

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

**EXPERIENCES RELATED TO MODERN CONTRACEPTIVE USE
AMONG FISHERMEN AND THEIR PARTNERS IN THE ACCRA
METROPOLIS**

**HAROLD ADI ANITEYE
(10305909)**

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

JULY, 2016

DECLARATION

I, Harold Adi Aniteye, do hereby declare that except for the references used and duly acknowledged, this dissertation is in my own words, done under stringent supervision and has not been submitted in whole or in part simultaneously elsewhere for another degree.

Harold Adi Aniteye

(Student)

Signature

Date

Dr. Agnes M. Kotoh

(Supervisor)

Signature

Date

INTEGRI PROCEDAMUS

DEDICATION

I dedicate this research to Dr. Patience Aniteye. Thank you so much for your support and God richly bless you.



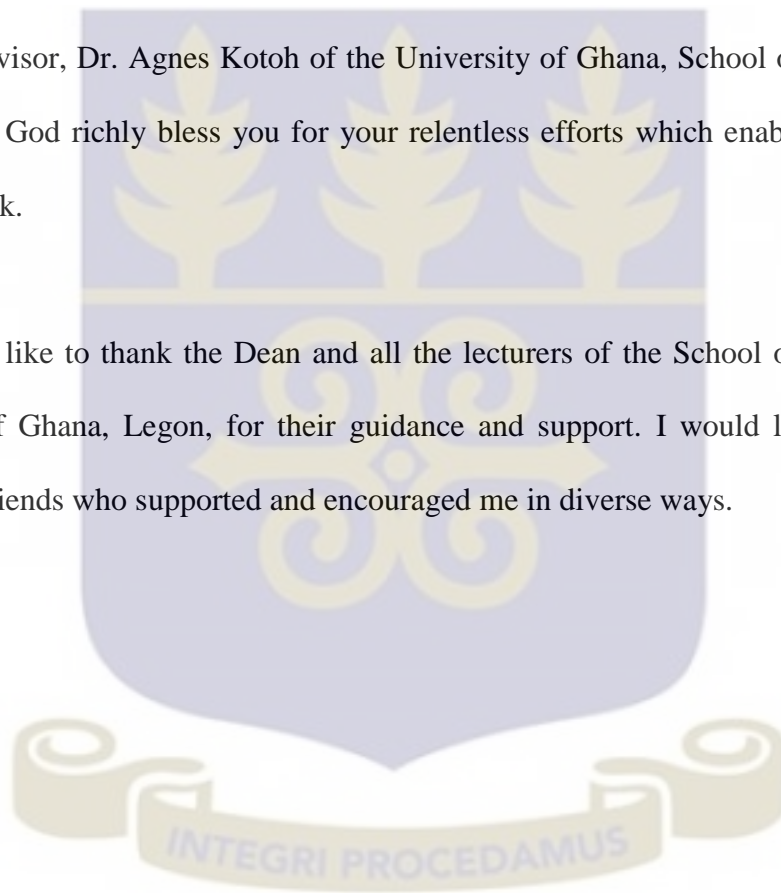
ACKNOWLEDGEMENTS

I would like to thank God Almighty for giving me the knowledge and strength to finish this thesis.

I sincerely express my gratitude to the wonderful participants who availed themselves to share their experiences with me.

To my supervisor, Dr. Agnes Kotoh of the University of Ghana, School of Public Health, Legon, I say God richly bless you for your relentless efforts which enabled me come up with this work.

I would also like to thank the Dean and all the lecturers of the School of Public Health, University of Ghana, Legon, for their guidance and support. I would like to thank my family and friends who supported and encouraged me in diverse ways.



LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
AMA	Accra Metropolitan Area
DRC	Democratic Republic of Congo
ECP	Emergency Contraceptive Pills
FP	Family Planning
GES	Ghana Education Service
GHS	Ghana Health Service
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HP	Health Professional
ICPD	International Conference on Population and Development
IEC	Information, Education & Communication
IUD	Intra Uterine Device
MOH	Ministry of Health
NDHS	Nigeria Demographic and Health Survey
PPAG	Planned Parenthood Association of Ghana
SHEP	School Health Education Programme
SMI	Safe Motherhood Initiatives
SSA	Sub Saharan Africa
STI	Sexually Transmitted Infections
TFR	Total Fertility Rate
TPB	Theory of Planned Behaviour
UNFPA	United Nations Population Fund
WHO	World Health Organization

TABLE OF CONTENTS

Content	Page
DECLARATION.....	i
DEDICATION	ii
ACKNOWLEDGEMENTS	iii
LIST OF ACRONYMS	iv
TABLE OF CONTENTS	v
LIST OF TABLES	x
ABSTRACT	xi
CHAPTER ONE.....	1
INTRODUCTION	1
1.1 Background.....	1
1.2 Problem statement	5
1.3 Theory of Planned Behaviour.....	7
1.3.1 Theory of Planned Behaviour (Netemeyer, Ryn, & Ajzen, 1991)	7
1.4 Significance of study	10
1.5 General objective	11
1.6 Specific objectives.....	11
1.7 Research questions	11
CHAPTER TWO.....	12
LITERATURE REVIEW	12
2.1 Introduction	12
2.2 Availability of modern contraceptives	12
2.3 Getting men involved in Family Planning.....	13
2.4 Perceived factors influencing contraceptive use	15

2.5 Knowledge and Attitudes towards contraceptives.....	16
2.6 Subjective norms influencing use of contraceptives	18
2.7 Contraceptive Ideation.....	19
2.8 HIV/AIDS among fisher folk	21
2.9 HIV/AIDS in the fisheries sector in Africa	22
2.10 Perceived side effects of female contraceptive methods.....	23
2.11 Summary of review	24
CHAPTER THREE	25
METHODOLOGY	25
3.1 Introduction	25
3.2 Study Design	25
3.3 Study Area	25
3.4 Target Population and Selection of Participants	26
3.5 Study Variables	26
3.6 Data Collection and Tools	26
3.7 Pre-Testing	27
3.8 Data Analysis.....	28
3.9 Inclusion Criteria	29
3.10 Exclusion Criteria.....	29
3.11 Ethical considerations.....	29
3.12 Methodological Rigour.....	30
3.13 Data management	31
CHAPTER FOUR	32
RESULTS.....	32
4.0 Introduction	32

4.1 Demographic Characteristics of Participants	32
4.2 Major Themes and Sub-Themes.....	34
4.3 Knowledge about Contraceptives.....	36
4.3.1 Sources of knowledge.....	36
4.3.2 Types of contraceptives	36
4.3.3 Knowledge of contraceptives as a preventive measure	37
4.3.4 Lack of knowledge of long-term methods.....	38
4.4 Access to Contraceptives, Availability and Barriers to Access.....	38
4.4.1 Sources of contraceptives	38
4.4.2 Cost of contraceptives	39
4.4.3 Adolescents access to contraceptives	40
4.4.4 Barriers to access	40
4.5 Attitudes towards Contraceptives	41
4.5.1 Attitudes towards permanent contraception	41
4.5.2 Positive attitudes towards contraception	42
4.5.3 Negative attitudes towards contraception.....	43
4.6 Beliefs about Contraceptives	44
4.6.1 Beliefs concerning authority for contraceptive decisions	44
4.6.2 Personal beliefs concerning contraceptives.....	45
4.6.3 Community beliefs concerning contraceptives.....	45
4.7 Contraceptive Use and Non-Use	46
4.7.1 Benefits of contraceptives	46
4.7.2 Experiences/side effects	48
4.7.3 Myths and misconceptions	49
4.8 Socio-Cultural Perspectives Concerning Contraceptives	50

4.8.1 Pronatalistic nature of Ghanaians	50
4.8.2 Transitions in Ghanaian culture.....	51
4.9 Perceptions about Contraceptives.....	52
4.9.1 Personal perceptions about contraceptives	52
4.9.2 Community perceptions about contraceptives.....	53
CHAPTER FIVE	54
DISCUSSION.....	54
5.0 Introduction	54
5.1 Discussion of Findings	56
5.1.1 Knowledge and use of contraceptives	56
5.1.2 Access and availability of contraceptives.....	57
5.1.3 Attitudes of respondents towards contraceptives	60
5.1.4 Subjective norms towards contraceptives.....	62
5.1.5 Perceived Behavioural Control.....	63
5.1.6 Behavioural intention	65
5.2 Limitations of study.....	65
CHAPTER SIX	66
SUMMARY, CONCLUSION, IMPLICATIONS AND RECOMMENDATIONS ...	66
6.0 Introduction	66
6.1 Summary.....	66
6.2 Conclusion.....	67
6.3 Implications for Policy, Research, Education and Practice.....	67
6.4 Recommendations	68
REFERENCES	70
REFERENCES	70

APPENDICES 74

 APPENDIX 1: INFORM CONSENT FORM..... 74

 APPENDIX 2: FOCUS GROUP DISCUSSION GUIDE..... 77



LIST OF TABLES

Table 4.1: Demographic characteristics of participants.....33

Table 4.2: Major Themes and Sub-Themes.....35



ABSTRACT

Contraceptive use has been studied globally and in sub-Saharan Africa. Evidence abounds in the literature concerning high knowledge of contraceptives and low use for various reasons. This study used a qualitative design to explore the experiences related to modern contraceptive use among fishermen and their partners in the Accra Metropolitan Area. Focus group discussions and in-depth interviews were held with purposively selected fishermen, their leaders and partners between 15-59 years. Thematic content analysis was used to analyze the data. Eight major themes and 21 sub-themes emerged from the data. The key findings included participants' high knowledge of contraceptives and minimal use attributable to a multiplicity of factors including myths and fallacies, entrenched cultural beliefs relating to pronatalism, religious beliefs and beliefs concerning moral decadence on the part of women. Knowledge about female condom and permanent contraception was low among men and women; a few men had a strong aversion for permanent contraception. Most participants could not connect condom use with the prevention of sexually transmitted infection (STI). The men who used condom complained bitterly of lack of sensitivity during coitus. Emergency contraception was known by a few but wrongly utilized. In conclusion, although the fishermen and their partners had knowledge about contraceptives, the overarching reasons for non-use were some entrenched beliefs, attitudes they had developed towards contraception and erroneous ideas from oral tradition. It is recommended that behavioural change communication be reinforced by Community Health Nurses working in the fishing community coupled with community-based distribution of free condoms. Also, family planning could be highly subsidized to defray some cost borne by users.

CHAPTER ONE

INTRODUCTION

1.1 Background

Contraception is a major part of reproductive health that allows one to choose whether and when to have a child. There are numerous contraceptive methods available to men and women in Ghana. Although most adults, who are sexually active, have at a point in time used a method of contraception, consistent use has been inhibited by a number of factors such as high cost of some contraceptive methods, lack of information and dislike of side effects (Wright, Fawson, Frost, & Turok, 2015). Factors that influence choice of contraceptive method include, access, cost, the influence of sexual partner and personal preference (Wright, Fawson, Frost, & Turok, 2015).

High unmet needs for contraceptive use is found to contribute to low contraceptive use in many Sub-Saharan African (SSA) countries including Nigeria, Tanzania and Ghana (Adjei et al., 2015). In Ghana, modern contraceptive prevalence rate is lowest among currently married women in the youngest (15-19) and oldest (45-49) age groups (19% and 18%, respectively) (Ghana Statistics Services, 2015). In order to improve modern contraceptive use in Ghana, it is important to make available family planning commodities. Ghana was one of the first African countries to formulate and implement a National Population Policy in 1969 which aimed at providing information on safe and effective contraceptive methods to individuals and making them available (Adjei et al., 2015).

In Ghana, there is limited information on the family planning commodities available in the health facilities (Adjei et al., 2015). Long-term relationships have been reported to be

associated with long-term methods of contraception but consistent contraceptive use may not necessarily result in a long-term relationship status. Couples in stable sexual relationships may have less motivation to avoid pregnancy and therefore be less likely to use a contraceptive method (Wright et al., 2015).

Men have rarely been involved in reproductive health issues such as sexuality and birth spacing (Ijadunola et al., 2010). According to Ijadunola et al. (2010), men have often been excluded from participating in many FP programmes which often viewed as women's affair. However, men are the heads of families and decision makers in all issues including reproductive health. Men decide on the number of children (Toure, 1996). Husbands often influence the use of any method of FP by women therefore their involvement in contraception have been advocated as a strategy for improving contraceptive use (Ezeanolue et al., 2015).

Additionally, findings have indicated that since men are the decision makers, they are expected to initiate discussions on FP and the number of children the couple want to have (Wright et al., 2015). Women are implementers of what men have decided, without question (Wright et al., 2015). While men may want to increase involvement in contraceptive use, and in spite of the fact that they are decision-makers, they might not have the required knowledge about contraceptives; hence the need to involve them (Wright et al., 2015).

Evidence indicates that the involvement of men can lead to contraceptive uptake through the pathway of increased spousal communication. The 1994 International Conference on Population and Development (ICPD) then stressed the need to involve men in

reproductive health. However, FP programmes have customarily focused on women as the primary beneficiaries and men have been considered as the silent companions of the services (Akafuah & Sossou, 2008). More than three decades after ICPD, men's participation in FP programmes is still low and not the focus of most research. As a result, information on their contraceptive prevalence is scarce.

Some men view contraception as a source of infidelity; dissatisfaction of contraceptive methods, perceptions of family planning as a woman's territory and fear of partner sexual indiscriminate are some barriers that usually affect male involvement in family planning (Kabagenyi et al., 2014).

Despite the pivotal role of health professionals in implementing contraceptive use, some of the experiences patients go through at health facilities discourages contraceptive use (Wood, Maepa, & Jewkes, 1997). In some cases, a contraceptive method is not provided until patients are subjected to uncomfortable questions about their sexuality, whether they had spouses, why some had sex so young and whether some had even informed their guardians. Some health professionals go as far as scolding patients and this tends to provoke emotions of shame, unhappiness and fear. There have also been reported instances in which patients had been declined contraception if they had previously attended a General Practitioner (GP) or did not have parental consent (Wood et al., 1997).

In some situations, health professionals (HPs) give a method but refuse to provide necessary information about it because the patient did not attend the nearest clinic. As a result, some patients clearly perceive HPs as transgressing their professional roles to an unacceptable degree and see them as out of touch with patients in their advice about

contraceptive use. These experiences tend to affect the patronage of contraceptives. It is important that services provided in the use of contraceptives be greatly improved. These concerns could be addressed by improving supervision, initiating continuing education for staff, values clarification workshops, curricular changes and offering information leaflets.

Fishing communities in Ghana may be one of the areas subjected to such experiences. They are known for their dense population and the low prevalence of contraceptive use despite efforts to make contraceptives universally accessible (Kissling et al., 2005). Fishing is an occupation, which comes with a high risk and can contribute to either risk confrontation or denial. This extends to display of bravery and risk-taking in both the social and sexual arena (Kissling et al., 2005). People who engage in fishing are often neglected socially and have a low status and opinion of themselves, which can cause, among men, amplified or 'oppositional' forms of masculinity that test the behavioural norms adopted by those in society. In this context, masculinity often includes the expectation of numerous sexual partners. Fisher folk in many parts of the world are also known for their alcohol consumption as this is thought to help them manage the dangers or stresses of their occupation (Kissling et al., 2005).

The prevalence of STIs including HIV in some fishing communities especially in deprived settings in some developing countries is known to be high in comparison with national average prevalence rates. According to Kissling et al. (2005), fishermen who also work in related occupations such as fish trading and processing are at risk due to the fact that they are often within the fishermen's sexual networks. This vulnerability is due to the nature and dynamics of fishing and the fish trade, which is known to increase their risk.

This study sought to explore the experiences related to modern contraceptive use among fishermen and their partners in the Accra Metropolitan Area.

1.2 Problem statement

In sub-Saharan Africa (SSA), high maternal mortality and morbidity rate have been attributed to high fertility, unplanned pregnancy and unsafe abortion (Umoh & Abah, 2011). Research has shown that contraceptive practice improves maternal health (Prateek & Saurabh, 2012). However, the number of unwanted pregnancies and unmet need for contraception remains high in the region. AFIDEP (2012) revealed that contraceptive use resulted in an estimated 32% decrease in maternal deaths in SSA translating to an estimated 88,227 lives of mothers saved. Family planning, which is one of the building blocks of the Safe Motherhood Initiatives (SMI), reduces maternal morbidity and mortality achieved through contraception (Umoh & Abah, 2011). As a result of the benefits of contraception, the WHO has continued to develop and suggest schemes to achieve improved maternal and infant health worldwide. However, contraceptive use varies within societies, religious groups and other groups (Ghana Statistical Service, 2014).

In 1994, the International Conference on Population and Development (ICPD) called for men to play an active role in reproductive health matters in order to improve upon maternal and child health. The shift of reproductive health frameworks to include men will help accomplish this objective. Even though contraception is available to decrease the incidence of unintended pregnancy, research on the contraceptive behaviour of male has been given little attention (Wright et al., 2015).

Evidence from Kenya suggests that there is high prevalence of sexually transmitted infections (STIs) including HIV in fishing communities especially among deprived populations (Ondondo, Waithera, Mpoke, Kiptoo, & Bukusi, 2014). The prevalence of HIV (20% to 28%) among fishing communities was higher compared to the general population. This was attributed to the fact that fishermen tend to have multiple sexual partners because they find themselves away from home for long periods. Little is known about the sexual behavior of fishermen in Ghana and this may pose a threat to the general population and the fishing industry. Fishermen are vulnerable due to their demographic profile, the availability of commercial sex in fishing ports and the subcultures of risk taking (Allison & Seeley, 2004).

Women's vulnerability also stems for their lesser economic and social position in society (Allison & Seeley, 2004). As a result, they are subjected to unintended pregnancies and STIs. This often leads to unsafe methods of abortion, which leads to morbidity and mortality. It has been recognized that contraception is important in preventing unintended pregnancy. However, studies indicate that a substantial percentage of women in Ghana have, at some time, resorted to the voluntary termination of an unwanted pregnancy (Allison & Seeley, 2004).

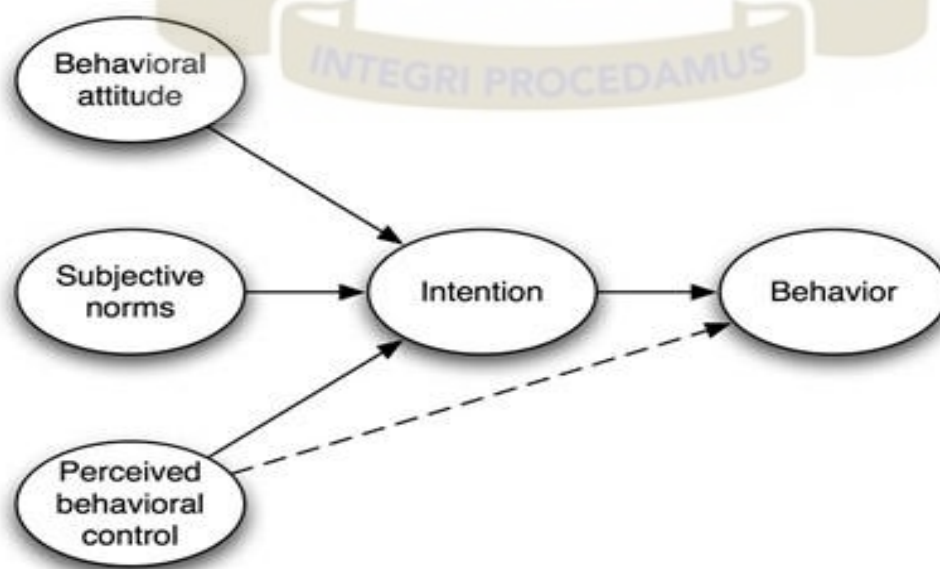
In some societies contraception is viewed as a source of infidelity. The use of contraceptives also provides some experiences that affect one's behaviour. For instance, health professionals (HPs) are of great importance in implementing contraceptive use but some patients go through experiences at health facilities regarding contraception that discourages their use. Studies have shown that some patients are even scolded by HPs and this tends to provoke emotions of shame, unhappiness and fear that may have an

impact on the utilization pattern of contraceptives among fishermen and their partners (Wood et al., 1997). Contraceptive use among fishermen and their partners and their experiences is not known. This study is designed to determine contraceptive use among fishermen and their partners and explore their experiences with contraception to inform policy and programmes that promote family planning.

1.3 Theory of Planned Behaviour

There is evidence that people's intention to perform a behaviour is influenced by an array of factors including their attitudes, what their significant others' stance are with respect to their performance of the behaviour and the existence of factors such as side effects that facilitate or impede the performance of the behaviour (Ajzen, Netemeyer, & Ryn, 1991). The Theory of Planned Behaviour (TPB) operates on the principle that the best way to predict behaviour is to measure behavioural intention, which in turn is seen to be a function of three autonomous variables, i.e. attitude, subjective norm and perceived behavioural control.

1.3.1 Theory of Planned Behaviour (Netemeyer, Ryn, & Ajzen, 1991)



This theory is an extension of the theory of reasoned action. Both theories envisage that the likelihood of an individual performing a particular action is determined by intentions of the individual towards the behaviour. Behavioural intentions are factors that inspire the performance of behaviour, which is evident in the determinations and preparedness of an individual to try the behaviour (Ajzen et al., 1991). Behavioural intentions directly result from attitudes towards the behaviour, the subjective norms towards the behaviour after which the TPB builds a third component which is perceived control towards enactment of the behaviour (Ajzen et al., 1991).

Attitude towards a behaviour is a person's overall assessment of the end result of the behaviour. It is assumed to have two components, which work in unison. These are one's beliefs about consequences of the behaviour and positive or negative judgments about the features of the behaviour associated with it. A person with strong beliefs about a particular behaviour will be more likely than not develop a positive attitude to that behaviour and vice versa (Ajzen et al., 1991).

Perceived behavioural control is the degree to which a person feels able to act out the behaviour. It refers to how much control a person has over the behaviour and how confident he or she feels with respect to performing or not performing the behaviour. It is determined by control beliefs concerning facilitators or impediments to the presentation of the behaviour. Perceived control is also influenced by how the alleged authority augments or impedes the performance of that behaviour (Ajzen et al., 1991).

Subjective norms are a person's own evaluation of the social pressure to perform the target behaviour. Subjective norms are presumed to have two components, which work in

interaction: beliefs of other people, who may be in some way important about the behaviour and the preparedness of an individual to enact behaviour. This is defined as his/her intention. A person's attitude, subjective norms and perceived behaviour predict his/her intention hence an individual's particular behaviour is a precursor to the performance of a behaviour (Ajzen et al., 1991).

This theory has been applied to various studies in order to predict the phenomenon of human behaviour. In the context of blood donation, to test directly the TPB, Giles, Mcclenahan, Cairns, & Mallet, (2004) found that attitude, subjective norm and perceived control together accounted for 60.5% of the variation in behavioural intention. They also discovered that there was strong evidence of a direct association between perceived behavioural control and intention, not mediated by attitude and subjective norm.

Furthermore, Giles et al. (2004) reported two studies on blood donation, both of which were intended to explore a model based on the TPB. The results from these studies corroborate with those of Giles and Cairns (Giles and Cairns, 1995) and indicate that the theory is a useful predictor of blood-donating intentions and behaviour. In the first study, for example, 76% of the variance in blood-donating intention was clarified, with self-efficacy proving to be a more significant predictor than perceived control. In fact, self-efficacy was found to be the most significant predictor of behavioural intention.

Interestingly, an analysis of the fundamental beliefs did suggest that self-efficacy is linked to a 'fear of needles', 'lack of previous experience', 'perceived inadequate health status' and the perception that donating blood is 'time consuming', all of which could have vital practical implications. This provides evidence that people's intention to

perform a behaviour is influenced by an array of factors including their attitudes, what their significant others' stance are with respect to their performance of the behaviour and the existence of factors that facilitate or impede the performance of the behaviour (Ajzen et al., 1991). Therefore, a couple's intention to use contraceptives could be influenced by these factors thus; the Theory of Planned Behaviour will be employed to inform this study.

1.4 Significance of study

With the increase in unintended pregnancies and abortions, it is imperative that this study be carried out to shed some light on why contraception is not being adopted with respect to these problems. The tendency of fishermen to engage multiple sexual partners because of time spent away from home is amongst other risk factors for unintended pregnancies and unsafe abortion (Ondondo et al., 2014). Despite the high number of advertisements through all forms of media on contraception, contraceptive methods available and how they can be used, yet use among the general population is low (Ghana Statistical Service 2015). However, contraceptive use among fishermen is not known. These call for a study that examines contraceptive use and experiences among fishermen and their partners. This may affect the behaviour of fishermen and their spouses towards them and may either encourage or discourage them from its use. The densely populated fishing communities continue to increase in number which poses some concern with respect to their general health since resources available in those areas are already in short supply. There is therefore the need to determine what factors encourage or discourage their use of contraceptives as well as determine what informs their choice of a method.

The findings of this study will add to the knowledge of contraceptive use and may reveal the contraceptive use among fishermen and their spouses. This study may also inform programmes aimed at improving contraceptive use and help address associated challenges appropriately to improve upon the health of the public.

1.5 General objective

To examine experiences related to the use of modern contraceptives among fishermen and their partners in the Accra metropolitan Area.

1.6 Specific objectives

- To ascertain the knowledge of contraceptives among fishermen and their partners.
- To examine factors that influence fishermen and their partners to use or not use contraceptives.
- To explore the experiences of fishermen and their partners regarding contraceptive use.

1.7 Research questions

- Do fishermen and their partners have knowledge about contraceptives?
- What are the factors that influence fishermen and their partners to use contraceptives?
- What are the experiences fishermen and their partners have had with the use of contraceptives?

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature based on the objectives and theoretical framework guiding this study. The databases employed in searching for information included Pub Med, Sage, Google scholar and Wiley. Some keys words employed in the literature search were “theory of planned behaviour”, “perceived factors influencing contraceptive use”, “knowledge and attitudes towards contraceptives”, “subjective norms influencing use of contraceptives”, “Experiences of contraceptive use”, “Availability of modern contraceptives” and “Contraception Ideation.”

2.2 Availability of modern contraceptives

One of the major obstacles to contraceptive use in Ga East municipality of Ghana of contraceptive methods is availability (Adjei et al., 2015). The accessibility of modern contraceptives and perceived factors affecting them were determined by health centres in the Ga East municipality of Ghana. A cross-sectional study involving quantitative and qualitative techniques was employed. Data were obtained from 51 health facilities, which were randomly selected. Univariate and multiple logistic regression techniques were used in testing associations between certain qualities of the centres and availability of each category of contraceptive. In-depth interviews with the managers of the facilities were used in collecting the data and then analysed according to emerging themes. The study indicated that there was a low availability of long acting reversible contraceptives (LARC) such as implants (14 %) and IUDs (14 %) within the health facilities. Combined oral contraceptives (82 %) and male condoms (78 %) and were the most available types.

2.3 Getting men involved in Family Planning

In the past, family planning programmes had focused on women in order to relieve women of the burden of excessive child bearing as well as reduce the incidences of maternal and infant death through the use of modern contraception methods. The majority of research and information campaigns have been centered on women (Kabagenyi et al., 2014). The belief that family planning is largely a woman's business, with the man playing fringe role is as a result of its focus on women. In society, husbands make most of the important decisions for their families (Kabagenyi et al., 2014). Effective communication is therefore essential and must be carried out between husbands and wives in order to ensure equality in matters of reproductive health.

Campaigns to motivate men can build up male support for family planning and encourage men to discuss family planning with their partners (Mustafa et al., 2015). In order to reach men, however, suitable communication channels must be made to address male concerns through such campaigns. Men tend to be less responsive to the health benefits than economic benefits of family planning which commonly may appeal to women (Mustafa et al., 2015). Working with half of the population cannot lead to societal changes hence to create an environment of gender equality men must be engaged. Engaging men in family planning-sharing power means sharing the responsibility for using contraception and contributing to maternal and child health care.

Research on male involvement established that men are more likely to support family planning and to use a method themselves if services and educational programmes are targeted at them (Ijadunola et al., 2010). The media is being used in Togo to encourage positive attitudes toward family planning among particular groups. In Sierra Leone, men

meet to learn about the benefits of family planning and how to prevent sexually transmitted diseases (Ijadunola et al., 2010). Family planning services in Ghana are currently targeted at men have increased male involvement. Health facilities offering family planning services should have certain characteristics such as sexually transmitted diseases services, a range of methods beyond condoms and vasectomy and guarantee configuration, privacy and comfort (Akafuah & Sossou, 2008).

Accessibility to information on choice and merits of family planning method and side effects should be adequate. Flexible hours and short waiting time would be helpful. Services should also be affordable. Service providers should be knowledgeable, patient, polite, persuasive, warm, and discreet and trustworthy (Ijadunola et al., 2010). Efforts should be made to design a male-friendly service delivery system at the existing service delivery facilities. Research shows that when men communicate with their spouses and partners about planning their next child family planning use surges (Ijadunola et al., 2010). Variations in gender equality and family planning can happen in a short time, improving women's health, family health, enabling women's contributions to the country and building the development potential for the nation to ensure effective male participation in the family planning programme, it will be essential to provide men with adequate information on family planning and contraception methods through designing and appropriate Information Education & Communication (IEC) materials (Mustafa et al., 2015). Overcoming the perception among males that acceptance of contraceptive methods is a threat to their status is what programmes must work towards. Outreach programmes for men should use men as educators, promoters and providers (Kabagenyi et al., 2014). Male involvement in family planning would therefore not only ease the responsibility borne by women with respect to decision making for family planning

matters, but would also hasten the understanding and practice of family planning in general (Kabagenyi et al., 2014).

2.4 Perceived factors influencing contraceptive use

A study conducted by (Dynes, Stephenson, Rubardt, & Bartel, 2012) outlines the fact that despite the widespread implementation of family planning programming over the past several decades, contraceptive prevalence continues to decline low in many low income, particularly in Sub-Saharan Africa. Their study stated that although there is a gradual decline in fertility in some Sub-Saharan Africa countries, our region of the world continues to prove the greatest gaps in contraceptive use by economic status, residence, and educational level. The study also revealed that community norms are important to matters of gender and power relations such as attitudes toward sex and family planning, religious beliefs and fertility preferences (e.g., ideal number of children, gender preferences of children).

The effects of the community on contraceptive use exists through mechanisms of social structures related to gender norms that eventually influence the way people think about family planning and fertility. Fuse (2010) found a gender preference for sons over daughters in 16 of 28 countries in Sub-Saharan Africa. Son preference has implications on the decision to have another child and has an indirect effect on the treatment of female infants and children. This may influence whether or not contraceptives should be employed. Contraceptive use has also been associated to individual ideational components, including communication with the spouse, perceived spousal agreement to contraception, perceived normative support, perceived peer behaviours, perceived self-efficacy for contraceptive use, and positive attitudes about contraception.

In contrast, negative attitudes such as fear of unfavourable effects or perception of the demerits of contraception are often mentioned reasons for lack of contraceptive use. Some studies have correlated the ideation model with contraceptive use and contraceptive intention in various settings. Using a score for ideation derived from several variables, these studies showed upsurges in the level of ideation are associated with a rise in contraceptive prevalence and intention to use.

Some perceptions discovered from a study by Babalola, Kusemiju, Calhoun, Corroon, & Ajao, (2015) included “The use of contraceptive injection can make a woman permanently infertile, People who use family planning end up with health problems, Contraceptives reduce women's sexual urge, Contraceptives can cause cancer , Contraceptives can lead to deformed new-borns, Contraceptives are hazardous to women's health and Women who use family planning could become immoral.” Such perceptions were found to inhibit the utilization of contraceptives as such exposing the women to unintended pregnancies and the dangers of unsafe abortions.

2.5 Knowledge and Attitudes towards contraceptives

A study by (Miller, 2011) revealed that although almost 60% of the students believed that Emergency Contraceptive Pills (ECP) should be available without a prescription, only half of the students stated that they would feel comfortable using. This discovery reflects an increase in the knowledge of college students that ECP is undeniably a method of contraception rather than abortion. Some of those students who may not feel comfortable using it themselves had no issues with others using it. Participants who indicated that they would be comfortable using ECP were more liable than those who were not comfortable or who were unsure to have previously heard of ECP, to have a higher

knowledge level of ECP and to have taken a health course that discussed ECP. Additionally, the participants who indicated being comfortable with ECP were more likely to have rated it as a method of contraception rather than using it for abortion. Though this information is not surprising, it is imperative and useful because it indicates that increased consciousness and knowledge about ECP may be related to attitudes that are more accepting of its use (Miller, 2011).

Kendra L. Fleminga, Abby Sokoloff (2008) conducted a study to ascertain teenagers' and young women's perceptions of and attitudes about the Intra Uterine Device (IUD) in order to evaluate the feasibility of efforts to increase the utilization of this method of contraception in this age group. A significant link was found between having heard about the IUD from a health care provider and the interest that developed in the method indicated that providers might positively impact IUD interest and use. Further, from this study, a large section of participants indicated that they were unsure about the IUD because of common reasons such as IUD-induced amenorrhea, fear of pain with insertion. However, these were concerns that could easily be addressed by a health care provider.

Borrero, Farkas, Dehlendorf, & Rocca (2013) set out to investigate the racial and ethnic disparities in men's contraceptive knowledge and attitudes. The postulated that considering that most couples in the US are race-concordant differences in men's contraceptive knowledge and attitudes may contribute to differences in contraceptive use. They examined a set of questions about attitudes thought to influence contraceptive use: likelihood of adverse effects with hormonal methods; attitudes about condom use; doubts

of the medical system and the government in promoting contraception; and attitudes about pregnancy.

Attitudes of the study participants were assessed with 4- or 5- point Likert scale. It was discovered that awareness of contraceptive methods varied depending on the method among all the men. While 99% and 95% of men had heard of condoms and pills, respectively, only 64% had heard of IUDs, and 37% had heard of the implant. Awareness of female sterilization (88%) was less common than awareness of male sterilization (58%). Method-specific knowledge varied by item as well, with higher levels of knowledge about condoms than about long-acting and hormonal methods. For instance, 97% of men knew that a condom cannot be reused, and 94% knew that condoms expire.

According to their study Black and Hispanic men were less likely to have heard of many contraceptive methods such as female and male sterilization, IUDs, injectables, the vaginal ring and emergency contraception compared to white men. With respect to attitudes they discovered that noteworthy differences in multivariable analyses were that black men were less likely than whites to view condoms as a hassle to use and more likely to believe that the government tries to limit minorities by promoting birth control. In addition, Hispanic men were more likely than whites to believe that pregnancy should be planned.

2.6 Subjective norms influencing use of contraceptives

In Tanzania, a study was conducted by Irani & Speizer (2014) using the Theory of Planned Behaviour to explaining how subjective norms and behavioural control translated into actual use of contraception. Participants were asked to cite reasons for

why some young people with similar characteristics were not using contraception even if they wanted to avoid getting pregnant.

Participants were then asked about their knowledge and understanding of interpersonal communication between sexual partners with regards to contraception. In addition, they were asked to describe the impact of other relatives on this decision-making process. All the female participant groups cited that the husband's willingness to use family planning played a major role in their decision to use contraception. The married/cohabiting women stated that some spouses considered contraception as a sign of infidelity while others said that husbands/cohabiting partners were less likely to accept the use of condoms than single men.

A female married long-term resident gave her own example of how for the past 3-4 years she had been secretly visiting the health care centre to receive her three-monthly depot injections. She preferred this method to the contraceptive pill as the pill required daily intervention and the packet of pills could always be discovered at home. All the male groups generally stated that contraception was the responsibility of women. Upon further probing, married women said that positive support from sisters-in-law as well as mothers-in-law played a great influence on their use of contraceptives.

2.7 Contraceptive Ideation

In Nigeria, a study conducted by (Babalola et al., 2015) showed that only 15.1% of married women use any contraceptive method, with 9.8% using a modern method.

The end result of such low contraceptive patronage includes unintended pregnancies and maternal mortality due to associated complications with pregnancy and childbirth. The fertility rate of Nigeria remains high with an average rate of 5.5 children per woman in her reproductive age (Babalola et al., 2015).

Nigeria has one of the highest maternal mortality ratios worldwide standing at an estimated 630 deaths per 100 000 births in 2010 (Babalola et al., 2015). However the Nigerian Demographic and Health Survey (NDHS) conducted in 2013 found no change in contraceptive prevalence since 2008. Furthermore the fertility desires between Nigerian men and women continue to be high. Like in other societies, Nigeria men are the final decision-makers on key household issues which often include those related to the health of family members, education of children, family size, timing and of pregnancies. The attitudes women toward family planning are affected by their partners (Babalola et al., 2015).

This research explored factors associated with contraceptive ideation amongst urban men in Nigeria. Low-to-medium levels of contraceptive ideation were indicated amongst most respondents (Babalola et al., 2015). Men are vital household decision-makers in Nigeria and their ideational inclination toward family planning could impede acceptance and use of contraceptives by couples. The association of ideation with the level of education was expected and consistent with previous research. Individuals who are educated are more likely to exhibit ideational characteristics that favour contraceptive use than their uneducated peers. The average ideation score was higher for Christians than for Muslims and this was in agreement with previous findings in other research settings (Babalola et al., 2015).

Increased household wealth among Nigerian urban men did not show the expected connection with ideation score in the present study with an unclear reason for this unexpected finding. A prominent difference in contraceptive ideation was found between Kaduna and Ibadan even after adjusting for religious affiliation and other socio-demographic (Babalola et al., 2015). The higher level of contraceptive ideation in Ibadan compared with Kaduna was resonant of the north–south disparities in health-protective attitudes and outcomes discovered from other studies in Nigeria. The variance in mean ideation score across communities remained even after adjusting for the calculated community compositional and individual characteristics (Babalola et al., 2015).

This finding indicated that factors functioning at the community level could have an impact on the way individuals think about contraception and family planning. Even though the data did not allow community variables to be specifically identified, it is fair to assume that they might include family planning supply factors and the support of community, level of fertility in the community, gender norms, level of community organizing around family planning issues and religious leaders (Babalola et al., 2015).

2.8 HIV/AIDS among fisher folk

HIV/AIDS prevalence among fishing communities is highest amongst other risk groups (Allison & Seeley, 2004). Mobility, time spent away from home, access to cash on a daily basis in an overall context of poverty, availability of commercial sex in fishing ports and the subcultures of risk taking and hyper masculinity among some fishermen are some factors that predispose them to the vulnerability of contracting HIV/AIDS (Allison & Seeley, 2004).

A study conducted by (Ondondo, Waithera, Mpoke, Kiptoo, & Bukusi, 2014) along Lake Victoria Beaches in Kisumu County, Kenya revealed that HIV prevalence was 23% (95% CI: 18.5 - 28.1) among the 300 fishermen with an incidence rate per of 4.2 per100 person-years among fishermen and the findings were comparable to rates found in previous studies among subpopulations of men considered at higher risk for HIV infection.

Seeley et al. (2012) found that incidence rate of HIV was 4.9 person-years among fishing communities (with 5.2 person-years among men) on the shores of Lake Victoria in Uganda. Young age, being single, recent sexual intercourse with sex worker/casual partner, and unprotected sex with new sexual partners were considerably associated with new HIV infection.

HIV infection places a high burden on fishermen experience amongst other problems. Unsafe sex could be the most relevant predisposing factor for HIV acquisition as suggested by this study. Success in curtailing the HIV menace resides in call for innovative strengthening of safer sex HIV preventions strategies invigorated with the use of antiretroviral drugs. Well-targeted risk reduction interventions for fishermen are urgently needed to prevent new HIV infections among most at risk subpopulations and the general population.

2.9 HIV/AIDS in the fisheries sector in Africa

In Africa, poverty is still a largely confined to rural areas. The economic development of the rural areas is therefore crucial to the mitigation of poverty in Africa. There is high international demand for fish products hence Africa's fisheries can be an engine of

growth nonetheless the livelihood of fisheries are under serious threat (Gordon, 2005). Fishing communities on Lake Victoria recorded the earliest cases of HIV/AIDS in 1982 devastating scale of HIV/AIDS in Africa soon became apparent but despite this the rural community has been slower to recognize this fact. As a result very little attention has been paid to HIV/AIDS programmes that specifically targeted fishing communities (Gordon, 2005).

(Kissling et al., 2005) compared HIV prevalence among fisher folk with the general population and with other groups generally considered at high risk of HIV infection. Studies conducted in Africa show that fisher folk had prevalence rates of 24.0% in Uganda, 30.5% in Kenya and 20.3% in the Democratic Republic of Congo (DRC) with rates 4.8, 4.5 and 5.8 times higher than in the general population respectively. Compared to truck drivers, a known risk group, the incidence of HIV/AIDS infection in Uganda and Kenya was 1.8 and 2.1 times respectively (Kissling et al., 2005). With respect to absolute numbers, 44,000 fisher folk in Kenya were infected as compared with 8,000 truck drivers while 33,000 Ugandan fisher folk compared with 5,000 truck drivers were infected. This study in Kenya confirms that rates of HIV infection are even slightly higher for fisher folk than even for commercial sex workers (Kissling et al., 2005).

2.10 Perceived side effects of female contraceptive methods

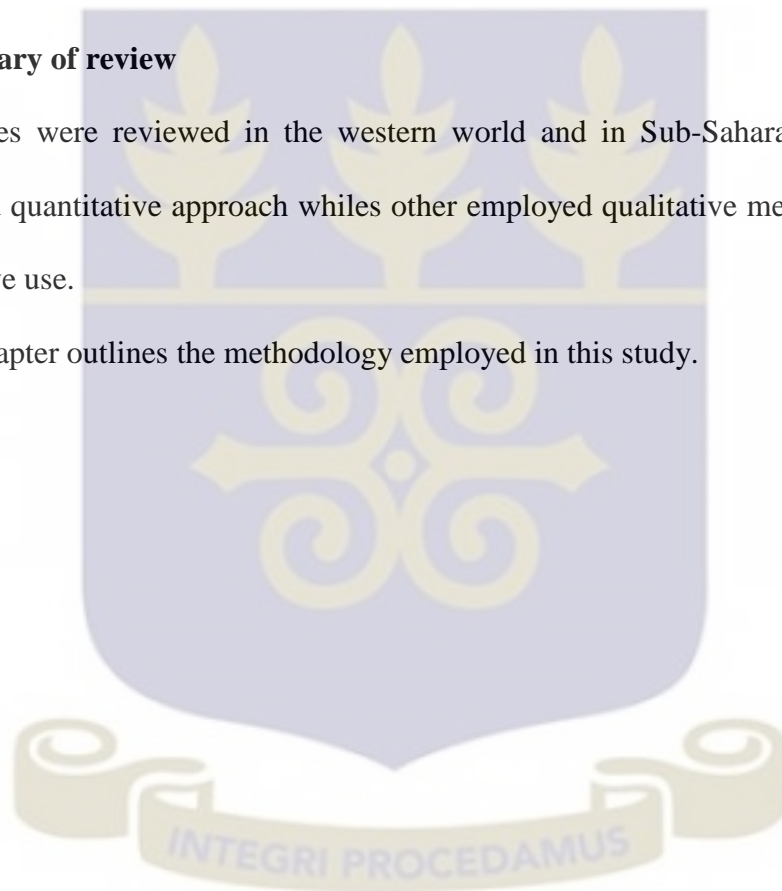
A common deterrence among men to support their partner in the use of a contraceptive method was due to perceived side effects which were blamed for increasing women's risks of infertility, illness and for reducing sexual pleasure (Kabagenyi et al., 2014). Several observed side effect particularly irregular and lengthy bleeding, as well as vaginal dryness and decreases in sex drive or libido was a source of frustration for men

(Kabagenyi et al., 2014). Profuse bleeding in was seen as having damaging effects on marriages. This was because long periods of blood loss supposedly led to women's general fatigue and dampened their libido. The number of opportunities for men to have sex with their spouse was also discovered to be limited by bleeding thus serving as a precursor and motivation for developing sexual relations outside marriages (Kabagenyi et al., 2014)

2.11 Summary of review

Many studies were reviewed in the western world and in Sub-Saharan Africa. Some studies used quantitative approach while others employed qualitative methods to explore contraceptive use.

The next chapter outlines the methodology employed in this study.



CHAPTER THREE

METHODOLOGY

3.1 Introduction

This section describes the research design, research setting, target population, inclusion and exclusion criteria. The sample size and sampling technique, data collection procedure and analysis as well as ethical considerations are presented.

3.2 Study Design

This was a qualitative study that employed focus group discussions and in-depth interviews in gathering the data. Qualitative studies often provide answers to the *whys* and *how* of human behaviour, opinions, and experiences that are difficult to obtain through quantitatively oriented methods of data collection (Mayan, 2001). The current study provided in-depth information about personal experiences of fishermen and their partners related to the use of modern contraceptives and explained why they do or do not practise contraception.

3.3 Study Area

The study site Ashiedu Keteke sub metro is the smallest yet the most populous in the Accra Metropolitan area. In spite of it being in heart of the capital city and the centre of commercial activities, it is deprived in many respects. The population of the sub metro is a mixture of indigenous Gas who live in communities along the coast and migrants from various parts of the country. They live in communities a bit further away from the coast. The indigenes live in communities such as James Town, Bukom, Sempe, Ngleshie. The migrants reside in Agbogbloshie, Yam market, Kokomba market, Sodom and Gomorrah, all urban slums. Its boundary extends from the north through Obetsebi Lamptey circle,

the Graphic Road through the Agbogbloshie road along the police barracks to Kinbu Traffic Light. The Korle-lagoon and Mortuary road are on the west and Barnes Road to Kwame Nkrumah Mausoleum is on the east, while the Gulf of Guinea is on the south. This study was carried out in James Town, which is located in the Ashiedu Keteke Municipality of the Greater Accra Region of Ghana. James Town is a fishing community and is densely populated. The largest ethnic group is the Ga-Dangme ethnic group followed by the Akan's. They are predominantly Christians but have a wide range of other religions such as Islam, Traditionalists as well as Atheists. The main occupation of the indigenes is fishing.

3.4 Target Population and Selection of Participants

The target population comprised of men and their female partners in their reproductive age. The study participants were purposively selected. This sampling method ensured that the target population is fairly represented and only individuals who could provide adequate information about the phenomena under study were selected.

3.5 Study Variables

The variables identified in this study included perceived behavioural control, subjective norms, knowledge, accessibility, behavioural intentions, attitudes and beliefs regarding contraceptive use.

3.6 Data Collection and Tools

The researcher conducted six focused group discussions (FGD) with three age categories of fishermen (15-24 years, 25-40 years and 41-59 years). Their partners were also categorized into three age groups (15-24 years, 25-40 years, 41-59 years) and engaged in

FGDs. Each focus group had six homogeneous participants. In addition, eight traditional and opinion leaders e.g. the chief, queen mother, chief fishermen and chief fishmonger were also engaged in in-depth interviews. The interviews and FGDs were conducted in one of the offices of the Fishermen Council. The tool for data collection was an interview and focus group guide. The interview guide was such that less sensitive questions came first to allow them to relax and speak freely.

Participants' permission was sought before the discussions were recorded. The sensitive questions came later after rapport had been established. The issues explored included, contraceptive use, perceived behavioural control, subjective norms and behavioural intentions that influenced the use of contraceptives, experiences as well as knowledge, attitudes and beliefs towards contraception. The researcher ensured that all non-verbal communication from participants such as mannerisms and facial expressions were recorded in the field notes as required in qualitative studies.

3.7 Pre-Testing

Pre-testing of the interview guide and the focus group guide were done to ensure participants understood the questions as intended and to reveal any unforeseen problems that may be encountered. Pre-testing was conducted in Chorkor, a community with similar as James Town. The necessary modifications of the questions were done before the start of the study.

3.8 Data Analysis

The data collected was transcribed verbatim and analyzed using thematic content analysis. Data analysis and data collection were done concurrently. The former started as soon as data collection was initiated. This means that as the researcher started the initial interviews, information or ideas obtained from these first few interviews were used to inform subsequent interviews. During qualitative analysis, the use of field notes is crucial since they help capture all non-verbal communication from participants to help make meaning of the emerging data. When all the interviews had been conducted and transcriptions done verbatim, the researcher read each transcript over and over again. Reading the transcripts many times allowed the researcher to immerse himself in the data to familiarize himself with the data. Emerging themes from the transcripts were noted and written in the margin of the transcripts. This was done for all the data set. Having noted down all emerging themes, these were all written down, the researcher took note of patterns among the recorded themes. Using these observed patterns, the themes were grouped hierarchically into main or major themes and sub-themes. The main themes were broad concepts that served as umbrella terms under which appropriate sub-themes were captured. Using the identified major themes and sub-themes, all the transcripts were coded. Thereafter, with the use of a computer, all information relating to a particular sub-theme were copied and pasted in folders that had been labeled with the appropriate sub-themes. This ensured that all information provided by different participants on the same issue was all put in one folder. This facilitated retrieval and writing of narratives for each major theme and corresponding sub-themes. During analysis all the non-verbal communication (mannerisms and facial expressions) captured in the field notes were brought to bear on the interpretation of the data. For instance, a frown or show of disgust facially, by a participant over a question may reveal his or her attitude about the issue

being discussed. The entire content of the field notes was used to augment the interpretation of the data collected. The use of quotes or exemplars was made to illuminate the findings as they were presented.

3.9 Inclusion Criteria

The criteria for inclusion in the sample were married couples or cohabiting partners living together in the same house. Participants were between 15 to 59 years for both men and women who had lived in the locality for at least one year. This age range conforms to respondents used in the 2014 Ghana Demographic and Health Survey (Ghana Statistical Service 2015).

3.10 Exclusion Criteria

People who were excluded in this study were single men and women, those who were mentally challenged and those outside the age categories of 15-59.

3.11 Ethical considerations

Ethical approval was sought from the Ghana Health Service Ethics Review Committee. Letters of introduction were obtained from the University of Ghana, School of Public Health and sent to community and opinion leaders for permission to conduct the study.

Before data collection started the study was thoroughly explained to the participants and their informed consent for participation sought. The study procedure was explained to participants in 'Ga' (the local language of the indigenes research setting). They were informed of the option to decline to participate, withdraw from the study or decline to answer any question they found uncomfortable.

Participants were assured of confidentiality throughout the study with regards to the information they provided. All information concerning individual participants remained anonymous and confidential. All data collected were protected and secured on storage devices. Access to data was limited to the Principal Investigator and research supervisor. The Principal Investigator has no conflict of interest in the study.

Participants were informed that participating in the study was voluntary and they had the right to decline to participate or withdraw from the study. Participants were informed that there were no direct benefits from participating in the study. However, they were informed that information obtained from this study could be relevant for use in developing and implementing interventions to improve sexual and reproductive health in general. They finally gave their consent through signing, writing initials or thumb printing. Also participants' permission was sought before the discussions were recorded.

3.12 Methodological Rigour

In qualitative study, ensuring trustworthiness or rigour is paramount. Trustworthiness refers to the credibility of the study. There are several measures for ensuring trustworthiness. These include methodological coherence, respondent validation or member checking, a thick description of the setting and data collection procedure, prolonged engagement in the field among others (Polit, Beck & Hungler, 2001). A school of thought contends that trustworthiness in qualitative research could also be ensured through credibility, transferability, dependability and confirmability (Polit, Beck & Hungler, 2001).

Transferability is the extent to which the findings of a study can be applied in similar settings (Polit & Beck, 2004). This is achieved through vivid description of the research setting and ensuring the number of participants is adequate. According to Polit & Beck, (2004), confirmability is required to ensure that the findings of a study reflect ideas and views of the participants and not the researchers. In order to ensure confirmability, the researcher kept an audit trail, which is a record of all decisions taken throughout the research as well as the reflections and prejudices of the researcher that were bracketed prior to the research.

Dependability has to do with a detailed account of the processes involved in gathering data and it provides the opportunity for others to replicate the study. Dependability was achieved following in-depth description of the research design, background of participants and methods used in collating and analyzing the data (Polit & Beck, 2004).

3.13 Data management

The demographic data of participants were separated from the interview data to ensure connections between could not be made. The interview materials (digital recorder and transcripts) were kept under lock and key in the researchers' possession and were only accessible to the researcher and supervisor. The transcripts would be kept for five (5) years following completion of the study and in the event that they are needed for further analysis, ethical clearance will be obtained.

The next section outlines the findings of the study.

CHAPTER FOUR

RESULTS

4.0 Introduction

This chapter presents the findings of the study that explored the experiences and use of contraceptives among fishermen and their partners in the Accra Metropolitan Area. A total of six FGDs were carried out with groups of fishermen and their partners within the age groups of 15-24 years, 25-40 years and 41-59 years. For a deeper understanding of the phenomenon being studied from the perspectives of the participants, eight in-depth interviews (IDIs) were carried. In the next section, the demographic characteristics of the participants are presented.

4.1 Demographic Characteristics of Participants

Forty-four participants 22 men and 22 women were used in the study. Some of the participants were engaged in FGDs and others in-depth interviews. All the participants were between the ages of 15 to 59 years and categorized into three age groups (15-24 years), (25-40 years) and (41-59 years). Six participants formed a FGD group. Additionally, a participant was selected from each of the age groups for the IDIs.

Regarding their educational level, 15 had no formal education, 23 had basic education, 6 had high school education and none had any form of tertiary education. Twenty-three of the participants were Christians, 16 were Muslims and five did not belong to any religious group. Eighteen women and ten men were customarily married with the rest cohabiting. Most of them had one to six children with few of them having two children.

In relation to their occupation 22 were fishermen and 22 were fishmongers. The majority of the participants belonged to the Ga ethnic group. Only five were from different tribes; Dagomba, Ewe and Ashanti. In the section that follows, the major themes and their corresponding sub-themes are discussed.

Table 4.1: Demographic characteristics of participants

Characteristic	Frequency
Age groups	
(15-24 years)	12
(25-40 years)	15
(41-59 years)	17
Sex	
Males	22
Females	22
Ethnic backgrounds	
Ga	39
Dagomba	1
Ewe	2
Ashanti	2
Religion	
Christians	23
Muslims	16
None	5
Educational level	
None	15
Basic	23
High school	6
Tertiary	0
Marital status	
Married	28
Cohabiting	16
Parity (No. of children)	
1-2	12
3-6	32

4.2 Major Themes and Sub-Themes

Thematic content analysis of the data generated from the study yielded seven major themes and twenty-one sub-themes. The major themes were: (i) knowledge about contraceptives (ii) accessibility, availability and barriers to access (iii) attitudes towards contraceptives, (iv) beliefs related to contraceptive use. (v) contraceptive use and non-use. (vi) socio-cultural perspectives concerning contraceptives (vii) perceptions about contraceptives.

The subthemes were: (i) sources of knowledge of contraceptives, (ii) knowledge of types of contraceptives, (iii) knowledge of contraceptives as a preventive measure, (iv) lack of knowledge on long term contraception, (v) sources of contraceptive supply, (vi) cost of contraceptives, (vii) adolescents' access to contraceptives, (viii) barriers to access to contraceptives, (ix) attitudes towards permanent contraception, (x) positive attitudes towards contraceptives, (xi) negative attitudes towards contraceptives, (xii) beliefs concerning authority for contraceptive decisions, (xiii) personal beliefs concerning contraceptives, (xiv) community beliefs concerning contraceptives, (xv) benefits of contraceptives, (xvi) experiences and side effects, (xvii) myths and misconceptions, (xviii) pronatalistic nature of Ghanaians, (xix) transitions in Ghanaian culture, (xx) personal perceptions about contraceptives, (xxi) community perceptions about contraceptives.

Table 4 presents major themes and their corresponding sub-themes.

Table 4.2: Major Themes and Sub-Themes

Number	Themes	Sub-themes
1	Knowledge	<ul style="list-style-type: none"> • Sources of knowledge of contraceptives • Knowledge of types of contraceptives • Knowledge of contraceptives as a preventive measure • Lack of knowledge of long term contraception
2	Access and availability to contraceptives & barriers to access	<ul style="list-style-type: none"> • Sources of contraceptives • Cost of contraceptives • Access of contraceptives to adolescents • Barriers to access
3	Attitudes towards contraceptives	<ul style="list-style-type: none"> • Attitudes towards permanent contraception • Positive attitudes towards contraception • Negative attitudes towards contraception
4	Beliefs about contraceptives	<ul style="list-style-type: none"> • Beliefs concerning authority for contraceptive decisions • Community beliefs concerning contraceptives • Personal beliefs concerning contraceptives
5	Contraceptive use and non-use	<ul style="list-style-type: none"> • Benefits of contraceptives • Experiences and side effects • Myths and misconceptions
6	Socio-cultural perspectives concerning contraceptives	<ul style="list-style-type: none"> • Pronatalistic nature of Ghanaians • Transitions in Ghanaian culture
7	Perceptions about contraceptives	<ul style="list-style-type: none"> • Personal perceptions about contraceptives • Community perceptions about contraceptives

In the ensuing sections, the themes and their corresponding sub-themes are presented in turns and quotes from participants are used to illumine the findings. The quotes have been italicized; the age groups and description of types of participants have been written below each quote.

4.3 Knowledge about Contraceptives

4.3.1 Sources of knowledge

The findings of the study showed that the sources of knowledge of contraceptives were mainly the television, non-governmental organizations (NGOs) concerned with reproductive health and community health nurses who regularly visit the fishing community to organize their monthly outreach and satellite clinics. When the participants were asked about the sources of their knowledge on contraception, one of the participants from the FGDs expressed his views as follows:

Yes, we watch it on the television. We have male and females condoms. At first there was none for females, but now we have some for females. (Male participant 1, 35 years).

Another participant, a mother of two, also said:

The nurses in brown come around and talk to us for some time after which they share condoms free of charge. (Female participant, 24 years).

4.3.2 Types of contraceptives

The vast majority of participants had knowledge on the types of contraceptives available to them. They cited the condom, combined oral contraceptive pills, which they referred to as “pees”, injectables and implants. Knowledge of the male condom was high. Most of the participants however did not know about the female condom. Some respondents mentioned emergency contraceptive pills as a family planning method. A few respondents, mainly women, mentioned the loop. A participant from the FGDs described condoms as follows:

The penis socks is what I know. Sometimes it tears so I prefer to have sex without it because what is the point of wearing it if in the end it will still tear? (**Male participant 5, 59 years**).

Another participant, from the in-depth interview group expressed:

Me, I use the one put in the arm. Before that, I used the injection one that lasts for five years for about twelve years and it started to give me problems two years ago so I went to have it removed... I have tried the five years one twice and it gave me problems. (**Female participant, 42 years**).

Since many participants did not cite the female condom as a contraceptive method, the method was described and they were asked what they knew about it. A participant from the FGDs responded as follows:

A female rubber? We haven't heard of that before. It is the type for the man that we know for many years. (**Male participant 6, 47 years**).

4.3.3 Knowledge of contraceptives as a preventive measure

The findings of the study showed that the vast majority of the participants lacked knowledge on the use of condoms as a means of preventing STIs. However, most participants were able to associate contraceptives with the prevention of unwanted pregnancies. A participant from the FGDs reported his knowledge of contraceptive as follows:

I know it [contraception], it is done to prevent giving birth to many children, especially when there is not enough money to use to take care of the children. They say there is a metal they put in the arm, and there is the injectable, which lasts for three months. (**Female participant 3, 32 years**).

A few participants cited the use of herbs to help prevent STIs. A participant from the FGDs stated:

I have not looked into that (modern contraception and STI prevention) but we have some herbs we boil and drink after sex to cleanse our system of such diseases because today, today we can't trust women. They are small like sticks and some man brings them to us occasionally, but I don't think he is around. (Male participant 2, 53 years).

4.3.4 Lack of knowledge of long-term methods

The majority of participants lacked knowledge about vasectomy and tubal ligation as long-term methods of contraception. One of the participants interviewed said:

I have not heard of such a thing before (long term contraceptive methods). It is the condoms I know for the men and the pees (pills) the women take in order to prevent pregnancy. (Male participant 6, 45 years)

Another participant reiterated:

We don't know any such thing. The one we know of are the ones we have mentioned to you. They are the common ones here and the ones we usually use. Nobody has ever mentioned those words to us. I can't even remember the names you mentioned. What did you say they are again? (Female participant 1, 36 years).

4.4 Access to Contraceptives, Availability and Barriers to Access

4.4.1 Sources of contraceptives

The findings from the study showed the hospital, clinic, polyclinic, drugstore and pharmacy shops were the main sources of contraceptives for the community members. When asked about where they obtain contraceptives, a participant from the FGD gave the following responses:

They (health professionals) also do it at the clinic at the top and also some pharmacies give “pees” (pills) that the women take and it is good for them. (Male participant 4, 29 years).

One of the participants interviewed also said:

It (access) is not difficult at all. The women especially, are taken care of in the hospital and we, the men if we need condom we go to the drugstore. They have various types depending on your pleasure. (Male participant 3, 27 years).

4.4.2 Cost of contraceptives

The majority of participants did not consider the cost of contraceptives as a problem. Most of them stated that many of the available methods were affordable. Only a few of them complained about the price of contraceptives. They said that occasionally, some types of contraceptives particularly condoms were given to them free. A few of the participants however, mentioned that they were sometimes charged heavily for contraceptives when the provider noticed their desperation. A participant mentioned his experience during one FGD as follows:

Some of them know we are desperate and they increase the price and make money from us through that. (Male participant 2, 33 years).

Another participant interviewed her expressed views in the following statement:

No. If you have ten cedis or five cedis you will get some. There are some for three months, five years, any type that you want. The price depends on the duration. The longer the duration the more expensive it is. Most people don't want to pay because they can buy beer and other things but don't want to buy contraceptives. (Female participant, 23 years).

Furthermore, a participant from the FGDs said:

They come and do it here at Mantse Agbonaa park for free. They come to the chief's house and also do it for free. With the hospital itself, when they are being truthful, when you go, they don't take any money but now when we go, every month, they collect one cedi. That is the cost of the needle. Apart from one cedi, they don't take anything. (Female participant 4, 24 years).

4.4.3 Adolescents access to contraceptives

The findings from the study showed that adolescents within the community were occasionally educated on contraceptives. They also have access to contraceptive services when needed. One of the participants engaged in the FGDs said:

They are even doing some (contraception) for school girls. They come and talk to them and do it for them. Girls of today, they are easily cornered [lured] by men, so it is good that it is being done for them. They are more vulnerable these days than in the past. (Female participant 6, 41 years).

One of the participants interviewed also expressed:

Yes, it (contraception) is done for them when they are old enough. For the young women, they are lied to by the men so if you do not do it (contraception) for them, they will get pregnant easily. (Male participant, 39 years).

4.4.4 Barriers to access

Factors that hindered access to contraceptive use among participants included shyness, financial constraints, husbands' attitudes, attitudes of health providers and religion were identified as a barrier to access. A participant from the FGDs stated:

Well, for me sometimes I am shy of what people will say and sometimes my husband will think I am sleeping with another man if he sees me going, so it

makes it very difficult for me. Last time, I heard my neighbour shouting about his wife sleeping with other men that was why she went to do the family planning without his consent. It was very bad. I am sure plenty people could hear them but they didn't care. (Female participant 4, 22 years).

In a few cases, religion was identified as a barrier to access. A participant cited religious beliefs as reasons for non-procurement and use of contraceptives in one of the FGDs:

Some of my sisters won't speak the truth but some of us don't do it because the Holy Bible said we should give birth plenty and fill God's land so they don't like using it. It is a very wrong mindset. If we fill the earth with people, food won't reach us. (Female participant 2, 26 years).

Some participants cited the attitude of nurses as a barrier to access to contraceptives. Some nurses were also reported to be good and humane. A participant interviewed expressed:

Sometimes when you go to the clinic, the nurses shout at me for not coming for my injection when the time was due. They talk to me anyhow but there is a particular nurse who is very good to me but she doesn't come everyday. When I go and she is not there I just come home and go again when she is there. (Female participant, 35 years).

4.5 Attitudes towards Contraceptives

4.5.1 Attitudes towards permanent contraception

The findings of the study indicated that the majority of participants seemed not to have any knowledge about long-term contraception. When vasectomy and tubal ligation were explained to them, some participants showed strong negative attitudes towards them. A few participants mentioned that they would not allow their spouses to have such procedures performed. Some male participants could not accept and live with the fact that their young wives would stop having children when tubal ligation is done. They could not comprehend why a person's fertility would be curtailed especially through

unnatural means. One of such participants from the FGDs vehemently expressed as follows:

I won't allow it (tubal ligation) because I can't imagine my wife not being able to give birth even if I sleep with her. It will worry my mind all the time. (Male participant 3, 56 years).

It was found that just as the males had a strong aversion for permanent contraception, some of the female participants considered permanent contraception as completely unacceptable. One of the participants from the FGDs stated:

As you look at me and my age, I will not give birth again and I have lost my sexual desire!!! I am not interested in sex anymore!!! Even pills, I wasn't taking, how much more something that involves being cut by a knife? (FGD Female Participant 2, 47 years).

Opinions differed among the participants in relation to permanent contraception. One of the participants interviewed expressed:

I would. At our age now, we have four children and wouldn't want to give birth anymore so if she wants to do it and it will be safe for her, then she can do it. (Male Participant, 52 years).

4.5.2 Positive attitudes towards contraception

The majority of participants expressed positive attitudes towards contraceptives mainly due to the benefits derived from them, including protection from unwanted pregnancies.

One of the participants who took part in the FGDs mentioned:

Left to me alone, it is good for me. It is very good for me. I have only one child but if I wanted to do it, I would use the injection again. It lasts for a long time and have told my colleagues to try it if they do not want children now. (FGD Female Participant 1, 24 years).

Another participant who was interviewed stated:

Yes. They explained it to me very well and I understood it. When I started using it, I started growing fat. I had normal menses also, so it was good for me and I like using that one. (Female participant, 25 years).

4.5.3 Negative attitudes towards contraception

A few of the participants had negative attitudes towards contraceptives due to the reportedly numerous side effects, the requirement for pregnancy tests to be performed at health facilities before administration of a method and issues of morality related to contraceptive use. Some men mentioned that infidelity on the part of the women was the reason behind their negative attitudes towards contraceptives. A participant from one of the FGDs stated:

When you are using the injectable and you stop for a while and you go back for them to start again, they will make you do a lab test before they will do it for you and because of the lab test I don't like going. (FDG Female Participant 5, 19 years).

Furthermore, an interviewed participant mentioned:

There are some (women) who are not morally upright, if they don't want to get pregnant, they will go and do it. There are others who are not so (immoral) but do it to protect themselves. So for me I don't think I like using it because of morality. (Male Participant 2, 28 years).

In relation to the issue of contraceptive use and immorality, one of the FGD participants expressed:

"No. The enjoyment (from sex) is our only source of joy. We are on the sea 24hrs then after that, we mend our nets. Small joy we want to enjoy, you say "wear

socks". Me, I don't like using it and the same for my brothers here and those who are not here. (Male participant 3, 31 years).

Another participant who was interviewed said:

You can't trust women these days and they are very good at hiding things but you cannot hide pregnancy forever. I won't allow that in my house! If she (spouse) wants to do it (contraception) she should get another man. (Male participant, 29 years).

4.6 Beliefs about Contraceptives

4.6.1 Beliefs concerning authority for contraceptive decisions

The majority of participants recognized the man as the authority for contraceptive decision-making. A few however stated that the woman was responsible for making that decision. Also, a few participants mentioned the couple as the decision-making body on whether to use contraceptives or not. Concerning contraceptive decision-making, a participant who was interviewed expressed her views as follows:

After my first born, I spoke to my husband that if he wants sex, he should allow me to do contraception so that our child can grow a bit before another one comes so he agreed and took me to Ussher Clinic where I took the three months' injection. (Female participant, 23 years).

Another interviewed participant said:

My wife, all she does is, she tells me then I will allow her to do it. I don't have a problem with that at all, even though some women do it in order to sleep with a lot of men. (Male participant, 40 years).

One participant from the FGDs mentioned:

My man, he controls the house so I have to ask him first. I can't do it without his knowledge. I remember a friend of mine went to do some (contraception) without telling her husband and she was kicked out of the house! (Female participant 6, 33 years).

4.6.2 Personal beliefs concerning contraceptives

The findings of this study showed that on a personal level, participants had some positive as well as negative beliefs concerning contraceptive use. The positive beliefs appeared to emerge from or be related to the benefits derived from contraception, especially protection from unwanted pregnancies and births while religious reasons were the main source of other participants' negative beliefs. One of the participants from the FGDs expressed:

Well, I believe it is good. It is good, because when I don't want to give birth but want to have sex I can, without any problems. My husband likes sex so if I wasn't using it, I would have a lot of children by now. (Female participant 1, 22 years).

In relation to beliefs concerning contraception, a participant from one of the FGDs had negative sentiments:

Left to me alone, I don't believe it is good because we need to be able to have children to the glory of God and some people have had a meeting and said no, we should control the number of children we have. I don't believe it is good. (Male participant, 43 years).

4.6.3 Community beliefs concerning contraceptives

The majority of participants did not think their community members believe contraceptives are beneficial. This is due to numerous misconceptions and myths they

have concerning contraceptive use such as not being able to give birth again after use, bleeding and high blood pressure. A participant from one of the FGDs gave a vivid description of typical misconceptions in the community as follows:

As for my community people hmmm, some of them I don't think they believe it's good because of some of the things they have heard, like not being able to conceive again after using it so most of them don't use it. Look at the number of children here; an evidence that they are not using it. The children are not going to school. They are so many and they don't even get food to eat. Some even get killed by cars because they can't be taken care of by parents. (Female participant 3, 50 years).

Additionally, an interviewed participant lamented:

For some of the people in the community, it is good for them but most of them it is not good for them because they get BP (high blood pressure) when they use it and they are young and are not supposed to have BP so they do not use it because of this. A young sister of ours died and we were told she went to do family planning and that she got BP and died so we don't believe family planning is good for all of us. (Male participant, 55 years).

4.7 Contraceptive Use and Non-Use

4.7.1 Benefits of contraceptives

Mothers, children, families, the community and the country as a whole are the main beneficiaries of contraceptive use according to participants in the study. The benefits mothers reportedly derive from contraception include protection from unwanted pregnancies and having time for themselves. Proper care of family members, financial stability and freedom from the issues associated with large family sizes such as inadequate food were the family benefits stated by participants. With respect to the community, the cited benefits were control of social vices such as stealing, peace within

the community and prevention of overcrowding. The benefits children derive include opportunity to attend school and the advantage of receiving proper care from their parents. Population control for better care and economic stability were the benefits that are derived by the country. A few of the male participants also mentioned the benefits they personally derive from the use of contraceptives. These include protection from STIs as well as having enough to cater for the family.

Two of the participants interviewed expressed:

It will help all of us. The children will grow up nicely and since they will be given proper care they will not engage in stealing and “sakawa” (fraudulent behaviour). The whole community will be unified as a big family where everyone looks out for each other. We will become a large family. (Female participant, 36 years).

It is good for development so that we can go ahead in life. Things are not good now but if we don't control our number, a small country like Ghana will suffer because we don't have many things to look after us but our number keeps increasing. (Male Participant, 42 years).

One participant from the FGDs mentioned:

The mother will be able to take good care of her children. Children need to go to school so they become better people in future. Unfortunately, my mother had six of us and they couldn't take care of us and even though I am intelligent I couldn't get money to continue my school so ended up smoking fish. (Female participant, 19 years).

One of the participants interviewed said:

There might be someone who might be giving birth to a large number of children. She can use family planning to protect herself from pregnancies. It helps the mother a lot because as women we take care of the house and have a lot of work

to do. If we have too many children we can't do other things in the house like cooking and our husbands will be angry even though they impregnated us. (IDI Female participant, 37 years).

One participant from the FGDs expressed:

What I like about it is that when you sleep with a woman with an STI, it will protect you and prevent you from contracting an illness. People of today are bad and sleeping with each other so you can't tell the diseases they carry so this thing (contraceptive, condom) helps us protect ourselves so we don't die early. (Male participant 5, 24 years).

4.7.2 Experiences/side effects

The majority of participants mentioned various experiences, including side effects they encountered with the use of contraceptives. These included bleeding, headaches, irregular menses and weight gain. A few of the participants also stated that they had heard of cases of high blood pressure and fibroids following use of contraceptives. Some participants also mentioned that they could not lift heavy items after insertion of implants or having the injectable. Most of the men also complained that their condoms kept tearing during intercourse. One of the interviewed participants expressed:

In the beginning if you are not aware and you start with it, you will not have your menses regularly. If you have your menses every month and you are put on a contraceptive, you won't have your menses that regularly. There can also be spotting. I didn't like that and also the injection made me ill so I take the everyday pills even though I forget sometimes. (Female participant, 23 years).

A participant from the FGDs said:

Protection from giving birth by heart, that is what I like. What I didn't like is that I became big after sometime and headaches. It made me eat plenty! That is the only thing that is worrying me. (Female participant 5, 31 years).

Two participants interviewed mentioned:

Family planning has helped my family and me. There is a benefit to some people. To some people too, it is not beneficial. The only problem I had was I bled a lot after it was done for me so I felt very weak for some days but in the end I was fine. (IDI Female Participant, 44 years).

I don't like the five years injection because they say when you do that, you can't lift heavy objects. They tell us at the hospital so if my children are not at home I can't even lift a bucket because am afraid that the contraceptive will not work so I wait for them to come and help me. (Female participant 27 years).

Furthermore, a participant from the FGDs said:

My friend, the condom has failed me sometimes. It easily tears and everything (semen) pours. What is the point of wearing it then if it will tear? (FGD male participant 3, 58 years).

4.7.3 Myths and misconceptions

The findings of this study showed that the majority of participants had various myths and misconceptions concerning contraceptive use. They included the development of uterine fibroids and high blood pressure after use and inability to conceive again when ready.

One of the participants from the FGDs mentioned her experiences:

There are some who say it is not compatible with them. Some also say when they use it, their blood pressure rises. Some also say when they use it, they bleed a lot. (Female Participant, 44 years).

Two participants during FGDs said:

I have heard it destroys the womb and gives fibroids and you won't be able to give birth again because they will remove your womb. (Female participant 3, 34 years).

They say it is not good and that it gives fibroids so I went to the hospital and told them people say the contraceptives are not good and that it has side effects but they told me we should not listen to those people but that it is good. If it were not good it wouldn't be made for people to use. (Female Participant 4, 23 years).

One of the participants interviewed expressed:

Many of them are also afraid that they won't give birth again when they want children and because of that they do not use it. (Female participant, 28 years).

4.8 Socio-Cultural Perspectives Concerning Contraceptives

4.8.1 Pronatalistic nature of Ghanaians

A few of the participants were of the view that child bearing is to be encouraged in Ghanaian society because that is our cultural heritage; hence the use of contraceptives is contrary to the promotion of human reproduction. One of the interviewed participants stated:

From the beginning I can say I know nothing about it but now I am old and I speak to people about it. I always say if its 2 or 3 you can take care of very well, give birth to them and maintain yourself. If you take care of them well and they grow up they will also take of you. So in general that is the advice you can give to people to also think of. My father had 24 children and 96 grandchildren before he died. Back then we didn't have this education so we didn't know. (Male participant, 55 years).

4.8.2 Transitions in Ghanaian culture

The findings of the study showed that customary rites that served as checks and balances in the past and help prevent unwanted pregnancies have been abandoned due to westernization and globalization. A few participants believe that the present generation, their characteristics and the way they behave differ from that of past generations. They also believe that curiosity and adventurous desires among the youth have culminated in widespread moral decadence in the country. They mentioned that the behaviour of the present youth is a reflection of what they are taught. Family planning was also described as something novel.

A participant interviewed expressed the following views:

In the past, after a woman had her period, there are some number of days you have to wait to have sex with her if you want to prevent pregnancy but the current generation can't adhere to that. If they are made to know the challenges you face when you give birth when you are not prepared to look after the child, it will help a lot. Due to the curiosity of this current generation, the matter has worsened and also due to their adventurousness the things they are taught, they practice them which has led to the immorality. If they are taught how to abstain from sex properly, it will go a long way to help. Sometimes our customs also play a part. Some people want to give birth to a lot of children for them to be appreciated. So they have to be advised that we are in a different time now and the way things were done back then cannot be done now. (Male participant, 59 years).

Another participant, a 43-year-old mother of 3 gave some of the cultural practices that controlled unwanted pregnancies in the following narratives:

We will benefit a lot from it. We spend a lot of money to feed our children because we can't sit down for them to suffer. We can use all that money for something else. And also the people will live healthily. Our forefathers were very smart, at first you needed to go through some customs before you enter marriage and any

man that marries you will be the first man to have sex with you. If that custom wasn't done you had no right getting pregnant so pregnancies were checked. Other customs also taught the woman how to behave when she gets married, taking care of herself and that of her children. So after these are done and she goes to her marital home there is peace but we have stopped them now. At first we didn't have family planning. (Female Participant, 43 years).

4.9 Perceptions about Contraceptives

4.9.1 Personal perceptions about contraceptives

Findings from the study indicated that the majority of participants had positive perceptions concerning contraceptives. A few participants on the other hand expressed negative perceptions concerning contraceptives. The positive perceptions were mainly associated with the benefits of protecting women from unwanted pregnancies while the 'infidelity' reportedly associated with contraception was the underlying reason for the negative personal perceptions.

A participant from the FGDs expressed:

They are using it for bad things. Because of contraceptives, some of the women get additional partners aside their husbands. (Male participant 4, 37 years).

One of the participants who was interviewed stated:

We have a proverb that says that "prevention is better than cure" so if learned people say we should use these contraceptives and we use them it will benefit not just the woman but me, the man too. (Male participant, 57 years).

4.9.2 Community perceptions about contraceptives

A few of the participants were of the view that contraceptives are the Western way of controlling people of the black race while very few of them perceived the use of contraceptives as immoral. A participant who was interviewed said:

It is a good thing that the intelligent people have brought but most people don't like using it because they say anything from the white man for black people is not good for us. (Male Participant, 43 years).

One participant in the FGDs mentioned:

There are some who use contraceptives and behave immorally. They sleep with any man they find because they feel they are using contraceptives. Because of that they like using it to protect themselves because they want to enjoy. They will enjoy and die. (Male participant, 40 years).

Additionally, one other interviewed participant expressed:

Some have said before that the white man brought this to control the number of blacks. Yes, they have said that before so most men believe it is not a good thing to use. Most people also believe that it is wrong to use contraceptives and that they haven't come across it in the Holy book (Bible) but ask yourself, is sleeping with multiple women in the Holy book? (Male participant, 57 years).

CHAPTER FIVE

DISCUSSION

5.0 Introduction

This study set out to examine the knowledge modern contraceptives among fishermen and their partners in the Accra Metropolitan Area and experiences of users. The qualitative approach was used since there is paucity of research on the phenomenon being studied and the qualitative design was deemed to be the appropriate research approach to elucidate the phenomenon. The theory of planned behaviour (Ajzen et al., 1991) informed the study. This theory was considered appropriate because its constructs and relationships among them would best explain the behaviours of the study participants.

The objectives of the study were to:

- To ascertain the knowledge of contraceptives among fishermen and their partners.
- To identify factors that influence fishermen and their partners to use or not use contraceptives.
- To explore experiences fishermen and their partners have had with contraceptive use.

The key findings of the study included:

- Only a few of the participants knew that condoms can prevent STIs. Most of them knew that condoms could prevent pregnancy but not STIs. They were not aware of the dual protection of condoms and could not tell the relationship between condom use and prevention of STIs.
- Some of the male participants could not accept and live with the notion that use of permanent contraception (vasectomy and tubal ligation) would curtail their fertility and stop them from having children permanently. They want to know and

believe that they are fertile and can have children when they want; except when naturally, advance age terminates their fertility. They want to have the power to control their own fertility rather than allowing a “White man’s medicine” (contraceptives) to temper with their God-given fertility and make them permanently sterile. To them, this was completely unacceptable.

- Some of the participants, mostly male, perceived contraception as a foreign measure that white people want to use to decrease the population of blacks for ulterior motives.
- Knowledge of contraceptives was high but use was low; most participants knew about the types of contraceptives and where to get them including the cost and side effects. But there were numerous myths and misconceptions or fallacies about modern contraceptives.
- Knowledge and use of the male condom was higher than that of the female condom. There was paucity of knowledge about the female condom and no participant was using the female condom. There was also lack of knowledge about the permanent methods of contraception. In addition, most of the males were not aware that use of the male condom is only effective if it is correct and consistent. Most of the male participants were of the view that contraception is something that should be in the female domain. Some men (in both FGDs and the IDIs) particularly those in the 41-59 years age group were of the view that for male partners to prevent infidelity on the part of their female partners, they should champion decisions about contraception.

- Most of the participants reported that condom use is not common among fishermen because they did not enjoy sex with condoms due to loss of sensitivity during coitus and maximum arousal.
- Infidelity on the part of women was one major barrier to contraceptive use. Some men prevented their partners from using contraceptives because they thought their partners would cheat on them if they permit them to use contraceptives. They argued that when they use contraceptives they know they would not get pregnant and be caught so other men would have opportunity to sleep with their women when they go fishing for weeks.
- Religion was another barrier to contraceptive use because the Bible enjoins us to be fruitful, to multiply and fill the earth and subdue it.
- Knowledge about emergency contraception was very low; the few participants who knew about it did not use it correctly. Emergency contraception was used as a means of contraception just like the usual types of contraceptives.
- A participants use herbs to prevent STIs.
- Male involvement in contraception.

5.1 Discussion of Findings

5.1.1 Knowledge and use of contraceptives

This study demonstrated as in many other studies (Nsubuga, Sekandi, Sempeera, & Makumbi, 2015; Somba, Mbonile, Obure, & Mahande, 2014, Omo-Aghoja et al., 2009) that there was a high level of knowledge of contraceptives but low use. Both male and female participants were highly knowledgeable about contraceptives in general but not much was known about the types, especially the female condom, permanent contraceptive methods and emergency contraception. Participants were knowledgeable

about condoms, oral contraceptive pills (which they called “pees”), the injectables, implants and IUDs. Despite their high level of knowledge, use was low. This discrepancy could be largely attributed to the numerous myths and fallacies held by participants. The male participants thought contraception is a Western idea that has infiltrated African culture due to westernization and globalization.

They believed the white people have ulterior motives of decreasing population size in Africa and contraception is one way of achieving their aims. Other erroneous ideas included infidelity on the part of women who use contraceptives, inability to control one’s God-given fertility, numerous side effects and complications of contraceptives including death and the need to adhere to Biblical commands. These findings have implications for education, especially behavioural change communication, counselling and service or practice. The 2003, 2008 and 2014 Ghana Demographic and Health Surveys (Ghana Statistical Services, 2003, 2008, 2014), the 2007 Ghana Maternal Health Survey (GMHS) and Annual Reports of the Ministry of Health (MOH) and Ghana Health Service (GHS) attest to the high contraceptive knowledge and low use among the Ghanaian populace.

5.1.2 Access and availability of contraceptives

Access to contraceptives

Access to contraceptives is pivotal to their use. In this study both male and female participants of all age groups knew where to obtain contraceptives; the hospital, clinics, health centres and drugstore or pharmacies were the most popular sources cited. A few respondents cited access to contraceptives via community-based distribution by Community Health Nurses during outreach or satellite clinics. Though cost was not seen

a barrier to contraceptives use, some participants in leadership positions were of the view that they should be made free. They argued that if contraceptives are completely free this will ensure widespread use.

The results show disagreement among participants regarding adolescents' access to contraceptives. Young participants argued that making contraceptives available to adolescents would reduce unwanted pregnancies, teenage pregnancies, unplanned births and unsafe abortions. Older participants and community and opinion leaders argued that access to contraceptives by adolescents would accentuate social vices. They feared that young people will engage in indiscriminate sex and were worried about its ramifications for themselves and society.

Making contraceptives available to adolescents is a highly contested issue in the literature (Williamson, Parkes, Wight, Petticrew, & Hart, 2009). Two schools of thought exist; one contends that the youth are sexually active and need to be protected from STIs and unwanted pregnancies among others. The other school of thought is of the view that adolescents should be encouraged to abstain from sex and not be given the leeway to indulge in sexual intercourse in an early age by introducing them to contraceptives. Religious beliefs appeared to be an underlying factor for this position. This is not surprising since Ghana is a secular country de jure but a religious country de facto. The 2010 population census showed that the vast majority of Ghanaians are Christians. It is therefore not surprising that Ghanaians frown on contraceptives being given to adolescents. Meanwhile, the GHS is of the view that due to increasing problems associated with adolescent pregnancies in Ghana, information and they should be provided with counseling services. The GHS maintains it is appropriate that sexually

active adolescents who seek contraceptive services be counseled and served (Ghana Health Service, 2003). Ironically, some nurses working with the GHS allegedly exhibit judgmental attitudes towards adolescents seeking contraceptives in health facilities that are supposed to be adolescent-friendly. This untoward behaviour of some nurses should be checked through workshops.

The curricula of most basic and high schools cover reproductive health and sexuality. It is believed that if these subjects were well handled by competent and committed teachers who are highly knowledgeable in the area, the youth in school would be well placed to make informed choices about their sexuality. The Ghana Health Service (GHS) and Ghana Education Service (GES) through SHEP have the dual responsibility to ensure that students have the information they need to make informed decisions and also protect them from early sex. This controversy has been discussed over the years; resulting in the establishment of Adolescent Friendly Health Services (AFHEs) in some public health facilities in the country. The PPAG, Willows Foundation and UNFPA are NGOs and development agencies are part of the efforts to help young live responsibly. They train some young people as peer educators to disseminate information among their contemporaries.

In Ghana, due to the entrenched religious beliefs, sex education in homes is a herculean task and virtually non-existent. Mayhew (2004) considered Ghana as a conservative country where sexual issues are not discussed in homes. Parents should be encouraged to talk to their young children about sexuality so that wayward peers do not lead these youngsters astray.

5.1.3 Attitudes of respondents towards contraceptives

Attitude is essential to the use or non-use of contraceptives. The vast majority of participants appeared not to have any knowledge about long-term contraception. After this was explained to them, a minority of participants showed strong negative attitudes towards vasectomy and tubal ligation. Some male participants could not accept and live with the fact that their young wives would stop having children when tubal ligation is done. They could not comprehend why a person's fertility would be curtailed especially through unnatural means. A few participants (mostly men) mentioned that they would not allow their spouses to have such procedures performed. Attitude may influence the interpretation, judgement and recall of attitude-relevant information. Fishermen's attitudes towards long-term contraceptives after explaining it to them could be due to their poor knowledge base. Specifically, poor knowledge about vasectomy and tubal ligation as contraceptive methods could be attributed to their low educational status, which may imply that the vast majority cannot read or use the Internet to improve upon their knowledge. These findings are consistent with that of a study by (Fabrigar, Petty, Smith, & Crites Jr., 2006) which showed that increases in knowledge are associated with better attitudes. The authors also found that attitudes were better predictors of behaviour when they were built on good knowledge than when they were based on little knowledge. In this study, most of the participants expressed positive attitudes towards contraceptives mainly due to the benefits derived from them, including protection from unwanted pregnancies, having time to engage in other activities as well as having sufficient resources because of their small family sizes. This finding corroborates the findings of a study conducted by (Kapito, Kazembe, Maluwa, Malata, & Odland, 2012) where adolescents had positive attitudes towards contraceptives due to its ability to prevent

unwanted pregnancy. This attitudes of the adolescents was described as phenomenal because of their young ages.

On the other hand, a few of the participants had negative attitudes towards contraceptives due to the reportedly numerous side effects they experienced, morality issues and the seemingly undesirable requirements for numerous pregnancy tests to be performed by users at health facilities before administration of a method. Regarding the negative attitudes of participants in this study towards contraceptives resulting from perceived side effects, similar findings were obtained by (Kallner, Thunell, Brynhildsen, Lindeberg, & Danielsson, 2015). They observed that Swedish women expressed negative attitudes towards contraceptives because of their side effects.

The issue of infidelity deterring women from using contraceptives agrees with the findings a study conducted by Kabagenyi et al. (2014). The fishermen in this study believed that when their partners use contraceptives, they can cover up their extra-marital sexual activities during their long absence from home (when they go fishing). They found it completely unacceptable that other men would have sex with their spouses and expressed their sentiments in a popular local song thus: “*Aaaaye fe notse, notse nfo; esa ni otse ohie*” (Someone else is enjoying more than the real owner and it behooves on the real owner to be vigilant) These beliefs of the fisher folk boil down to the element of trust in relationships. According to them trust between spouses could be endangered by modern contraceptives.

5.1.4 Subjective norms towards contraceptives

According to the theory of planned behaviour, subjective norm is the perceived social pressure to perform or not to perform a behaviour. In this study, many women could not use contraceptives because their partners think they will be unfaithful. The few women who used contraceptives do so because their male partners consented or they will not face opposition from them. This behaviour of some of the fishmongers is consistent with the descriptions in the theory of planned behaviour (Ajzen et al., 1991) where people behave in ways they think significant others would want them to.

Some of the fishermen could not bear the thought that apart from ageing their partners could be rendered infertile for life via tubal ligation. They could not accept the fact that contraception could permanently affect their partners' fertility. It therefore follows it is not possible for women with such partners to use contraceptives. Also, some of the fishermen felt that use of contraceptives would encourage their partners to be unfaithful. Women with such partners are also likely not to use contraceptives. They would rather not use contraceptives since their significant others (partners) are not happy about such behaviours. Additionally, it was discovered that the majority of females do not take contraceptive decisions on their own. The man is seen to be the head of the household and is usually final decision maker. Some women reported of being sacked from the houses by their partners after using contraceptives without the knowledge of the men. This finding is consistent with the findings of a study in Kenya by (Ochako et al., 2015) which pointed out the importance of the male partners' views in determining use or non-use of modern contraceptives.

A study conducted in Tanzania by (Laili Irani, , Ilene Speizer, 2014) showed that all the female participants in the FGDs said that their husbands' willingness to use family planning played a major role in their decision to use contraceptives. Married and cohabiting women stated that some spouses considered contraceptive use as a sign of infidelity. This finding corroborates with the findings in this study.

5.1.5 Perceived Behavioural Control

This study showed that the majority of the participants had positive perceptions concerning contraceptives. The protection it provides from unwanted pregnancy and the ability to manage a family size were the main reasons given for such positive perceptions. Despite the benefits of contraceptive, the vast majority of the participants were unwilling to use contraceptives. Even though the participants perceived themselves as having control over or volition concerning contraceptives use, they deterred by side effects, myths and misconceptions, which strongly militated against their perceived behavioural control. They mentioned perceived infidelity on the part of women contraceptive users and seemingly use of contraceptives by white manufacturers to control the black population. This may explain the low prevalence rate of contraceptives; a finding consistent with the findings of a study conducted by Dynes, Stephenson, Rubardt, & Bartel,(2012) outline the fact that despite the extensive implementation of family planning programmes over the past several decades, contraceptive prevalence remains low in many low income countries, particularly in Sub-Saharan Africa (Mustafa et al., 2015), (Adjei et al., 2015). A school of thought contends that having knowledge about something does not necessarily translate to performance of behaviour; for instance, some rural people may know that boiling their water before drinking may be the best practice but they may not boil their water before drinking for various reasons (Giles et al., 2004).

There is also the notion that, one would perform a behaviour provided there are the enabling factors to help to do so. Thus, the theory of planned behaviour amongst others shows how multiple factors determine the performance of a behaviour. Knowing this fact is essential for behavioural change communication.

Interestingly, some perceptions held by participants in a study by (Babalola et al., 2015) were that: “The use of contraceptive injection can make a woman permanently infertile, people who use family planning end up with health problems, contraceptives reduce women's sexual urge, contraceptives can cause cancer, contraceptives can lead to deformed new-borns, contraceptives are dangerous to women's health and women who use family planning could become promiscuous.” These results were consistent with the findings of this research.

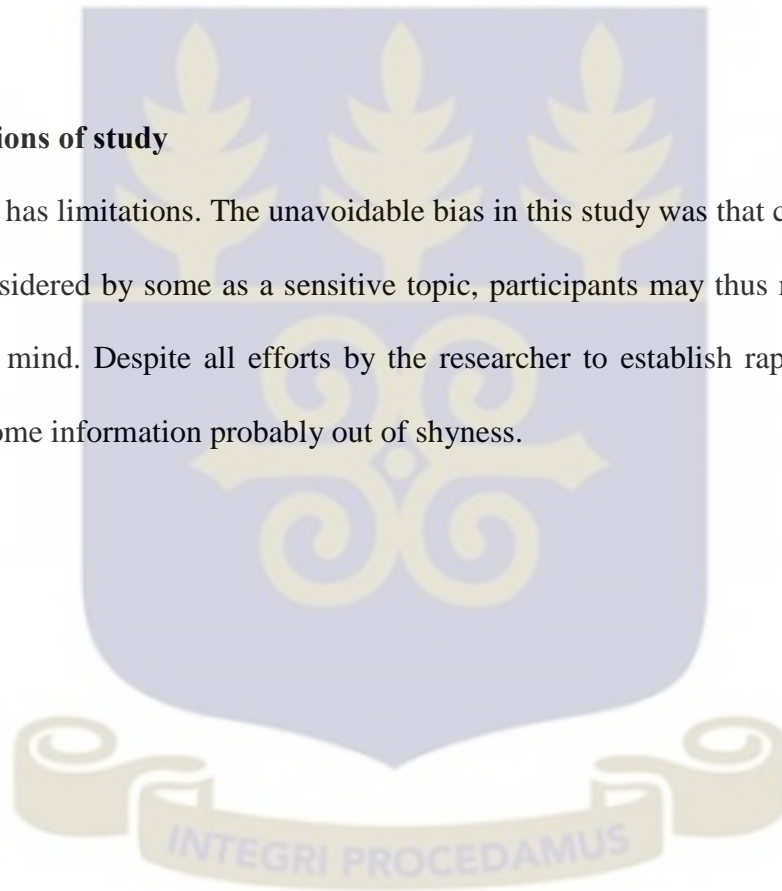
Perceived behavioural control in the theory that guided this study, refers to a person's perception of the ease or difficulty of performing the behaviour of interest (Ajzen et al., 1991). It is worthy to note that besides the positive and negative perceptions of participants in this study; they knew that they had the ultimate power to decide to use contraceptives or not. They were cognisant of how easy or difficult it is for them to use contraceptives or not. For instance, a few participants knew they could not accept vasectomy or tubal ligation. Mentally, the thought of being sterile, to them was unbearable, thus they have decided not to do it nor let their partners undergo tubal ligation. The men who wanted to control their family sizes also supported their partners. Meanwhile the participants who disliked the condom due to lack of sensitivity with its use chose when to use it and when not. The decisions were taken by themselves.

5.1.6 Behavioural intention

According to the (TPB) (Ajzen et al., 1991), attitudes and beliefs, subjective norms and perceived behavioural control together help one to form intentions to perform a behaviour. In this study, most of the participants did not carry out the behaviour of using contraceptives largely for fear of side effects. The few who reported using contraceptives may have had their intention to use contraceptives culminated by their attitudes and beliefs, subjective norms and perceived behavioural control.

5.2 Limitations of study

Every study has limitations. The unavoidable bias in this study was that contraceptive use is often considered by some as a sensitive topic, participants may thus not have said all they had in mind. Despite all efforts by the researcher to establish rapport, they could have kept some information probably out of shyness.



CHAPTER SIX

SUMMARY, CONCLUSION, IMPLICATIONS AND RECOMMENDATIONS

6.0 Introduction

This chapter presents the summary, conclusion, implications and recommendations.

6.1 Summary

This study explored the experiences related to the use of modern contraceptives among fishermen and their partners in the Accra metropolis. The qualitative research design was selected because of its inherent qualities of studying phenomena in their naturalistic settings and elucidating aspects of a phenomenon which little is known. This brings to the fore meanings of the phenomena from those being researched. The theory of planned behaviour (TPB) (Ajzen et al., 1991) to inform the study helped to elicit information on the knowledge of contraceptives among fishermen and their partners, the underlying factors that influenced use or non-use of contraceptives among fishermen and their partners the repertoire of experiences of contraception fishermen and their partners have had. In line with qualitative research, focus group discussions and in-depth individual interviews were carried out with fishermen and their spouses, selected via purposive sampling. Six FGDs with three male and three female groups in the following age groups were done and eight In-depth interviews were also conducted with both males and females. The data generated from the group discussions and interviews were analyzed using thematic content analysis; seven themes and twenty-one sub-themes emerged. Key findings included high knowledge of contraceptives but low use due to a myriad of reasons including fallacies and real side effects, strong aversion towards permanent contraception, contraceptives creating an avenue for moral decadence in married women

and the numerous benefits of contraception to women, children, families and the nation. Findings further showed mistrust of the Western world as using contraception to reduce population of black people. Theory of planned behaviour is shown to be appropriate for the discussion of study findings.

6.2 Conclusion

Fishermen and their spouses in the AMA have a wealth of interesting information to share on their individual and collective experiences regarding contraceptives. The experiences include what some of them have gone through and what they have heard from their colleagues. These experiences contributed to their strong beliefs and attitudes towards contraception. Even though some of their thoughts, beliefs and notions are erroneous and have no scientific or empirical bases, they strongly hold onto them and these guide their behaviours and those of their spouses. Although, most of the participants were aware of the benefits of contraception, using it unreservedly is a matter of concern to them.

6.3 Implications for Policy, Research, Education and Practice

The findings of this research have implications for policy, research, education and practice. Regarding policy, it would be helpful if the government through the MOH and the GHS consider making most, if not all modern contraceptive completely free. Community participation has been described as key for the success of community-based health programmes thus for future research with fishing communities and similar community groups, the researcher suggests action research with the involvement of community members to develop relevant health education programmes that would help demystify the fallacies of community members about contraceptive use. Future

researchers could work out modalities with those being researched to determine how best the side effects of contraceptives could be mitigated to encourage prospective users. Education on family planning should be hyped; teaching the fishing community via audio-visual aids and culturally acceptable and understandable techniques to promote modern contraceptives. There is evidence that the use of posters placed in health facilities in languages communities do not understand are not helpful. Since the television was identified as the main source of family planning information, more television programmes could be telecast on the subject in languages the communities understand and at times they are likely to watch television. Community-based distribution should be accentuated and Community Health Nurses and other sources of FP knowledge cited should be used to continue educating the communities.

6.4 Recommendations

Based on the findings of the study, the following recommendations are made:

- The Food and Drugs Authority should assess the quality of condoms in the country.
- The Ghana Health Service should:
 - strengthen community-based distribution of contraceptives by community health nurses, community health officers and village volunteers in order to reach all potential users.
 - Intensify education on emergency contraception and monitor its use.
 - Organize workshops and in-service education to help improve staff attitudes.
- Nurses should educate populace on contraceptives and demystify wrong ideation.

- The Pharmacy Council mandate should be given to pharmacists to educate the populace.
- Chemical sellers should be monitored and supervised to dispense contraceptives.
- NGOs in reproductive health should educate communities and establish community-based distribution of contraceptives.



REFERENCES

- (AFIDEP), A. I. for D. P. (2012). *Investments in Family Planning will Stimulate Socio-Economic Development in Africa*. <http://doi.org/10.1177/0022146513479002>
- Adjei, K. K., Laar, A. K., Narh, C. T., Abdulai, M. A., Newton, S., Owusu-Agyei, S., & Adjei, S. (2015). A comparative study on the availability of modern contraceptives in public and private health facilities in a peri-urban community in Ghana. *Reproductive Health*, 12, 68. <http://doi.org/10.1186/s12978-015-0058-z>
- Ajzen, I., Netemeyer, R., & Ryn, M. Van. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, 50(2), 179–211. <http://doi.org/10.1016/j.drugalcdep.2011.10.011>
- Akafuah, R. A., & Sossou, M.-A. (2008). Attitudes toward and Use of Knowledge about Family Planning among Ghanaian Men. *International Journal of Men's Health*, 7(2), 109–120. <http://doi.org/10.3149/jmh.0702.109>
- Allison, E. H., & Seeley, J. a. (2004). HIV and AIDS among fisherfolk: a threat to “responsible fisheries”? *Fish and Fisheries*, 5, 215–234. <http://doi.org/10.1111/j.1467-2679.2004.00153.x>
- Babalola, S., Kusemiju, B., Calhoun, L., Corroon, M., & Ajao, B. (2015). Factors associated with contraceptive ideation among urban men in Nigeria. *International Journal of Gynecology & Obstetrics*, 130, E42–E46. <http://doi.org/10.1016/j.ijgo.2015.05.006>
- Borrero, S., Farkas, A., Dehlendorf, C., & Rocca, C. H. (2013). Racial and ethnic differences in men’s knowledge and attitudes about contraception. *Contraception*, 88(4), 532–8. <http://doi.org/10.1016/j.contraception.2013.04.002>
- Dynes, M., Stephenson, R., Rubardt, M., & Bartel, D. (2012). The influence of perceptions of community norms on current contraceptive use among men and women in Ethiopia and Kenya. *Health & Place*, 18(4), 766–773. <http://doi.org/10.1016/j.healthplace.2012.04.006>
- Ezeanolue, E. E., Iwelunmor, J., Asaolu, I., Obiefune, M. C., Ezeanolue, C. O., Osuji, A., ... Ehiri, J. E. (2015). Impact of male partner’s awareness and support for contraceptives on female intent to use contraceptives in southeast Nigeria. *BMC Public Health*, 15(1), 879. <http://doi.org/10.1186/s12889-015-2216-1>
- Fabrigar, L. R., Petty, R. E., Smith, S. M., & Crites Jr., S. L. (2006). Understanding Knowledge Effects on Attitude-Behavior Consistency: The Role of Relevance, Complexity, and Amount of Knowledge. *Journal of Personality and Social Psychology*, 90(4), 556–577. <http://doi.org/10.1037/0022-3514.90.4.556>
- Fuse, K. (2010). Variations in attitudinal gender preferences for children across 50 less-developed countries. *Demographic Research*, 23, 1031–1048. <http://doi.org/10.4054/DemRes.2010.23.36>

- Ghana Statistical Service. (2003). Ghana 2003: results from the Demographic and Health Survey. *Studies in Family Planning*, 36, 158–162. <http://doi.org/10.1111/j.1728-4465.2005.00056.x>
- Ghana Statistical Service. (2014). Ghana Demographic and Health Survey, (1), 1–5. <http://doi.org/10.1007/s13398-014-0173-7.2>
- Ghana Statistical Service, & Ghana Demographic Health Survey. (2008). *Ghana Demographic and Health Survey 2008: Ghana Statistical Service, Ghana Health Service, Ghana AIDS Commission. Ghana Statistical Service (GSS) Ghana Demographic and Health Survey*. Retrieved from [http://www.dhsprogram.com/pubs/pdf/FR221/FR221\[13Aug2012\].pdf](http://www.dhsprogram.com/pubs/pdf/FR221/FR221[13Aug2012].pdf)
- Giles, M., Mcclenahan, C., Cairns, E., & Mallet, J. (2004). An application of the Theory of Planned Behaviour to blood donation □ : the importance of selfefficacy, *19*(4), 380–391. <http://doi.org/10.1093/her/cyg063>
- Gordon, a. (2005). *HIV / AIDS in the fisheries sector in Africa*. Retrieved from www.worldfishcenter.org
- Ijadunola, M. Y., Abiona, T. C., Kay, T., Tafolabf, O., Esimai, O. a, & Olaolorun, F. M. (2010). Male Involvement in Family Planning Decision Making in Ile-Ife , Osun State , Nigeria, *14*(December), 43–51.
- Kabagenyi, A., Jennings, L., Reid, A., Nalwadda, G., Ntozi, J., & Atuyambe, L. (2014). Barriers to male involvement in contraceptive uptake and reproductive health services: a qualitative study of men and women’s perceptions in two rural districts in Uganda. *Reproductive Health*, 11(1), 21. <http://doi.org/10.1186/1742-4755-11-21>
- Kallner, H. K., Thunell, L., Brynhildsen, J., Lindeberg, M., & Danielsson, K. G. (2015). Use of contraception and attitudes towards contraceptive use in Swedish women - A nationwide survey. *PLoS ONE*, 10(5), 1–13. <http://doi.org/10.1371/journal.pone.0125990>
- Kapito, E., Kazembe, A., Maluwa, A., Malata, A., & Odland, J. O. (2012). Attitudes towards contraceptive use among schooling adolescents in Malawi. *Journey of Research in Nursing and Midwifery*, 1(4), 47–55.
- Kendra L. Fleminga, Abby Sokoloff, and T. R. R. (2008). NIH Public Access, *42*(2), 157–162. <http://doi.org/10.1037/a0030561>.Striving
- Kissling, E., Allison, E. H., Seeley, J. a, Russell, S., Bachmann, M., Musgrave, S. D., & Heck, S. (2005). Fisherfolk are among groups most at risk of HIV: cross-country analysis of prevalence and numbers infected. *Aids*, 19(17), 1939–1946. <http://doi.org/10.1097/01.aids.0000191925.54679.94>
- Laili Irani, , Ilene Speizer, C. B. (2014). Attitudes and Cultural Norms around Contraceptive Use among Young Adults of Urban Dar es Salaam, Tanzania. *Igarss 2014*, (1), 1–5. <http://doi.org/10.1007/s13398-014-0173-7.2>

- Miller, L. M. (2011). College student knowledge and attitudes toward emergency contraception. *Contraception*, 83(1), 68–73.
<http://doi.org/10.1016/j.contraception.2010.06.005>
- Mustafa, G., Azmat, S. K., Hameed, W., Ali, S., Ishaque, M., Hussain, W., ... Munroe, E. (2015). Family Planning Knowledge, Attitudes, and Practices among Married Men and Women in Rural Areas of Pakistan: Findings from a Qualitative Need Assessment Study. *International Journal of Reproductive Medicine*, 2015, 1–8.
<http://doi.org/10.1155/2015/190520>
- Netemeyer, R., Ryn, M. Van, & Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, 50, 179–211.
[http://doi.org/10.1016/0749-5978\(91\)90020-T](http://doi.org/10.1016/0749-5978(91)90020-T)
- Nsubuga, H., Sekandi, J. N., Sempeera, H., & Makumbi, F. E. (2015). Contraceptive use, knowledge, attitude, perceptions and sexual behavior among female University students in Uganda: a cross-sectional survey. *BMC Women's Health*, 16(1), 6.
<http://doi.org/10.1186/s12905-016-0286-6>
- Ochako, R., Mbondo, M., Aloo, S., Kaimenyi, S., Thompson, R., Temmerman, M., & Kays, M. (2015). Barriers to modern contraceptive methods uptake among young women in Kenya: a qualitative study. *BMC Public Health*, 15, 118.
<http://doi.org/10.1186/s12889-015-1483-1>
- Omo-Aghoja, L. O., Omo-Aghoja, V. W., Aghoja, C. O., Okonofua, F. E., Aghedo, O., Umueri, C., ... Inikori, K. a. (2009). Factors associated with the knowledge, practice and perceptions of contraception in rural southern Nigeria. *Ghana Medical Journal*, 43(3), 115–121. <http://doi.org/10.4314/gmj.v43i3.55326>
- Ondondo, R. O., Waithera, Z., Mpoke, S., Kiptoo, M., & Bukusi, E. A. (2014). Prevalence and Incidence of HIV Infection among Fishermen along Lake Victoria Beaches in Kisumu County, Kenya, (June), 219–231.
- Prateek, S. S., & Saurabh, R. S. (2012). Contraceptive practices adopted by women attending an urban health centre. *African Health Sciences*, 12(4), 416–21. Retrieved from <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3598279&tool=pmcentrez&rendertype=abstract>
- Service, G. H. (2003). *Ghana Maternal Health Survey 2007*. Ghana Statistical Service.
- Somba, M. J., Mbonile, M., Obure, J., & Mahande, M. J. (2014). Sexual behaviour, contraceptive knowledge and use among female undergraduates' students of Muhimbili and Dar es Salaam Universities, Tanzania: a cross-sectional study. *BMC Women's Health*, 14(1), 94. <http://doi.org/10.1186/1472-6874-14-94>
- Umoh, A. V., & Abah, M. G. (2011). Contraception awareness and practice among antenatal attendees in Uyo, Nigeria. *The Pan African Medical Journal*, 10, 53. Retrieved from

<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3290883&tool=pmcentrez&rendertype=abstract>

Williamson, L. M., Parkes, a, Wight, D., Petticrew, M., & Hart, G. J. (2009). Limits to modern contraceptive use among young women in developing countries: a systematic review of qualitative research. *Reprod Health*, 6(1742-4755 (Electronic) LA - eng PT - Journal Article), 3. <http://doi.org/10.1186/1742-4755-6-3>



APPENDICES

APPENDIX 1: INFORM CONSENT FORM

Title: Experiences and use of modern contraceptives among fishermen and their partners in the Accra Metropolis

Principal Investigator: Harold Adi Aniteye

Address: College of Health Sciences, School of Public Health, P. O. Box LG 13, University of Ghana, Legon.

General Information about Research

The prevalence of sexually transmitted diseases and the dense population in fishing communities is of great concern. The major reason is the high unmet needs for contraceptive use, which contributes to low contraceptive use in many Sub-Saharan African countries. The aim of this study is to examine experiences and use of modern contraceptives among fishermen and their partners in the Accra metropolis. This research invites your participation through answering of some questions. This activity would take not more than 60 minutes of your time and we plead your indulgence in this study.

Possible Risks and Discomforts

There are no known risks to you personally if you agree to participate in this study. However, there might be some discomfort associated with disclosure of personal information other personal questions and time factor.

Possible Benefits

You will not directly obtain any benefit from participating in the study. However, information obtained from this study would be relevant in developing and implementing interventions to improve upon sexual and reproductive health

Confidentiality

The interviews will be recorded. You are assured that any information you give will be treated with utmost confidentiality and will not be disclosed to any persons. At the end of the study, any personal identifying information about you or your child will be destroyed. Also, in the course of the study, we will protect any information about you or your child to the best of our ability and you will not be named in any reports. The only people who would have access to this information will be the principal investigator, his immediate supervisor and the research assistants.

Compensation

The participants in this study were informed they would be given a token as compensation.

Voluntary Participation and Right to Leave the Research

Your decision to participate in this study is entirely voluntary and you may talk to any person you feel comfortable with about your indulgence in the study. You can ask as many questions as you want about the research study to help you better understand your participation in the study. You are under no obligation to participate in this study and you have the right to refuse this invitation. If at any point in time, you take the decision to discontinue your participation in the study, you are free to do so and this would not have any consequences on you or your child whatsoever.

Contacts for Additional Information

If you have any further questions about the research and in case of any unforeseen circumstances, you may contact the immediate supervisor of the Principal Investigator, school of public health and the Ghana health services, whose addresses are listed below;

Supervisor: Dr. Agnes Millicent Kotoh School of public health,
Contact number: 0242216542
University of Ghana

Hannah Frimpong Ghana Health Service, Tel: +233-0302681109
Ethics review Committee +233-0302679323



VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title (*Experiences and use of modern contraceptives among fishermen and their partners in the Accra Metropolis*) has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

Date

Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits; risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

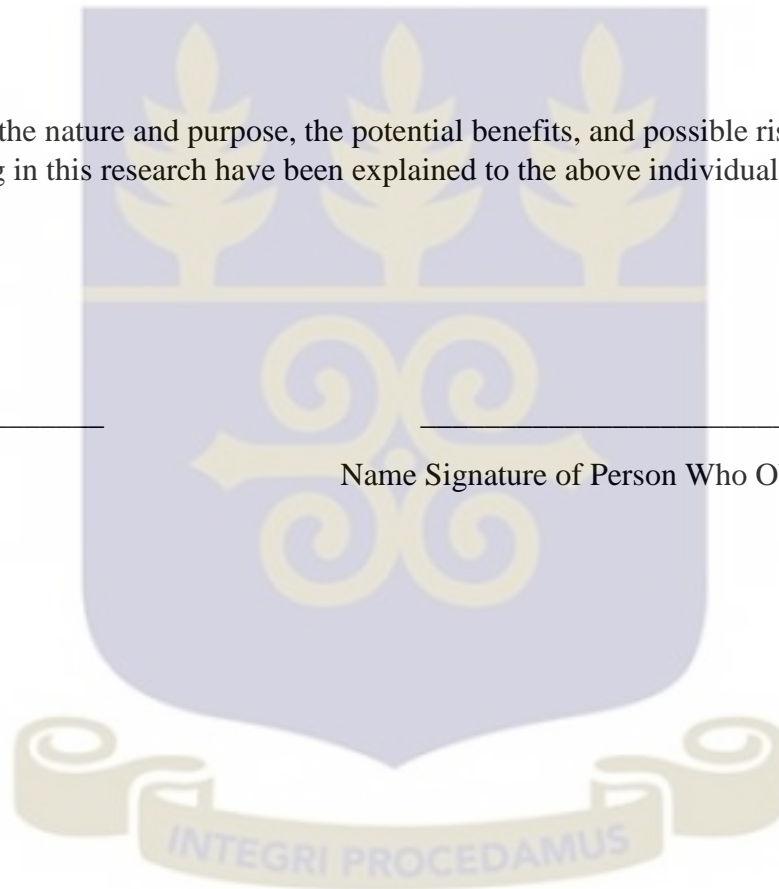
Date

Name and signature of witness

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

Date

Name Signature of Person Who Obtained Consent



APPENDIX 2: FOCUS GROUP DISCUSSION GUIDE

TOPIC GUIDE FOR RESEARCH ON THE EXPERIENCES AND USE OF CONTRACEPTIVES AMONG FISHERMEN AND THEIR SPOUSES IN THE ACCRA METROPOLIS

GUIDING QUESTIONS

1. Can you please share with me what you know about contraceptives?

Probes

What are the types?

- Types for men
- Types for women

2. What are the main uses of contraceptives?

Probes

- Knowledge of use for prevention of pregnancy
- Knowledge of use for prevention of STIs

3. What are the benefits derived from contraceptive use?

Probes

- Benefits for mothers
- Benefits for children
- Benefits for families
- Benefits for society
- Benefits for Nation

4. Can you please tell me what you know about availability /accessibility of contraceptives?

Probes

- Where can one obtain contraceptives?
 - Are contraceptives free?
 - How would you describe the cost of contraceptives?
 - How would you describe the accessibility of contraceptives in your area?
 - What are the challenges/barriers associated with access to contraceptives?
 - Any financial, geographical, social, cultural or other barriers to access to contraceptive
 - What about access of contraceptives to adolescents/the unmarried in your area?
5. How do people perceive contraception?
- Share some of the stories you have heard about contraceptives in your community with me (Personal)
6. What beliefs do you have about contraceptives? What about your community's beliefs?
7. What do you think are your community members' attitudes, perceptions, beliefs towards contraceptives?
8. Tell me about your own attitudes towards contraceptives.
9. Do you use or have you ever-used contraceptives? If so what type? If no why?
10. Any likes and dislikes?
11. What are you experiences with contraceptive use? (Male and female methods)
12. Can you share some of your experiences, both positive and negative?
13. Who makes the decision concerning contraceptive use?
14. Do you know about vasectomy and tubal ligation?