* (2010), used parts of the framework to assess accessibility and utilization of schistosomiasis-related health services in a rural area in Brazil. Recently, this framework was applied/validated by Yakob and Ncama

(2016), who investigated the impact of socio-ecological factors on access and accessibility to HIV/AIDS treatment and care services in Ethiopia. The framework has been tested and proven as reliable for determining predictors of access to healthcare.



Source: Adapted from Carlos dos Reis et al. (2010); Yakob and Ncama (2016); Anderson (1960).

Figure 1.1: Conceptual Framework for Access to Family Planning.

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

This chapter presents the analysis of literature related to the subject matter of this study. It is divided into five sections which are the theorectical perspective, access to family planning services, range of family planning services, family planning in Ghana, and factors influencing access to family planning.

2.2. Theoretical Perspective

This study is underpinned by Andersen's (1960), healthcare utilization model (AHUM). The model was propounded by Andersen, a professor of health at the University of California, Los Angeles in 1960, but has evolved overtime. The model was developed to predict and explain access and use of healthcare. According to Andersen (1960), an individual's decision to access or utilize healthcare services is a function of three main characteristics. These characteristics include: predisposing factors; enabling factors; and need factors (Andersen & Newman, 1973; Aday & Andersen, 1981; Andersen, 1995).

Predisposing factors comprise of social structure, health beliefs and demographics (Andersen, 1960). Examples of social structure are education, occupation, ethnicity, social networks among others. Health beliefs embrace of knowledge, attitude and values of the individual. Demographics have to do with the individual's age and gender (Andersen & Newman, 1973; Aday & Andersen, 1981).

Enabling factors are those that facilitate the use of healthcare such as family income, proximity, and free health care, availability of health personnel and facilities, social support and health insurance coverage (Andersen, 1960). It also involves traveling and waiting time for health care (Andersen & Newman, 1973; Aday & Andersen, 1981).

Need factors motivate the use of health care (Andersen, 1960). Need variables, which influence use of health services include perceived healthcare need and empirically determined health problems. Anderson (1995), explains that perceived need refers to how people view their own general health and functional state, as well as how they experience symptoms of illness, pain, and worries about their health and whether or not they judge their problems to be of sufficient importance and magnitude to seek professional help. Empirically determined health problems also represent professional judgment about people's health status and their need for medical care (Andersen & Newman, 1973; Aday & Andersen, 1981; Andersen, 1995). Andersen's (1960), model has received some criticisms from scholars and researchers, however, it remains one of the most widely adopted models to explain healthcare utilization behaviour (Phillips, Morrison, Anderson & Aday, 1998; Gelberg, Andersen & Leake, 2000; Babitsah, Gohl & von Lengerke, 2012).

Making inference from Andersen's model, the researcher conceptualises that access to family planning services can be influenced by three main factors. These are client, provider and community level factors. Client factors are the characteristics of the person accessing family planning. For instance, the age, education, income, parity among others, of the client or consumer. Individuals who have knowledge of family planning (FP) and the financial capability are more likely to access it compared to individuals who know little about FP or do not have the purchasing power.

Factors at the provider's level such as provider attitude, availability, quality and cost of FP are also crucial in determining access to family planning. People may have the knowledge and money to pay for the FP services, but if the services are not available, access may be problematic.

Community level factors can also play an important role(s) in determining family planning access. Such factors include spousal and community members' influence, religious beliefs, cultural beliefs and others. Women who do not have the support of their husbands are less likely to access family planning compared to women who have the full support of their husbands. Studies found that the presence of a mother-in-law and husband's approval were significantly associated with family planning accessibility (Apanga & Adams, 2015; Prata *et al.*, 2017). These factors are synonymous with Andersen's (1960), predisposing, enabling and need factors.

2.3. Access to Family planning in public and private health facilities

In many developing countries, family planning services are provided largely by the public health facilities (Peters, Mirchandani & Hansen, 2004). However, the contribution of the private sector to delivering family planning services cannot be unrated. It has been suggested that, supporting the private sector can help scale up family planning service delivery in developing nations (Peters *et al.*, 2004). There is evidence to show that the quality of FP services differs between private and public health facilities (Agha & Do, 2009).

For instance, in the United States of America, it was found that only one in four women accessed FP from public health facilities (Frost, 2001). However, the public facilities provided wide ranges of modern FP methods than private health facilities.

Choice of health facility was influenced by socio-economics status of the individual. The insured, poor, young and unmarried were more likely to visit public health facilities while the non-insured preferred private health facilities. This suggests that access to FP is influenced by socio-economic factors (Frost, 2001).

In Kenya, Agha and Do (2009), found that the private sector performed better in areas like availability of infrastructure and services. Moreover, patient–provider communication and patient satisfaction were high in private hospitals (Agha & Do, 2009). However, no significant difference in provider skill was found. In a comparative study of three Sub-Saharan countries namely; Ghana, Tanzania and Kenya, it was confirmed that private facilities do well in interpersonal quality than public facilities but not in technical quality (Hutchinson, Do & Agha, 2011). Patient satisfaction was high in private facilities due to short waiting time and adequacy of FP methods (Hutchinson *et al*., 2011). However, the authors failed to explore the influence of socio-economic factors such as education and income on FP access.

Ugaz *et al.* (2016), found low knowledge and poor attitudes among private providers in Bangladesh. To help address unmet family planning needs effectively in developing countries, it was recommended that in-service training should be organized for health providers (Judge *et al*., 2011). Judge *et al*. (2011), argued that this will help increase providers' knowledge and reduce inequity in family planning care.

2.4. Range of Family Planning services

There are two main types of family planning, the natural and modern family planning (GSS, 2014). The latter is mostly provided in healthcare facilities or family planning outlets such as pharmacies (Kayembe *et al.,* 2006). Studies found that the male condom was the most common modern FP method accessed in healthcare facilities in Congo, followed by pills and injectables. Other FP methods include IUD, implants, spermicides and diaphragm (Kayembe *et al.,* 2006).

2.5. Family Planning in Ghana

Family planning (FP) is an important intervention for population management (Amo-Adjei & Darteh, 2017). Ghana in her quest to control population growth adopted family planning (Amo-Adjei & Darteh, 2017). During the revision of the 1969 Population Policy in 1994, family planning was incorporated into the population policy (Amo-Adjei & Darteh, 2017). It has been featured consistently in Ghana's development agendas with the recent being Ghana Shared Development Agenda II (2014-2017) (Amo-Adjei & Darteh, 2017).

The key rationale for implementing the intervention was to help control high population growth in the country through health education and the provision of family planning services such as contraceptives (GSS, 2014). For instance, Ghana's contraception programme is expected to provide education, information and counseling to couples who want to space or limit child birth (GSS, 2014). Other expectations include providing the populace with affordable and a wide-range of family planning services, and to disseminate health information on Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs) like HIV and AIDs (GSS, 2014). Despite efforts to make family planning services

accessible to all, evidence shows that unmet family planning needs remains high in Ghana (Apanga & Adams, 2015; GSS, 2014).

To help throw more light on the state of family planning and its related issues in Ghana, valuable statistics were drawn from the 2014 Ghana Demographic Health Survey (GDHS) report (GSS, 2014). It is the most recent nationwide health survey report. It is stated in the report that, over 30% of currently married women and 42% of unmarried sexually active women have unmet need for family planning in Ghana. For instance, it is noted that exactly 57% and 87% of currently married women and sexually active unmarried women have demand for family planning respectively. However, per the time of the survey, only 47% and 51% of the respective demands had been met. This supports the point that unmet family planning need in Ghana is high (GSS, 2014).

These notwithstanding,contraception use in Ghana has increased over the last six years (GSS, 2014). Between 2008 and 2014, the use of modern contraception increased from 24% to 27% while the use of traditional contraception increased from 17% to 22% respectively, suggesting that Ghanaians are gradually embracing family planning (GSS, 2014). More than one in four currently married women are using some method of contraception and about 45% of sexually active unmarried women had used contraceptives per the time of the survey (GSS, 2014).

Spacing and stopping childbirth, preventing pregnancy and sexually transmitted infections are the main reasons for family planning use in Ghana (Apanga & Adams, 2015). There are two major types of family planning in Ghana, thus the traditional and modern (GSS, 2014). It appears that Ghanaians have more taste for modern methods than traditional methods.

Statistics show that as at 2014, 22% of women in Ghana had used the modern methods while only 5% had used the traditional methods (GSS, 2014). The common traditional methods used include rhythm, withdrawal and folk method (GSS, 2014). The common modern methods used include the following: injectable (8%), pills (5%), implants (5%), and male condom (8%). Overall, about 22% and 5% use modern and traditional family planning methods respectively (GSS, 2014).

The acceptability rate of family planning in Ghana varies from region to region (GSS, 2014). Among the ten regions, the Volta region takes the lead with 32% coverage while the Northern region occupies the last position with 11% (GSS, 2014). Unexpectedly, contraceptive use is high among rural dwellers than urban dwellers (26% and 27% respectively) (GSS, 2014). In addition, contraceptive use in Ghana increases with education (GSS, 2014). Among the currently married women, 34% of those with at least secondary education use contraceptives against 19% of married women with no education (GSS, 2014). Other factors influencing the use of family planning in Ghana include parity, religion, marital status and proximity to the health facility (GSS, 2014).

2.6. Factors influencing access to family planning

Access to family planning can be influenced by a number of factors (Nalwadda *et al.*, 2011). This section of the literature review looks at empirical studies on factors influencing access to family planning in Ghana and beyond. The review is structured according to client level factors, provider level factors and community level factors.

2.6.1. Predisposing (Client level) factors influencing access to family planning

This section presents predisposing (client level) factors that could influence access to FP as evidenced by existing literature. Studies in both developed and developing countries have found that predisposing (client level) factors can influence access to family planning (Leyser-Whalen, Rahman & Berenson, 2011; Judge *et al*., 2011).

Socio-demographic characteristics

A survey by Leyser-Whalen et al. (2011), in Texas following Hurricane Ike found that among the hurricane evacuees, it was more difficult for Black women to access contraceptives as compared to White and Hispanic women. Leyser-Whalen et al. (2011), report that in addition, lack of access was associated with the frequency of unprotected sex. Women who had more unprotected sex were less likely to get contraceptives. In another study, lack of knowledge and misconceptions on the part of clients were found as barriers to Emergency Contraceptive (EC) use in Canada (Shoveller et al, 2007). Shoveller et al. (2007), explain that utilization was poor among women with low awareness of EC outlets.

In developing countries, studies have found that many women do not have access to family planning (Apanga & Adams, 2015, Speizer et al., 2000). Extant literature attribute this to socio-economic factors (van Zijl, Morrini & van der Spuy, 2010). Ackerson and Ziclinski (2017), did an extensive review of literature on promoters and inhibitors of access to family planning in Sub-Saharan Africa. Studies found that lack of trust in orthodox medicines, desire for many children, financial constraints, misconceptions about FP (Mugisha & Reynolds, 2008), perceived unqualified providers and lack of knowledge (van Zijl, Morrini & van der Spuy, 2010), were individual level factors influencing access to family planning.

Education

Using secondary data from six Sub-Saharan African countries, including Ghana, Stephenson et al. (2007), revealed that FP uptake was influenced by clients' level of education, their desire to space child birth, parity, marital status, age, exposure to FP information and wealth.

For example, Christians were more likely to use family planning than Muslims. Moreover, women family planning use was prevalent among women in their reproductive age (less than 40 years).

Proximity to health facility

In Pakistan, Azmat et al. (2015), found that proximity to the health facility, age, wealth quintiles, location of last delivery, and communication with husband were predictors of FP access. Women who stayed closer to the health facility were more likely to have access to family planning as compared to their counterparts who stayed far from the health facility. Among the urban poor in the same country, Stephenson and Hennink (2007), found that educational status of women, access to a functioning television or radio, number of children or parity were determinants of family planning use. Client's level barriers restricting use of family planning included cognitive, economic and physical barriers. In analyzing trends and patterns of family planning in Uganda, Andi et al. (2014), recommended that creating awareness and subsidizing the cost of family planning would improve accessibility.

Parity

In Ghana, the situation is not significantly different from what have been reported above. Apanga and Adam (2015), in their cross sectional survey of women in the Upper East Region of Ghana found that access to family planning was influenced by different factors. These researchers found that parity and educational status of women were significantly associated with accessing family planning. For instance, women with three or more children were more

likely to enroll on family planning than women with no children. The rationale for using family planning was to space child birth or prevent pregnancy and sexually transmitted infections. However, misconception, fear and restriction from partners were barriers to accessing family planning (Apanga & Adam, 2015). In the same region, Adiana et al. (2015), found that educational status, marital status, parity and fertility preference were factors influencing family planning uptake. However, family planning use in the region was below expectation.

Using data from the 2008 Ghana Demographic Health Survey, Crissman, Adanu and Harlow (2012), found a significant association between women's sexual empowerment and family planning uptake even after adjusting for demographic variables. Other significant predictors included formal education, wealth and women in a cohabitating relationship. The authors recommended that reducing gender inequalities in sexual empowerment could facilitate access to family planning. In a follow-up qualitative study to the 2014 Ghana Demographic Health Survey, Staveteig (2016), established that, the risk of side effects and attitudinal resistance were barriers to family planning uptake in Ghana.

2.6.2. Enabling (Provider level) factors influencing access to family planning

This section presents enabling (health provider level) factors that could influence access to FP as evidenced by existing literature. Factors that influence access to family planning exceed personal level factors since provider level factors can also determine access to family planning (Shoveller *et al*., 2007; Ackerson & Ziclinski, 2017).

Availability

Through in-depth interviews, Mugisha and Reynolds (2008), revealed that supply availability, providers knowledge and skill in family planning and workload of health providers influenced access to family planning. These researchers explain for example, that shortages of preferred family planning methods might discourage women from enrolling on family planning.

Health provider attitude

In Canada, Shoveller et al. (2007), found that negative provider attitude and some unfriendly institutional policies restricted access to family planning. Catholic health facilities as part of their policy refused to provide contraceptives due to their religious orientation. Moreover, provider imposed restrictions were found in India (Calhoun et al., 2013). Health providers used client's age, parity, partners' consent and marital status as requirements for providing long-acting and permanent FP methods. The judgmental attitude of health providers was also a significant barrier to access (Ackerson & Ziclinski, 2017).

Notable among them were negative attitude of FP providers, age restrictions, consent requirement and shortage of contraceptives. Other barriers found include inadequate provider knowledge of long-acting methods, high cost, inadequate FP professionals and poor service organization (Nalwadda, 2011). In Kenya, provider level barriers varied from facility to facility (Tumlinson et al., 2015). Tumlinson et al. (2015), found that private health facilities were more likely to impose age restrictions to FP than public health facilities. In addition, providers that lacked in-service training were more likely to impose restrictions across most methods. To help reduce provider level barriers like negative attitude in Kenya and Ethiopia, studies have recommended the need for in-service training for FP providers (Judge, Peterman & Keesbury, 2011).

Proximity to health facility and working hours

Inconvenient operating hours of health facilities has been found as a barrier for working women to access family planning (Tuoane, Madise and Diamond, 2004). Other significant barriers include; the lack of clearly defined family planning guidelines, poor provider attitude, transportation cost and recurrent shortages of preferred FP methods (Tuoane et al., 2004).

Proximity to a health facility (Ackerson & Ziclinski, 2017), availability of various FP methods and good provider reputation were significantly associated with FP uptake in Pakistan (Azmat et al, 2015). Similar findings have been reported in the Sub-Saharan region (Tumlinson, Okigbo & Speizer, 2015). For instance, in South Africa, van Zijl et al. (2010), found that limited factual knowledge of health providers about some family planning methods like intrauterine devices (IUDs) affected its accessibility. In Uganda, Nalwadda et al. (2011), found that young people faced many provider level barriers when accessing family planning.

Cost and quality of services

Evidence shows that unmet family planning need in Kenya is high among female sex workers (Corneli et al., 2016). This is due to lack of supportive clinic infrastructure, high cost of FP, inconvenient working hours, compulsory HIV testing, negative provider attitude and discouragement from sex partners (Corneli et al., 2016). In Ghana, Stanback and Twum-Baah (2001), did a survey and found that clients' safety, health and morality concerns were among the reasons why providers restricted access to some family planning methods. Other studies also suggest the need for subsidy for the cost of family planning as a measure to improve access to family planning in Uganda (Andi et al., 2014).

2.6.3. Need (Community level) factors influencing access to family planning

This section presents need (community level) factors that could influence access to FP as evidenced by existing literature. The influence of community level factors on access to family planning cannot be underestimated.

Support of husband/Partners

Even though there is paucity of research in this regard, the available literature shows that the support of a husband (Mugisha & Reynolds, 2008), and community members are significant determinants of access to family planning (Ackerson & Ziclinski, 2017). In India, partner consent was a perquisite requirement for family planning (Calhoun, 2013). In Ghana, opposition from husbands has been found as a significant barrier to family planning uptake (Apanga & Adam, 2015, Staveteig, 2016). Prata *et al*. (2017), also found that partner involvement and communication (Azmat *et al*., 2015), improved family planning uptake interestingly, the presence of a mother-in-law alone restricted the uptake of family planning in Pakistan. Husband's approval and the approval of other family members and religious acceptance were also significant factors determining the uptake of family planning (Azmat *et al.,* 2015).

Cultural beliefs and stigma

It is believed that community restrictions may even be higher in African regions due to the collective nature of their culture and the strong influence of extended family system (Aransiola & Akinyemi, 2014). For instance, in Nigeria, Aransiola and Akinyemi (2014), found that community misconceptions of family planning, low partner support and traditional pro-natalistic beliefs and tendencies were barriers to FP use among urban slum dwellers.

Shoveller *et al*. (2007), found that some conservative cultural beliefs and practices, and social norms discouraged women from going for contraceptives. Adiana *et al.* (2015), found that an exposure to an integrated primary healthcare services was significantly associated with family planning use in the Upper East Region of Ghana. Moreover, studies across the globe have found religious beliefs and practices as significant factors influencing access (Crissman *et al*., 2012; Hindin, McGough & Adanu, 2013; Staveteig, 2016). However, none of these studies compared family planning use in private and public health facilities.

Given the gaps identified in the literature about the seeming lack of in-depth analysis of predisposing (client level), enabling (health provider level) and need (community level) factors that influence access to FP services among women who attended the selected health care facilities, it was imperative that a study of this nature was conducted to bring out these hidden factors. It was anticipated that doing this would help contribute to knowledge on the topic and the discipline as a whole.

CHAPTER THREE

METHODS

3.1. Introduction

This chapter focuses on the way data were collected and analyzed for the study. The chapter discusses the profile of the study area and present the research approach, the study design as well as data collection tools and sampling method.

3.2. Study Design

Descriptive cross sectional design using quantitative methods was employed to collect data for the study. Descriptive cross sectional study is a type of observational study that analyses data collected from a population or sample population at a specific point in time (Creswell, 2009). The choice of the design for the study was based on the fact that it may prove and/or disapprove the assumption that predisposing (client), enabling (health provider), and need (community) factors influence access to family planning services. Moreover, findings and outcome can create new theories/studies and in-depth research. The use of quantitative approach for the study was allowed for generalization of the research findings (Creswell, 2009).

3.3. Study Area

The study was conducted at both public and private health facilities in the Ga South Metropolis in the Greater Accra Region of Ghana. The following facilities were considered: Ga South Municipal Hospital, Ngleshie Amanfrom Health Centre, Finney Hospital and Fertility Centre, and St, Banabas Hospital. The Ga South Municipality is located in the

Greater Accra, the capital city of Ghana. It forms part of the sixteen (16) Metropolis, municipalities and districts in the Greater Accra Region. The population of the Ga South Metropolis according to 2010 population and housing census stood at 411,377 with 201,222 males and 210,155 females (GSS, 2014). There are 35 recognized orthodox medical health facilities in the municipality; 8 are public health and 27 are private.

3.4. Variables

The study measured both dependent and independent variables as explained below.

Dependent variable

The dependent variable is access to family planning services.

Independent variables

The independent variables are:

1. Predisposing (Client) factors: socio-demographic characteristics
2. Enabling (Health provider) factors: competence, attitude, skilled staff.
3. Need (Community) factors: culture, beliefs, husband support.

3.5. Study Population

The study recruited women who attends the selected health facilities for maternal health and family planning services. These women are within the reproductive age (WIFA) of 15-49 years attending the various facilities at the time of the study. Information on potential factors influencing access to family planning services at the selected health facilities were obtained from the participants.

3.5.1. Inclusion Criteria

The study includes women who attends the selected health facilities, who consent to participate in the study and are within the reproductive age of 15-49 years.

3.5.2. Exclusion Criteria

The study excludes women who do not attend the selected health facilities, who do not consent to participate in the study, and are below 15 or above 60 years.

3.6. Sampling method

In selecting respondents to respond to the questionnaires, a systematic random sampling was used. A systematic random sampling is a method of selecting samples based on a system of intervals in a numbered population (Creswell, 2009). This method of sampling gave all respondents an equal chance of being selected for the study. It reduces human bias in the selection and thus provides a sample that represents the population (Creswell, 2009).

Half of the questionnaires were administered at the public health facilities and the other half at the private health facilities selected. The daily attendance book at the maternal health clinics of these facilities were examined to determine the average attendance level. The sampling interval was also determined by dividing the average attendance level by the expected daily questionnaires to be administered. Using the attendance book at the maternal health clinics, the first respondent was selected from the first sample interval randomly by balloting. The next respondent was therefore, a sample interval from the first respondent. If an attendant declines to participate, the next sample interval respondent from her will be selected.

3.6.1. Sample Size Determination

Sample size was determined by the formula:

$$n = \frac{Z^2 p(1-p)}{E^2}$$

Where,

n = the estimated sample size

E = the desired margin of error (0.05) Z is the statistic for level of confidence (95%) =1.96

P = the proportion of uptake of family planning service among women in fertility age (23.3%)

Using this formula, the sample size for the study was 270. Adding 10% to cater for non-response gives a total sample size of 301.

3.7. Data Collection

The data collection instrument for the study were structured questionnaires. The structured questionnaires with close ended questions were designed to cover the following sections. Section A covered the predisposing (client) factors: socio-demographic characteristics and others. Section B covered the enabling (health provider) factors: quality, attitude, availability etc. Section C covered the need (community) factors: culture, beliefs, and husband support and others. The questionnaires were administered to the respondents by the researcher and two research assistants through interviewer-administered strategy and in the participants' own dialect. The administration of the questionnaires was conducted at the respective selected health facilities and each took a maximum of 15 minutes to administer.

3.8. Data Analysis

All quantitative data (answered questionnaires) were collected, checked, entered and analysed with STATA version 15. Results are presented in frequencies and percentages. Bivariate analysis was used to determine the association between the independent and the dependent variables. Multivariable was used to determine factors influencing family planning and level of significance was set at $p<0.05$.

3.8.1. Quality Assurance

The questionnaire was structured and questions were simplified to enable respondents answer the questions without difficulty. Pretesting of the questionnaires was conducted at the Ga South Municipal Hospital using 10 respondents to test for the validity of the questionnaires. Validity refers to the extent to which a concept is accurately measured in a quantitative study (Creswell, 2009). The study looked at the extent to which the questionnaires can provide adequate information to evaluate access to family planning services based on the objectives of the study. The principal investigator reviewed data from the questionnaires for completeness. Two research assistants were employed to conduct the data entry. Efforts were made to explain to all eligible women the nature of the study.

3.9. Ethical Considerations

The study proposal was submitted to Ghana Health Service Ethics Review Committee for review and clearance before commencement of data collection. Permission was sought from the health facilities concerned before data collection. The following ethical issues were addressed in the study.

Consenting

The principal Investigator and the research assistance read and explained information on the consent form to the participants. This was done individually prior to data collection.

Potential risks/benefits

Participants were not judged by the answers provided by anyone related to the study. However, it is expected that the information provided will aid in formulating strategies to improve family planning services in the GSMA.

Privacy and confidentiality

Participants were assured of confidentiality and privacy of the information provided. Priority was given to protect all information given by the participant in this research. The response was not discussed outside the research team and study codes were used on all data forms (competed questionnaires). All responses were treated as confidential as no names were placed on the questionnaires. Similar codes were used for Hospitals in the district to avoid easy tracing of data source by a third party.

Data Storage and usage

All documents were kept in a locked cabinet accessible to only the principal investigator. All data files were stored on a personal computer and password protected.

Voluntary withdrawal

The research purpose was explained to respondents after which they were asked to participate in the study on their own volition. Participants were informed that they can withdraw from the study anytime during the study and that was not to affect their rights in anyway.

Reward / compensation

Participants were not required to pay any fees for taking part in the study. Neither did the researcher pay respondents any money for their participation.

Participant consent

Written informed consent were obtained from those who agree to participate in the study. For non-literate women, the consent information sheet was read in full in the participant's own dialect and they were made to place a thumb print on the consent form to signify their acceptance to participate in the study.

Conflict of interest

All the cost involved in the study was borne by the principal researcher. She thus had no conflict of interest to declare.

CHAPTER FOUR

ANALYSIS OF RESULT

4.1. Introduction

This chapter presents the results of the study. It is divided into seven sections. Which are Socio-Demographic Characteristics of Respondents (Client Factors), Family planning characteristics, Enabling (Health provider) factors, Perception of respondents of health provider factors, Need (Community) factors, Association between use of family planning method and socio-demographic characteristics of respondents, Factors influencing access to family planning methods.

4.2. Socio-Demographic Characteristics of Respondents (Client Factors)

A total of 300 participants were involved in the study. Table 4.1 gives a summary of the demographic characteristics of respondents. A quarter 75 (25%) of them were between the ages of 15 and 25 years inclusive, 180 (60%) were in the age range of 26-35 years inclusive and 45 (15%) were in the age range of 36 to 50 years inclusive. About 81 (27%) of the respondents were yet to give birth, 137 (45.7%) had given birth at least 2 times, 67 (22.3%) had given birth at 3 or 4 times and 15 (5%) of them had given birth at least 5 times. About 251 (83.67%) of the participants were Christians. In terms of the occupation of the respondents, it was seen that the number of respondents employed in any form of business or the other outweighed the number of respondents that were not employed. Those employed formed 264 (88%) of the total number of respondents, 20 (6.7%) of the respondents had no formal education and 106 (35.3%) of the respondents had JHS as their highest level of

education. Majority, 252 (84%) of the respondents were married. 84 (28%) of the respondents were staying in McCarthy Hill and about a quarter of the participants were staying in Barrier. Over half 167 (55.6%) of the respondents had stayed in the current area of residence for at least 5 years.

Table 4.1: Socio-Demographic Characteristics of Respondents (Client Factors)

Variables	Frequency (N=300)	Percentage
Age		
15-25 years	75	25
26-35 years	180	60
36-50 years	45	15
Number of birth		
None	81	27
1-2 births	137	45.67
3-4 births	67	22.33
> 4 births	15	5
Religion		
Christian	251	83.67
Muslim	49	16.33
Employment status		
Employed	264	88
Unemployed	36	12
Occupation		
None	36	12
Farmer	3	1
Seamstress	49	16.33
Public/Civil servant	52	17.33
Trader	156	52
Others	4	1.33
Period of occupation		
<5 years	154	58.33
6-10 years	76	28.79
11-15 years	20	7.58
>15 years	14	5.3
Highest level of education		
None	20	6.67
Primary	36	12
JHS	106	35.33
SHS	82	27.33
Tertiary	56	18.67
Marital status		
Single	43	14.33
Married	252	84
Divorced/separated	5	1.67

Area of residence		
McCarthy hill	84	28
Barrier	73	24.33
Bortianor	48	16
Mile 11	30	10
Others	65	21.67
Time of stay in current residence		
≤ 5 years	167	55.67
6-10 years	91	30.33
11-15 years	22	7.33
>15 years	20	6.67

4.3. Family planning characteristics

Of the 300 participants interviewed, 31.67% (n=95) of the participants had used a family planning method before. About 95 (31.6%) of the respondents who had access to family planning method in the facility were interviewed. About 70 (69.31%) of the respondents who had used family planning method were currently on a family planning method, 10 (30.3%) of them had used a family planning method in less than a year, and about 7 (21.21%) of them last used a family planning method in 5 to 10 years and more than 10 years each. The most used family planning method was condom 29 (30.53% of the respondents who had access to family planning method) while the least used family planning method among those who had had access to family planning method was morning pills. About 19 (20%), 15 (15.8%) and 12 (12.6%) of the respondents who had had access to family planning method had used or used diaphragm, oral contraceptives and Depo Provera respectively. About 11 (11.6%) of them had used or were currently using IUD while 7 (7.37%) of them had used or were currently using implants. The results are shown in table 4.2 below.

Table 4.2: Family planning characteristics

Variables	Frequency	Percentage
Use FP		
No	205	68.33
Yes	95	31.67
Access FPM from current facility		
Yes	70	69.31
No	31	30.69
Currently on family planning method		
Yes	62	65.26
No	33	34.74
Last time family planning method was used		
<1 year	10	30.3
1-5 years	9	27.27
5-10 years	7	21.21
>10 years	7	21.21
Type of family planning method		
Condom	29	30.53
Diaphragm	19	20
IUD	11	11.58
Oral contraceptives	15	15.79
Depo Provera	12	12.63
Morning pills	2	2.11
Implant	7	7.37

4.4. Enabling (Health provider) factors

Of the 95 participants who had access to family planning methods, 38 (40%) of them spend about 3 hours to get to the health facility from their respective homes while about half, 46 (48.4%) of them self-drive to the health facility. About 6 out of every 10 of the patients had access to family planning method visited the health facility by appointment. About 70 (73.7%) of them said they could make an appointment to the family planning unit on the first try. About 46 (48.4%) of the respondents who had access to family planning method said they called the health facility once to make an appointment. Most 36 (37.5%) of the participants who had access to family planning method said they could wait as long as 90 minutes in the health facility before they were called. The results are shown in table 4.3 below.

Table 4.3: Enabling (Health provider) factors

Variables	Frequency	Percentage
Time spent to get to HF		
30 minutes	21	22.11
60 minutes	26	27.37
120 minutes	10	10.53
180 minutes	38	40
Means of transport to HF		
Walked	21	22.11
Self-drive	46	48.42
Public transport (Troski)	28	29.47
Appointment to HF		
Makes an appointment	56	58.95
Just walk in	39	41.05
First try appointment		
Yes	70	73.68
No	25	26.32
Appointment time calls		
Once	46	48.42
Twice	30	31.58
Thrice	10	10.53
More than thrice	9	9.47
Waiting time		
30 minutes	22	23.16
60 minutes	32	33.68
90 minutes	36	37.89
120 minutes	5	5.26

4.4.1. Perception of respondents of health provider factors

About two-thirds of the respondents who had access to family planning methods agreed that there were comfortable waiting rooms in the health facility where they had access to their family planning services. About 70 (73.6%) of them agreed that, there were friendly staff in the health facility, 80 (84%) of the respondents agreed that the health practitioners told them what to expect before examinations, 75 (78.9%) of them agreed that the use of family planning method was clearly explained to them and 73 (76.8%) of them agreed that they were informed of the possible side effects of family planning methods. The results are shown in table 4.4 below.

Table 4.4: Perception of respondents on health provider factors

Variable	Disagree (%)	Somewhat disagree (%)	Agree (%)
Comfortable waiting room	4 (4.21)	28 (29.47)	63 (66.32)
Find staff Friendly	1 (1.05)	24 (25.26)	70 (73.68)
Finds staff are well trained	1 (1.05)	19 (20)	75 (78.95)
Had enough privacy	6 (6.32)	30 (31.58)	59 (62.11)
Practitioner spends time to know me	3 (3.16)	32 (33.68)	60 (63.16)
Can discuss my concerns with practitioner	2 (2.11)	18 (18.95)	75 (78.95)
I feel that I can trust health practitioner	0 (0)	31 (32.63)	64 (67.37)
Practitioner tells me what to expect before exams	0 (0)	15 (15.79)	80 (84.21)
Use of FPM was clearly explain	2 (2.11)	18 (18.95)	75 (78.95)
Informed of possible side effects	5 (5.26)	17 (17.89)	73 (76.84)

4.5. Need (Community) factors

Of the 95 participants who had access to family planning, 55 (57.9%) of them said they did not receive consent from their husband or partners, 66 (75%) of them said they were influenced by their partner to stop using family planning method and about 52 (55%) of them said their religious belief had an influence on their use of family planning method. About 11 (11.6%) of the participants with access to family planning method said that their community had an influence on them using family planning method while only 2 (2%) of them said that they had been stigmatized by their community or their religion for using family planning method. The results are shown in table 4.5 below.

Table 4.5: Need (community) factors

Variables	Frequency	Percentage
Received Husband/ partner consent		
Yes	40	42.11
No	55	57.89
Influence by partner to stop using family planning method		
Yes	66	74.74
No	24	25.26
Religious influence on FP		
Yes	52	54.74
No	43	45.26
Community influence on FP		
Encouraged use	11	11.58
Discourage use	7	7.37
No influence	77	81.05
Community / religiously stigmatized		
Yes	2	2.11
No	93	97.89

4.6. Association between use of family planning method and socio-demographic characteristics of respondents

Of the 300 participants interviewed, 59 (28.8%) of those who have not used any family planning method were between the ages 15 to 25 years inclusive, 119 (58.5%) of them were within the age range 26 to 35 years and 27 (13.2%) of them were between the ages 36 to 50 years. Of the 95 participants who had used family planning method before, 16 (16.8%) of them were within the age range 15 to 25 years inclusive, 61 (64.2%) of them were within the age range of 26 to 35 years and the remaining 18 (19%) of them were within the age range of 36 to 50 years.

Of the respondents who had used family planning method before, 9 (9.5%) of them had not given birth before, 50 (52.6%) of them had given birth at least 2 times, 29 (30.5%) of them had given birth three or four times while 7 (3.9%) of them had given birth for at least 5 times.

The number of times a participants had given birth showed a significant association with the use of family planning method (p<0.001).

Period of occupation, period of stay in current residential area, reason for facility visit, and the number of years a participant had been visiting the health facility all showed significant association with access to family planning method (p<0.05). Tables 4.6a and 4.6b report more on the association between use of family planning and participants' socio-demographic characteristics. Whiles religion, level of education, marital status, and first time facility visit showed no significant association between the use of family planning and participant socio-demographic characteristics.

Table 4.6a: Association between use of family planning method and Socio-demographic characteristics of respondents

		USE FPM			
Variables	**Total (%)**	**No (%)**	**Yes (%)**	**χ^2-value**	**P-value**
Age				5.5558	0.062
15-25 years	75 (25)	59 (28.78)	16 (16.84)		
26-35 years	180 (60)	119 (58.05)	61 (64.21)		
36-50 years	45 (15)	27 (13.17)	18 (18.95)		
Number of birth				23.0314	<0.001***
None	81 (27)	72 (35.12)	9 (9.47)		
1-2 births	137 (45.67)	87 (42.44)	50 (52.63)		
3-4 births	67 (22.33)	38 (18.54)	29 (30.53)		
More than 5 births	15 (5.00)	8 (4.80)	7 (3.90)		
Religion				0.0263	0.871
Christian	251 (83.67)	172 (83.9)	79 (83.16)		
Muslim	49 (16.33)	33 (16.1)	16 (16.84)		
Employment status				0.0233	0.879
Employed	264 (88)	180 (87.8)	84 (88.42)		
Unemployed	36 (12)	25 (12.2)	11 (11.58)		
Occupation				3.6638	0.453
Farmer	3 (1.14)	2 (1.11)	1 (1.19)		
Seamstress	49 (18.56)	37 (20.56)	12 (14.29)		
Public/Civil servant	52 (19.7)	35 (19.44)	17 (20.24)		
Trader	156 (59.09)	102 (56.67)	54 (64.29)		
Others	4 (1.52)	4 (2.22)	0 (0)		
Period of occupation				9.577	0.023*
1-5 years	154 (58.33)	112 (62.22)	42 (50)		
6-10 years	76 (28.79)	52 (28.89)	24 (28.57)		
10-15 years	20 (7.58)	8 (4.44)	12 (14.29)		
>15 years	14 (5.3)	8 (4.44)	6 (7.14)		
Highest educational level				2.8701	0.58
None	20 (6.67)	13 (6.34)	7 (7.37)		
Primary	36 (12)	29 (14.15)	7 (7.37)		
JHS	106 (35.33)	71 (34.63)	35 (36.84)		
SHS	82 (27.33)	55 (26.83)	27 (28.42)		
Tertiary	56 (18.67)	37 (18.05)	19 (20)		
Marital status				**Φ**	0.394
Single	43 (14.33)	29 (14.15)	14 (14.74)		
Married	252 (84)	174 (84.88)	78 (82.11)		
Divorced/separated	5 (1.67)	2 (0.98)	3 (3.16)		
Residential area				3.2887	0.511
McCarthy hill	84 (28)	60 (29.27)	24 (25.26)		
Barrier	73 (24.33)	54 (26.34)	19 (20)		
Bortianor	48 (16)	29 (14.15)	19 (20)		
Mile 11	30 (10)	20 (9.76)	10 (10.53)		
Others	65 (21.67)	42 (20.49)	23 (24.21)		

%: column percentages. χ: Pearson's chi square value. **φ**: Fisher exact test. *: p-value<0.05. **: p-value<0.01. ***: p-value<0.001.

Table 4.6b: Association between use of family planning method and Socio-demographic characteristics of respondents

		USE FPM			
Variables	**Total (%)**	**No (%)**	**Yes (%)**	**χ^2-value**	**P-value**
Period of stay in current area				12.9162	0.005**
≤ 5 years	167 (55.67)	126 (61.46)	41 (43.16)		
6-10 years	91 (30.33)	57 (27.8)	34 (35.79)		
10-15 years	22 (7.33)	14 (6.83)	8 (8.42)		
> 15 years	20 (6.67)	8 (3.9)	12 (12.63)		
1st visit at this facility				1.5664	0.211
Yes	97 (32.33)	71 (34.63)	26 (27.37)		
No	203 (67.67)	134 (65.37)	69 (72.63)		
Reason for visit				62.5356	<0.001***
ANC	232 (77.33)	179 (87.32)	53 (55.79)		
PNC	12 (4)	9 (4.39)	3 (3.16)		
FPC	23 (7.67)	0 (0)	23 (24.21)		
GYNC	33 (11)	17 (8.29)	16 (16.84)		
Period of visiting this facility					0.004**
First visit	97 (32.33)	71 (34.63)	26 (27.37)		
<5 years	179 (59.67)	124 (60.49)	55 (57.89)		
6-10 years	18 (6)	8 (3.9)	10 (10.53)		
10-15 years	4 (1.33)	0 (0)	4 (4.21)		
>15 years	2 (0.67)	2 (0.98)	0 (0)		
Long term relationship				0.7287	0.393
Yes	32 (66.67)	22 (70.97)	10 (58.82)		
No	16 (33.33)	9 (29.03)	7 (41.18)		

%: column percentages. χ: Pearson's chi square value. **φ**: Fisher exact test. *: p-value<0.05. **: p-value<0.01. ***: p-value<0.001

4.7. Factors influencing access to family planning methods

The logistics regression model was used to determine the level or magnitude of the association between the independent variables and the dependent variable (family planning). In crude odds ratio , the women in the age range 26 to 35 years having access to family planning methods was 1.89 higher compared to women in the age range 15 to 25 years (95% CI: 1.00-3.56). From the multiple logistic regression model, the odds of a woman in the age range 26 to 35 years using family planning method was 1.54 higher compare to women in the age range 15 to 25 years (95% CI: 0.75-3.15). In addition, the crude odds ratio of women

in the age range 36 to 50 years inclusive was 2.46 higher than that of women in the age range 15 to 25 years (95% CI: 1.09-5.54) while the adjusted odds ratio showed that the odds of women in the age range 36 to 50 years was 17% more than that of women in the age range 15 to 25 years (95% CI: 0.46-3.00), though it was not statistically significant. Age was a significant factor for women to have access to family planning method as reported in the simple logistic regression model ($p<0.05$), but was not a significant factor in predicting women's likelihood of accessing family planning method in the multiple logistic model ($p> 0.05$).

Women were more likely to use a family planning method as their number of births increases. Compared with women with no birth, the odds of women having access to family planning method was 4.60 times more for women with at least 2 births (95% CI: 2.12-9.98), 6.11 times for women with 3 to 4 births (95% CI: 2.62-14.21) and 7.00 times for women with at least 5 births (95% CI: 2.05-23.91) all in the crude odds ratio. In the unadjusted odds ratio, compared with women with no birth, the odds of women having access to family planning method was 5.73 times for women with at least 2 births (95% CI: 2.38-13.77), 8.53 times for women with at 3 to 4 births (95% CI: 3.13-23.21) and 7.92 times for women with at least 5 births (95% CI: 2.01-31.22), all of which were statistically significant.

Additionally, the crude odds ratio of a woman who had stayed in her current residential area for 6 to 10 years having access to family planning method was 1.83 times more than that of women who had stayed in their residential area for at most 5 years (95% CI: 1.06-3.18) and that of the adjusted odds ratio was 1.49 times more likely for women who had stayed in their residential area for 6 to 10 years compared with those who had stayed in their residential area for at most 5 years (95% CI: 0.82-2.71). Similarly, the crude odds ratio of women who had

stayed in their residential area for 11 to 15 years having access to family planning method was 1.76 times the odds of women with at most 5 years of stay in their current residential area (95% CI: 1.76-12.06) while the adjusted odds ratio was 1.58 (95% CI: 0.56-4.5).

The crude or unadjusted odds ratio of women with more than 15 years of stay in their current residential area compared with women with at most 5 years of stay in their current residential area having access to family planning method was 4.61 (95% CI: 1.76-12.06). The adjusted showed an odds ratio of 5.02 of having access to family planning method for women with more than 15 years of stay in their current residential area compared with women with at most 5 years of stay in their current residential area (95% CI: 1.7-14.82). Overall, the period of stay in current residential area had an effect on a woman having access to family planning method both in the simple logistics and the multiple logistic regression ($p<0.05$). The results are shown in table 4.6 below.

Table 4.7: Factors influencing access to family planning methods

	Simple logistic model			Multiple logistic model		
Variables	**UOR**	**95% CI**	**P-value**	**AOR**	**95% CI**	**P-value**
Age						
15-25 years	ref		0.049*	Ref		0.461
26-35 years	1.89	(1, 3.56)		1.54	(0.75, 3.15)	
36-50 years	2.46	(1.09, 5.54)		1.17	(0.46, 3)	
Number of births			<0.001***			<0.001***
None	ref			Ref		
1-2 births	4.60	(2.12, 9.98)		5.73	(2.38, 13.77)	
3-4 births	6.11	(2.62, 14.21)		8.53	(3.13, 23.21)	
> 4 births	7.00	(2.05, 23.91)		7.92	(2.01, 31.22)	
Religion			0.871			0.664
Christian	ref			Ref		
Muslim	1.06	(0.55, 2.03)		0.85	(0.4, 1.81)	
Employment status			0.879			0.677
Employed	ref			Ref		
Unemployed	0.94	(0.44, 2.01)		1.20	(0.51, 2.85)	
Highest level of education			0.596			0.409
None	ref			Ref		
Primary	0.45	(0.13, 1.54)		0.59	(0.16, 2.26)	
JHS	0.92	(0.34, 2.5)		1.33	(0.44, 4.04)	
SHS	0.91	(0.33, 2.55)		1.18	(0.38, 3.69)	
Tertiary	0.95	(0.33, 2.79)		1.79	(0.54, 5.98)	
Marital status			0.421			0.210
Single	ref			Ref		
Married	0.93	(0.47, 1.85)		0.55	(0.25, 1.23)	
Divorced/separated	3.11	(0.46, 20.76)		1.65	(0.21, 12.77)	
Area of resident			0.515			0.561
McCarthy hills	ref			Ref		
Barrier	0.88	(0.43, 1.78)		0.92	(0.42, 2)	
Bortianor	1.64	(0.78, 3.46)		1.61	(0.71, 3.69)	
Mile 11	1.25	(0.51, 3.06)		1.02	(0.37, 2.77)	
Others	1.37	(0.68, 2.74)		1.52	(0.7, 3.32)	
Period of residential stay			0.007**			0.029
≤ 5 years	ref			Ref		
6-10 years	1.83	(1.06, 3.18)		1.49	(0.82, 2.71)	
11-15 years	1.76	(0.69, 4.48)		1.58	(0.56, 4.5)	
>15 years	4.61	(1.76, 12.06)		5.02	(1.7, 14.82)	
First time facility visit			0.212			0.497
Yes	Ref			Ref		
No	1.41	(0.82, 2.4)		1.24	(0.67, 2.28)	

UOR: unadjusted odds ratio. AOR: adjusted odds ratio. CI: confidence interval. Ref: reference category. *:p-value<0.05. **:p-value<0.01. ***: p-value<0.001.

CHAPTER FIVE

DISCUSSION OF RESULTS

5.1. Introduction

This chapter presents the findings of the study in the context of the research objectives, the conceptual framework and the literature review. There are 3 sections in this chapter.

The benefits of family planning have become increasingly recognised worldwide and include improved health, economic and social outcomes for women and families, as well as public health, economic, and environmental benefits at the population-level (Singh, Darroch, Ashford, & Vlassoff, 2009). Despite, the benefits associated with family planning, access to family planning services in Ghana remains low. Therefore, resulting in a high unmet need for family planning services. (Singh, Darroch, Ashford, & Vlassoff, 2009)

For instance, over 30% of currently married women and 42% of unmarried sexually active women have an unmet need for family planning in Ghana (GSS, 2014). To improve access to FP services in Ghana, it is a matter of necessity that stakeholders are furnished with evidence-based information on determinants of accessibility in Ghana. Therefore, the aim of this study was to explore the range of FP services accessed by women and identify the determinants of access to such services in Ghana.

5.2. Range of services

The first objective of this study was to assess the range of family planning methods accessed by women in the GSMA. It was found that many of the respondents had never used any family planning method before (68.3%). This suggests that women in the GSMA do not have adequate access to family planning. This finding corroborates earlier studies (GSS, 2014, Apanga & Adams, 2015). This possesses a threat to Ghana's socio-economic development and has public health implications as well. For example, if women in their reproductive age are not practicing family planning, the possibility that they cannot space their children is high. Giving birth to many children can lead to overcrowding, poor nutrition, poverty and over population growth. It is therefore suggested that stakeholders should implement health interventions such as health education, to promote access to family planning services. However, the interventions may be less effective if other barriers to accessing family planning like misconceptions, fear, and the influence of partners and judgmental attitudes of providers are not also addressed. (Apanga & Adams, 2015, Staveteig, 2016, Ziclinski, 2017)

This study's findings also revealed that among the respondents who have used family planning before, many of them were currently on FP (65.2%). This means that unavailability of family planning services may not be barriers to access in the GSMA. This suggests that factors contributing to the low access to family planning services in Ghana can also be attributed to attitudinal and community-related barriers like husband's disapproval. Going forward, community sensitization and educating husbands or men on the essence of family planning are necessary to promote access to family planning services in Ghana. (Apanga & Adams, 2015)

In addition, the findings also revealed that the following family planning methods were accessed by women in the GSMA. These include condoms, diaphragm, oral contraceptives, Depo Provera, IUD, implant and morning pills in order of magnitude. This implies that condoms are the frequently used family planning methods. This is consistent with findings of earlier studies. For instance, a nationwide survey by the Ghana Statistical Service revealed that the common modern methods of FP used in Ghana include condoms, injectable, pills and implants (GSS, 2014). In Congo, Kayembe et al., (2006) also found condoms were the most common modern FP method accessed in healthcare facilities, followed by pills and injectable. Other FP methods were IUD, implants, spermicides and diaphragm.

Moreover, it was interesting to find that none of the respondents in this study did use the traditional methods of family planning. This implies that Ghanaians have high preference for the modern methods of FP than traditional methods like rhythm and withdrawal. The reasons may be that the respondents perceive modern methods to be more effective and easy to use.

5.3. Factors associated with access to family planning

5.3.1. Predisposing/ client level factors

The second objective of this study was to evaluate how predisposing factors influence access to family planning. Earlier studies have shown that predisposing or client-level factors like age, education, marital status, parity, income among others influence access to family planning (Crissman, Adanu and Harlow, 2012, Azmat et al. 2015). Similarly, in this study, parity emerged as a significant predictor measure of access to family planning services. For example, a study found that women with three or more children were more likely to enroll in family planning than women with no children. This implies that the women in this study used

family planning as a means to space their children by preventing pregnancies (Apanga &Admas, 2015). Women who space their children stand a greater chance of giving them better care and education coupled emancipation from economic hardships.

However, access to family planning was not significantly associated with respondents' age, education, religion, marital status and occupation. These findings contradict earlier findings (Stephenson and Hennink 2007). It also contradicts with the assumptions of the underpinning model, the Healthcare Utilization Model by Andersen and Newman (1973) and the conceptual framework. What might have accounted for the contradiction in findings may be due to the differences in the socio-cultural orientation of respondents.

The influence of culture and religion on health care utilization among Ghanaian remains high (Andi et al. 2014). For instance, a typical Ghanaian married woman might have the purchasing power and knowledge about FP, but without the approval or support of her husband, she will not enroll in family planning. Also, in Africa, especially Ghana, women who give birth to many children are celebrated. For instance, among the Asantes, a woman who gives birth to ten children is rewarded with a sheep, locally known as "*badu adwan*" which literally means (tenth child's sheep). These among other conservative cultural beliefs and practices can discourage women from accessing family planning services (Andi et al. 2014, Ackerson & Ziclinski 2017, Mugisha & Reynolds, 2008, van Zijl, Morrini & van der Spuy, 2010). Therefore, it is recommended that to improve access to family planning in Ghana, health education should focus on attitudinal and behavior change.

5.3.2. Enabling/ provider level factors

Apart from client-level factors, provider level or enabling factors can also influence access to family planning services. It was found in this study that women who were on family planning perceived provider-level factors to be appropriate or conducive for family planning. For instance, the majority of the women perceived that the health facilities had comfortable waiting areas and maintained privacy. Health providers were perceived to be friendly, competent and trustworthy. Moreover, providers engaged women in FP decisions, explained side effects and had ample time with clients. This implies that improving provider-level factors can result in improvement in access to family planning services (Ackerson & Ziclinski, 2017).

However, earlier studies have found that negative provider attitudes and some unfriendly institutional policies restricted access to family planning. For instance, judgmental attitude of health providers has been found to be a significant barrier to access (Ackerson & Ziclinski, 2017). Other barriers include inadequate provider knowledge of long-acting methods, inadequate FP professionals and poor service organization (Nalwadda, 2011). In this regard, the researcher recommends that to improve access to family planning, in-service training for providers should emphasize on attitudinal change.

In addition, proximity to a family planning facility and other facility-related factors like waiting time can influence access to family planning. In this study, the majority of the respondents spent a maximum of sixty minutes to reach the health facility. Also, waiting time in this study was perceived by the women to be acceptable. This is because many of the respondents accessed by appointment. This means that facility-level factors were perceived to be conducive for family planning. Hence, respondents were more likely to have access to family planning services.

This is consistent with findings of previous studies. Ackerson & Ziclinski, (2017) found proximity to a health facility, availability of various FP methods as factors significantly associated with FP uptake in Pakistan (Azmat et al, 2015. In effect, improving the structures of health facilities has implications for improving access to family planning. These findings are supported by the assumptions of Andersen Healthcare Utilization Model, which states that provider-level factors can influence access to health care services like family planning. (Andersen & Newman, 1973; Aday & Andersen, 1981)

5.3.3. Need/ community level factors

The fourth and last objective underpinning this study was to evaluate how need/community-level factors influence access to family planning. Andersen and Newman (1973) argued that access or use of health services like FP could also be determined by community-level factors such as religion and cultural beliefs. In this study, the findings revealed that among the women who were using family planning services, many did not require the consent of their partners before accessing family planning services. This confirms that women empowerment can influence access to family planning (Crissman, Adanu & Harlow, 2012). It was also established that the majority of the women experienced fewer restrictions from husbands regarding family planning use.There is evidence to show that spousal support promotes access to family planning services (Mugisha & Reynolds, 2008). For example, studies found that opposition from husbands as a significant barrier to family planning uptake (Staveteig, 2016, Prata et al. 2017).

In addition, the findings of this study revealed that among the women who use family planning, their religious beliefs were not against it. Thus, religion was not a barrier to

accessing family planning. Consistently, prior studies found that religious acceptance was a significant determinant of access to family planning (Azmat et al., 2015). Shoveller et al. (2007) found that some conservative cultural beliefs and practices and social norms discouraged women from going for contraceptives. Moreover, studies across the globe have found religious beliefs and practices as significant factors influencing access (Crissman et al., 2012; Hindin, McGough & Adanu, 2013; Staveteig, 2016). This finding is educative. Stakeholders in their quest to improve access to family planning should consider promoting women sexual and reproductive health right, educating men, and soliciting for the support of faith-based institutions. (Shoveller et al. 2007)

In addition, it was informative to know that among the respondents currently on family planning, the majority perceived that community members had no influence on their decision to access FP coupled with little or no stigmatization. This implies that the respondents were able to access family planning services because community-level barriers were minimal. However, prior studies found community misconceptions about family planning methods and traditional pro-naturalistic beliefs and tendencies as barriers to FP use (Aransiola & Akinyemi, 2014). Moving forward, strategies should be implemented to reduce stigmatization at the community level. This would motivate non-user to also enroll in family planning programme.

5.4. Chapter summary

Access to family planning services can be influenced by client, provider and community level factors. The findings of this study revealed that women in Ghana access various types of family planning methods included injectable, condoms, pills among other. In addition, women who were on family planning had children; perceived provider-level factors as

acceptable and encountered little or no restrictions from their partners, culture, religion and community. These findings to some extent are consistent with existing literature and the assumptions of the Andersen and Newman's Healthcare Utilization Model. (Andersen & Newman, 1973; Aday & Andersen, 1981)

CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1. Chapter introduction

This chapter of the dissertation presents a summary of the study, conclusions, contribution to knowledge (where implications for policy and practice and methodology are presented), recommendations, limitations to the study and finally the direction for future research.

6.2. Summary of the study

This section presents the summary of the study based on the general objective of the study. Rapid population growth has both health and socio-economic implications. The benefits of family planning to population control have been documented. It has been found to be a more cost-effective intervention for controlling population growth (Seigh, Ashford & Hussain, 2016). Despite the benefits associated with family planning, many developing countries like Ghana are yet to embrace this timely public health intervention (Seigh, Ashford & Hussain, 2016). One key contributing factor to the unmet need for FP, especially in Sub-Saharan Africa is access to family planning services (Seigh, Ashford & Hussain, 2016). Identifying context-specific determinants of access to family planning is necessary for public health interventions. Access to family planning services in Ghana remains problematic and has received little attention from researchers. In this regard, the aim of this study was to evaluate access to family planning in the GSMA in the Greater Accra Region of Ghana. A cross sectional study using quantitative methods was applied to collect data for analysis. Generally, the findings suggest that access to family planning services in the study area was low or poor.

Thus, many of the women had never used any family planning method before. It could therefore, be concluded that there was high unmet need for family planning in Ghana.

The conclusions of the study related to the specific objectives have been presented below.

6.3. Conclusions of the study

This section presents the conclusions of the study as they relate to the specific objectives.

6.3.1. Predisposing/ client level factors

The study concludes on the basis of the predisposing/client factors as follows.

Out of the 300 women respondents, it was found that the majority of them were between 26-35 years, had given birth twice, were Christians and employed. In addition, the majority of the respondents were traders, had attained junior high education, married (84%) and lived in an urban area. It was also revealed that the majority of the respondents had never used any family planning method before (68.3%). Among the respondent who had used family planning before, the majority were currently on at least one family planning method (65.2%), with the facilities understudied as their service providers. Also, the majority of the respondents had used family planning in less than a year (30.3%), with condom (30.5%) as the common family planning method.

6.3.2. Enabling/ provider level factors

The study concludes on the basis of the enabling/provider level factors as follows.

Regarding facility-related factors, it was found that the majority of the respondents spent not more than sixty minutes to reach the health facility (27.3%). Self-drive was the common

means of transportation for the majority of the respondents. Moreover, the majority of the respondents visited by appointment (58.9%), called once to make an appointment and waited not more than sixty minutes to see the health provider.

Provider-level factors were perceived to be acceptable or conducive for accessing family planning services. The majority of the respondents perceived that the providers were friendly, competent, spent enough time with them during consultation, involved them in care decisions by discussing issues, and explained possible side effects of FP methods. In addition, the providers were perceived to be trustworthy coupled with a comfortable waiting area and maintained enough privacy.

6.3.3. Need / community level factors

The study concludes on the basis of the enabling/provider level factors as follows.

Furthermore, community-level factors were perceived to be conducive to accessing family planning. In other words, many of the users of family planning services perceived no community- level barriers to access. For instance, they did not require their partners' consent or approval before accessing family planning and experienced no restriction from partners. Stigma associated with FP use was perceived to be minimal among users coupled with little religious resistance. It was found that among the factors associated with access to family planning, age, parity, period of visit to health facility, reason for visit and period of stay in current location emerged statically significant.

6.4. Contribution to knowledge

The contribution of this study to knowledge in the areas of policy and practice/management, methodology cannot be underestimated. These have been presented below.

6.4.1. Contribution to policy and practice / management

Improving access to family planning services in developing countries like Ghana has public health implications, such as population control resulting in less overcrowding, reducing poverty among others (GSS, 2014). The findings of this study provide valuable information for health policy and practice. It has been established in this study that the use of family planning services in Ghana remains low. However, the findings also revealed that among users of family planning services, provider and community level barriers were perceived to be minimal. This suggests that the low utilization of family planning services may not be associated with provider and community-related factors, but personal level factors like misconceptions, desire for many children, perceived risk of side effects among others. This provides the basis for policy makers in Ghana and other countries to develop or reformulate appropriate policies in the relevant areas so as to increase uptake of family planning.

Management of health care institutions with family planning or maternal and child health units may be able to deduce appropriate strategies towards enhancing coverage of FP access based on the findings of this study accordingly. This is due to the finding that among women who had used family planning before, many of them were currently using it. In this regard, it could be concluded that these women had positive experiences. Therefore, they were motivated to continue using it. Condom was found to be the most common family planning method used by the respondents. This implies that condoms are more accessible than the other methods of family planning.

In addition, since the study concluded that continuity of use was high because facility-level factors like provider attitudes and distance from the health facility were favorable or conducive to respondents, it is necessary that health care managers consider these factors when they drawing up their family planning programmes. Another area suggested for consideration by management of health care institutions relate to the community-level factors such as stigma and partner's disapproval were minimal. Therefore, reducing provider and community level barriers could promote access to family planning in Ghana and other countries with similar programmes. In view of the fact that another conclusion was that women in Ghana do use family planning services to delay childbirth and those women with at least one child were more likely to access family planning than women with no child, management of healthcare institutions could consider this issue as important in developing health educational programmes. Hence, parity was a significant determinant of access to family planning in Ghana. In addition, it could be concluded that women in their reproductive age are more likely to access family planning than other age groups.

6.5. Recommendations

Based on the findings of the study, the following recommendations were made.

To improve access to family planning, the researcher recommended that the Ministry of Health in collaboration with other stakeholders should intensify health education on family planning. Educating both women and men on the benefits of family planning can go a long way to promote access to family planning services.

The low utilization of family planning services among respondents could be attributed to negative perceptions and misconceptions and cultural beliefs. In this regard, health education should focus on changing negative perceptions, especially misconceptions about side effects.

In addition, users of family planning services should be identified and trained as 'ambassadors or disciples' to propagate the 'gospel' of family planning. This would help in changing negative perceptions and misconceptions of family planning.

It was surprising to find that women with more than five births were less likely to access family planning compared with women with more than one birth. In the quest to control rapid population growth, health educators should focus much attention on women with many births.

Even though both facility and community level factors were perceived to be favorable among users of family planning, same cannot be said of non-users. To make family planning accessible to all, barriers at all levels should be reduced or if possible be eliminated completely.

6.6. Limitations to the study

The conduct of a study of this nature was bound to face some challenges. Notably, it was found that personal level factors like misconceptions, desire for many children, perceived risk of side effects were contributing to the low utilization of family planning services, however, these assertions were not substantiated due to resource constraints, and partly due the quantitative nature of the study. Other constraints to the study included the small sample size and the fact that one health facility and municipality out of the total number of health

facilities and metropolitan, municipal and district Assemblies in Ghana were used for the study. These may somehow limit the generalisation of the findings to populations outside the study area. This notwithstanding, the findings could be generalised to the defined population accordingly.

6.7. Future Research

In view of the above limitations to the study, it is therefore, suggested that future studies may consider adopting qualitative approaches like interviews to explore in depth the reasons behind the low utilization of family planning services among women in the GSMA. That notwithstanding, the findings of this study provides evidence-based information for public health policies and practice.

REFERENCES

Ackerson, K., & Zielinski, R. (2017). Factors influencing use of family planning in women living in crisis affected areas of Sub-Saharan Africa: A review of the literature. *Midwifery, 54*, 35-60.

Aday, L. A., & Andersen, R. M. (1981). Equity of access to medical care: a conceptual and empirical overview. *Medical care*, 4-27.

Aday, L. A., & Andersen, R. (1974). A framework for the study of access to medical care. *Health services research*, 9 (3), 208 – 210.

Adebowale, S. A., & Palamuleni, M. E. (2014). Determinants of unmet need for modern contraception and reasons for non-use among married women in rural area Burkina Faso. *Etude de la Population Africaine*, 28 (1), 499 – 502.

Agha, S., & Do, M. (2009). The quality of family planning services and client satisfaction in the public and private sectors in Kenya. *International Journal for Quality in Health Care*, 21 (2), 87-96.

Amo-Adjei, J., & Darteh, E. K. (2017). Unmet/met need for contraception and self-reported abortion in Ghana. *Sexual & Reproductive Healthcare.*

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: does it matter? *Journal of health and social behavior*, 8 (2), 1-10.

Andersen, R., & Newman, J. F. (1973). Societal and individual determinants of medical care utilization in the United States. *The Milbank Memorial Fund Quarterly. Health and Society*, 10 (2), 95-124.

Andi, J. R., Wamala, R., Ocaya, B., & Kabagenyi, A. (2014). Modern contraceptive use among women in Uganda: An analysis of trend and patterns (1995-2011). *Etude de la population africaine= African population studies*, 28 (2), 1009 – 1013

Apanga, P. A., & Adam, M. A. (2015). Factors influencing the uptake of family planning services in the Talensi District, Ghana. *Pan African Medical Journal*, 20 (1),23-30

Aransiola, J. O., Akinyemi, A. I., & Fatusi, A. O. (2014). Women's perceptions and reflections of male partners and couple dynamics in family planning adoption in selected urban slums in Nigeria: a qualitative exploration. *BMC Public Health*, 14 (1), 869.

Azmat, S. K., Ali, M., Ishaque, M., Mustafa, G., Hameed, W., Khan, O. F., & Munroe, E. (2015). Assessing predictors of contraceptive use and demand for family planning services in underserved areas of Punjab province in Pakistan: results of a cross-sectional baseline survey. *Reproductive health*, 12 (1), 25 – 36

Babalola, S., & Fatusi, A. (2009). Determinants of use of maternal health services in Nigeria-looking beyond individual and household factors. *BMC Pregnancy and Childbirth*, 9 (1), 43-51.

Benagiano, G. (1996). Benefits from family planning services. *The European journal of contraception & reproductive health care: the official journal of the European Society of Contraception*, 1 (3), 225-230.

Calhoun, L. M., Speizer, I. S., Rimal, R., Sripad, P., Chatterjee, N., Achyut, P., & Nanda, P. (2013). Provider imposed restrictions to clients' access to family planning in urban Uttar Pradesh, India: a mixed methods study. *BMC health services research*, 13 (1), 532-541.

Cleland, J., Bernstein, S., Ezeh, A., Faundes, A., Glasier, A., & Innis, J. (2006). Family planning: the unfinished agenda. *The Lancet*, 368 (9549), 1810-1827.

Corneli, A., Lemons, A., Otieno-Masaba, R., Ndiritu, J., Packer, C., Lamarre-Vincent, J., & Dulli, L. (2016). Contraceptive service delivery in Kenya: A qualitative study to identify barriers and preferences among female sex workers and health care providers. *Contraception*, 94 (1), 34-39.

Creswell, J.W. (2009). *Research Design: Qualitative, Quantitative and mixed method approaches.* Third edition.

Crissman, H. P., Adanu, R. M., & Harlow, S. D. (2012). Women's sexual empowerment and contraceptive use in Ghana. *Studies in family planning*, 43 (3), 201-212.

d'Ambruoso, L., Abbey, M., & Hussein, J. (2005).Please understand when I cry out in pain: women's accounts of maternity services during labour and delivery in Ghana. *BMC public health*, 5 (1), 140 – 160

Frost, J. J. (2001). Public or private providers? US women's use of reproductive health services. *Family Planning Perspectives*, 4-12.

Gelberg, L., Andersen, R. M., & Leake, B. D. (2000). The Behavioral Model for Vulnerable Populations: application to medical care use and outcomes for homeless people. *Health services research*, 34 (6), 1273 –1298

Gizaw, A., & Regassa, N. (2011). Family planning service utilization in Mojo town, Ethiopia: A population based study. *Journal of Geography and Regional Planning*, 4 (6), 355 – 357

Hindin, M. J., McGough, L. J., & Adanu, R. M. (2013). Misperceptions, misinformation and myths about modern contraceptive use in Ghana. *Journal of Family Planning and Reproductive Health Care*,

Hutchinson, P. L., Do, M., & Agha, S. (2011). Measuring client satisfaction and the quality of family planning services: a comparative analysis of public and private health facilities in Tanzania, Kenya and Ghana. *BMC health services research*, 11(1), 203-205

Judge, S., Peterman, A., & Keesbury, J. (2011). Provider determinants of emergency contraceptive counseling and provision in Kenya and Ethiopia. *Contraception*, 83 (5), 486-490.

Kayembe, P. K., Fatuma, A. B., Mapatano, M. A., & Mambu, T. (2006). Prevalence and determinants of the use of modern contraceptive methods in Kinshasa, Democratic Republic of Congo. *Contraception*, 74 (5), 400-406.

Leyser-Whalen, O., Rahman, M., & Berenson, A. B. (2011). Natural and social disasters: racial inequality in access to contraceptives after Hurricane Ike. *Journal of Women's Health*, 20 (12), 1861-1866.

Maurer, F. A., & Smith, C. M. (2013). *Community/public health nursing practice: Health for families and populations*. Elsevier Health Sciences.

Mugisha, J. F., & Reynolds, H. (2008). Provider perspectives on barriers to family planning quality in Uganda: a qualitative study. *Journal of Family Planning and Reproductive Health Care*, 34 (1), 37-41.

Nalwadda, G., Mirembe, F., Tumwesigye, N. M., Byamugisha, J., & Faxelid, E. (2011). Constraints and prospects for contraceptive service provision to young people in Uganda: providers' perspectives. *BMC health services research*, 11 (1), 220-221

Ochako, R., Mbondo, M., Aloo, S., Kaimenyi, S., Thompson, R., Temmerman, M., & Kays, M. (2015). Barriers to modern contraceptive methods uptake among young women in Kenya: a qualitative study. *BMC public health*, 15 (1), 118-110

Phillips, K. A., Morrison, K. R., Andersen, R., & Aday, L. A. (1998). Understanding the context of healthcare utilization: assessing environmental and provider-related variables in the behavioral model of utilization. *Health services research*, 33(3 Pt 1), 571-599

Peters, D. H., Mirchandani, G. G., & Hansen, P. M. (2004). Strategies for engaging the private sector in sexual and reproductive health: how effective are they? *Health policy and planning*, 19 (suppl_1), i5-i21.

Prata, N., Bell, S., Fraser, A., Carvalho, A., Neves, I., & Nieto-Andrade, B. (2017). Partner support for family planning and modern contraceptive use in Luanda, Angola. *African Journal of Reproductive Health*, 21 (2), 35-48.

Reis, D. C. D., Kloos, H., King, C., Quites, H. F. O., Matoso, L. F., Coelho, K. R., & Gazzinelli, A. (2010). Accessibility to and utilisation of schistosomiasis-related health services in a rural area of state of Minas Gerais, Brazil. *Memórias do Instituto Oswaldo Cruz*, 105 (4), 587-597.

Singh, S., Sedgh, G., & Hussain, R. (2010). Unintended pregnancy: worldwide levels, trends, and outcomes. *Studies in family planning*, 41 (4), 241-250.

Smith, D. J. (2003). Patronage, per diems and the "workshop mentality": the practice of family planning programs in southeastern Nigeria. *World Development* 31(4), 703-715.

Sohail, M. (2005). Accessibility and quality of government primary health care: achievement and constraints. *The Bangladesh Development Studies*,63-98.

Staveteig, S. (2016). Understanding unmet need in Ghana: Results from a follow-up study to the 2014 Ghana Demographic and Health Survey.

Stanback, J., & Twum-Baah, K. A. (2001). Why do family planning providers restrict access to services? An examination in Ghana. *International Family Planning Perspectives*, 37-41.

Stephenson, R., Baschieri, A., Clements, S., Hennink, M., & Madise, N. (2007). Contextual influences on modern contraceptive use in sub-Saharan Africa. *American journal of public health*, 97 (7), 1233-1240.

Stephenson, R., & Hennink, M. (2004). Barriers to family planning service use among the urban poor in Pakistan: Opportunities and choices. *International Family Planning Perspectives*, 111-109

Tumlinson, K., Okigbo, C. C., & Speizer, I. S. (2015). Provider barriers to family planning access in urban Kenya. *Contraception*, 92 (2), 143-151.

Tuoane, M., Madise, N. J., & Diamond, I. (2004). Provision of family planning services in Lesotho. *International family planning perspectives*, 77-86.

Ugaz, J., Banke, K., Rahaim, S., Chowdhury, W., & Williams, J. (2016). Private providers' knowledge, attitudes and misconceptions related to long-acting a permanent contraceptive methods: a case study in Bangladesh. *Contraception*, 94 (5), 505-511.

Van Zijl, S., van der Spuy, Z. M., & Morroni, C. (2010). A survey to assess knowledge and acceptability of the intrauterine device in the Family Planning Services in Cape Town, South Africa. *Journal of Family Planning and Reproductive Health Care*, 36 (2), 73-78.

Wolff, B., Blanc, A. K., & Ssekamatte-Ssebuliba, J. (2000). The role of couple negotiation in unmet need for contraception and the decision to stop childbearing in Uganda. *Studies in family planning*, 31 (2), 124-137.

Yakob, B., & Ncama, B. P. (2016). A socio-ecological perspective of access to and acceptability of HIV/AIDS treatment and care services: a qualitative case study research. *BMC public health*, 16 (1), 155-170

APPENDICES

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Appendix A: Participant's information sheet

Title of the Study: **Access to Family Planning Services among Women Attending Health Facilities in the Ga South Municipality, Greater Accra Region.**

Background of the study

My name is Gloria Korkor Amedalor. I am an MPH student of University of Ghana School of public health. I am undertaking a research study on the topic ***"Access to Family Planning Services among Women Attending Health Facilities in the Ga South Municipality, Greater Accra Region".*** The purpose of this study is to access family planning services among women in the Ga South Municipality. This inform consent is to ensure that you understand the purpose and your responsibilities in the research before you decide whether to participate or not. This study is part of the requirements for the award of master of public health degree. I would like to seek your approval and permission to ask you some few questions on access to family planning.

Procedures/nature

You will be require to answer some few question that will take you a maximum of 20 minute to enable us analyse the work

Risks and benefits of the study

This work will help the hospital know how access to family planning services is helping you. It will also show the problems facing you and your other colleagues though they will not be

able to tell who provide which information. The information will also arouse the interest of policy makers to pay more attention to how family planning services are rendered and put in some intervention where necessary. The study will not be of any risk or cost to you. Because I have taken care of the cost and protecting your identity as well.

Voluntary participation/withdrawal

You can at any point during the study discontinue participation. I will not force you to partake in the study. Your decision to leave will not affect you when you come back to this hospital or any other hospital for service. But will be happy if you can help us to end.

Confidentiality

All information provided during this research will be protected as much as possible. No discussion will be held regarding the research outside the team. All information will be treated as confidential as no names will placed on the questionnaires.

Gloria Korkor Amedalor
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College of Health Sciences
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In case of further information or clarification, contact the Ghana Health Service Ethical Review Committee Administrator, Ms. Hannah Frimpong, on Tel Number: +233-0302681109/ 233-0302679323/ Fax + 233-0302685424, Mobile 0507041223.

Email: Hannah.frimpong@ghsmail.com

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Appendix B: Participants Certificate of Consent

Access to Family Planning Services among Women Attending Health Facilities in the Ga South Municipality, Greater Accra Region.

I have read through the foregoing information/the foregoing information has been read and interpreted to me and I fully understand all that has been explained to me about the objectives, benefits, risks and my right to withdraw from the study at any time without any consequences to me. I have been given opportunity to ask questions and have been answered satisfactory. I therefore agree to participate in the study.

Please confirm your participation by signing below.

Signature……

Date……

P.I/Research Assistant's name…….

Signature …….. Date ……

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Appendix C: Questionnaire

Title of the Study: Access to Family Planning Services among Women Attending Health Facilities in the Ga South Municipality, Greater Accra Region.

Name(s) and affiliation of researcher(s)

Principal Investigator: Miss Gloria Korkor Amedalor

Email: iamglorylyn@mail.com

I am a student of the School of Public Health, University of Ghana. I am conducting this research in partial fulfilment for the award of masters of public health (MPH) degree. Be assured of strict confidentiality of the responses you give to the questions below.

Name of facility……..

Section A: Predisposing / Socio-Demographic data (client factors)

Age

1. Which of the following is your age range?

15-20 ( ) 21-25 ( ) 26-30 ( ) 31-35 ( ) 36-40 ( ) 41-45 ( ) 46- <50 ( )

Parity

2. How many times have you given birth?

0 ( ) 1-2 ( ) 2-4 ( ) >5 ( )

Religion

3. Which of the following describes your religious orientation?

Christian ( ) Muslim ( ) Traditionalist ( ) Others (state)……

Employment status

4. What is your employment status?

Employed (….), Not Employed (___)

Occupation

5. What is your occupation? _____.

Farmer ( ) seamstress ( ) public/civil servant ( ) trader ( ) Others (state)…….

6. How long have you had this occupation? _____

1-5 year ( ) 6-10 years ( ) 11-15 years ( ) >15 years ( )

Education

7. What is your level of education?

Primary (___) JHS (_) SHS (_) Tertiary (___) no formal (…..) Other (___)

Marital status

8. What is your marital status?

Married (___) Widowed (___) Divorced/Separated (___) Single (___)

9. If you are not presently married, are you in a long-term relationship?

Yes (___) No (___)

Residence

10. Where do you live?

McCarthy hill ( ) Barrier ( ) Bortianor ( ) Mile 11 ( )

11. How long have you been staying there?

1-5year ( ) 6-10years ( ) 11-15years ( ) >15years ( )

Family Planning visit

12. Is this your first visit here?

Yes (___) No (___)

13. If not, for how long have you been visiting this clinic/facility? _____.

year ( ) 6-10 years ( ) 11-15 years ( ) >15 years ( )

14. What is the reason for your visit?

ANC (__) PNC (___) family planning clinic (__) Gynecological clinic (__)

Use of Family planning method

15. Have you used any family planning method before?

Yes (__) No (__)

If no, do not continue with the remaining interview

16. If yes, did you access it from this hospital?

Yes (__) No (___)

17. If no, where did you access it?……

Use of a contraceptive method

18. Are you still using a contraceptive method?

Yes…… No……

19. If no, when did you stop using it? .....

<1 year ago ( ) 1-5 years ago ( ) 5-10 years ago ( ) >10 years ago ( )

Type of family planning method used

20. Which type of family planning method did you use /are you using?

Condom (___) Diaphragm (___) IUD (___) Oral Contraceptives (___)

Depo Provera (__) Morning-after Pill (___) Implant (___) Tubal ligation (___)

Section B: Enabling (Health Provider) factors

Time spent to travel to the health facility

21. How long does/did it take you to get to the facility? _____.

30 minute ( ) 60 minute ( ) 120 minute ( ) 180 minute ( )

Means of travel to the health facility

22. How do you get there?

I walk (___) I drive (___) I get a ride from someone (___) I take the bus/trotro (___) other …….

Availability of Family Planning Services

23. Do you have to make an appointment prior to coming to the family planning clinic or can you just walk in?

I have to make an appointment (___) I can walk in (___)

24. Could you make an appointment on the first try?

Yes (___) No (___)

25. If appointment, how many times did you call for an appointment?

Once ( ) twice ( ) thrice ( ) >3 times ( )

Waiting time at the Family Planning Clinic

26. Once in the clinic, how long do you have to wait before you are seen? (In minutes)

30 min ( ) 60 min ( ) 90 min ( ) 120 min ( ) >120 min ( )

Attitude of health providers and Quality of FP services

Please tick how much you agree with these statements about your visit to the family planning clinic.

27. I find the waiting room comfortable

Disagree ( ) Somewhat agree ( ) Agree ( ) neutral ( )

28. I find the staff friendly

Disagree ( ) Somewhat agree ( ) Agree ( ) neutral ( )

29. I find the staff well trained

Disagree ( ) Somewhat agree ( ) Agree ( ) neutral ( )

30. I have enough privacy during my visit

Disagree ( ) Somewhat agree ( ) Agree ( ) neutral ( )

31. I feel that the main practitioner spends time to get to know me

Disagree ( ) Somewhat agree ( ) Agree ( ) neutral ( )

32. I feel I can discuss my concerns with the practitioner

Disagree ( ) Somewhat agree ( ) Agree ( ) neutral ( )

33. I feel I can trust the practitioner

Disagree ( ) Somewhat agree ( ) Agree ( ) neutral ( )

34. The practitioner tells me what to expect before the examination

Disagree ( ) somewhat agree ( ) Agree ( )

35. I feel that the use of the family planning method was clearly explained to me
Disagree ( ) Somewhat agree ( ) Agree ( ) neutral ( )

36. I was informed about possible side effects of the family planning method
Disagree ( ) Somewhat agree ( ) Agree ( ) neutral ( )

Section C: Need (Community) factors

Husband's / Partner's Consent

37. Did you get consent from your partner for use of the family planning method?

Yes ( ) No ( ) N/A ( )

Husband's / Partner's Influence on Family Planning Decision

38. Were you influenced by your partner in deciding to stop using it?

Yes ( ) No ( )

Religious Influence on use of family planning

39. Does your religion encourage use of family planning?

Yes ( ) No ( )

Community's influence on family planning method decision

40. How did your community influence your decision to use a family planning method?

Encouraged use ( ) Discouraged use ( ) No influence ( )

Stigmatization on use of Family Planning

41. Were you stigmatized by the community or religious sect for use of a family planning method?

Yes ( ) No ( )