TO USE OR NOT TO USE: FACTORS INFLUENCING UTILIZATION OF FAMILY PLANNING SERVICES IN BOMFA SUBDISTRICT, EJISU JUABEN

BY

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DECLARATION

I hereby declare that this dissertation is an original work based on my own research except for the citations that has been duly acknowledged and that it has not been submitted towards the award of any other degree.

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DEDICATION

This work is dedicated to my husband, Vincent Ankamah Lomotey and my children, Adoley and Adorkor for their patience, support and encouragement.

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LIST OF ABBREVIATION

AIDS	Acquired Immune Deficiency Virus
FGD	Focus Group Discussion
GDHS	Ghana Demographic and Health Survey
HIV	Human Immunodeficiency Virus
JSS	Junior Secondary School
IEC	Information, Education and Communication
IUD	Intra Uterine Device
LAM	Lactational Amenorrhoea Method
PPAG	Planned Parenthood Association of Ghana
SDA	Seventh Day Adventist
TFR	Total Fertility Rate
VFT	Vaginal Foaming Tablet

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ABSTRACT

Family planning is a cost effective health intervention that has immediate benefits for women, children and families. However, in the Bomfa subdistrict for the past five years, 1997-2001 the family planning acceptor rate has never exceeded 5%. The objective of this study was therefore to determine the factors accounting for this low acceptor rate.

A descriptive cross sectional study was carried out over a four-week period. A total number of 170 persons, 76% females and 24% males were interviewed using structured questionnaires and focus group discussions to assess their practices, beliefs and attitudes towards family planning. Some aspects of the results were analysed in relation to sex.

The findings of the study revealed that 32.4% of the respondents were currently using a family planning method. Education was found to be positively related to contraceptive use among females. The major reason for non-use of contraceptives was the fear of side effects. Eighty percent of the respondents discussed the use of family planning with their friends and neighbours. Child spacing is greatly valued but fertility regulation to some extent was seen as a woman's responsibility.

It is therefore being recommended that Information, Education and Communication activities on family planning should be intensified through community durbars and identified male and female groups to dispel misconceptions and allay fears about side effects. Awareness on the importance of spousal communication and male involvement in reproductive health issues should also be promoted.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background Information

The world's population has reached six (6) billion and is growing rapidly by nearly 80 million each year. It is estimated that by 2050, the world's population will increase by 50% that is from 6.1 billion to 9.3 billion. Developing countries will account for 85% of this projected growth.[1] The demographic transition from high fertility and high mortality to low fertility and low mortality has been substantially completed in the developed world and is underway in most of the developing world. Nevertheless in many countries of Sub-Saharan Africa, the Near East and South Asia the population continues to grow at 2% a year or more and the average woman bears four to seven children.[2]

In Ghana, between 1960 and 1984 the population doubled from about 6.7 million to 12.3 million with a growth rate of 3.1% per annum[3] Currently the population is about 18.4 million.[4] Ghana's population could be described as a young population with about 48.2% of the people being under age 15 years. This represents a high dependency ratio.[5]

Rapid population growth if not controlled, could outstrip the provision of infrastructure and social services. Slower population growth aids development in that more of the population will be in their productive years and thus resources can be invested into

education, job creation and better health care. As more people choose family planning fertility falls and population growth slows.

Family planning services are therefore, designed to assist couples and individuals in their reproductive ages to space or limit the number of births, prevent unwanted pregnancy, manage infertility and improve their reproductive health. Family Planning is a cost effective health intervention that has immediate benefits for women, children and families.

Globally, about half a million women die every year from complications of pregnancy and childbirth.[6] In developing countries, women are 30 times more likely to die from pregnancy related causes than those in the developed world. It is estimated that a third of all maternal mortality and infection could be avoided if all women had access to a range of modern, safe and effective family planning services that would enable them to avoid unwanted pregnancy. Prevention of unwanted pregnancy would mean a reduction in more than 78,000 maternal deaths that result from unsafe abortions yearly in developing countries.[1]

Closely spaced pregnancies are more likely to result in low birth weight infants who are more vulnerable to illness and thus less likely to survive. In many countries birth spacing alone could prevent 20% of infant deaths. Babies born less than two years after a sibling are almost twice as likely to die as those born after an interval of at least two years.[6]

Throughout the world governments are aware of both the need and benefits of family planning. Thus Ghana was one of the first sub Saharan African countries to sign the world's leaders declaration on population in 1967. In 1969 the government issued a general policy paper on population planning for national progress and prosperity and this included provisions for family planning services. The objective of the policy paper was to reduce the population growth from 3.1% to 1.7% by the year 2000. Mass publicity and educational campaign was therefore launched to create awareness on the need for Family Planning.[3]

The 1988 Ghana Demographic and Health Survey showed that 79% of currently married women had knowledge about family planning but there had been almost no change in attitudes and practices from those of the 1960's. The contraceptive prevalence for 1988 was 13%. Most Ghanaian women still preferred to have large families and probably saw their childbearing abilities as a form of social and economic security. Children are considered as property of the extended family. A woman who has no child surviving is branded as useless because she has nothing to pass on to her family and society. In certain societies such women are ostracized. Children are also valued for their contribution towards farm labour. The population of Ghana thus continued to grow rapidly.

In 1994 there was renewed effort to control the effects of rapid population growth by the Government. This led to a revision of the 1969 population policy, which emphasized

improving the quality of life rather than reduction in numbers. Some of the objectives of the revised policy include:

- Integration of population issues in all aspects of planning and development at all levels;
- To provide Information Communication and Education (IEC) on the value of small family size and reproductive health;
- To ensure accessibility and affordability of family planning services for all couples and individuals to enable them regulate their fertility;
- To educate the youth on reproductive health in order to guide them towards responsible parenthood;
- To integrate family planning services into maternal and child health care services so as to reduce infant, child and maternal mortality;
- To educate the general population about the cause, consequences and prevention of HIV/ AIDS.

Some of the strategies adopted to achieve these objectives revolved around improving the range of family planning methods, intensification of the activities of family planning clinics and commercial distribution outlets with special emphasis on provision of IEC Programmes to reach the male population at all levels.

The Ministry of Health provides family planning services through a network of Maternal and Child Health/Family planning clinics, health centres and hospitals. Complementing the efforts of the Ministry of health are Non-governmental Organizations such as, the Planned Parenthood Association of Ghana (PPAG) and the Ghana Social Marketing

Foundation (GSMF), which are involved in Community Based Distribution of contraceptives and IEC activities. Other private participating agencies include Ghana Registered Midwives Association, Private Clinics and Chemical Sellers. It is estimated that 46% of women get their methods from Ministry of Health outlets and about 39% from pharmacies and chemical sellers.[7]

The Ejisu-Juaben District

The Ejisu-Juaben district is one of the 18 districts in the Ashanti Region. It lies in the South-Eastern part of the region. It covers an area of about 1635 square kilometers with a population of 120,968.[4] The district is divided into 5 sub-districts namely Kwaso, Ejisu, Bomfa, Juaben and Achiase. Ejisu is the district capital.

Most of the inhabitants are subsistence farmers. Others engage in Kente weaving and petty trading as their sources of income. Few are employed as factory hands in the wood industry and the oil palm plantation at Juaben.

With the exception of Juaben that enjoys pipe borne water, most of the communities use either boreholes or wells as source of drinking water. Only a few towns are connected to the national electricity grid.

Bomfa Subdistrict

The study took place in the Bomfa Subdistrict that is located in the North-Eastern part of the District and shares boundaries with Juaben in the North, Achiase in the South,

Asante Akim North District in the East and Kwaso Subdistrict in the West. The total land area of the sub district is 264 square kilometres, which is approximately 16% of the total land area of the district. For administrative purposes the subdistrict has 9 recognized communities namely Bomfa, Adumasa, Nobewam, Kubease, Duampompo, New Koforidua, Boamadumase, Hwereso and Sekyere. The projected population for the year 2001 is 19,200 with an annual growth rate of 2.7%. (Projected from 1984 census figures since that of the year 2000 has not been released).

Ethnic and Religious Groups

The inhabitants are predominantly Akans but there are other ethnic groups such as Ewes, and Kotokolis. Asante Twi is the most common language used. The principal religions are Christianity, Islam and Traditional.

Educational Institutions

The total number of schools in the subdistrict is 29. The breakdown is as follows:

Seven Preschools

Thirteen Primary schools

Nine Junior Secondary Schools

There are no Senior Secondary or Tertiary Institutions

Electricity and Telecommunication services

The Bomfa Subdistrict does not have electricity nor telecommunication services.

Road Network and Transportation

Most of the communities are located along the main Accra–Kumasi road. With the exception of Boamadumase, all the roads leading to the communities are tarred. Taxis and Minibuses serve as the major means of transportation. During the rainy season some parts of the Boamadumase community become inaccessible.

Occupation

The inhabitants are predominantly farmers and petty traders. There are no factories or industries to provide employment opportunities.

Health Services

Table 1:1 below presents the distribution and ownership of health facilities in the Bomfa Subdistrict.

TABLE 1.1 HEALTH FACILITIES

Facility	Location	Ownership
Bomfa Health Centre	Bomfa	Government
Huttel Health Centre	Boamadumase	The Presbyterian Church
SDA Clinic	Nobewam	Seventh Day Adventist Church
Daasebre Health Services	Adumasa	Private

The Bomfa Health Centre provides Clinical and Reproductive and child health services at the facility and on outreach basis. The family planning methods provided include; the Pill, Condoms, Vaginal Foaming Tablets, Intra Uterine Devices, Injectable and Implant.

Clients who opt for Sterilization are referred to either Juaben or Komfo Anokye Teaching Hospital. Staff of the Bomfa health Centre also provides family planning services on outreach basis at the Huttel Health centre. The SDA clinic and the Daasebre clinic do not provide family planning services (Table 1.1).

The PPAG has two Community Based Distributors in Nobewam and New Koforidua respectively providing contraceptives such as the Pill, condoms and Vaginal Foaming Tablets. There are ten (10) Chemical shops in the Bomfa subdistrict providing the same range of services.

1.2 Statement of the Problem

The family planning acceptor rate for the past five years has generally been low in the Bomfa Subdistrict. The rates for the district and regional levels had also been fluctuating. From Table 1.2, in 1997, the acceptor rate for the region was 26% and that of the district was15%. Both figures dropped to as low as 5.7% and 10% respectively in the year 2000. In the Bomfa Subdistrict the acceptor rate has never exceeded 5% for the past five years despite the improvement in the range of family planning methods and IE&C activities on the value of spacing and limiting births. There is lack of information as to why there is this very low Acceptor Rate.

In a sub-district like Bomfa, which is not endowed with adequate infrastructure, there is a need to control fertility rates in order to ensure that social services are not over stretched. Moreover the lack of employment opportunities coupled with the fact that

most of the inhabitants are subsistence farmers whose incomes generally tend to be unstable, makes it imperative for couples to plan their families.

Table1. 2: Family planning Acceptor Rate (1997-2001)

	1997	1998	1999	2000	2001
REGIONAL (Ashanti)	26	12	12	10	11
DISTRICT(Ejisu-Juaben)	15	13.5	14.5	5.7	10.7
SUBDISTRICT (Bomfa)	4.2	0.70	3.8	2.6	4.8

Sources: Annual Reports of Ashanti Region, 1997 - 2001

District Health Profile, Ejisu-Juaben, 2000

Reproductive and Child health Annual Reports, 1997-2001

1.3 Rationale for the study

In family planning programs there can be gaps between services offered and the services clients need. A better understanding of the factors influencing client's use of family planning services can help bridge the gap. Conducting a study to identify some of these factors is therefore necessary in order to design an intervention programme to improve the coverage of family planning services in the sub district.

CHAPTER TWO

2.0 LITERATURE REVIEW

The Programme of Action, principle 8 of the International Conference of Population and Development states, " all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have information and means to do so" [1]

The development of modern contraceptives has given people the freedom and ability to plan their families. The use of contraceptives by couples worldwide has increased from less than 10% to about 60% over the last 3 decades. Family planning programmes have contributed considerably to decline in average fertility rates for developing countries from about six to seven per woman in the 1960's to about three to four children at present.[8]

However, 350 million couples worldwide do not have access to the full range of modern contraceptives. Surveys from developing countries indicate that more than 100 million women want to delay the birth of their next child or to stop having children but are not using a contraceptive method thus creating a situation of an unmet need.[1]

In Ghana contraceptive prevalence increased from 13% in 1988 to 22% in 1998 for all methods. For modern methods the prevalence was 5% in 1988,10% in 1993 and 13% in 1998. The Total Fertility Rate (TFR) has declined from 6.4 to 4.6 in 1988 and 1998 respectively. The two child fertility declined observed within this period far exceeds the increase in contraceptive prevalence over the same period and is inconsistent with International experience in the relationship between fertility and contraceptive prevalence. TFR will fall to 3.7% births per woman if all the unwanted births were prevented. About 23% of married women have an unmet need for Family Planning. It is estimated that 11% have unmet need for spacing and 12% unmet need for limiting. [9]

Westoff and Ochoa in 1991 defined unmet need as the percentage of married, fecund women not using contraception but wanting to space or limit their next birth as well as those who are not pregnant or amenorrheic and whose last birth was unwanted or mistimed.[10]

2.1 DETERMINANTS OF FAMILY PLANNING UTILIZATION

According to the Hermalin's model there are two main proximate determinants of contraceptive use; these are motivation to control fertility and the cost of regulation, which operate through a set of Socioeconomic and demographic variables. At any given point, motivation is regarded as a function of the interaction between supply of children and demand for children. The cost of regulation includes economic costs (money and time), social cost (outcome of transgressing social norms favoring

childbearing) health and Psychic costs which refers to the consequences of experimenting with something new that may be risky or unpleasant.[11]

Studies in Ghana, Indian, Pakistan, Philippines and Zambia as well as Guatemala consistently found that fear of side effects; lack of husband support and lack of knowledge are the major factors contributing to the non-use of family planning methods. Other factors include poor access to or limited range of contraceptive choice.[12]

2.1.1 Fear Of Side Effects

Many couples stop or refuse to use contraception because of real or perceived side effects. Some of the side effects commonly cited are headaches, amenorrhea, prolonged bleeding and weight gain. In a study conducted in the Philippines nearly 40% of non-Contraceptive users said they were concerned about side effects. In Pakistan a large portion of women who had heard of modern methods of contraception feared the harmful effects from using them. The range was 40% for female sterilization and 70% for Intra Uterine Devices. [12]

In Ghana fear of side effects is the most frequently cited reason for non-use of contraceptives and this accounts for 16% of the reasons given. It was more likely to be mentioned by women with an unmet need for limiting than for spacing.[10]

2.1.2 Consent of Spouse and Significant Others

The traditional African pattern of male involvement in fertility decision-making is clearly reflected in many studies. A study in Nigeria among married students revealed that, one out of every five women who were not using a contraceptive method gave husband's objection as the reason for non-use. Another study reported that men fear their wives use of contraceptive will undermine their own authority as head of the household or encourage their wives to be promiscuous.[13] The 1998 Ghana Demographic and Health Survey revealed that 21% of women indicated that their partners or someone else is opposed to their use of contraception. Spousal influence is an exclusive right exercised only by the husband. Thus the limited impact of family planning in Ghana could partly be attributed to neglect of men as equal targets in such programmes.[14]

Whilst husbands and male partners have tremendous impact on a woman's contraceptive use or non-use other family members play a significant role as well. In some countries parents and In-laws view grandchildren as necessary to extend the family line, to provide financial support for parents during old age or to provide labor on family farms. Studies conducted in Egypt and Zimbabwe showed that mothers in law influence women's decision about family size and contraceptive use is encouraged only as a means of limiting births once a couple has the number of children they wanted.[12]

2.1.3 Discussion of family planning utilization

A study in Ghana indicated that the two most important factors determining contraceptive use were communication between spouses (including wives perception that husbands supported their contraceptive use) and people outside the family who offered encouragement and support for family planning use.[15]

In Addis Ababa the use of contraceptives was nearly doubled among women who received counseling with their husbands as compared to those who did not. The coverage was 33% and 17% respectively.[16]

2.1.4 Quality Of Family Planning Services

The quality of family planning services is likely to be an important determinant of contraceptive use by increasing adoption of methods and significantly increasing continuity of contraceptive use. A range of situational factors such as knowledge of location of clinics and other supply sources, their proximity, and reputation of family planning personnel and suitability of clinic procedures are known to influence the decision to adopt family planning methods. To explore the linkages between quality of care and continued contraceptive practice, a study in Indonesia revealed that 72% of women who had been denied their choice of contraceptive method at the clinic they attended discontinued use within 12 months.[17]

Separate studies in Gambia and Niger reported that in both countries contraceptive discontinuation was substantially higher among women who perceived that they had not received adequate counseling about side effects. [17]

A study in Ghana showed that most providers especially nurses, imposed unnecessary restriction for family planning methods based on age, marital status, weight, parity and spousal consent. More than half of the providers enforced marriage requirements and spousal consent for at least one reversible method with the aim of upholding social mores or protecting the health of the client. The dangers of contraceptive use are often exaggerated thereby limiting access.[18]

2.1.5 Socio Economic Status of women

Other studies have shown that women who earn income, contribute to their family's support are more likely to use contraception than women who do not.[19] Findings from a study conducted in Mali, Nigeria and Ghana indicate that a woman's level of education is positively related to the adoption of family planning methods.[20]

The literature reviewed indicates that several factors contribute to the utilization of family planning services. These factors may be socio-cultural, health or programme related. Most of the studies involved women with limited information regarding the attitude and behaviour of men.

2.2 OBJECTIVES

General Objective

To identify the factors which influence utilization of family planning services in the Bomfa sub district, Ejisu Juaben District.

Specific Objectives

1. To describe socio-demographic characteristics such as age, marital status, education and contraceptive use.

2. To describe the attitude, beliefs and practices of both men and women towards family planning.

3. To describe the perception of both female and male users of the Bomfa Health Centre about the quality of family planning services in terms of access to relevant information, privacy, waiting time, availability of methods and provider attitude.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study Type

The study is a descriptive cross sectional study, which was carried out within a four-week period June –July 2002 to determine the factors that influence utilization of Family planning services.

3.2 Study Area

The study was carried out in 5 communities out of a total of nine communities in the Bomfa subdistrict. The communities were Bomfa, Hwereso, Nobewam, Adumasa and Boamadumase. The study population was women in their reproductive age that is 15-49 years and men above 15 years.

3.3 Sample Size

$$N = \frac{\pi (1-\pi) z^2}{e^2}$$ (Source Kirkwood, 1996)

Where N = Sample Size

π = Proportion of women using Family planning – 4.8%

z = 1.96 at 5% Significance level

e= Error margin of 3%

Therefore $N = \frac{0.05\ (0.95)\ 1.96^2}{0.03^2}$

The required sample size = 202

With an assumption of 10% non-response the sample size will be 220. But a total number of 170 respondents were interviewed because of time constraint and resources.

3.4 Sampling Procedure

Five communities were selected by simple random sampling. All the names of the nine (9) communities were written on a paper and put in a box. Five of them were then picked one after the other. Anytime a community was picked the name was recorded until the five communities had been selected.

After the communities have been selected, on the day of data collection the centre of the community was located. The central point differed from one community to the other; in some cases it was a lorry station, a market or a park for social gathering. A sharpened pencil was then spanned on the ground. The direction of the pointed edge was chosen as the starting point. Moving in that direction every third house was selected. Upon entering the house the consent of eligible individuals was sought and interviewed. If there were no eligible persons the next third house was selected. The procedure was repeated until the required number of respondents was obtained. The number of people interviewed was evenly distributed for the five communities because the population of the communities was not readily available. Thus 34 respondents were interviewed in each community.

3.5 Variables

The dependent variable is utilization of family planning services. Table 3.1 shows the independent variables.

TABLE 3.1 Description of independent variables

INDEPENDENT	INDICATOR
Age	Age As At Last Birth Day
Marital Status	Married, Widowed, Divorce, Separated, Single
Educational Level	No education, Primary, JSS, Secondary, Tertiary
Religion	Christianity, Islam, Traditional
Occupation	Farming, salaried worker, Trading and others
ATTITUDE AND BELIEFS	• Preferred number of children and birth spacing • Reasons for being for or against family planning • Who decides contraceptive use and family size

INDEPENDENT	INDICATOR
PRACTICE	• Past use of family planning methods • Current use of family planning methods • Intention to use a family planning method • Sources of information about family planning • Discussion about the use of family planning • Reasons for non-use
QUALITY OF FAMILY PLANNING SERVICES	• Use of the Bomfa health Centre for family planning services • Access to relevant information • Privacy • Waiting time • Provider Attitude • Availability of methods

3.6 Data Collection Tools and Techniques

A questionnaire was administered to assess the beliefs and attitudes of respondents towards contraceptive use, and perception about the quality of family planning services. See Appendix 1. On the day of data collection the research assistant upon entering a house introduced herself, explained the purpose of the study to eligible persons, sought for verbal consent and then proceeded with the interview.

Four (4) Focus group discussions were organized; two groups of females and two groups of males in two selected communities, Hwereso and Bomfa respectively. A guide (Appendix 2) was used to get in-depth information about their beliefs and attitudes towards family planning to support the quantitative data obtained. The participants were recruited through the help of the Village Health Committee members. There were about 10 participants in a group with their ages ranging from 16 to 45 years. There was one moderator (the researcher) who coordinated the discussion and a recorder to keep a record of the content of the discussion. A tape recorder was also used to assist in the capturing of information. After self-introduction, the participants were encouraged to feel free and express their opinions since there were no right or wrong answers. Each FGD lasted for about an hour.

3.7 Data Processing and Analysis

During the data collection, the researcher monitored the process to ensure that research assistants adhered to the research procedures. Also at the end of each day each questionnaire was cross-checked for completeness and internal consistency. Problems identified were discussed with research assistants. Each questionnaire was given a serial number. The information obtained was coded, keyed into the computer and analysed using the EPI INFO Statistical Package.

A report of the FGD was prepared using the participants' own words. A list of the key opinions expressed by both groups was categorized in relation to the objectives. The most useful quotations were used as a narrative text to support the quantitative data.

3.8 Ethical Consideration

Permission to proceed with the study was obtained from the Regional Health Authorities, the District Assembly and Community Leaders. The purpose and objectives of the study was clearly discussed with the respondents and a verbal consent was sought. Respondents were assured of confidentiality.

3.9 Training and Pretesting

A one-day training was organised for two research assistants from the District Health Administration, Ejisu. The rationale and objectives of the study were explained after which they were taken through basic interview techniques such as asking questions in a neutral manner, how to record answers to open ended questions without sifting or interpreting them and also translation of the questions into the local language. Pretesting of the questionnaires was carried out in the Ejisu Subdistrict. Some corrections were made. These included rephrasing of ambiguous questions, closing of open-ended questions and addition of other relevant questions.

3.10 Limitations to the study

Due to time and financial constraints the sample size was scaled down to 170 from 220 thereby limiting the extent to which the findings may be generalized. Also because of the low utilization of the Bomfa Health Centre, exit interviews and observations that could have provided firsthand information for the assessment of the quality of family planning services could not be carried out. The assessment was based on responses

from a few people who had ever used the facility within the last two years there is therefore the tendency of recall bias by respondents.

CHAPTER FOUR

4.0 FINDINGS

A total number of 170 persons were interviewed. One Hundred and Thirty (76%) of them were women and 40(24%) were men.

Table 4.1: Distribution of respondents by Age, Education and Marital Status

	FEMALE		MALE	
SOCIO – DEMOGRAPHIC CHARACTERISTIC	FREQUENCY N=130	PERCENTAGE (%)	FREQUENCY N=40	PERCENTAGE (%)
AGE				
15 – 19	10	7.7	2	5.0
20 – 24	24	18.5	6	15.0
25 – 29	29	22.3	7	17.5
30 – 34	24	18.5	8	20.0
35 – 39	23	17.7	5	12.5
40 – 44	13	10.0	5	12.5
45 – 49	7	5.4	3	7.5
50 – 54	0	0	1	2.5
55 – 59	0	0	3	7.5
EDUCATION				
No education	31	23.8	1	2.5
Primary	36	27.7	5	12.5
Middle / JSS	61	46.9	27	67.5
Secondary	2	1.5	7	17.5
Tertiary	0	0.0	0	0.0
M ARITAL STATUS				
Single (Never Married)	20	15.4	10	25.0
Married / Living Together	101	77.7	29	72.5
Widowed	1	0.8	0	0
Divorced/Separated	8	6.2	1	2.5

4.1 SOCIO – DEMOGRAPHIC CHARACTERISTICS

Age

The ages of the respondents ranged from 15-59 years. For the females, age group, 25-29 had the largest number of respondents 29(22.3%) and 45-49 years had the smallest 7(5.4%). For the males, age group, 30-34 had the largest number of respondents 8(20%) and 50-54 years formed the smallest 1(2.5%). The age distribution is shown in Table 4.1.

Educational level

Most of the respondents had had education up to Middle or JSS level, 61 (46.9%) for females and 27 (67.5%) for males respectively. Thirty-six (27.7%) females and 5(12.5%) males had Primary education. Only 2(1.5%) females and 7(17.5%) males had Secondary education. Thirty-one (23.8%) females and one(2.5%) male had no education. None of the respondents had education up to Tertiary level as shown in Table 4.1

Marital Status

Majority of the respondents, 130(76%) were married or living together. One hundred and one (77.7%) females were married, 20 (5.4%) were single and 9(6.9%) were divorced, or widowed. Twenty-nine males (72.5%) were married, 10(25.0%) single and 1(2.5%) divorced. It is worth noting that for the 30 persons who were single, 17 were in a sexual relationship. See Table 4.1.

Religion

One hundred and Forty (82.4%) of the respondents were Christians belonging to various denominations such as the Catholic, Presbyterian, Pentecost and Spiritual churches. Seventeen (10%) were Moslems while 13 (7.6%) practiced Traditional religion.

Occupation

Majority of the respondents were farmers, 78 (45.9%), and 55(32.4%) were petty traders. Nineteen (11.2%) were Artisans comprising of carpenters, tailors, hairdressers and dressmakers. Fifteen (8.8%) were unemployed. The occupation of respondents is shown in Figure 1.

Figure 1: OCCUPATION OF RESPONDENTS

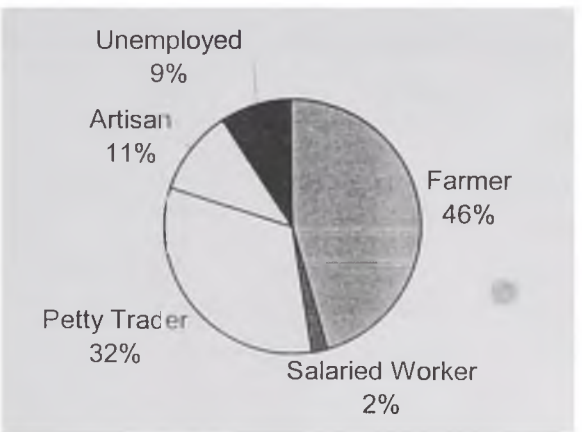


Table 4.2: Distribution of number of living children of respondents

NUMBER OF CHILDREN	FREQUENCY	PERCENTAGE (%)
0	29	17.1
1	26	15.3
2	26	15.3
3	29	17.1
4	22	12.9
5+	38	22.4
TOTAL	**170**	**100**

Number of Children (Living)

Table 4.2 shows the distribution of number of living children, which ranged from none to 10. Twenty-nine (17.1) had no children, 103(60.6%) had 1 to 4 children and 38 (22.4 %) had more than 4 children.

4.2 SOCIO-DEMOGRAPHIC CHARACTERISTICS AND CURRENT USE OF FAMILY PLANNING METHODS.

Table 4.3: *Current use of Family Planning Methods by Sex*

SEX	CURRENT USE OF FAMILY PLANNING METHODS		
	YES	NO	TOTAL
FEMALE	39 (30%)	91 (70%)	130 (100%)
MALE	16 (40%)	24 (60%)	40 (100%)
TOTAL	**55**	**115**	**170**

4.2.1 *Current use of Family Planning Methods by Sex*

From Table 4.3, 30% of women and 40% of men were currently using a family planning method.

Table 4.4*: Age and Current Use of Family Planning Methods*

Age group	CURRENT USE OF FAMILY PLANNING METHODS				
	FEMALE		MALE		
	YES	NO	YES	NO	TOTAL
15-19	0	10 (11%)	1 (6.3%)	1 (4.2%)	**12**
20-24	8 (20.5%)	16 (17.6%)	3 (18.8%)	3 (12.5%)	**30**
25-29	10 (25.6%)	19 (20.9%)	1 (6.3%)	6 (25%)	**36**
30-34	8 (20.5%)	16 (17.6%)	4 (25%)	4 (16.7%)	**32**
35-39	5 (12.8%)	18 (19.8%)	0	5 (20.8%)	**28**
40-44	5 (12.8%)	8 (8.8%)	2 (12.5%	3 (12.5%))	**18**
45-49	3 (7.7%)	4 (4.4%)	3 (18.8%)	0	**10**
50-54	0	0	1 (6.3%)	0	**1**
55-59	0	0	1 (6.3%)	2 (8.3%)	**3**
TOTAL	**39(100%)**	**91(100%)**	**16**	**24**	**170**

4.2.2 Age and Current Use of Family Planning Methods

From Table 4.4, current use of family planning among women and men though not uniform showed a rise with age. For the women, a peak of 25.6% was observed at age 25-29 and dropped to 7.7% at age 45-49. With the men, it rose from 6.3% at age 15-19,a peak of 25% was observed at age 30-34 and dropped to 6.3 % for age 55-59.

4.2.3 *Marital Status and Current Use of Family Planning Methods*

Table 4.5 shows that the use of family planning was highest among married men and women 48.3% and 34.7% respectively. For those who were not married but were in a sexual relationship it was 20.0% for both women and men. The divorced, separated and widowed were currently not using any method.

Table 4.5: *Marital Status and Current Use of Family Planning Methods*

Marital Status	CURRENT USE OF FAMILY PLANNING METHODS					
	FEMALE			MALE		
	YES	NO	TOTAL	YES	NO	TOTAL
Single	4 (20%)	16 (80%)	**20 (100%)**	2 (20.0%)	8 (80.0%)	**10(100%)**
Married	35 (34.7%)	66 (65.3%)	**101 (100%)**	14 (48.3%)	15 (51.7%)	**29(100%)**
Separated/ Divorced/ Widowed	0	9 (100%)	**9 (100%)**	0 (100%)	1 (100%)	**1 (100%)**
TOTAL	39	91	**130**	24	16	**40**

4.2.4 Educational level And Current Use of Family Planning Methods

The percentage of current users for both men and women shows an increasing pattern from no education 25% to Middle school 37.5% and then a decrease at the Secondary level 22.2%. It is worth noting that the pattern observed is not statistically significant p value > 0.05. This was because the sample of respondents who had had secondary education was small. See table 4.6.

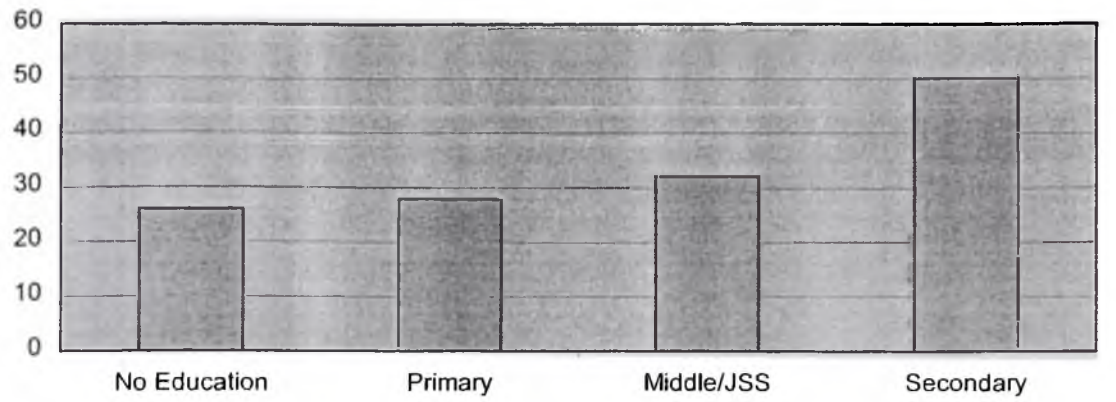
4.6: Educational level And Current Use Of Family Planning Methods

	CURRENT USE OF FAMILY PLANNING METHODS		
	YES	NO	TOTAL
No Education	8 (25%)	24 (75%)	**32(100%)**
Primary	12 (29.3%)	29 (70.3%)	**41(100%)**
Middle/JSS	33 (35.7%)	55 (62.5%)	**88(100%)**
Secondary	2 (22.2%)	7 (77.8%)	**9(100%)**
TOTAL	**55**	**115**	**170**

4.2.4. Educational level And Current Use among females.

Current use of family planning among females showed an increasing pattern from no education 25.8 % to Secondary level, 50%. This is illustrated by Figure 2.

Figure 2: Educational level and current use among females



4.3 PRACTICE OF FAMILY PLANNING

4.3.1 Past use of family planning methods

Out of the 170 persons interviewed 100 (58.82%) had ever used a family planning method while 70 (41.18%) had never used any method as shown in Table 4.7.

Table 4.7: Past Use of Family Planning Methods

USE OF FAMILY PLANNING METHODS	FREQUENCY	PERCENTAGE (%)
Ever used	100	58.82
Never used	70	41.18
TOTAL	170	100

4.3.2 Current use of family planning methods

One hundred and fifteen (67.6%) of the respondents were not using any method. Only 55 (32.4%) were currently using a family planning method (22.4% for modern methods and 10% for traditional methods such as periodic abstinence and withdrawal). For all women currently using a method the Pill was the most commonly used modern method 16(41.0 %) followed by the Injectable 3 (7.7%). None of the women reported condom use. With the men, the condom and the Injectable follow the Pill. None of the men reported the use of VFTs and withdrawal. See Table 4.8.

Table 4. 8: The Distribution of the type of methods currently being used

	FEMALE		MALE	
METHOD	FREQUENCY	PERCENTAGE (%)	FREQUENCY	PERCENTAGE (%)
Condom	0	0	3	18.8
Injectable	3	7.7	2	12.5
Female Sterilization	2	5.1	1	6.3
Lactational Amenorrhea Method	1	2.6	1	6.3
Pill	16	41.0	6	37.5
Vaginal Foaming Tablet (VFT)	2	5.1	0	0
Withdrawal	1	2.6	0	0
Periodic Abstinence	13	33.3	2	12.5
Intra Uterine Device	1	2.6	1	6.3
TOTAL	**39**	**100**	**16**	**100**

4.3.2.1 Current use of methods among married women

Among married women, 21(20.8%) were using modern methods and14 (13.9%) were using traditional methods.

4.3. 3 Other " methods" of family planning currently being used

Five (4.3%) of those who were not using any of the methods discussed above were using different kinds of substances to prevent unwanted pregnancies. The breakdown was as follows:

- Taking of saccharin before sexual act 2 (1.7%)
- Having an enema of herbs some few days before ones menses 2 (1.7)
- Drinking of Nescafe 1 (0.9%)

4.3.4 Sources Of Acquisition of Family Planning Services by Current Users

The most common source of acquisition of family planning services by current users was the Drug stores. The break down was as follows for the 55 current users:

- Twenty- three (41.8%) Drug stores
- Fourteen (25.5%) health centres and hospitals
- The remaining 18 were using natural family planning methods such as periodic abstinence and withdrawal.

Participants of the focus group discussion expressed the following opinions about why the drug store is most preferred in terms of procedures, proximity and time. They had this to say:

> " In The drug store there is nothing like getting a card, no queue you get what you want immediately".
>
> "Through conversation with friends some get to know certain drugs that can be used to prevent pregnancy. Such persons who want to use it go straight to the drug store to buy".
>
> " The drug store is just around us, no consultation fee, no interview ".

4.3.5 Intention to use family planning methods

Out of the 70 who had never used any method 31(44.3%) intend to use a method in the future, while 34(48.6%) never intend to use. Five(7.1%) were not sure if they would ever use a method.

4.3.6 Reasons for non-use of family planning methods

The major reasons given for currently not using a method or not intending to use a method were side effects and the want for more children as indicated below.

- Fear of side effects (34%)
- Wanted more children (26%)
- Sub fertility (10%)
- Against Religious beliefs (7%)
- Too expensive (3%)
- Menopause (2%)
- Others (18%) Some of these included infrequent sex, inconvenient to use and others did not give any reasons.

Findings from the focus group discussion from both men and women also show side effects as a major reason why people do not practice family planning. This is what some of the participants had to say:

> "Sometimes the nurses do not tell us of the side effects and even if you have side effects and you go to them, they keep reassuring you that it will stop but it

doesn't. I know of a woman who was using IUD and was having problems but the nurse did not take heed till she collapsed. If it happens like that then no one will go for it". Female (F)

" After using the method for a long time it makes the woman very weak and sick during pregnancy and child birth" Male (M)

"It gives abdominal distention and it makes you bleed a lot" (F).

"After using the pill I became so obese and had some fibroids so as for family planning my entire family has vowed never to use any". (F)

" Sometimes the methods can fail" (M)

Another man had this to say about religious beliefs:

" There is no record of family planning in the bible that's why people are not using it".

4.3.7 Discussion of Family Planning Utilization

Out of the 170 persons interviewed 100 (58.8%) indicated that they discussed the utilization of family planning with others while 70(41.2%) did not. Majority of the respondents discussed family planning with their friends and neighbours (80%). Fifteen percent discussed it with their spouses or partners. Discussion was least with Health workers, 1%. Table 4.9 represents the distribution of the different people respondents discussed family planning with.

Table 4.9: Distribution of people with whom respondents discuss the use of family planning

PERSONS	FREQUENCY	PERCENTAGE (%)
Spouse	15	15
Mother	1	1
Sister	3	3
Friends and Neighbours	80	80
Health Worker	1	1
TOTAL	**100**	**100**

4.10: Discussion of Family Planning and Current Use among females

	CURRENT USE OF FAMILY PLANNING METHODS		
	YES	NO	TOTAL
Spouse	5 (71.4%)	2 (28.6%)	**7 (100%)**
Friends/ Neighbours/ Relatives	21 (37.5)	35 (62.5%)	**56** (100%)
Health Worker	0	1(100%)	**1 (100%)**
Do not discuss	13 (27.1%)	35 (72.9%)	**48** (100%)
TOTAL	**39**	**73**	**112**

4.3.7.1 Discussion of Family Planning and Current Use among Females

Table 4.10 indicates that current use was highest among women who discussed family planning with their spouses, 71.4%. For those who discussed with their friends and those who did not discuss with anyone it was 37.5% and 27.1% respectively.

4.3.8 Exposure to family planning messages

The radio was the most common source of information on family planning.

- Eighty two (48.2%) of the respondents had heard family planning messages on the radio
- Forty Four (25.9%) from the health facility
- Nineteen (11.2%) Friends and Relatives
- Sixteen (9.4 %)from the television and
- Nine (5.3%)did not indicate their source of information. These persons do not approve of family planning because of their religious belief and others because they were menopausal had no interest.

4.4 ATTITUDES AND BELIEFS TOWARDS FAMILY PLANNING UTILIZATION

4.4.1 Reasons for approving or disapproving the use of family planning

One hundred and forty seven (86.5%) out of the 170 persons interviewed approve of the use family planning while 23 (23.5%) did not. The major reasons for approval and disapproval were as follows:

Reasons for Approval

- It helps to space birth thus eases financial burden (66%)
- It makes the children grow healthily (17%)
- The mother is free to work (2%)
- The mother usually remains healthy (2%)

A woman summarized the reasons for approving family planning in the focus group discussion as follows:

"*Family planning makes the woman strong all the time, if you are healthy then you will give birth to healthy children and you'll also be able to work to take care of them*"

Reasons for disapproval

- Those who disapproved of family planning gave two reasons. Four (2%) indicated that it is against their religious belief and 19(11%) because of side effects.

4.4.2 Partner 's Attitude towards Family Planning

Sixty-five (58.0%) of the 112 women who were currently in a union (married or in a sexual relationship) indicated that their partners approve of family planning, 16(14.3%) had partners who disapprove of its use and 31(27.7%) did not know their partners attitude. Twenty-seven (77.1%) men reported of their partners' approval, 4(11.4%) had partners who disapprove and the remaining 4(11.4%) did not know of their partners' attitude as shown in Table 4.11.

4.11: Partner 's Attitude towards Family Planning

	FEMALE		MALE	
PERSONS	FREQUENCY	PERCENTAGE (%)	FREQUENCY	PERCENTAGE (%)
Approves	65	58.0	27	77.1
Disapproves	16	14.3	4	11.4
Don't Know	31	27.7	4	11.4
TOTAL	112	100	35	100

Table 4.12: *Partner Approval And Current Use Among Females*

Partner Attitude	CURRENT USE OF FAMILY PLANNING METHODS		
	YES	NO	TOTAL
Approves	28 (43.1%)	37 (56.9%)	**65** (100%)
Disapproves	3 (18.7)	13 (81.3%)	**16** (100%)
Don't Know	8 (25.8%)	23 (74.2%)	**31** (100%)
TOTAL	**39**	**73**	**112**

4.4.3 *Partner Approval And Current Use among Females*

Table 4.12, shows that women who indicated that their partners approved of family planning reported the highest use, 43.1%. For those whose partners disapproved and those who did not know of their partner's attitude it was 18.7% and 25.8% respectively.

4.4.4 Decision to use family planning methods

Out of the 147 respondents who were in a union (the married and single in a relationship), 72 (49%) indicated that the decision to use family planning methods was made by themselves, 38(25.9%%) by their spouses and the rest 37(25.1%) by both (Table 4.13).

Table 4.13: Decision to use family planning methods

	FREQUENCY	PERCENTAGE
Self	38	25.9
Spouse	72	49
Both	37	25.1
TOTAL	**112**	**100%**

Participants of the focus group discussions expressed similar views on who decides on contraceptive use as the husband, the wife, or the couple.

"The decision lies with you the woman, as for the man he gets up takes his cutlass and off he goes. The burden of caring for the children rests on you. If you have to go and fetch water one will be at your back and the other on your shoulders". (F)

"It depends on both (couple). If the woman does not agree you cannot use it". (M)

"If the man does not give his consent and you do it, then it can even lead to break up of the marriage" (F)

"The responsibility lies with the man because if your children become wayward everybody will refer to the child using your name" (M)

"The decision lies with the woman because she experiences the woes of caring for children. (M)

4.4.5: Decision to use family planning and current use

From Table 4.14, 39.1% of women who had their spouses or partners deciding on contraceptive use were current users. The percentages for those who decide together and those deciding by themselves were 30.4% and 28.0% respectively. With the men, 50.0% indicated that the decision to use family planning was taken with their partners, 46.2% took the decision by themselves and 37.5% by their partners.

Table 4.14: Decision to use family planning and current use

	CURRENT USE OF FAMILY PLANNING METHODS					
	FEMALE			MALE		
	YES	NO	TOTAL	YES	NO	TOTAL
Self	7 (28.0%)	18 (72.0%)	**25 (100%)**	6 (46.2%)	7 (53.8%)	**13 (100%)**
Spouse	25 (39.1%)	39 (60.9%)	**64 (100%)**	3 (37.5%)	5 (62.5%)	**8 (100%)**
Both	7 (30.4%)	16 (69.5%)	**23 (100%)**	7 (50.0%)	7 (50.0%)	**14 (100%)**
TOTAL	**39**	**73**	**112**	**16**	**19**	**35**

Table 4.15: Distribution of the number of children desired by respondents

	FEMALE		MALE	
NUMBER OF CHILDREN	FREQUENCY	PERCENTAGE (%)	FREQUENCY	PERCENTAGE (%)
1	1	0.8	0	0
2	10	7.7	2	5.0
3	30	23.1	9	22.5
4	35	26.9	9	22.5
5	18	13.8	11	27.5
6	21	16.2	4	10.0
7+	10	7.7	5	12.5
** Non numeric response	5	3.8	0	0
TOTAL	**130**	**100**		**100**

4.4.6 Desired number of children

The number of children desired ranged from 1 to 15 children. Seventy-six (58.5%) of women and 50% of men desired one to four children. However, Five (3.8%) of women indicated that it is God who decides on the number of children to have. See Table 4.15

Findings from the focus group discussions show social, economic and religious reasons for an ideal family size as follows:

" As for giving birth is good, I think 6 is okay. Death can occur at anytime so if you give birth to three they can all die but with 6 some will die and some will remain".(F)

" I think if you give birth to 4 children you'll have less financial constraints in taking care of them" (M)

"I think having 12 children is good because some can go to the farm with you and some can send the food stuffs to the market to sell".(M)

"It is nice to have both sexes, so six; 3 boys and 3 girls "(F)

"I feel giving birth is Gods gift. He can choose to give you the number He wants. Thus the issue is how to space them and not the number".(F)

4.4.7 Child spacing

The figures presented show the views of respondents about the number of years a person should wait between the birth of one child and the other as indicated by respondents. The mean number of years is 3.7. The distribution is shown below:

- One to three years 99(58.2%)

- Four to six years 57(33.5%)
- Seven to ten years 11(6.5%)
- Don't Know 3 (1.8%).

4.5. QUALITY OF FAMILY PLANNING SERVICES

Use of Bomfa health Centre for Family planning Service

Out of the 170 persons interviewed only 8(4.7%) had ever sought for family planning services in the Bomfa Health Centre. Three of them were current users. The breakdown was as follows:

- Two were using the Pill and
- One was using IUD
- The other five used the Pill and stopped because of side effects.

When the facility was visited

Out of the 8 persons who had visited the facility, only 1 had used it within the last six months and 7 of them more than two years ago.

Availability of methods

All the 8(100%) had their method of choice at the health centre.

Privacy

Seven (87.5%) described the privacy provided during their visit as very adequate and 1(12.5%) said it was adequate.

Told Side Effects

Four (50%) were told of the side effects whilst the other 4 (50%) were not told.

Three (75%) of those who were not told were currently non-users because they experienced some side effects whilst 1(25%) was currently using.

Two (50%) of those who were told of the side effects were current users and the other 2 (50%) were not using.

Told When To Return

Seven (87.5%) were told when to return and 1(12.5%) was not told.

Attitude of the provider

All the 8(100%) described the attitude of the provider as being friendly and respectful.

Time Spent at the facility

Seven (87.5%) spent below one hour and 1(12.5%) spent about an hour.

The amount of time clients preferred to spend at a facility

All 8(100%) indicated that they wanted to spend not more than an hour in a facility.

What will make one continue to use a facility

All 8(100%) indicated that the warm reception provided by staff would make them continue to use a facility. However one of them mentioned in addition the availability of the method of choice.

CHAPTER FIVE

5.0 DISCUSSION

5.1.1 Socio–demographic characteristics and Current use of Family planning

In Ghana about one in four married women who want to avoid pregnancy are not using a method of contraception due to social and cultural factors that tend to influence sexual practices and reproductive health.[9]

Sex

In this study, current use of family planning was higher among males than females (Table 4.3). Forty Percent of men were currently using as compared to 30% of women. .The higher use among males could be attributed to the fact that men with multiple partners are likely to report use with any partner.

Age

Current use of family planning showed a rise with age though not uniform. A peak of 25.6% was observed for age group 25-29 among females and this dropped to 7.7% at age 45-49 years (Table 4.4). The 1998 GDHS reported a peak of 24% at age 35 –39 and lowest use of 12% at age 45-49. The lowest use observed in age group 45-49 is consistent with the GDHS. Though the peak percentage observed compares favourably with the GDHS, the age group differed.

Marital status

Thirty-five (34.7%) of married women and 20% of unmarried women were current users. This confirms the fact the use of contraceptives is not restricted to only married persons (Table 4.5).

Education

Research findings suggest that education is positively related to contraceptive use.[21] Current use of family planning showed an increasing pattern from no education, 25.8% to 50% at the Secondary level among females. The 1998 GDHS showed a similar pattern of 13 % for women with no education and 42% for those who had secondary education. The relationship between current use and educational level was found to be non significant the p value >0.05. This is because the sample of respondents who had had secondary education was small.

5.1.2 Practice of Family Planning

The 1998 GDHS reported that the current use of modern methods of family planning is 13 % and 9% for traditional methods. Though a higher use of modern methods, 20.8% and 13.9% for traditional methods was observed in this study, the pattern is similar.

Among all women, the Pill was found to be the most popular modern method 41.0 % followed by the Injectable 7.7% for the females. With the males the condom and Injectable followed the pill respectively (Table 4.8), which is consistent with the 1998 GDHS. The male-female difference observed was due to difference in condom use.

Three men reported condom use but no woman reported of its use. The 1998 GDHS also showed that men were three times likely to report condom use than women.

Forty two percent of current users reported using the drug stores as their source of supply of contraceptives and 26% used health facilities. A similar pattern is shown in the GDHS 32% and 29% respectively. This shows that drug stores serves as an important source of supply for modern methods (the pill and condom) within the private sector. The drug stores were the most preferred because of proximity and convenience.

Studies in India, Zambia and Ghana consistently found that lack of knowledge, fear of side effects and lack of husbands support are some of the factors accounting for the non-use of family planning methods.[12]

The impact of contraceptives on a woman's health, whether real or perceived, was found to be a major reason for the non-use of family planning in this study. Thirty four percent of the respondents, who were currently not using a method, cited the fear of side effects as the main reason for non-use. This is about twice that of what was observed in study by Govindasamy and Boadi (2000) and the 1998 GDHS. Their findings indicated that fear of side effects accounts for 16% and 18% respectively for the reasons for non-use of methods in Ghana. [10] The high percentage observed in this study may be due to misconceptions or false information that needs to be addressed.
It is worth mentioning that a few 8 (7%) cited religious opposition as a reason for non-use. Spousal consent however was not stated as a reason for non-use.

A greater proportion of the respondents 80% discussed the use of family planning with their friends and neighbours and 15% with their spouses. This clearly reflects the difficulty that couples often have in talking to each other about issues that affect their sexual life.

Females who discussed family planning with their spouses reported the highest use of 71.4%. This was approximately twice that of those who discussed it with their friends or neighbours (37.5%) and about thrice that of those who did not discuss with anybody, 27%, (Table 4.10). In diverse settings spousal communication has been consistently associated with greater contraceptive use. In Ghana women who had discussed contraceptive use with their husbands were twice as likely to be current users than those who had not which is consistent with this study. [21]

5.1.3 Beliefs and Attitudes towards Family Planning

A positive attitude towards family planning facilitates its use. Majority of the respondents 86.5 % indicated that they approve of the use of family planning based on health and economic reasons." *Family planning makes the woman strong all the time, if you are healthy then you will give birth to healthy children and you'll also be able to work to take care of them",* said a woman during the FGD.

The mean number of years for birth spacing preferred was 3.7 years, which is comparable to the actual birth intervals of more than 3 years reported in the 1998

GDHS. Even those who indicated that children are gifts from God also emphasized the need for child spacing. This reflects to some extent the value placed on child spacing.

Fifty-eight percent of women indicated that their partners approved of the use family planning, 14.7% disapproved and 27.7% did not know of their partners' attitude. A highest use of 43.1% was reported among those whose partners approved of family planning as compared to those who partners disapproved, 18.7% (Table 4.12). This suggests that partner approval play a role in the use of family planning methods.

The results of this study also show that about 50% of those in a relationship leave the decision to use family planning with their spouses or partners, only 25% make the decision together. The idea of shared commitment by couples to regulate their fertility was not clearly demonstrated. Family planning was portrayed as a woman's concern as expressed by a man in the FGD, *"The decision lies with the woman because she experiences the woes of caring for children"*

5.1.4 Perception about the Quality of Family Planning Services

The perception of clients regarding the quality of services is significantly related to the probability of subsequent adoption of a family planning method. A study by Koenig et al., 1997 demonstrated that what might be most critical is not the absolute number of methods offered but the degree of trust, rapport and confidence established between the provider and the client.[17] All the 8 persons who had ever used the Bomfa Health Centre for family planning services indicated that the warm reception offered by the

provider is what would cause them to continue the use of the facility with only 1(12.5%) mentioning in addition the availability of the method of choice.

It is worth noting that those who were using other health facilities were doing so because of access. Most of the communities in the subdistrict are located on the main Accra-Kumasi road and therefore they preferred to get transport straight to Konongo, in the Asante Akim north District, than to take a vehicle, stop at a junction and then take another one to the Bomfa health centre.

A study by Cotton et al. showed that providing women with adequate counseling on side effects can also improve the chances that women would continue using a method. [22] In this study it was observed that out of the four who were not told of side effects, 3(75%) had stopped using the method because they experienced some side effects as compared to 2(50%) of those who were told. This was consistent with findings from the FGD. *"Sometimes the nurses do not tell us of the side effects and even if you have side effects and you go to them, they keep reassuring you that it will stop but it doesn't. I know of a woman who was using IUD and was having problems but the nurse did not take heed till she collapsed. If it happens like that then no one will go for it"*, said a woman.

5.2 CONCLUSION

Current use of family planning among women was observed to increase with the level of education, from no education to secondary level. The current use of family planning was 32.4%, 22.4% for modern methods and 10% for traditional methods. A major reason for non-use of family planning methods was fear of side effects. Counseling women therefore about how the use of contraceptives can affect health is important. Majority of the respondents discussed family planning with their friends and neighbours, the importance of promoting spousal communication cannot be over emphasized.

Though child spacing was greatly valued, the views expressed by both men and women during the FGD showed that the decision to use contraceptives was seen as a woman's responsibility. This was because; it is the woman who goes through the ordeal of childbirth and care.

Finally, all the respondents who had ever used the Bomfa Health centre indicated that the friendly and respectful attitude of the staff would make them continue to use the facility. This underscores the fact that interpersonal relationship between service providers and clients may influence a client's decision to continue the use of a family planning method or a facility.

5.3 RECOMMENDATION

Based on the findings of this study the following recommendations are being made.

To The District Health Management Team

1. Information Education and Communication on family planning should be intensified to:
    - Dispel misconceptions and allay fears about side effects through community durbars and identified male and female groups
    - Encourage satisfied clients in communities to share their experience during out reach programmes on family planning.
    - Increase awareness on the importance of communication between partners on reproductive health issues through religious, women and youth organizations.
    - Educate young men about sexual responsibility during school health programmes
2. Provision of family planning services on outreach basis should be intensified to improve access.
3. The District Health Management Team should liase through forum and meetings with the Drug stores so as to capture information on clients who obtain family planning methods from such sources.

To the family planning service Provider

- Clients should be provided with adequate counseling on the side effects of methods

- Side effects reported by clients should be investigated for the necessary action to be taken.

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APPENDIX 1

QUESTIONNAIRE ON FACTORS INFLUENCING UTILIZATION OF FAMILY PLANNING SERVICES

INTRODUCTION

Good morning, I am..... working with the Ministry of Health and undertaking a study in family planning. The aim of this study is to identify the factors that affect utilization of family planning services in order to obtain information, which would be used to improve the delivery of services.

We count on your cooperation to answer the questions candidly. All responses will be treated as confidential.

Date of interview .....

Community .....

Serial Number.....

Name of Interviewer.....

SECTION ONE : BACKGROUND INFORMATION

1. Age .....

2. Sex [ ] F [ ] M

3. Occupation
   - [ ] Farmer
   - [ ] Salaried worker
   - [ ] Petty Trader

   Other specify .....

4. Educational level
   [ ] No Education
   [ ] Primary
   [ ] Middle/J.S.S
   [ ] Secondary
   [ ] Tertiary and above

5. Religion
   [ ] Roman Catholic /Anglican
   [ ] Protestant
   [ ] Spiritual
   [ ] Islam
   [ ] Traditional
   Other Specify .....

6. Marital status
   [ ] Single(In a relationship)
   [ ] Married
   [ ] Divorced/Separated
   [ ] Widowed
   [ ] Single(Not in a relationship)

7. How many children do you have?.....

SECTION TWO : ATTITUDE AND BELIEFS

8. How many children would you prefer to have in your lifetime? .....

9. How long should one wait between the birth of one child and the other? .....

10. Who decides on the number of children to have?

[ ] Self
[ ] Spouse/Partner
[ ] Mother
[ ] Father
[ ] Mother in law

Other specify.....

11a. Do you approve of family planning?

[ ]Yes [ ] No

Give reasons for your answer

.....

.....

12. Does your partner/spouse approve of family planning?

[ ]Yes [ ] No [ ] Don't know [ ] Not Applicable

13. Who decides on the use of family planning methods?

[ ] Self
[ ] Spouse/Partner
[ ] Mother
[ ] Father
[ ] Mother in law
[ ] Not Applicable

Other specify.....

SECTION THREE: PRACTICE

14(a) Have you or your partner ever used any family planning method?

[ ]Yes [ ] No

IF NO SKIP TO QUESTION 16a

14(b) If yes which method?

[ ] Condom
[ ] Injectable
[ ] Norplant
[ ] Female Sterilization
[ ] Male Sterilization
[ ] L A M
[ ] Pill
[ ] Vaginal Foaming Tablet
[ ] Withdrawal
[ ] Natural Family planning
[ ] Intra Uterine Device

Other specify .....

14(c) How long did you use the method? .....

15(a) Are you currently using any method?

[ ]Yes [ ]No

15 (b) If yes which method?

[ ] Condom
[ ] Injectable
[ ] Norplant
[ ] Female Sterilization
[ ] Male Sterilization
[ ] L A M
[ ] Pill
[ ] Vaginal foaming tablet
[ ] Withdrawal
[ ] Natural Family planning
[ ] Intra Uterine Device

Other specify .....

15 (c) If no why?

.....

.....

16(a) If you have never used any method do you intend to use one in the future?

Yes [ ] [ ] No

16(b) If no why?

[ ] fear of Side effects
[ ] Religions beliefs
[ ] Wants more children
[ ] Spouse opposed
[ ] Too expensive
[ ] Menopause

Other specify.....

17(a) Do you discuss Family Planning utilization with others ?

[ ] Yes [ ] No

17(b) If yes with whom? [ ] Spouse/Partner
[ ] Mother
[ ] Father
[ ] Sister
[ ] Brother
[ ] Mother in law [ ] Friends/Neighbours.

18. Do the people you discuss family planning with approve of its use?

Yes [ ] [ ] No [ ] Don't Know

SECTION FOUR: QUALITY OF FAMILY PLANNING SERVICES

19(a). Have you ever sought for Family Planning Services in the Bomfa Health Centre?

[ ] Yes [ ] No

.....

19(b)If no why?

.....

.....

If Answer is NO Skip to Question 28

20. If yes, how long ago did you seek for family planning services in the Bomfa Health Centre?

[ ] less than 6 months

[ ] 6 months – 12 months

[ ] 13months –18

[ ] 2 years and above

21. Did you get the method of your choice? [ ] Yes [ ] No

22. Were you told of the side effects? [ ] Yes [ ] No

23. How would you rate the privacy provided during your visit?

[ ]Very Adequate [ ]Adequate [ ] Not Adequate

24. Were you told when to return? [ ] Yes [ ] No

25. How will you describe the attitude of the provider?

[ ]Friendly [ ] Respectful [ ] Disrespectful [ ]Hostile [ ]Indifferent

26. (a) How long did you spend? [ ]Below one hour [ ] Above one hour

(b) How long will you like to spend in a facility?

.....

27. What will make you continue to use a facility for family planning services?

.....

.....

28. Where do you usually get information on family planning?

[ ] TV [ ]Radio [ ] Newspaper [ ]Health facility [ ] Relatives

Other Specify.....

APPENDIX 2

FOCUS GROUP DISCUSSION GUIDE

Good morning, I am Alberta Lomotey working with the Ministry of Health but currently a student of the School of Public Health. I am undertaking a study in Family Planning in your community. The findings would be used to improve the delivery of Family Planning services. I would therefore like to discuss a few issues with you. With me is ..... to help me with the recording.

There are no right or wrong answers. So please feel free to express your views.

Could you please introduce yourselves.

1. What have you heard about family planning?

2. Where do you get information on family planning?

3. Is family planning important?

4. Who decides on the number of children one should have in a union?

5. How many children should one have in a lifetime and why?

6. Who decides contraceptive use and why?

7. What are the reasons why people do not use family planning methods?

8. Where do people prefer to have their family planning methods?

9. Why do people prefer such outlets?