

**SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
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**WOMEN'S ACCEPTANCE OF SELF-ADMINISTERED HORMONAL
CONTRACEPTIVES**

BY

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**THIS DISSERTATION IS SUBMITTED TO THE DEPARTMENT OF
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DECLARATION

I, **QUARSHIE-AWUSAH WORLASI KOJO ANTONIO**, the author of this dissertation proposal declare that with the exception of references to other people's work which have been duly acknowledged, this work is my own work. This had not been submitted in part or whole anywhere for any degree



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DATE

(ACADEMIC SUPERVISOR)

DEDICATION

This dissertation is dedicated to the memory of Mrs Margaret Dogbe Quarshie-Awusah who was with me throughout this gruelling period and gave me the space to go back to school to commence this programme. You silently encouraged me when I wanted to give up.

Rest In Perfect Peace



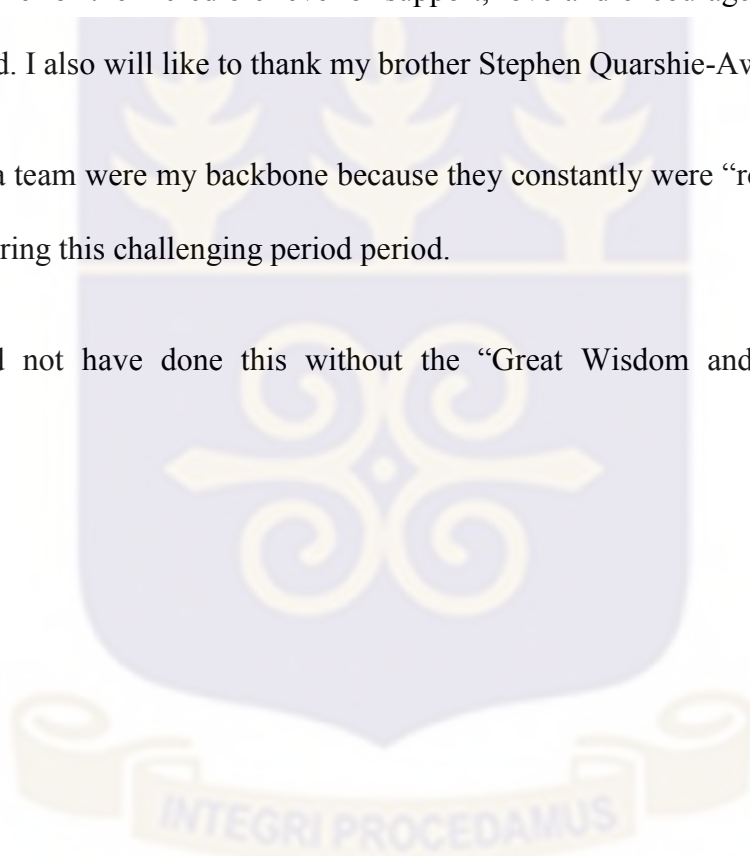
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My thanks and appreciation goes to Dr. Augustine Ankomah who encouraged and supported me when I expressed my interest the Master's in Public Health Programme.

My children Elorna and Dzidefo did not have Daddy at home during the weekends for a year and children as they are, they surprisingly understood that Daddy was busy and gave Daddy the permission to be out of the home for that long. My thanks also go to Awo Sika Quarshie-Awusah - my wife for the incredible level of support, love and encouragement she provided during the period. I also will like to thank my brother Stephen Quarshie-Awusah

The PSI - Ghana team were my backbone because they constantly were “rooting” for me and urging me on during this challenging period period.

Finally, I could not have done this without the “Great Wisdom and Architect of the Universe”.



ABSTRACT

Background: Injectable contraceptives are the most used form of contraception in Ghana. Its introduction was faced with misconceptions, doubt and disbelief. DMPA-IM is the first choice of injectable administered by service providers in health care centres in Ghana. DMPA-SC is a subcutaneous form of injectable that can be self-administered. Socio-cultural values and factors affect patient's willingness to accept and access self-administered hormonal contraceptives.

Objective: The objective of the study was to find out the pre-product level of acceptance of self-administered hormonal contraceptive (DMPA-SC) in Ghana.

Methodology: Patients on provider administered hormonal contraceptive were interviewed at the Dansoman Polyclinic. In-depth interviews were conducted within a period of two weeks. Thirty-five patients and four service providers were interviewed to assess their knowledge on the product and also to determine factors affecting their willingness to access self-administered hormonal contraceptives.

Results: Service providers strongly recommend intensive training on the use of self-administered contraceptive to patients before its introduction. According to service providers, easy access to the product, availability and price are the main determinants of patient's willingness to accept. Patients believe that price of the product and its accessibility at both the pharmacy and hospital will increase the number of people willing to access this method. Also patients agree that proper training on self-administration is required to assure safety and prevention of self-inflicted injury. Factors such as level of education, privacy and wealth are also determinants in patient's willingness to access self-administered contraceptives.

Conclusion: All service providers were ready to accept the product and to counsel patients in their choice making. Patients will accept the product based on the differing factors. The

determining factors should be addressed before the introduction of self-administered hormonal contraceptive.

Keywords: Contraception, acceptance, determinants, self-administered, preference



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LIST OF ABBREVIATIONS

DMPA-SC - Depot Medroxyprogesterone Acetate Subcutaneous Injection

DMPA-IM - Depot Medroxyprogesterone Acetate Intramuscular Injection

GDHS – Ghana Demographic Health Survey

WHO – World Health Organization



CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

According to the National Demographic and Health Survey, the rate of injectable contraceptive usage in Ghana has increased from 0.3 percent in 1988 to 8 percent in 2014 (GDHS, 1998; 2014), making injectable contraceptives the most used family planning method for married women in Ghana. The survey also revealed that while injectable usage increased to 8 percent, 92 percent of Ghanaian women are aware of injectable contraceptives as a method for family planning and contraceptive use. Depo Provera is the most widely used injectable contraceptive in Ghana. Data suggests that women who attained primary level education record the highest use of injectables at 9.6 percent compared to women who have completed secondary education, 6.6 percent (GDHS, 2014). In Ghana, 90 percent of the injectables used are provided through the public sector compared to 9.2 percent that are provided in the private health sector. The advantages of injectable contraceptives are numerous; they are highly effective, reversible, convenient and compared to the other methods, are long lasting, ensure privacy and secrecy and have a failure rate of less than 1 percent (Adetunji, 2011).



Figure 1: Figure showing DMPA-IM injection system¹

¹ **Source:** Dawn (2016). Depo Provera Side Effects. Retrieved from: <https://www.verywell.com/women-share-depo-provera-side-effects-906703>

A common type of injectable contraceptive used by women around the world, including Ghanaian women is the Depot Medroxyprogesterone Acetate Intramuscular Injection (DMPA-IM) or generally known as Depo Provera. DMPA-IM is administered intra muscular rather than sub-cutaneous. This injection system is shown in figure 1 above.



Figure 2: Figure showing DMPA-SC injectable system².

An alternate to Depo Provera IM is an all-in-one injectable contraceptive that combines the drug and the needle in the Uniject™ injection system. It is smaller and lighter compared to the separate needle and syringe combination. This all-in-one system has a shorter needle, slightly lower dosage in terms of the ingredients 104 mg DMPA versus 150 mg DMPA, it is easy to use and requires minimal training for usage unlike the DPMA IM. Figure 2 shows DMPA-SC injectable system.

This new injectable is known by its brand name as Sayana®Press and was introduced by Pfizer. For the purposes of this research, the reference will be Depot Medroxyprogesterone Acetate Sub-Cutaneous Injection (DMPA-SC). DMPA-SC is a three-month, progestin-only, all-in-one injectable contraceptive. DMPA-SC's Uniject™ method is especially suitable for

² **Source:** Spieler (2011). Contraceptive Technologies Offer New Options. Retrieved from: <https://blog.usaid.gov/2011/09/contraceptive-technologies-offer-new-options/>

community-based distribution as well as for women who want to self-inject the contraception. DMPA-SC and the possibility of self-injection can improve access to a safe and effective contraceptive option in low-resource settings and increase women's autonomy in utilizing it (PATH, 2015).

The proposal reported in this submission is a pre-product acceptability study aimed at finding out if women are willing to self-inject DMPA-SC

1.2 Problem Statement

Fewer and better-spaced childbirths remain a challenge for married women in Ghana. Currently, 31 percent of married women have an unmet need for DMPA-SC. The reasons for this unmet need are multi-dimensional. They include: lack of confidentiality at service delivery points, unavailability of commodities, myths and misconceptions about contraceptive use, lack of knowledge, provider attitude, and the cost of service delivery. These barriers have been identified as contributing to the inability or difficulties faced by married women as it pertains to spacing and reducing on the number of births. This context necessitates the need for this study.

The design of DMPA-SC as a modern family planning method responds to the challenges raised above which includes confidentiality of patients, negative provider attitude amongst others. Though the benefits of DMPA-SC have already been noted, a yet unanswered question is whether women currently on DMPA-IM are willingly to switch to DMPA-SC especially as it responds to the above mentioned challenges.

DMPA-SC studies elsewhere have revealed a demand for self-injection among patients. In Senegal and Uganda, providers spontaneously discussed the potential for self-injection (Burke et al., 2014). Almost half of patients in Uganda who received provider-administered DMPA-SC (45 percent) were moderately or very willing to use the self-inject method and

over a fifth (22 percent) of patients in Senegal who received DMPA-SC said they were moderately or very willing to self-inject (Burke et al., 2014). The first woman to self-inject DMPA-SC in Senegal enrolled in the joint PATH-Ministry of Health operational feasibility research study in October 2015 and by December 31, 379 women had elected to enrol in the study and self-inject (ReproNet, 2015)

PATH and FHI360-led DMPA-SC studies in low-resource settings have provided evidence of high acceptability among patients and providers. These studies have similarly provided evidence that DMPA-S can be safely introduced into family planning programs and administered by trained community health workers (Burke et al., 2014). However, there are variations in patient acceptability of self-injection in these two countries.

This study therefore seeks to assess women who are currently on provider administered DMPA-IM's willingness to migrate to self-injecting DMPA-SC and their perceptions of self-administered injectable family planning contraceptives given the challenges associated with other contraceptive methods - DMPA-IM - identified in the previous chapter.



1.3 Conceptual Framework

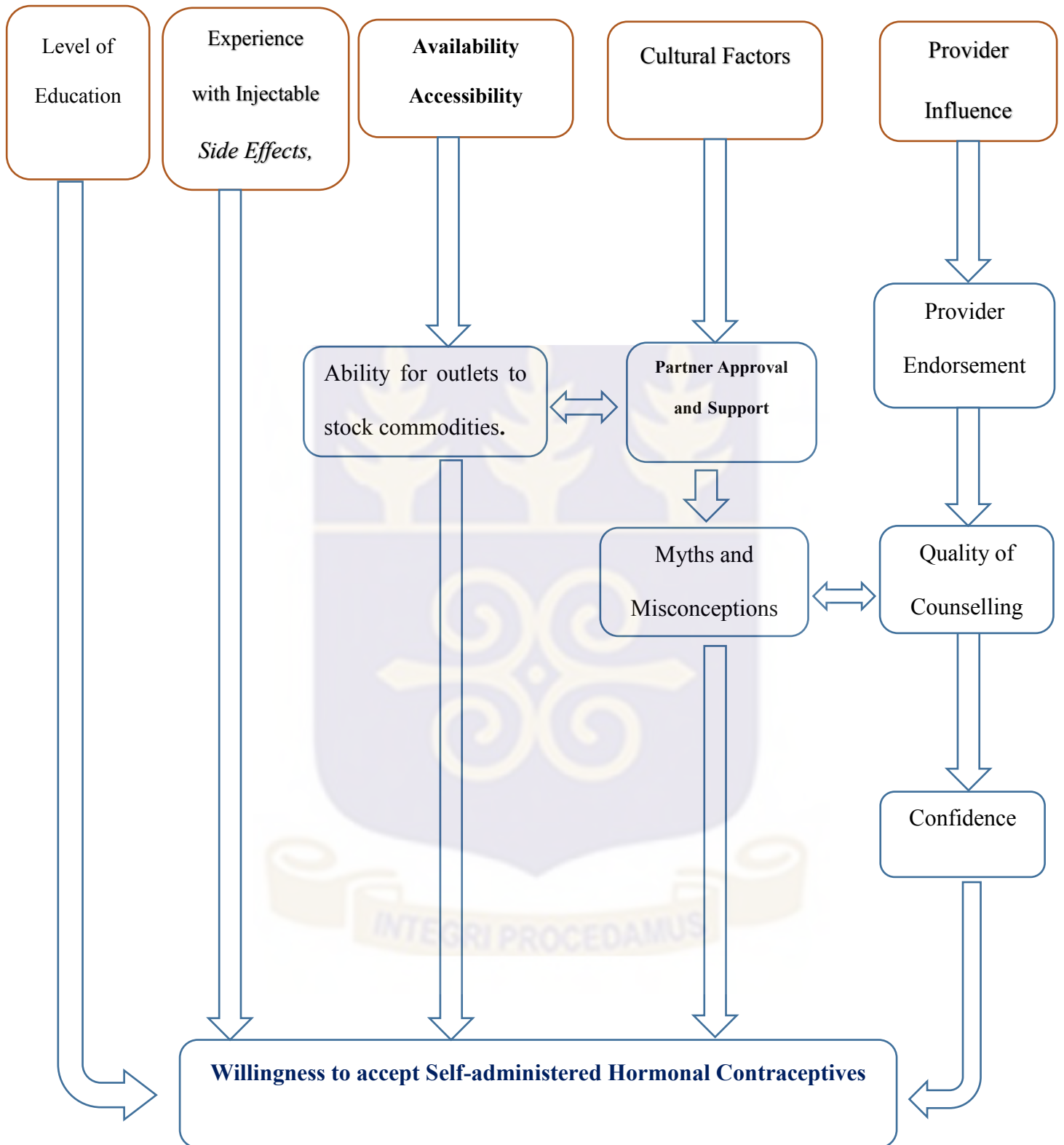


Figure 3: Conceptual Framework

There are multiple factors that influence behaviour like the one being studied. The uptake of family planning is beset with all manner of challenges which are complex for example, myths and misconceptions or not so complex like access and pricing. In the case of willingness to self-inject a contraceptive, the independent variables identified in the conceptual framework are multi - dimensional. They are classified under 5 thematic areas – level of education, experience with injectable (positive or negative), access/availability, cultural factors and provider influence.

Other than the “Experience with Injectable” which has a direct impact on the willingness to self-inject according to the conceptual framework, some of the other independent variables under a particular theme can influence other variables under another theme. For example, a service provider’s quality of counselling may be influenced by the myths and misconceptions of the community. In addition, the ability to pay for the contraceptive may be directed related to a partner’s lack of support for the initiative. In the event that the woman is not financial independent, her ability to purchase the contraceptive without spousal assistance is greatly diminished.

The conceptual framework also seeks to point out how though clustered under the 5 thematic areas, there are independent variables that have a direct influence on the willingness to self-inject. Cost and availability are two examples of independent variables that have a direct impact on the willingness to self-inject. This conceptual framework seeks to demonstrate how some variables have a direct influence on willingness to self-inject whilst other interrelated variables indirectly influence willingness to self-inject. This study seeks to understand from the users’ perspective how each of these variables will have a direct and indirect influence on their willingness to self-inject. It is anticipated that some evidence will come up which will support or challenge the importance of the variables outlined above.

1.4 Justification of Study

The Ghana Health Service (GHS) aims to meet a contraceptive prevalence rate goal of 39 percent by 2017 through a variety of means, including expanding the method mix. GHS has reached out to its partners, namely USAID, UNFPA, PSI, and the Population Council to undertake a feasibility and acceptability study regarding DMPA-SC self-injection and by extension, the introduction of the contraceptive in Ghana. Understanding the feasibility of introducing DMPA-SC in Ghana's health delivery system as well as the acceptability of self-injection among women will help to inform both the procurement and scale-up of DMPA-SC in Ghana

This proposed study though not funded, will contribute to the related studies in Ghana funded by USAID Ghana and led by the Population Council through the Evidence Project. The larger study which will recruit patients in selected public health facilities in urban and rural areas is aimed at assessing the feasibility and acceptability of DMPA-SC self-injection among family planning patients and facility-based family planning providers in Ghana.

While the larger study intends to recruit women for the product trial, there is still the need to determine whether women would be willing to self-inject the contraceptive. The proposed population of this study are women who use the injectable – DMPA -IM as their family planning method.

This study therefore seeks to determine if this group of women who use injectable contraceptive DMPA-IM as their means for reducing and spacing childbirths will be willing to switch to a self-injection hormonal method – DMPA-SC to achieve their primary objective of fertility management.

1.5 Objectives of Study

1.5.1 General Objective

The general objective of the study is to find out the pre-product level of acceptance of DMPA-SC in Ghana by describing the product and the mode of use as well as identifying the reasons that will influence women's likelihood to self-inject DMPA-SC.

1.5.2 Specific Objectives

The specific objectives of this study are;

- To assess the acceptance of self-injected contraceptives - DMPA-SC among women currently using DMPA-IM.
- To identify the reasons of acceptance and willingness to self-inject after counselling by service providers
- To assess if women will go to pharmacies and chemicals shops to purchase DMPA-SC.
- To assess the price point's patients will be willing to pay for DMPA-SC.
- To understand if service providers in the public sector family planning services will support the process of self-injection by their patients who were originally on provider administered injection method (DMPA-IM).

1.6 Research Questions

The following research questions will guide this study;

- Will current users of DMPA-IM become confident enough to self-inject DMPA-SC if provided with counselling?
- Will service providers support self-injection by their patients?
- What factors prevent women from taking injectable as an FP method?

- What factors encourage women to take injectable as an FP method?
- Will service providers be willing to train and counsel their patients on self-injection?
- Are women willing to purchase DMPA-SC from pharmacies and chemical shops?
- What price will they be willing to pay more for DMPA-SC?
- What are the current myths and misconceptions on hormonal family planning methods and will they persist with the new method?



CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Contraceptive use in sub-Saharan Africa

Although sub-Saharan Africa still has the lowest level of contraceptive use among all the major regions of the world (United Nations, 2011), over the past two decades, the proportion of married women using modern contraceptive methods has increased in almost every country in the region. One of the most noticeable things that has accompanied the rising contraceptive usage in many countries in the region is the change in the method mix. Initially, the pill was the main modern method of contraception in most countries in the region. However, in recent years, the use of injectable contraceptives has increased and the rate of increase has been so fast in many countries that they have become the leading method Lande R; Richey C, (2006). Adetunji (2011) noted that Africans who used injectables in 2009 (6.8 percent) was about double the global average (3.5 percent).

The education level of respondents in Adetunji's study was positively correlated with utilization of family planning services. This finding suggests that people with higher educational levels are more likely to go for family planning services than their counterparts with lower educational attainment. This is in line with other studies that show that women with higher educational levels tend to be better informed about family planning services and are more likely to use the services (Apanga & Adam, 2015).

Hindin, McGough and Adanu (2014) discovered that, fear of side effects are the leading reasons for non-use of contraceptives in Ghana. Menstrual irregularities due to hormonal methods and concerns that prolonged contraceptives usage can lead to infertility, particularly among young women emerged as other concerns hindering the use of contraceptives. Hearsay about side effects and misinformation were also common reasons for non-use. The study also

found out that women believed that blood tests are required for clinicians to recommend the best method (Hindin, McGough, & Adanu, 2014).

Burke et al. (2014) found that current DMPA-IM patients accepted the DMPA-SC, with a high percentage (≥ 80 percent) preferring DMPA-SC over DMPA-IM. The participants' main reasons for this preference included fewer side effects, liking DMPA-SC with fast administration, less pain and method effectiveness. According to the researchers, DMPA-SC was generally felt to be safe and well tolerated in the populations studied.

In the context of Ghana, the public sector has been the main supplier of family planning services. The service provider potential of the private medical sector has not been realized, nor has that of the pharmacies which, given the requisite training and authorization can be another source raising DMPA-SC use by another incremental level. The positive traits of the injectable illustrates another lesson, that contraceptive technology is important which has led to exceptionally high levels of use in countries as disparate as Indonesia, Thailand, Peru, Nicaragua, and South Africa (Ross & Agwanda, 2012).

Evidence shows that a woman will choose a product keeping in mind her spouse's choice and whether the product will interfere with their enjoyment of sexual activity or the ability of the product to be used in secrecy without their partner discovering. The study furthermore found that with preventive measures or products, the target will prefer if it came in variety; in terms of dosage, product options, conditions for use, since that will help to use the little resources available to develop products that the target will actually be interested in using (Luecke et al., 2016).

On testing the acceptance of an HIV antiretroviral intra-vaginal ring in Kenya, researchers found that, about 97 percent of the total of 692 women were in favour of the new product and would be willing to exchange their old product for the new product. The study however

identified that, culture, habits, physical and physiological issues may affect the use of the new product (IVR). The belief that participants sexual behaviour, their hygiene and practices during menstruation, their experiences and fears of side effects, discomfort of the vaginal ring, the product interference during sexual intercourse, their partners support and approval, hormonal effects, their plans about reproduction amongst others are part of the issues that will affect the use of the product. Fear of using the product came from some women believing that the product may cause pain during sexual intercourse, some also worried about their partners support and others were worried about the presence of the ring being unveiled during sexual intercourse. The researchers described the study as successful as they were able to mobilize especially women younger than age 25 to partake in the study (McLellan-Lemal et al., 2016).

Researchers discovered that most teenage women were able to self-administer DMPA-SC after a short training. They also made it clear they would be willing to use DMPA-SC if it was made available to them out of the clinic. Most participants welcomed news of DMPA-SC self-injection because it will decrease transport cost to the hospital every few months and will clear the trouble of having to miss work in order to go for injections. Researchers however believe that as much as this maybe convenient to users, there will still be the need for some sort of communication between health care providers and users of DMPA-SC. This may be so because, users may forget the right injection procedure because of the lag time between the first injection and the next - three months. The study nevertheless revealed that 67 percent of its 176 participants wanted to self-administer DMPA-SC (Williams, Hensel, & Fortenberry, 2013).

Most women did not want to have to return to a clinic three months after DMPA-IM injection. These group of women strongly supported the need of self-administering of DMPA-SC in their homes. Like other researchers, (Upadhyay, Zlidar, & Foster, 2016) self-

injection of DMPA-SC will cut down delays in going to clinics for injection which sometimes lead to inconsistent use of contraceptive and in places where the DMPA-IM access requires long travel, self-injection will save time and cost. The study noted that while a greater number of women believe they have the ability to self-administer DMPA-SC others believe they could not do it right and it has to be done at a health clinic.

Women who found it difficult to get prescriptions when their birth control refill was up gave positive response to self-injection of DMPA-SC. Women who had just had an abortion at the time of the study who were at most risk for repeat pregnancy were also interested in self-injection of DMPA-SC. The study results augurs well for self-injection of DMPA-SC. Results reveal that it is totally feasible as similar successes have been achieved with conditions like migraines and diabetes whose patients self-administer their drugs (Upadhyay et al., 2016). Notwithstanding, (Williams et al., 2013) believes that diabetes patients have to inject their medicine frequently by themselves and that gives them some sort of expertise in injection but DMPA-SC users may inject after three months and they may forget the procedure required to properly inject the contraceptive.

Some women nonetheless had faith in their ability to self-inject DMPA-SC to the extent that they were sure they would be able to advise other women on the manner of usage. Some of the women also believed that self-injection of DMPA-SC proved to be less painful. A considerable number of women however disagreed and said they were unlikely to opt for self-injection of the injectable contraceptive. The study conducted to find out how feasible self-injection of DMPA-SC was, found 20 percent of the women did not want to part-take in self-injecting and also, they found it hard to self-inject DMPA-SC because of complications with using the device. The study also found that, DMPA-SC has no record of side effects compared to DMPA-IM which had records of irregular bleeding, changes in weight where some women loss weight during the period of use and others gain weight. One outlier that

came to light during the study concerned the issue of fertility. With DMPA-SC users, the women went back to their original state of fertility 12 months after they stopped the taking the injectable while in DMPA-IM, it took 30 months to return to their fertility state. The study further showed that DMPA-SC has no interactions with other enzyme inducing drugs in the body thus there will be no need for dose adjustments with patients taking other drugs (Tseng & Hills-Nieminen, 2013).

DMPA-IM use is discontinued after some time because of its side effects particularly, irregular bleeding, and difficulties with access to the contraceptive. Reports show that only 53 percent of women continue to use DMPA-IM after the first year of use. The ability of DMPA-SC to capture and meet the needs of the 47 percent of women that fail to continue using DMPA-IM is sufficient justification for rolling-out the use of DMPA-SC. Early research on the feasibility of DMPA-SC shows the participants continued self-injecting after one year. The women involved were questioned about past contraceptive use, demography, and their plans for pregnancy in future. The women who were interested in self-injecting were trained on how to do so and were given full kits containing prefilled syringes, calendar dates for the next injection together with manuals detailing how the injection is to be taken. Two participants in the study voiced their inability to feel comfortable with self-injection of the DMPA-SC. The study also revealed that the solution to raising the number of women who use contraceptive in developing countries is the DMPA-SC. They note that DMPA-SC is a long-term contraceptive and women in developing areas like long-term contraceptives due to their effectiveness. These women also liked the privacy and secrecy involved in self-injecting DMPA-SC. In the study however, continuous use of contraceptive was not reflected in the findings but other important determinants of contraceptive use such as a cut down in time spent journeying to clinic, cost of travel to clinic and healthcare cost that comes to every user once they visit the provider is reduced. The study did not only focus on self-injection of the

DMPA-SC but also looked at health providers who administer the injection providing a part of the participant experience with the required DMPA- SC. Those who did not like the self-administering of DMPA-SC were handed over to the health providers for assistance (Beasley, White, Cremers, & Westhoff, 2014).

Burkina Faso, Senegal, Uganda and Niger are the first four sub-Saharan countries in which PATH and partners have undertaken DMPA-SC pilot and introduction studies (Sayana®Press: Pilot Introduction and Evaluation 2013). Between June 2014 and October 2015, PATH administered over 230,000 doses of DMPA-SC in these four sub-Saharan countries (Sayana®Press: Product and Project Summary, 2016). DMPA-SC has been also introduced in at least five additional countries including Bangladesh, Democratic Republic of Congo, and Nigeria by a range of public sector and private sector organizations.

According to PATH, DMPA-SC introductions in Burkina Faso, Niger, and Senegal have made injectable contraceptives a routine part of community-level healthcare for the first time, giving women convenient access in their own villages. In Uganda, the DMPA-SC pilot introduction activities are built on the Ministry of Health's commitment to expand community-based delivery of injectable contraceptives (Sayana®Press: Pilot and Introduction Evaluation, 2013).

In Burkina Faso, the DMPA-SC initiative was promoted by the 2012 London Summit on Family Planning, where the then First Lady of Burkina Faso, Chantal Campaoré, called on the global community to join Burkina Faso in a commitment to improve access to family planning to create “better prospects for millions of women and children.” The DMPA-SC introduction program was launched in Burkina Faso in July 2014. Preliminary data from 5 out of 23 total districts and two local nongovernmental organization partners involved in the introduction program indicated that approximately 5,729 women are using DMPA-SC and of

these, 1,659 are new users of family planning. In Burkina Faso, women obtain their DMPA-SC from clinic-based providers (Sayana®Press: Product and Project Summary, 2016).

In Uganda, DMPA-SC introduction was carried out at the community level in two districts. Community Health Workers (CHWs) were trained to administer DMPA-SC. Pre- injection and post-injection questionnaires were administered using personal digital assistants (PDAs) to experienced DMPA - IM users who received DMPA-SC instead of their usual DMPA-IM injection (Burke et al., 2014). One hundred and twenty participants (n=120) who opted to try DMPA-SC were monitored for three months post-injection to further assess their experiences and asked if they would select DMPA-IM or DMPA-SC for their next injection (Burke et al., 2014). Of these participants, 84 percent in the study preferred DMPA-SC due to fewer side effects, less pain and effects on menstruation (Burke et al., 2014). Nine participants declined the contraceptive during the enrolment period. Eligible DMPA-IM users who declined to receive DMPA-SC were interviewed about their reasons for declining, revealing that the product was new and they were afraid of side effects. In-depth interviews were also conducted among providers to assess their experience in providing DMPA-SC (Burke et. al., 2014).

In Senegal, DMPA-SC introduction was carried out in family planning clinics in three districts. Clinic-based providers were trained to administer the contraceptive. Two hundred and forty-two participants tried the DMPA-SC product, out of which 7 participants declined the product. Their reasons for declining were a lack of familiarity and trust of the product (Burke et. al., 2014). After three months of monitoring participants who decided to try the product, about 80 percent said they would select Sayana®Press, if both DMPA-IM and DMPA-SC were available. Their main reasons for selecting DMPA-SC included

experiencing fewer side effects, liking the method, fast administration, less pain, and method effectiveness (Burke et. al., 2014).

SUMMARY

The literature review indicates that there is huge potential for self-injection to be accepted in Ghana because the method was convenient as well as that it provide less pain and was effective in preventing unintended pregnancies.



CHAPTER THREE

3.0 METHODOLOGY

3.1 Study design

This is an individual level research to investigate participants' in-depth responses. In view of the descriptive responses from the participants, the study is a qualitative study using the Grounded Theory Study approach.

3.2 Study area and population

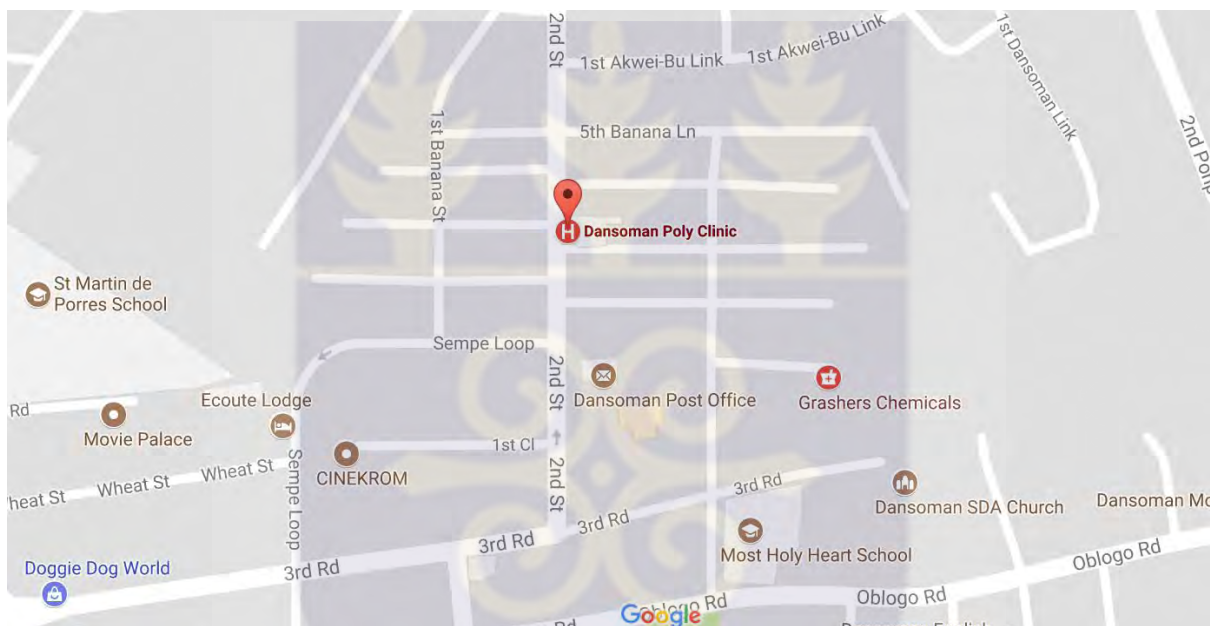


Figure 4. Map showing the location of the Dansoman Polyclinic

The study was undertaken in Dansoman (shown in figure 4) a suburb of Accra and it is approximately 7 km from the Central Business District of Accra. Dansoman is predominantly a working class community and it is one of the most diverse in Accra in terms of household income and ethnicity (AMA, 2014). The population of the area is estimated to be 56,267 people (AMA, 2014). Dansoman is in the Ablekuma South sub-metro of the Accra Metropolitan Assembly. According to the DHIMS, Dansoman and its environs have 46 private health centers, 2 Government Hospitals, 8 government facilities and 2 CHAG facilities. The Dansoman Polyclinic was chosen for the study because it is a focal service

provision centre for the Reducing Maternal Mortality and Morbidity Consortium for capacity building and demand generation as well as the fact that it was the first clinic in the community providing family planning services since the community was built thus they are recognised in the community as providers of family planning services

3.3 Sample size

Within the one week of sampling at the polyclinic the team conveniently recruited people into the study. A total of 35 women on injectable contraception were recruited. The reason for recruiting 35 women was that as part of the preparations for the data collection, the service providers indicated that for the period that we were sampling, we were likely to get on an average of 8 women a day coming for an injectable thus the researcher decided to speak to an average of 7 women a day who were on an injectable. Four service providers were also recruited making a total of 39 participants in all.

3.4 Data collection tools and techniques

For data collection, the study made use of an open-ended interview guide to obtain in-depth responses from participants. The responses were descriptive and hence a qualitative approach was to be used to analyse them. Analysis was based on themes from the descriptive responses given by the participants.

3.4.1 Data quality control

To ensure quality data collection and control, research assistants were trained by the researcher. The training exercise was necessary to ensure consistency. Research assistants were trained in data collection techniques and interviews as well as how to ensure the privacy and confidentiality of the participants. During the data collection process, the researcher accompanied the research assistants to ensure quality of work done.

3.4.2 Data entry and storage

All written answers from participants were scanned and kept in a secure venue. The audio recordings were transcribed by the researcher and then deleted. The transcribed data was kept safe and offline at all times until the end of the research. The transcribed documents were then destroyed.

3.4.2 Data processing and analysis

The descriptive data acquired from the interviews was organised. These were done by reviewing all the transcribed documents. The data was ordered in relation to the research topic and interview questions. These ordered topics were coded into themes that represented information provided by the research participants. These themes were critically analysed to produce the results from this study. Qualitative data analysis tool, Nvivo was employed in organising and understanding this data.

3.5 Sampling procedure

The sampling procedure that was used was convenience sampling. The participants were consecutively selected in their order of appearance according to their accessibility and their willingness to participate in the study. The selection process came to an end when the research team acquired the total number used for the research in the allocated time period.

3.5.1 Inclusion criteria

The target of the proposed study was 18-49 year olds currently using injectable (DMPA – IM) and presenting at Dansoman Polyclinic for family planning services. Women who presented from the beginning of the study period and were eligible were recruited until the sample size was attained. Overall, women who consented to be part of the study were recruited.

3.5.2 Exclusion criteria

The study was voluntary and excluded anyone who did not want to participate. Also excluded were women who did not use any injectable as a birth control method.

3.6 Study variables

When it comes to the variables in the study, the independent variables were;

- Providers willingness to support the process
- Counselling
- Level of education
- Myths and Misconceptions on the hormonal methods
- Willingness to participate
- Willingness to go and purchase from an OTCMS or pharmacy

The dependent variable was the willingness to self-inject their contraceptive method.

3.7 Ethical considerations

3.7.1 Potential benefits or risks

The results of the study will help women and other stakeholders in formulating policies and assist women in making the right choices as it pertains to family planning. There were no risks involved in this study.

3.7.2 Anonymity and Confidentiality

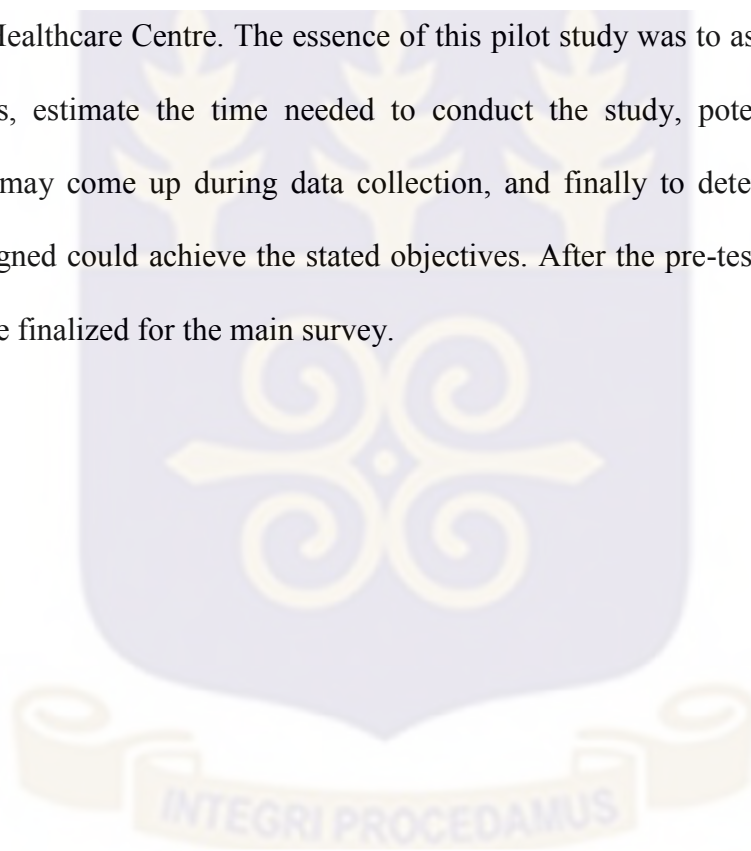
The participant were made to understand that none of the information collected from them will be used against them. The information collected will be solely used for academic purposes and for this research only. Confidentiality was maintained at all times during the data collection process. A trained provider informed a potential participant of the research

study and requested if she will be interested to provide informed consent. When the patient agreed to participate in the study, she was given an informed consent form to sign.

After agreeing to participate, participants were provided with basic information on DMPA-SC, key product attributes as well as a pictorial demonstration on the self-administration process.

3.7.3 Pilot Study

The study instruments was piloted in Kaneshie Polyclinic which had similar characteristics as the Dansoman Healthcare Centre. The essence of this pilot study was to assess the suitability of the questions, estimate the time needed to conduct the study, potential and possible challenges that may come up during data collection, and finally to determine whether the research as designed could achieve the stated objectives. After the pre-test, survey tools and instruments were finalized for the main survey.



CHAPTER FOUR

4.0 RESULTS AND DISCUSSION

The purpose of this research study was to find out the pre-product level of acceptance of DMPA-SC in Ghana by describing the product and the mode of use as well as identifying the determinants that will influence women to accept and self-inject DMPA-SC. The following questions informed this study:

- a) Will current users of DMPA-IM become confident enough to self-inject DMPA-SC if counselled?
- b) Will service providers support self-injection by their patients?
- c) What factors prevent women from taking injectable as a family planning method?
- d) Will factors encourage women to take injectable as a family planning method?
- e) Will service providers be willing to train and counsel their patients on self-injection?
- f) Are women willing to purchase DMPA-SC from pharmacies and chemical shops?
- g) What price will they be willing to pay for DMPA-SC?
- h) What are the current myths and misconceptions on hormonal family planning methods and will they persist with the new method?

Patients were recruited at the Family Planning Unit of the Dansoman Polyclinic for a week. In the course of the week, the researcher approached women who came into family planning unit, specifically women on injectable and introduced himself to them. He explained that he wanted to interview women who were on DMPA-IM about their willingness to try DMPA-SC. In-depth interviews were conducted upon the patients' agreeing to participate. During the interviews, study participants spoke openly about their experiences with DMPA-IM. They provided some history of their chosen family planning methods, its advantages and disadvantages and reasons why they prefer these family planning methods to other ones. The principal researcher conducted these interviews. Some of the interviews were in English, others in Twi and three in Ga. On average these interviews lasted about 12 to 15 minutes. The interviews were audio recorded and then transcribed at the end of the day. The research

findings in this chapter are hence based on the analysis of the interviews and observations made at the study location.

4.1 Background

The patients interviewed were women on hormonal injectable contraceptives who visit the Dansoman Polyclinic for their DMPA_IM shots every three months. They ranged from ages 19 to 44 years with an average age of 28 years. Figure 5 shows the age distribution of the research participants at the Dansoman polyclinic.

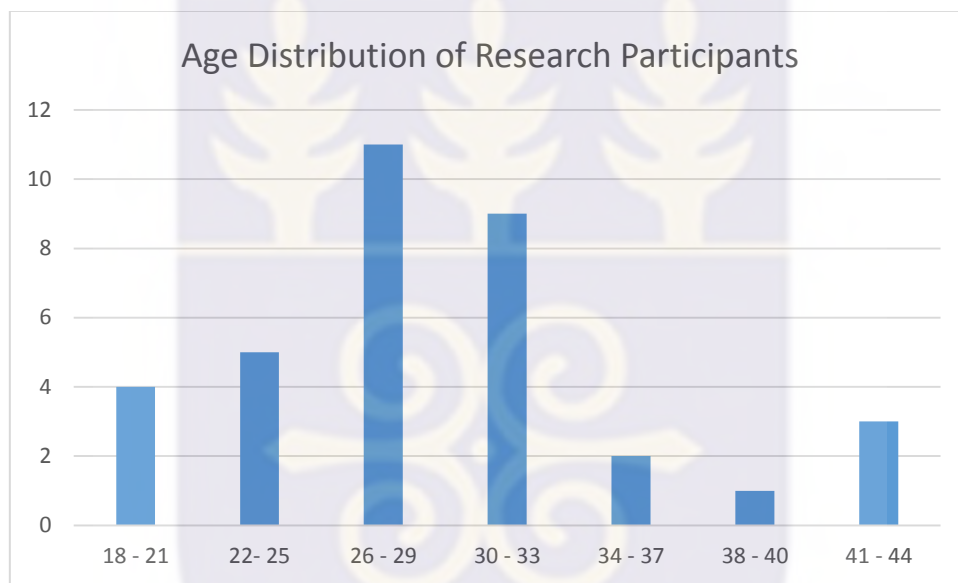


Figure 5. Age distribution of research participants at the Dansoman Polyclinic

The continuous hormonal contraceptive use ranged from 3 months to 4 years. Only 4 out of the 35 patients interviewed had tried two or more family planning methods. Twenty one of the patients are on DMPA as a means to avoid having more children. Eleven patients are on the contraceptive in order to correctly space out their children and four of the patients have not had any children yet.

4.2 Study findings

A. Knowledge of DMPA-SC

This theme focuses on the patient and service provider knowledge on DMPA-SC prior to this interview. Besides two patients who had heard about the product all the other patients had no knowledge of DMPA-SC. The patients with knowledge however could not provide any information on the product. Although health providers had knowledge on DPMA-SC they had a lot of unanswered questions about the product. Some of the responses include:

“This method was recommended to me by a doctor in Korle Bu..... I have to go back to him for details on it and for him to advise me on whether or not I should go in for it” (Patient 9)

“Yes I have heard about this one but I haven’t had a clear explanation to that” (Patient 34)

“Oh no, I haven’t heard about that. When I heard there was this new one coming I was interested in knowing how it works” (Service Provider 2)

“With that one, I don’t know whether it is the same as the Depo we’ve been giving them or there is something different about it” (Service Provider 1)

B. Level of acceptance of self-injected contraceptives

This section focused on the level of acceptance of DMPA-SC among women currently using DMPA-IM. Initial responses from patients were mixed with some willing to try the product while others stated clearly that the product is not something they will consider. A pictorial demonstration and little education later saw some patients changing their views.

“If it is introduced and we are taught how to use it, why not? I will go ahead and try it out”
(Patient 34)

“Yes I will like to try it. This is because it is convenient and it will save me time” (Patient 10)

“I have seen and understood but because I haven’t tried it before I can’t tell whether I want to. I haven’t done some before so maybe in three months’ time, if it is available, I will give it a thought” (Patient 8)

“I will be comfortable using self-injected contraceptive.” (Patient 1)

“I would say, we don’t have a problem with you introducing this. If we try it and it does not work for us, we will just go back to our previous methods..... if we do like it but health workers do not accept it, it won’t be possible to have it.” (Patient 11)

“I don’t think this is a good thing. I won’t try it. People are not supposed to inject themselves like this” (Patient 20)

“No this is not for me. I don’t know who will try this. Why should I be injecting myself when there are nurses to do that at the hospital?” (Patient 18)

Some patients think self-administration in itself is wrong. These patients want nothing to do with DMPA-SC. Others also will not want to think about trying because they are afraid of injuring themselves.

“Papa please I can’t. Being injected by someone is hard enough for me so I can’t do it myself... I won’t want to inject myself so I won’t buy it. I am really scared” (Patient 14)

C. Determinants of acceptance and willingness to self-inject after counselling

There is certainly enough evidence to suggest that medical self-administration is acceptable and even routine for some users. For instance, self-injection is common for patients with conditions such as diabetes, multiple sclerosis, infertility, and Addison’s disease. From this

study, it can be established that, study participants preferred decreased contraceptive associated costs for transportation to clinic, child-care and time taken from work. Potential avoidance of these costs was articulated during the interviews as benefits to self-administration of DMPA-SC. Also the little education during the interview saw some patients change their views from not willing to try to certainly looking forward to try out the product when it gets to the market.

“If you live a distant away from the hospital, it helps cut down transportation cost so then you won’t waste your time coming here.” (Patient 1)

“I think it should be for the elite and people who can’t make the time. I was due to take the injection on the 15th of June but anytime I pass by, I am told they have closed. I actually had to take a day off today to come here.”(Patient 10)

“If I am taught how to safely do it then I will be willing to inject myself.”(Patient 8)

“Both are good it depends on the availability of the drug...it should be affordable and accessible.”(Service Provider 1)

“If I go to the drug store to buy and I have a problem with it I can’t seek for further advice. So I think it has to be taught well here before I’m recommended to the drug store to buy.” (Patient 8)

“If it is a different drug then no. But so far as it is the same then fine. I don’t know what a different one will do. I have used this one for a while so I won’t be willing to use one that is different” (Patient 12)

D. Willingness to access DMPA-SC from pharmacies

Perception of others were a concern to some patients if seen patronizing the product from the pharmacy. It would be right to say patients who were concerned about not finding time away from work to come get their shots at the hospital preferred going to the pharmacy to acquire the product. Others, however were concerned about people's perception if seen going to the pharmacy for a family planning product. The hospital was the second choice as a point of sale of the DMPA-SC.

"I would be willing to go to the pharmacy to buy the injectable. For me that is the shortest and easiest way of getting it."(Patient 1)

"Yes I do not mind going to the pharmacy to get it because I am married. If you're not married and you go to the pharmacy, you're likely to find people's bad perception about you but for a married person it will be seen as family planning."(Patient 10)

"I don't mind getting it from the hospital or chemical shops either. It is just that there is none here" (Patient 11)

"Oh yes. It is basically the same product so, if say I come to the hospital and I don't get it, I can acquire it at the pharmacy... the hospitals too will work for me" (Patient 34)

"Yes I can go and buy it from the pharmacy but I prefer getting it from the hospital" (Patient 8)

"The pharmacy? Are you sure about this? And what about the young girls, can't they get their hands on it? They can go and stand in a drug store to buy it. These kids these days are very smart" (Patient 12)

"At the pharmacy, any child can walk in and say he is buying. What about that?" (Patient 23)

“...family planning will go up pretty high especially with the adolescents and young adults. They are also interested in the Depo-IM. As I said, it is a secret. When they come, no one knows that they have the injection. So we should involve everyone” (Service Provider 1)

Service Provider 2 expressed strong concerns about the services of pharmacies in the country. She recommended strongly that this product be only distributed through the hospital. Patient X also expressed similar concerns

“...because some of the people found at the pharmacies are not pharmacists they won't be able to do the right thing. Even emergency contraceptives at the pharmacy are now being used for family planning methods. Some women are facing problems with bleeding, amenorrhea... and they come to the clinics to complain... so the bottom line is that the pharmacies will not be able to educate them well on how to use it” (Service Provider 2)

E. Willingness to pay for DMPA-SC

All the patients were willing to pay for the DMPA-SC. The price that women will pay for DMPA-SC will depend on the service delivery channel. Women accessing it through the private sector including pharmacies and drug shops will likely pay different prices as to the price at the hospitals. During the interview almost all the women were aware of these price determinants. However they were willing to pay up to a certain amount.

“I will be willing to pay 5 cedi's due to its simplicity. What we currently take here is 1 cedi so 5 cedi's is acceptable because it takes care of transportation...Yes, I can pay 10 cedis for it so long as I can afford it. I wouldn't buy it if it's beyond 20 cedi's... I can't afford that.” (Patient 1)

“I think the average Ghanaian can afford 5 cedis...It’s a good recommendation. I don’t want to just hear about it, rather, see it in practice.”(Patient 10)

“I am a customer so I cannot put a price on someone’s product but since you insist then I think 2 or 5 cedis is fine... you can start with 5 cedis and when people start patronizing it can be increased” (Patient 31)

“Oh I can’t tell. But if it is the same medication, it could sell for 1 cedi and if it suits you an extra one cedi could be added for profit, making the cost 2 cedis” (Patient 30)

“Yes, well as at now we are not aware about the cost. The cost plays an important role. Because the regular Depo is 1 cedi per shot for three months making three cedis for the whole year. Transportation and other expenses come in. I hope the producers will consider all that, and make it easily available everywhere.” (Service Provider 1)

F. Service provider preference for DMPA-SC

Some service providers preferred DMPA-SC to DMPA-IM due to the convenience that comes with it. Others were of the view that the product be introduced to new patients since those exposed to the traditional DMPA-IM may not show interest.

“Yes, especially those who want the injectable to be prolonged. For some people who say they are travelling and don’t want to go to a new family planning unit can request the possibility of two shots at a go. But if the SC, is there, they can take it along, when the time is due, they can inject it themselves wherever they are. Some also think that family planning needs prescription especially those who are travelling out of the country. But without prescription, you can have your vaccine or injectable in your bag and take it along.”(Service Provider 1)

“Those on it will find it difficult to change. I feel a group of people who are new to family planning will start it. When they are given the choice to choose, the educated ones are most likely to pick the SC.” (Service Provider 2)

“I would encourage both. I can’t really give you an answer because I don’t know much about it. But once it is a family planning method we will have to. It is like trying to promote Depo-IM and not the implants or IUD. So, we promote all. Whichever is good for the patient is what she will decide.” (Service Provider 3)

“Like I was telling you, I don’t know much about the SC so I can’t say I prefer that one over the IM. Depending on the side effects the patient will decide. Nevertheless, we can have both. Once the patient is doing well we don’t have a problem” (Service Provider 4)

“... also, if they are able to administer the injections themselves, it is at a disadvantage for us the nurses because our work will go down and we will feel bad because me when I come to work and there is no work to be done I feel bored” (Service Provider 2)

G. Myths and misconceptions

As is typical in most Ghanaian communities, myths and misconceptions govern people’s way of life one way or the other. This reveals itself in the comments and questions posed by some of the patients and health workers.

“This is a new product about to surface, has it been used by anybody before?... The pharmacy I visit regularly to check my BP warned me to be careful and that I might fall or worse develop a stroke and that scares me... I am scared this product will do just that to me.”
(Patient 29)

“If it was a pill that would be fine. Injecting myself with a needle is unacceptable by everybody” (Patient 24)

“...people tend to talk about it. The side effects like excessive bleeding, amenorrhea, some bleed while others don't. It is quick to become a problem. People tell them that they will get fibroid. Others say that in the near future you might not be able to conceive again” (Service Provider 2)

“...people will take it and it won't be effective. It is only best to have nurses inject you. How can you inject yourself for it to work? I don't think self-administration will be effective” (Patient 25)

4.3 Discussions

In the following section the findings of the study are interpreted and further analysed.

A. Knowledge of DMPA-SC

It is the duty of the Ghana Health Service to provide information and education on family planning methods to both service providers and patients. There is little or no information available yet at the Ghana Health Service on DMPA-SC. This accounts for the deficit in knowledge especially among the service providers and no knowledge at all among the patients who visit the family planning units.

B. Level of acceptance of self-administered contraceptives

It is proven that patients in Sub-Saharan Africa prefer injectable contraceptives because they are effective, reversible, long lasting and private as in findings in Uganda and Senegal made by Burke in the paper *“Provider Acceptability of Sayana® Press: results from community health workers and clinic-based providers in Uganda and Senegal”*. With this new self-administered injectable however, patients have little to no knowledge of it and therefore are unable to decide on which option to use. To this end explanations and pictorial demonstration were needed to help illustrate as best as possible this option. Acceptance was, so too were the reasons for or against adoption. Some patients were willing and ready to try out the product

right after the demonstration if the product were available. Some needed assurance of safety and effectiveness before deciding to try. Others however were not in any way willing to try out the product. The determinants of this acceptance level are discussed in the next theme.

C. Determinants of acceptance to self-administer after counselling

Acceptance to self-administering contraceptives depends on a number of factors including cost of transportation, cost of product, level of education, wealth and status in the community, time, accessibility and perception of user. Patients were willing to try DMPA-SC if it would save them time and cost of transportation. These were mostly educated and employed women who could hardly find the time to attend the clinic. This finding is supported by Arthur et al in “*Correlates of contraceptive use among Ghanaian women of reproductive age (15-49 years)*”. Level of Education also played a major role as more educated patients were more willing to try DMPA-SC and less educated patient were not. Patients would be willing to self-administer given proper education, training and counselling (Nketiah-Amponsah, Arthur, & Abuosi, 2012). As presented by Cover et. al in Uganda, given proper training and education patients will surely be more confident at the second period of self-administration (Cover et al., 2017).

D. Willingness to access DMPA-SC from pharmacies

Patients who indicated their willingness to accept and try DMPA-SC preferred acquiring the product from the nearest pharmacy to their homes. On the other hand, patients who were not willing to try the product only suggested the hospital as the place to acquire the product. Unmarried adolescent and young adults will be unwilling to acquire the product from pharmacies for fear of negative perception from neighbours. It was clear in the interview that such young adults and adolescent have to get their DMPA-IM shots in secret and from trustworthy nurses who could maintain patient confidentiality. S (Wood & Jewkes, 2006). Although there is few barriers that impede or prevent the delivery of contraceptives to young

and unmarried adults, as discussed by Ross et al in Uganda, misconceptions, fears and socio-cultural expectations are obstacles to their contraceptive use (Ross & Agwanda, 2012).

E. Price point for DMPA-SC

There is enough evidence to support that patients will prefer similar pricing for the DMPA-SC as that of the DMPA-IM. Though willing to pay a little more, most patients would not want to pay more than 5 cedis for this product.

F. Service provider preference for DMPA-SC

Service providers require more knowledge and training on DMPA-SC. Service providers' knowledge on DMPA-SC was insufficient in addressing patient needs and concerns. It was obvious service providers are willing to promote, educate and train patients on the use of DMPA-SC. They will provide and propose this service to patients together with all other family planning procedures.

G. Myths and misconceptions

Women's choice of family planning is affected by people's perception and misinformation (Hindin et al., 2014). For the avoidance of criticism patients secretly get on family planning methods. This is even more so for unmarried people. Tales of never conceiving and acquisition of fibroid among other diseases are told and this prevents young adults from engaging or seeking out family planning services. Some partners believe family planning methods are evil and should not even be considered at all (Hindin et al., 2014).

CHAPTER FIVE

5.0 CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

The findings of this research points to the lack of knowledge of self-administered hormonal contraceptives by service providers and patients at the Dansoman Polyclinic. The main determinants of women's acceptance of self-administered contraceptives are time, cost of transportation to access DMPA-SC, cost of product, level of education, fear of injury, product knowledge and effective use the product, accessibility of product and perception of self-injection by user. Also, service provider's ability to educate their patients on benefits and use of DMPA-SC will further determine patients' response to the product. Misconceptions, misinformation and wrong perceptions are barriers that will prevent patient usage of the product. These have been the major barrier to contraceptive use in Ghana over the years. Introduction of DMPA-SC will face similar challenges as the current family planning methods faced in their introductory stages.

5.2 Recommendation

1. This study provides evidence that DMPA-SC can be safely introduced into family planning programs. Before its introduction however, intense education and demonstration of its use must be carried out to help equip service providers who will in turn provide the needed services to patients at the health centres.
2. DMPA-SC should be introduced into groups with high level of acceptance to self-administration. Education and training on administration and safe keeping will be required. Willingness of this group to start using self-administered contraceptives will help less willing groups onto this contraceptive.
3. To introduce DMPA-SC into the less educated in Ghana, education and training will have to be intensified. Proper knowledge and understanding of the use of DMPA-SC,

benefits of DMPA-SC as a family planning method and training of DMPA-SC can outweigh myths and misconceptions. Brochures and patient-instructor booklets may be made available for easy reference before injection dates.

4. For proper market penetration of the product this paper proposes there be an intensive education and visual training on hormonal contraceptives including DMPA-IM and DMPA-SC.
5. While this research focused exclusively on women who used the injectable method of contraception, further research should be undertaken that broadens the analysis of contraceptive use, practices and dissemination across the country. This analysis should incorporate all noted methods of family planning – traditional, pill, the patch, IUDs and injectable. The end result would be a more thorough and comprehensive understanding of the status of family planning initiatives in Ghana and the methods that have proven to be most effective for women of all socio-economic brackets.

5.3 Limitations

1. Financial and time constraints did not allow for the recruited of the proposed sample size.
2. Failure to critically analyse demographics and religious constraints may lead to failure to identify some determinants.

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7.0 APPENDICES

7.1 Appendix 1 – Informed Consent

Project Title: Determinants of Women’s Acceptance of Self-Administered Hormonal Contraceptives.

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Background

I am Antonio Quarsie-Awusah, a student from the School of Public Health, University of Ghana, Legon. I am conducting a research on Determinants of Women’s Acceptance of Self-Administered Hormonal Contraceptives. The main objective of the study is to find out the pre-product level of acceptance of DMPA-SC in Ghana.

Procedures

The study will involve observations and interviews on family planning method for women. Advantages and disadvantages and if and why women will prefer self-administered hormonal contraceptives. Respondents will not be forced to respond to questions. You are therefore encouraged to participate in this study since your input is much appreciated. This is purely an academic research forming part of the requirement for the award of a Master of Public Health Degree.

Risk and Benefits

The results of the study will help the women and other stakeholders in formulating policies and assist women in making the right choices for birth control plan. There are no risks involved in this study.

Right to Refuse

Participation in this study is voluntary. Participants may decide whether or not to answer a particular question or all questions. You have the right and are at liberty to withdraw from the study at any point however, participants are encouraged to participate fully.

Anonymity and Confidentiality

I would like to assure you that whatever information you will provide will be handled with strict confidentiality and will be used purely for research process. Your responses will not be shared with anybody who is not participating in the study.

Costs/or payments to subject for participation in research

Participants will not be charged for any form of payment neither will they be given any form of cash or compensated in any other form.

Dissemination of Results

A presentation would be organized for all stakeholders to disseminate the results of the study. A copy of results from the study will be kept at School of Public Health, University of Ghana for reference.

Before taking Consent

Do you have any question you wish to ask concerning the study? Yes / No

If you answer **yes** to the above, please indicate your question below

.....
.....

Voluntary Consent

I have read the foregoing or it has been read to me. I have had the opportunity to ask questions and any questions I have asked have been answered to my satisfaction. I therefore consent voluntarily to participate in this study.

Signed/Thumbprint: Date.....

Interviewer's Statement

I, the undersigned, have explained this consent form to the subject in English language and that she / he understands the purpose of the study, procedures to be followed, as well as the risks and benefits of the study.

The participant has fully agreed to participate in the study.

Signature of Interviewer

Date

Address

If you have any questions later please, contact

Supervisor (School of Public Health): Professor Richard Adanu

Principal Investigator: **QUARSHIE-AWUSAH ANTONIO** (05556543243)

Administrator of GHS – ERC: Ms. Hannah Frimpong (0243235225 / 0507041223)

7.2 Appendix 2 – Interview Guides

7.2.1 Health practitioner interview guide

Interview ID _____

DETERMINANTS OF WOMEN’S ACCEPTANCE OF SELF-ADMINISTERED HORMONAL CONTRACEPTIVES

By

Antonio Quarshie-Awusah

Thank you for accepting to participate in this study. Now that you have finished signing the consent form we shall begin.

Interviewer Name: _____

Interview Date: _____

Start Time: _____

End time: _____

[Instructions to interviewer]

DEMOGRAPHICS

Name: _____

Age: _____

Telephone: _____

Hospital: ₁ Dansoman Poly Clinic ₂ Other. Specify: _____

1. For the past 9 months, about how many of your family planning patients opted for DMPA - IM, in your opinion?

Answer: _____

1a. Of these women, about how many have come continuously for their injection, in your opinion?

Answer: _____

2. As a provider who has administered and Depo®-IM, in your opinion, what will be the advantages of DMPA-SC when compared to Depo®-IM? (*probe: acceptability; mode of injection; fewer side effects; mode of injection; shorter needle*)

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3. As a provider who has administered Depo®-IM, in your opinion, what are the **disadvantages** of DMPA-SC when compared to Depo®-IM? (*probe: cost; storage*)

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4. Now that you have discussed the advantages and disadvantages, as a provider who has administered Depo®-IM and you know about Depo®-SC do you prefer one over the other? Why? Why not?

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5. Will you encourage your patients who currently come to you for the Depo®-IM to consider self-injecting Depo®-SC?

Yes No.....

5a.) Provide reasons

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.....

6. Will you be willing to teach and counsel the women you currently provide Depo®-IM on the right and correct procedures for self-injection?

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7. What criteria will you use to approve (or not approve) patients who opt for home self-injection?

7a. [*If none approved*], did you feel any hesitations or convictions to not approve home self-injection?

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8. In your opinion, are there certain types of patients who are better suited for DMPA-SC? (*Probe: age; youth; strong social support*)

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9. In your opinion, are there certain types of patients who are better suited for DMPA-SC self-injection? (*Probe: age; youth; strong social support*)

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10. In your opinion, what factors (things) must be in place for a patient to continue using DMPA-SC for as long as she wants to?

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11. Based on your experience participating in this study, what would you recommend to Ghana Health Service if they want to introduce DMPA-SC in the whole country?
(Probe: volume; distribution; storage; disposal; different facility types)

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12. In your opinion, in what ways would the addition of DMPA-SC to the contraceptive method mix potentially affect family planning in Ghana?

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We have come to the end of the interview. Do you have something else to add or any questions?

Additional comments/questions from participant:

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Thank you for your time.



7.2.2 Patient Interview Guide

Interview ID _____

**DETERMINANTS OF WOMEN'S ACCEPTANCE OF SELF-ADMINISTERED
HORMONAL CONTRACEPTIVES**

By

Antonio Quarshie-Awusah

Thank you for accepting to participate in this study. Now that you have finished signing the consent form we shall begin.

Interviewer Name: _____

Interview Date: _____

Start Time: _____

End time: _____

[Instructions to interviewer]

DEMOGRAPHICS

Name: _____

Age: _____

Telephone: _____

Hospital: ₁ Dansoman Poly Clinic ₂ Other. Specify: _____

HISTORY

1) Do you use any family planning method?

₁ Yes

₂ No

Why No? [GO TO 4]

2) Which method do you use?

₁ Injectable

₂ Tablets

₃ Condoms

₄ Withdrawal

2a) How long have you been using this method?

2b) Have you tried any other method?

₁ Yes

₂ No

If yes, please tell us which one

2c) Why did you change/stop using this method?

2d) For the injectable, which injection method do you currently use?

₁ Provider

₂ Self

3) Why do you use this family planning method? (injectable)

[Tick all that apply]

₁ Affordable

₂ Durable

₃ Long lasting

₄ Durable

₅ Effective

₆ Easy to use

₇ No side effects

₈ Safe

₉ Other. Specify

4) Will you be willing to try a new family planning method?

₁ Yes ₂ No

Why?

SELF-ADMINISTERED CONTRACEPTIVES

5) Have you heard about self-administered injectable contraceptives?

₁ Yes ₂ No [Present material on self-administered injectable and GO TO 7]

6) What do you remember about these self-administered injectable contraceptives?

[Put down everything participant says]

[Present material on self-administered injectable]

7) Do you have any questions to ask me about these self-administered injectable contraceptive? [Write down every question before you provide patient with answers]

1 _____

2 _____

3 _____

4 _____

5 _____

WILLINGNESS TO USE SELF-INJECTED CONTRACEPTIVES

8) Do you think self-injected contraceptives are good?

- ₁ Yes ₂ No

Why?

9) Will you be comfortable using self-injected contraceptives?

- ₁ Yes [GO TO 11] ₂ No

10) If No, why?

[Tick all that apply]

- ₁ Safety ₂ Trust ₃ Fear ₄ Price
₅ Effective ₆ Disapproval ₇ Side effects
₉ Other. Specify

11) Can you go to the pharmacy to buy self-injected contraceptives?

- ₁ Yes ₂ No

Why?

10a) Please suggest any other way you believe will be effective in distributing these injectable? _____

12) About how much do you think these self-injected contraceptives should cost?

- ₁ ≤GHS 20 ₂ GHS 21-50 ₃ GHS 51-100 ₄ GHS 101-150
₅ GHS 151-200 ₆ GHS 201-250 ₇ GHS 251-300 ₈ GHS > 300

