

**HEALTH SYSTEMS CAPACITY FOR COUPLE FOCUSED APPROACH TO
FAMILY PLANNING IN THE NEW JUABENG MUNICIPALITY**

BY

STELLA KONADU OWUSU

**A DISSERTATION PRESENTED IN PARTIAL FULFILLMENT FOR THE
AWARD OF MASTER OF PUBLIC HEALTH (MPH) DEGREE**

AUGUST 2010

DECLARATION

I Stella Konadu Owusu, hereby declare that, except for references to other studies done which have been duly acknowledged, this work is the result of my research under the supervision of Dr. Richard Adanu and that the work has not been presented either in whole or part anywhere for a degree. I am therefore responsible for any mistakes or omissions that may be found there in.

.....
Stella Konadu Owusu

(Student)

.....
Dr Richard Adanu

(Supervisor)

DEDICATION

This work is dedicated first to God Almighty for his mercies, guidance and protection.

I also dedicate it to my husband, brothers, sisters and friends who encouraged me in hard times to spur me on till this work is done. I say to them God richly bless you.

ACKNOWLEDGEMENT

I wish to express my sincere gratitude to my supervisor Dr Richard Adanu for his immense support, comments and guidance and for the privilege of being under his supervision.

I also, extend my warm thanks to the entire staff and clients of the New Juabeng Municipality who took part in the research for their contribution by availing themselves in answering the questionnaires although some of them were so busy at the time.

More thanks go to all the lecturers and staff of the School of Public Health who supported this work to be successful.

The final gratitude goes to my family and friends who helped me in diverse ways to accomplish this.

I say thanks to you all.

ABSTRACT

Introduction: The concept of health systems deals with the issues of governance, information, medicines and technologies, financing, human resource and service delivery. However this study focuses only on the human resource and the service delivery aspects of the health systems.

Studies have made it clear that counseling couples together about family planning influences correct use of methods, and their continuation, bringing about high success rates and satisfaction in family planning. In Ghana although the total fertility rate for women 15-49 is 4.0 births per woman, the contraceptive prevalent rate is only 24% and the level of couple involvement in family planning is low in Ghana (GDHS, 2008).

Having low contraceptive prevalence rate may imply that there are still high unmet needs and more women are resorting to abortions to control their fertility. (Almualm, 2007).

Aim: The study set out to explore the Health Systems' capacity in the New Juabeng Municipality towards implementing Couple Focused Approach to Family Planning.

Methods: It was a cross-sectional, descriptive, qualitative and quantitative research. Purposive and convenience sampling was used in selecting the study group because it was realized that although there were quite a number of clients who practice family planning, many of the women were doing so secretly. A total of 148 clients (135 female and 11 males) who had visited the clinic for at least 2 times and had both couple in agreement were interviewed using both open and closed ended questionnaires but 2 of the responses were rejected and 146 were used for the analysis. There were 6 key informants

who were also interviewed on the subject. The responses were coded and analysed using Epi Info software version 3.4.1 and Microsoft Office Excel 2007. Descriptive statistics using charts, graphs and frequency tables were employed to present the results.

Results: The result of the study has shown that the Municipality is doing quite well in family planning in general. However, the concept of Couple Focused Approach seems to be a new concept that most of the providers are not familiar with let alone knowing what it entails. The providers need additional training to be able to deliver the couple focused approach to family planning. The responses from both the providers and the clients during the interviews suggest that adequate counseling should be given to the clients to enhance couple focused approach to family planning.

Conclusion: In the era where Ghana is advocating for repositioning of family planning it is important to consider adopting the Couple Focused Approach to Family Planning in the Municipality to enhance the uptake of family planning.

Table of Contents

DECLARATION	ii
DEDICATION	iii
ACKNOWLEDGEMENT	iv
ABSTRACT	v
LIST OF TABLES	ix
LIST OF FIGURES.....	x
LIST OF ABBREVIATIONS.....	xi
CHAPTER ONE	1
INTRODUCTION.....	1
1.1 Background	1
1.2 Statement of the Problem	4
1.3 Research Questions	5
1.4 General objective	5
1.5 Rationale for the study	6
1.6 Operational Definition of variables	7
CHAPTER TWO	9
LITERATURE REVIEW	9
2.1 Health systems capacity	12
2.2 Human Resource capacity.....	13
2.3 Staff attitude	15
2.4 Method Availability	16
2.5 Access to Family Planning Services.....	16
2.6 Family planning programs.....	17
2.7 Including men in health programs	19
2.8 Including men in Family Planning.....	19
2.9 Lack of Adequate Logistic Facilities	20
2.10 Financing	21
CHAPTER THREE.....	23
RESEARCH METHODOLOGY	23
3.1 Study design	23
3.2 Study Area	23

3.3 Variables	24
3.4 Study Population	24
3.5 Sampling method	24
3.6 Sample size.....	25
3.7 Inclusion and exclusion criteria	25
3.8 Data collection tools and techniques	26
3.9 Quality control measures.....	26
3.10 Data processing and analysis	27
3.11 Ethical Consideration	27
3.12 Informed consent	28
3.13 Limitation of the Study	28
3.14 Pre-testing.....	29
3.15 Validity and Reliability	29
CHAPTER FOUR	30
RESULTS.....	30
4.1 Introduction	30
4.2 Socio-Demographic Background of the Respondents	30
CHAPTER FIVE	45
DISCUSSIONS	45
5.1 Human resource capacity	45
5.2 Effective Counseling	46
5.3 Method Availability	46
5.4 Family Planning Programmes and Public Education	47
5.5 Privacy.....	48
5.6 Couple involvement.....	48
CHAPTER SIX	49
CONCLUSION AND RECOMMENDATIONS	49
6.1 Conclusion.....	49
6.2 Recommendations.....	49
REFERENCES	51
APPENDICES.....	53

No.		Page
LIST OF TABLES		
Table 4.1	Socio-demographic features of respondents	31
Table 4.2	The number and professional background of the family planning service providers at the study facilities	32
Table 4.3	Clients' views about the notion that having male counselors/ providers will encourage more men to do family planning	37
Table 4.4	Clients' views on what could be done to encourage more couples to participate in family planning	40

No. **Page**

LIST OF FIGURES

Figure 4.1	Clients' perception about service delivery and staffs' attitude towards clients	34
Figure 4.2	Clients whose spouses have ever visited the family planning clinic	41
Figure 4.3	Reasons given for Spouses not visiting the family planning clinics	42

LIST OF ABBREVIATIONS

AIDS	Acquired Human Immunodeficiency Syndrome
BMC	Budget Management Centre
BTL	Bilateral Tubal Ligation
CHPS	Community-Based Health Planning and Services
CPR	Contraceptive prevalence rate
CSM	Contraceptive Social Marketing
FPHP	Family Planning and Health Program
FHI	Family Health International
GDHS	Ghana Demographic Health Survey
GHANAPA	Ghana Population and AIDS Project
HIV	Human Immunodeficiency Syndrome
IEC	Information, Education and Communication
IUD	Intrauterine Contraceptive Device
LAM	Lactational Amenorrhoea Method

RCH	Reproductive and Child Health
STIs	Sexually transmitted infections
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

1.1 Background

The concept of health systems deals with the issues of governance, information, medicines and technologies, financing, human resource and service delivery. However this study focuses only on the human resource and the service delivery aspects of the health systems.

Family planning is highly useful and saves lives. Although this is a well established fact, resources and attention directed toward improving family planning programs in developing countries in recent years have been diminishing, even though need remains high. It has been estimated that satisfying the unmet need for contraceptive services in developing countries would prevent 52 million unintended pregnancies a year, thereby saving 1.5 million lives and preventing 505,000 children from losing their mothers (Solo et al., 2005). To address this need, the U.S. Agency for International Development (USAID) has identified Repositioning Family Planning as a priority for its work in Africa.

In the face of scarce resources, weak infrastructure in the health systems, and a growing focus on HIV/AIDS, it is extremely difficult for African country programs to make significant gains in strengthening their family planning programs and thereby raising contraceptive prevalence. USAID has undertaken a project to document the success of

the family planning programs in Ghana, Malawi, and Zambia to provide guidance in this strategy (Solo et al., 2005).

Ghana's Population Policy in 1969 was one of the first on the African continent. However, on the 20th anniversary of the policy in 1989, an assessment documented the lack of progress in achieving the goals the policy had set out, in part because of the lack of grassroots involvement in its development and the lack of a strategic plan for implementation. The policy was revised in 1994 taking these factors into account, and the 1990s saw much more progress in improving family planning in Ghana. (Solo et al., 2005)

The advancement of family planning programs has diverted attention of researchers from just contraceptive usage to psychosocial issues and quality of care which results in client satisfaction. (Seltzer, 2002).

Although involving men in family planning is highly beneficial, most family planning services are focused on women only. Many reasons account for this. One of such reasons is that providers are more familiar and comfortable with this approach. They are also confronted with the feasibility of serving couples—for example, whether it would increase their work load, costs more, require more infrastructures, affect privacy and confidentiality, disempowering women, or lessen their autonomy in making family planning choices. Moreover, the providers lack knowledge about what couple-focused services is about and how to provide such services (Institute for Reproductive Health, 2008).

The success of family planning programs can be influenced by such factors as infrastructure and service availability, essential equipment for family planning services, availability of contraceptive methods, availability of services with family planning, provider qualifications, experience, training and attitude. The provision of family planning services requires appropriately trained staff and a reliable supply of material and financial resources.

Just like every customer care service, there is again the need for those involved in providing family planning services to show respect for the client's opinion and more so to provide confidentiality.

Some clients may find that despite their knowledge or will, they may not be able to practice family planning due to the fact that there are elements of the health system that block, or discourage them. Even though a woman may know that it is dangerous to her health to have more children, she may not seek family planning services for fear of a violent reaction from her spouse. Many people who go to health facilities are further discouraged because they feel that the health workers will humiliate them, ask them difficult questions, and conduct unpleasant procedures. The costs involved on a monthly basis, may be yet another deterrent factor.

In Ghana between 1996 and 2002, the program focus was on extending the range of family planning services offered to the public, providing more choice in methods and developing strategies to reach special groups, such as adolescents and men. In addition, provision was made for women to have increased access to family planning by modifying its policy to indicate that the consent of a partner is desirable but not necessary to make

an informed choice. In the case for adolescents, contraceptives can be provided in consultation with all relevant parties, including persons in loco parentis and trained service providers (Hong et al, 2005). Now there is a shift of focus towards couple involvement in family planning whereby there is recognition that the couple relationship influences women's decisions, their satisfaction with and their ability to use family planning correctly (Institute for Reproductive Health, 2008). This study examines the capacity within the health systems that enhances the couple focused approach to family planning within the New Juabeng Municipality.

1.2 Statement of the Problem

In Ghana although the total fertility rate for women 15-49 is 4.0 births per woman, the contraceptive prevalent rate is only 24% (GDHS, 2008).

The total demand for family planning among women is 59 percent but only 40 percent of the demand is currently being met, which implies that the contraceptive needs of three-fifths of currently married women are not being met (GDHS, 2008). This may be due to these women not having their partners' support in the family planning practice.

Having low contraceptive prevalence rate may imply that there are still high unmet needs and more women are resorting to abortions to control their fertility. (Almuallm, 2007).

Although, research has shown that counseling couples improves family planning use, most programs serve only women (Lundgren et al, 2006).

Also the level of couple involvement in family planning is low in Ghana (GDHS, 2008).

There are inadequate programs in place towards the implementation of couple focused approach to family planning in Ghana. Most family planning programs have been targeted at women and children leaving the men out; and there are very few men who are directly involved in the provision of family planning services (Hong et al, 2005).

1.3 Research Questions

- Are there enough human resources to effectively carry out the couple focused approach to family planning?
- Do the health systems have adequate training for staff to implement the couple focused approach to family planning?
- Do the health systems organise adequate family planning programs that would encourage couples to take joint decisions about family planning?
- Does dominance of women in reproductive health delivery affect male involvement in family planning practice?
- Would engaging more male counselors/providers in family planning services motivate more males into accessing the services?

1.4 General objective

To explore the capacity of the health systems to practice Couple-Focused Approach to family planning services in the New Juabeng Municipality of the Eastern Region.

Specific objectives

- To describe the human resource capacity of the New Juabeng Municipality towards implementing Couple-Focused Approach to family planning services within the Municipality.
- To ascertain the level of family planning method availability in the study area.
- To identify programs organised in favour of Couple-Focused Approach to family planning.
- To identify the level of public education given to enhance Couple-Focused Approach to family planning in the area.
- To assess the extent of couple involvement in family planning in the Municipality.

1.5 Rationale for the study

Promoting couple focused approach to family planning in Ghana will greatly help address the problem of child spacing and this will in turn help check overpopulation with its attendant poverty problems.

The study will help to create awareness about the health systems' capacity in terms of Couple-Focused Approach to family planning and the results will be made available to policy makers and implementers of family planning programs to provide guidance to

organizations that wish to include a couple-focused approach in their services and promote male involvement in family planning in Ghana.

A Chinese proverb says that “if there is peace in the home, there will be peace in the country”. This implies that if there is good planning at home this will also reflect in the country.

The study would not only encourage Couple Focused Approach to family planning, it will also stimulate policy planners and implementers to strategize and put in systems that would make Couple- Focused Approach to family planning more feasible.

1.6 Operational Definition of variables

Health Systems Capacity for Couple-focused Approach to Family Planning: in this study, the Health Systems Capacity for Couple-focused Approach to Family Planning refers to the human resource availabilities, access to facilities, method availabilities and public educations and communications that enhances the Couple-Focused Approach to Family Planning. It also includes the feasibility of serving couples, about what Couple-Focused services entail and how to provide them.

Couple-Focused Approach to Family Planning: Couple-Focused Approach to family planning refers to offering services to women and their partners. The approach seeks to help programs and enable providers improve services by implementing simple interventions that give increased attention to couple issues without decreasing the woman’s autonomy.

Married: The idea of “Married” used in this thesis refers to couple having a stable relationship and does not necessarily mean that they have formally performed their marriage rites.

CHAPTER TWO

LITERATURE REVIEW

This chapter presents a review of literature and theoretical framework related to the study. The literature review is on health systems capacity, human resource capacity, staff attitude, method availability, access to family planning services, family planning programmes, including men in health programs, including men in family planning, and lack of adequate logistics facilities.

Advances in research is creating the awareness that family planning services that involve and address both couple lead to correct use of methods and bring satisfaction to them. It also decreases the incidence of unplanned pregnancies (Lundgren et al, (2006). Studies from family planning programs in several countries show that involving husbands in counseling led to improved outcomes like higher contraceptive use rates, lower method discontinuation, and significant reduction in pregnancy and abortion rates. Reviews of family planning programs have resulted in the realization of the need to address the challenges of serving men and building staff capacity to implement couple-focused services (Institute for Reproductive Health, 2008).

The Primary Health Care document of 2008, has established that in sub-Saharan Africa, the contraceptive prevalent rate is as low as 21% as against that of other developing regions which have had a considerable increase over the last 30 years and now stands as high as 61%. Everywhere, abortion rates have been found to be reduced as a consequence of increases in the contraceptive use. On the contrary, Sub-Saharan Africa has seen

increase in the absolute numbers of abortions and “almost all are being performed in unsafe conditions” (WHO Report 2008).

With a Total Fertility Rate (TFR) of 4.0 in 2008, Ghana is seen as having achieved its fertility target of 4.0 children per woman two years before the target year (2010). This TFR is also considered as one of the lowest in sub-Saharan Africa (GDHS, 2008). Coupled with the modern method Contraceptive Prevalence Rate (CPR) of 17%, the country is now well on the way to meeting the goals set out in the National Population Policy of 1994: to reduce the TFR to 5.0 by 2000, 4.0 by 2010, and 3.0 by 2020, and to increase modern CPR to 15% by 2000, 28% by 2010, and 50% by 2020. (Solo et al., 2005). Although the TFR has declined and contraceptive prevalence has increased, unmet need remains high and women continue to have more children than they desire. In addition, there are important issues of inequity in the improvements in terms of bringing services to the poor and to the whole nation (Solo et al, 2008).

In Ghana, governments’ support of family planning programs began in 1969, with some of the major program initiatives being the Contraceptive Social Marketing (CSM) project (1987- 1990), the Ghana Family Planning and Health Program (FPHP) (1990-1996) and more recently, the Ghana Population and AIDS Project (GHANAPA) (1996-2000). The initial focus of these projects was to increase demand and utilisation of modern methods for family planning through social marketing. The FPHP continued social marketing strategies and worked to expand the capacity of the public and private sectors to provide family planning services, supplies, and information, including addressing sexually transmitted infections (STIs) and HIV infections (Hong et al 2005).

The 1993 Situation Analysis Study for family planning services has brought about efforts made in developing protocols, standards and guidelines for family planning services as well as training nurses to provide family planning services. In-service training programs have often been targeted on nurses, as they usually offer the nonsurgical family planning methods. Also, doctors are thought to have had enough skills in the nonsurgical methods in the course of their training their and again they deliver just a small part of family planning services (Hong et al, 2005).

The establishment of Ghana National Family Planning Programme came about because of the view that couples should have the opportunity to decide on how many children they want to have and when to have them. They should also be free to choose which contraceptives method they would like to use, without being coerced or intimidated to act contrary to what they would prefer. This means that there is the right of gender equity in decision making, and the educational and service needs of both sexes must be met.

Moreover, family planning also means that people have ongoing availability of a full range of safe and effective contraceptive methods that enable them to take action according to these decisions. This ability to take action is also based upon the cost of contraceptives, ideas people have about the different methods (sometimes correct and sometimes erroneous), and the support or lack thereof of the partners, extended family members, and wider community. Unfortunately, there are still many women in the world who die each year from pregnancy-related conditions. A considerable number of these women want to limit or space their pregnancies but are without the means to do so effectively (in other words they have unmet needs) (Almualm, 2007).

The economic situation in the world today is such that it is very difficult to have many children and be able to educate them to become productive citizens of their societies. This has therefore influenced families to limit the number of children they intend to have. Unfortunately, in sub-Saharan Africa, scarcity of resources and information, falling donor support, extreme poverty, profound inequalities between men and women, and early marriage severely limit women's ability to achieve their childbearing goals. There often exists a gap between the numbers of children women say they want and the number they have (Almualm, 2007).

Determining factors that affect family planning behaviors help in understanding effective ways of promoting such behaviors. It has been widely accepted that simply providing information to people does not make them change their behaviors. Information is only one of the factors that contribute to behavior change. Particularly in the area of family planning, where there is a profound influence exerted by culture, taboos, tradition, sex-role definitions, and a reluctance to openly discuss these matters, it is important to understand contributing and inhibiting elements that will support or encourage healthy family planning behaviors.

2.1 Health systems capacity

The health systems capacity for Couple –Focused Approach to Family Planning is about structures in terms of human resource, methods availabilities, program implementations and customer care services within the health care delivery system which can impact on outcomes of couple focused approach to family planning. To be effective the health care system should have enough human resource with adequate

training to meet the staff needs for the implementation (Haq and Hafeez, 2009). There is also the need for sufficient programs that would tackle key barriers to couple focused approach to family planning and support couples to take joint decisions and implement family planning. Access to family planning services as well as availability of methods and funds are very crucial (FHI, 2007).

2.2 Human Resource capacity

The effectiveness of family planning programmes largely requires the efforts of qualified or experienced staff that are supervised by an experienced nurse, midwife or doctor and if lay workers are used for community- based distribution, they must also be trained in appropriate technical skills and attitudes with proper supervision. All staff involved in providing family planning services need to be proficient in offering contraceptive methods and counseling. Periodic refresher courses given to all staff for updating on their training on reproductive health services are highly essential. (Baochang and Zhenming, 2009).

Many family planning providers must be trained in routine administrative and managerial tasks, such as record keeping, referrals and inventory control, to enable them perform these activities.

Providers need good interpersonal skills. They are again supposed to be trained in culturally sensitive, unbiased communication techniques that encourage open, interactive relationships with clients-listening, clarifying, encouraging clients to speak,

acknowledging client feelings, and summarising what has been said are necessary skills to enhance this kind of communication. Appropriate knowledge and communication skills of the workers are, as said by Haq et al, (2008), to be “key to their confidence and elementary for the success of the system”.

Moreover, providers should be taught strategies for effective counseling of clients to enable them choose methods appropriately. Family planning providers should be competent to render high quality contraceptive care service which include the use of visual and other support materials and to identify clients with special needs, such as those with a high risk of STIs, post-abortion clients, breast-feeding women, and adolescents and offer them their appropriate services. Culturally acceptable Information, Education and Communication (IEC) materials containing information on the benefits, side effects and contraindications of different methods, and how to use them need to be provided to enable individuals and couples make free contraceptive choices. (Rakhshani et al 2005).

At a workshop organized in Kenya by the Engenderhealth, to encourage men to learn more about family planning, support their partners' efforts and to take active role in preventing the spread of STIs, participants were of the strong view that policy makers, program managers, health care workers and other care providers can hinder male involvement. ((Wegner et al, 1998).) Their biases may cause them to deny services or supplies to clients and their “arbitrary policies or inadequate attention to clients needs”, can also deter people from participating in the services (Wegner et al, 1998). However, these personnel are often not aware of their own prejudices. Many health care providers lack adequate information and training to provide care to men. To improve the

reproductive health of all individuals, programs must reach out to providers and supply them with the information and training to provide quality care and to assess their own attitudes and biases about methods and clients. (Wegner et al, 1998).

2.3 Staff attitude

Health care services are now regarded more as a commodity, and also people have, high expectations regarding health and health care. (Kickbush, 2007). Family planning clients are said not to be looking for technical competence alone. They also want health-care providers to be understanding, respectful and trustworthy (Bossyns and Lerberghe, 2004). Clients want health care providers to respect their beliefs. Increasingly, there is the realisation that in finding solutions to health problems, one should consider the “socio-cultural context of the families and communities where they occur” (WHO, 2008). Family planning service providers must therefore show respect for the client's opinion and the need for confidentiality. However, there are concerns that health systems do not provide an adequate respect to such needs, but they are driven by interests and goals that are different from people's expectations. (Inglehart and Welzel, 2005). Again, it has been documented that clients want health care services in which people are treated as individuals with rights and not as mere targets for programmes. These people are “willing to respect health professionals but want to be respected in turn, in a climate of mutual trust” (Anand, 2002).

2.4 Method Availability

Quality of service can only be provided with a steady regular supply of contraceptive commodities (FHI, 2007). The National Reproductive Health Service Policy and Standards of Ghana (2003) have elaborated the methods which are to be available within the health sectors of the country. The short term methods include male and female condoms, spermicides, oral contraceptive pills, combined injectables, LAM and natural family planning methods. The long term ones are: intrauterine contraceptive device, hormonal implants, and progestin only injectables. The voluntary surgical contraceptives which are bilateral tubal ligation and vasectomy are the permanent ones. The emergency contraceptives are also available but it has been cautioned that it should not be promoted as a regular family planning method.

2.5 Access to Family Planning Services

Clients should be able to access family planning services easily without any inconveniences. In the ideal situation, family planning services should be available at health centres, outreach health posts and also through community-based distribution channels, when appropriate. Special attention needs to be given to some groups, like adolescents, unmarried women and men, for them to feel comfortable when using the services and in order to avoid the risk of stigmatisation by the community (UNFPA 1999). The Ghana Reproductive Health Service Policy Standards (2003) states that: “The different services shall be made available at all levels of the health systems based on the

category of staff at each level”. According to the policy, the sub-districts should have both male and female condoms, spermicidal, oral contraceptives, Lactational Amenorrhoea Method (LAM), natural family planning, implants, injectables, IUD, and emergency contraceptives. The Regional and Teaching Hospitals should also offer in addition to what is offered at the sub-district level, Voluntary Surgical Contraception (VSC) (i.e. bilateral tubal ligation and vasectomy).

Richey and Salem (2008) have established that clients’ ability to obtain easy access to family planning services make them better acceptors. Widely speaking, people can only be said to have good access to services when service delivery points are easily available to everyone; everyone knows where to locate these services; everyone feels welcome; services are free of avoidable managerial and medical barriers; and people have a variety of contraceptives methods to choose from.

2.6 Family planning programs

The Revised National Population Policy of 1999 considers men as important partners in family planning in terms of contraceptive use and decision making. The policy indicated that special emphasis of IEC program shall be provided to reach the male population in their homes, clubs and associations on the health, social and economic hazards of prolific child bearing and on the need for the male population to assume greater responsibility for the upkeep of their wives and children. To this effect, family planning services specifically directed at the male client shall be vigorously pursued (Boadi, 2009).

Now that more recognition is being given to men's involvement in reproductive and contraceptive decisions and behavior, there is the need to operationalise the desirable parameters for men's contraceptive involvement. In addition to their use of condoms, vasectomy or withdrawal methods, if a couple relies on a female method, men can provide support to their spouses. These can be in the form of helping the women to pay for method costs and picking up supplies, to offering empathy and emotional support for women experiencing uncomfortable side effects. (Darroch, 2009).

Varieties of ways can be used to provide the various service-delivery strategies to meet those needs of enhancing couple focused approach to family planning. These include using primary health care facilities; special clinic hours for men or couples whose husbands may not be able to visit the regular MCH/FP clinics; STDs clinics, integration of FP promotion in AIDS prevention programs, mobile units, organized groups, income generating schemes, employment-based programs, youth programs and peer counseling, male-to-male community-based distribution of condoms, social marketing, involvement of private agencies and medical practitioners.

Including men (that is couple-focused approach) must also include the effort to reach out to traditional leaders and lineage heads. Family planners are beginning to identify the importance of listening to, and are open to the needs identified by communities, and this is usually done through chiefs and other opinion leaders (Boadi, 2009).

2.7 Including men in health programs

A study has made it known that in some countries; female clients suggested that men be included in existing programs for women. In an organization in Pakistan, a start to men's program was effected after some female clients had requested that men be included. A sign that read "Entrance by Males strictly forbidden" was removed and staff members began to encourage women to bring their husbands. As a result, couples' now have the opportunity to discuss sensitive issues with a counselor, a service that had not previously been offered. In the particular clinic referred to above, the demand for services turned out to be so great that the clinic built a 2nd floor and now houses men's and women's services in the same facility but separated by floors and hours of operation (Wegner et al, 1998).

2.8 Including men in Family Planning

Men's involvement in family planning programmes helps to increase recognition of other RH issues, like the prevention of STDs, and also increase acceptance of family planning within the community. Such activities include couples counseling, promotion of condom use, special clinic hours for men, peer-group sessions and social groups. Considering men's perspectives and their motivation must be integral to activities organised to promote family planning. Men's contraceptive use enables them to share the responsibility of family planning with their female partners. Certain activities can be organised with specific focus to meet the needs of male users (UNFPA 1999).

Despite clear evidence that addressing couples improves family planning use, most family planning programs serve only women. While resource and ethical concerns may not encourage refocusing of programs, it may be possible to integrate a “couple perspective” into services. Many women are interested in discussing couple-related issues with their providers, but providers rarely provide those opportunities (Institute for Reproductive Health Washington, 2008).

Findings from a pilot study to test whether incorporating couple approaches into counseling result in improved contraceptive use and satisfaction showed that providers and clients value male involvement, yet struggle with the challenge of promoting women's autonomy while encouraging shared responsibility for contraceptive use (Institute for Reproductive Health Washington, 2008). It further revealed that providers were unclear how to address couple and sexuality issues during family planning counseling, yet were comfortable including men in other services such as pregnancy counseling. Men frequently accompany their partners in the clinic waiting room and also seek STI services. Providers and clients expressed concerns with practical barriers such as protecting confidentiality, decreasing patient waiting time and making services “partner friendly”. The couple approach has been developed based on these results, as well as successful approaches from international programs (Institute for Reproductive Health Washington, 2008).

2.9 Lack of Adequate Logistic Facilities

Tuoane et al. (2004) have established that lack of adequate infrastructure and inappropriate health system structures does not promote the appropriate utilisation and

delivery of quality services. Clients are more likely to access services at facilities where there are basic infrastructures that both provide for client comfort and supports quality of service.

A study carried out in Bangladesh about male involvement in family planning reported the lack of appropriate logistic and structures (i.e., clinic, methods, supply and follow-up) for males in family planning. The national family planning programme and its providers had neglected men's access to both information and services (Hossain, 2003).

This pertains to many states including Ghana where before undertaking this study a man was asked why men often do not participate in family planning but often leave everything to the women. He answered that it is because of the fact that with the exception of the male condom and vasectomy, which in his opinion, even many women disapprove of, all the rest of the products are for women. He therefore saw no need for visiting the family planning clinic.

2.10 Financing

Financing is a very important aspect in family planning. A World Bank discussion paper has warned that poor countries, wealthy donors, and aid agencies are ignoring the fact that family planning add to the improvement in a state economies. (The World Bank Group, 2010). The paper went on to argue that family planning programs have mostly been subject to under-funding. Both governments and donor agencies have not been well committed financially to support family planning and, have resulted in shortfalls of contraceptive supplies which pose a growing problem.

In the 2007 a global survey carried out on family planning revealed that most professionals commonly recognized inadequate budget as one of the most challenging elements for family planning programs to achieve progress (Richey and Salem, 2008). According to the survey report, donor or government funding for family planning have been decreasing. Between 1995 and 2005 for instance, “International donor funding for family planning decreased by 34% - from US\$723 million to \$477 million” (Richey and Salem, 2008). Many programs can no longer solely depend on public or donor funding as had been previously done. The need has therefore come to find ways to make the program more sustainable.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Study design

This study is a cross sectional, descriptive, qualitative and quantitative study.

3.2 Study Area

The New Juabeng municipal area covers an estimated 110 square kilometres constituting 0.57% of the total land area of the Eastern Region of Ghana. It shares boundaries with East Akim Municipality on the north-east, Akwapim North District on the south and Suhum Kraboa Coattar District on the west and Yilo Krobo District on the east. It has a diverse ethnic population with the Akan group dominating. Christianity is the main religion with other smaller religious groups. Trading sedentary work, Wood Processing and subservient farming are the main sources of income. There are 156 communities with a population of 152,858 and a growth rate of 4 %. There are 9 family planning clinics that provide the family planning services including the Regional Hospital and 8 sub-Municipal facilities. They are Zongo Clinic, Oyoko Health Centre, Jumapo Health Centre, Densuano/Old Estate RCH, Effiduase RCH, Asokore/Akwadum, Adweso RCH and Koforidua RCH. However looking at the service records from the previous years, it was realized that the Regional Hospital which offers the full range of family planning services provides the greater number of services.

3.3 Variables

Dependent: ability of facility to provide couple focused family planning services

Independent: staff training; method availability; family planning programmes and public education, privacy; staff attitude, special programmes; educated on method; counseling; clinic hours; referral; encouraged to come with spouse.

3.4 Study Population

Key informants from the service providers (i.e. staffs who are directly involved in the family planning service provision) and all clients (men and women) practicing family planning, who had visited the clinic a minimum of two times, with both partners in agreement were interviewed.

3.5 Sampling method

Purposive and convenience sampling was used in selecting the study group because it was realized that although there were quite a number of clients who practice family planning, many of the women were doing so secretly.

The Regional Hospital which provides full range of services in addition to being a referral point was involved in the study. In addition, out of the 8 clinics which provide family planning services, 5 clinics namely Akwadum, Zongo, Effiduase, Asokore and the Koforidua Reproductive and Child health unit (RCH) were chosen purposively. These clinics offer wide range of services including IUD and implant insertions. Moreover as

compared to other clinics, according to the 2010 first quarter records, these clinics were seeing to more clients.

3.6 Sample size

Since the numbers of clients who have both couples agreeing to practice family planning and had visited for at least two times were found to be small, no sampling calculation was done. Clients who visited the clinic during the data collection period and had both partners agreeing to were contacted for the study. Those who agreed to be part were interviewed and out of them, 11 males and 137 females were interviewed. However, two of them were rejected and were not included in the analysis because one of them said the partner “does not support the idea of family planning” and the other said that she and the husband “have separated for now”.

3.7 Inclusion and exclusion criteria

To be eligible, the client should be either a male or female who has visited the clinic for at least two times and has agreed with his/her spouse to practice family planning. Those who were practicing without the agreement of the other partner and those who were not in stable relationships were excluded.

3.8 Data collection tools and techniques

The data collection was carried out using two different tools. In-depth interviews were conducted for key informants using checklist to assess the health systems capacity. Notes and tape recordings were taken for additional views which could not be reflected in the check list.

Clients who had visited the facilities for at least two times and had the two couples in agreement were also interviewed using a questionnaire. Their perceptions about the health systems and their influence on couple- focused approach to family planning were elicited. The questionnaires were administered to both female and male clients by five research assistants and the checklist for the service providers were administered by the principal investigator.

3.9 Quality control measures

The interview guide and questionnaires were pretested at the Regional Hospital by both the principal investigator and the research assistants and the necessary amendments were made. In order to avoid biases, the five research assistants who were neither nurses nor working in the family planning clinics were selected and trained prior to the data collection. They were visited at intervals to make sure they were doing the correct thing. Those found to be doing otherwise were corrected and guided. The responses were

checked, edited, cleaned and entries started the same day. This was done in order to remember the details of the interviews.

3.10 Data processing and analysis

Recorded messages were transcribed and arranged into themes.

The responses were coded and analysed using Epi Info software version 3.4.1 and Microsoft Office Excel 2007.

Descriptive statistics using charts, graphs and frequency tables were employed to present the findings.

3.11 Ethical Consideration

Ethical clearance was sought from Ethical Review Board of the Ghana Health Service prior to conducting the study.

An introductory letter signed by the head of department was sent to the New Juabeng Municipality, seeking permission to undertake the study in the Municipality and another one was sent to the Regional Hospital at Koforidua.

The research method posed no risks to the respondents. They were not required to write their names to ensure anonymity. Privacy was provided during administration of the questionnaires and their responses were handled confidentially by keeping them under lock to prevent others from getting in touch with them.

The project was funded by the researcher and there was no conflict of interest.

3.12 Informed consent

Participants were informed about all the aspects of the research that could have reasonably been expected to influence their willingness to participate. The respondents were informed that the study was part of an academic exercise. They were also informed that participation was purely voluntary and that at any point in time one could opt out. Opportunities were given to them to ask questions for further clarifications. Confidentiality and anonymity was assured.

A copy of the thesis document would be given to the New Juabeng Municipal Health Directorate and the Regional Hospital for perusal.

3.13 Limitation of the Study

Due to limited funds a community survey which would have shown more representation of the opinion of the general community on couple focused approach could not be carried out.

3.14 Pre-testing

In order to correct the problems with the data collection instruments, questionnaires were pretested by the research assistants using ten clients, and the principal investigator also pretested the checklist for the key informants at the Regional Hospital. Amendments were made to items that were not clear before the actual data collection was carried out. Further, it enabled the assistants to familiarize themselves with the tools before the actual work took off.

3.15 Validity and Reliability

The study can be said to be valid because as many clients as possible were interviewed and as such it is very certain that similar results would be obtained using the same instruments to measure in another study. On the issue of reliability, interview guides and questionnaires were reviewed by other people and pretested. Ambiguous and misleading questions were reframed to make it capable of measuring the Health Systems Capacities for Couple Focused Approach to Family planning.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter deals with the analysis and the discussions of the field data. It looks at the socio-demographic background of the respondents and the analysis for the Health systems capacities. It takes into consideration the responses from the key informants and complementing them with that of the clients’.

There were six facilities which were used for the study. They are the Regional Hospital and five sub-Municipal clinics which were the Koforidua RCH, Akwadum Asokore, Effiduase, and Zongo clinics. A total of 146 clients (135 females and 11 males) and 6 key informants from each facility were interviewed.

The total number of clients interviewed from the facilities had the break down as follows: 55 (37.7%) were from the Regional hospital; 53 (36.3%) from the Koforidua RCH with; 17 (11.6%) from Akwadum; 9 (6.2%) from Asokore; 7 (4.8%) and 5 (3.4%) from Zongo and Effiduase respectively.

4.2 Socio-Demographic Background of the Respondents

The socio-demographic features of the respondents are necessary for family planning use. This section, therefore, provides the general characteristics of the respondents' age sex, marital status, number of children living, occupation of respondents and their spouses, educational background of respondents and their spouses, religion and ethnic origin. The table below shows the socio-demographic characteristics of the respondents.

Table 4.1: Socio-Demographic Features of Respondents

Variables	Frequency	Percentage (%)
Age (years) of the respondents		
18-19	2	1.4
20-29	57	39
30-39	68	46.5
49-49	17	11.7
50-52	2	1.4
Sex of respondents		
Males	11	7.5
Females	135	92.5
Number of living children of respondents		
None	11	7.5
1-4	122	83.6
≥5	13	8.9
Religion of respondents		
Christians	133	91
Moslems	13	9
Ethnicity of respondents		

Akan	81	55.5
Ewe	27	18.5
Krobo	20	12.3
Others	18	13.7

4.3. Health Systems Capacity

This section presents the results obtained from the interviews conducted and questionnaires administered for the study. It deals with providers' training, in-service training, referrals and STIs management, service delivery and staff attitude, effective counseling, method availability, privacy, having male health workers, and outreach and education programmes organised to promote the couple focused approach to family planning in the New Juabeng Municipality.

4.3.1 .Providers' Training

Table 4.2: The number and professional background of the family planning service providers at the study facilities

Facility	Midwifery	Public Health Nursing	Community Health Nursing	Enrolled Nursing	Total No. of Providers
Asokore	1	-	2	-	3
Regional Hospital	4	-	-	2	6
Koforidua RCH	2	-	-	-	2
Effiduase	3	-	2	-	5

Zongo	2	1	3	1	7
Akwadum	2	-	2	-	4
Total	14	1	9	3	27

The above table depicts the total number of family planning providers and their professional training backgrounds. There were a total of 27 family planning providers in the six facilities that were used for the study. Of the total, there was 1 Public Health Nurse, 14 Midwives, 9 Community Health Nurses and 3 Enrolled Nurses.

To the question of how many had been officially trained to provide family planning services, the answers showed that 21 (78%) of them had formal trainings to provide the short term methods which include the barrier and oral methods, and the injectables. The trainings lasted for 1 week. The Midwives (14 of the 21 persons) had additional 1 week training in IUCD and Implant insertions. The remaining 6 (22%) had been trained on the job. In addition to that, there are two obstetrician/gynaecologists who perform the bilateral tubal ligation (BTL) and vasectomy. They also see to referred cases from the sub- municipal clinics.

4.3.2. In-service Training

The staff of all the facilities had had in-service training for a duration lasting less than 1 week (1-3 days). For the period that had elapsed since the last in-service training, three of the facilities gave ≤ 6 months whereas the remaining 3 reported between 6-12 months.

Moreover, from the interviews conducted, the providers believe that they need special training to be able to render couple focused service. They were of the view that they are not delivering better couple focused approach to family planning because they had not received any special training on couple focused care. So to enable them render better care to couples, they would need to be trained for the purpose. For instance, one provider said:

“We lack the special skill for couple focused approach so we only deliver what we know”.

4.3.3 Referrals and STIs Management

All the 6 facilities manage STIs and use protocols. Should there be the need for referral the five clinics refer their clients to the Regional Hospital where they are managed by trained medical officers or obstetrician/gynaecologists at the hospital. The Hospital's clients are also referred to either Akosombo or La General Hospital on occasions where for one reason or the other, there is no Obstetrician/Gynaecologist around and the clients need the services of a specialist.

4.3.4 Service delivery and staff attitude

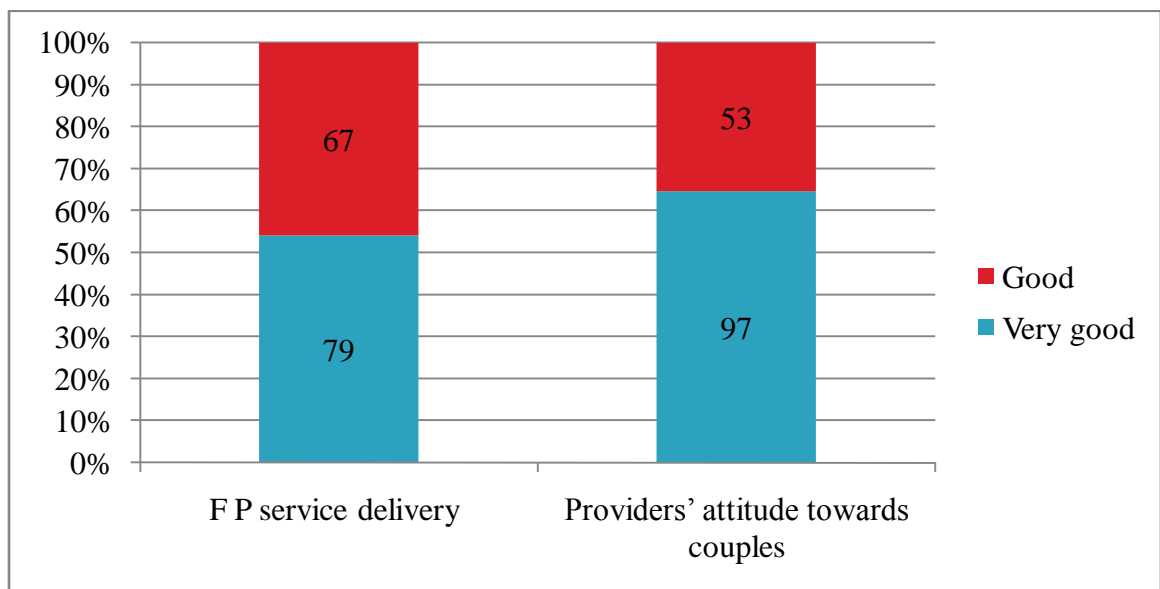


Figure 4.1: Clients' perception about service delivery and staffs' attitude towards clients

The above figure depicts clients' perception about the quality of service delivery and staff attitude. Most clients were satisfied as the results proved that 79 (54.1%) (**n=146**) said the service delivery was very good and 67 (45.9%) said that service delivery was good. For the staff attitude 93 (63.7%) of the clients said it was very good whereas 53 (36.3%) responded that it was good.

4.3.5 Effective Counseling

The responses from both the providers and the clients during the interviews suggest that adequate counseling should be given to the clients to enhance couple focused approach to family planning. Asking the clients what they think should be done to encourage couple involvement in family planning, 36% of the male respondents said that there should be good counseling to the women with special emphasis on the initial counseling to get the women informed to encourage their husbands to accompany them to the clinics. There were 10% of the women respondents who also said that the women must be counseled to encourage their husbands to come with them.

Answering the question whether the clients were told to come with their spouses, 59 (40.4%) said yes and 87 (59.6%) said no. This affirms the responses of another 7 of the clients who said that they were not informed to come with their spouses when they were asked why their spouses had never visited the family planning and perhaps the other 11(7%) who said they do not know.

Moreover, in the course of having the in-depth interview with the service providers, one of the key informants stressed there is the need to tell the clients to come with their spouses. This shows that some of the providers tell clients to bring their spouses while others are not committed to that.

Again another key informant said that to enhance couple focused approach to family planning,

”We must give good counseling to the Family Planning clients focusing on the reproductive systems functions”

4.3.6 Method Availability

With the exception of the Asokore family planning clinic that does not offer Implants insertion, all the 5 facilities provide all the temporary methods. The Regional Hospital on the other hand offers the permanent ones as well- namely: bilateral tubal ligation for women (BTL) and vasectomy.

It was found that only 2.1% of clients could not get the method of their choice. These clients could not get the implants. It happened during the later part of 2008 when the clinics had run out of stock because it was not available at the Medical stores.

4.3.7 Privacy

It was realized that the Regional Hospital and two other facilities had enough structures and were well suited to provide sufficient privacy for counseling. For the three others the family planning clinics are sited at places where the client privacy is not assured. However there were screens and cubicles in place to ensure that clients are not exposed during procedures.

4.3.8 Having Male Health Workers

Table 4.3: Clients' views about the notion that having male counselors/ providers will encourage more men to do family planning

Clients' views	Frequency	Percent (%)
Strongly agree	39	26.7
Agree	82	56.2
Disagree	13	8.9
Strongly disagree	2	1.4
Don't know	10	6.8
Total	146	100.0

Table 3 shows that the majority of the respondents are of the view that having male counselors and providers would encourage more men to accompany their spouses when they are visiting the family planning clinic.

The providers were also asked if they think engaging men in service provision would have any impact on the couple focused approach. Three of them responded no and three also said yes. Other views expressed by the key informants include:

- *“Involving men will encourage men the more. But since they do not have midwifery background, it would not be appropriate to engage them in IUD insertion. They can therefore offer counseling services”.*
- *“I am sure involving men in family planning would encourage more men to patronise so training more male health workers in family planning counseling will help a lot”.*

4.3.9 Outreach and Education Programmes

There were 2 key informants who said that they had no outreach programs. For the other 4 who answered in the affirmative, some mentioned schools and churches as the places that they were sometimes invited to give health talks and others also said they have the outreach services at the surrounding villages within their catchment areas. The two who had no outreach attributed it to the presence of CHPS compound in the communities where services are rendered to the people and therefore had no need to organise more.

Probing into how often the outreach programs are carried out, three of them said monthly whereas one said it has no format but honours invitations as and when they come.

Asked what programs are in place to encourage couple involvement, three of the key informants said that they have plans to organise programs like durbars, and tea party to invite couples and educate them about family planning but due to lack of funds it had not been effected.

The clients were also asked what they thought could be done to encourage more couples to be involved in family planning and the responses were as follows:

From the female responses 61% (n=135) were of the view that Ghana Health Service should embark on education on family planning through mass media campaigns and organising durbars concerning the importance of family planning and that the focus should be more on men. There were 10% who said that the women must be counseled to encourage their husbands to come; 8% suggested organising door to door campaign; another 8% said those couples practicing family planning should be used to encourage their peers to get involved; and on an interesting note, 2% said it should be made compulsory for men to accompany their wives before they were seen. The views are recorded in the table below.

Table 4.4: Clients’ views on what could be done to encourage more couples to participate in family planning

Females’ Views (n=135)	Frequencies	Percentages %
Counsel on side effects and misconceptions	8	6%
Educate on the importance of family planning through media/durbars	82	61%
Educate the people using peers	11	8%
Embark on door to door campaign/service delivery	11	8%
Counsel women to encourage their husbands to accompany them	14	10%
Use male providers/counselors to offer services at work places	3	2.4%
Make it compulsory for women to bring husbands	2	1.6%

Don't know	4	3%
Males response (n=11)		
Education through media/door to door campaign	6	55%
Work place service delivery and advertising through the media	1	9%
Good counseling, and encourage the women to bring their husbands	4	36%

The male responses were similar to that of the females. In addition to what is in the table above, they also stressed the need to organise public education using the local dialects in order to reach more of the target groups.

4.3.10 Couple Involvement

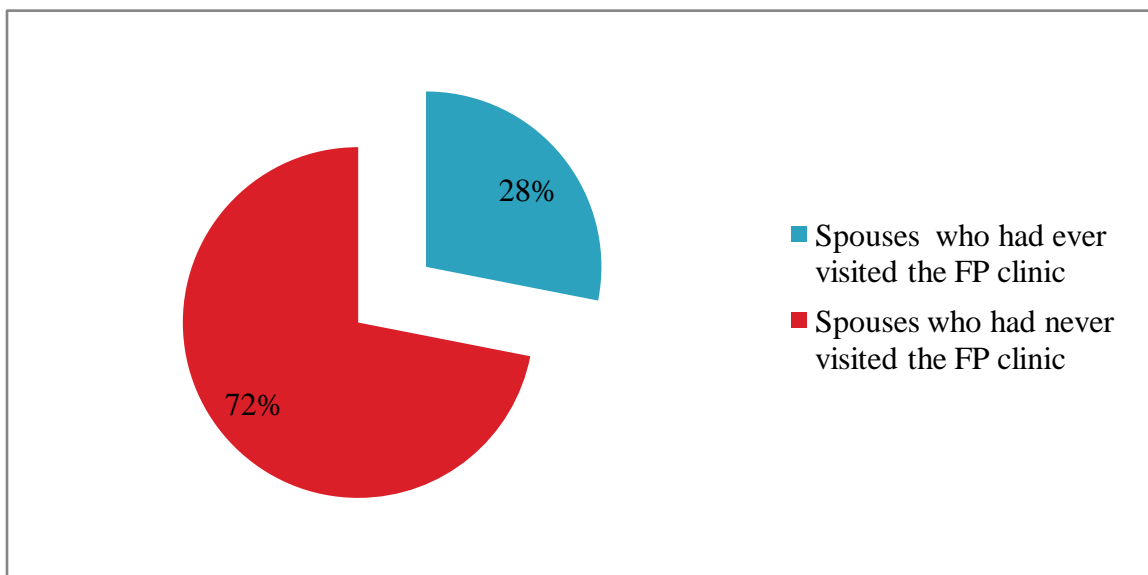


Figure 4.2: Clients whose spouses have ever visited the family planning clinic

(N=42)

From figure 4.2 out of the 146 respondents, only 41 (28.1%) had had their spouses ever visiting the Family Planning Clinic and 105 (72%) had never had their spouses coming to the clinic even though they agree to the family planning practice. Among those whose spouses had ever come to the clinic (n=41), 37 (92.2%) had ever come together and the other 4 (9.8%) did not.

To the question of how often the couple visited the clinic together, 16 (39.0%) had visited once; 11(26.8%) of them said once a while; 10 (24.4%) said most of the time and 4 (9.8%) responded always.

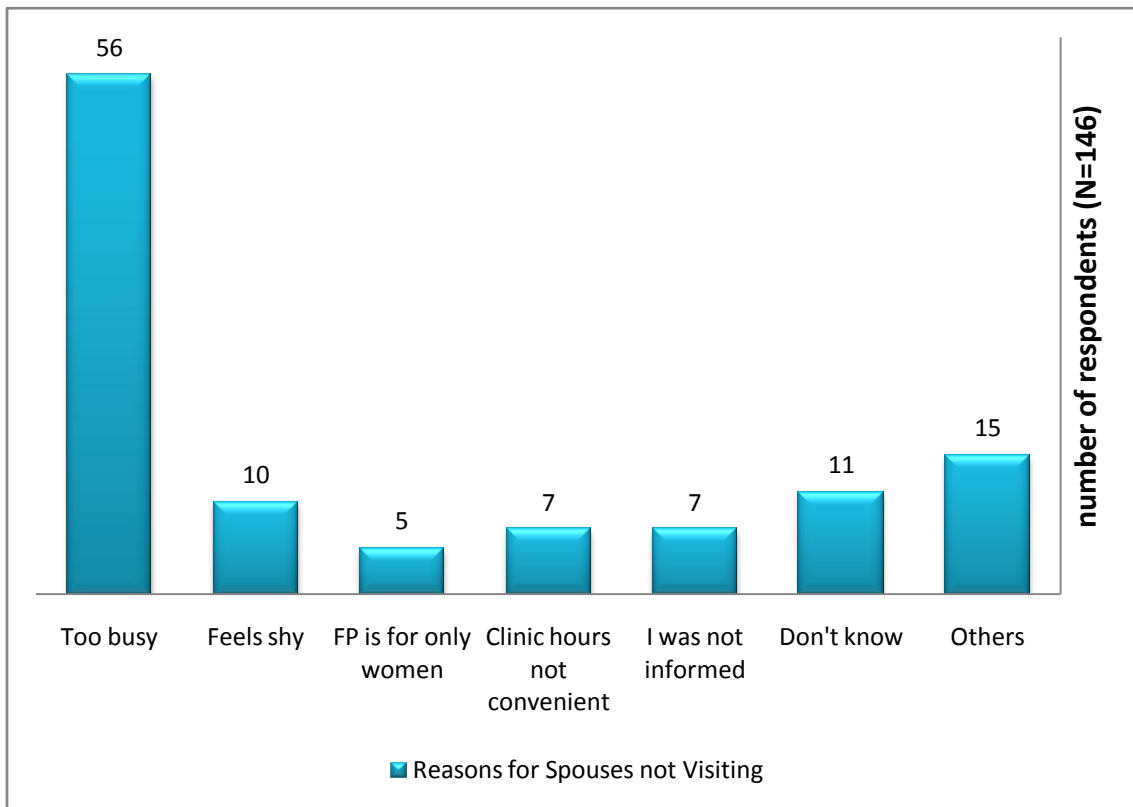


Figure 4.3: Reasons given for Spouses not visiting the family planning clinics

The majority of the spouses i.e. 56 (50%) gave their reasons for not visiting the Family Planning Clinic as being too busy. Those who did not visit as a result of shyness were 10 (9%); 7 (6%) were not informed while another 7(6%) also responded that the clinic hours do not favour them; whereas 5% associate family planning to women’s issues; and 11(10%) do not know why their spouses do not visit the clinic. This means there is less spousal communication concerning family planning among them. It may also buttress the point made by the 7 persons who said they were not told to bring their spouses to the clinics.

Suggestions to enhance couple focus approach to family planning.

The informants gave suggestions to enhance couple focused approach to family planning in the municipality and the responses have been recorded as follows:

- *“ We need to intensify education through the media and community durbars”;*
- *“We should encourage women to bring their husbands”;*
- *”Men should be given priority”;*
- *”Couple who come together needs to be praised”;*
- *”We must provide enough privacy”;*
- *“Sign posts should depicts that couples are welcome”,*
- *”We should give good counseling focusing on the reproductive systems functions” and*
- *”Show good attitude to them”*

4.3.11 Clinic working Hours

In an attempt to find out whether there are any special clinic hours to cater for those whose schedules do not enable them come to the clinic, the hours for service delivery was asked. There were two of the informants who said they offer 24 hours service because they stay within the compounds of the clinics. The other 4 do not have those structures so their services are rendered within the normal working hours i.e. from Monday-Friday, 7:00 am - 5:00 pm. On the other hand, if the clinic is heavy and there are clients by the closing time, the staffs would make sure all the clients are seen to before they close.

CHAPTER FIVE

DISCUSSIONS

This chapter deals with the discussion of the findings from the study of the Health Systems capacities towards couple focused approach to family planning in the New Juabeng Municipality of the Eastern Region of Ghana. The discussions were based on the objectives for the study: to describe the human resource capacity of the New Juabeng Municipality towards implementing couple-focused approach to family planning services within the Municipality; to ascertain the level of family planning method availability in the study area; to identify programs organised in favour of couple-focused approach to family planning; to identify the level of public education given to enhance couple-focused approach to family planning in the area and to assess the extent of couple involvement in family planning in the Municipality.

5.1 Human resource capacity

The study results show that 78% (21) of the providers had formal training in family planning and only 22% (6) did not have. Again there were periodic refresher trainings for them. However, there was no special training on couple focused care and as a result, there is the need for training to integrate the couple focused approach to the family planning service delivery before its implementation. This confirms that training is a very crucial element in service delivery as was said by Haq et al, (2008) that appropriate knowledge and communication skills of the workers are “key to their confidence and elementary for the success of the system”.

In fulfillment of set standards as given by Baochang and Zhenming (2009) that periodic refresher course given to all staff for updating on their training on reproductive health services are highly essential, all of them had had in-service training for a duration lasting less than 1 week (1-3 days). However, it would be more appropriate if the duration for the training would be extended to ensure better knowledge and skill transfer. This would lead to improvement in the Family planning service delivery in the Municipality.

5.2 Effective Counseling

The results showed that most of the service providers did not encourage the clients to invite their spouses to accompany them to the clinics. Only 59 (40.4%) of the clients attested to the fact that they were encouraged by the providers to invite their spouses and 87 (59.6%) of them responded otherwise. It further showed that the respondents considered effective counseling very crucial and needs to be improved to enhance the couple focused approach to family planning. More emphasis was made on the initial counseling to encourage the clients. Although the Reproductive Health Rights does not require spousal consent, it is preferred (G H S 2003) as that would enhance method continuation and improve success rate as documented by the U.S.A. Institute for Reproductive Health (2008).

5.3 Method Availability

Looking through the annual records from 2007 - 2009 and that of the 1st quarter of the 2010, it was revealed that the Hospital alone sees over half of all the family planning clients in the municipality annually. It also came out clear that the hospital has all the necessary logistics available in terms of structure and methods as well as the technical

knowledge to deliver full range of services to the clients. This has confirmed the assertion of Tuoane et al. (2004) that clients are more likely to access services at facilities where there are basic infrastructures that both provide for client comfort and supports quality of service. This is because the Regional Hospital has all the standard infrastructures and 53 (36.3%) of the respondents were from the Regional hospital.

5.4 Family Planning Programmes and Public Education

Findings revealed that there were not many campaigns about family planning in the municipality even though there was attention on male involvement in family planning. Some of the informants attributed this to lack of funds. This affirms the assertion by the World Bank Group (2007) that family planning programs have mostly been subject to under-funding. It also confirms the survey findings by Richey and Salem, (2008) which points to the fact that family planning professionals have recognized inadequate budget as one of the most challenging elements for family planning programs to achieve progress. It was also found that there were no arrangements for organising special clinics for couples even though couples who visit the clinics together were given priority of care in order to motivate the men to accompany their wives. Signposts to the clinics do not suggest that couples are welcome and signposts can be very important in advertising available services.

5.5 Privacy

The Regional Hospital and two other facilities had enough structures and well suited to provide sufficient privacy for even those who feel shy to access with less difficulty. For the three others the family planning clinics are sited at places where the clients who feel shy would find it challenging to access their services. Especially in our societies where many people think family planning is for only women. There would therefore be the need for relocation or improvement on the infrastructure to encourage more clients to access the services.

5.6 Couple involvement

The results proved that couple involvement in family planning in the New Juabeng Municipality is very low. Among the respondents (n=146) who even had agreed with their spouses to practice family planning, only 28% of them had ever visited the family planning clinics together. Moreover, throughout the study period, only 11 couples were accessible for the study.

The majority (59.6%) (n=146) of the clients were not told (encouraged) to come with their spouses. This might prevent the couples who might have visited together had they had the information to visit together from doing so. On the other hand, since those who had not ever come had majority of them attributing it to their spouses being too busy, efforts need to be made to reach to them at the work places as was suggested by some of the clients.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

The general objective of this study was to explore the capacity of the health systems to practice couple-focused approach to family planning services in the New Juabeng Municipality of the Eastern Region. The result of the study has shown that the Municipality is doing quite well in family planning in general. However, the concept of couple focused approach seems to be a new concept that most of the providers are not familiar with let alone knowing what it entails. There is therefore the need to invest more into couple-focused approach to family planning in Ghana to enhance higher contraceptive use, decrease method discontinuation, unwanted pregnancies and lower abortion rates. This would go a long way to improve on reproductive health services and move Ghana towards achieving the Millennium Goal 5 come the year 2015.

6.2 Recommendations

- The Ghana Health Service should include couple counseling in the policy for family planning to enable all districts to adopt the concept.
- The Municipality needs to solicit for funds from local agencies who are interested in Reproductive Health issues to enable it intensify education on family planning stressing on the need for couple involvement. In order to get the message well to the people, the message can be packaged in the common local dialects like Akan, Ewe, Krobo and other significant dialects in the Municipality.

- The local FM stations like the Eastern FM and the Sunrise FM can be engaged to present the message at a time that more people can be accessed.
- All Family planning staffs need to be trained in couple counseling to enable them offer better couple focused approach to family planning. The counseling should not only dwell on the side effects and the eligibility criteria of the various methods but needs to include informing the client about the importance of getting the spouses involved.
- The family planning providers should be sensitized to tell clients to encourage and invite spouses to accompany them to the clinics.
- The New Juabeng Municipality should organise programs at work places focusing on men. For example service delivery outlets can be opened at work places to offer services including counseling and STIs management to men.
- Peer counselors should be trained to encourage more couples to get involved in family planning.
- The signposts to the clinics need to be redesigned to depict couple involvement. This would encourage more men to accompany their wives to the clinics for counseling to improve on acceptance and method continuation.
- Lastly since the responses give evidence that most of the inhabitants in the municipality belong to one religious affiliation or the other, the religious leaders should be convinced to encourage their members to get involved in family planning with their spouses.

REFERENCES

- Almualm Y.K.A. (2007). Knowledge, attitude and practice of Husbands towards modern family planning in Mukalla, Yemen, 2
- Anand S. (2002). The concern for equity in health. Journal of Epidemiology and Community Health, 56:485–487.
- Baochang G.and Zhenming X. (2009). The Effect of Family Planning on Women's Lives
- Boadi E. (2009). Program Manager at Pathfinder International, a US-based NGO that does extensive work in the areas of family planning and reproductive sexual health in Ghana, in an interview with The Statesman. Mon, Nov 23
- Bossyns P, Van Lerberghe W. (2004). The weakest link: competence and prestige as constraints to referral by isolated nurses in rural Niger. Human Resources for Health, 2:1–8.
- Darroch J. E. (2009). The Alan Guttmacher Institute, special tabulations from the 1995 National Survey of Family Growth.
- Ezeh A.C, Seroussi M. Raggars H. (1996). Men Fertility, Contraception use and Reproduction Preferences. Calvert, Macro International, March. (DH comparative studies No. 18) 45.
- Family Health International (2007). Strategies for Improving Availability, Access and Acceptability.
- Fleischman J., Moore A. (2009). Center For Strategic & International Studies International Family Planning A Common-Ground Approach to an Expanded U.S. Role, A Report of the CSIS Global Health Policy Center
- Ghana Health Service (2003). National Reproductive Health Service Policy Standards 2nd Edition, 9-11
- Ghana Statistical Service, Ghana Health Service (2009). Ghana Demographic and Health Survey 2008
- Haq Z, Iqbal Z, Rahman A. (2008). Job stress among community health workers: a multi-method study from Pakistan. International Journal of Mental Health Systems. 2:15; 10.1186/1752-4458-2-15.
- Haq Z., Hafeez A. (2009). Knowledge and communication needs assessment of community health workers in a developing country: a qualitative study © 2009 Haq and Hafeez; licensee BioMed Central Ltd.

Hong R., Fronczak N., Chinbuah A., and Miller R. (2005). Ghana Trend Analysis for Family Planning Services, 1993, 1996, and 2002, 1

Hossain K. J. (2003). Male Involvement in Family Planning in Bangladesh: Factors Constraining Low Use and the Potential for Augmenting the CPR Centre for Policy Dialogue-UNFPA Paper 27: 20

Inglehart R., Welzel C. (2005). Modernization, cultural change and democracy: the human development sequence. Cambridge, Cambridge University Press.

Kickbush I. (2007). Innovation in health policy: responding to the health society. Gaceta Sanitaria, 21:338–342.

Lundgren R., Suzanne M. Schweikert, Lavoie K., MA, and Hodge K. (2006). Family planning services: A woman's right or a shared responsibility? lundgrer@georgetown.edu

Seltzer J. R. (2002). Population Matters, Policy Brief. A Rand Program of Policy Relevant Research Communication. <http://www.rand.org/labor/popmatters>.

Richey C., Salem R. M. (2008) Elements of Success in Family Planning Programming Population Reports 57: 19

Solo J., Odonkor M., Pile J. M., and Wickstrom J. (2005). The Acquire Report, Ghana Case Study: 'Give Them the Power' A Repositioning Family Planning Case Study The challenges of a changing world Care, 1.

Tuoane, M., N.J. Madise, and I. Diamond (2004). Provision of family planning service in Lesotho. International Family Planning Perspectives 30(2):77-86.

U.S.A. Institute for Reproductive Health (2008).

UNFPA (1999). Reproductive Health in Refugee Situations an Inter-Agency Field Manual

Wegner M.N., Landry E., Wilkinson D. and Tzanis J. (1998). Men as Partners in Reproductive Health: From Issues to Action. International Family Planning Perspectives 24:1

The World Bank Group (2010). <http://go.worldbank.org/U1JFPYG4Y0>

WHO Report (2008). Primary Health Care – Now More Than Ever; Geneva

APPENDICES

Check list for Health Systems Capacity for Couple Focused Approach to Family Planning in the new Juabeng Municipality

This study is being undertaken by an MPH student and is intended to find out about the capacities within the health systems that enhances offering services to couples. You are being asked to answer some questions. The information given would be treated confidentially and would be used for academic purposes only. You are however at liberty to respond or not.

FORM NUMBER

--	--	--

Name of Interviewer:

Date of interview

--	--	--

Name of Facility:

CHECK LIST FOR HEALTH SYSTEMS CAPACITY

NO	QUESTION	RESPONSE	CODE	VARIABLE
1	How many Family Planning service providers do you have?	1 2 3 4 ≥5	1 2 3 4 5	Q1HRNO
2	Educational background of providers (Last school attended)			Q2EDUC
3	How many have formal training in family planning?	1 2 3 4 5 6	1 2 3 4 5 6	Q3FTRG
4	If yes, how long was the duration of training? (List the period).	≤ 1 week ≤ 2 weeks 1 month 2 months ≥ 3months	1 2 3 4 5	Q4TDURX

5	Have you received in-service training?	Yes	1	Q5INSTRG
		No	2	
6	If yes, what was the duration of the training?	≤ 1 week	1	Q6INSDRXN
		≤ 2 weeks	2	
		1 month	3	
		2 months	4	
		≥ 3 months	5	
7	When was the last time you received training?	< 3 months	1	Q7LASTRNG
		3-6 months	2	
		6-12 months	3	
		Other (specify)	4	
8	What are the family planning services available in your facility?	Barrier methods	1	Q8MTHAVLB
		Oral methods	2	
		Injectables	3	
		Implants	4	
		Vasectomy	5	
		BTL	6	
9	Do you manage sexually transmitted diseases	Yes	1	Q9STI
		No	2	
10	If yes, do you use protocols in the management?	Yes	1	Q10PROT
		No	2	
11	Where do you refer your clients (if it becomes necessary)?	1	Q11REF
		2	

			3	
12	What are your clinic working hours?	Normal working hours Anytime at all Weekends and holidays as well	1 2 3	Q12WKHRS
13	Do you have any outreach programmes?	Yes No	Yes No	Q13OTRCH
14	If yes when do you have them?(place and time)		Q14WTRCH
15	Where do you have them		

16. Have you been trained on how to offer services to couples?

Yes [] No []

17. If yes how long ago?

.....
.....
.....

18. What does that entail?

.....
.....
.....

19. Do you think the facility is well equipped for Couple Focused Approach to family planning?

.....
.....
.....
.....
.....

20. Do you have any programme in place to enhance couple focused approach to family planning?

21. Yes [] No []

22. If yes, specify

.....
.....
.....
.....

23. If no, what do you think prevents that?

.....
.....
.....
.....

24. What in your view should be put in place to enhance the Couple Focused Approach to family planning?

.....

Questionnaire on Health Systems Capacity for Couple Focused Approach to Family Planning in the new Juabeng Municipality

This study is being undertaken by an MPH student and is intended to find out about the capacities within the health systems that enhances offering services to couples. You are being asked to answer some questions. The information given would be treated confidentially and would be used for academic purposes only. You are however at liberty to respond or not.

FORM NUMBER

Name of Interviewer:

Date of interview

Name of Facility:

DEMOGRAPHIC INFORMATION

NO	QUESTIONS	ANSWERS	CODES	VARIABLES
1	Age			Q1age
2	Sex	M F	1 2	Q2sex
3	Marital status	Single married	1 2	Q3marry
4	Number of living children	None 1 2 3	1 2 3 4	Q4child

		4 ≥5	5 6	
5	Occupation of respondent	Farmer Trader Civil servant Self employed Other (specify).....	1 2 3 4 5	Q5occup
6	Occupation of spouse	Farmer Trader Civil servant Self employed Other (specify).....	1 2 3 4 5	Q6spwork
7	Educational level of respondent	None Primary Middle Tertiary	1 2 3 4	Q7edulevR
8	Educational level of spouse.	None Primary Middle Tertiary	1 2 3 4	Q8edulevS
9	Religion	Christianity Moslem Traditional Others (specify)	1 2 3 4	Q9rel
10	Ethnicity	Akan Ewe Krobo Other(specify)	1 2 3 4	Q10ethnic

11	Place of residence		Q11reside
----	--------------------	----------------	--	-----------

Section II

12	Has your spouse ever been to the family planning clinic?	Yes No	1 2	Q12fpuse
13	If yes did you come together?	Yes No	1 2	Q13tog
14	How often?	Always Most of the time Once a while Once	1 2 3 4	Q14freq
15	If no why? Give reasons		Q15why
16	How would you rate the service delivery in the clinic?	Very good Good Bad Very bad	1 2 3 4	Q16service
17	How is the providers' attitude towards couples?	Very good Good Bad Very bad	1 2 3 4	Q17atid
18	Are you told to come with your spouse?	Yes No	1 2	Q18told
19	Do you always get the methods you want?	Yes No	1 2	Q19avail
20	If no which method could you not get?	Oral method Injectable	1 2	20getmeth

	(state method(s))	Implant	3	
		IUCD	4	
		Condom	5	
		BTL	6	
		Vasectomy	7	
21	Having male counselors/ providers will encourage more men to do family planning.	Strongly agree	1	Q21mcouns
		Agree	2	
		Disagree	3	
		Strongly disagree	4	
		Don't know	5	

22. What do you think should be done to encourage more couples to practice family planning?

.....

.....

.....

.....

.....

.....

FAMILY PLANNING ACCEPTORS FOR NEW JUABENG MUNICIPALITY

2007

Sub Municipal	Acceptors	Population	WIFA
Jumapo and Oyoko	605	17465	4017
Effiduase/Asokore/Akwadum	638	29164	6708
Koforidua RCH/Zongo	3155	50522	11620
Regional Hospital	5790		
Medical Village	666	53597	12327
Municipal Total	10854	150748	34672

2008

Sub Municipal	Acceptors	Population	WIFA
Jumapo	196	17710	40916831
Oyoko	337		
Effiduase	264	29572	6831
Asokore	130		
Akwadum	243		
Medical Village	516	54347	12554
Koforidua RCH	1688	51229	11834
Regional Hospital	5312		
Municipal Total	8686	152858	35310

2009

Sub Municipal	Facility	New and continuing Acceptors
Jumapo	Jumapo	214
	Suhyen	2
Oyoko	Oyoko	700
Effiduase	Effiduase	280
Asokore/Akwadum	Asokore	109
	Abrodua	48
	Akwadum	372
Koforidua RCH	Koforidua RCH	2611
	Debrakrom	31
	Social welfare	31
Zongo Clinic	Zongo Clinic	371
	Magazine	106
Adweso	Medical Village	237
	Agavenya	247
	Betom	34
	Atekyem	5
Densuano/Old Estate	Densuano	138
	Old Estate	37
	Nyamekrom	173
	Nsukwao	36
	Regional Hospital	6904
Municipal Total	–	12685

2010 1ST Quarter Report

Facility	Acceptors	Population	WIFA
Jumapo	141	10662	2463
Oyoko	184	10189	2354
Effiduase	213	13308	3074
Asokore	98	15870	2808
Akwadum	223	4941	1141
Koforidua RCH	846	34194	7899
Regional Hospital	2259		
Debrakrom	55		
Social Welfare	19		
Zongo	204		
Magazine	74	5113	1181
Medical Village.	119	34853	8051
Agavenya	90	3853	890
Densuano	66	3618	836
Old Estate	43	12308	2860
Municipal Total	4685	157168	36306