

**SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA**



**BARRIERS TO FAMILY PLANNING AMONG MARRIED WOMEN IN THE GA
WEST MUNICIPALITY, GREATER ACCRA**

BY

BARBARA COMFORT AHORSU

(10598431)

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DECLARATION

I BARBARA COMFORT AHORSU do hereby declare that, apart from references made to works done by other authors in relation to this subject area which have been duly acknowledged, this work was done by me under supervision. I further declare that this work has not been submitted for the award of any degree in this university or elsewhere.

BARBARA COMFORT AHORSU
(STUDENT)

.....

SIGNATURE

.....

DATE



DR ALFRED EDWIN YAWSON
(SUPERVISOR)

.....

SIGNATURE

.....

DATE

DEDICATION

My humble effort I dedicate to my loving mother Theresa Dagadu who taught me to believe in hard work and encourages me to go higher in my education.

To my siblings Joseph, Irene, Regina, Benjamin and Christopher for their prayers and support throughout my studies.

I also dedicate this work to my best friend Dennis K. Worlanyo for supporting and encouraging me to believe in myself.



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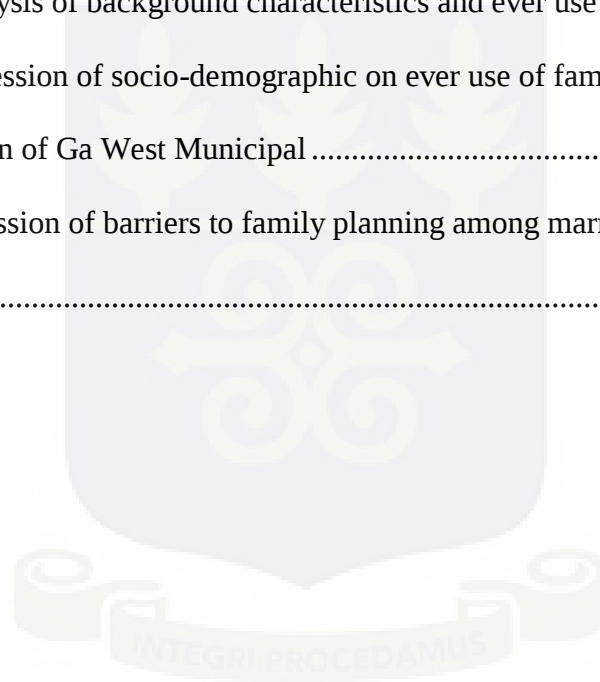
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LIST OF ACRONYMS

CBR	-	Crude Birth Rate
GDHS	-	Ghana Demographic Health Survey
GHS	-	Ghana Health Service
GFR	-	General Fertility Rate
GWMHD	-	Ga West Municipal Health Directorate
GWAR	-	Ga West District Annual Report
GSS	-	Ghana Statistical Service
HIV	-	Human Immunodeficiency Virus
JHUCCP	-	John Hopkins University Center for Communication Programs
IFPP	-	International Federation of Planned Parenthood
NGO	-	Non-Governmental Organization
STI	-	Sexually Transmitted Infections
TFR	-	Total Fertility Rate
UNICEF	-	United Nations International Children's Fund
UNFPA	-	United Nations Population Fund
USAID	-	United State Agency for International Development
WHO	-	World Health Organization.

OPERATIONAL DEFINITIONS

Family planning- a method adopted with the aim to prevent unplanned pregnancies.

Ever use of family planning- The use of any family planning method before the time of this study.

Current use of family planning- The use of any method of family planning at the time of this study.

Barriers of family planning- Any limitation to the use of family planning.



ABSTRACT

Background: Family planning utilization can significantly improve maternal health and reduce maternal mortality. Research have shown that women who have access to better family planning services are more likely to use contraception, are less likely to have unintended pregnancies, and thus have fewer abortions as well as promote gender equality, educational and economic empowerment for women. The objective of this study was to examine the barriers to family planning use among married women in the Ga West Municipality.

Methods: The study used a cross-sectional study design with quantitative research tools. A multi stage sampling method was used to recruit 385 married women for the study. A structured questionnaire was designed and used to collect data from respondents. Data from administered questionnaire was analyzed using STATA version 14.

Results: The study found that there is adequate knowledge of family planning among respondents. Majority (75.8%) have ever used family planning. However, current use of family planning was found to be low (17%). The age ($p=0.001$) and educational level ($p=0.018$) of respondents were significantly associated with ever use of family planning.

Conclusion: Most of the married women have adequate knowledge on family planning. The commonly used family planning method is the calendar method which is less effective and unreliable. Husband's disapproval is the major barrier to family planning acceptance and use by the married women.

Keywords- Barriers, Family planning.

CHAPTER ONE

INTRODUCTION

1.1 Background

Globally, rapid population growth does not match with available resources of countries and constitute a significant problem facing most countries in the world today (Mekonnen & Worku, 2011). As population grows, more resources are required and greater demand is put on national resources. In theory, population increase should cause an economic gain from increase in workforce and production which would elevate national income levels. However, in real life, research in several countries have revealed that rapid population growth has led to more poverty for majority of people (Singh et al., 2003). It is widely documented that high fertility coupled with rapid population increases can impede the chances for economic advancement, is also associated with increased maternal and child mortality. According to World Health Organization (WHO), sexual and reproductive health challenges contribute to 18 percent of all ill conditions worldwide and 32 percent of women of fertile age (15 to 49 years old) worldwide. Annually, about fifty million women endure disease conditions that are associated with conception and birthing, and over 529,000 lose their lives (WHO, 2005). It is estimated that one woman dies every eight minutes in developing countries from unsafe abortion arising from unplanned pregnancies which constitutes one of the common causes of maternal morbidity and mortality. Evidence also shows that about 75 million unplanned and/or unwanted pregnancies occur each year globally and this contribute significantly to rapid population growth (Amalba, Mogre, Appiah, & Mumuni, 2014).

Going by this, efforts are underway to promote and device channels of controlling the human population and contraception is a feasible answer to slow the speedy developing populations (Mekonnen & Worku, 2011). By use of family planning to avert unplanned and complicated pregnancies and to allow enough space between childbirths, to a large extent women can minimize the likelihood of mortality and morbidity that occurs as a result of impediments that are due to conception and labor (Norton, 2005; WHO, 1994). Deschner and Cohen (2003) reported that when contraception services are adequate to reach the increasing need for family planning or impregnation, the occurrence of abortion significantly reduces.

One of the latest survey has estimated the funds used in giving advanced family planning methods in the developing countries was estimated to be US \$ 7. 1 billion in 2003 and this prevented 187 million unwanted pregnancies, sixty million unintended births, 105 million interrupted pregnancies, 22 million stillbirths, 215,000 maternal-related deaths yearly.

Studies have shown that, 201 million women in developing countries require but fail to use advanced contraception as family planning methods of which 137 million are likely to have unplanned pregnancy but fail to use any method, and an extra sixty-four million are depending on a non-reliable orthodox ways (Singh al. 2003). Most high risk categories, including the deprived and teenagers, have problem with accessibility to high-standard contraceptive methods. Family planning programs can help avoid sexually transmitted infections (STIs), including HIV, by using the barrier methods for both sex (condoms) for double safety (Dehne & Snow, 1999; WHO, 2005).

Contraceptive popularity in the developing countries has moved up substantially throughout the past forty years, from some 10 percent of women in 1965 to approximately 60 percent in 2000 (Ross & Stover, 2004). In Asia and Latin America, contraceptive frequency is now at 71 percent and 64 percent respectively, showing that extent of the need towards family planning has been fulfilled. However, prevalence of family planning has increase at a slow pace in Africa, where use of any or all type is 27 percent and used by families in birth spacing but not to limit births (USAID, 2004). In spite of the increase in contraception rate over the past decades, most women are still exposed to unwanted pregnancies. Approximately, 29 percent of women between the ages of 15 to 49 in the developing countries have an unmet need for advanced contraception: indicating, they have sexual intercourse, can conceive, and are not willing to have a child anymore or in few years to come but fail to use advanced means of contraception. Many (20%) refuse to use any type of birth control, some (9%) are using orthodox forms, which can be occasional avoidance of sex or pull out method that have comparably high failure rates (Singh el. 2003).

There is a considerable need for contraception, preconception and procreative health in Africa, especially in remote places. Evaluation of 21 sub-Saharan countries with grand total of 46 million rural women of fertility group (age 15 to 49 years) indicated that 18 percent had unmet needs for family planning and reproductive health (DHS, 2002).

In 1994, Ghana had a revised population policy which focused on a routine integration of population variables into development planning with a renewed focus on fertility decline through birth control programmes. The programme was significantly targeted to reduce the total fertility rate (TFR) from 5.5 to 3.0 by the year 2020 (National population council, 1994). As a result the

government in collaboration with non-governmental organizations has become active and involved in the promotion of family planning aimed at decreasing fertility and enhancing health outcomes. Adequate information and acceptance of family planning have gone up remarkably in Ghana, and the country is progressively attaining its set goals on demographic plan. According to the Ghana Demographic and Health Surveys, contraceptive use in totality among married women has gone high throughout the past 15 years, from 13 percent in 1988 to 25 percent 2003.

The Ga West Municipality has a total fertility rate of 2.9, which is higher than the regional average of 2.6. Both General fertility rate (GFR) and Crude birth rate (CBR) of the Municipality are 89.2 percent and 26.3 percent which are higher as compared to that of the Greater Accra Region representing 75.7 percent and 22.7 percent respectively. The high rate could be as a result of low or non-acceptance of contraception among female and males towards preventing pregnancy.

To safeguard the health of women and to reduce the fertility rate to the barest minimum, the awareness and use of family planning is crucial to finding solutions associated with it. This research work is therefore conceived to investigate the barriers to family planning among wives who are fertile and fall within age 15 and 49 in the Ga West Municipality.

1.2 Statement of problem

While the merits of family planning for the well-being of families worldwide have been well recorded and harnessed, family planning programmes around the sub-Saharan Africa are significantly lower as other health issues has taken over the recognition of government and

supporters (USAID, 2002). Apanga and Adam (2015), observed that women face many barriers to access and use family planning and the low patronage of family planning services in Africa, is largely blamed on several factors. Consequently, most pregnancies in sub-Saharan Africa are unplanned due to low use of family planning (Nyarko, 2015).

Population growth in sub-Saharan Africa is currently 2.5 percent, which represents the highest rate of growth in the world (USAID, 2002). According to USAID (2002), fertility has declined significantly throughout the world, but African women on the average have between 5 and 6 children and in a few countries it is as high as 7 children.

Although the use of modern contraceptives continues to increase across sub-Saharan Africa, it lags far behind that of North Africa (40%), Asia excluding China (43%), and Latin America (59%) (USAID, 2002).

The Ghana demographic and health survey reported that even though family planning awareness in Ghana is high, its use is as low as 15 percent (GDHS, 2010). Among married women only 25 percent currently use modern contraceptives. A major factor underlying high birth rates is the low use of modern contraceptives and studies have shown that only 15% of married women in sub-Saharan Africa make use of modern contraceptive methods as compared to Western Europe where 70 percent use these methods as birth control methods (WHO/ UNICEF/ UNFPA 2000).

The Ga West District population is fast growing but with relatively low-level sustainable development, hence making the district one of the poorest districts in the Greater Accra Region (GDHS, 2010). This has led to the people's inability to provide for themselves and their families

the basic necessities of life. The 2014 District Health Directorate Annual Report indicated that the contraceptive prevalence rate was 15%, which is far below the national prevalence of 25% (GDHS, 2014). Engle (1992) identified barriers that may impede the involvement and the use of family planning or contraceptives as birth control methods among women. Among such include; poverty, unemployment, education, religion, culture, income, age, cost of contraceptives, gender bias (male deciding on contraceptive use in household), value for children, number of children desired, fear of contraceptive use (side effects) and availability and accessibility of family planning services.

The Ga West District health directorate has embarked on a number of family planning programmes and services in collaboration with NGOs to help couples reduce their fertility rate. Reduction in fertility lowers the pressure on already limited resources in both the cities and rural towns (GWHD, 2010). Despite the appreciable involvement of married women in the family planning programmes in the district, married women in the rural communities such as Sapeiman, Kpobiman, Kuntunse, Gatsikorpe and Medie consistently have higher number of children (GWMHD, 2014). Meanwhile, many research have not been conducted to evaluate the barriers that lead to the low utilization of family planning services among married women in rural communities such as Ga West District.

1.3 Justification

Family planning utilization can significantly improve maternal health and reduce maternal mortality and research findings show that women who have access to better family planning services are more likely to use contraception, are less likely to have unintended pregnancies, and

thus have fewer abortions as well as promote gender equality, educational and economic empowerment for women (Apanga & Adam, 2015). The United States Agency for International Development (USAID) reported that in areas where family planning services are introduced and promoted, abortion-related deaths decline as contraceptive use rises (USAID, 2001).

Moreover, studies showed that every dollar spent on family planning 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 (Eliason et al., 2014).

The Ga West District recorded the least among other districts in the distribution of women who use modern contraceptives as family planning methods according to the Ghana Demographic and Health survey in 2014. The Ga West District annual report showed that there has been a percentage increment in the use of family planning methods since its introduction in 2005 till date with a percentage of 15 percent and 18 percent respectively (GWAR, 2014). However, this is way below the national target of 30 percent (GHS Annual Report, 2012). The poor family planning acceptance and use in the Municipality could partly be attributed to a number of barriers to the use of family planning, which impede women involvement and usage to control fertility rate. These barriers have led to women giving birth to more children than they can cater for mostly in the rural towns in the Municipality.

The study seeks to establish the barriers that significantly influence the family planning usage to assist in providing measures for corrections and to serve as a baseline for progress

measurement. The research is necessary to provide adequate data and information on the barriers that are more likely to impede the use of family planning at the village and community level. The findings of this research will provide additional guidelines regarding the need to continuously monitor the identified barriers to family planning services within the Municipality. The study will also assist in the development and implementation of appropriate guidelines by the Municipality in order to enhance reproductive and maternal health education.

1.4 Research Questions

1. What is the level of knowledge of family planning among married women of fertility age in the Ga West Municipality?
2. What are the family planning methods that are commonly used among married women of fertility age in the Ga West Municipality?
3. What are the factors that serve as barriers to family planning acceptance and use among married women of fertility age in the Ga West Municipality?

1.5 Objectives

1.5.1 General Objective

The main objective of the study is to determine the barriers to family planning among married women of fertility age in the Ga West Municipality.

1.5.2 Specific Objectives

1. To assess the level of knowledge on family planning among married women of fertility age in the Ga West Municipality.

2. To determine the family planning methods that are commonly used among married women of fertility age in the Ga West Municipality.
3. To determine the factors that serve as barriers to family planning acceptance and use among married women of fertility age in the Ga West Municipality.

Conceptual Framework

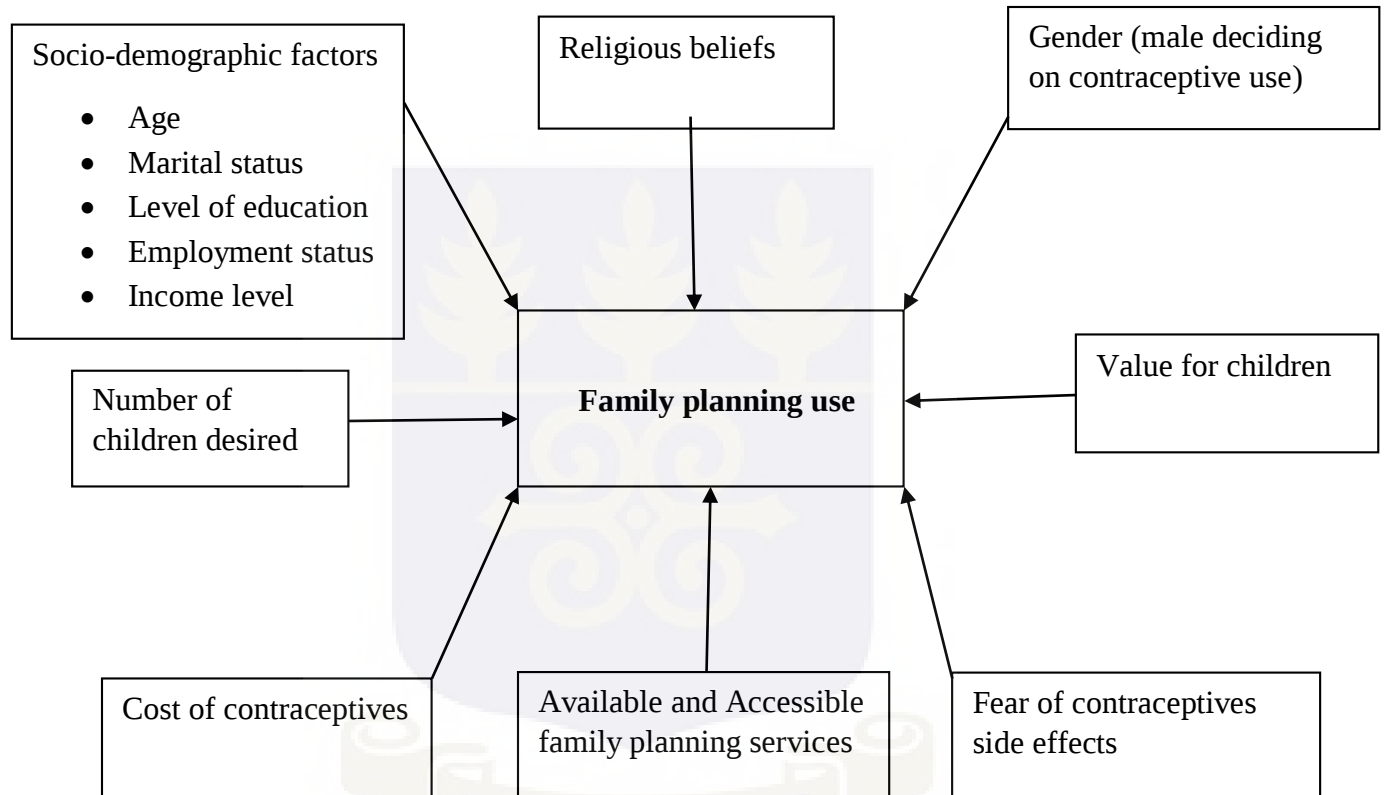


Figure 1.1: Conceptual framework

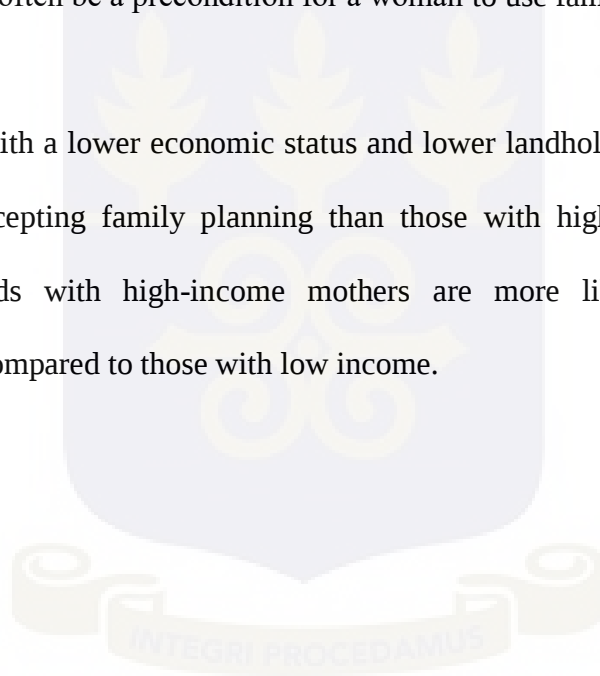
1.6 Explanation of conceptual framework

There are major barriers that may impede family planning use among married women. These barriers have the potential to influence women acceptability and use of family planning methods. Education status of the mother is related to family planning acceptance and contraceptive use. According to data from Demographic and Health Surveys in Ghana, women with no education

have large families of 6-7 children, analogous to those of women with education having between 3-4 children. (Castro Martin; et al., 1996). Better educated women have broader knowledge, higher socioeconomic status and less fatalistic attitudes toward reproduction than do less educated women.

With respect to gender bias (male deciding on contraceptive use), most countries of the world, particularly developing nations, still have male-dominated cultures. For example, in sub-Saharan Africa ancestral customs give men rights over women's procreative power. In such situations, husband's approval may often be a precondition for a woman to use family planning.

Women in households with a lower economic status and lower landholding relatively may have lower percentage of accepting family planning than those with high economic status. This suggests that households with high-income mothers are more likely to access modern contraceptive methods compared to those with low income.



CHAPTER TWO

LITERATURE REVIEW

2.1 Family Planning

Family Planning has been explained as a way of thinking and living that is adopted voluntarily, upon the basis of knowledge, attitudes and responsible decisions by individuals and couples, in order to promote the health and welfare of family groups and thus contribute effectively to the social development of a country (Prachi et al., 2008). Family planning was identified as a significant component of primary health care in the declaration of reproductive health at the International Conference on Population and Development (WHO, 2012). It plays a major role in reducing maternal mortality and significantly helps to contribute towards the achievement of the sustainable development goals (WHO, 2004). Unintended pregnancy, unsafe abortion and sexually transmitted diseases including HIV infection continue to be a major reproductive health problems, globally especially in Africa (Ohene, 2012). Family planning can reduce the number of deaths among women and it accounts for about 30% of all deaths in sub-Saharan Africa (MacPhail, 2011).

In developing countries, almost one-third of currently married women have an unmet need for family planning, 11 percent for spacing their children and 20 percent for limiting childbearing (Muia, 2000).

Providing sexual health and contraceptive services in an age-appropriate environment and manner is of importance to young women (Tripp & Viner, 2012). However, there are barriers that have very high propensity to impede the effective use of family planning services. Among

most married couples, lack of adequate knowledge and awareness has been found to be associated with failure to use contraceptives (MacPhail, 2011). Lack of detailed and accurate information on contraceptives has resulted in reluctance to adopt family planning methods, as some potential users want to know their side-effects (Muia et al., 2000).

Studies conducted among married women in Ethiopia revealed that about 44 percent had ever used emergency contraceptives and less than 10 percent had accurate knowledge regarding when to use contraceptives (Tamire et al., 2011). In a study in Nigeria, major factors that influenced the choice of contraceptives for users were convenience, cost and effectiveness (Oye-Adeniran et al., 2010).

2.2 Knowledge about family planning methods and contraceptive use

According to UNFPA (2002), over 350 million couples worldwide (more than one-third of all couples) do not have access to a full range of modern family planning information and services. The use of modern contraceptive methods, by improving reproductive health, has a positive impact on women's overall health and quality of life. To enhance this beneficial effect, knowledge, attitude and perceptions about the use of the contraceptive is of significant concern.

One of the factors which might affect efficiency of family planning counseling is the source of information or the counselor. It has been reported that, the most adequate source of information on family planning is the general practitioner (Topsever et al., 2006). In countries that individuals are more exposed to information through media, women have better knowledge of several types and can take decisions on various choices (JHUCCP, 2001).

A research carried out in Guatemala showed that the extent to which advanced contraceptive awareness and acceptance among married women residing in remote places differed significantly from individuals located in the cities. The outcome estimated that low level of awareness and cognizance for advanced family planning methods stands to be a significant barrier to modern family planning use in Guatemala, especially in the local population. (IFPP, 2006).

Similar studies conducted in the USA have revealed that married couples who are educated and have received institutional sex education in schools, a clinic, a societal group, or church have a high likelihood of past contraceptive use than those who had not (Topseveretal, 2012).

Studies done in Kwazulu region in South Africa showed that contraceptive users are mostly denied in depth knowledge about contraceptives to help them make an inform decision (USAID, 2002). It is reported that, the effectiveness, likely health problems associated with family planning, and its managements are often left unattended to during counseling of clients of family planning therefore creating perceptions in the minds of users (Tripp, 2012). The USAID reported that most often than not, more information on contraceptive use is provided on advantages than on disadvantages. It also opined that, less information and knowledge are given about how to cope with contraceptive side effects than on actual health issues (USAID, 2002).

2.3 Factors influencing family planning

Majority of countries worldwide, especially poor nations have gender issues due to their culture. In sub-Saharan region of Africa, ancient practices grants husbands the privilege rights over their wives reproduction. In such circumstances, the spouse confirmation is usually granted as a

prerequisite for a female to access contraceptives. A study conducted in Nigeria among married women revealed that most women were not using contraceptives and had little knowledge about its use. About 60 percent respondents attributed the nonuse of contraceptives to husband's disapproval (Akinrinola et al., 2010).

Studies indicated that the commonly used advanced contraceptives in places where women have less power over their fertility are those that are difficult to be identified especially, injectables (Wright, 2002). However, research in the Kassena- Nankana locality in the Upper East region of Ghana revealed the traditional and religious information on fertility behavior can be affected by the predominant socio-economic conditions (Adongo et al., 1998).

A study of the family planning attitudes and practices of Ethiopian elites was conducted with a sample of 99 Orthodox Christian priests and 86 Muslim religious leaders. The authors found that 24 percent of Orthodox Christian and 80 percent of Muslim religious leaders had heard of family planning. Among those who were married 89 percent and 92 percent respectively, 6 percent of the Orthodox Christians and 26 percent of the Muslims practiced contraception. Religious leaders were found to be less favorably disposed toward family planning than other elite groups such as teachers and community leaders (Carol, 2000).

In a survey of 81 African Christians and 40 Muslims religious leaders residing in the Yoruba area of southwest Nigeria, 12 percent of the Christians and 78 percent of the Muslims reported having preached against family planning. Data from a study in Jordan show that four out of five

Jordanians religious leaders and the general public reported that family planning agrees with the teachings and practice of Islam (Carol, 2000).

According to data from Demographic and Health Surveys for nine Latin American countries, women with no education have large families of 6-7 children; analogous to those of women in the developed world (Castro Martin; et al., 1996). Higher educated women have broader knowledge, higher socioeconomic status and fewer attitudes toward reproduction than lower educated women.

According to USAID, providers of family planning services provide less or in some cases no information on the management of side effect of contraceptives. This, thus negatively affect contraceptive use as contraceptive users may either switch a method or entirely stop using contraception with even a minimal sign of side effect (USAID, 2002).

2.4 Geographical distribution, accessibility and availability of family planning services

It is generally accepted that family planning services are significantly linked to reduction in fertility. The immediate variables of the current fertility reduction in the developing countries has been the increased acceptance of contraception. Studies in the past indicates that the availability and accessibility of family planning services is an essential factor influencing contraceptive behaviour (JHUCCP, 2000).

Worldwide over 350 million couples (more than one-third of all couples) do not have access to a full range of modern family planning information and services, the United Nations Population Fund (UNFPA) have estimated (UNFPA, 2000). The distribution of family planning services in Africa is hindered by numerous barriers that are insignificant and often deter potential users. Such barriers include age and parity requirements for some methods, husbands' approval, unwillingness to serve unmarried women, difficulty with outreach programs, health workers who provides family planning services only in the hospitals and clinics, and time-consuming medical and laboratory examinations. In Zanzibar, for example, health professionals refuse to provide contraceptives to unmarried women. In Botswana, Burkina Faso and Senegal on the other hand, it is easier for unmarried women to get a contraceptive than for 33 married women because of requirements for husbands' approval for those who are married. In some countries (Kenya, Burkina Faso) there is a rigorous parity requirement to have an IUD (JHUCCP, 1999). In Zimbabwe, most service providers have minimum age requisite in spite of guidelines that allow the distribution of family planning services to all without restriction (Rosen and Conly, 1998). In a few countries, overly restrictive medical requirements limit access to contraception. In a few countries, unnecessary restrictions include requiring oral contraceptive users to have blood tests every three to six months and prohibiting injectable contraceptive use in women without children. Provider bias against certain methods also influences the choices offered to clients. (JHUCCP, 1999).

Effective family planning services should offer a variety of methods and commodities so that the method most suitable for a client can be provided. Choice of family planning methods increases the level of acceptance and user continuation of services (Hatcher et al., 2001). Services also

need to be available with a frequency convenient for clients. “Accessibility” of family planning services mainly means the extent to which suitable contraceptives are available and the extent to which people in a specified area who wanted contraceptives can easily reach services. In a broader view, however, accessibility is a concept that have different aspects which does not include only nearness and travel time to service providers, it also involves economic, psychological and attitudinal costs, understanding and the perceptions of prospective users. A study in Vietnam indicated that accessibility was positively linked with contraception for several subgroups of women (Singh et al., 2000).



CHAPTER THREE

METHODOLOGY

3.1 Profile of Study Area

The Ga West Municipality is currently the third largest of the seven districts in the Greater Accra Region with its capital being Amasaman. Ofankor, Medie, Adjen Kotoku and Pokuase are some of the major towns found in the Municipality. The Municipality lies within latitude $50^{\circ} 48^1$ North, $5^{\circ} 29^1$ North and longitudes $0^{\circ} 8^1$ West and $0^{\circ} 30^1$ West respectively and occupies a land area of 284.01sq km. The Municipality is located in the southern part of Ghana. It shares boundaries with Akwapim South District to the North, Ga East and Accra Metropolitan Assembly to the East and Ga South to the South and West. The Municipality has about 300 scattered communities. The study population is heterogeneous, comprising of Gas, Akans, Ewes, and Hausa among others.

The Municipality is zoned into six zonal councils namely Pokuase, Mayera, Ofankor, Ayikai, Doblo, Kotoku and Amasaman.

The population for Ga West Municipality for the year 2010 was 217,091 with a growth rate of 3.4 percent. Female population represents 49 percent of the total population whilst male population was 51 percent (Ghana statistical service, 2010). The Municipality remains predominantly peri-urban. The population is mainly concentrated along the peri-urban areas of the Municipality particularly on the border with the Accra Metropolitan Assembly and Ga East District Assembly. The 2000 population figure also showed a density, which was much higher

than the national density though lower than that of Greater Accra Region (with 895.5 persons per sq. km). Figure 3.1 illustrates a map of the study area.

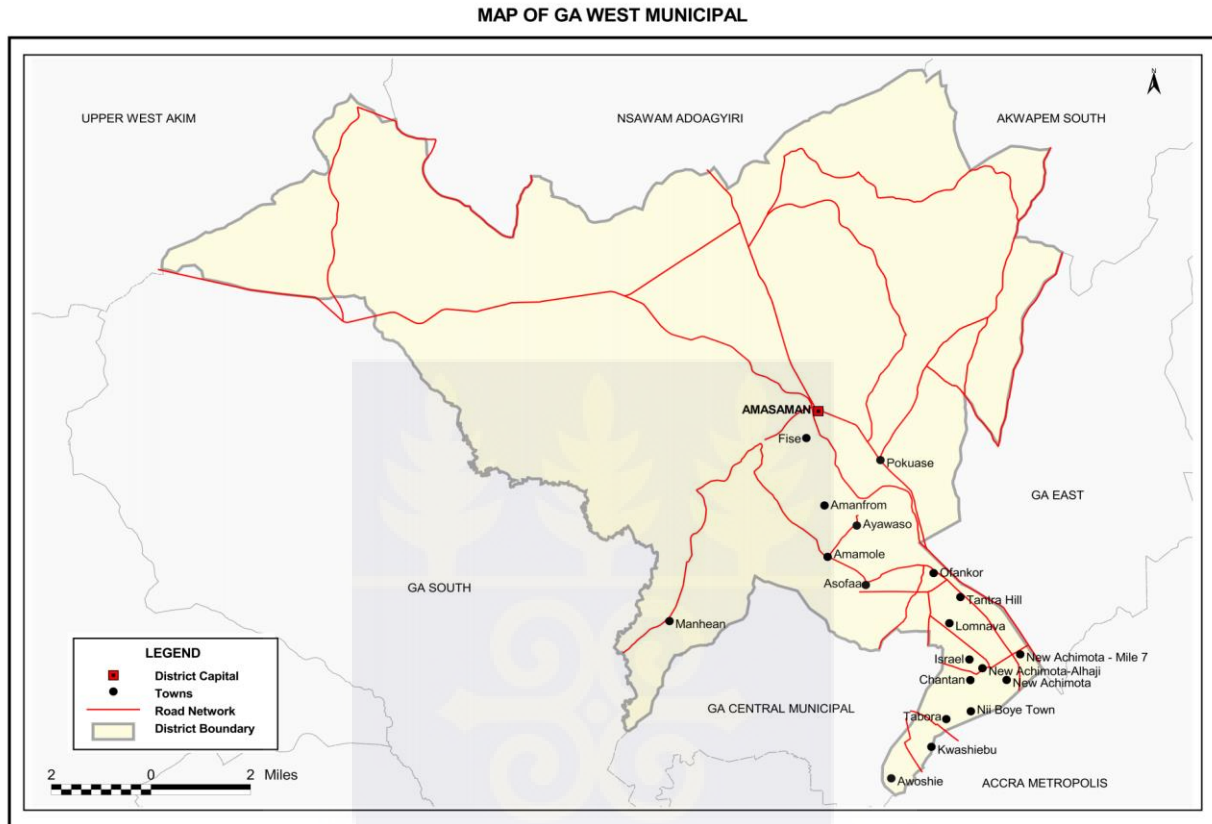


Figure 3.1: Map of Ga West Municipal

Source: Ghana Statistical Service, GIS

3.2 Study design

This study was a cross-sectional design using quantitative study tools to describe the barriers to family planning among married women of fertile age in the Ga West Municipality of the Greater Accra Region.

3.3 Study Population

The study population included married women that were within the reproductive age groups of 15 - 49 years in households.

3.3.1 Inclusion Criteria

Women who were within the reproductive age of 15-49 living within the Ga West Municipality were included in the study.

3.3.2 Exclusion Criteria

Women who were not married but within the reproductive age of 15-49 years were excluded from the study. Women who were not from the Ga West municipality but who were present at the time of the study were excluded.

3.4 Variables

The study variables made up of the dependent and independent variables.

3.4.1 Dependent variable

Use of family planning.

3.4.2 Independent variables

- Socio-demographic characteristics e.g. age, marital status, educational level, employment status and monthly income.

- Knowledge about family planning
- Access and availability of family planning services
- Gender (male deciding on contraceptive use)
- Religious beliefs
- Cost of contraceptives
- Number of children desired
- Value for children

3.5 Sample size determination

The sample size for the study was calculated using Cochran's sample size formula illustrated below:

$$n = \frac{Z \times Z \times P \times Q}{D \times D}$$

Where: n= desired sample size

Z= Reliability coefficient for 95% confidence level usually set at 1.96

P= the proportion in a target population estimated to be using family planning methods is 35%

Q=1-p

d=degree of accuracy desired set at 0.05 probability level.

Substituting,

$n = (1.96)^2 (0.35 \times 0.65) / (0.05)^2 = 350$. Adding 10% to make up for non-response and wrongly filled or incomplete questionnaire gave a total sample size of 385.

Thus a total of 385 respondents were selected from in five selected communities in the Ga West Municipality namely; Sapeiman, Kpobiman, Kuntunse, Gatsikorpe and Medie.

3.6 Sampling procedure

A multi stage sampling method was used. Five communities in the Ga west Municipality was purposively selected. This method was used since the five communities were reported to have a very high fertility rate and low involvement and awareness of use of family planning in the Ga West Municipal Health Directorate report of 2010. There was an equal allocation of participants within the five selected communities. This was done by dividing the 385 participants equally among the five selected communities. A sample size of 77 participants from each of the five selected communities were used for the study. Households within each house's residents lived were selected using systematic sampling Techniques. The respondents were randomly selected in the households and interviewed.

3.7 Data Collection Instrument

A pretested structured questionnaire was used as the data collection instrument for the study. The questions that were asked included general socio-demographic characteristics, general family planning history, knowledge and perceptions about the use of family planning methods, awareness of health institutions and facilities that provides family planning services. Informed consent was obtained from participants and questionnaire was administered in the local language of respondents.

3.8 Sampling Technique

Consecutive sampling technique was used. This means that every eligible person was selected until the required sample size was obtained.

3.9 Data processing

Data were cleaned, coded and entered into Microsoft Excel. The data was validated and exported to STATA (statistical analysis software) Version 14.

3.10 Data Analysis

Descriptive statistics such as means, cross-tabulations, and frequencies were used to describe demographic characteristics of the study participants with 95% confidence intervals (CI). The results were presented using tables, graphs. Chi-square test statistics was conducted to determine association or relationship between family planning use and socio-demographic variables. Bivariate analysis was conducted to determine the factors that served as barriers to family planning use and multiple logistic regression was performed on variables found to be statically significant in the Bivariate analysis. Statistical significance was accepted at a 5% probability level ($P \leq 0.05$).

3.11 Data quality control

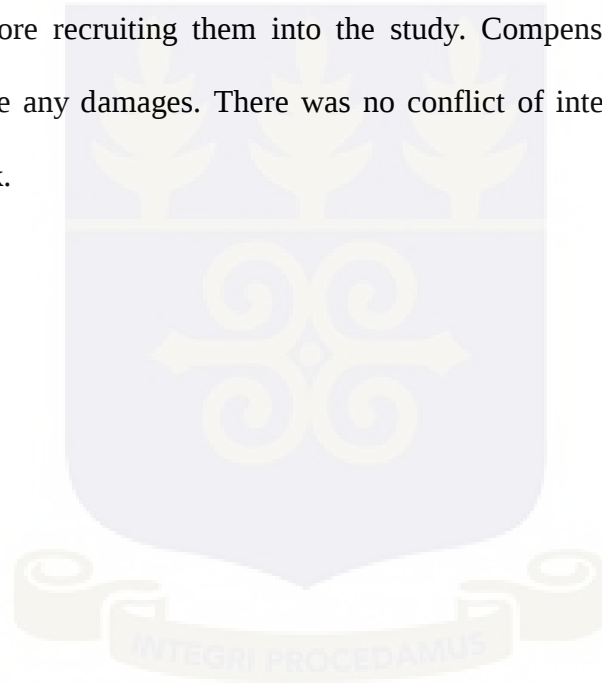
Two (2) Data Collection Assistants were trained on how to effectively administer questionnaires and obtain information form participants.

Feedbacks were used to make the necessary modifications necessary to optimize the questionnaire.

3.12 Ethical considerations

Study proposal was submitted to the Ghana Health Service's (GHS) Ethical Review committee for review and clearance before commencement of data collection.

Approval was obtained from the Ga West Municipal Assembly and Municipal Health Directorate. Subjects were recruited from households. There were no potential risks to the recruited participants. Data collected was known only to the researcher and it was used for only this research work. Participants had the chance to opt out at any time within the study and their consent was sought before recruiting them into the study. Compensation was to be paid to participants if there were any damages. There was no conflict of interest and I the researcher funded the research work.



CHAPTER FOUR

RESULTS

4.1 Socio-demographics characteristics of study participants

A total 385 married women of fertility age participated in the study. The maximum age was 48 and the minimum 16. The mean age of the participants was 32.2 (SD=7.8). Majority 188 (48.8%) of the women were between age group 20-30 years while 185 (48.1%) were above age 30 years. Most 74 (19.2%) of the women have been to the tertiary institution and 150 (39.0%) had senior high school education. While 99 (25.7%) of the women have been to the junior high school, 53 (13.8%) have been to the primary school and only 8 (2.1%) did not attend any school. Most 342 (88.8%) were Christians, 38 (9.9%) were Muslims while 5 (1.3%) professed the African Traditional Religion.

With respect to employment status of the women, majority 245 (63.6%) of them were engaged in in-formal employment, 96 (24.9%) were engaged in formal employment while 44 (11.4%) were unemployed. The monthly income of most 197 (51.2%) was between GHS500 and GHS1000 while 156 (40.5%) had monthly income of less than GHS500. Table 4.1 illustrates details of the socio-demographic characteristics of the study respondents.

Table 4.1: Socio-demographics characteristics of study participants

Variable	Frequency(385)	Percentage (%)
Age		
<20 years	12	3.1
20-30 years	188	48.8
>30 years	185	48.1
Educational status		
None	8	2.1
Primary	53	13.8
JHS	99	25.7
SHS	150	39.0
Tertiary	74	19.2
Religion		
Christians	342	88.8
Muslims	38	9.9
African Traditional Religion	5	1.3
Employment		
Formal	245	63.6
In-formal	96	25.0
Unemployed	44	11.4
Household monthly income		
>GHS 1000	197	51.2
GHS500-GHS1000	156	40.5
<500	32	8.3

4.2 Knowledge of Family Planning

Figure 4.1 shows married women knowledge of family planning. The married women were asked questions to assess their level of knowledge regarding family planning. A score of 1-3 correct answers was regarded as inadequate knowledge, 4-6 correct answers was moderate knowledge and a score of above 7 correct answers was rated adequate knowledge. The results showed that, most of the married women had adequate knowledge about family planning representing 46.8% (180/385), 31.4% had moderate knowledge while only 21.8% (84/385) had inadequate knowledge as shown in figure 4.1 below.

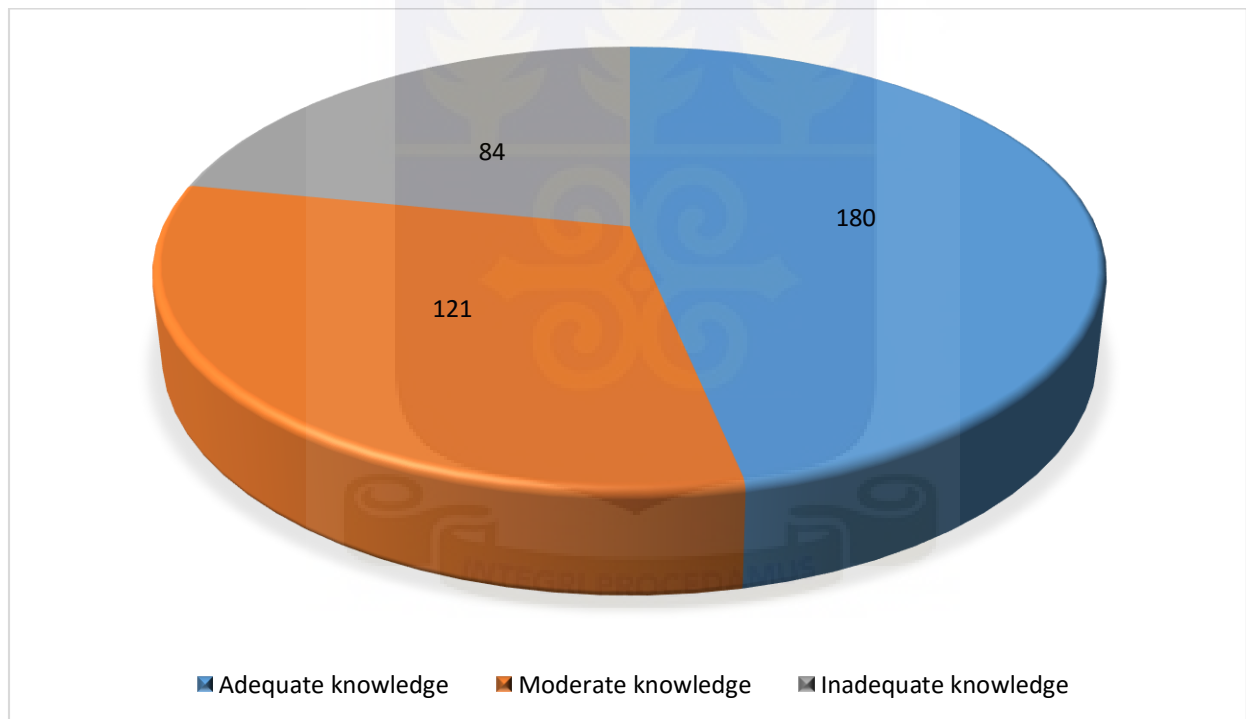


Figure 4.1: Knowledge of respondents on family planning

4.3 Distribution of level of knowledge by background characteristics.

Table 4.2 shows the distribution of level of knowledge by background characteristics.

Age was not significantly associated with the level of knowledge. Seven out of 12 (58.3%) of the women in age group below 20 had moderate knowledge. Ninety-three out of 183 (49.5%) women in the age- group 21-30 had adequate knowledge and 96 out of 196 (49%) women in the age group >30 had adequate knowledge.

Table 4.2: Distribution of level of knowledge by background characteristics

Characteristic	Inadequate	Moderate	Adequate	X ² (p-value)
Age				6.815 (0.146)
<20	3 (25)	7 (58.3)	2 (16.7)	
21-30	43 (22.9)	52 (27.7)	93 (49.5)	
>30	38 (19.4)	62 (31.6)	96 (49.0)	
Education status				68.742 (0.001)
None	1 (12.5)	6 (75.0)	1 (12.5)	
Primary	10 (18.9)	30 (56.6)	13 (24.5)	
Junior High	20 (20.2)	16 (16.2)	63 (63.6)	
Senior High	26 (17.3)	39 (26.0)	85 (56.7)	
Tertiary	17 (23.0)	22 (29.7)	35 (47.3)	
Religion				15.876 (0.014)
Christianity	76 (22.2)	94 (27.5)	172 (50.3)	
Muslim	6 (15.8)	14 (36.8)	18 (47.4)	
Traditionalist	1 (20.0)	3 (60.0)	1 (20.0)	
Employment				6.882 (0.032)
Formal	59 (24.1)	75 (30.6)	111 (45.3)	
In-formal	32 (33.3)	20 (20.8)	44 (45.8)	
Unemployed	25 (56.8)	7 (15.9)	12 (27.3)	
Household income				2.777 (0.249)
<500	9 (28.1)	8 (25.0)	15 (46.9)	
500-1000	26 (16.7)	45 (28.8)	85 (54.5)	
>1000	33 (16.8)	40 (20.3)	124 (62.9)	

Educational status was significantly associated with the level of knowledge ($\chi^2=68.742$, $p < 0.05$). Six women who had not been to any school had moderate knowledge. Thirty women who had only primary school education had moderate knowledge. Sixty-three women who had completed junior high school had adequate knowledge. Thirty-five women who had tertiary degree had adequate knowledge. Women who had attained junior or high school education had majority with adequate knowledge whilst majority of those with lower education status had moderate knowledge.

Religion was significantly associated with the level of knowledge ($\chi^2=15.876$, $p < 0.05$). One hundred and seventy-two Christians had adequate knowledge. Fourteen of the Muslims had moderate knowledge, and three traditionalists had moderate knowledge. Majority of Christian and Muslims had adequate knowledge.

There was significant association between employment and level of knowledge ($\chi^2=6.882$, $p < 0.005$). One hundred and eleven of those who were in formal employment had adequate knowledge and only twelve of those who were unemployed also had adequate knowledge.

There was no association between income and level of knowledge. Fifteen of the participants who earned less than ₵500 had adequate knowledge likewise eighty-five who had income between ₵500 and ₵1000 and one hundred and twenty-four who had income above ₵1000.

4.4 Source of information on family planning

Table 4.3 gives a summary of the source of information on family planning services among married women in the Ga West Municipality. Most of the women 85.5 percent obtain their information from the media, TV, Radio and Newspaper. Sixty three percent of the women also receive information on family planning through their friends and family. The women who said they receive information from health workers were 111 (28%). Seven women also receive information from books and magazines. The internet and social media is also one of the major ways the married women receive information in the Ga West Municipality, 190 (48%) women receive information from these source. 23 women do not know any source of information on family planning.

Table 4.3: Source of information on family planning

Source	Frequency	%
Health workers/ facility	111	28
Media, TV, Radio, Newspaper	340	85.6
Books and magazine	70	17.7
Internet and social media	190	48
Friends and relatives	250	63
Do not know any source	23	5.8

4.5 Utilization of family planning methods in the Ga West Municipality

Table 4.4 shows the utilization of family planning methods in the Ga West Municipality. The married women who said they had ever used a family planning method were 292 (75.8%) however only about half of them used a contraceptive at their first intercourse. Ninety-two of the

women have ever experienced a contraceptive failure; fifty-four went to see the family planning provider, five took emergency contraceptive and thirty-three did nothing.

Most of the women (104) currently rely on the calendar/safe period method as a means of birth control; twenty-four use condoms, fifty-seven use oral pill, seven-three use emergency contraceptive pill, sixty use injectable, twenty-one use intra-uterine device and fifty-seven use withdrawal method.

Table 4.4: Utilization of family planning methods in the Ga West Municipality

Variable	Frequency	%
Ever use a family planning contraceptive	292	75.8
Used a contraceptive at first intercourse	145	36.6
Current family planning method being used		
Condom	24	6.1
Oral pill	57	14.4
Emergency contraceptive pill	73	18.4
Injectable	60	15.2
Intra-uterine device	21	5.3
Withdrawal method	57	12.9
Safe period/calendar method	104	26.3
Ever had a Family planning contraceptive failure	92	23.2
Action after contraceptive failure		
Went to family planning provider	54	58.7
Took an emergency contraceptive	5	5.4
Did nothing	33	35.9

4.6 Barriers to utilization of family planning services among married women of fertility age in the Ga West Municipality

Table 4.5 shows the barriers to utilization of family planning services among married women of fertility age in the Ga West Municipality. Most of the married women (77.1%) said that disapproval from their husband makes them not to utilize family planning services. One hundred and twenty-one (31.6%) of the women said bad attitude of health workers prevents them from assessing family planning services. The fear of side effects, stigmatization, unavailability and accessibility were also noted by some of the married women.

Most women (257) said that, their religious conviction influence their use of family planning services and 262 said that they are not given adequate knowledge on family planning services. Twenty-six percent also said that cost of family planning services also serves as a barrier for them.

Table 4.5: Barriers to utilization of family planning services among married women of fertility age in the Ga West Municipality

Variable	Frequency	Percentage (%)
Bad attitude of health workers	122	31.6
Stigmatization	155	40.3
Disapproval from husband	297	77.1
Fear of side effects	117	30.4
Conflict with religious conviction	257	66.8
Inadequate knowledge on FP	262	68.5
Cost of family planning services	104	27.0
Unavailability of FP services	127	33.0
Poor accessibility of FP services	130	33.8

4.7 Bivariate analysis of Background characteristics of study respondents and ever use of family planning

A bivariate analysis was done to identify association between the background characteristics of respondents and ever use of family planning. The results showed that age of married women was significantly associated with ever use of family planning ($X^2 = 15.49$, $P = 0.001$). Majority 178 (95.2%) of the women aged between 2- and 30 years ever used family planning and those above 30 years ever used family planning. More women, 89 (89.9%) who had Junior High School education ever used family planning compared to those who had tertiary education (69).

Educational level was also significantly associated with ever use of family planning ($X^2 = 11.93$, $P = 0.018$). Most of the women who attained Senior High School (SHS) education ever used family planning while 15 of them who never had any form of formal education ever used family planning.

The study found that household monthly income was significantly associated with ever use of family planning ($X^2 = 3.932$, $p = 0.047$). More (124) women who earned between GHS 500 AND GHS 1000 ever used family planning. The knowledge level of married women about family planning was also significantly associated with ever use of family planning. Most (111) women who had adequate knowledge of family planning ever used family planning as shown in table 4.6.

Table 4.6: Bivariate analysis of background characteristics and ever use of family planning

Variable	Ever use of family planning		df	X ²	P-value
	Yes-n (%)	No-n (%)			
Age			2	15.49	0.001
<20 years	8 (66.7)	4 (33.3)			
20-30 years	178 (95.2)	9 (4.8)			
>30 years	174 (93.5)	12 (6.5)			
Educational level			4	11.93	0.018
None	15 (78.9)	4 (21.1)			
Primary	51 (96.2)	2 (3.8)			
JHS	89 (89.9)	10 (10.1)			
SHS	146 (97.3)	4 (2.7)			
Tertiary	69 (93.2)	5 (6.8)			
Religion			3	6.109	0.106
Christian	276 (80.7)	66 (19.3)			
Muslim	27 (71.1)	11 (28.9)			
African Traditional Religion	4 (80.0)	1 (20.0)			
Household Monthly Income			1	3.932	0.047
>GHS 1000	67 (81.7)	15 (18.3)			
GHS 500-GHS 1000	124 (87.3)	18 (12.7)			
<GHS 500	37 (75.5)	12 (24.5)			
Employment			1	0.689	0.407
In-formal	132 (86.8)	20 (13.2)			
Formal	45 (73.8)	16 (26.2)			
Unemployed	26 (78.8)	7 (21.2)			
Knowledge of Family Planning			2	26.81	0.001
Adequate knowledge	111 (88.8)	14 (11.2)			
Moderate knowledge	93 (82.3)	20 (17.7)			
Inadequate knowledge	41 (77.4)	12 (22.6)			

4.8 Sources of family planning services

Respondents were made to identify the various sources where family planning services are provided and where they obtained family planning services. The Pharmacy was the most identified source of family planning services for married women in this study representing 78% while only 2% identified friends and relatives as their source of family planning services. Figure 4.2 shows the distributions of respondents' responses on sources of family planning services.

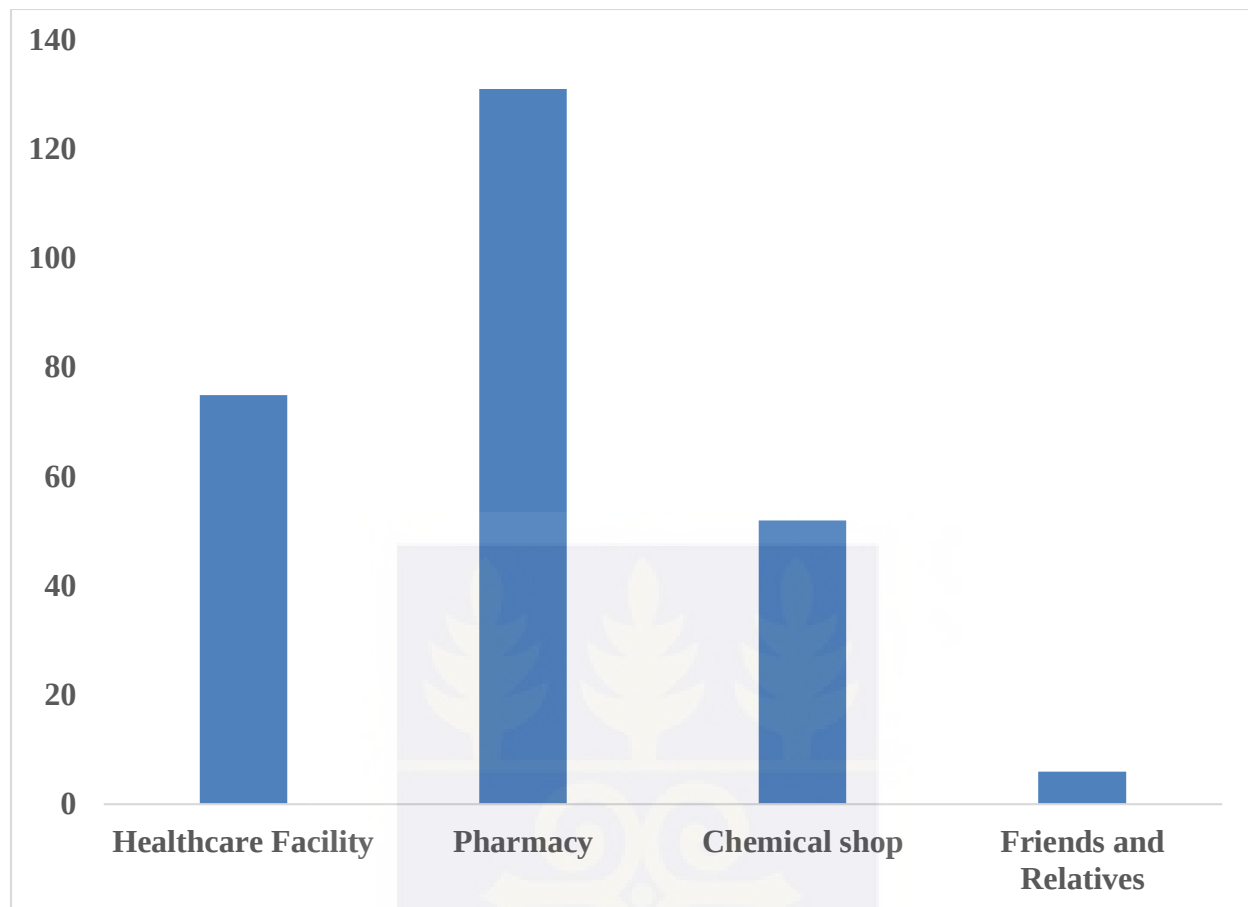


Figure 4.2: Sources of Family Planning services

4.9 Attitude of married women towards family planning

The attitude of participants towards family planning was assessed in this study. Their responses to questions measuring attitude were quantified to determine the proportion of married women with positive attitude towards family planning. Women who responded in the affirmative to the questions were classified as having positive attitude towards family planning while those who responded in the negative were categorized as having negative attitude. Those who were undecided in their responses were seen as having neutral attitude towards family planning. As illustrated in figure 4.3, more than half 221 (57.4%) of the women have positive attitude towards family planning.

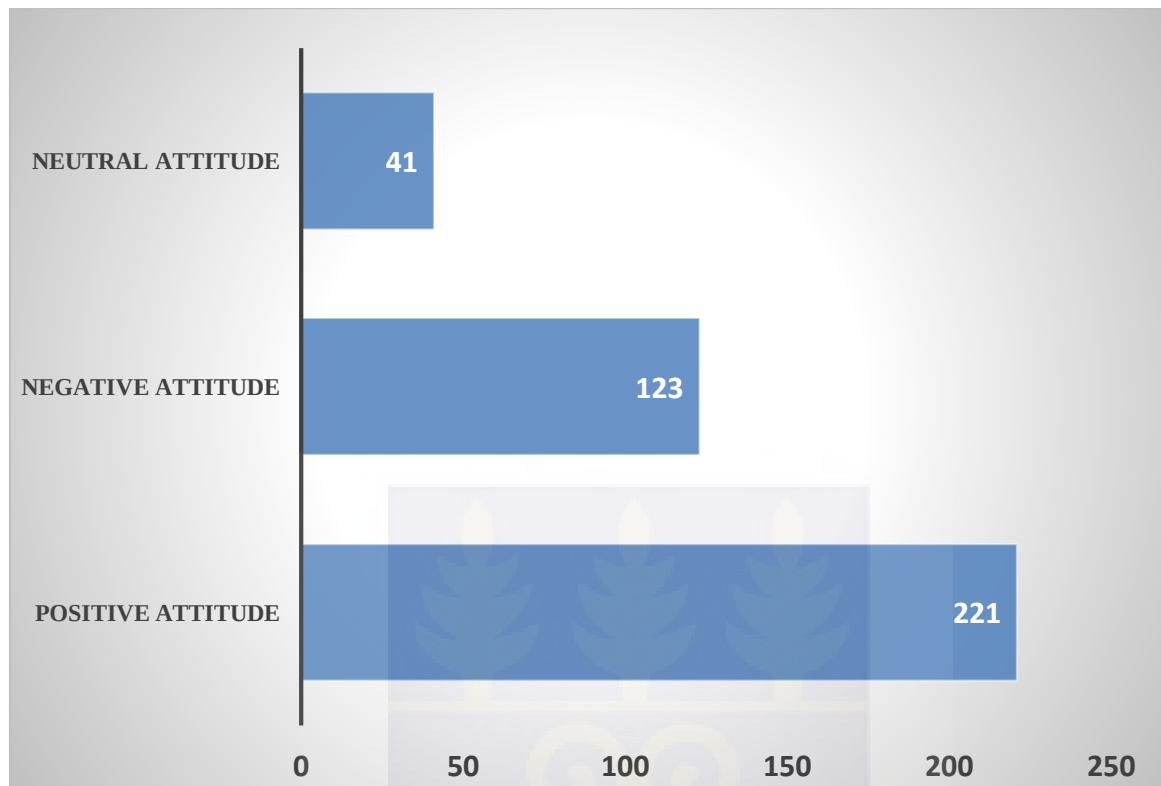


Figure 4.3: Attitude towards family planning

4.10 Current use of family planning

The current family planning use among married women in this study was examined. The findings revealed that only 17.4% of the respondents currently use a family planning method indicating a family planning prevalence of 17.4%. Figure 4.4 illustrates respondents' current use of family planning.

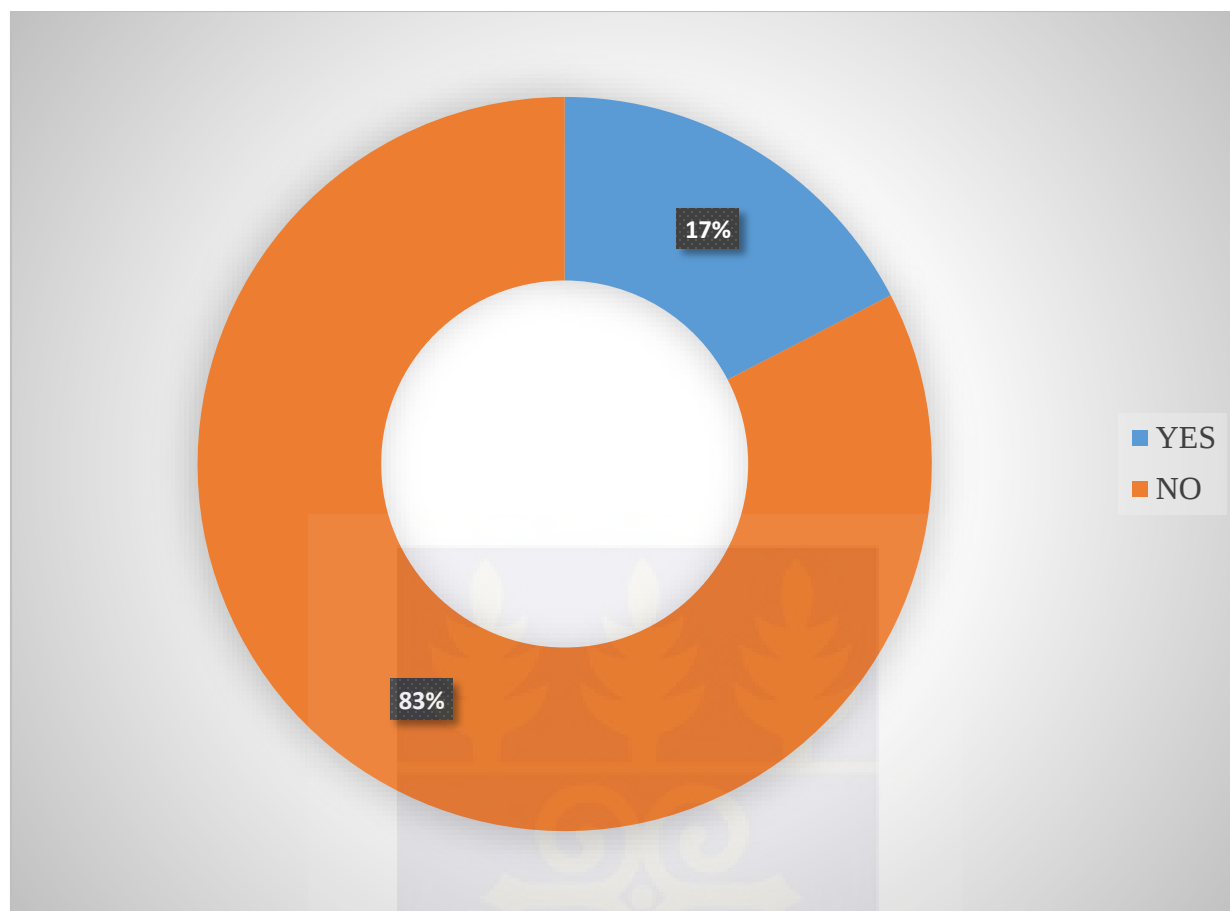


Figure 4.4: Current use of family planning among married women

4.11 Logistic regression of socio-demographic factors and ever use of family planning

Multivariate logistic regression analysis was done to identify socio-demographic determinants of ever use of family planning among married women. The results are shown in table 4.7. The age, educational level, household monthly income and religious affiliation of married women were significant determinants of ever use family planning in bivariate analysis. However in multivariate analysis, only educational level and religion of respondent were significant determinants of ever use family planning while age and household monthly income were not.

In bivariate analysis, married women who were between 20-30 years were significantly more likely to have ever used family planning compared to those below 20 years and above 30 years (OR= 9.89, 95% CI 2.50-39.08). Those who were above 30 years were also 7 times more likely to have ever used family planning compared to those below 20 years (OR= 7.67, 95% CI 2.02-29.13).

In terms of educational level, women who had SHS and tertiary level of education were more likely to have ever use family planning both in bivariate and multivariate analysis compared to those without any form of formal education (OR= 6.2, 95% CI 1.39-27.49; OR= 6.51, 95% CI 1.57-26.92).

Additionally, married women who professed the Christian faith were significantly more likely to have ever used family planning compared to married women of other religions (OR=0.16, 95% CI 0.03-0.85).

Women who reported that their household monthly income was above GHS 1000 were found to be 4 time more likely to have ever used family planning compared to married women whose household monthly income was less than GHS 1000 in bivariate analysis (OR= 4.21, 95% CI 1.51-16.23). Meanwhile, this was not significant in multivariate analysis.

Table 4.7: Logistic regression of socio-demographic on ever use of family planning among married women of Ga West Municipal

Variable	Bivariate OR (95% CI)	P-value	Multivariate OR (95% CI)	P-value
Age				
<20 years	1.		1.	
20-30 years	9.89 (2.50-39.08)	0.001	2.51 (0.23-27.87)	0.453
>30 years	7.67 (2.02-29.13)	0.003	1.06 (0.11-9.94)	0.962
Educational Level				
None	1.		1.	
Primary	6.8 (1.13-40.82)	0.036	6.83 (0.92-50.86)	0.061
JHS	2.37 (0.66-8.55)	0.186	2.95 (0.59-14.70)	0.186
SHS	6.2 (1.39-27.49)	0.016	12.69 (1.72-93.67)	0.013
Tertiary	6.51 (1.57-26.92)	0.010	6.71 (1.16-38.89)	0.034
Religion				
African Traditional Religion	1.		1.	
Islam	0.87 (0.25-3.06)	0.831	0.34 (0.08-1.46)	0.147
Christianity	0.16 (0.03-0.85)	0.032	0.06 (0.01-0.70)	0.025
Household Monthly Income				
<GHS 500	1.		1.	
GHS 500-GHS 1000	3.03 (0.96-9.55)	0.058	2.80 (0.84-9.42)	0.095
>GHS 1000	4.21 (1.51-16.23)	0.031	3.47 (0.91-8.36)	0.148
Employment				
Unemployed	1.		1.	
Formal	1.46 (0.59-3.59)	0.409	1.46 (0.47-4.53)	0.514
In-formal	1.74 (0.23-2.76)	0.302	0.56 (0.24-3.75)	0.741

4.12 Logistic regression of barriers to family planning among married women of Ga West Municipal

As shown in table 4.8, married women who considered attitudes of health workers to be bad were 2.63 times more likely to have ever used family planning (OR=2.63, 95% CI 1.16-5.94). Similarly, married women who identified poor access of family planning services as a barrier to

family planning were less likely to ever use family planning compared to those who do not see accessibility as a barrier to ever use of family planning (OR= 0.16, 95% CI 0.06-0.46).

Table 4.8: Logistic regression of barriers to family planning among married women of Ga West Municipal

Variable	Ever Use FP	COR OR(95% CI)	AOR OR(95% CI)
Bad attitude of health workers	YES	2.63 (1.16-5.94)*	2.61 (0.89-7.65)
	NO	1.	
Stigmatization	YES	0.72 (0.30-1.72)	0.80 (0.28-2.28)
	NO	1.	
Disapproval or opposition from husband	YES	1.36 (0.49-3.73)	2.01 (0.59-6.77)
	NO	1.	
Fear of side effect	YES	1.14 (0.48-2.72)	0.99 (0.35-2.86)
	NO	1.	
Conflict with religious conviction	YES	0.48 (0.21-1.08)	0.51 (0.17-1.56)
	NO	1.	
Inadequate knowledge of use	YES	0.53 (0.24-1.20)	0.74 (0.25-2.18)
	NO	1.	
Cost of family planning services	YES	1.34 (0.56-3.21)	2.68 (0.66-10.99)
	NO	1.	
Non- availability of FP services	YES	0.82 (0.33-2.02)	-
	NO	1.	
Poor accessibility of FP services	YES	0.16 (0.06-0.46)***	-
	NO	1.	

CHAPTER FIVE

DISCUSSION

5.1 Introduction

This chapter discusses the findings of the study and attempt to compare the results with other studies in order to identify similarities and differences in findings.

5.2 Knowledge of Family Planning

This study found that the number of married women in this study with adequate knowledge of family planning was high compared to those having moderate and inadequate knowledge. This finding is crucial since the potential use of family planning depends to a larger extent the level of knowledge one has about family planning. Meanwhile, this finding affirms findings by the Ghana Demographic Health Survey that currently, 98% of all women knew of family planning (GSS, 2014). Another study on determinants of low family planning use and high unmet need in Butajira District, South Central Ethiopia reported that about 99% of women knew at least a modern method of family planning (Mekonnen & Worku, 2011). The high knowledge of family planning among married women found in this study could be attributed to the continuous audio and visual advertisements that are common in the media landscape of Ghana seeking to promote family planning use. It could also be partly due to other health education and promotion interventions such as outreach programs in churches, communities and social gatherings aimed at educating women on the need for family planning.

Additionally, the study found that background characteristics of the married women such as educational status was significantly associated with knowledge of family planning. This could be

explained by the fact that women who attain higher educational level are more likely to read about family planning. This finding is in keeping with a study by Anjum et al, (2014) which reported that women level of education was a predictor of knowledge of family planning method. Religious affiliation of the women was also found to be significantly associated with their knowledge of family planning. This could be linked to the different positions of various religious faith relative to family planning and the efforts constantly being made to inform members about family planning methods that are not in keeping with the beliefs of the particular religious faith. This is supported by findings that religion cannot be separated from the fertility situation particularly in the African context where religion plays a key role in fertility decisions of families (Gyimah et al, 2006).

The mass media (Television, Radio and Newspaper) constitute the main source of information on family planning for married women in this study similar to another study in Ghana which found that the television and radio were the leading source of obtaining information on family planning by women (Adjei et al., 2015). Contrary to this, Eliason et al. (2014), revealed in their study in the Nkwanta District, Volta Region of Ghana that the main source of family planning information was health workers. The difference in findings could be explained by the fact that, while television and radio are commonly found in the Greater Accra Region with good connectivity, the widespread nature of CHPS zones in the Volta region enable family planning information to be carried out to the door steps of women by healthcare staff in the CHPS zones. Also, findings from Nigeria, that friends were a major source of family planning information among married women of reproductive age at 33.8% (Egede et al., 2015) differs from findings in this study. The second most identified source of family planning information by the study

respondents was the healthcare facility and this is suggestive of the fact that, married women visit the health facility for ante-natal care they educated on family planning.

5.3 Ever use and current use of family of family planning

The study results showed that majority of the married women in this study ever used family planning. More than 75% of them reported ever use of family planning and this agrees with findings of a study in Ethiopia that found that ever use of family planning methods among married women was more than 77% (Mekonnen & Worku, 2011). However, the estimated current use of family planning was 17% and this is less than findings in the Ghana Demographic Health Survey that the current use of modern method of contraceptives among married women was 22% (GSS, 2014). It is further lower than the 25.4% found by Mekonnen and Worku (2011) in their study. The difference in the current use of family planning could be accounted for by the large sample size of 5746 married women in their study compared to the 385 sample size used in this study.

The most widely method of family planning currently used as reported by married women in this study was the natural method of safe periods and calendar method. However, according to literature natural method is the least of the effective methods of family planning. This contradicts findings by another study that injectables and pills were the widely used method by women using family planning in their study (Mekonnen & Worku, 2011).

Despite the fact that majority of the married women had knowledge of family planning, current use was low (17%). This indicates that knowledge per use of family planning may not translate

into use. This is supported by findings in earlier studies in India (Prachi et al., 2008), and Nigeria (Egede et al., 2015), that knowledge of family planning alone does not equate to use.

5.4 Barriers to family planning

Educational level was found to be significantly associated with ever use of family planning and this agrees with findings that family planning use increases with increasing educational level (Achana et al., 2015). Another study by Eliason et al., (2014) revealed that women who had no form of formal education were significantly less likely to use family planning compared to those who had formal education.

Disapproval from husband was cited by majority (297/385) of the women as a barrier to their acceptance and use of family planning. This affirms results of another research that in sub-Saharan Africa, contraceptive use was strongly influenced by men's opinions and couples' dynamics (Anguzu et al., 2014). Similarly, a study found that 43% of Namibian men and 46% of Ghanaian men believed that women who use family planning might become promiscuous and due to fear of spousal disapproval, some women also oppose family planning use (Burdette, Haynes, & Hill, 2014). A study in Zambia also found that two in five married women who were not practicing family planning cited their husband's disapproval as the reason for not using contraceptives (Do & Kurimoto, 2006). Apanga and Adam (2015), also assessed factors influencing the uptake of family planning services among reproductive age women in the Talensi District of the Upper East Region of Ghana, and found that one of the major reasons for non-use of family planning services was opposition from husbands.

In this study, inadequate knowledge of family planning methods is identified as a barrier of family planning. This is similar findings by Hindin, Mcgough & Adanu (2014), that knowledge of various family planning methods and of basic reproductive biology was low among respondents and hence, acting as a barrier to contraceptive use in Ghana. This implies that a good knowledge of family planning methods among married women is important in order to promote use as this will make them better informed and more confident in deciding which form or method of family planning to use. This is supported by the fact that, in industrialized countries with high knowledge level of family planning, virtually all married women use family planning (Morgan, 2014).



CHAPTER SIX

CONCLUSION AND RECOMMENDATION

6.1 Conclusion

This study examined the barriers to family planning among married women in the Ga West Municipality of the Greater Accra Region. The findings revealed that, most of the married women have ever used family planning. However, the current use of family planning among married women in the study area was low.

Majority of the married women have adequate knowledge on family planning.

The commonly ever use family planning method by the married women is the calendar method which is not reliable, indicating that most of them are not using any modern contraceptive.

Husband disapproval, is the major barrier to family planning acceptance and use by the married women.

6.2 Recommendation

There is the need to educate women on the full range of modern contraceptive methods available in order to equip them with the knowledge to be able to make inform decision as far as family planning is concern.

The Ghana Health Service need to focus on targeting men in family planning education.

The Ga West Municipal Health Directorate need to involve the opinion leaders in the community such as; the chief and the assembly members to help deal with the cultural beliefs that give men the reproductive power over women.

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APPENDICES

APPENDIX 1 QUESTIONNAIRE

QUESTIONNAIRE ON UTILIZATION OF FAMILY PLANNING METHODS AMONG MARRIED WOMEN OF FERTILITY AGE (15-49) IN THE GA WEST MUNICIPALITY

PARTICIPANTS CONSENT

Introduction

My name is Barbara Comfort Ahorsu, a student of the School of Public Health, University of Ghana. I am conducting a study on the barriers to family planning among married women of fertility age in the Ga West Municipality. The information collected from you will help the School of Public Health of the University of Ghana, the Ministry of Health and other stakeholders to put in measures that will address sexual and reproductive health needs and improve family planning utilization among married women of fertility age in the municipality.

I assure you that, the information will be treated with total confidentiality and privacy and will not be shared with except for the intended purpose. I kindly request you to participate and provide answers as possible to the questions. You may choose to withdraw from the interview at any stage if you wish. But I will be very happy to have you complete the questionnaire fully. It will take you between 15-20 minutes of your time.

Thank you.

Participant's consent: Yes []

Questions	Code	Questions	Code
Questionnaire ID	QID	Interviewer Code	ICODE
Question number	QN		
Date	DATE		
Municipality	MUN		
Sub municipality	SUBMUNI		

PLEASE TICK THE RESPONSES APPLICABLE

Q N	Questions	Coding categories	Skip to	CODES
Section A: Demographic characteristics of respondents				
1	Age of respondent			AGE
2	Education level of respondents	None.....1 Primary.....2 JHS.....3 SHS/Tech/Voc.....4 Tertiary.....5		EDU
3	Occupation	Employed.....1 Unemployed.....2		

4	Household income	Less than GHS500.00.....1 GHS500.00-1000.....2 Greater than GHS1000.00.....3		
5	Religion of Respondents	Christian.....1 Islam.....2 Traditional.....3 Other(specify).....4		REL
Section B: Knowledge of married women of fertility age on family planning services in the Ga West Municipality				
6	Please do you know about FP contraceptives? If no skip to section C	Yes.....1 No.....2		FP_KNOW
7	How long now have you known contraceptives?	0-1 year.....1 1-2 years.....2 3 or more years.....3		FP_KNOWTIME
8	Which type of FP method do you know about?	Condoms.....1 The pill.....2 Injections.....3 Implants.....4 IUD.....5 Natural FP methods.....6 Emergency contraceptive.....7 All the above.....8 Others(specify).....9		FP_KNOWTYPE
9	What are the sources of Family Planning services that you know?	Health workers.....1 Media(TV, radio, newspapers).....2 Books and magazines.....3 Internet and social media.....4 Friends and relatives.....5		FP_INFOSOURCE
10	Have you ever gone for family planning counselling?	Yes.....1 No.....2		FP_COUNSEL
Section C: Gender issues facing married women of fertility age in the Ga West Municipality				
11	Do you	Yes.....1		FP_DISCUSS

	discuss family planning with your husband?	No.....2		
12	Does your husband approve the use of family planning contraceptives? If yes skip to 17	Yes.....1 No.....2		FP_APPROVE
13	What are your husband's reasons for non-approval of family planning contraceptives?	It makes partner promiscuous.....1 Family planning contraceptives cause infertility.....2 Family planning contraceptives reduces sexual satisfaction.....3 Family planning can cause health problems.....4		FP_NONAPPROVE
14	Family planning contraceptive use is the responsibility of females	Agreed.....1 Disagreed.....2		FP_RESPONSE
Section D: level of utilization of family planning services among married women of fertility age in Ga West Municipality				
15	Have you ever used family planning contraceptive? If no skip to 29	Yes.....1 No.....2		FP_EVERUSED
16	Did you use family planning contraceptives at your	Yes.....1 No.....2		FP_FIRSTSEXUAL

	first sexual intercourse ?			
17	Which type of family planning have you ever used? (Tick all that apply)	Condom.....1 Oral pills.....2 Emergency contraceptive pills.....3 Injectable.....4 Withdrawal method.....5 Safe period/calendar method.....6 Other (specify).....		FP_EVERUSED
18	Are you currently using any family planning contraceptive? If no skip to 23	Yes.....1 No.....2		
19	Which type of family planning method are you currently using?	Condom.....1 Oral pills.....2 Emergency contraceptive pills.....3 Injectable.....4 Withdrawal method.....5 Safe period/calendar method.....6 Other (specify).....		FP_USE
20	How often do you use family planning contraceptives?	Occasionally.....1 When the need arises.....2 Not often.....3		FP_USEFREQ
21	Did you use FP contraceptive in your last sexual act? If no skip to 26	Yes.....1 No.....2		FP_LASTSEX
22	What FP contraceptive method did you use	Please specify.....		FP_TYPESEX

	in your last sexual act?			
23	Have you ever had contraceptive failure? If no skip to 28	Yes.....1 No.....2		FP_FAILURE
24	If yes, what did you do about the FP contraceptive failure?	Went to family planning provider...1 Took an emergency contraceptive..2 Did nothing.....3 Other(specify).....4	IF NO QN 2 8	FP_FAILREA CTION
25	Where do you often get your FP contraceptives when you need them?	Health centers /hospitals.....1 Chemical shops/pharmacy.....2 Friends.....3 Other specify.....4		FP_SOURCE
26	Why don't you use FP contraceptives?	Give reason(s).....		FP_NONUSER EASON

Section D:Barriers to utilization of family planning services among married women of fertility age in the Ga West Municipality

37	What are the main barriers to family planning services? (please tick)			
A	Bad attitude of health workers	Agree.....1 Disagree.....2		FP_ATTII
B	Health facilities providing FP services are not friendly	Agree.....1 Disagree.....2		FPP_UNFRI
C	Stigmatization against FP contraceptive users	Agree.....1 Disagree.....2		FP_STIGMA
D	Disapproval	Agree.....1		FP_DISAPPR

	l or opposition from husband	Disagree.....2		OVE
E	Fear of FP contraceptive side effect	Agree.....1 Disagree.....2		FP_SIDEFFEC T
F	Family planning causes infertility	Agree.....1 Disagree.....2		FP_INFERTIL E
G	Conflict with religious conviction	Agree.....1 Disagree.....2		FP_REL
H	Inadequate knowledge on the effectiveness and use of FP contraceptives	Agree.....1 Disagree.....2		FP_KNOWL
I	Family planning increases quality of children	Agree.....1 Disagree.....2		FP_VALUE
J	Cost of family planning services	Agree.....1 Disagree.....2		FP_COST
K	Non availability of FP services	Agree.....1 Disagree.....2		FP_AVAILAB LE
L	Poor accessibility of family services	Agree.....1 Disagree.....2		FP_ACCESS

Appendix 2: Consent form

INFORMED CONSENT FORM

Title: Barriers to Family Planning among married women in the Ga West Municipality, Greater Accra

Researcher: Barbara Comfort Ahorsu

Research supervisor: Dr. Alfred Edwin Yawson

Address: School of Public Health, University of Ghana, Legon

Introduction

My name is Barbara Comfort Ahorsu, a Master of Public Health student of University of Ghana. As part of my academic requirements, I am conducting a study on the barriers to family planning among married women of fertility age.

General information about the research

Studies have shown that a number of family planning programmes and services has been carried out to help couples reduce their fertility rate so as to reduce population pressure on resources in the Ga West Municipality. Despite the appreciable involvement of married women in the family planning programme in the district, married women involvement and use of family planning methods is very low causing them to have higher number of children. Family planning programs can prevent sexually transmitted infections (STIs), including HIV, by promoting male and female condoms for dual protection. Family planning also prevents unintended pregnancy which can lead to unsafe abortion, maternal and child mortality.

I am doing this study on married women of fertility (15-49 years) to find out the factors that influence low or non-use of family planning methods. The information that will be obtained from the married women will help us understand why they don't use family planning contraceptives and also help us make informed decisions to improve family planning use.

If you agree to participate in the study, I would interview you concerning your knowledge on family planning and factors that affect your choice and decision to use family planning contraceptives.

Possible benefit

We will understand barriers to family planning among married women of fertility age.

Possible risk and discomfort

There is no risk associated with your participation in the study.

Confidentiality

All information you provide will not be disclosed to anyone and your name will not appear in any report or publication. The information will be kept in a safe place and only the researcher will have access to the information.

Compensation

There is no cost to you for participating in the study.

Voluntary participation and right to leave the study

You are invited to participate in the study and your participation is voluntary.

You can refuse to withdraw from the study for any reason without any consequences.

Please feel free to ask questions at any time regarding this study. You will be given a copy of the consent form if you agree to participate in the study.

Contact for additional information

If you have any question about the study, please feel free to contact Barbara Comfort Ahorsu, MPH student, University of Ghana, Tel – 0208322783 Email: ahorsuakorfa@gmail.com

Dr. Alfred Edwin Yawson (Supervisor), Email: aeyawson@ug.edu.gh

Voluntary agreement

The above document describing the benefit and risk of the study has been read and explained to me.

I have been given the opportunity to ask any question on the study and it has been answered to my Satisfaction. I understand that I have the right to withdraw from the study at any time without any consequences.

Name of Participant.....

.....

Date

.....

Signature/thumbprint of participant

Declaration by witness (if participant cannot read the form herself)

I was present while the benefits, risks and nature and purpose of the study were read to the participant. All questions were answered and the participant has agreed voluntarily to take part in the study.

.....

.....

Date

Name and signature/thumbprint

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this study have been explained to the above individual.

.....

.....

Date

Name and signature of participant

