

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

**FAMILY PLANNING METHOD CHOICE AMONG MARRIED WOMEN IN
THE GOMOA WEST DISTRICT.**



**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, 2012

DECLARATION

I hereby declare that except for quotations and references to other works which have been duly acknowledged, this dissertation is a result of my own work and that it has not been presented either in whole or part in any university for the award of another degree.

.....

.....

Millicent Okletey

Date

(Student)



.....

Dr. Ayaga .A. Bawah

Date

(Supervisor)

DEDICATION

This work is dedicated with love to the memory of my late father Vital Moses Narteh Okletey. He gave me the greatest gift a father can give a daughter and the desire to excel. He taught me to be strong of heart in all situations.

It is to my husband Augustine Annan and my son Kojo Baidoo Annan for their incredible support, understanding and encouragement.

To my mum and siblings who patiently prayed with me and gave encouragements throughout this write up.



Acknowledgement

My profound gratitude goes to the Almighty God in his sovereignty made it possible for me to go through this course successfully.

My sincere thanks go Dr. Ayaga A. Bawah for supervising my work. I am grateful for his advice, essential and fruitful comments, patience and guidance throughout the research period.

I would like to acknowledge the generous help and advice of Dr. Augustine Ankomah head of department of Population, Family and Reproductive Health, School of Public Health Legon

I would like to thank my field supervisor, Dr. Yaw Ofori Yeboah and the entire staff of Gomoa West District Health Directorate for their support during data collection.

I greatly appreciate the medical superintendent, Dr. Ameh and his staff at the catholic hospital Apam, for providing accommodation and making sure we had something to eat during our stay at the Gomoa West district.

I am grateful to all the young ladies who helped in the data collection Naomi, Hannah, Mary, Abigail and Sarah.

To my friends and colleagues I say thank you for your support, advice, encouragement and contributing in diverse ways during the writing of this dissertation.

Shirly thanks for accepting to transcribe the focus group discussion.

Finally my special thanks go to the Ministry of Health for granting me scholarship to pursue this course.

Contents

DECLARATION	ii
Acknowledgement	iv
LIST OF TABLES	viii
LIST OF FIGURES	ix
ACRONYMS	x
DEFINITION OF TERMS	xi
CHAPTER ONE	1
1.0 INTRODUCTION	1
1.1 Background of the study	1
1.2 Statement of the problem	4
1.3 Justification	5
1.4 OBJECTIVES	6
1.4.1 General Objective	6
1.4.2 Specific Objectives	6
CHAPTER TWO	7
2.1.0 Family planning method choice and method use in general	7
2.1.1 Family planning method ever used and reasons for discontinuation	8
2.1.2 Current use of family planning method and reason for use	10
2.2.0 Socio-demographic factors and family planning method use	12
2.2.1 Age	12
2.2.2 Number of children/parity	13
2.2.3 Educational level of women	14
2.2.4 Female Autonomy	15
2.2.5 Spousal Communication and Partner Involvement/Support	15
2.3.0 Family Planning Service Delivery Factors	16
2.3.1 Availability of preferred method	16
2.3.2 Restriction to Service	17
2.3.3. Parity restriction and spousal request consent	18

2.3.4 Financial cost of family planning method.....	19
3.0 METHODS	20
3.1 Study Design.....	20
3.2 Study Area / Location	20
3.3 Conceptual framework.....	23
3.3.1 Variables	26
3.4 Target population	26
3.5 Sampling	26
3.5.1 Sample size calculation for the quantitative component.....	26
3.5.2 Sampling method for quantitative data collection	27
3.5.3 Sample size for qualitative component	28
3.5.4 Sampling method for qualitative data collection	28
3.5.5 Inclusion/ Exclusion Criteria	29
3.6 Data collection techniques/methods and tools	29
3.7 Quality Control.....	30
3.8 Data Processing and Analysis.....	31
3.9 Ethical Consideration/ Issues	32
3.9.1 Pretesting/Pilot Study.....	33
3.9.2 Limitations	33
CHAPTER FOUR.....	35
4.0 RESULTS	35
4.1.0 Socio-demographic characteristics of respondents	35
4.2.0 Types of Contraceptive methods ever used among married women and reasons for discontinuation.....	38
4.2.1 Family planning methods ever used among married women.....	38
4.2.2 Reasons for family planning method discontinuation and method ever used.....	40
4.3.0 Current use of family planning method among married women	41
4.3.1 Reasons for current family planning method use among married women in Gomoa West District.....	44
4.4.0 Chi-square test to determine associations between socio-demographic characteristics and type of method choice	47
4.4.1 Multinomial logistic regression on selected socio-demographic characteristics of married women and family planning method choice in Gomoa West District.	49

4.5.0 Services delivery factors on family planning method use	51
4.5.1 Availability of choice of method	51
4.5.2 Information given to clients on choice of method	52
4.5.3 Laboratory test and spousal consent request	55
4.5.4 Cost of contraception and method choice	58
CHAPTER FIVE	59
5.0 DISCUSSION	59
5.1 Types of Contraceptive methods ever used among married women and reasons for discontinuation	59
5.1.2 Current family planning method use and reasons for use	61
5.2.0 Selected socio-demographic and family planning method choice and use	63
5.3.0 Service delivery factors influencing family planning method choice and use	64
5.3.1 Financial cost of family planning method	66
CHAPTER SIX	68
6.0 CONCLUSIONS AND RECOMMENDATIONS	68
6.1 Conclusions	68
6.2 Recommendations	69
APPENDICES	74

LIST OF TABLES

Table 4.1.0: Background Characteristics of respondents in the Gomea West Districts.....	37
Table 4.2.0: Frequency distribution of married women who have ever used contraception by age specific method in the Gomoa West District.....	39
Table 4.3.0: Frequency distribution of age of married women and current use of family planning method by specific methods in the Gomoa West District.....	43
Table 4.3.1: Reasons for current family planning method use among married women in Gomoa West District.....	46
Table 4.4.0: Chi-square test to determine association between selected socio-demographic characteristics of respondents and the type of method choice.....	49
Table 4.4.1: Multinomial logistic regression of selected socio-demographic characteristics (independent variable) of married women and family planning method choice (dependent variable) in Gomoa West.....	50
Table 4.5.0: Service delivery factors on contraceptive use in the Gomoa West District.....	51
Table 4.5.1: Cost of family planning method and current method use by specific method....	57

LIST OF FIGURES

Figure 1: A conceptual framework showing the relationship between explanatory variables and family planning method choice.....	25
--	----

ACRONYMS

AIDS	-	Acquired Immune Deficiency Syndrome
DHD	-	District Health Directorate
DHS	-	Demographic and Health Survey
DMPA	-	Depo-Medroxy-Progesterone Acetate
FGD	-	Focus Group Discussion
GDHS	-	Ghana Demography and Health Surve
GHS	-	Ghana Health Service
GNPP	-	Ghana National Population policy
GSS	-	Ghana Statistical Service
HIV	-	Human Immunodeficiency Virus
IUCD	-	Intra Uterine Contraceptive Device
LAM	-	Lactational Amenorrhoea Method
LTM	-	Long-Term Method
PRB	-	Population Reference Bureau
STM	-	Short-Term Method
TFR	-	Total Fertility Rate
UN	-	United Nations
WHO	-	World Health Organization
WIFA	-	Women In Fertility Age

DEFINITION OF TERMS

Family Planning Method: Spacing or limiting child birth by using traditional or modern means

Married woman: Any female between age 15-49 who is married by ordinance, customary or cohabitating.

Choice: The chance or ability to choose between different things. For the purpose of this study, choice and preference will be used interchangeably.

Social Network: Includes friends, neighbours, extended family, church and youth groups, political and other informal associations where women socialize and can obtain information on issues including family planning.

Woman: A female between 15-49 years.

Ever User: A married woman who has used any form of contraception/family planning method sometimes in the past but was currently not using any method at the time of data collection.

Discontinuation: Having used a contraceptive method in the past whether or not the method was properly used or provided adequate protection against unintended pregnancy.

Current User: A married woman who was using any form of contraception at the time of data collection irrespective of the duration of use and switching between methods.

For the purpose of this study, family planning and contraception will be used interchangeably.

ABSTRACT

Introduction: Global population increased to 7.0 billion in 2011 and nearly all of that growth is in the developing countries. Sub-Saharan Africa of which Ghana is not an exception has the highest fertility rate in the world. The GDHS (2008) report indicates that contraceptive prevalence rate has decline in the past five years to 24% in 2008. The Gomoa West District Health Directorate 2010 annual report indicates that family planning acceptor rate has reduced from 40% in 2009 to 33% in 2010 and Depo provera is the choice of method among women. The slow pace of family planning usage in Ghana poses a challenge to the country's goal of reducing maternal mortality through the use of family planning. It is therefore necessary to examine the factors associated with family planning method choice among married women in the Gomoa West District to help plan interventions to meet those needs.

Methods: A population-based cross sectional survey using both quantitative and qualitative instruments was employed for data collection. Women In fertility Age (WIFA) between the ages of 15-49 years who were married, resident in the Gomoa West District and have ever used or were currently using any method of contraception as at the time of the survey were sampled for the study.

Results: Thirty-five percent had ever used family planning method sometime in the past but currently are not using any method whereas 64.5% were currently using. The most ever used modern method is the Injectables (72.9%), the Pill (16.8%) and the Implants accounted for 8.4%. Little over half (50.5%) ever users discontinue due to side effect of the method while 20% was due to desire to have another child. Modern methods are the most preferred methods (97.5%) while 2.5% use traditional method. Injectables accounted for 60%, Implants (17.4%) and the Pill (11.8%) respectively and method use increase. Sixty-eight percent of current users were for spacing births, 22.5% for limiting and 8.5% for preventing unintended pregnancy. There was statistically significance between age, number of children and educational level and the choice of family planning method use.

Conclusion: Injectables (Depo provera and Norigynon) is the preferred choice of family planning method among married women in the Gomoa West District. Health service delivery factors such as frequent stock outs of family planning commodities, non-availability of method

mix as well as lack of appropriate and quality information on methods might have contributed to the low uptake of Long-Term Methods.

Keywords: family planning method, current user, ever user, discontinuation, choice

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background of the study

Global population increased to 7.0 billion in 2011 and nearly all of that growth occurred in the developing countries (Population Reference Bureau, 2011). Sub-Saharan Africa of which Ghana is not exempted has the highest average fertility rate in the world (Sharan, Ahmed, May & Soucat, 2009). The World Bank (2009) reported that the Total Fertility Rate (TFR) in Sub-Saharan Africa was 5.1, more than twice that of South Asia, Latin America and the Caribbean. High fertility rate coupled with inadequate spacing between births, can lead to high maternal and infant mortality (Mekonnen & Worku, 2011).

In 2010, the World Health Organization estimated that a total of 358, 000 maternal deaths occur each year worldwide and 99% of these deaths occur in developing countries (WHO, 2010). The same report showed that nearly two-thirds of the maternal deaths (204, 000) occurred in sub-Saharan Africa. Family planning and spacing of births is one of the strategies that can be used to avoid these deaths (Ali, Rayis, Mamoun & Adam, 2011). Addressing the current desperate state of maternal health in sub-Saharan Africa should therefore be considered as a global public health problem if sub-Sahara Africa is to achieve the Millennium Development Goal 5 (Improving maternal and reproductive health). Vital to achieving this goal is the prevention of unintended pregnancy through increasing access to and use of effective contraception.

Family planning is the process of fertility regulation whereby individuals adopt contraceptive methodologies or other means to regulate the number of children they would want to have. It is often adopted either for spacing or stopping of childbearing (WHO, 2005). Family planning

allows individuals and couples to expect and get their desired number of children by spacing and timing when to have children and this is achieved through the use of contraceptive methods. In addition to spacing and limiting the number of children, it improves maternal health, empowers women and enhances their economic development (Ferdousi et al., 2010). A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy (WHO, 2012). Making a decision as to whether to have or not to have children is among some of the difficult decisions a woman has to make pertaining to her reproductive health (Gertner, 1989). This is because the ability of women to take control over their reproductive decisions rest on the opinion of the social world. Reproductive decisions and choices are most likely to meet a person's needs based on precise, relevant information given to the individual.

“The concept of informed choice in family planning can be applied to a wide range of sexual and reproductive health decisions which focuses on the reproductive and sexual right of the individual as to whether to seek to avoid pregnancy, whether to space and to time, when to have children, whether to use family planning and what method to be used, whether or when to continue or switch methods’ (Olaitan, 2011).

The principle of informed choice focuses on the individual and for most women; family planning decisions also reflect a range of outside factors such as economic, environmental, gender roles and female autonomy, social networks, partner support and religious beliefs. To some degree these factors influence the individual's decision on when to have children, contraceptive preferences, sexual and reproductive behaviour (Oladeji, 2008).

Reports from the International Conference on Population and Development gave directives that; countries are to recognize the appropriate family planning methods for couples and individuals who differ according to their age, parity, family size preference and some other factors. The same report emphasized that, countries are to make sure that men and women have access to information on contraceptives and the widest possible range of safe and effective family planning methods in order to enable them to exercise free and informed choice (UNFPA, 1996). Available data indicates that, when contraceptive methods are limited, it prevents the individual and couples to get a method that suits their needs which results in lower levels of contraceptive use. This is because individuals and couples go through different stages in their reproductive life cycle and their needs and desires may change. They may shift from wishing to delay childbearing, to space pregnancies and finally to stop childbearing. Moreover, many marriages and unions break up and new ones are formed (Bruce, 1990). Using both observed and simulated information, Anrudth (1989) found that increasing the number of family planning methods available in a country and enhancement in the quality of family planning services by expanding the choice of different family planning methods available would improve in the general practice of family planning and this can result in fertility reduction.

A study done in five countries showed that, each new method of contraception introduced in a national family planning intervention seems to add an additional level of contraceptive use to the existing contraceptive prevalence and similar increases were found in South Korea, Thailand and Hong Kong (Freedman & Berelson, 1976). A study done in Matlab Bangladesh, by Phillips and colleagues (Phillips et al., 1998) revealed that, increasing the choice of contraceptive methods increased overall prevalence. This finding was coherent with the assumption that a better choice

through easier access to methods leads to contraceptive use by couples which could lead to greater satisfaction and fewer unintended pregnancies (Ross, Hardee, Mumford & Eid, 2001).

The choice of a family planning method cannot be achieved if there is inadequate supply. Therefore providing a choice for couples does not essentially mean that every facility should provide all the methods but the entire effort on what is suitable to a particular geographical area, must be acceptable so that potential users have equitable access to different types of family planning methods (Bruce, 1990).

1.2 Statement of the problem

One of the goals of the Ghana National Population Policy (GNPP) 1994 was to reduce the Total Fertility Rate (TFR) to 4.0 by 2010 and to 3.0 by 2020 by increasing modern contraceptive prevalence rate to 28 percent by 2010 and to 50 percent by 2020. The policy target is to achieve a minimum birth spacing of at least two years for all births by 2020 (GNPP, 1994). As a result, family planning programmes were designed by the government of Ghana to regulate the number and spacing of children within a family, basically to control population growth and reduce the TFR in order to ensure that each family has equal access to the limited resources of the country (Hong, Fronczak, Chinbuah & Miller, 2005).

People choose contraceptive methods that are commonly used in their community because other people have used it and they tend to get more information about these methods (Oladeji, 2008). The Ghana Demography and Health Survey, 2008 report showed that, there has been substantial increase in contraceptive use in the late 1980s and 1990s, from 13 to 22 percent among married women. However, over the past decade, increases have been dwindling. The contraceptive prevalence rate increased from 22% among currently married women in 1998 to 25% in 2003, and has declined in the past five years to 24% in 2008 indicating a reversal in the trend (Ghana Statistical Service, 2009). The slow pace of family planning up take in Ghana poses a challenge

to the country's goal of reducing maternal mortality through the use of family planning. Indeed, several questions need to be asked regarding the recent decline in contraceptive use rates in the country as shown by the most recent GDHS report. Is it an issue of lack of proper implementation of Ghana's population policy? Or does it have to do with general lack of interest among women in contraceptive use? Or perhaps, it has to do with factors that are yet to be understood? Several researches have been done on family planning in Ghana but that of the Gomoa West District have not been fully explored. It is therefore essential to examine the factors associated with family planning method choice among married women to help plan and draw programmes to meet those needs.

1.3 Justification

The 2008 GDHS report showed that, the Central Region recorded a high TFR of 5.4 which is above the National TFR of 4.0. Compared with other regions of the country, it was among the regions that recorded low (17%) of any modern method of contraception. This high TFR coupled with low contraceptive use will result in increased population growth rate with its socio-economic and health implication on the people especially women.

The 2010 Annual Report of the Gomoa West District Health Directorate in the Central Region indicated that *depo-medroxy-progesterone acetate* (DMPA) popularly known as Depo Provera is the preferred family planning method choice followed by male Condom, the Oral Contraceptive Pills (OCP), and injection Norigynon. Family planning acceptor rate also decreased from 40% in 2009 to 33% in 2010. The observed situation in the District could be associated with the method mix available in the various health facilities in the District. The age of women opting for a method, number of children they have and intention for use whether for spacing or for limiting could be taken into consideration. Some of these factors might have affected the method

preference in the district. This study is intended to provide some understanding of the socio-demographic and service delivery factors associated with family planning method choice among married women in the Gomoa West District. Findings from the study will provide information that would help orient and improve family planning services, programs and interventions as well as inform health education campaigns on family planning. It would also be an important tool for the District health programme planners and policy decision makers when reviewing their strategies for improving family planning services.

1.4 OBJECTIVES

1.4.1 General Objective

To assess the factors which are associated with family planning method choice among married women in the Gomoa West District.

1.4.2 Specific Objectives

The study intends to achieve the following specific objectives.

1. To determine the types of contraceptive methods use among married women who are currently using or have ever used a method of family planning in the Gomoa West District and reasons for the choice of methods.
2. To describe the socio-demographic factors associated with family planning method choice.
3. To explore health services delivery factors affecting women's choice of family planning methods.

CHAPTER TWO

2.0 LITERATURE REVIEW

Literature was reviewed on factors which are associated with family planning method choice and method use such as socio-demographic and health services delivery.

2.1.0 Family planning method choice and method use in general

Couples use family planning methods to either limit size of their family or delay the next birth.

Decision to initiate family planning use differs according to the circumstances of couples and individuals concerned. Couples using family planning to stop having children adopt contraception when they have had the number of children they want. When contraception is used to space births, couples may start to use family planning earlier with the intention of delaying a possible pregnancy. Awareness of contraceptive choice is vital for improving women's reproductive health and providing effective family planning services. Women make contraceptive decisions based on information from early adopters in their social networks (Kohler, 1997). Conversations about the contraceptive experience of early adopters tend to focus on current contraceptive use as a result, if early adopters tend to favour Pill, then Pill users will have a higher representation in social networks, then the diffusion of information will tend to favour this particular method. 'Nine out of every 10 contraceptive users in the world rely on modern methods' (UN contraceptive prevalence wall chart 2007). Short-acting and reversible methods are more commonly used than other methods in developed countries whereas longer-acting and highly effective methods are used more frequently in the developing countries. Thus, in developed countries, method choice is highest for the pill (16%) and the male condom (14%). Globally, traditional methods are considered as non-effective. In developing countries however these methods are still being used in Western Asia, Middle and Western Africa (UN, 2009). A study done among women attending antenatal clinic in Nigeria confirm this finding as majority

of respondents prefer the traditional methods (52.7%) followed by modern (artificial) method. Surgical (sterilization) was the least preferred modern method (Adinma, Agbai & Nwosu, 1998).

Mekonnen and Worku (2011) in their study among women in their reproductive age in South Central Ethiopia revealed that the calendar method, Lactational Amenorrhoea (LAM) and withdrawal (16.5%, 14.5% and 12.3%) respectively had ever been practiced by married women.

2.1.1 Family planning method ever used and reasons for discontinuation

The GDHS (2008) report showed that 60% of currently married women have used a method of contraception at some time in the past. Fifty percent of the proportions of ever users have used a modern method whereas 29% have used a traditional method. The Pill was the most commonly used method among currently married women (23%) followed by injectables and the male Condom (19%) each.

Frost and colleague (Frost, Singh and Finer, 2007) observed similar findings in a study conducted in the United States (U.S) which showed that 38% of women in the study use the Pill whereas 32% use the male condom. The high level of Pill and Condom could be attributed to the fact that these studies were carried in developed countries where education among women is high and they could remember to take their medication.

In contrast to these findings, a case control study conducted among Human Immunodeficiency Virus (HIV) positive and negative women in South Africa revealed that majority (69%) of the participants self-reported using the barrier method mainly the male condom and 56% used the hormonal method. However, among those who used the hormonal method, injectables were more commonly used than Oral Contraceptive Pill (Kaida et al., 2010). The study further showed that HIV positive women were more likely to use the barrier method (condoms). This observation however could be due to the fact that the study was conducted in a high HIV prevalence setting

where usage is more likely to be related to prevention of infection. For example, South Africa has the world's largest absolute number of people living with HIV (UNAIDS Global Report, 2010). The study setting could therefore have influenced the method preference among women.

A study done in Brazil revealed that hormonal methods are the most common discontinued method among women followed by the condom. Reasons that were given by study participants for discontinuation of hormonal methods specifically the Pill were due to side effects such as nausea and vomiting, headaches, dizziness, stomach ache, cramps and swelling and bleeding between cycles. The same proportion of women who discontinued reported that the Pill made them lose weight while others complained of weight gain. Results from the study further showed that small proportion of the women stated that lack of accessibility and cost of the contraception was the reason for discontinuation (D'Antona, Chelekis, D'Antona & Siqueira, 2009).

Parr (2003) found that, contraceptive discontinuation was higher among women with primary education and in the younger reproductive ages. The same study showed that wanting another child or having a recent pregnancy was highly reported among women between 20-40 years. Concern about one's health was more prevalent among women who were above 30 years than among younger women. Health concern was more likely to be reported among women who used the Pill or Injectables. Parr also asserts that relatively high percentage of women who used condom or withdrawal reported opposition by their partners. Problems with supply particularly issues about the cost of methods formed major reasons for discontinuation.

Side effects, lack of accurate information and misinformation can be a reason for discontinuing a method. Women who discontinue use due to side effect perceive that it will interfere with spousal sexual relation and a sense that the side effects signify divine disapproval (Casterline & Sinding, 2000).

2.1.2 Current use of family planning method and reason for use.

The GDHS (2008) report showed that about one in four married women (24%) was currently using some method of contraception. Modern methods of contraception account for almost all use with 17% of married women reporting use of a modern method as compared and 7% using a traditional method. The most widely used methods among married women are Injectables (6%), Pills and rhythm (5%) respectively followed by male Condoms and female sterilization (2%) each. The same report showed that, among currently married women, the proportion currently using modern method of contraception rises with age from 8% of those who were less than 20 years to 19% among 35-39 and 40-44 after which it declines. Female sterilization is mostly used by currently married women age 40 years and above and among younger women, but less than 1% use sterilization. Apart from women who were 45-49 years, Injectables and rhythm are the two most commonly used by married women in every age group. Apart from women in their late 40s, Pills are the third most commonly used method after injectables and rhythm in every age group.

A study done in Vietnam by Dang (1995) reported that 60% of currently married and non-pregnant women use a contraceptive and most of these women rely on modern method precisely the IUCD. The same study indicated that, when the study participants fertility and background variables were controlled, the odds of contraception use rose with each five-year age group. The study further showed that, age has no influence as to whether couples use a modern or traditional method. However the odds of method use among women with no formal education was 34% lower than among women with secondary or higher education. The observed findings from this study could have been influenced by the study setting where the survey was done.

In a nationwide survey conducted among married women in Kuwait, Shah et al., (2001) found that about 52% of Kuwaiti married women were currently using some form of contraception at the time of the survey and 79% reported they had ever used a family planning method some time in their lives. Three quarters of the married women were using modern methods of contraception at the time of the survey. Oral Contraceptive Pill (OCP) was the leading method which was followed by the Intra Uterine Contraceptive Devices (IUCDs). The same study also revealed that contraception was generally used for spacing children. This confirms a similar finding from a study conducted among women in the United State of America (U.S.A) which indicated that 38% of women who use family planning method, use the pill but in contrast Frost, Singh & Finer (2007) found that 32% prefer the male condom. The observed situation could be that, in developed countries, there are more educated women who can make their own decisions on which methods they want to use.

Black et al., (2009) did a study in Canada and found that among contraceptive users, the most frequently used methods of contraception were condoms (54.3%), oral contraceptives (43.7%) and withdrawal (11.6%) and the choice of contraceptive method varied by age. Further analysis from the same study found significantly higher odds of no contraceptive use among those who were over 40 years old and those without higher education which will be discussed in subsequent sub-section. A study done in the Brazilian Amazon (D'Antona, Chelekis, D'Antona & Siqueira, 2009), showed that married women prefer sterilization and have low acceptability of reversible method especially the hormonal method. This finding could have been influenced by the characteristics of the type of health services in the study area. They also extended their sample of women beyond those who were married or sexually active in reproductive age to include those who were unmarried and those who have already passed their reproductive period. A research

done in rural Southeastern Nigeria showed that, majority of the clients accepted injectables hormonal contraceptives (71.8%) followed by the IUCDs (14.4%). The Implants were accepted by 6.9% and female sterilization was accepted by 3.2% (Chigbu, Onwere, Kamanu, Okoro & Feyi-Waboso, 2010).

Mekonnen and Worku, 2011 in a study in South Central Ethiopia found that, about 25.4% of married women were practicing family planning at the time of the study and three-fourth of the women who were using family planning method prefer Depo-provera, then about 10% and 6.1% of the women choose the Pill and Implants respectively. The study further revealed that only 68% of the women indicated that their partners supported the use of family planning in the study area. This might have accounted for high preference for the Depo-provera which can be used without the knowledge of the one's partner.

2.2.0 Socio-demographic factors and family planning method use

Research around the world has found that many factors affect contraceptive use and studies have shown that women's age, parity, educational level and residence in urban areas were significantly and positively associated with current use of family planning method (Khan & Rahman, 1996; Mahmood & Ringheim, 1996; Shah et al., 2001). The husband's view on family planning also has been consistently found to be a significant factor affecting contraceptive use (Joesoef, Baughman & Utomo, 1988; Mahmood & Ringheim, 1996).

2.2.1 Age

Currently married young women are less likely to use long-acting and permanent family planning method. This could be that, young currently married women would like to have children and therefore will resort to short-acting methods which they could discontinue any time they want to have children. A study conducted in the U.S among young women (15-24 years) at risk of unintended pregnancy indicated majority of respondents were using the barrier methods

specifically condoms (44%) followed by the oral contraceptive pill and then injectable. Only few (2%) in the same study were using implants (Raine, Minnis & Padian, 2003). The GDHS 2008 report showed the male condom (3.6%), the pill (1.3%), and injectables (0.2%) were the most commonly used modern method of contraception among married women between the ages of 15-24. Whereas older women, (45-49 years) are more likely to opt for more permanent and long-acting method of contraception. Khan, Mishra, Arnold & Abderrahim 2007, also observed similar trend when a comparative study was done in developing countries analyzing data from the Demographic and Health Survey.

2.2.2 Number of children/parity

Available data indicates that, multiparous women are more likely to use a long-acting method than women with fewer children. Adinna, Agbai & Nwosu (1998) in their study reported that, as compared with other women, multiparous women with five or more children used the Intra Uterine Contraceptive Device (IUCD). This finding could be that these women might have achieved the desired number of children and are therefore using this method to either limit or stop childbearing. A study using data from the 1988 Vietnam Demographic and Health Survey found that women with three or more children were more likely to use a modern method than were those with fewer children (Dang, 1995). Khan and Rahman (1996) in their study found that the Injectables, IUCDs were the preferred choice by relatively young or women with low parity. This indicates that these women tended to adopt a more effective and LTM for spacing. In contrast and as expected, the permanent method was the preferred choice by relatively older or high parity women.

2.2.3 Educational level of women

Studies have shown the association of a woman's education on contraceptive decision making and choice as well as having an influence on women reproductive desires and behaviours. A study done in Nepal showed that women with secondary or higher education are more likely to use hormonal methods. Results from the same study indicated that, the use of condoms and traditional methods of contraception rose with education (Gubhaju, 2006). This is because educated women can learn about and use modern contraceptive methods more effectively than uneducated women. The study further revealed that availability of injectables in Nepal might have contributed to its accessibility. However, uneducated women in Nepal are likely to use sterilization because government programmes promoting contraceptive usage are targeted at uneducated women. This could be that higher fertility rates were observed in women with little or no education in Nepal. The study design might have influenced the findings of this study. Similar findings were observed in Pakistan where about 43% of educated women were using the pill while 21.4% were using injectables. Among uneducated women in the same study, 32.5% prefer the pills and about 23% had tubal ligation. The same paper asserts that educated women can learn about the use of contraceptive more effectively than uneducated women. Also education empowers women with increase autonomy in every aspect of life. Findings from Khan and Rahman (1996) found that, in Bangladesh the use of Pill and other methods (Condoms and traditional methods) increased with education whereas the use of the permanent methods (female sterilization) by relatively poor or uneducated was particularly explained by the provision of incentives offered by the family planning programme.

2.2.4 Female Autonomy

Female autonomy is the ability of the woman to take decisions without necessarily requiring permission from their male partners. In the context of fertility female autonomy therefore implies the ability for a woman to actually take decisions about her reproductive choices such as controlling her fertility in a safe, affordable and effective ways without requiring permission from her husband or partner. Results from a study conducted by Stephenson, Beke & Tshibangu (2008) in the Eastern Cape of South Africa indicates that, there is the probability of women who control their earnings to use the pill and a more permanent method rather than the injectables. This is because these women who have control over their reproductive health are able to make decisions for themselves and do not need permission from their partners before deciding which family planning method to use.

2.2.5 Spousal Communication and Partner Involvement/Support

A panel study in the Kasina Nankana District of Ghana affirms that husband-wife communication about family planning predicts contraceptive use when other factors were controlled. The study further revealed that discussion among couples promotes contraceptive use (Bawah A., 2002). Many women are unable to communicate their personal preferences because of fear of physical desertion by their partners. It is not amazing that many women choose methods of contraception that do not require their partner's knowledge (Maharaj, 2000). Available studies showed that, in many African countries like Ghana, males often dominate in making important decisions in the family including reproduction, family size and contraceptive use (Caldwell & Caldwell, 1987; Adongo et al., 1997). In Indonesia, a study conducted by Joesoef, Baughman and Utomo, 1988 found that a husband's support was the most momentous and influential issue in contraceptive use. This finding could be that the study setting is Muslim

dominated and religion might have contributed to the results. Moreover, both Islamic and cultural traditions support the dominant role of the husband in decisions regarding family life. That is husband's approval plays an important role in decision to practice contraception. High levels of injectable use were among women whose husbands disapprove of family planning. Therefore a woman who perceives that her partner may not approve the use of contraceptives may use it in secret (Magadi & Curtis, 2003).

Marchant et al., (2004) from their study found that majority of respondents (women) reported that their partners were the major decision-makers regarding fertility issues in marriage. As a result most women in the study used family planning without their partner's knowledge. Since men are the principal decision makers in marriage, their choice of a family planning method will be taken into consideration before a woman could opt for a method. Considering one's partner choice could affect women choice.

2.3.0 Family Planning Service Delivery Factors

2.3.1 Availability of preferred method

The choice of methods available plays a vital role in women's acceptability of family planning and enables them to sustain their continuation of use (Ross, Hardee, Mumford & Eid, 2002). A range of family planning methods available increases the chance that prospective users will find the methods that best suit their reproductive needs. (Freedman & Berelson, 1996; Ross, Hardee, Mumford & Eid, 2002). The method mix can reflect provider bias, supply problems, client attitude towards method, preferences, values, and convictions all of which gives a clear insight of what is lacking in service provision (Bertrand & Knowles, 1994). Family planning methods available to clients may not only affect the likelihood of contraceptive use, but can also influence the method women will choose (Pebley & Brackett, 1982). In their study, Pebley and Brackett

however collected data on availability of specific methods that is the Pill, IUCD, Condom and female sterilization which might have influenced their results. They also used the knowledge of a family planning outlet as a measure of availability in their analysis. This can cause bias in their findings since knowledge of a family planning outlet does not necessarily mean the methods are available. They also assumed that contraceptive availability significantly increases the possibility that women will practice contraception. A study done in Nigeria among educated women in Edo state indicates that the Pill was more available and easy to purchase due to the stigma attached to the use of Condoms (Osemwenkha S.O. 2004).

2.3.2 Restriction to Service

The presence or absence of barriers to fertility regulation is an essential determinant of the pace of fertility decline or its delay in many countries. Some of these barriers are: limited method of choice, medical restriction, provider bias and misinformation. The collective consequence of several inhibiting factors preventing women from easy access to fertility regulation may be slight but yet influential that couples who desire to space or limit family size may not be able to achieve their goals (Campbell, Sahin-Hodoglugil & Potts, 2006). In Ghana, situational analysis of data collected from a purposive sampling of providers known for creating barriers to services in two surveys conducted in 1993 and 1996 revealed a wide variety of service restrictions which hinder access to family planning methods. Some of the restrictions include marriage requirement, minimum age restrictions, parity, and spousal consent request as well as laboratory test requirement (Stanback & Twum-Baah, 2001). However, in Stanback and Twum's study, they used a "negative deviance" strategy by targeting providers who were most likely to impose restrictive barriers to services. This made their sampling method a purposive one and this might have contributed to the observed findings in their study. A study conducted in Pakistan among field-workers who distributes contraceptives in communities, showed that one-in-five family

planning field-worker belief that couples should have at least two sons before they begin using contraception and almost half believe that no one younger than 21-25 years should use the Pill (Shelton, Bradshaw, Hussein, Zubair, Drexler & Mckenna, 1999). Stanback, Qureshi , Sekadde-Kigonde , Gonzales and Nudley, 1999 in their study found that service providers require that women who access family planning services be menstruating as a proof that they are not pregnant at the time they start using a hormonal method or IUCDs. The same report indicates that substantial proportion (67%) of non-menstruating women in Cameroon and 78% in Kenya were denied family planning. They therefore concluded that simple history taking could provide an effective way of excluding pregnancy.

2.3.3. Parity restriction and spousal request consent

Konje and Ladipo (1999) in their study noted that providers can be over enthusiastic in their control of contraception supplies and as a result impose inappropriate contraindications for their use. In many countries, some providers discourage nulliparous women from obtaining oral contraceptives and IUCDs. For parity restrictions, Stanback and Twum-Baah, 2001 found that providers were of the view that women must have a minimum number of children before they can be given a method. This is because many of the providers (94%) believe that, the hormonal method particularly the injectables could delay fertility or cause permanent infertility. Also for IUCD, providers added that the cervix of some of the clients' were tight. The study further revealed that providers who requested for spousal consent were of the view that family planning is a decision of both partners and the husband might oppose family planning or the wife's choice. Moreover, service providers request for non-evidence-based requirement that women be menstruating as a proof that they are not pregnant at the time they start using hormonal methods or IUCD is common and therefore women who were not sure were asked to do pregnancy test before service was provided.

2.3.4 Financial cost of family planning method

The cost of contraceptives varies extensively in different markets and between branded and generic products. A study done by Levin, Caldwell & Khuda, 1999 in rural Bangladesh to find out if cash prices influenced family planning choices, it was realized that respondents put little emphasis on cost. Studies done in Egypt, Nepal, Pakistan and Zambia by Casterline and Sinding (2000) revealed that not only the fear of health side effects of contraceptives deters women from using a method, but also the financial cost of managing the side effects as well as potential loss of labour and productivity.

CHAPTER THREE

3.0 METHODS

3.1 Study Design

A community based cross sectional analytic study design was used for the quantitative (questionnaire survey) part of the study and a descriptive design was used for the qualitative (Focus Group Discussions) between May-June 2012. The respondents were Women In Fertility Age between the ages of 15-49years who are married, residents in Gomoa West District and have ever used or are currently using any method of family planning. These respondents were purposively sampled for the study.

3.2 Study Area / Location

Gomoa West District is one of the seventeen Districts in the Central Region. The District was split into two, Gomoa East and West Districts in 2008. The Gomoa West District covers an area of one thousand and twenty-two (1,022.0) square kilometers. It is bordered on the east by the Gomoa East District; on the west and northwest by Mfantiman Municipal and Ajumako- Enyan-Essiam districts respectively; on the north and northeast by Agona West and Effutu Municipals and on the south by the Atlantic Ocean. The District is further sub-divided into 6 sub-districts which are Apam, Mumford, Dago, Oguaa, Osedzie and Onyadze sub-districts. The District has seven towns and Area councils for local administration. The district capital is Apam which is about 68km from Cape Coast, the Regional Capital, and 69km from Accra.

The district has a population of 135,189 with 100 well demarcated settlements and localities (GSS, 2012). The population growth rate is estimated at 2.4%. Most of the major communities and medium-sized towns are found along the coast with fishing as their main economic activity. The Fante-speaking group (Gomoa), constitute majority of people in the district and they are

mainly farmers. However, there are pockets of Ewe and Ga speaking people along its coastal beaches who engage in fishing just like any coastal town. Most of the communities are connected to the national electricity grid. There are two Paramount chiefs in the Gomoa West District. They are Assin Paramountcy and Gomoa Ajumako Paramountcy. The traditional capital is however at Gomoa Assin.

A significant characteristic of the District population is the high rate of migration of the people. It is observed that the migration trend is heaviest towards the cocoa growing areas of other districts and regions. This has led to a significant male-female population disparity. This observation can be explained by the fact that more males than females migrate from the area. The “Gomoa Two Weeks” - a two week -return home of Gomoa migrants from other areas in Ghana to have family re-unions and attend local festivals attests to the migrant nature of the people.

The District experiences two rainfall seasons that is; the major rainfall season occurs between April and July and the minor season occurs between September and November. Just like other districts in the coastal belt of the Central Region, dry seasons are experienced mostly between December and March. This pattern is however changing with the major rainy season starting late and thus reducing in its duration. Mean annual rainfall currently ranges between 70 and 90mm in the Southern coastal belt and between 90 and 110mm in the North-Western semi-deciduous forest areas.

The District experiences two wind systems, the south-western monsoon winds, whose direction influences the rainfall pattern and the north-eastern trade winds (dry harmattan winds). The effects of the harmattan winds are felt terribly between January and February.

The District has two main vegetation zones; these are the coastal savannah and the moist semi-deciduous forest. Lands in the District generally slopes gently from the coastal south to the north with isolated hills on forest dissected plateaus in the north, and coastal plains in the south. The district is one of the deprived districts in the Central Region and the inhabitants are mainly fishermen and subsistence farmers. The seasonal nature of economic activities (fishing and farming), has contributed enormously to the poor socio-economic situation in the District. This has led to the seasonal migration of the people especially the youth to other districts for survival. Most of the crops grown by farmers are maize, cassava, water melon, pineapple, vegetables among others. There is also salt winning during the dry season. There are natural resources like rivers, streams, lagoons, beaches, forest reserves, quarry stones and traces of mineral deposits in the District.

Water supply, sanitation and waste disposal possess an emerging problem threatening the health status of all the major communities in the district. Of all the numerous problems these factors poses, solid waste disposal is most highlighted in communities like Apam, Mumford and Dawurampong. Most of the communities do not have a refuse site and a final waste disposal site. The situation in Apam, the District capital is described as critical since it is the most populous town in the district. Most inhabitants do not have toilet facilities in their homes and tend to defaecate in the bush, on the beaches and on refuse dumps. Despite numerous health educations, behavioural change has woefully been insignificant. Emanating from this sticky situation are the main health problems such as diarrhoea, skin infections, malnutrition, high incidence of typhoid and infant mortality rates (www.ghanadistricts/district Ion 1.com)

Even though about 93 percent of the settlements have pipe-borne water systems, potable water is not flowing through them for some because the pipe lines are being re-laid throughout the

District and people need to pay to be connected. Therefore, most communities rely on water supplied by tankers from Winneba, hand dug wells, boreholes and streams.

Although the Gomoa West District has many access roads, most of these roads are in deplorable conditions and as a result, majority of the communities do not have easy access to transport. All the current telecommunication networks in the Country can be accessed in almost all the communities in the District.

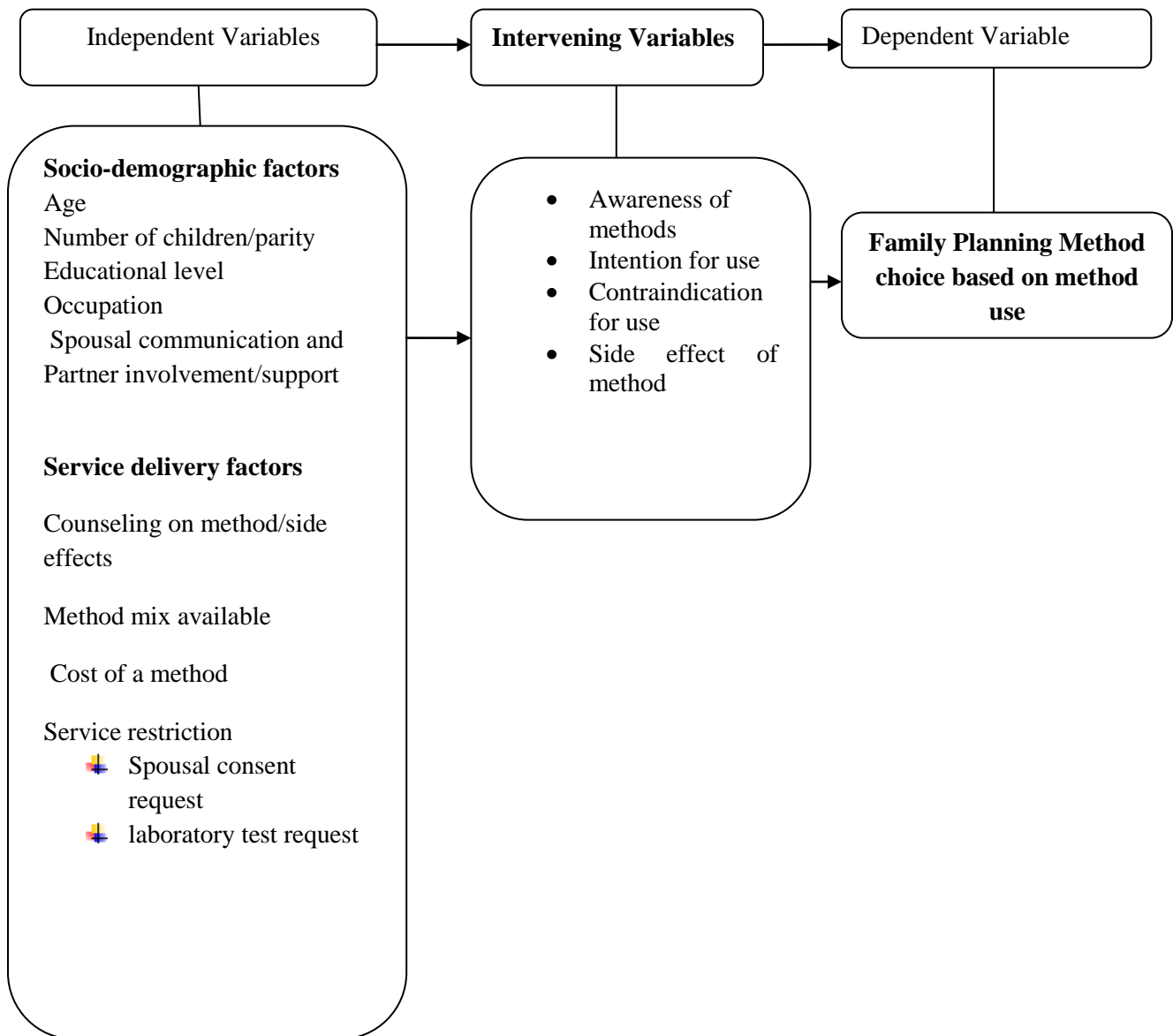
There are currently twenty-five health institutions in the District. That is: one mission hospital, two community clinics, six health centers, one Reproductive and Child Health (RCH) unit, one Nutrition Rehabilitation Centre, thirteen functional Community-Based Health Planning Services (CHPS) Compounds and one private maternity home. The overall health situation in the district, especially the level of utilization is very low due to many causative factors some of which are economic and socio-cultural. Gomoa West District was chosen for the study because 2010 District Health Directorate (DHD) report showed that the acceptor rate for family planning has dropped from 40% to 33%.

3.3 Conceptual framework

Figure 1 depicts a conceptual framework that explains the pathways through which the independent variables (socio-demographic and service delivery factors) affect the dependent variable (family planning method choice). Family planning method choice was divided into long-term, short-term and traditional methods. Several factors determine the choice of contraception and method use among married women. Researches around the world have established that many factors influence contraceptive use and method choice. Women's age, parity, educational level, Occupation and female autonomy were significantly associated with current use and method choice (Khan & Rahman 1996; Mahmood & Ringheim, (1996); Adinna,

Agbai & Nwosu 1998; Gubhaju, 2006 ; Stephenson, Beke & Tshibangu 2008). Other studies have also found that, the association between husband's approval and support has a bearing on contraceptive use and method choice (Joesoef, Baughman & Utomo, 1988,). Moreover, women who communicate and discuss reproductive issues with their partners are more likely to adopt and use contraception which will eventually affect method choice (Bawah, 2002). Service delivery factors which can affect contraceptive use and method choice among married women are method mix available, counseling and education on choice of methods as well as cost of method. This will further determine if married women will opt for modern or traditional method and if a modern method is adopted will subsequently lead to whether the woman will choose Long-Term Method (LTM) or Short-Term Method (STM). The intervening variables are interplay between the dependent variable and the independent variables. These variables of which health service providers have little control over could have an effect on method choice and method use.

Figure 1: A conceptual framework showing the relationship between explanatory variables and family planning method choice.



3.3.1 Variables

The variables which were measured include; socio-demographic characteristics of the respondent and factors that are associated with method preference such as: socio-demographic and health services delivery factors (independent variables) and the dependent variables are family planning method choice based on use which could be modern or traditional method. Married women, who opt for a modern method, could choose either long-acting or short acting depending on the intention for use.

3.4 Target population

The study population was currently married women in their reproductive age and was either currently using any method of family planning or had ever used any method in the past. The researcher restricted the sample to the above target group because the interest was only to know the methods currently being used by women or those that they had ever used and reasons for their choice of method.

3.5 Sampling

3.5.1 Sample size calculation for the quantitative component

The GDHS (2008) report indicates that 24% of currently married women are using any method of family planning and this was used to decide the sample size for this study. The sample size was calculated using the formula below:

$$n = \frac{Z^2 P(1-P)}{d^2}$$

at a 95% confidence interval and a margin of error of 5%

Where n = sample size.

P = estimated proportion of married women who use any method of contraception.

d = margin of error (standard value of 0.05).

Z = confidence level (standard value of 1.96).

$$\text{Therefore, } n = \frac{(1.96)^2 \times 0.24 \times (1 - 0.24)}{(0.05)^2} = 280$$

To make up for possible effects of non-response rate, 10% of the sample size was added to 280 giving a total sample size of 308.

Field work yielded 320 and 310 completed questionnaires was included in the analysis.

3.5.2 Sampling method for quantitative data collection

Gomoa West District is sub-divided into six (6) sub-districts namely; Apam, Dago, Mumford, Ogua, Onyadze and Osedzie. The six (6) sub-districts were sampled proportionate to the size of the population of women of reproductive age. The total population of women of reproductive age in the entire District was the target population. The total population of women of reproductive age in the entire district is 28,307.

Sample size (n) =308

Therefore, total number of participants is distributed as follows; Apam (65), Ogua (71), dago (67), Mumford (41), osedze (42) and Onyandze (23) making a total sample size of 309

The six (6) sub-districts with each having at least three (3) health facility zones, the names of all the communities in the sub-district were numbered on pieces of paper and one community was randomly selected from each zone. Using one health facility as a land mark, the community is divided into four and data collectors were distributed to the four sections. On arrival in a household, a screening question was asked to identify women of reproductive age who are married and are either currently using or have ever used a contraceptive. Depending on the number in the household, about two to three respondents were systematically selected and interviewed until the desired sample size was obtained. When the quota for the sample was not achieved, a neighbouring community in the same sub-district close to the randomly selected

community was included in the sampling. Field work yielded 320 but 310 completed questionnaires were included in the analysis.

3.5.3 Sample size for qualitative component

Four (4) Focus Group Discussions (FGDs) were conducted. Each group had between 6-7 participants to ensure effective participation and easy moderation. Participants were married women between 17 – 44 years. Two FGDs were conducted among family planning users at chosen clinics offering integrated family planning services. The remaining two FGDs were conducted in a neutral setting in the community without particular selection for family planning use amongst community members. A total of twenty-Six (26) married women participated in the FGD. The FGDs helped to explore and probe participants' opinion on ideal family size, family planning decision-makers, and perceived problems associated with achieving ideal family size, as well as health services delivery and socio-demographic factors that hinder family planning method choice were discussed.

3.5.4 Sampling method for qualitative data collection

A purposive sampling method was used to select participants for the FGDs. The six sub-districts were divided into two zones. Ogua , Onyadze and Osedzie sub-districts formed one zone and Apam, Dago and Mumford sub-districts were also grouped as one. With the help of family planning service providers in the facilities, women who reported at the family planning clinic for either continuation or as first time clients were approached and the purpose of the study explained to them. The women were asked if they would participate and when they consented to be part of the study, they were included. These women formed the FGDs for women who were currently using family planning methods at the facility setting.

During the community survey, married women who completed the questionnaire were informed about the focus group discussion session. After they were briefed about the objectives of the

study, verbal consent was obtained from each study participant and when they consented to be part of the discussion, they were included. They formed the second group of current and ever users in the community for the second group of FGD session.

3.5.5 Inclusion/ Exclusion Criteria

Respondents included in the study were married women (either ordinance, customary or cohabitating) between the ages of 15-49 years and were either currently using or had ever used a method of family planning. Women excluded were women under age 15 years, non-users of family women above forty-nine years and those who were not married, as well as married women undergoing infertility treatment. Additionally, women on visit to the district were not interviewed.

3.6 Data collection techniques/methods and tools

A structured questionnaire was used to collect the quantitative data and an interview guide for the FGDs was used for the qualitative data collection. The GDHS (2008) questionnaire on contraception was adopted and modified to suit the quantitative study.

The questionnaire was used to obtain socio-demographic information including district of resident, age, number of children, educational level, occupation, religion, ethnicity and the highest educational level attained by respondents. Additional information obtained include availability of method choice and cost of method, intention for use, reasons for discontinuation or switching methods, where the current method was obtained and information given by providers on chosen method. Focus Group Discussion sessions were conducted in areas chosen on the basis of convenience and in isolation from the general community. Participants were arranged in a semicircle fashion to ensure eye contact with participants as well as minimize formality. Two female facilitators conducted each session, the principal researcher led and moderates the discussion while the trained assistant observed the discussion and was taking

notes. Sessions were moderated such that, the views participants who were contributing more were balanced with the views of the more reserved individuals. Guidelines for the discussion were outlined for participants to be guided in the discussions but the actual flow of discussions within a given topic was quite free and all participants were encouraged to participate in the discussions. Care was taken to ensure that all topics on the FGD guide for the discussion received equal attention and emphasis.

In each zone setting, there was one group each of women between the ages of 17-32 and 33-44 to help participants of a particular age group to express their views and contribute effectively to the discussion. Care was taken that married women from the same household were not recruited in the same FGDs to prevent non-participation. The FGDs were conducted in 'Twi' by the principal researcher and where participants needed clarification, the trained assistants explained to them in Fante. The discussions were taped-recorded, transcribed verbatim into English.

3.7 Quality Control

This involves measures put in place to guarantee that data collected is of good quality to ensure that results obtained are accurate and valid. The following measures were put in place to ensure quality control.

- Female research assistants with appropriate background were recruited and trained for two days so that they will have basic knowledge and techniques in data collection and also adhere to ethical principles regarding protecting study participants from harm in the research.
- During data collection process, questionnaires were coded with respective research assistant's serial number and initials. Completed questionnaire were double checked each day on the field and within 24 hours to ensure all information has been properly collected

and recorded. Also feedback on unclear responses and omission were noted and confirmed from respective research assistants.

- Errors and omissions detected were discussed with identified research assistant and where necessary, they were asked to go back and make corrections.
- Data collected that was obviously inconsistent were not included in data processing and analysis.
- Data collected was entered twice by two different personnel to ensure validity. The principal researcher ascertained how the data was coded and entered into the computer.

3.8 Data Processing and Analysis

Data cleaning was done and only completed questionnaires were entered into Statistical Package for Social Sciences (SPSS) for data processing and analysis. Recoding of some of the responses were done and transferred to STATA version 11 for analysis. Results from the analysis were presented using descriptive statistics. Further bivariate (cross tabulations) were done and chi-square test was done to determine the associations between selected demographic characteristics of respondents and family planning method choice (Long-Term Method, Short-Term Method and Traditional method).

Multinomial logistic regression was used for modeling family planning method choice. Where the socio-demographic factors showed some form of association in the chi-square test, they were included as the independent variables. Categories of family planning methods (the dependent variable) in the multinomial logistic regression were: Long-Term Method; including female sterilization, Intra Uterine Contraceptive Device (IUCD) and the Implant. The Pill, Injectables (Depo provera and Norigynon), male Condom, Emergency contraception and Lactational Amenorrhoea Method (LAM) constitute Short-Term Method. Traditional Methods were

rhythm/calendar method and withdrawal. The reference category of the dependent variables was traditional method. The logit coefficient was exponentiated to translate it into odds ratios an approximation of relative risk. A significance level of 5% was considered hence all associations with a p-value less than 5% were considered significant.

Notes were taken during the FGDs and findings were confirmed by listening to the recordings. Transcribed responses were categorized, ordered, coded and analyzed manually. Themes arising from the focus group discussions were incorporated in the quantitative findings.

3.9 Ethical Consideration/ Issues

The dissertation proposal was sent to the Ghana Health Service Research Ethics Committee for approval before embarking on the study. Permission to conduct the study was sought from the District Assembly as well as from the District Health Directorate of Gomoa West District. Permission was also sought from the chiefs and elders of the communities which were randomly selected for the survey before commencing the study.

All the participants (married women) were provided with voluntary informed consent both written and verbal. Information letters and consent form were available in English and intensive explanations given in 'Fante', 'Twi' and 'Ga/dangme' to ensure participants have comprehensive understanding of the study objectives, potential risks and benefits and assurance of confidentiality. Participants were given the opportunity to refuse to participate and the right to opt out at any point in the course of the interview. Participants' confidentiality and privacy was respected during questionnaire administration and FGDs. Names of participants were not used in the write-up since both the questionnaire and responses from participants of the FGD's were coded. The findings from the study were reported such that the names of respondents were not used in the write up to reduce possibility of tracing information gathered back to respondents.

All information was treated as confidential. Data collected was only accessed directly by those involved in the research. Data entered in the computer was protected by a code and only known by the principal researcher and any data stored on external drive was kept safely together with the questionnaires and note taken from the FGDs together with any recordings made.

Sensitive information such as use of contraceptive without respondent partner knowledge was protected from public knowledge and was not traced to the participants. The communities in general stand to benefit from the results of this study through dissemination of its findings and its application to improve the health information, education and communication in the District. Even though participants were not compensated or paid for participating in the research, their inputs were recognized and appreciated. The research was self-sponsored and apart from its academic and public health importance, the principal researcher has no personal interest in the study.

3.9.1 Pretesting/Pilot Study

The data collection tools and instruments were validated by pre-testing in Nsuekyir one of the communities Apam. This community was not part of the communities randomly selected for the actual study. The pretesting ensured that respondents did not have any difficulties understanding the questionnaire. Ten of the questionnaires were pre-tested after which corrections were made where necessary.

3.9.2 Limitations

The study purposely selected married women who have either ever used or are currently using family planning method which could have biased the results.

Respondents who were ever users but currently are not using a method might have suffered from recall bias which might have affected the findings from the study.

Due to the sensitive nature of the study, women who were using a method without their husband's knowledge might have denied using a method hence could have resulted in under reporting of current or ever used.

Information on service delivery factors associated with family planning method choice was obtained from respondents which could be subjective.

CHAPTER FOUR

4.0 RESULTS

This chapter provides information on the variables measured and discusses major issues and findings from the study. Data were collected using both quantitative and qualitative technique. The quantitative data was analyzed using STATA version 11 and the qualitative data was manually analyzed. A total of 310 married women between the ages of 15-49 years who were either using contraceptive at the time of the study or had previously used contraceptives were selected for the study. Additional information on intention for use, reasons for discontinuation if they were no longer using and their experiences at the facility where they had the method was obtained. Results from both the quantitative and qualitative have been triangulated and presented according to the variables measured.

4.1.0 Socio-demographic characteristics of respondents

Of the three hundred and ten (310) respondents who were included in the analysis, about half of them (50.3%) were between the age bracket 20-29, followed by the age group 30-39 (35.8%) and 40 years and above constituted 12.3% while those less than 20 years were 1.9%. The average age was 30 years, whereas the minimum and maximum ages were 18 and 49 years old respectively. It was observed that participants of the study were relatively young. Most of the respondents (61.3%) had between 1-3 children with the mean and maximum number of children being 3 and 11 in that order. The highest level of education attained by majority of the respondents was Primary/ Junior High School/Middle School (64.2%) followed by Senior High School/Tertiary (10%) whereas 25.8% of respondents had no formal education. This reechoes the need for girl child education

As seen in table 4.1.0, 45.8% of respondents were traders and fishmongers. Farming was the next highest occupation (19.7%) which was not surprising because economic activities in the

District are mainly fishing and subsistence farming. Seventeen percent of respondents consisting of housewives, students and apprentice were considered unemployed and were not earning any form of income. Respondents who reported as either being professionals or skilled workers were 12.3%. Unskilled workers consisting mainly of female porters and labourers constituted 5.2% of the study population.

The most predominant ethnic group (91.9%) was Fante with few Ga/Dangme, Ashante, Akyem, Akwapim, Ewe and Nzema all together (8.1%). This was to be expected as the indigenous population is predominantly Fante. A great majority of the respondents (90.3%) were Christians with few Moslems, Traditionalist and those who did not belong to any religious group constituting 9.7%. As can be seen from table 4.1.0, 22.9% of the respondents were from the Ogua sub-district, followed by Dago 21.6% Apam 20% and the least were from Onyadze sub-district. This observed trend was because respondents were sampled from the sub-districts proportionate according to the population of WIFA.

Table 4. 1.0 Background Characteristics of respondents in the Gomoa West District (N=310)

Socio-demographic characteristics	freq	percent
Age		
< 20	5	1.6
20-29	156	50.3
30-39	111	35.8
40+	38	12.3
Number of Children		
No child	6	1.9
1-3	190	61.3
4-6	98	31.6
7+	16	5.2
Level of education		
No formal education	80	25.8
Primary/JHS	199	64.2
Secondary +	31	10.0
Occupation		
Professionals/Skilled workers	38	12.3
Trader/Fishmonger	142	45.8
Farmer	61	19.7
Unskilled worker	16	5.2
Unemployed	53	17.1
Ethnicity		
Fante	285	91.9
Others	25	8.1
Religion		
Christian	280	90.3
Others	30	9.7
Place of residence (sub-districts)		
Apam	65	21.0
Mumford	41	13.2
Dago	67	21.6
Osedze	43	13.9
Ogua	71	22.9
Onyadze	23	7.4
Total	310	100

To be able to offer explanations for some of the results obtained in the quantitative data, a total of 26 married women who were either currently using or had ever used family planning method sometime in the past were interviewed using Focus Group Discussions (FGDs). Of the 26 married women who participated in the FGDs, 61.5% had at least primary education, 34.6% no education and only 3.8% had secondary education. Majority of participants (73.1% were traders, 15.4% were fishmongers, 7.7% were skilled workers and 3.8% were unemployed. Most of the participants for the FGDs were currently using family planning methods (84.6%) while 15.4% had ever used a family planning method.

4.2.0 Types of Contraceptive methods ever used among married women and reasons for discontinuation.

4.2.1 Family planning methods ever used among married women

Of the Three hundred and ten (310) married women who reported as either ever used or currently using a family planning method, 109 (35.2%) had ever used family planning method sometime in the past but no longer currently using. Among those women, 98.2% of them used a modern method whereas 1.8% used a traditional method. As shown in table 4.2.0, the most predominant modern method ever used was injectables consisting of Depo provera and Norigynon (72.9%), the Pill contributed 16.8% and the Implants accounted for 8.4%. The Implant was the only Long Term Method (LTM) ever used. However, the male Condom (1.9%) was the least method ever used. The low use of the male Condom could be attributed to the fact that because the focus was on the methods women used, they might have underreported the use of Condom which is mostly used by males.

Table 4.2.0 Frequency distribution of married women who have ever used contraception by age and specific method in the Gomoa West District (N=109)

	All methods ever used	Modern methods ever used	Modern Methods N (%) = 107 (98.2)				Traditional Method
			Implants	Pill	Injectables	Male Condom	N (%) = 2 (1.8)
Age	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	Calendar/ Rhythm method
< 20	2 (1.8)	1 (0.9)	0 (0.0)	0 (0.0)	1 (0.3)	0 (0.0)	1 (50.0)
20-29	46(41.8)	45 (42.1)	2 (22.2)	3 (16.7)	38 (48.7)	2 (100.0)	1(50.0)
30-39	41 (38.2)	41 (38.3)	5(55.6)	9 (50.0)	27 (34.6)	0 (0.0)	0 (0.0)
40+	20 (18.2)	20 (18.7)	2 (22.2)	6 (33.3)	12 (15.4)	0 (0.0)	0 (0.0)
Total	109*	107	9	18	78	2	2
% total		98.2	8.4	16.8	72.9	1.9	1.8

*should have added to 110 but one was recorded as missing value.

4.2.2 Reasons for family planning method discontinuation and method ever used.

Women who reported that they had used a family planning method in the past but were currently not using any method were asked why they stopped using the method. Several factors were enumerated for their discontinuation. Reasons for discontinuation varied from the desire to have another child to respondents defaulting. Of the total number of the 109 respondents, 55 (50.5%) discontinued the method due to side effects. It was observed that most respondents who discontinued because of side effect used Implants, Pill and Injectables all of which are hormonal. Desire to have another child was the second most reported reason for discontinuation by these respondents 22 (20.2%).

Some also discontinued as a result of separation, divorce, partner's death while for others it was due to defaulting 8 (7.3%) each. Partner disagreeing with the method accounted for 7 (6.4%) and 3 (2.8%) of the women was due to menopause. Other factors such as loss of weight, too much weight gain, hair loss and discomfort with the use of Condom (male) were among the other reasons 6 (5.5%) these women discontinued the contraceptive type they adopted. In the qualitative study, participants gave various reasons for discontinuation of a method.

“My husband advice me to do it but it was later when the problems (side effect) came and I informed my mother then she told me to stop because she went through a lot of problems when she did it. She said since our blood is the same, I will also go through the same problems so I stopped.” (FGD Respondent)

“I went for some (implants) and I went to remove it. The month I removed it I got pregnant but I have delivered my baby” (FGD respondent)

“I was using the three months type (Depo provera) and I changed to the five years (implants) but I want to change it because it is making me fat.”

“The reason why I stopped was that it makes my waist pain so hard that I'm not able to do anything again so I stopped. So I wanted to stop and menstruate for some months before I go for another and I got pregnant.”

A 42 year old also discontinued because of menopause “.....me I am not giving birth again (menopause) so I have stopped”

4.3.0 Current use of family planning method among married women

The level of current use of family planning methods is the most widely used and valuable measure of the success of a family planning intervention. It can be used to estimate the reduction in fertility attributable to the use of contraception. As shown in table 4.3.0, among the total number of respondents who reported as either ever used or currently using a family planning method, 200 (64.5%) were using a method of family planning at the time of the study. Modern method of family planning accounted for almost all the methods use. Of the 200 women who reported that they were using family planning at the time of the survey, 97.5% of them reported using modern methods while 2.5% used a traditional method.

Injectables comprising Depo provera and Norigynon were the predominant methods used (60%), followed by Implants (17.4%) and the Pill (11.8%). The least modern methods use were female sterilization and male Condom (4.1%) each. The low reported Condom use as a family planning method among married women could be attributed to the fact that respondents were women and might have reported the method they are using rather than that of their partners. Of the traditional methods, the calendar/ rhythm and withdrawal methods accounted for 60% and 40% respectively.

This observation follows similar trend of contraceptive use in the District as reported by the Gomoa West 2010 District Health Directorate (DHD) annual report. The increase in the use of LTMs especially Implants (17.4%) among current users as compared with ever users (8.5%) could be attributed to an intervention put in place by the DHD to increase the acceptor rate of LTMs in the district. As shown in table 4.3.0, the proportion of married women using any

method of family planning increases with age. That is, it ranges from 1% among married women who are less than twenty years old to 55.4% among 20-29 age group after which it declines to 8.8% among those who are 40 years and above. It is not surprising that the use of contraceptives decline at higher ages because many of these women would have passed their menopausal ages and would probably have no need for family planning. The use of permanent family planning method (female sterilization) by married women increases from 37.5% among those in the age bracket 30-39 to 62.5% among 40 years and above and younger women who are less than twenty years, there is non-use. Apart from married women who were less than twenty years, Implants and Injectables were the most frequently used methods in every age group followed by the Pill and then male Condom. The least methods used were the Emergency Contraception and Lactational Amenorrhoea Method (LAM).

Table 4.3.0 Frequency distribution of age of married women and current use of family planning method by specific methods in the Gomoa West District (N=200).

Age			Modern Method N(%) =195 (97.5)								Traditional Method N (%) = 5(2.5)		
	All methods N (%)	Modern methods N (%)	Long-Term Method N(%) = 44(22.6)			Short-Term Method N(%) = 151(77.5)					Any traditional method N (%)	Calendar /Rhythm method N (%)	Withdrawal N (%)
			Female sterilization N (%)	IUCD N (%)	Implants N (%)	Pill N (%)	Injec- tables N (%)	Male condom N (%)	LAM N (%)	Emer- gency Contra- ception N (%)			
< 20	3 (1.5)	2 (1.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	2(1.7)	0 (0.0)	0(0.0)	0 (0.0)	1 (20.0)	0(0.0)	1 (50.0)
20-29	110 (55.0)	108 (55.4)	0 (0.0)	1(50.0)	18(52.9)	13 (56.2)	67(57.3)	6(75.0)	1(100)	2 (100)	2 (40.0)	2(66.7)	0 (0.0)
30-39	69 (34.5)	68 (34.9)	3(37.5)	0 (0.0)	14(41.2)	9(39.1)	41 (35.0)	1(12.5)	0(0.0)	0(0.0)	1 (20.0)	0(0.0)	1 (50.0)
40+	18(9.0)	17 (8.8)	5(62.5)	1(50.0)	2 (5.9)	1(4.4)	7(6.0)	1(12.5)	0 (0.0)	0 (0.0)	1 (20.0)	1 (33.3)	0 (0.0)
Total	200	19 5	8	2	34	23	117	8	1	2	5	3	2
% Total		97.5	4.1	1.0	17.4	11.8	60.0	4.1	0.5	1.0	2.5	60.0	40.0

4.3.1 Reasons for current family planning method use among married women in Gomoa West District.

Women who reported that they were using family planning methods were asked about the method used and reasons for the choice of the method. Varied reasons were given for current use of family planning method. These were from spacing births to preventing unwanted pregnancy. Majority of married women who were currently using a method were using it for spacing 136(68%). The same proportion of women reported using implants, the Pill, Injectables, male Condom, Emergency Contraception as well as rhythm and withdrawal methods as a way of spacing. Those using for limiting birth 45(22.5%), were using female sterilization, Intra Uterine Contraceptive Device (IUCD), Implants, the Pill, Injectables, male Condom and the rhythm methods. Using it to prevent unwanted pregnancy 17(8.5%) was the next reason given for usage with few stating that they used it to treat infertility and menstrual irregularity (0.5%) each. The types of method used among women who are using it to treat infertility and menstrual irregularities were the Pill and Injectables respectively. Those who were using it to prevent unintended pregnancy were students and apprentice so they could complete schooling and the apprenticeship without any unintended pregnancy. During the FGDs it was observed that, there were misinformation about some of the method and this is what some of the participants has to say.

“People told me that the ten years is dangerous because I might want to have children later and I will not be able to do so. I got scared and went for the three months so if I get five years (Jadelle) I will like it. I want to use that type so that when I decide to have children, I can do that. (FGD participant)”

Due to lack of partner support and involvement, some of the women may be using the method in secret. This is what some of the women said during the qualitative data collection.

“When you use the pills, you might forget and leave it at a place where he will see and will ask what this is or where it is coming from and you will not know what to say. But the injection solves that since you take it once in the hospital and he will not see it let alone ask questions”. (FGD respondent)

“..... my husband asked me to go for the injections because when I take the pills I throw out. So I also went for it. I was using the one month method. And I stopped and went for the pills” and I was vomiting so I went for the three months method. With the three months the nurses recommended that for me”.

“My husband said I should go for the three months method, so I also went and asked for that one. Laughed: in the beginning my husband did not agree but now he even reminds me of my next schedule date”.

“.....for me, it’s because the one month did not work for me that is why I changed to the three months method”.

A 35 year old also gave reason for choosing the method she is using.

“For me I have not done some before but people have been scaring us about the five years method. They also said that when you do that one, your menses will not come and the blood will accumulate in your womb causing fibroid. Some also said that if you take the five years type your heart will be beating and you can even collapse. Since I have done some before, I decided to choose the three month so that if it is good for me then I will take the five years because I do not want to give birth again because I have seven children”.

Table 4. 3.1 Reasons for current family planning method use among married women in Gomoa West District.

Reasons for current method	Modern Methods								Traditional Methods		Total
	Long-term Methods			Short-Term Methods					Calendar/ Rhythm	Withdrawal	
	Female sterilization	IUCD	Implants	Pill	Injectables	Male Condom	Emergency Contraception	LAM			
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	
For spacing births	0 (0.0)	0 (0.0)	25(73.5)	19(82.6)	83(70.9)	6(75.0)	1(50.0)	0 (0.0)	1 (33.3)	1 (50.0)	136 (68.0)
For limiting/stopping birth	8(100)	2 (100)	8 (23.5)	1 (4.4)	23(19.7)	2(25.0)	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)	45 (22.5)
For treating infertility	0 (0.0)	0 (0.0)	0(0.0)	1(4.4)	0 (0.0)	0 (0.0)	0(0.0)	0 (0.0)	0 (0.0)	0(0.0)	1 (0.5)
For treating menstrual Irregularity	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1(0.85)	0(0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0(0.0)	1 (0.5)
Preventing unwanted pregnancy	0 (0.0)	0 (0.0)	1 (2.9)	2 (8.7)	10 (8.6)	0(0.0)	1(50.0)	1(100)	1(33.3)	1 (50.0)	17 (8.5)
Total	8	2	34	23	117	8	2	1	3	2	200

4.4.0 Chi-square test to determine associations between socio-demographic characteristics and type of method choice

As shown in table 4.4.0, a chi-square test was done to determine the association between selected socio-demographic characteristics of respondents who were using family planning method at the time of the survey. The results indicates that the age of a married is associated with whether she will choose Long-Term Method, Short-Term Method or traditional method ($P < 0.01$). In addition to the age of the woman, the number of children a woman has and level of education are also related to the type of family planning method used ($P < 0.01$). Moreover, there is association between the level of education of married women and method choice which is significant but the association is a weak ($P = 0.039$). However, there is no significant association between occupation, discussing family planning with one's partner and the choice of a method of contraception $p > 0.05$ ($p = 0.099$ and 0.609) respectively. This could have been as a result of the study setting as there were few highly educated women in the study population.

Table 4.4.0 Chi-square test to determine associations between selected socio-demographic characteristics of respondents and type of method choice

Age Group	Methods			Total N (%)	P-value
	Long-Term Method	Short-Term Method	Traditional method		
< 20	0 (0.0)	2 (1.3)	1 (20.0)	3 (1.5)	0.002**
20-29	19 (43.2)	89 (58.9)	2 (40.0)	110 (55.0)	
30-39	17 (24.6)	51 (73.9)	1 (1.5)	69 (34.5)	
40+	8 (18.2)	9 (6.0)	1 (20.0)	18 (9.0)	
Number of children					
No child	0 (0.0)	4 (2.7)	1 (20.0)	5 (2.5)	0.009**
1-3	18 (40.9)	93 (61.6)	3 (60.0)	114 (57.0)	
4-6	21 (47.7)	49 (32.5)	1 (20.0)	71 (35.5)	
7+	5 (11.7)	5 (3.3)	0 (0.0)	10 (5.0)	
Educational level					
No formal education	19 (43.2)	35 (23.2)	0 (0.0)	54 (27.0)	0.039*
Primary	21 (47.7)	98 (64.9)	5 (100)	124 (62.0)	
Secondary+	4 (9.1)	18 (11.9)	0 (0.0)	22 (11.0)	
Occupation					
Professional	8 (18.2)	20 (13.3)	3 (60.0)	31 (15.5)	0.099
Trader/Fishmonger	16 (36.4)	71 (47.0)	2 (40)	89 (44.5)	
Farmer	13 (29.6)	27 (17.9)	0 (0.0)	40 (20.0)	
Unskilled worker	1 (2.3)	9 (6.0)	0 (0.0)	10 (5.0)	
Unemployed	6 (13.6)	24 (15.9)	0 (0.0)	30 (15.0)	
Discussing family planning with partner					
Yes	26 (59.1)	93 (61.6)	2 (40.0)	121 (60.5)	0.609
No	18 (40.9)	58 (38.4)	3 (60.0)	79 (39.5)	
Total N (%)	44	151	5	200 (100)	

Note: Statistically significant at * $p < 0.05$; ** $P < 0.01$; *** $p < 0.001$ and $p > 0.05$ is not statistically significant

4.4.1 Multinomial logistic regression on selected socio-demographic characteristics of married women and family planning method choice in Gomoa West District.

Since the dependent variable is a three category variable, the most appropriate model to use is a multinomial logit model. Multinomial models are most appropriate when the dependent is more than two categories without any natural ordering to the different category of the variable. The dependent variable in this case contraceptive method choice classified as a). Long-Term Methods b). Short-Term Methods and c). Traditional methods. The reference category is traditional methods so the interpretation of the results is relative to that class. As shown in table 4.4.1, when the significant socio-demographic factors in the chi-square test were put in the multinomial logic regression model none were significant this is because the p-values were all greater than 0.05 at 95% confidence level.

Table 4.4.1 Multinomial logistic regression of selected socio-demographic characteristics (independent variable) of married women and family planning method choice (dependent variable) in Gomoa West District.

Independent variables (socio-demographic characteristics)	Dependent Variables (Family planning method choice)			
	Long-Term Method		Short-Term method	
	Relative Risk (P-values)	95% Confidence Interval	Relative Risk (P-values)	95% Confidence Interval
Age	1.03 (0.685)	0.883, 1.209	0.996 (0.544)	0.856, 3.575
Number of children				
No child (referent)				
1-4 children	4.4e-07 (0.998)	-9689.92, 9657.65	1.18e-06 (0.998)	-9685.937, 9658.629
5+ children	1.396 (1.000)	--10002.72, 10057.49	3.384 (1.000)	-10024.83, 10027.27
Level of education				
No formal education (referent)				
Some level of education	1.92e-07 (0.990)	-2548.12, 2518.81	4.31e-07 (0.991)	-2548.124, 2518.81
Employment level				
Unemployed (referent)				
Some form of employment	37.857 (0.993)	-792.4403, 2518.002	39.781 (0.993)	-792..3904, 799.7572
Spousal communication about family planning				
No (referent)				
yes	0.664 (0.578)	0.096, 4.579	0.564 (0.544)	0.891, 3.575

Table 4.5.0 Service delivery factors on contraceptive use in the Gomoa West District

Factor	Yes		No	
	N	(%)	N	(%)
Availability of preferred method	254	83.4	51	16.6
Liking the method given for method not available	15	30	35	70
Counselling on the side effect of preferred method	215	70.5	90	29.5
Education on what to do if side effect occurs	177	58.0	128	42.0
Education on other methods available	264	86.6	41	13.4
Urine test request before method provided	222	72.8	83	27.2
Spousal consent request before service provision	37	12.1	268	87.9

4.5.0 Services delivery factors on family planning method use

Service delivery factors that influence family planning method choice and use depend on availability of methods and their inherent variability, the information given to clients, as well as cost of methods.

4.5.1 Availability of choice of method

Out of a total of three hundred and ten respondents, 83.4% had their choice of method while 16.6% did not get their preferred choice of method at the facility they visited. Among those who stated they did not get their preferred choice, 70% did not like the available method they were given. This observation can contribute to discontinuation of method and results in decrease in the acceptor rate of family planning method. Below are some of the responses from the FGDs

“When I went she said the injection was not there and gave me the pills me too I have never used the pills so I don’t like it and she said then I should take the one month type and I rejected that one too and went later to take the three months method”.” said the three months

method will be good for me so I did that one but the last time I went the three months type was finished so I went for the one month. I did not like it but has to take it like that”.

Moderator: *Why?*

“Is just the pain that made me stopped so I waited until the three months type was available then I went for it”.

“When I went they told me it was left with the three months type so I did that one.”

4.5.2 Information given to clients on choice of method

Majority of the respondents (70.5%) said they were counseled on the side effects of the method they chose whereas 29.5% did not receive counseling on the side effects. If the appropriate information on side effects of the method chosen by the women is not given, it could lead to frequent complaints about the method and subsequent discontinuation. Concerning education on what to do if side effects of the method chosen occurs, 58% received counseling while 42% did not receive counseling. As indicated in table 4.0, about 87% of the respondents reported that they were educated on other family planning methods available while 13% were not. Information given to clients differs from giving total information on the various methods available and their side effects to only laying emphasis on some of the side effects to clients. The following were some of the findings from the FGDs.

“The first time I went to the clinic, I told the nurse I wanted to do it and she sat me down to explain the various methods and the way they work. About five different types and I chose the three months type (FGD participant recounted.)

“For me they (service providers) explained everything to my understanding and I know when to do and when I can have my children. Even if I do not have my menses I am not afraid. It doesn't disturb me in any way and I can eat and do everything. It's just too good that I like it”. All participants were laughing and clapping again and again”.

“When I went, I made my choice after the explanations was given on the methods and she told me that with the three months method, some get their menses and some don't. But if I don't, I shouldn't think it's a problem. So truly my menses was not regular so I reported and she said it's nothing.”

A 33 year old also said also recounted that:

“..... there are so many things they talk to you about. With me, they told me to come anytime I have problem so I went home and when I had my menses, It flowed for one week and didn't stop so I went and they said it won't cause any problem. But if I want the pills it will stop the flow. So she gave me her number and said I should call when it stop and call if it doesn't. So I called her and told her that it has passed and she said it will come. She told me to take blood tonic if I see too much blood.

“.....for me I did mine here and they used a book to explain them to me that they have one month, three months, five months and ten years. The one for the young women and those for the old women”.

A17 years old said:

“As for me the nurses told me I can't take the ten years type because I had never given birth. So they explain everything to my mother and I chose the three month type (feeling shy and talking undertone)”.

A 35 year old said:

“For me, I think they (nurses) don’t take their time to explain the various methods and their various side effects because all that I was told were that when I notice any change in my body that I do not understand, I should come. So when I started bleeding for one week, my husband went to the clinic and informs the nurse and a tablet was given for me to take before the blood stopped”.

“For me I realize my stomach was growing big and my husband started complaining about it so I went and told them to get me a drug that will help reduce my stomach laughing so one madam said she had some drugs which helped her stomach to reduce so she will bring me some (FGD participant)”

“They (nurses) told me that sometimes my menses will be more and can also take some time before it will come. Even though I don’t get my menses regular, I am not scared because it has made me fine. I have grown fat but people are saying it is because the blood (menses) is locked (not flowing).”

“.....she brought so many out and explained to me. There and then I asked for the five months method. The woman said the way I am the five years will not work for me so she said I should do the ten years method. So I did the ten years method after she checked me”.

It was also observed from the discussion that providers give information on only the methods available in their facility. This is what a discussant has to say:

“.....for me I don’t know of the type that you said can be placed in the womb. This is my first time of hearing it. The nurses did not talk about it.

One woman lamented and said,

“They (service providers) said some was not there and there isn’t some at all and when you even go to the big cities, there is none there so I decided to choose the three month type”.

(Respondent from FGD)

A 23 year old also shared her experience.

“ For me I did the five years type, I was not told I could lose weight and now everybody is asking me why am losing weight so I want to go and remove it”.

“When I went the nurses explained all the five types and their names so that I will choose the one I want, the nurse did not choose for me. Another woman affirms, yes as for me they showed me five methods”. (Another respondent from FGD)

4.5.3 Laboratory test and spousal consent request

As represented in table 4.4.0, majority of the respondents (88%) reported that, service providers did not request for spousal consent before choice of method given whereas 12.1% indicated spousal consent request was made. Frequent urine test request (72.8%), could be due to the suspicion that, most of the women have low educational level and easily forget about the scheduled date for the next supply. Therefore for the service providers to ensure that those who delay are not pregnant, might request for urine pregnosticone test before service is provided. Spousal consent and urine test requests could restrict service for women who cannot afford for the total cost and this can prevent some of the women from opting to use family planning method. A 33 year old gave account of what transpired when she went to the facility.

“Initially when you go, they (service providers) will ask so many questions (history taking) so that what you know, you will tell them. After they ask you the above questions, she will say there is one month, three months, five months (five years) and ask you to choose. Then you will look at the one that you think you like then you choose it. And they will test you before to see if you are not pregnant. Because some will not know that they are pregnant and will come for the contraceptive, go home and the stomach will begin to show that same month, all laughing. So whether you like it or not you will take a test first.

Another discussant affirms that whether you are menstruation or not some providers still request for the urine test to be done.

“If you go and have had your menses, they will still say you should do the test. Because some will not (might have missed their period) but will say they have. If you were menstruating, they (service providers) will give you cotton wool and ask you to go and bring a bit of your blood to be sure before they give”.

“When I went that was the day I was menstruating I told them and they said no I should go and test and bring the results. They explained that, sometimes people menstruate even when they are pregnant. So it was after they explained that I understood”.

It came to light that some of the clients do not even know why the urine test is requested. When questions were asked as to why they were being asked to bring their urine, one of the participants said, *“Some of us may have diabetes so that if they detect it you can start treating it”.*

Though majority (87.9%) said spousal consent was not requested before service was provided during the questionnaire survey, participants reported they were asked if they had discussed it with their partners. A 29 year old said,

“For me, they (service providers) asked me if I had discussed it with my husband, though I did not discuss it with him because I know what I have been going through to take care of the children, I denied and said yes so they will do it for me”.

Table 4.5.1 Cost of family planning method and current method use by specific methods

Cost of Family planning method	Modern methods		Long-Term Methods		Short-Term methods			
	Long-term Method	Short-Term Method	IUD	Implants	Pill	Injectables	Male Condom	Emergency Contraception
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Less than 1 Cedi	0 (0.0)	18 (12.8)	0 (0.0)	0 (0.0)	6 (27.3)	10 (9.1)	2 (28.6)	0 (0.0)
1-3.99 Cedis	14 (38.9)	100 (70.9)	2 (100)	12 (35.3)	16 (72.7)	79 (71.8)	4 (57. 1)	1 (50.0)
4-6.99 Cedis	12 (33.3)	21(14.9)	0 (0.0)	12 (35.3)	0 (0.0)	19 (17.3)	1(14.3)	1(50.0)
7+ Cedis	10 (27.9)	2 (1.4)	0 (0.0)	10 (29.4)	0 (0.0)	2 (1.8)	0 (0.0)	0 (0.0)
Total	36	141	2	34	22	110	7	2

4.5.4 Cost of contraception and method choice

The cost of a family planning commodity varies with the type of method being use. As indicated in table 4.4.1, LTM costs between 1-3.99 Cedis to 7 .00 Cedis and above whereas STM cost between less than 1.00 Cedis to 7.00 Cedis and above. The cost includes consultation, urine test request and the actual cost of the method chosen. The fluctuating cost of LTM could be attributed to the fact that some of the women had their method under promotional situation. It could also be as a result of the facility which the method was obtained. It is observed that the cost of female sterilization was not known by all the women who opted for it due to the circumstance under which it was opted for. Most of the women assert that, they did it during child birth and for that matter the cost was added to the hospital bill.

When participants of the FGDs were asked if the cost of a method contributed to the choice they make. A 20 year old said,

“.....as for me I did it here and they told me that the three and one month type cost one Cedis, but the five years cost seven Cedis. So I realized that if the one month is one Cedis and I have to be taking this injection for five years then I will prefer the five years that is why I chose the five years”.

A 30 year old also contributed by saying that,

“.....for me it is about the cost. Though I would like to use the five years, I learnt that it cost seven (7.00) Cedis, so I am now saving to go for that one”.

Others also said it is not about the cost though they would like to use the LTM (five years method), it is the misconception people have about it that scares them. And so this prevents them from choosing the five years method.

CHAPTER FIVE

5.0 DISCUSSION

Report from International Conference on Population and Development (1994) directed countries to recognize that appropriate family planning methods for couples and individuals differ according to their age, parity and family size preference. The same report emphasized that, individual countries are to ensure that men and women have access to information on contraceptives and the widest possible range of safe and effective family planning methods in order to enable them to exercise free and informed choice. A number of factors restrain women from deciding whether and when to have a child. These factors include partner's approval and support, availability of family planning method choice, financial cost, provider bias and misinformation. The existence or nonexistence of these factors to fertility control is an essential determinant of the rate of fertility decline or its delay in many towns and communities (GSS, 2009).

5.1 Types of Contraceptive methods ever used among married women and reasons for discontinuation.

The study revealed that 35.2% of married women in the Gomoa West District had ever used a form of family planning method sometime in the past. The most ever used methods are modern methods and the preferred choice of method among married women in the district was the injectables (Depo provera), then the Pill, Implants and male Condom. Though Depo provera remained the preferred choice in the district, the pattern of other methods ever used has changed slightly since the pill and Implant has taken the place of male Condom. The observed result is different from what has been reported in the most recent GDHS (2008) which indicates that 60% of currently married women have ever used a method of contraception. Perhaps the low level of

ever users results from the fact that is a predominantly rural fishing community with a higher preponderance of pronatalism. Also, the observed mix of method use is different from the 2008 which showed that the Pill was the most commonly used method at 23%, followed by the Injectables and the male Condom (19%) each. Period differences or education which followed the publication of the GDHS might have contributed to the observed trend. The observed findings from the study could also be attributed to an action plan set by the District Health Directorate (DHD) to increase the acceptor rate of family planning and also to increase the use of LTM.

The major reasons given for family planning method discontinuation were due to side effect of the method (50.5%) and the desire to have another child (20.2%). Partner disagreeing accounted for 6.4%. Factors that influence contraceptive discontinuation are myriad and varied. A little over half (50.5%) of ever users reported that, they discontinued the method due to side effect and this proportion used Implants, the Pill and injectable which are all hormonal. The second reason given for discontinuation was the desire to have another child (20.2%). Some of the side effects mentioned by participants during the survey and FGDs were weight gain or loss, hair loss and excessive bleeding during menstruation while others were also concern about them not having their menses. This finding agrees with a study done in the Brazilian Amazon by D'Antona, Chelekis, D'Antona and Siqueira in 2009. Their results showed that hormonal method especially the Pill is the most common discontinued method followed by Condom. Reasons for discontinuation in their study were headaches, stomach cramps and swelling and bleeding between cycles. Other reasons are weight gain or lose with the use of the pill partner disagreement and due to menopause. Similar reasons for discontinuation were given during the focus group discussion of this study. Though participants who reported of similar side used the

Implants, both are hormonal. However factors which might have contributed to the findings in the Brazilian Amazon could be that, because female sterilization was the overall preference of the study group, women who use the Pill, after having the number of children they desire eventually would opt for female sterilization. In contrast to Brazilian findings, it appeared that married women in this study do not have a range of methods available to them and for that matter are unable to switch to a method that meet their personal as well as reproductive needs and could have contributed to the discontinuation rate. A study done in Ghana by Parr, 2003 found that, contraceptive discontinuation was higher among younger women in their reproductive age. Justifications given for discontinuation were health problems with the method they were using and wanting to have another child or a recent pregnancy. What might have contributed to this finding could be that, younger women probably were using the method for spacing and when they desired to have more children, discontinued.

5.1.2 Current family planning method use and reasons for use

Among current users, Injectables (60%) were the predominant method use, followed by Implant, the Pill, female sterilization and male Condom in that order but the use of IUCD was low (1%). The low usage of the IUCD in the district could be attributed to the fact that women do not have information on this method as health service providers give information on methods that are available.

It was also noted that, contraceptive use increased with age and declined in older age. This could be attributed to the fact that older women might have exceeded their reproductive age as studies has shown that women are reaching early menopause. In contrast with the finding in this study, Shah et al., (2001) found that the OCP was the leading method followed by the IUCD. The observation could be due to the fact that every country adopts the appropriate family planning methods for couples and individuals who differ according to their age, parity and family size

preference. Furthermore condom use was found to be low in this study which contradicts findings by Frost, Singh & Finer (2007) who found that 32% of their respondents preferred the male condom. The difference may be due to the fact that this study was conducted only among married women whose reason for use of any method was more for spacing than other reason as compared to that of Frost, Singh & Finer (2007) who conduct their study among all women who may have more reasons such as preventing conception as well as Sexually Transmitted Infections (STIs). In contrast to this study, D'Antona, Chelekis, D'Antona & Siqueira (2009) found that, among married women of reproductive age, the irreversible method (female sterilization) is the most common method use by participants of their study. The hormonal methods especially the Pill is the second most commonly used method followed by the Condom, traditional methods and LAM. The difference may be due to the fact that preference for sterilization was a strong feature of the study population and this might have resulted in both early discontinuation as well as non use of reversible methods. The use of injectables which was found to be predominant in this study was similar to the findings in the recent GDHS (2008) report which also found that the injectables were the most used method. Onwere, Kamanu, Okoro and Feyi-Waboso ,2010 in their study found that majority of new clients who visits the family planning clinic accepted the injectables (71.8%), followed by the IUCDs then the implants was accepted by 6.9% and the least method chosen was the female sterilization. Though findings about the injectables agrees with the findings of this study, the other methods opted by respondents of their study was in contrast with that of this study. The authors however could not explain the reason for the choice of respondents. Factors which could have influence their results may be due to factors in the study setting where spousal support and male involvement in family planning is low and as a result, women who desire to use family planning method would have to use it in secret.

The observed results are similar to results reported in the annual district report by the Gomoa West District Health Directorate (DHD) (2010). The increase in the use of LTMs especially Implants (17.4%) among current users as compared with ever users (8.5%) could be attributed to an intervention put in place by the DHD to increase the acceptor rate of LTMs in the district.

Reasons given for contraceptive use in the study were varied. Most of the participants were using for spacing (68.0%) while others were using it for limiting or stopping birth and preventing unwanted pregnancy (22.5%) and (8.5%) respectively. It was noted that the most common methods use for spacing birth include Implants, Injectables and the Pill. However among those using family planning for limiting child birth, the most common method use were female sterilization, Implants, the Pill and injectables. Few were observed to use IUCD, male Condom, Emergency contraception, LAM, Calendar and withdrawal. One will expect that those who desire to limit birth should have opted for the LTM whereas those for spacing birth, the STM but those who desire to limit birth, some were found to be using STM. In contrast to this finding, D'Antona and colleagues in their study found that women who want to space birth use the reversible method and those who desire to limit will opt for a permanent (irreversible) method. Shah et al finding that most women used the methods for child spacing agrees with the findings of this study. This implies that most women will use a family planning method for child spacing.

5.2.0 Selected socio-demographic and family planning method choice and use

A chi-square test done using age of married women, parity, educational level, occupation and discussing family planning with partner showed that age, parity and educational level of women is associated with a type of contraceptive method used by married women. This finding agrees with studies done by Khan & Rahman, 1996; Mahmood & Ringheim, 1996; Shah et al., 2001. However, there was no significant association between occupation of a married woman and

discussing family planning with partner and the type of family planning method use. In contrast to this finding, Joesoef, Baughman & Utomo, 1988; Mahmood & Ringheim, 1996, Bawah, 2002) found that the husband's view on family planning and communication with one's partner has been a significant factor influencing contraceptive use. Moreover, when the significant variables in the chi-square test were put in a multinomial logit model, none showed any level of significance, though the coefficients were in the expected direction. Factors that might have contributed to this outcome could be due to the sample size used in this study as well as a range of method mix available in the district. It could also be that awareness of methods in the communities might have influence respondents choice. This is because Kohler in his study found that women make contraceptive decision based on information from early adopters in their social networks and therefore if early adopters tend to favour a particular method then users of that particular method will be higher in that particular social network. From the FGDs, it was noted that misinformation about other methods like the Implants and the IUCD might have narrowed the women's choice to variety of methods. Women will therefore have no choice than to use what is available to them. Another factor that could also be that the predictor variables do not influence each other and hence having no associations with the outcome variable.

5.3.0 Service delivery factors influencing family planning method choice and use

Concerning availability of methods in the facilities respondents visited, majority (83.4%) had their choice whereas 16.6% did not get their preferred choice. However, among those who did not get their choice of method, 70% stated they did not like the available method that was given by the service provider especially those that were given the injection Norigynon. This was confirmed by a participant in the FGD who has to wait till she had her preferred choice. This situation can lead to discontinuation rate which will further result in decrease in acceptor rate of contraception and consequently result in unintended pregnancies. The non-availability of method

choice could be related to what was observed by Bertrand and Knowles, 1999. In their study, they found that the method mix can be as a result of provider bias, supply problems or client attitude towards methods. Findings from this study was confirmed during the FGDs as some of the participants' reported that they are not aware of existence of the IUCD as a method for family planning until the day of the discussion. Others also mentioned that service providers just mention what was available as at the time client was accessing service. As a result they have no choice than to choose from what was available. This was observed during data collection as there was shortage of the injectables at some of the facilities and clients' have to use the Pill while waiting for resupply of the injectables. When women's choice of a method is available, it helps them to sustain continuation of use.

Thirteen percent of the respondents reported that they were not educated on other methods available when they accessed service at the facility. Women who are not given information about other methods they could use might not be able to switch methods in case they react to the method they opted for initially. Some of the women who participated in the focus group discussion reported that they were asked about the method they wanted without giving any information on other methods available. Majority of the respondent asserts that they were counseled on the side effects of the method they choose and a little over half (58%) also confirm they were told what to do if side effects occur. An observation made during the FGDs was that women who were given information about side effect were not afraid when it occurred. Whereas those who were not educated on the side effect of the method they chose had to go back to the facility to report before they were educated and reassurance given. As a result, those who were currently using as at the time of the discussion were agitating of discontinuation. It also appeared that emphasis were laid on problems client may have with her menstrual cycle like amenorrhoea,

spotting and excessive bleeding neglecting other side effects like headache, weight gain or loss with the use of the hormonal during the counseling session.

Most of the respondents stated that urine test was requested before service was provided (72.8%) whereas 27.2% reported that urine test was not requested. Some of the participants from the FGDs reported that even though they informed the service providers they have had their menses; providers explained that some women may be pregnant but still be menstruating. Others who went to the facility while in their menses were asked to take a sample of the flow for inspection before they were given the method. Majority of the respondents reported that spousal consent was not requested before service was provided. However service providers asked if they had discussed it with their partners before deciding to use a method. Some of the participants during the FGDs said they denied and said yes they had discussed it with their partner so that providers will render services to them. The observed situation in the district could be attributed to the fact that literacy level is low among women and for that matter some of them forget their schedule dates which could lead to unintended pregnancies. It appeared that women in the district are not given enough information on a range of family planning method available to them so they can make informed choice. Emphasis is laid on problems clients may have with their menses neglecting other side effects especially with the hormonal.

5.3.1 Financial cost of family planning method

Majority of the respondents reported that they paid some amount for the method they opted for while 17% said either it was free, do not know or could not remember the cost of the method. Among those who did not know the cost, it was noted that almost all of them had the female sterilization and as a result the cost was added to the hospital bill. Among those who do not remember, it was observed that some were ever users and had the method some time back and for that matter might have forgotten about the price. When respondents were asked if the price or

cost of the method informed them to choose, majority said no while a few others said they calculated the cost of the long-term method and that of the short-term method and they decided to opt for the long-term method. Still for some who desire the long-term method but due to financial constrain has to opt for the short-term method so they could save enough money to be able to pay for the long term method. Therefore individual women choose a type of method depending on how they could pay for that method. However for women who desire long-term method but are not using is because of misinformation they have about the Implants. Non-users in the communities where these women live are of the view that if they do not have their menses, they can develop fibroid, have heart attacks or even become barren. These and many other reasons were given for not opting for the Implant.

CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

This study shows that married women who are 40 years and above are more likely to fall within ever users because at this age, they may either be approaching or be in their menopause and hence will not think of having more children or spacing birth. Married women who are using the hormonal (Implants, Pill and Injectables) are likely to discontinue use depending on the intensity of perceived side effect of the method. Current contraceptive use increases with age and decline with women who are 40 years and above.

Injectables (Depo-provera and Norigynon) are the choice of family planning method among married women in the Gomoa West District. Most of the participants of the study were using the family planning method for spacing births which might have accounted for the use of the short-term method.

There is a strong relationship between the age of a married woman and the choice of family planning method. Moreover, the level of education and the number of children a woman has influence her choice as to whether to choose long-term or short-term family planning method.

It appears that some of the women lack adequate information about the IUCD and the Implants. Health service delivery factors such as frequent stock out of some of the family planning commodities in the District, non-availability of method mix as well as lack of appropriate and quality information on methods might have contributed to the low usage of Long-Term Methods in the Gomoa West District. Furthermore, service providers give adequate information women on the methods that are available at the facility and not on all family planning methods.

6.2 Recommendations

The National Stores and other stakeholders should ensure there is frequent supply of family planning commodities in the country to curtail frequent shortages of the commodities at the Regional Medical Stores and the Districts as a whole.

The Central Regional Medical Stores should have mechanisms of alerting the various districts in the regional when they sense that there will be the possibility of shortage of family planning commodity so the districts can request for more depending what they have in stock.

The District Health Management Team (DHMT) should sensitize the communities and reach married women by using new educational strategies such as married women who are using the Long-Term Method specifically the Implant and the IUCD to share their experiences with other women to motivate them to opt for these long-term methods. This strategy can be done through community durbar and target women groups and organizations in the district.

The District Health Directorate should organize in-service training or refresher courses for the service providers in family planning counseling and education.

The District Health Directorate should motivate its staff to train or sponsor hardworking staff who are interested in midwifery to increase the number of midwives in the District so that they can provide services for the clients who genuinely will need the IUCD.

REFERENCE

- Adinma J.I., Agbai O. A., & Nwosu B. O. (1998). Contraceptive choices among women attending an antenatal clinic. *Adv. Contraception* 14 (2), 131-145
- Adongo P. B., Phillips J. F., Kajihara B., Fayorsey C., Debpuur C. & Binka F. N. (1997). Cultural factors constraining the introduction of family planning among the Kassena-Nankana of Northern Ghana. *Social Science Medicine* 45 (12); 1789-1804
- Ali A. A., Rayis D. A., Mamoun M. & Adam I., (2011) Use of family planning methods in Kassala, eastern Sudan. *Bio Medical Central Research Notes* 4 (43), doi: 10.1186/1756-0500-4-43.
- Anrudth K. J (1989). Fertility reduction and the quality of family planning services. *Studies in Family Planning* 20 (1), 1-16. Stable URL <http://www.jstor.org/stable/1966656>. Accessed 17/07/2012
- Bawah A. A., (2002). Spousal Communication and family planning behaviour in Navrongo: A longitudinal assessment. *Studies in Family Planning*, 33 (2), 185-190
- Bertrand J., Magnani R. & Knowles J. (1994). Handbook of indicators for family planning evaluation. Chapel Hill: Evaluation project.
- Black A., Yang Q., Wu Wen S., Lalonde A. B., Guilbert E. & Fisher W. (2009). Contraceptive use among Canadian women of reproductive age: Results of a national survey. *Obstetric Gynaecology Canada* 31 (7); 627-640
- Bruce J. (1990). Fundamental elements of the quality of care: A simple framework. *Studies in Family Planning* 21 (12); 61-91. Stable URL <http://www.jstor.org/stable/1966669>. Accessed 24/02/2021
- Caldwell J. C. & Caldwell P. (1987). The cultural context of high fertility in sub-Saharan Africa. *Population and Development Review* 13 (3), 409-437
- Casterline J. B. & Sinding S. W. (2000). Unmet need for family planning in developing countries and implications for population policy. *Population and Development Review* 26 (4); 691-723
- Chigbu B., Onwere C., Kamanu C., Okoro O. & Feyi-Waboso P. (2010). Contraceptive choices in rural Southeastern Nigeria. *Nigerian Journal of Clinical practice*, 13 (2); 195-199
- D'Antona A. O., Chelekis J. A., D'Antona M. F. L. T. & Siqueira A. D. (2009). Contraceptive discontinuation and non-use in Santarem, Brazilian Amazon. *Cad. Saude Publica, Rio de Janeiro* 25 (9); 2021-2132.

- Dang A. (1995). Differentials in contraceptive use and method choice in Vietnam. *International Family Planning Perspective* 21 (1); 2-5
- Demographic and Health Survey 2008. Accra, Ghana: GSS, GHS, and ICF Macro.
- Ferdousi S. K., Jabbar M. A., Hogue S. R., Hahmood A. R., Ara R., & Khan N. R.,(2010). Unmet need of family planning among rural women in Bangladesh. *Journal of Dhaka Medical College* 19 (1), 11-15
- Freedman R. & Berelson B. (1976). The record family planning programmes. *Studies in Family Planning*; 7 (1) 1-40
- Gertner N., (1989). Interference with reproductive choice. In Cohen S. & Taub N. (Eds.), *Reproductive Laws of for the 1990s: Contemporary issues in Biomedicine, ethics and society*. Clifton, New Jersey Press, 307-328.
- Ghana National Population Policy revised edition (1994). National Population Council 1994, 56.
- Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF Macro. 2009. *Ghana Gomoa West District profile* Retrieved from ghanadistricts.com/districts1on1
- Gomoa West District (2010). Annual Report obtained from District Health Directorate
- Gubhaju B. (2009). The influence of wives and husbands education levels on contraceptive method choice in Nepal, 1996-2006. *International Perspective on Sexual and Reproductive Health* 35 (4), 176-185
- Hong R., Fronczak N., Chinbuah A. & Miller R. (2005). Ghana trend analysis for family planning services 1993, 1996 & 2002. DHS trend analysis reports No 1 Calverton Maryland USA
- Joesoef M. R., Baughman A. L. & Utomo B. (1988). Husband's approval of contraceptive use in Metropolitan Indonesia: Program Implications. *Studies in family Planning* 19 (3); 162-168
- Kaida A., Laher F., Strathdee S. A., Money D., Janssen P. A., Hogg R. S. & Gray G. (2010). Contraceptive use and method preference among women in Soweto, South Africa: The influence of expanding access to HIV care and treatment services. *PloS One* 5 (11): e13868.doi:10.1371/journal.pone.0013868
- Khan M. M. A. & Rahman M. (1996). Determinants of contraceptive method-choice in rural Bangladesh. International Centre for Diarrhoeal Disease Research (ICDDR) Working paper 117
- Kohler H.P. (1997). Learning in social networks and contraceptive choice. *Demography* 34 (3); 369-383. Accessed from <http://www.jstor.org/stable/3038290> on 17/02/2012

- Levin A., Caldwell B. & Khuda B. (1999). Effect of price and access on contraceptive use. *Social Science & Medicine*. 49 (1); 1-16
- Magadi M. A. & Curtis S. L. (2003). Trends and determinants of contraceptive method choice in Kenya. *Studies in Family Planning*. 34 (3), 149-159.
- Maharaj A. (2000). Promoting male involvement in reproductive health. *Agenda Feminist Media*, 37-47 retrieved from <http://www.jstor.org/stable/4066433>.
- Mahmood N. & Ringheim K. (1996). Factors affecting contraceptive use in Pakistan. *The Pakistan Development Review* 35 (1); 1-22
- Mekonnen W. & Worku A.(2011). Determinants of low family planning use and high unmet need in Butajira district south central Ethiopia. *Reproductive Health Journal* 8 (37), 1-8 doi: 10.1186/1742-4755-8-37
- Millennium Development Goals. Retrieved from www.itu.int/ITU-D/ict/mdg/goals.html. date: 15/02/2012.
- Oladeji D. (2008). Socio-cultural and norms factors influencing family planning choices among couples in Ibandan metropolis, Nigeria. *European Journal of Scientific Research* 23 (2), 212-218
- Olaitan O. L. (2011). Factors influencing the choice of family planning among couples in south west Nigeria. *International Journal of Medicine and Medical Sciences* 3(7), 227-232.
- Parr N. J. (2003). Discontinuation of contraceptive use in Ghana. *Journal of Population and Nutrition* 21 (2); 150-157
- Pebley A.R. & Brackett J. W. (1982). The relationship of contraceptive availability to contraceptive use. *International family Planning Perspective* 8 (3); 84-92. Retrieved from <http://www.jstor.org/stable/2947884>. Accessed: 10/07/2012.
- Phillips J. F., Simmmons R., Koenig M. A. & Chakraborty J. (1988). Determinants of reproductive change in a traditional society: Evidence from Matlab, Bangladesh. *Studies in Family Planning* 19 (6); 313-334
- Population Reference Bureau 2010: Population Data Sheet .Retrieved from www.prb/publications/datasheet/2010/2010wpds.apx. Date: 01/02/2012. Retrieved from: www.hsph.harvard.edu/population/policies/Ghana.htm
- Ross J., Hardee K., Mumford E. & Eid S. (2001). Contraceptive method choice in developing countries. *International family Planning Perspectives*; 28(1), 32-40
- Sarmad R., Akhtar S. & Manzoor S. (2007). Relationship of female literacy to contraceptive use in urban slums of Khushab (Punjab). *Biomedical* .23 (1)

- Shah N. M., Shah M. A., Al-Rahmani E., Behbehani J., Radovanovic Z. & Menon I. (2001). Trends, Patterns and Correlates of contraceptive use among Kuwaitis 1984-1999. *Medical Principles and Practice* 10; 34-40
- Sharan M., Ahmed S., May J., & Soucat A., (2010). Family planning trends in Sub-Saharan Africa: Progress, prospects and lesson learnt: Chapter 25. Retrieved from siteresources.worldbank.org/AFRICAEXT/.../family_planning_25.
- Shelton J. D., Bradshaw L., Hussein B., Zubair Z., Drexler T. & Mckenna M. R. (1999). Putting unmet need to test: Community-based distribution of family planning in Pakistan. *International Family Planning Perspectives* 25 (4); 191-195
- Stanback J. & Twum-Baah K. A. (2001). Why do family planning providers restrict access to services? An examination in Ghana. *International Family Planning Perspectives* 27(1) 37-41
- Stephenson R., Beke A., & Tshbangu D. (2008). Community and health facility influences on contraceptive method choice in the Eastern cape, South Africa. *International Family Planning Perspective*, 34 (2), 62-70. Doi: 10.1363/34062
- UNAIDS (2010). Global report on AIDS epidemic retrieved from www.unaids.org/globalrepot/documents/20101123_globalreport_full_en_pdf 15/02/2012
- UNFPA (1996). Programme of Action Adopted at the International Conference on Population
- WHO (2010) Trends in maternal mortality:1990-2008 estimates developed by WHO, UNICEF, UNFPA and the World Bank
- WHO (2011). World contraceptive use 2011. United Nation department of economic and social affairs. WorldBankAnnualReport(2009). Retrieved from siteresources.worldbank.org/EXTAR/www.unaids.org/globalrepot/documents/20101123_globalreport_full_en_pdf 15/02/2012

APPENDICES

1.0 Informed Consent Form for the questionnaire

Research Title: Family Planning Method Choice among Married Women in the Gomoa West District.

Institutional affiliation

School of Public Health

College of Health sciences

University of Ghana

Legon.

Tel. 0244-412168/0274-474899

Background

My Name is Millicent Okletey a student from School of Public Health conducting a research on family Planning method preference among married women in the Gomoa West District. The study is purely for academic work for the award of Master of Public Health.

Procedure

Information to be collected includes socio- demographic data, current or ever user of family planning method, method preferred, intention for use, reason for stopping or switching method where applicable, and perceived quality of service received during the last visit.

Discomforts, risks and benefits

You may feel uncomfortable with some of the questions I will be asking you. However, the information you will give, will be very helpful to me, providers of family planning services and the entire Gomoa West District.

Right to refuse

Your consent to participate in this study is voluntary; you are not under any obligation to do so. You are at liberty to withdraw from this study. However I will be grateful if you can complete it.

Anonymity and confidentiality

Be assured that any information given will be used purely for the purpose of the research. All information given will be handled with strict confidentiality.

For any further information and enquiries, you can please contact my academic supervisor Dr. Bawah on tel. **0244-714164** or the head of department of Population, Family and Reproductive Health. School of Public Health, University of Ghana, Legon. Tel. **0261-524407**

Before taking consent

Do you have any questions that you wish to ask? (if yes, question to be noted below).....
.....
.....
.....

Consent

I..... having understood the study, after having the consent explained to me thoroughly in English/ Fante /Twi /Ga language do hereby agree to take part in the study.

Signature/Thumbprint.....

Interviewer statement

Ithe undersigned , have explained the purpose of the study , its risks and benefits to the subject in the language he understands. The subject has agreed to take part in the study.

Signature of interviewer.....

Date

1.1 QUESTIONNAIRE FOR RESEARCH ON FAMILY PLANNING METHOD PREFERENCE AMONG MARRIED WOMEN IN THE GOMOA WEST DISTRICT

Dear Respondent,

This research is being carried out to determine family planning method preference among married women in the Gomoa West District. I would therefore like to take a little of your time for you to answer the following questions. I assure you that, the information you will provide will be strictly kept confidential and will not be hold against you in any way.

Respondent ID Number	House Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Place of Residence (sub-district)		
Interviewer ID Number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> ID Number Initials	
Date of administration of Questionnaire	Day Month Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Interview Consent has been read to participant	Yes..... <input type="checkbox"/> No..... <input type="checkbox"/> IF NO READ CONSENT	
Consent has been obtained	IF YES CONTINUE IF NO END	
DEMOGRAPHIC INFORMATION	RESPONSE	CODE
1. Age (In completed years)	<input type="text"/> <input type="text"/>	
2. What is your current level of education?	Primary/Middle Sch./JHS Secondary/Post Secondary HND/University/ Higher No Education.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

3. What work do you do?	Fish monger..... Farming..... Petty trading..... Teaching..... Police Officer..... Health Worker..... Banking..... Housewife..... Hairdressing..... Apprentice..... Seamstress..... Student..... Female Porter..... Other.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4. What is your Religion?	Christian..... Moslem..... Traditional/Spiritualist..... No Religion.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
5. Which Ethnic Group do you belong?	Fante..... Ashanti/Akwapim..... Ga/Dangbe..... Ewe..... Others.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
6. Have you ever been pregnant? IF NO SKIP TO QUESTION 8	Yes..... No.....	<input type="checkbox"/> <input type="checkbox"/>
7. If YES how many children	List number of children.....	<input type="text"/> <input type="text"/>
8. How many boys? How many girls?	Boys..... Girls.....	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Contraception Information	Response	Code
9. Have you heard of contraception or family planning? If NO skip Question 10	Yes..... No.....	<input type="checkbox"/> <input type="checkbox"/>

<p>10. Which ways or methods have you heard that a couple can use to delay or avoid pregnancy?</p> <p>Tick as many methods participant will mention spontaneously</p> <p>For methods not mentioned spontaneously ask and tick but write 2 against the ticked box</p> <p>For methods which respondents do not know after prompting, leave it blank</p>	<p>Tubal Ligation (Female sterilization).....</p> <p>Vasectomy (Male sterilization).....</p> <p>Pill.....</p> <p>IUD (Intra Uterine Device)</p> <p>Depo/ Norigynon (Injectables).....</p> <p>Jadelle (Implants).....</p> <p>Male condom.....</p> <p>Female condom.....</p> <p>Diaphragm.....</p> <p>Foam or jelly.....</p> <p>Emergency Contraception.....</p> <p>Lactational Amenorrhoea Method (LAM).....</p> <p>Withdrawal.....</p> <p>Rhythm/Calendar method.....</p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>
<p>11. Apart from what has been listed, which other ways or methods have you heard women or men can use to avoid pregnancy?</p>	<p>List Other Methods Mentioned.....</p> <p>.....</p> <p>.....</p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>
<p>12. Have you or your partner EVER used anything to delay or avoid getting pregnant?</p> <p>IF NO SKIP TO QUESTION 18</p>	<p>Yes.....</p> <p>No.....</p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p>
<p>13. If yes which method have you used</p>	<p>Modern method</p> <p>Traditional method.....</p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p>

<p>14. If modern method which type?</p>	<p>LONG-TERM METHOD.....</p> <p>Tubal Ligation (Female sterilization)</p> <p>IUD.....</p> <p>Jadelle (Implants).....</p> <p>Vasectomy.....</p> <p>SHORT- TERM METHOD.....</p> <p>Pill.....</p> <p>Depo/ Norigynon (Injectables).....</p> <p>Emergency Contraception.....</p> <p>Male condom.....</p> <p>Female condom.....</p> <p>Diaphragm.....</p> <p>Foam or Jelly.....</p> <p>Lactational Amenorrhoea Method (LAM).....</p>	<p>A</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p>B</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>
<p>15. If Traditional method, which of the traditional methods?</p>	<p>Rhythm/Calendar Method.....</p> <p>Withdrawal.....</p> <p>Others.....</p> <p style="text-align: center;">Specify</p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>
<p>16. About the first time that you did something or used a method to avoid getting pregnant, how many living children did you have?</p> <p>IF NONE RECORD 00</p>	<p>Number of children.....</p>	<p><input type="text"/> <input type="text"/></p>

<p>17. Why did you STOP/DISCONTINUE the family planning method?</p>	<p>I want to have another child.....</p> <p>Because of side effect.....</p> <p>Because of a medical condition.....</p> <p>My husband did not agree.....</p> <p>Because of menopause.....</p> <p>Because the method failed.....</p> <p>Because of divorce/separated/widow.....</p> <p>I defaulted/stopped.....</p> <p>Other reason.....</p> <p style="text-align: center;">Specify</p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>
<p>18. Are you or your partner CURRENTLY doing something or using any method to delay/avoid pregnancy?</p> <p>IF NO SKIP TO QUESTION 21</p>	<p>Yes.....</p> <p>No.....</p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p>
<p>19. Which method are you or your partner using?</p> <p>If modern method, which of the methods?</p> <p>If Traditional method, skip to question 19</p>	<p>Tubal Ligation (Female Sterilization).....</p> <p>Vasectomy (Male Sterilization).....</p> <p>IUD (Intra Uterine Device).....</p> <p>Jadelle (Implants).....</p> <p>Pill.....</p> <p>Depo/Norigynon (Injectable).....</p> <p>Female condom.....</p> <p>Male Condom.....</p> <p>Diaphragm.....</p> <p>Foam/Jelly.....</p> <p>Emergency Contraception.....</p> <p>Lactational Amenorrhoea (LAM).....</p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>

SERVICE DELIVERY	RESPONSE	CODE
<p>23. The last time you use a method, how much did you pay in total? Including cost of method and any consultation you may have had?</p> <p>RECORD COST IN THE SPACE PROVIDED</p>	<p>Cost Ghana Cedis.....</p> <p>Free.....</p> <p>DON'T KNOW/CANNOT REMEMBER.....</p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>
<p>24. Where did you obtain the method?</p>	<p>Gov't hospital.....</p> <p>Gov't health center.....</p> <p>Gov't health post/CHPS.....</p> <p>Family Planning Clinic.....</p> <p>Mobile Clinic.....</p> <p>Field Worker/ Outreach/ Peer Educator.....</p> <p>Private Hospital/Clinic.....</p> <p>Pharmacy/Chemical Drug Store.....</p> <p>Other.....</p> <p style="text-align: center;">Specify</p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>
<p>25. Was your preferred method available?</p> <p>If No, Answer Question 26 as well</p>	<p>Yes.....</p> <p>No.....</p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p>
<p>26. Did you like the method you finally choose?</p>	<p>Yes.....</p> <p>No.....</p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p>
<p>27. Were you told about the side effects or problems you might have with the method?</p>	<p>Yes.....</p> <p>No.....</p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p>

28. Were you told what to do if you experience side effects or problems?	Yes..... No.....	<input type="checkbox"/> <input type="checkbox"/>			
29. Were you ever told by the health worker about other methods of family planning that you could use?	Yes..... No.....	<input type="checkbox"/> <input type="checkbox"/>			
30. Did the service provider asked you to do any laboratory test (example urine test) before providing the service.	Yes..... No.....	<input type="checkbox"/> <input type="checkbox"/>			
31. Were you asked to bring your husband before your preferred choice or method provided?	Yes..... No.....	<input type="checkbox"/> <input type="checkbox"/>			
32. How many times were you asked to come for review in a year? FOR IUD, JADELLE & TUBAL LIGATION USERS ONLY	Once..... Twice..... Three times..... When Necessary..... Other specify	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
33. How many packets of pills did you get the last time? Record the number of packets supplied	<table border="1" style="margin: auto;"> <tr> <td style="width: 30px; height: 20px;"></td> <td style="width: 30px; height: 20px;"></td> <td style="width: 30px; height: 20px;"></td> </tr> </table> <p>FOR PILL USERS ONLY</p>				

<p>34. Why are you using family planning?</p>	<p>For spacing births.....</p> <p>For limiting / stopping number of Children.....</p> <p>For treating Infertility.....</p> <p>For treating menstrual Irregularity.....</p> <p>Other (specify).....</p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>
<p>35. What inform or motivate you to use family planning method?</p>	<p>Advertisement (radio, TV etc.).....</p> <p>Friend or family member is using.....</p> <p>Advice from a health worker.....</p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>
	<p>THANK YOU FOR YOUR TIME</p>	

2.0 INFORMED CONSENT FOR FOCUS GROUP DISCUSSION

Family Planning Method Choice among Married Women in the Gomoa West District

I am a student of the School of Public health of the University of Ghana, Legon assisted by a research assistant. I am conducting a research in family planning method choice among married women in the Gomoa West District to find out your experiences at the facility where you obtained the method have used in the past or using now. Your contributions and information given in the research will not be disclosed to anyone and will be kept in confidentiality except for academic purposes. You are at liberty to choose to or not to participate in the research. The information you will give will be used to plan for interventions that will improve family planning services in the Gomoa West District.

The discussions will take about 45-60 minutes of your time and your responses will be **audio taped** with your permission and these tapes would be kept under lock and key and destroyed after a maximum period of one year. This study will not pose any harm to you but rather some personal information will be required from you.

Your participation in the study is purely voluntary and so you can choose not to participate at any time during the discussions. There will be no penalty against you if you decide not to be part of the study. There would be no financial or material benefits from participating in this study except for snacks after the discussions.

In case you have questions for clarification concerning this study please contact the principal researcher at the following address Millicent Okleley School of Public Health, university of Ghana Legon. Mobile phone numbers 0244-412168/ 0274-474899 or contact my academic supervisor at the School of Public Health, Department of population, Family and Reproductive Health, Legon- Accra. Thank You.

I have read the information given above, or the information above has been read to me and I understand. I have agreed to participate knowing that I have the right to withdraw at any time during the research.

Name of participant

Signature

Thumbprint

Date

Name of witness

Signature

Thumbprint

Date

Name of researcher

Signature

Thumbprint

Date

2.1 Focus group discussion guide on family planning method preference among married women in the Gomoa West District.

Study: Socio-demographic and health services related factors associated with family planning method preference: An exploratory study.

Location:.....

Date:.....

Started time:.....

End time:.....

Age of participants.....

Occupation of participants.....

Introduction

I welcome all of you to this discussion. I thank you for the time you spared to participate in this discussion. We will introduce ourselves before commencing the discussion. My name is Millicent Okletey a student from the School of Public Health University of Ghana, Legon and am here with Miss/ Mrs,Can you please tell me your names, age, number of children, occupation and if you are currently using or have ever used a family planning method, whether traditional or modern method and which type you were using.

Purpose

I want you to share your experiences, ideas, comments, suggestions and recommendations on the topic we will be discussing.

This research is to help me understand and know the challenges you faced or you are facing now when you decided to use family planning method.

This will help send feedback to policy makers and also it will help address these challenges.

All information will be treated with confidentiality.

Explain guide lines for discussion

In this discussion there will be no right or wrong answer.

Everyone should feel free to share her view, experiences and opinion on each issue that will be raised.

Everybody will be given the opportunity to talk therefore, if one person is talking, there will be no interruption until she finished.

In order for me to get each person's ideas there will be no side discussions. Anyone can contribute to the discussion at any time.

You are at liberty to agree or disagree with someone's opinion in a cordial and respectful manner. We will spend about forty- five (45) to sixty (60) minutes for the discussion and snacks will be provided depending on your choice, whether you want it mid-way or after the discussion.

Create a relaxing atmosphere

Issues of women interest will be raised such as the economic situation coupled with high school fees. Participants will be allowed to share their views.

Main Issues for Discussion

GENERAL ISSUES

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

Probe:

- Men and family head
- Whether women are involved
- What happens if only men take decisions alone in the family?

2. **What do you think is ideal family size?**

Probe to find out number of children that a couple should have that should be ideal for a family and if this affects the family in terms of financial, social, economic status, etc

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

Probe to find out from respondents how they understand and perceive family planning.

Example, for spacing, limiting and treating infertility

SERVICE DELIVERY FACTORS

1. If a woman wants to plan her family, where will she get help or information as to the possible ways she can plan her family?

Probe to obtain information on where to get information on family planning. For example Public health facility, private, pharmacy, herbalist, friends and family members or even people in the community etc. Probe further which the information will be the most appropriate to help the person make an informed decision?

2. Can you share some of your experiences at the health facility when you were there?

Probe for information on their experiences such as:

Counseling,

History taking,

Registration,

Physical examination and education on all methods of family planning as well as the side effects of the various methods particularly the method participants opted for etc.

3. Why did you choose the method you have ever used or are currently using?

Probe to find out if participants were using it for:

Spacing

Limiting

Probe for other reasons like non-availability of method so they have to choose this method.

Partner or any family member does not agree to family planning so they have to use it in secret.

Medical condition so they have no option than to choose what will suit their situation.

4. Were you satisfied with the education given pertaining to other method available, side effects, what to do if they occurred,. Probe further to find out if participants who did not get the method they want and had to choose what was available were satisfied with the method they finally choose.
5. Have you change methods since you started using family planning method?
Probe to find out if participants had change methods and the reason why they changed the method.
6. Was your choice influenced by your partner, family member, friend or any other person?
Probe to find out if the choice they made was influenced by any factors
7. Why were you or are you using family planning?
Probe to find out intention for use that is if for limiting or for spacing or any other reason for using family planning.

Conclusion

What do you think can be done to improve quality of services at the facility?

Probe for further clarification.

Thank Participants for making time and congratulate them for their contributions.