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HØGSKOLEN I OSLO
OG AKERSHUS

Esther Maame Efua Arhin

The pull and push factors in the acceptability and use of contraceptives among women in the Kwabre-east district of Ghana

Master's Thesis in International Social Welfare and Health Policy

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Dedication

I dedicate this thesis to my beloved husband; Francis Aboagye, and my children; Kwaku Gyumah Forkuo Aboagye, and Akosua Oforiwaa Nyamekye Aboagye.

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I thank the Lord Almighty for how far he has brought me. This thesis would not have been possible without the grace, mercy, and wisdom of the Lord, Lord i thank you for seeing me through my MIS program. When it got to the point of giving up the Lord stengthened me, Ebenezer, may your name be forever praised.

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Contents

Abbreviations

CHPS	Community-based Health Planning and Services
FP	Family Planning
GNFPP	Ghana National Family Planning Program
IPT	Intermittent Preventive Treatment
MDG	Millennium Development Goal
MNH	Maternal and Neonatal Health
MPS	Making Pregnancy Safer
PHC	Primary Health Care
PMM	Preventing Maternal Mortality
SDG	Sustainable Development Goal

Abstract

This study explores why some women are able to use contraceptives and why others are not able to use contraceptives in relation to pregnancies in the Kwabre East District of Ghana. The study employs the qualitative method of research and the main data collection instrument is in-depth face-to-face interview. Data from the field was analyzed with existing literatures and the results show that the main factors influencing contraceptive use are based on socio-cultural, environmental, contextual and religious. Some of these factors are the side effects of some of the contraceptives, poor education on the use of contraceptives, the culture of silence, geographical accessibility, cost, and religion.

1Chapter one: Study background

1.2 Introduction

It is argued that one of the most cost-effective methods to prevent maternal, infant, and child mortality globally is increasing family planning services. Again, family planning interventions help to lower mortality and thereby contributing to the Millennium Development Goals (MDGs) as well as the proposed Sustainable Development Goals (SDGs). Family planning aids in the reduction of unwanted pregnancies which is estimated to prevent one-quarter to one-third of all maternal deaths. Indirectly, family planning contributes to positive health outcomes, such as family planning interventions contributing to poverty reduction, increasing gender equity, preventing the spread of sexually transmitted diseases (STD), reducing unwanted pregnancies, and reducing infant mortality (Government of Ghana 2015).

However, studies indicate that there is generally high total fertility rate for many West African countries which is associated with the low prevalence rate of contraceptives. There is also high rate of infant and maternal mortality in this region. Although Ghana has better reproductive health indicators compared to many neighboring West African countries, comparably, it is not as favorably as other successful developing countries, such as Egypt, Brazil, and Thailand with lower fertility rates and higher modern Contraceptives prevalence rates.

Further studies show that Ghana's population is growing quickly. Over the last 90 years, there has been more than tenfold increment, that is, the population has increased from 2.3 million in 1921 to 24.7 million in 2010. The population has doubled over the last 30 year with an annual growth rate of 2.5 per cent. The population of Ghana is further expected to double again in 28 years and this would lead to a population of almost 50 million people by the year 2038 (Government of Ghana 2015).

Ghana's population is young, that is, 38 per cent of the population is under 15 years of age as a result of the high population growth rate. The high fertility rate coupled with high population growth rate in Ghana has further resulted in high child dependency ratio which negatively impacts social transformation and development. Although there has been advances

in Ghana's socioeconomic indicators, the country still faces key health and developmental challenges in the pursuit to achieve its strategic goals. The high population growth rate drains the country's natural resources, and thereby heightens the poverty rate and threatens future development gains (Government of Ghana 2015).

Hence, dynamics in Ghana's population can be turned into a valuable ""demographic dividend"" only through investing in family planning and reproductive health programs in order to promote population change through a lower fertility rate and more balanced population age structure. "Demographic dividend" means "the economic benefit a society enjoys when fertility and mortality rates decline rapidly and the ratio of working-age adults significantly increases relative to young dependents" (Government of Ghana 2015).

"Universal access to contraception has been a key global health goal for decades, as currently exemplified in Family Planning 2020and the Sustainable Development Goals". Based on this, a number of survey have been conducted to understand fertility and its correlates but there are problems associated with how surveys capture fertility regulation strategies, especially those strategies that do not involve modern contraception methods. For instance, the use of traditional contraceptives methods were seen to be underreported in surveys conducted in France in the 1970s and also in Burkina Faso and Ghana recently (Cicely Marston et al. 2017). This research therefore employs qualitative research method to understand women's perception and knowledge on contraception and the reasons why some women uses contraception and why other women do not use contraception.

This chapter brings to light an understanding of the subject matter of this thesis which is contraceptives within the broader concept of reproductive health. The chapter further presents policies and programs on reproductive health/contraception in Ghana. The research objectives and research questions are also presented in this chapter. In addition, the study's relevance, study's limitation, and structure of the paper are presented in this chapter.

1.2 Reproductive health

Reproductive health is the situation where "people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so". This involves "the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable" contraceptives of their

choice. Contraceptives can therefore be termed as methods of fertility regulation (WHO 2016) since it enables men and women to decide on the number of children to have. This asserts that men and women could give birth to the number of children they think they can take care of (WHO 2015).

The definition of reproductive health asserts that individuals have a right to be provided with information and education on issues concerning their reproduction health. Also, reproductive health needs should be accessible to men and women, be of good quality, and conform to societal norms so that men and women can comfortably accept and use them.

This thesis finds out why some women are able to use contraceptives and why others are not able to use contraceptives in relation to pregnancies in the Kwabre-East district of Ghana.

However, reproductive health being a right suggests that states have the responsibility to ensure its protection and fulfilment. This involves states putting in place programs and policies that will enhance the reproductive health of men and women within its jurisdiction. In other to enhance this, the World Health Organisation (2007) has come out with a strategic approach that aims to "strengthening sexual and reproductive health policies and programmes" of states. "The WHO Strategic Approach (…) involves a three-stage process for assisting countries to assess reproductive health needs and priorities, test policies and programme adaptations to address these needs, and then scale up successful interventions". This approach was made to overcome the hurdles that policy makers face in formulating best policies and programs and also to ensure that reproductive health policies and programs address the needs of men and women.

1.3 Reproductive health and reproductive health policies in Ghana

1.3.1 Profile of the Republic of Ghana

Ghana is a West African country that shares borders with Togo on the east, Cote d'Ivoire on the west, and Burkina Faso on the north. Ghana became independent in 1957, and became the first Sub-Saharan Africa to gain independence. The Republic of Ghana is a unitary state with ten administrative regions which is sub-divided into smaller units called districts. There are 216 districts in Ghana which are administered by the district assemblies.

The population of Ghana indicated by report of the 2010 population census is 24,658,823 representing 30.4% increase over the 2000 population census. Ashanti region is the most populous region with a population of 4,780,280, which represents 19.4% of the total country's population. From the total population, total male population is 12,024,845 and the female population is 12,633,978, indicating a sex ratio of 95.2. There is predominance of females in all the regions except Western region where the male population is approximately equal to the female population as indicated by the regional sex ratios (GSS 2012).

42.9% of the population aged between 12 years and older were married while 42.0% had never been married at the time of the census. Also, 10.2% of this population had been married before but were separated, widowed or divorced at the time of the census. The census further shows that females are more likely to be married (43.9%) than males (41.7%) with the proportion of females divorced or widowed higher than that of males (GSS 2012)

Further, report of the 2010 population census shows that 71.2% of the population of Ghana are Christians, 17.6% are Islam, and 5.2% of the population adhere to traditional religion whereas 5.3% are not affiliated to any religion. In terms of literacy, Majority (74.1%) of the population aged 11 years and older is literate. In terms of sex, males represent 80.2% of the literate population whiles the literate female population is 68.5%.

1.3.2 Reproductive health situation in Ghana

"The global Millennium Development Goal (MDG) 5 target for maternal health is to reduce the number of women who die in pregnancy and childbirth by three quarters between 1990 and 2015". When this target is applied to Ghana, "maternal mortality should fall to 145 cases per 100,000 live births" (Ghana 2016). Based on statistics from the Ghana Health Services (GHS), there has been reduction in Maternal Mortality ratio of "740 per 100,000 live births in 1990, to 590 in 1996 with a further reduction of 540 in 2000, to 541 in 2005 and finally to 350 in 2010", but Ghana's maternal mortality ratio does not meet the MDG target of 185 per 100,000 by 2015 since the reduction drift falls short of the 5.5 percent annual decline requirement (Otinkorang 2007).

According to Otinkorang (2007) the lack of resources allocation to deserved communities and the abandonment of some components in the fight against Maternal Mortality have contributed to the inability to meet the Millennium Development goal target.

1.3.3 Reproductive health/family planning programs and policies in Ghana

In an attempt to enhance reproductive health in Ghana, a number of policies and programs have been instituted. For instance, to achieve the MDG 5 target, maternal mortality was declared a national emergency in 2008 by the Government of Ghana in order to develop the MDG Acceleration Framework (Ghana 2016). A number of interventions have also been introduced to improve maternal health and reduce the high maternal mortality incidence in Ghana. Some of the health interventions aimed at reducing maternal mortality includes the following: Safe-Motherhood Initiative; Preventing Maternal Mortality Program (PMM); Making Pregnancy Safer Initiative; Maternal and Neonatal Health Program; Ghana VAST Survival Program; Maternal Health Project; Prevention and Management of Safe Abortion Program; Intermittent Preventive Treatment (IPT); and Roll Back Malaria Program (ECOSOC 2007).

The various programs have different objectives and packages. For instance, the Safe-Motherhood Initiative which is a National Reproductive Health Service delivery is delivered through the Primary Health Care (PHC) Program. Its major components include; family planning, antenatal care, labor and delivery care, postnatal care, prevention of unsafe abortions, management of unsafe abortions, and health education. These Services are provided at the grass root level, that is; closer to the communities and they are provided by the various district hospitals, clinics, health centers and health posts (ECOSOC 2007).

One component of the Safe Motherhood Initiative which aims at promoting maternal health is the Preventing Maternal Mortality Program (PMM). "The program focuses on interventions that improve the availability, quality and utilization of emergency obstetric care. Activities range from improving services at health facilities to improving access to care" (ECOSOC 2007).

Another component of Safe Motherhood Initiative is Making Pregnancy Safer (MPS) Initiative delivered through the Primary Health Care Program. It has four interventions which are: care during pregnancy, care during and after birth, postpartum family planning, and community component (ECOSOC 2007).

Maternal and Neonatal Health Program (MNH) is another key component of the Safe Motherhood initiatives. This program covers Antenatal Care, Labor and Delivery Care, Postnatal Care, and etc. (ECOSOC 2007).

Also, Ghana VAST Survival Program an intervention aimed at reducing maternal mortality is an initiative to control the problem of Vitamin A deficiency in Ghana, and to reduce maternal and child mortality accompanying vitamin A deficiency. Through this program Vitamin A is promoted as part of normal treatment for measles, and children over 6 months of age are given periodic Vitamin A supplements, as well as mothers within 4 weeks of delivery given Vitamin A supplements (ECOSOC 2007).

Besides these numerous maternal health interventions, "maternal mortality rate is still relatively high and improvements are very slow". According to the Ghana Service Provision Assessment Survey conducted in 2003, "the lack of family planning services in most health facilities" is a barrier to improving maternal health care in Ghana (ECOSOC 2007)

Under the Fact sheet number 351, the World Health Organization (WHO) highlighted the necessity for contraceptives to be made available to people who need them[1]. As at 11 July, 2012, the government of Ghana purchased about quarter of all contraceptive commodities (FFP2020 2012). Also as part of maternal health care, contraceptive was added to services provided freely for women by the government in 2013. The Planned Parenthood Association in Ghana (PPAG) has also played an active role in making contraceptives free in Ghana's public sector (FP2020 2014).

In Ghana, family planning has been prioritized as a key strategy to address the health, social, and economic issues of the country. Efforts to promote family planning in Ghana started in 1969 when the family planning council was established. Further, Ghana's first population policy was developed in 1969 with the aim to reduce the high population growth in Ghana and enable sustainable socio economic development (service 2015).

Family planning enables people to acquire the number of children they desire and also helps in the spacing of pregnancies. This is done through the practicing of contraceptive methods (WHO 2015). In Ghana a group of family planning commodities is provided for those who need them. These are: "Short-term methods, Long-term methods, Permanent methods". In

[1] Available at http://who.int/mediacentre/factsheets/fs351/en/ (accessed on 05/05/2016)

order to make these family planning options known to those who may need them, a number of public educations have been made in the form of campaign. These campaigns include: "The 'I Care campaign to boost the image of service providers'" held in 1990 as a social marketing strategy. A campaign was mounted for the long term family planning method in 1998. And further in 2001, the '"Life Choices' campaign" was launched. (Odoi-Agyarko 2003).

Also to involve men in family planning, family planning activities which include "workplace activities, community activities, and workshops" are provided for men by organizations such as "The Planned Parenthood Association of Ghana (PPAG) and other NGOs such as the Ghana Social Marketing Foundation (GSMF), Rural Help Integrated (RHI), Muslim Family Counseling Services, Young Women Christian Association (YWCA) and Young Men Christian Association (YMCA)" (Odoi-Agyarko 2003).

1.4 Objectives of the study

1.4.1 Overall objective

This study explores why some women are able to use contraceptives and why others are not able to use contraceptives in relation to pregnancies in the Kwabre East District of Ghana.

1.4.2 Specific objectives

1. To explore people's perceptions and knowledge on different types of contraceptives.

2. To find out the type(s) and specific brands(s) of contraceptives that people use most.

3. To find out the perceptions that people have about the different types of contraceptives

4. To find out how and where women get access to contraceptives.

5. To find out how women get information concerning contraceptives.

6. To find out the agents responsible for reproductive health education, service delivery, and information dissemination.

7. To find out government programs and policies on reproductive health.

8. To make possible recommendations depending on the research findings.

1.5 Research questions

1. What are the various facilitators and barriers to the acceptability and use of contraceptives among women in the Kwabre East district of Ghana?

2. What type(s) of contraceptives do people use most?

3. Which agents are responsible for reproductive health services delivery?

4. Which individuals/ institutions are responsible for reproductive health education in Ghana and how is information regarding reproductive health communicated to women in the Kwabre East district of Ghana?

5. What government policies on reproductive health are in place?

1.6 Relevance for the study

This research focuses on the pull and push factors in the acceptability and use of contraceptives among women in the Kwabre East district of Ghana and it is relevant because:

1. Through qualitative approach, the study explores people's perceptions on contraceptives and highlights the various facilitators and barriers to contraceptive use

2. The study brings to light some government programs and policies on reproductive health and the findings and recommendations will contribute to improving the acceptability and use of contraceptives among women in the Kwabre East district of Ghana and will also help in interventions and programs aimed at addressing and improving contraceptives use.

3. The study findings will further enable health care providers and NGOs involved in reproductive health services provision to better understand people's perceptions on contraceptives and how to meet people's contraceptives needs.

1.7 Study limitations

One limitation concerns the sensitivity of the subject under study. In Ghana, people are reserved to discuss matters involving sexuality especially with the opposite sex. I faced the challenge of getting male participants to freely express their perceptions and experiences on the subject. In some cases respondents withdrew from the research after the introductory stage.

Also, there was gender-based limitation. Interviews were conducted with both married and unmarried men and women and I (the researcher) being a female, there was a challenge in getting responses from some male respondents on some of the research questions due to the sensitive nature of the subject of the research. I therefore employed an experienced and elderly male research assistant who assisted in the interviews with these male participants.

Also limited time and resources was a challenge to this study. The research was conducted within limited time frame and with the researcher's own funds and that hindered me from collecting all important data for the research.

Further, there is a challenge to the representativeness of the sample. The research employed the qualitative approach and data was collected from 20 participants. This number of participants is not large enough for the sample to be representative of the population. Therefore, the results of the research cannot be generalized to the whole population.

Again, there was a problem associated with 'the researcher as an insider'. The research was conducted in my own community and basically in the local Ashanti Twi dialect. In this regard, I (the researcher) was familiar with the cultural norms, values, and morals of the society and I was therefore tempted to take for granted some aspects of people's perception and experiences which were seen to be important in the research findings.

1.8 Structure of the thesis

The thesis consists of six chapters. Chapter one is the study background, chapter two is the literature review and theoretical framework, chapter three is the methodology, chapter four presents the results, chapter five is discussion of results, and chapter six is conclusion and recommendations.

1.9 Conclusion

This chapter has presented an introduction to the subject matter of this research, that is, contraception within the broader perspective of reproductive health, reproductive health programs in Ghana, research objectives, research questions, study's relevance, study's limitation, and structure of the thesis.

2 Chapter two: Literature Review/Theoretical framework

2.1 Introduction

This chapter provides the theoretical and conceptual framework for the study. Building upon previous works on reproductive health and women use of contraceptives, this literature seeks to: explore the concept of contraception by defining it, the benefits associated with the use of contraceptives, global disparities in contraceptive prevalence, types and kinds of contraceptives used and factors or determinants of women contraceptive use.

The review was guided by the objectives and research questions stated in chapter one of this study.

2.2 Defining contraception

Contraception is the deliberate use of artificial methods or other techniques to prevent pregnancy as a consequence of sexual intercourse. It could also be described as an intentional prevention of conception through the use of various devices, sexual practices, chemicals, drugs, or surgical procedures (Darroch, et al. 2011). This means that a behavior become a contraceptive if its purpose is to prevent a woman from becoming pregnant.

2.2.1 Benefits associated with contraception

Various benefits are associated with the use of contraceptives by women as outlined by many scholars. These benefits include: fewer unintended pregnancies; fewer maternal and new-born deaths; and healthier mothers and children (Connor1968) (Singh et al. 2009). Among the benefits as outlined by Singh et al. (2009) are, greater family savings and productivity; and better prospects for educating children, strengthening economies and reducing the pressure on natural resources in developing countries. Among the major benefits of a woman's ability to space and limit pregnancies comprise: a direct impact on their health and well-being as well as outcome of pregnancies (WHO 2012; 2013).

Preventing unintended pregnancies by contraceptive use reduces induced abortion - as well as avoiding potential complications of pregnancy including maternal morbidities and mortality (Campbell & Graham, 2006). Ahmed et al., (2012) found that contraceptives were responsible for 44% reduction in maternal deaths in 172 countries across the globe in 2008 and that satisfying unmet need at that time would have led to a further 29% reduction (104,000 maternal deaths avoidance) (Ahmed et al. 2012). In developing countries, the increasing use of contraceptives in the 1990s has resulted in a 40% decline in maternal deaths, and each 1 percentage point increase in the use of contraceptives reduces the maternal mortality ratio by 4-8 deaths per 100,000 live births (Cleland, et al. 2012). Reynolds et al., (2008) found that in 2008, unintended HIV-positive births averted by use of contraceptives ranged from 178 in Guyana to over 120000.

The MATLAB Controlled long-term studies in Ghana and Bangladesh also showed that better access to contraceptives and increased use effects reduced fertility, improved birth spacing, women's participation in the paid labor-market, earnings, assets, and body-mass indexes, and also improved children's schooling and body-mass indexes (Canning &Schultz 2012). In sub-Saharan Africa, contraceptive implants alone have the potential to avert 1.8 million of the 14 million unintended pregnancies that occur annually (Hubacher, Mavranezouli, & McGinn, 2008).

In 2012, contraceptives used in developing countries were projected by the World Health Organization to have prevented 218 million unintended pregnancies, averted 55 million unintended pregnancies and births, 138 million abortions. Further estimates mean the prevention of an additional 54 million unintended pregnancies, including 21 million unplanned births, 26 million abortions (WHO 2012).

Cleland et al. (2006) underline the macroeconomic importance of the use of contraceptives as seen in reducing poverty, youth dependency and hunger, and restated how important it is in attaining the MDGs.

2.2.2 Geographical Prevalence of Contraceptive Use

Varying percentage levels exit within the geographical locations in the world as far as the contraceptive prevalence rates are concerned. Contraceptive prevalence is defined as the

percentage of women of reproductive age (15-49 years.) who are or whose partners use any method of contraception at a given point in time (WHO, 2013). Globally, the use of contraceptives has increased from 55% to 63% between 1990 and 2010 (Alkema et al. 2013). The United Nations in a 2013 report explain that globally, contraceptive prevalence is 63%, with nine out of ten woman of reproductive age in a union using contraceptives (United Nations 2013).

As a region, sub-Saharan Africa has the lowest level of contraceptive prevalence, with only 21% of women of reproductive age who are married or in a union using some method of contraception and contraceptive prevalence level below 20% have been reported in Western Africa (UN, 2009). In 2010, Sub- Saharan Africa still has the lowest prevalence (31%) and is currently facing a problem in fertility decline (Alkema et al. 2013).

Family planning practice was introduced in Ghana in 1970. The objective then, according to the Ghana National Family Planning Program (GNFPP) was to make family planning services available to all couples with a view to encouraging them to adequately plan their families. Implicit in this objective was fertility control. There was a rapid increase in contraceptive use from 12.9% in 1988 to 25.2% in 2003, and since then contraceptive use has not significantly changed (Ghana Statistical Service & Ghana Health Service 2008).

In Ghana, the 2014 Demographic and Health Survey indicate that the demand for family planning is 57%, but only 47% of that need is being met (Ghana Statistical Service & Ghana Health Service 2015).

2.2.3 Type(s) and specific brands(s) of contraceptives

Currently, there are two major classifications of contraceptives – modern contraceptives and traditional contraceptives. The medically accepted modern contraceptives are the barrier methods (both male and female condoms, diaphragms, cervical caps, contraceptive sponges and spermicides), hormonal methods (combined oral contraceptives, progestinonly pills, contraceptive patch, injectable birth control, vaginal rings, implantable rods), emergency contraceptives, intrauterine methods (copper IUD and hormonal IUD) lactational amenorrhoea method (LAM), and sterilization (tubal ligation, sterilisation implant and vasectomy). The traditional methods are rhythm (or fertility awareness/periodic abstinence

method), withdrawal (coitus interruptus) and folk methods (other traditional culture-specific methods).

Modern contraceptive methods comprise female sterilization, male sterilization, pills, Depot Implants, male condoms, female condoms, Intra Uterine Devices (IUD), Lactational Amenorrhea Method (LAM) and emergency contraception (WHO 2008; 2013). On the other hand, traditional methods comprise rhyme method (periodic abstinence) and withdrawal. Although the WHO considers all these methods to be safe for all persons, the effectiveness of the latter group is questionable. Globally, modern contraceptive utilization has increased in the recent past – from 54% in 1990 to 57% in 2012 (WHO 2012).

The concept of contraceptives and family planning, as earlier stated, is an old one. It rose out of a universal need for people to enjoy sex and not be saddled with a pregnancy after the act; that is, being able to space or limit births (Glasier, et al., 2006). Methods such as celibacy, sexual taboos, abstinence, withdrawal (coitus interruptus), and induced abortion were commonly used by many ancient societies (Woods, Hensel, and Fortenberry 2009).

By the middle ages, barrier methods such as vaginal sponges and cervical caps were also used in the Middle East including ancient Egypt several thousand years before the common-era, while rock salts were used as spermicides (McFarlane and Grossman 2014). In China, women drank lead and mercury to control fertility, which often resulted in sterility or death (Moss 2015). In the West, the combination of the witch-hunt and the great plague in medieval times helped suppress birth control.

The United Nations (2013) indicate that the most common methods worldwide are female sterilisation (26%), IUDs (14%) and the emergency contraceptive (the pill at 9%). According to the UN 2009 report, nine out of every 10 contraceptive users in the world rely on modern methods, with the developed countries relying more commonly on short-acting and reversible methods whereas longer-acting and highly effective clinical methods are used more frequently in the developing countries (United Nations 2009). The UN report further observed that in the developed countries as a whole, the most commonly used methods are the pill (18 per cent prevalence) and the male condom (16 percent). By contrast, in developing countries the methods with the highest prevalence were female sterilization (22%) and the IUD (15%), accounting together for 61 per cent of overall contraceptive use. However, in the world as a whole, female sterilization is the most commonly used method of contraception, being the

method selected by 20 per cent of women aged 15 to 49 who are married or in union (UN, 2009).

The type of contraceptive used may therefore vary depending on the intention and the geographical location of the user. According to Population Reference Bureau (2009), cited in Creanga et al. (2011), in less developed countries modern contraceptive methods are used by only 43% of women of reproductive age, and a wide gap in use is seen between the highest and lowest wealth quintiles (52% versus 35%, respectively).

In Ghana, the 2014 Ghana Demographic and Health Survey (GDHS) reports that contraceptive prevalence among currently married women of ages 15-49 years is 26.7%, of which 22.2% was from the use of modern contraceptives and 4.5% was from traditional methods. Among these population, injectable (8.0%), implants (5.2%) and pills (4.7%) are the most commonly used modern methods and rhythm method (3.2) which is the most common traditional method is more used than male condoms (1.2%) (GSS, 2015).

2.2.4 Sources to the access of contraceptives

Contraceptives in Ghanaian population are accessed from diverse sources as documented in earlier studies. Among them are public medical facilities under the health ministry, non-governmental health institutions (private health facilities, pharmacy/chemical sellers) and other sources such as friends and religious bodies (Ghana Statistical Service & Ghana Health Service 2008). It was evident however that, family planning (FP) services still reside within health institutions, possibly because the methods available require expertise from within such facilities significantly determining the source of service (Agha and Meekers 2008). The private sector, mostly chemical shops serve as sources of non-clinical contraceptives such as condoms and pills (Agha and Meekers 2008).

2.2.5 Sources of Women Contraceptives Information

There is evidence that Family Planning (FP) messages through media may play an important role in increasing the knowledge of FP methods and through this increased knowledge is their acceptance and use, especially in those areas where the literacy level is low (Easterlin & Crimmins, 1985; Saluja et al., 2011; Fikree et al. 2001). Several empirical studies have shown that mass media campaigns may lead to behavioral changes and in this way reduce fertility

(Olaleye & Bankole, 1994; Jato et al. 1999; Agha & Van Rossem 2002; Islam &Kabir, 2000; Cheng, 2011; Rabbi 2012). For example, in Bangladesh, mass media exposure was found to be a significant differential of fertility, even after controlling for the effects of contraception and socio-economic status (Rabbi 2012). Cheng (2011) established that in Taiwan mass media and social networks played important roles in disseminating contraceptive knowledge and that women transformed this knowledge into behavior - that is, contraceptive knowledge reduced fertility. Another study in Pakistan showed that people who had exposure to condom advertisements on radio or TV experienced increases in the following areas: perceived availability of contraceptives, discussion of FP, approval of FP, and procurement of contraceptives (Agha & Meekers, 2010).

The main sources of information for young women about contraceptives are friends, radio and nurses (Oye-Adeniran *et al,* 2006) where clients of family planning services have prior counseling about side effect of methods which enable them in choosing help to counter the side effects. Again, communication through mass media (radio, television, or print) is an appealing strategy for the promotion of family planning because of its potential for expansion and its ability to address (in entertaining or informative way) issues that in many settings are culturally taboo methods (Mwaikambo et al. 2011).

2.2.6 Essential factors associated with effective use of contraceptive methods

Differences in the use of contraceptives pattern has also been ascribed to social and cultural differences. There are many such factors affecting the use of contraceptives:

Knowledge of contraceptives

Knowledge of contraceptives is considered one of the essential factors associated with effective use of these methods. A lack of knowledge of FP sources and methods is often cited as a key variable in determining contraceptive use (Bongaarts & Bruce, 1995; Casterline & Sinding 2000; Korra 2002). It is expected that the more people know about and accept modern contraceptives, the more they will use them (Nijmegen Centre for international development, 2012). Knowledge about contraceptives and their side effects may affect their actual use also indirectly, through its effect on the attitudes people have regarding contraceptive use (Easterlin & Crimmins 1985; Chipeta et al.2010; Fikree et al. 2001; Smith

2002). Nigerian women with positive attitudes towards contraception (i.e. those who approved FP and those who discouraged early marriages) were found to use contraceptives more than other women (Odimegwu, 1999). Exposure to contraceptive information through the media could also influence current contraceptive use. Studies in Kenya, Malawi, Burkina Faso, and Ivory Coast, revealed that women who reported being exposed to family planning information in the media were more likely to be using contraception (Stephenson et al. 2007). Condon J. T., J. Donovan, and C. J. Corkindale(2001) further showed in their study on the relationship between attitude and behavior among adolescents in Baltimore that positive attitudes towards contraception had a significant effect on contraceptive use. Davidson and Jaccard (1979) also provide evidence that married women's attitudes towards birth control are positively correlated to their actual use and author's reference found district-level use of contraceptives to be positively affected by knowledge and acceptance of contraceptives in African countries.

Biney (2011) observed that lack of knowledge about contraceptives among Ghanaian women led to failure of contraceptive use which in turn led to unintended pregnancies and induced abortions. Similarly, Lindstrom and Hernandez (2006) found that limited knowledge of contraceptive methods among recent rural-urban migrants in Guatemala was associated with unmet need and limited choice of contraceptives.

Education

Education is also closely linked to the use of contraceptives: more educated women are more likely to use Family Planning (Bogdan et al. 1992; Rutenburg et al. 1991). Education provides people with the knowledge and skills they need to live better lives (Nijmegen Center for Economics, 2012). Education of women is one of the key factors driving fertility reduction. Women with higher levels of education are more likely to delay and space their pregnancies and to seek health care and support (UNESCO 2011). Education influences women's reproduction by increasing their knowledge of fertility, by increasing their socioeconomic status, and by changing their attitudes towards fertility control (Castro-Martin 1995). Educated women had better odds of using modern contraceptive methods than uneducated married women. A study in Catalonia, Spain indicates that those factors which most of the time influence the use of family planning methods are level of education (Saurina *et al*., 2012). Similarly, in five African countries, women with a secondary education or higher were

more likely to use contraception than women with no education (Stephenson et al. 2007). In addition, in Pakistan, women's education also played an important role in relation to contraceptive use, as literate women were more likely to use contraceptives than illiterate women (Ahmad et *al.*2007).

Geographical location

Another, closely related, characteristic of the context that may play a role is its level of urbanization. Women living in rural areas tend to use fewer contraceptives and have more children than their urban counterparts (Rutstein 2005). In the 1990s, urban fertility in Sub-Saharan Africa was on average almost 30% lower than rural fertility (Dudley & Pillet 1998). More recently, African countries like Ethiopia still show very high fertility rates in rural areas, whereas fertility in the cities has decreased considerably (Tadessand Headey 2012). A major reason might be that the costs of children are higher in more developed and urban areas than in rural areas (Smith and Gozjolko 2010). Similarly, married women who lived in rural areas had 30% lower odds of using modern contraceptives than urban married women (Lakew et al. 2013). Bongaats and Potter (1983) noted that contraceptive prevalence is higher among women in the urban areas. This is because FP clinics are in most cases located in urban areas; this affects accessibility of the services among the rural women.

A study by Tawiah (2013) in examining maternal health care disparities in five sub-Saharan Africa found that as at 2007, rural women were about twice less likely to use modern contraception than their urban mates in Ghana and Kenya. This has led to a situation where urban women in Ghana were found in a study, to be at lower odds of unintended pregnancy than their rural counterparts (Johnson et al. 2012).

Employment Status

In less developed countries modern contraceptive methods are used by only 43% of women of reproductive age, and a wide gap in use is seen between the highest and lowest wealth quintiles (52% versus 35%, respectively) (Population Reference Bureau, 2009, cited in Creanga et al. 2011). In addition, Lakew et al. (2013) in their study found that, wealthy women had two times higher odds of using modern contraceptives than poor married women, however, women who had worked or been employed had a 30% lower odds of using modern contraceptives compared to married women who had no employment history. Also, Okech et

and Kline (2007) observed that factors including the woman's income level, proximity to the provider and the religious background of the woman influence contraceptive use. The highest (58%) use of contraceptives was reported among women in formal employment placing further emphasis on the importance of economic standing of women on contraceptive use. Again, a study of wealth status and family planning reveals that modern contraceptive use is more than twice as high among the wealthiest women when compared to the poorest women (Family Health Initiative 2010).

Religion

Worldwide, religion has played a leading role in discouraging dissemination of information on FP use. Particularly, Catholics have a restriction in matters concerning contraceptive use (Gupta and Leite, 1999; Lanre 2011). Their teaching discourages the use of modern contraceptives on grounds that unnatural methods encourage promiscuity (e.g., Ntozi et al.1999) In countries that are predominantly Catholic (for example Brazil), the Catholic church is at the forefront of influencing government policies particularly in the area of limiting FP services available and discouraging fertility limiting behaviors (Gupta and Leite, 1999). However, there is no consensus regarding the use of contraception among the Muslims although conservative Islamic leaders have openly campaigned against the use of condoms and other birth control methods (Dawud 2008). Nevertheless, the influence of religion has stiffened the transmission of adequate and accessible information through radios, televisions and also through schools (Ntozi et al. 1999).

Marital Status

Pertaining to marital status, the argument is that married people highly depend on their spouses for approval of modern contraceptive use. In the contrary, the non-married women do not usually seek approval from any one in matters concerning contraceptive use. Thus, husband's non approval was cited as the major reason for non-use of modern contraceptive among the married women (Odimegwu 1999). Thus, the low utilization of modern contraceptive services among married women in many developing countries would not be surprising. On the same note, women in male headed households are regarded to have reduced odds of modern contraceptive use when compared to their counterparts in female headed households (Wener 1993; Sembajwe and Makatjane 1987).

Policy decisions and other health related factors

Contraceptive use could also be influenced by factors related to countries' direct policies and other health providers of the contraceptive services. For instance, a study by Oddens and Lehert (1997) found that the choice of contraceptive method was influenced by health care policy, the organization of the relevant services and differential provider preferences.

Other contextual factors

In the study on contextual influences on modern contraceptive use among women in Kenya, Malawi, Tanzania, Ivory Coast, Burkina Faso, and Ghana, Wamala et al.(2014) noted that women in the younger ages (especially the age group 20-29) were more likely to use modern contraceptive methods. These findings are supported by studies carried-out in the early 1980s (e.g., Bongaarts and Potter, 1983). Their study noted that age specific contraceptive prevalence rate increase with age of women until a maximum is reached in the age group 30 – 34 and declines at older ages. With regards to parity, the consensus is that contraceptive use is more likely among women with higher number of surviving children (Agyei and Migadde, 1995; Rutenburg, et al. 1991). Also, many women reject contraception because bearing and raising children is the path to respect and dignity (Barnett and stein 2001).

2.3 The concept of marriage

Marriage and family are two important concepts that cannot be avoided when addressing issues regarding contraception and pregnancies. The family system in the 'Akan' community (the study area) has been briefly outlined under the chapter on methodology.

In the Akan community, the family determines who and where an individual can marry/or marry from. There are also procedures of marriage as well as various marriage forms.

Numerous definitions have been given by theorists on marriage that ranges from the union between a man and a woman to the union of a man and a man, a woman and a woman. For this thesis, the definition of marriage given by Sherif Girgis, Robert P. George, Ryan T. Anderson (2011) is highlighted. According to them, marriage is a union between a man and a woman who make commitment to each other permanently and exclusively and with a common interest of bearing and rearing children together. The marriage is sealed and renewed through conjugal acts: acts that start the behavioral part of the reproduction process. These

conjugal acts unite the spouses as a reproductive unit and it is the basis on which marriage stands to be valuable and basic unit of society.

A number of marriage forms have operated in Ghana since colonial times, these are: customary law marriages; Ordinance (monogamous) marriages (under legislation introduced in 1884/1909); Islamic marriages (under the Marriage of Mohammeddans Ordinance which permits polygyny); and marriages based on mutual consent (Sally Baden et al. 1994). Sally Baden et al, (1994) calls the co-existence of various forms of marriages as "parallel systems" and hold the view that these parallel systems have led to the problem of who is "legally recognized as a wife or child" in Ghana due to the existence of marriages and concubinages in the country.

According to Sally Baden et al. there are quite a less number of concubinages (mutual consent forms of marriages) otherwise known as lover marriages ('mpena aware' in Akan language). This form of relationship or marriage is characterized by less family involvement usually proceeds the legal marriages. Older women who are divorced are more likely to engage in this form of marriages when extended family members become less involved in their consequent marriage issues (Sally Baden et al. 1994).

Contrarily to concubinage, customary law requires the consent of family in the marriage process and recognises marriage not just as a union between two individuals. Rather, marriage is seen as a union between families in customary marriage. This is evident in how the consent of families constitutes an element of customary marriage, followed by the payment of bride price with the holding of ceremonies (Sally Baden et al. 1994). There is no minimum age for marriage under customary law and this form of marriage also allows for polygyny which is reinforce by post-partum sex taboo and menstruation sex taboo. Also, customary marriages are required by the new legislation brought in 1985 to be registered within three months (Sally Baden et al. 1994).

Similar to the customary marriage that permits a man to marry as many women that he can afford, the Islamic marriage or marriage of Mohammeddans Ordinance also permits a man to marry as many as four women. Muslim marriages and divorces are supposed to be registered under the Mohammeddans Ordinance which is regulated by Islamic law but most Muslim marriages are regarded as customary marriages since they are not registered under this law (Sally Baden et al. 1994)

Unlike customary and Islamic marriages, marriages contracted under the Marriage Ordinance is monogamous, that is, there is no room for polygyny (one man marrying more than one wife) or polyandry (one woman marrying more than one husband). Neither of the partners to the marriage can marry another person whether under the Marriage Ordinance or customary law unless a partner dies or the marriage is legally dissolved. The law provides that, if a man presently married under the Ordinance marries another woman, this new wife will not receive any legal rights or benefits of a wife, and the man is said to have committed the offence of bigamy which is punishable by law (KMA 2017).

Marriages contracted under the ordinance can be held in three ways: ordinance marriages can be officiated by a Registrar of Marriages who stands to be an officer at the Registrar Generals Office, Metropolitan, Municipal or District Assembly (MMDA) and has the responsibility to perform marriages; another way is for the marriage to be contracted by a Marriage officer/Minister. A Marriage Officer is recognized as a "minister of a religious body who has been duly licensed and gazette to perform marriages"; the third way is for the marriage to be performed through Special License. In this type of marriage, the Registrar General's Office, Metropolitan, Municipal or District Assembly relinquishes certain conditions for an Ordinance Marriage such as "the length of time for notices or permits a venue (other than the Registrar General's Office, MMDA or church) to be used for the performance of the marriage" (KMA 2017).

2.3.1 Gender roles and power relation

According to psychologists such as Sandra Bem as cited by Crespi (2017), the division of people into groups is one of the cognitive processes that is unavoidable in humans and in human society. These groups can be based on race, age, religion, etc. one other basic categorization is based on gender, and gender is the first thing an individual can easily determine when she/he meets someone for the first time. This categorization of human beings based on gender is typical of man and also occurs automatic and therefore virtually impossible to suppress the tendency of using gender as the divider to fragment the world in two. The division of the world into two groups: males and; females tend to make human beings consider all males to be similar and all females' similar and thereby differentiating males from females (Crespi 2017).

Through socialization, gender roles are inculcated into the individual. Socialization is "the lifelong process of inheriting and disseminating norms, customs and ideologies, by providing an individual with the skills and habits necessary for participating within his or her own society" (Gyasi 2015). Gender socialization is "the process by which people learn to behave in a certain way, as dictated by societal beliefs, values, attitudes and examples" (Gyasi 2015). Gender socialization is said to begins as early as when an individual becomes pregnant (Gyasi 2015). This is realized through the comments and judgments that people make about the value of males over females even before the child is born. These gender stereotypes are a result of people having different expectations for males and females and the stereotypes are perpetuated by family members, teachers and other members of the society (Gyasi 2015). In the Ghanaian society for instance, when a woman gives birth to a male child she is said to have given birth to 'Nnipa'[2]. This stereotype is based on the perceptions that people have and the values placed on males over females.

Gender socialization continues through childhood and children learn at a very early age what it means to be a boy or a girl in the society through "their selection of gender-specific toys", also through "gender based assignments". Through countless activities, opportunities, criticisms (positive and negative), explicit behaviors, advices, direction, etc., children continue to go through the process of gender role socialization. Children in one way or the other, experience some form of gender bias or stereotyping, this can be based on the perception and expectation that "boys are better than girls at math or the idea that only females can nurture children" (Gyasi 2015). As children grow, other environmental elements reinforce the gender stereotypes and biases they are exposed to at home and thus these stereotypes and biases perpetuate throughout childhood and continue into adolescence (Martin, Wood, & Little, 1990 cited by Gyasi 2015).

A study conducted by Oxfam as cited by Gyasi (2015) revealed different gender roles inculcated in and expected of males and females. For instance, adolescent males were expected by their parents to be strong as adults, to behave like their fathers, and to be able to control and protect women. As a way of reinforcing gender roles, parents are tended to be proud of their sons if they are "tough, strong, brave, and more of a 'man'", and parents are also proud of daughters if they are "helpful in performing household chores, obedient, and

[2] 'Nnipa means human being in the Akan dialect

beautiful". "Boys were given priority and entitlement over their female siblings by being their providers and being made responsible for their security and honour" (Gyasi 2015).

As the individual grows into adulthood, the socialized roles manifest and the typical man behaves as a matured boy as he "perceives his role to be the provider for the family, a decision maker, an authoritarian, a protector who is powerful and strong, and who punishes his family members when they make mistakes" (Gyasi 2015). Women are expected by men to be dedicated and devoted to their families and the woman will earn the trust of her family and husband if these roles are fulfilled. Nevertheless "paid employment for women is perceived to jeopardise this role, threaten male supremacy, and challenge the control exercised by men. Men considered respect, obedience, and marital obligation as non-negotiable rights. Some men questioned their future role in the event of women becoming providers" (Gyasi 2015).

2.3.2 Power relation in marriage:

In marriage relationships, men and women play different roles; one of the essential differences in the roles played by women and men within marriage relationships involves power (Gerber 1991). Men are usually observed to exercise more power than women and this power possessed by men over women has been perpetuated through traditional gendered roles (DLP 2015). For instance, traditionally women are not expected to speak up in public meeting and this limits their access to decision making. Contrarily, a "real man" is traditionally expected to be outspoken; to be in control; to be able to impose his will (DLP 2015). This cultural expectation on the part of men tend to give men some kind of influence when it comes to decision making both in the family and in the public spheres.

Power is "the ability or potential to influence or control the behavior of another person". "If power is equated with an ability of some sort, then to say that a person has the power to do something is to say that he can do that thing. In this conception there is no implication that the person will do that thing. The most that may be ventured is that the person may exercise his ability" (Boyd C. Rollins and Stephen J. Bahr 1976).

In sexual relationships or marriage therefore, 'power' being equated to 'ability' implies that if men have power in marriage, then men can influence the behavior of women in marriage as

Rogers (1974)[3] argues (Boyd C. Rollins and Stephen J. Bahr 1976). There is therefore no implication that men will influence the behavior of women in marriage but it is likely that men will exercise their ability to influence women behavior in marriage. There is the possibility that an individual might have power over another but might not control the person's behavior. This happens when the person with high relative power makes no attempt to control the other person with less relative power (Boyd C. Rollins and Stephen J. Bahr 1976).

Boyd C. Rollins and Stephen J. Bahr (1976) argue that "power is not conceived as an attribute of an individual but as a characteristic of social interaction between two or more persons". All human beings are born equal in freedom and in rights but the society determine who should have more power and who should have less power in all spheres of life. Power balance between men and women is socially constructed and inculcated in them through socialized gendered roles. According to Cartwright (1959) as cited by Boyd C. Rollins and Stephen J. Bahr (1976), "power is a relationship between two agents; it is not an absolute attribute of a single individual". An individual cannot exercise his power on himself but rather the extent of his/her power can be realized when there is a social relationship.

In this concept of power, the phenomenon of interest is the relative power of a man and a woman in sexual relationship (or marriage) and not the personal attribute(s) of any one of them (Rodman 1972 cited by Boyd C. Rollins and Stephen J. Bahr 1976). To understand power, some theorists have identified resources and authority as the bases of power in marriage. "a resource is anything that one partner may make available to the other, helping the latter satisfy his needs or attain his goals" (Boyd C. Rollins and Stephen J. Bahr 1976). According to Rodman (1972) as cited by McDonald (1980), "the balance of marital power is influenced by the interaction of (1) comparative resources of husband and wife and (2) the cultural and sub cultural expectations about the distribution of marital power". Further, Burr (1973) predicted a relationship between economic resources (such as education and occupation) and marital decision making.

[3] "An ability does not have to be exercised" Rogers (1974:1420) as cited by Rollins and Bahr (1976).

2.4 Theoretical perspective of the study

This study adopts diffusion of preventive innovation as its theoretical framework in the scope of social sciences and health.

The diffusion model

According to Rogers (2002) diffusion is the process by which an innovation is transferred through certain channels over a period of time and among members of a social system. An innovation can be defined as "an idea, practice, or object that is perceived as new by an individual or unit of adoption" (Rogers 2002). One question which can be asked is "why do certain innovations spread more quickly than others?" This question can be explained by the characteristics of the innovation. These are: Relative advantage; Compatibility; Complexity; Trialability; and Observability (Rogers 2002).

Relative advantage is the rate at which an innovation is seen to be better than the idea it replaces (Rogers 2002) . With relative advantage, the objective advantage of the idea does not concern so much but rather what matters is whether individuals perceive the innovation to be advantageous. This study explores people's perception on the advantages they get from using contraceptives rather than the objective advantage of contraceptives

Compatibility is another characteristic of an innovation and can be defined as the rate at which an innovation is seen to be consistent with existing values and norms of the society, consistent with past experiences of individuals, and consistent with the needs of other potential adopters of the innovation (Rogers 2002). This perspective helps in understanding whether women use contraceptives because their society accepts it or they do not use them because society frowns on it.

Another characteristic of an innovation is complexity and it can be understood as the rate at which an innovation is seen as difficult to understand and use. Again, this characteristic of an innovation forms the basis of an understanding on how easy or difficult is it for women to understand and use contraceptives. This perspective is used to analyze the factors that influences the use of contraceptives among women.

Trialability is the rate at which an innovation can be experimented on a limited basis (Rogers 2002). This characteristic of an innovation helped in understanding why some types of

contraceptives are preferred over others. In analyzing people's perceptions on contraceptives, trialability as a feature of an innovation forms the basis of finding out peoples preference for contraceptives in general and specific types of contraceptives in particular.

Observability is the rate at which the results of an innovation can be seen by others (Rogers 2002). This characteristic of an innovation helps in understanding respondents perception on the use of contraceptives as well as the reasons why they use or do not use contraceptives.

Preventive innovations

Preventive innovation can be defined as "new ideas that require action at one point in time in order to avoid unwanted consequences at some future time" (Rogers 2002). According to Rogers (2002), the rewards that individuals receive for accepting and using preventive innovation are "often delayed in time, are relatively intangible, and the unwanted consequence may not occur anyway".

This research focuses on the pull and push factors in the acceptability and use of contraceptives in relation to pregnancies. Thus, using contraceptives to prevent unwanted pregnancies. When individuals use contraceptives they would not suffer the health related risks that unwanted pregnancies would have brought. This is what Rogers highlights as low relative advantage of preventive innovations and this low relative advantage according to him can affect the rate of diffusion and adoption of preventive innovation.

According to Rogers (2002), strategies that can be used to enhance diffusion of preventive innovation include the following: Change the perceived attributes of the preventive innovation; Use champions to promote the preventive innovation. Champion can be said to be someone who uses his personal influence to inspire the use of an innovation; Use peer support to change the norms and values of the society that concerns the preventive innovation; Practice "entertainment-education" to support preventive education. Thus, introducing educational values on prevention in entertainment messages.

With regards to Rogers's strategies, the study highlights some government policies on reproductive health as a whole and contraceptive use in particular and based on the research findings recommendations have been made under chapter 5 of this thesis on the strategies to be adopted in policies and programs towards enhancing contraceptive use.

2.5 Conclusion

This chapter has presented literature which has been reviewed on the subject matter of the study. The literature covers the concept of contraception, benefits associated with contraception, the types and brands of contraceptives, sources to the access of contraceptives, sources of contraceptive information available to women, and essential factors associated with effective use of contraceptive methods: education; geographical location; employment status; religion; marital status; policy decision and other health related factors. Literature on the concept of marriage, gender roles and power relation has also been reviewed. Again, the chapter presents the theoretical perspectives of the study, that is, diffusion of preventive innovation by Rogers (2002). The next chapter presents the methodology adopted in the study.

3 Chapter 3: Study methodology

3.1 Introduction

The purpose of this research is to identify the pull and push factors in the acceptability and use of contraceptives among women in the Kwabre-east district of Ghana. This chapter describes study design, study area, variables, study population, sample size estimation and sampling technique, data collection/technique, quality control, data processing and cleaning, data analysis and ethical considerations procedures involved in the study.

3.2 Research design

The research design refers to the master plan or framework guiding the conduct of the research (Yin 2003). He identified three conditions that determine the choice of a research design including the type of research questions asked, the researcher's control over actual behavior and the focus on current happenings. There are two types of methods of research which are normally the most used in the collection of data; these are identified as following: quantitative and qualitative methods (Ghauri et al. 1995). Since the focus of this research was to explore, understand and describe the factors influencing contraceptive use among reproductive women, the methodological approach was qualitative. Qualitative research is "an approach to social science research that involves watching people in their own territory and interacting with them in their own language, on their own terms." (Kirk, J. and Miller, M.L. 1986). Qualitative methods often refer to case studies where the collection of information can be received from a few studying objects (Bryman and Bell 2007). Furthermore, qualitative methods emphasize on understanding, interpretation, observations in natural settings and closeness to data with a sort of insider view (Ghauri et al. 1995). This implies that qualitative approach enabled me to study individuals in their natural setting (Creswell 2014) where their experiences occurs thereby enabling them to freely express themselves and give an undisrupted account of their perceptions on contraceptives.

Qualitative approach was best to use in this research because of the sensitive nature of the phenomenon under study. As I have highlighted above, in Ghana, individuals keep decisions on contraception to themselves and may shy away from discussion in public due to societal norms, values, perceptions, and people's worldviews. Through qualitative approach I was

able to interact with them in their local language and establish good rapport with them. I believe this enhanced their participation since they accepted me as an insider and not an outsider.

Again, through qualitative approach I was able to maintain "a focus on learning the meaning that the participants hold" about contraceptives throughout the research process (Creswell 2014). Thus, the pull and push factors in contraceptives acceptability and use was explored through individuals perceptions by conducting interviews and thereby reducing biases to some extent since the focus was not on the meaning that I (the researcher) brought into the research or the meaning that writers express in the literature I have reviewed (Creswell 2014).

Further, qualitative approach enabled me to give a "holistic account" (Creswell 2014) of contraceptives use. Thus, I have reported multiple perspectives such as pull factors, push factors, and government policies on contraceptives use in Ghana. A number of pull and push factors have also been identified and the findings have also been highlighted.

3.2.1 Research Philosophy

Research philosophy refers to the assumption and beliefs that govern the way we view the world (Saunders et al., 2007); it underpins the general approach and direction that a researcher chooses to take about the whole research. These assumptions about reality are closely linked with the methodological approach pursued and the methods employed in collecting data, as well as the sources from which the data are gained (Mason, 2002). In most case, research is influenced by two broad philosophical dimensions; positivism or interpretivism or phenomenological beliefs. Due to qualitative methodology adoption for this study, the interpretivism or phenomenological beliefs was assumed which rests on qualitative research (Bryman, 2012). In other words, the qualitative researcher operates from an interpretivist point of view, employing methods of data collection that are flexible and sensitive to the social context in which the data are being produced (Grix, 2004).

To the interpretivist, reality is a complex social construction of meanings, values and lived experience (Grix 2004). Thus, knowledge is therefore built through a social construction of the world. The interpretivist therefore tends to employ research methods and data collection techniques that allow the research subject to interpret his or her own experience of the world.

3.2.2 Research Strategy

Within the qualitative research design, the case study strategy was used to identify the pull and push factors in the acceptability and use of contraceptives among women in the Kwabre-east district of Ghana. According to Yin (2003), case study designs are particularly necessary for research study that seeks to explore or explain the "why" "how" and "what" aspects of the study. In the views of Bryman and Bell (2007), the case study design involves detailed and intensive analysis of a single or few cases where the complexity of the nature of the case is sincerely studied. However, there are limitations regarding the case study design; the external validity is questioned when using this method since one or a few cases cannot represent a certain group of individuals or organizations. The purpose of the case study is not to generalize the findings to other cases or larger populations (Bryman and Bell 2007). The focus is rather on the cases and their distinctive contexts and to create a framework for discussion of the issue. The multiple-case study design which has been chosen for this research allows the researcher to compare and contrast the findings from the different cases as well as to consider what is common and what is unique across the cases. This strategy helped me (the researcher) to choose few cases and probed deeply for explanations. It therefore enabled me to understand, describe and interpret the social conditions of the participants, the shared meanings of their everyday social worlds, and how they perceive the world around them in their social setting.

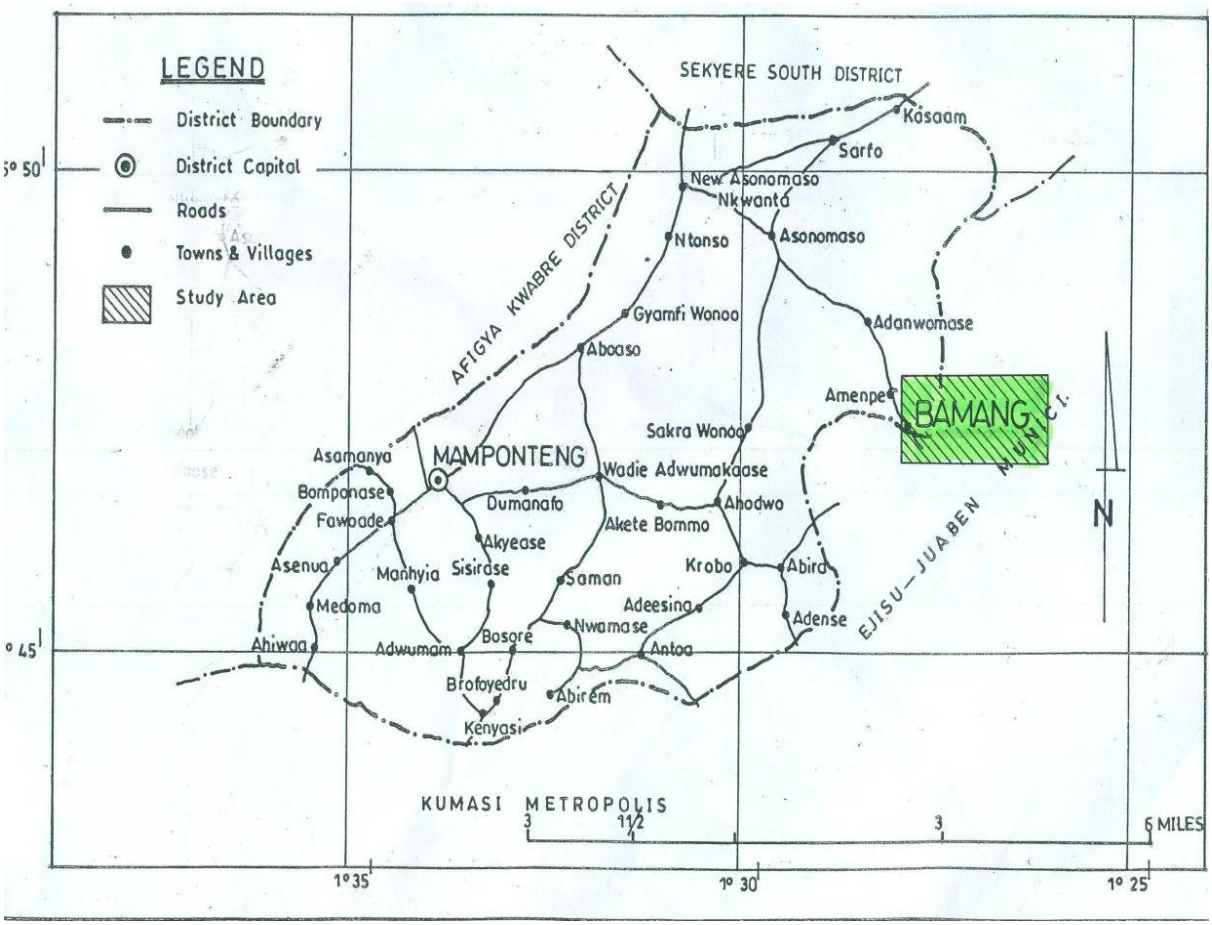
Finally, the case study approach enabled me to capture the words and the unadulterated experiences of my respondents in their cultural context. The data was thus very useful in explaining the phenomenon from the participants' perspectives.

3.3 Research site

To situate the study in its geographical, historical and cultural context, this section provides information about Kwabre East district, the study area. The description would enable readers to appreciate the context within which the phenomenon of contraceptive use among women is being discussed.

The research was conducted in the Kwabre East district of Ghana. The Kwabre East district is one of the thirty Administrative districts of the Ashanti region of Ghana and shares boundaries with Sekyere South District to the North, Kumasi Metropolis to the South, Ejisu

Juaben District to the East and Afigya Kwabre District to the West with total land area of 123 square kilometres. Its capital (Mamponteng) is approximately 14.5 kilometers from the Ashanti regional capital (Kumasi). According to the 2010 population and housing census, the district has a population of 115,106 with total fertility rate of 3.4 (2010 Population and Housing Census 2014)[4] compared to Ghana's total fertility rate of 3.28 children per woman (2010 Population and Housing Census 2013)[5].



This site is chosen for the research because of its established high fertility rate. Participants for the research were selected from both the rural and urban centers of the district. I conducted the study in one municipal district out of the 216 districts in Ghana. This relatively constrained sample might not be large enough to generalize to the other regions of Ghana. However, this municipal district was found to be representative because it has characteristics

[4] Available at http://www.statsghana.gov.gh/docfiles/2010_District_Report/Ashanti/KWABRE%20EAST.pdf(accessed on 22/05/2016)

[5] Available at http://www.statsghana.gov.gh/docfiles/publications/2010phc_monograph_women_&_men_in_Gh.pdf (accesses on 22/05/2016)

of both urban and peri-urban (rural) districts in Ghana. In Ghana, there are three different levels of districts: metropolitan, municipal and peri-urban. The selected district has characteristics of both urban and rural, while other districts were either urban or rural. The capital of one of the regions in Ghana is in this district, and is a nodal town (where roads from nearby villages and towns converge). All surrounding villages are accessible, and travelling expenses were less costly than if I had conducted the study in another district.

3.4 Political Administration

Both Mamponteng and Bamang, as already indicated are part of the Kwabre East District headed by a District Chief Executive who has political authority over the entire district. For effective administration, the district has been sub-divided into units. The unit or local committee is headed by an assembly man or woman (Kwabre East District Assembly 2006).

3.4.1 Traditional Political Administration

In line with Asante's culture, traditional administration is decentralized. Each unit is headed by traditional ruler who mobilizes the people at the local and community levels for development. Traditional leaders ensure peace in their local communities by settling disputes and conflicts under their jurisdiction.

The Family System - "Abusua" in Mamponteng and Bamang

The constitution of these sampled communities is based on the family system (*Abusua)*. Like any Ashanti town or village, there are eight established clans (*Abusua*) namely**:** *Oyoko, Bretuo, Agona, Asona, Asenie , Aduana (Atwea, Abrade) Ekuona* and *Asakyire.* Every native of the village is a member of one of the above clans (*Abusua)* and can trace his or her descent through the female line to the founder of the *Abusua*. Members of the *Abusua* are considered to have the same blood, and marriage between them is therefore forbidden (Nkansa-Kyeremateng 2010).

3.4.2 Inheritance and Succession System in the Study Area

Like Ashanti traditional system, both communities practice the matrilineal inheritance system. The principles governing inheritance stress sex and age – that is to say, men come before women and seniors before juniors. There is also uncle-nephew relationships that assumes a dominant position (Assimeng 1999) and gives priority to a man's nephew over his own children in terms of inheritance.

3.4.3 Profile of Mamponteng

Mamponteng is located at the south western part of the Kwabre East District in the Ashanti region of Ghana. The place is accessible from Kumasi from the Kumasi-Mampong main highway. Mamponteng is the capital town of the Kwabre East District and therefore hosts the residence of District Chief Exeecutive (DEC) and heads of all the decentralized units of government.

The 2010 population census puts the total population of the village at 2,628 (Ghana Statistical Service 2010). Majority (about 95 per cent) of the inhabitants are settlers. This implies that Mamponteng has seen very large diffusion in terms of culture, dialect, norms and values.

Traditionally, the people of Mamponteng are predominantly Ashantes, one of Ghana's major ethnic groups. Traditionally, Bamang is part of the *Adonten* division of the Asante union. This means that the *Odikro* (Chief) of Bamang serves the Golden Stool through the *Adontenhene. Adonten* is a military term in *Akan* language which refers to the main body or the middle infantry of the traditional army. Bamang stool also belongs to the *Asenie* clan.

The climatic condition of Mamponteng is not different from that of the general climatic conditions of the middle belt of Ghana.

Majority of the economically active population are self-employed, mainly in the private informal sector, which provides job opportunities, particularly for females with little or no formal education. There are also formal jobs which are predominantly controlled by 'foreign' inhabitants in the area of education (administrators and teachers), health (nurses, doctors and health administrators), assembly staff, decentralized unit staff and few private formal jobs.

In terms of education, the town is said to be highly literate as about 76 percent of the population of the district are literates. The district has all the educational facilities that can be found in all the big cities in Ghana. However, most of the educational facilities are located in Mamponteng with both public and private providers at all the levels (Basic, Secondary and Tertiary levels).

Access to healthcare in the city is adequately covered with a number of health facilities including 4 health centers, 3 maternity homes, 5 school clinics, 7 private clinics, 3 private hospitals (KEDA 2013).

3.4.4Profile of Bamang

Bamang is located at the south eastern part of the Kwabre East District in the Ashanti region of Ghana. The place is accessible from Kumasi by three routes. The most popular route by which the residents get to and from Kumasi is the Antoa - Bonwire road. Sections of this road particularly, from Duase to Antoa, are dusty with potholes and "trenches". The first alternative route is the Kumasi-Accra highway. At Ejisu, Bamang bound vehicles go through Juaben - Effiduase road and make a detour at Bomfa to Bonwire and then Bamang. The second alternative route is the Kumasi - Mampong highway, a detour at New Asonomaso through Old Asonomaso, Adanwomase and Bonwire to Bamang.

The people of Bamang are predominantly Ashantes, one of Ghana's major ethnic groups. Traditionally, Bamang is part of the *Adonten* division of the Asante union. This means that the *Odikro* (Chief) of Bamang serves the Golden Stool through the *Adontenhene. Adonten* is a military term in *Akan* language which refers to the main body or the middle infantry of the traditional army. Bamang stool also belongs to the *Asenie* clan. Within the *Adonten* division the *Odikro* (Chief) of Bamang is the *Nifahene* (Chief of the right wing) and is thus a very important personality in the *Adonten* division. Some of the prominent opinion leaders in Bamang include the Queenmother, the linguist, herbalists, religious leaders and teachers.

The climatic condition of Bamang is not different from that of the general climatic conditions of the middle belt of Ghana. The village used to have a large track of forest in the past, however, bushfires, indiscriminate felling of trees and continuous crop cultivation partly due to increased population have left very little of the forest. The soil of Bamang is loamy with

food crops such as cassava, maize, cocoyam, plantain, and vegetables are produced in Bamang.

Majority of the economically active population are self-employed, mainly in the private informal sector, which provides job opportunities, particularly for females with little or no formal education. The major economic activities in Bamang are '*kente'* weaving and farming. Almost all the economically active female population in the village is engaged in agriculture, mainly the cultivation of food-stuffs and vegetables for home consumption.

Data from the Kwabre East District Assembly Office at Mamponteng, shows that Bamang's population is growing steadily from 1663 in 2000 to 2079 in 2005. The 2010 population census puts the population at 2628. Forty-one per cent of the population fell within 0-14 year group, 52.3 per cent in the 15-64 year group and 6.2 per cent fell within the 65 years and above (Kwabre East District Assembly 2006). Majority (about 98 per cent) of the inhabitants are indigenes. This implies that Bamang has seen very little diffusion in terms of culture, dialect, norms and values. The nature of houses is mixed. Although there are relatively new houses, thus cement blocks houses, mud houses are still widely found in Bamang.

All the three major religions in Ghana namely Christianity, Islam and traditional religion, are well represented in the village although the Christian religion dominates in the village. Christian denominations that were found there are the Roman Catholic Church, Church of Pentecost, Assemblies of God Church and the Methodist Church. The rest are the Presbyterian Church, the Seventh Day Adventist Church, New Jerusalem Church, The True Church of Christ and the Healing Faith Church. Adherents of Islamic religion, however, constituted an insignificant proportion of the population. One small mosque in the village serves the Moslem community. A number of traditional gods (*Abosom*) were also found in the village.

In terms of educational infrastructure Bamang has only basic schools. These are: one Junior High School (public), one primary school (public), one primary school (private) and one pre-school (Government). These schools lack library, computers, and modern learning facilities.

The village has no hospital or clinic. The only semblance of a health facility is one small chemical shop which sells only basic drugs. The nearest health facility is located in Bonwire about two kilometers (2 km) from Bamang, but this facility has no permanent doctor. As a

result of these conditions, self-medication is rife in the village since the chemical shop in Bamang or the chemical shops in Bonwire, however, community health workers ocassionally visit the community to promote community health.

Access to potable water in Bamang is also problematic since the entire village had only one borehole serving the over 2000 inhabitants. The sanitation situation in the village is not ideal. Toilet facilities available in the village are pit latrines. All the people depend on public toilet facility except a handful of houses which have their own toilet facility.

Telecommunication services are available in the village. Vodafone mobile services, MTN, TIGO, and Airtel are all available with different signal strengths depending on one's location. The village receives broadcasts from all the major television stations in the country, thus Ghana Television, Metro Television, TV 3, and TV Africa.

Bamang like any other village in the Ashanti region of Ghana is a social as well as an economic community. Everyone is expected to participate in the major ceremonies. The most popular ceremonies are marriage, funeral celebrations and naming ceremony.

Like many other rural communities in Ashanti region, observation of taboos is an important aspect of their social lives. For the people of Bamang, Friday is a sacred day and the day is observed by all the inhabitants. No farming activity is undertaken on Fridays (site visit and study by the researcher).

3.5 Study Population

The study population was all reproductive women aged between 18-49 years in Mamponteng and Bremang of the Kwabre East District of the Ashanti region of Ghana. The areas were selected because the researcher had extensive experience and contacts working with the local population during National Service. Again, Mamponteng the district capital represents a town that has seen major development and receives all manner of people. Mamponteng therefore represents the urban area of the study while Bremang represents a rural setting of the study.

Criteria used to select villages were: diversity in size, density, occupations, infrastructure development, administrative importance, and distance/access to the researcher; good contacts for the researcher to gain rapid entry and collaboration in the village

(i.e., respected village health workers, cooperative village chiefs, and experienced government extension agents known to the researcher); and travel logistics for the researcher and translator given time constraints.

3.6 Target groups

Primary target group

The primary target groups are reproductive women aged between 18-49 years (married and unmarried). I selected reproductive women aged between 18-49 years because I believe women in this age category would be comfortable to discuss issues concerning sexuality with me than those who fall outside this age category. Also, both married and unmarried women were the primary target group because of the focus of the research which is to explore the pull and push factors in the acceptability and use of contraceptives among women.

Secondary target group

Secondary target group comprise of: married and unmarried men, community health nurse; and District health director. These individuals are the key informants of the research because one of the objectives of the research is to explore peoples' perception on contraceptives and these groups of people are fundamental in issues concerning contraceptives use. For instance, Health providers play an important role in the provision of contraceptives services.

3.7 Recruitment of participants

A total of 20 participants were selected for the research through different means. Thus, 8 reproductive women aged between 18-49 years (both married and unmarried), 8 men (either married or unmarried but are related to the women selected), 2 health workers and 2 officers from the Ministry of Health (the District Health Director and the Public Health Nurse). The study employed non-probability sampling techniques. I also employed a combination of purposive, convenience, and proportional sampling techniques to select the study areas and study participants. With purposive sampling, participants were purposefully chosen based on their ability to provide information relevant to the study (Patton 1990). In the first place, Purposive sampling was done in a strategic way so that those selected are relevant in answering the research questions. Individuals with different key characteristics were selected

in order to be able to answer all the research questions (Bryman 2012). I used a purposive sampling technique to select Mamponteng and Bremang (growing urban and a peri-urban or a village respectively).

I also purposively selected the public health nurse and the District Director of Health services for this study. I purposively invited those personnel for the study because of their positions (characteristics) and expertise in the topic under investigation. These people were considered key informants because of their ability to provide information on specific areas relevant to the study.

I also used proportional sampling to invite four reproductive women and four men from each of the two communities in the district. The primary purpose of this sampling process is to ensure that each stratum (circuit) was represented by an adequate sample size as part of the total population (Rea, & Parker 2005). The reason for using this procedure was to ensure that both urban and rural communities were represented in the study.

Also, I used the convenience sampling to select the reproductive women aged between 18-49 years (both married and unmarried) from the two communities. At Bremang, every Friday which is declared as 'holiday' by the traditional authorities, the Community Health Nurses from the District Health Office visit the community to provide health services to the inhabitants. So I took advantage of that day because most women including nursing mothers, pregnant women and those with minor sickness attend their services. At the center, I interacted with these women and conducted the interviews on them based on the criteria to participate in the study. Also, at Mamponteng I interviewed women who had visited the health center for Family Planning services.

Finally, I equally used the convenience sampling to select men who are connected with the reproductive women from the two communities. After selecting these women, I requested from these women to see their husbands (for those women who were married) and sexual partners (for those women who were not officially married but in a sexual relationship).

3.8 Data collection tools

Due to the nature and approach of the study, the qualitative methods of data collection were used. I therefore employed both primary and secondary sources of data.

The Primary data constitutes the information obtained from the instruments that were sent out to collect data from the study participants. The primary data sought from the respondents or participants who are those selected as the sample units. For this study and with emphasis on qualitative design, the in-depth semi-structured interview guide and observation were mainly used for data collection.

I also used secondary sources involving information derive from other people's works (published and unpublished works), official documents from the relevant organizations, and published work on programs and policies on contraception/family planning. The secondary data from documented sources including published literature, official records and internet search for current publications and information were evaluated and used for the study. The official records included information on the study area collected from the office of the Kwabre East District Assembly, the Ghana Health Service and the Ghana Statistical Service. The community official records provided an insight into the geographical, political, socio-economic, cultural and demographic context within which the study was being undertaken.

The relevant information from the secondary sources was reviewed to ensure proper understanding of the subject under investigation. It also helped to give an insight into existing information on the subject and identify gaps between current knowledge and how these gaps could be further investigated.

3.8.1 In-depth Interviews

Interview is a verbal conversation between two people with the objective of collecting relevant information for the purpose of research (Bailey, Hennink and Hutter 2011). It allows respondents to speak out their opinions, feelings, beliefs, insights, attitudes and experiences about a problem in question through the use of probing questions. The purpose of the interviews was to obtain description of the lived world of the interviewees with respect to the interpretations of the meaning of the described problem (Kvale 2009). With this instrument, it was possible to ask follow-up questions in order to get richer information. Informants were available to clarify immediate concerns and unclear statements (Gall, Gall & Borg 2007). Also through the establishment of trust and rapport with the informants, a researcher is likely to get more information by using in-depth interview compared to other methods of data collection.

To collect empirical data on the phenomenon being studied, four sets of interview guides - one for the reproductive women respondents, one for male respondents, another for district health officer, and another for community health nurse – were designed based on the research questions and the objectives of the study. These questions include 1. People's perceptions and knowledge on different types of contraceptives. 2. The type(s) and specific brands(s) of contraceptives that people use most. 3. The perception that people have about the different types of contraceptives 4. How and where women get access to contraceptives. 5. How women get information concerning contraceptives. 6. The agents responsible for reproductive health education, service delivery, and information dissemination. 7. Government policies on reproductive health.

Developing the Interview Guide

The nature of this study necessitates inquiry that focuses more on lived experiences than hypothetical scenarios or abstract concepts (Mason 2002). I therefore made preparations before meeting with an interviewee by outlining key themes and areas of interest that addressed my principal research questions.

I followed Bryman's (2004) advice on the use of the interview technique for data collection. Of particular importance in Bryman's methodology is developing an interview guide based on the research questions; seeking the participant's permission to be interviewed; arranging a mutually agreeable time and place for the interview; the identification of possible interview themes or subjects; deciding the mode of recording the interview (note-taking, tape-recording or both); and avoiding double-barrelled or multiple-barrelled questions.

The questions were simple, logical, straight to the point and easy to read and understand. It also included the combination of both open and closed ended questions to reduce respondent's fatigue (Bryman 2012) as well as allow for clarification and/or expression of opinion by respondents.

Conducting the Interview

All the interviews were audio recorded by my research assistant while I (the principal researcher) took written notes alongside. With this approach, both notes were compared and the gaps were filled. In taking notes of the interviews I used words and phrases that

respondents used in their natural speech. The essence was to capture their experiences in order to understand and interpret the meanings, whether assumed or intended, from their perspectives as close as possible.

The audio recordings were transcribed into English each day after the interview sections. This gave the research team the opportunity to check for inconsistencies in participant's responses. Where there were inconsistencies in respondent's answers, the researcher revisited the participant to clarify the inconsistencies. It also gave me the opportunity to do superficial analysis of the information and themes arising from them which informed further data collection. Interviews were transcribed in a meticulous manner without skipping a word. This path was pursued in order not to ignore or exclude any relevant information.

3.9 Reliability and validity

The two concepts reliability and validity are very important to take into consideration when carrying out a qualitative research since they help to determine the objectivity of the research. Reliability and validity could be seen as two different measurement instruments that illustrate the level of trustworthiness and credibility of a research. Bryman and Bell (2007) explain that reliability and validity are separated into internal and external concepts.

3.9.1 Reliability

Reliability can be defined as the extent to which a questionnaire, test, observation or any measurement instrument produces consistently the same results on repeated trials (Vaus 2002)

Internal reliability refers to whether there is more than one researcher within the study group thus the observers can agree as regards to what they see and hear. External reliability means to what extent a research can be completed again with results comparable to the original study. It might be difficult to achieve high external reliability since the scene and the setting is likely to change from the time of the original research to the time of a second one. However, a strategy mentioned by Bryman and Bell (2007) is to adapt a similar role as taken on by the original researcher in order to be able to replicate the initial research. To ensure that the questions in the interview guides were meaningful and easily understood by the respondents, both interview guides were piloted in other communities. Issues examined included length of the questionnaire, wording of questions, how respondents understood the questions and

ambiguities with respect to some of the questions. The pilot enabled me (the researcher) to modify some of the questions while some were completely removed.

3.9.2 Validity

Validity tells us the extent to which the instrument measures what it was created to measure. (Kombo &Tromp, 2006). According to Vaus (2002) there are several basic ways to assess instrument validity. Internal validity refers to what degree the researchers are able to agree and come to same conclusions, that is, if there is a good match between their observations and theoretical thoughts that they expand throughout the research (Bryman and Bell 2007). Internal validity is usually perceived as strength within qualitative research since the researchers tend to observe the social setting over a long period of time which generally results in excellent correspondence between observations and concepts (Bryman and Bell 2007). External validity, on the other hand, can be seen as a problem within qualitative research, since it refers to the extent that findings can be applicable in other social settings and qualitative researchers generally make use of small samples and case studies (Bryman and Bell 2007). In this thesis, all interviews have been recorded and after transcribing the interviews the material has been sent back to the interviewees to receive their approval of the transcript material in order to increase the validity and to decrease the possibilities of using the authors own interpretation of the data.

3.10 Data analysis

Qualitative data analysis involves the processes and procedures whereby a researcher presents an outcome from a qualitative data that have been collected from research participants. The procedure demands that the data is selected, organized, scrutinized, theorized, described, discussed, interpreted and made available to a readership (Bryman and Bell 2007).

Directly after each interview, verbatim expressions and notes written during the interview were reviewed, clarified, and expanded together with the translator. Within several days, a detailed transcript-like report of these notes was typed up following an outline in which each section sub-topic or idea was numbered.

All data collected were transcribed, arranged and organized to be used in data analysis. Transcribed data was then coded and themes were generated based on the research objectives

and research questions (Robert C. Bogdan and Sary Knopp Biklen 1992). An explanatory approach was employed to do thematic data analysis and conclusions drawn based on the research objectives and research findings. In reporting the information collected, some direct quotations were used. Reporting direct statements from research participants is important, because it helps to maintain the originality of data collected (Cohen, Manion and Morrison, (2007). Also, researchers' views based on the informants' answers were given backed up by literatures reviewed.

3.11 Ethical considerations

Ethics can be defined as a set of values standards and institutional schemes that help constitute and regulate scientific activity (Kombo & Tromp 2006). Therefore, the delimitations and observance of ethical standards was necessary to follow. First and in compliance with the Norwegian authority the minimum standards and requirements for research were met, thus the clearance and authorization for conducting a research was given by the Norwegian ethic committee and the Ghana national research council.

Harm to participants, lack of informed consent, invasion of privacy and deception (Bryman, 2012). In order to comply with this ethical standards, I ensured that the participants physical, sociological and psychological integrity was never compromised or set at stake as a result of the research process and outcomes, by creating a friendly format of the questionnaire with carefully selected neutral language and concepts not to cause annoyance from respondents and by approaching the topics with the necessary respect related to the studied matter. Deception was never an issue in the current research as the goals and objectives were expressed in a written way to the respondents.

Written or verbal permission were sought from all participants and the objective of the research was communicated to them and participants were also made aware that the research is purely for academic purpose and all responses from them were treated with strict confidentiality and that their names will not be mentioned in reporting otherwise with their permission. They were notified of the flexibility of the research. Thus, they were free to withdraw from the research at any time and also free to decide whether or not to participate in the research.

Also for confidentiality, all information gathered was strictly protected and tape recorders and notebooks were destroyed after the research (Bryman 2012). Participants were also assured that they would not be named in any report and their confidentiality would be maintained. The identities of persons and events as well as their actions and comments were altered with pseudonyms to preserve the anonymity and confidentiality of participants in the data. These were emphasized before commencing interview with participants.

Finally, to avoid plagiarism the sources of all materials consulted have been duly acknowledged.

3.12 Conclusion

This chapter has provided the rationale behind the choice of the research methods, sample size and a brief description of the research participants. Also data analysis procedure is discussed. This is a qualitative case study, where the phenomenon of women contraceptive use is characterized as a case. The main instruments for data collection were in-depth interview and key informant interviews. The next chapter presents the analysis and discussions of the field data.

4 Chapter four: Results

4.1 Introduction

This chapter presents the results of the interview data analyses. The presentation of the results is done in relation with the research questions including: 1. what are the various facilitators and barriers to the acceptability and use of contraceptives among women in the Kwabre East district of Ghana? 2. What type(s) of contraceptives do people use most? 3. According to the government policies who are the agents charged with the responsibility of reproductive health services delivery and how do women in the Kwabre East district of Ghana access these services? 4. Which individuals/ institutions are responsible for reproductive health education in Ghana and how is information regarding reproductive health communicated to women in the Kwabre East district of Ghana?

4.2 Demographic characteristics of Respondents

The demographic characteristics highlight the age, religious affiliations, marital status, educational attainment and the number of children of respondents.

4.2.1 Age of respondents

Since the study focused on the reproductive age of women in particular (18-49 years), I examined the age category of the women within this age bracket and the male counterparts. Most of the women participants were between the ages of 20-29years, while most of the male participants were between the ages of 40-49years. The result implies that, these women are in their prime age to give more birth and this is where efforts have to be made to educate and sensitize them of family planning services particularly contraceptive use.

4.2.2 Religious affiliations of respondents

From the data analyzed, the highest proportions of women across the study period were Christian denominations including the orthordose churches such as Catholics and Methodist. Worth noting is a steady rise in the proportion of women belonging to the charismatic

churches. It is a known fact that, the Catholic Church abhors contraceptive use as they believe in the gift of God in the number of children.

4.2.3 Educational attainment of respondents

With regards to education level, the highest proportion of the women across the study period had middle or Junior High School as their highest level of education attained. Further, the results revealed that while most of those with higher education are in the urban setting, those with lower level of education are found in the rural setting. The implication of this result is that educating these women would not be difficult especially using educative materials such as reading materials to facilitate public awareness in contraceptive use.

4.2.4 Employment status of respondents

The results also indicate that most of the women across the study period were employed with various vocations. While most of the women in the rural area are engaged in farming and petty trading, women in the urban area were into businesses and public service works.

4.2.5 Marital status of respondents

With regards to marital status, the largest proportions of women across the study period were married followed by the cohabiting group (‘mpena’ as locally called) while the rest were either single or divorced/separated/widowed.

4.2.6 Number of children of respondents

I also found out that most of these married women have more than two (2) children while the unmarried women have one (1). As most of the women aged between 20 to 29 years with more than 2 children already, the intensification of education on family planning services is critical for birth control and mother’s health.

4.3 Awareness of any contraceptives and modern methods (people’s perceptions and knowledge on different types of contraceptives)

This research question sought the views of study participants on their awareness levels of the types of contraceptives. My aim was to find out from the respondents, their knowledge on family planning methods particularly contraceptives. I realized that the awareness of any contraceptives and modern methods were very high among all respondents and there was little gender variation. The following statements from some of the reproductive women put their perceptions into proper perspective:

"I have heard about it and know some of them…the nurses tell you at the weighing centre, and they also talk to you about it after birth, they explain to you the various types and the ones that will be appropriate for you."

Another female shared her opinion and said;

"I have not done family planning before but those who have done it say that it causes illness…they have the one they put in the arm, the pills, and condom…there are a lot of them but I have not done it before."

> *"Contraceptives are used for protecting ourselves against pregnancy…I know of secure, end tablet, Lydia (Lydia is pills)…during my JHS time, the school had a teacher counsellor who organises counselling sessions for us on Fridays after worship…and I know counselling is conducted in schools, and children starting from primary 5 are taught about Family Planning…this is done through the Life Skills and Sexuality and Reproductive Health Education in primary and secondary schools to empower pupils, students and teachers on HIV prevention, sex and sexuality."*

"I have heard about family planning before…the nurses tell us when we go to weigh our children at the health centre…they say that there are different types: some are drugs, some are string that is put on the womb and in the arm…I also hear it on tv and radio."

> *"I went to do one, it was injection…one day I had blackout and collapsed, so I stopped that one…after I had my last child, I went to the hospital and now am using the implant…I was giving birth too much so I was interested in it…I like this implant, only that I do not menstruate."*

Also, it can be referred from the interview that knowledge on contraceptives is not only limited to women but also men have a great level of knowledge on contraceptives and its uses. A married man had this to say regarding contraceptive use;

> *"I combine both condom and withdrawal methods…my wife brought the condoms home for protection…but sometimes I start the action before I remember to wear the condom…so in the process, I continue the excitement but I withdraw when am about to ejaculate…sometimes ago, my wife discussed with me her intention to further her education and that means putting on hold getting pregnant…I agreed to*

her request and she said she doesn't want to deprive me of my sexual excitement and she is going for family planning measure…we all went to the family planning services center at a health center and they recommended various types of contraceptives."

4.4 Type(s) and specific brands(s) of contraceptives that people use most

This objective sought to find out from the participants the types and specific brands of contraceptives that they use. It also sought to know the reasons for using xthose brands from the respondents. Respondents (both men and women) have firm knowledge on the various types and brands of contraceptives which are categorized into modern and traditional types.

Respondents from a study in urban area (Mamponteng) showed higher levels of use of pills among married women.

4.4.1 What type of contraceptives have you used before?

"I have used condom before, only once…I have used panther condom, it was given to us freely."

"I know of secure, end tablet, Lydia (Lydia is pills)"

"I know contraceptives are the things you do to protect yourself if you do not want to get pregnant...I have heard of the contraceptive called Lydia (it is a Pill you take after 12 hours after sex, that is what I have seen before...I have used men condom before. I have taken end tablet before which is emergency contraceptive...It is a long time I used it, I don't like it but I don't have any reason. If I have sex with my partner, we use the withdrawal method…I don't like the condom because sometimes you hear there are fake ones around".

Similarly, another female respondent had this to say:

"I know of contraceptives and used Emergency contraceptives (End tablet) and condoms all my life…I have used condoms before but I stop using it because some people say that it can harm your womb, and sometimes too you hear that there are fake once".

Further, this research revealed that there is a high patronage and use of the pills over the other modern contraceptives. The interview results confirmed the results. Most of the respondents claimed that the pill is not costly. You are free to buy any quantity you want at a time because

there are different price packages. They are not given for free. I take the pills that is taken daily. (A female respondent from the rural setting).

Although almost all the women interviewed in this research had knowledge of male condoms and had tried it before, its current use is low because of its ability of preventing sexual pleasures. The statement below from one respondent confirms this.

"When my boyfriend uses condom I don't enjoy it. So me I do not like it. I prefer to do it without condom and take the emergency pills after the act".

For the men however, the male condom was the most ever used method. The male condom was less popular in the female study population. However, the sexually active unmarried females' current use was more than that of the married. Reasons such as lack of trust, wanting to become pregnant, stigma of associating condoms with HIV and STIs from prior prevention campaigns among others have been associated with community members avoiding condom use.

A male respondent had this to say;

"I have used condom before, only once and it was given to us freely… I have heard that some people want to use contraceptive, some also don't want to use it. Some use the calendar, some use pills and some also use implant".

It was observed that unmarried sexually active females used any modern and traditional methods of contraception much more than married females in this surveyed population. The withdrawal method was the most prominent of traditional methods used and non-married females "out-used" their married counterparts. A married man accounts confirmed the use of withdrawal method;

> *"for me, I try to withdraw from the woman when I'm about to ejaculate…I don't want any problem…I study my woman and therefore I tread cousciously…sometimes too, my woman tells me that she is in her danger period and so, once she tells me, I have the obligation to prevent pregnancy."*

4.5 Sources of family planning (FP) Messages

In this question, my aim was to enquire from the study participants how they got to know family planning measures especially contraceptive use in their communities. I also made further enquiry if these sources of information are accessible and reliable. The health post or

center dominated the sources of messages about contraceptives and its use among females than their male counterparts. Other sources included the media mostly electronic (both television and radio), friends, relatives, churches and other social groupings. Knowledge of Sources where FP methods could be obtained was not difficult for most of the respondents as most of the respondents knew a place where they could obtain FP services and this did not vary much by gender. Worth noting is the fact that while most of the women preferred the government hospitals/polyclinics, health centers, health posts, CHPS, FP clinics, mobile clinics/outreach services, community based surveillance volunteers (CBSV), field workers and peer educators as venues to obtain FP methods and services, the males preferred the private sector, i.e. the pharmacies, shops, bars and drug stores.

4.5.1 How did you get to know of contraceptives? (Mass media, partner, friends, family, co-worker, etc.)

This question sought to find out from the participants, the avenues or channels through which they got to know these contraceptives.

A female participant shared her account:

'… At the hospital, the nurses introduce you to them after child birth' (married woman respondent)…I heard about contraceptives at the hospital, and also on television…I have even seen the female condom on television before."

"They organised a program at the junction and educated women to protect themselves. I also hear it on television and radio. They used to come around in a car to educate us to protect ourselves."

Another female respondent collaborated this:

> *"I have heard about family planning before. The nurses tell us when we go to weigh our children at the health centre. They say that there are different types: some are drugs, some are string that is put on the womb and in the arm. I also hear it on television, and radio".*

"I always here it on television and radio…when I was leaving at Sewia, they used to come around in a car and announce that we should protect ourselves."

The interview with the Public Health Officer of the District Health Directorate on what the district has done to sensitize the public on family planning issues in the district. She outlined some of the measures:

"as a district, we strategized and prioritized on education of family planning issues which also involve the use of contraceptives…all the health centers in the district provide family planning service…apart from this, during antenatal services, midwives and other staff educate attendants on family planning and contraceptive use…post-natal services also include family planning and contraceptive use for mothers who regularly attend these services either at the health center or arranged area by the community health officials…the Community-Based Health Planning and Services (CHPS) concept has really helped as Community Health Workers are posted to this health post as permanent staff to improve the health of the residents…as part of their mandate, they are supposed to include education on various health related issues including family planning and contraceptive use…areas where there are no health post or CHPS Compound, regularly we send some community Health Nurses to provide health care services to the people…occasionally, we go to churches, mosques to educate their congregations on family planning methods…we also visit senior high schools to engage them on adult reproductive health issues and that include contraceptive use and abstainance from sex…in recent times, we have also been collaborating with some fun clubs and other identified social networking groups to use their platform to educate their members on family planning and other health related issues such as STI, hypetisese B', among others…again, during health week, we embark on public education with platform from the various local radio and community information centers on wide range of health related issues."

How accessible is this medium of information to you?

After participants had disclosed the sources of their information regarding contraceptives, I enquired from them how accessible the channel of information is to them. It emerged that there is a regular information flow from all the mediums mentioned.

"it is only when I go to the weighing centre that the nurses talk about that. the nurses tells us that when you are ready to use contraceptives, their doors are open…So, I think that whenever I went to hear more on contraceptives, I can go to the weighing centre…I also have radio and tv and almost every day I hear about it" (according to one respondent)

Another respondent's view added to this. This is what she said: "Very accessible…we have tv at home, so I see the advert on it." "In my two occasions that I have been to the hospital, I was rendered the service I needed.

The Public Health Officer also responded and said;

"I can tell you that all our services are accessible to everybody and at accessible locations, at least for the health centers, hospitals and CHPS Compounds in various communities, any time one visits the place, one is assured of getting information on family planning and contraceptive use…all our health centers provide family planning services as normal services and so it is an assured source of family planning information…in areas without health post, every week the community health officers visit the communities to attend to nursing mothers, weigh new-borns and use the opportunity to provide family planning education and information…the various television stations advertise contraceptive drugs on their networks and can be viewed by all."

What reasons account for relying on the particular medium?

Reasons for the preference for the medical or public health center varied: among them include the safety and availability of qualified officers to use the injectable, intrauterine device (IUD) implants and sterilization for example are usually administered at health facilities. A female participant's concern raised in an interview goes to confirm this assertion: During the interview it was revealed that respondents believed the best place to access contraceptive services was from the health facility.

"I prefer the health center because they educate our women very well before the provision of the service and it is also cheaper"-(Male, Urban)

"I will prefer to go to the hospital because if you use it and have problems, you can go back to the health facility and the problem can be corrected. They even examine you before they put you on a given method"-(Female, Urban)

"Something like the injection (injectable); you need (a) qualified health personnel to attend to you".

Another female respondent had this to say:

"I go to the hospital every month. The hospital has programs and education on contraceptives for women. They educate us on the need to give birth to the number of children that one can cater for…I receive the pills any time I need them. I only go to the nurse and tell her I need some pills and she gives me".

Similarly, a rural woman supported the earlier assertions:

"The services that the nurse has provided me has been very helpful. I have not experience any side effects from the pills because she tested my blood and knew that pills will be good for me before she prescribed. I have also not experience any

unwanted pregnancy and I am able to take care of my children without any stress because they are well spaced. Also, the pills are not expensive and I am able to buy them any time I need them".

An unmarried mother from a rural setting also had this to say:

"The CHPS Center has arranged to educate mothers on contraceptives every month and I also benefit from this program…but the first time I got educated on contraceptives, I was the one who went personally to seek for advice on family planning because I wanted to space my children".

"I remember the first day I went to the hospital to inquire about contraceptives, the nurses took me through the different types of contraceptives and how they are done."

However, this study has identified other relevant and growing sources of FP message dissemination particularly the rural women; this has been found to be social activities such as going to the market, fetching water, games, and visits to hairdresser's saloons. This can serve as a cheap means for FP messaging. The interview results confirmed to this.

"sometimes as women, when we meet anywhere for example markets, saloons and other places, we talk and share our experiences. It was after I started using contraceptives that I started talking about it, and now almost all my friends know am using contraceptive".

A female from a rural setting had this to say:

"they organised a program at the junction and educated women to protect themselves. I also hear it on television and radio. They used to come around in a car to educate us to protect ourselves".

The public health officer collaborated what the women have said;

"the health center is mostly the preferred place partly due to the availability of qualified personnel and confidentiality of the services provided…there is still shyness especially the males to walk to over the counter drug sellers or pharmacies and it is even worse for the females…but going to the hospital is seen as more confidential and promotes privacy…others also take advantage of our free condom distributions and other education platforms such as meeting times of social clubs and groupings."

4.6 Perceptions on the effects of the use of contraceptives

There were a number of benefits that the results revealed on the use of contraceptives in the life of women, family and the society at large. Most of the respondents considered contraceptive use as a way of reducing the number of unwanted pregnancies and abortions, maternal deaths from complications of pregnancy and childbirth. Other revelation on the benefits associated with contraceptives was also seen as improving overall health and wellbeing as well as health of mothers and children. A married respondent collaborated the findings as she said this:

> *"I went to the hospital and they told me that it is good to do it so that I will not give birth to so many children that I cannot cater for...family planning helps to space your children...and there will not be burden on you…family planning makes you secure and also makes your partner happy...it helps to avoid unexpected or unplanned pregnancy...it is very good for every woman to use contraceptives".*

This finding was supported by the view of a male respondent:

"…When I gave birth without spacing them, I really suffered but since I started using it (family planning) I have been able to space my children…I have (also) been able to save some money that I am hoping to use to support my child to continue her education."

Similarly, a female respondent shared her experience:

> *"this service has really helped me because I am out of unexpected pregnancy…it puts a lot of stress on me…I will have a small baby who has not started walking, and then another one will follow…There was also financial crises because my husband has no better job and when I give birth I cannot do my petty trading that brings money into the house…My unexpected pregnancy was also putting a lot of stress on my father because he has to feed me whenever I have no food in the house…So my father even advised me to go for family planning after my 6th baby…My friends were also making fun of me because almost every year they see me caring a fresh baby".*

Another married woman shared her experiences;

> *"When I decided to space my children, I went to see a nurse who works at the hospital and told her of my needs, she gave me the pills (but I cannot remember the name) and told me to go and try it and assured me that the pills will do me a lot of good…the piles have helped me a lot, and my children are well spaced…the eldest is 20, the next is 17, the third is 15, the fourth is 11…the woman is a nurse and has a big drug store in her house, when you go to her drug store, she will take a sample of your blood and test it after that before she will prescribe the best contraceptive to you."*

An unmarried woman provided an encounter that;

"most of my friends uses contraceptives but others do not and they have given birth to so many children and because of that they have moved from Kumasi to the village and they have become old prematurely".

A married woman who plan using contraceptives is worth noting;

> *"I got pregnant with my third child when I was not expecting to be pregnant and even my husband said it has come too earlier. I was not so happy with this pregnancy although I did not have too many children… I have now planned with my husband that when I stop breast feeding my child, I will start using contraceptives."*

4.7 Factors influencing contraceptive use

This question sought answers from study participants what influence them to use family planning methods particularly contraceptives. As the main goal of the study, I engaged the study participants what influence them in accepting and using contraceptive. The gap between knowledge and use may reflect the influence of a number of socio-cultural, environmental, contextual and religious factors that influence or hinder access to and acceptance of family planning (FP) methods. Some of these factors are the side effects of some of the contraceptives, poor education on the use of contraceptives, the culture of silence, geographical accessibility, cost and religion.

4.7.1 Side effects count

"I decided to use them…but latter I heard from people who are using them and the side effects, and that scared me because I thought when I do that I will also experience the negative side effects that they are experiencing…so I changed my mind from using it." (this comment came from one of the female respondents)

Another female respondent collaborated the earlier comments;

"Yes, I know someone like that…I have a sister who is interested to use contraceptives but because of the problems that her friend is experiencing from using contraceptives, (the one they put in the arm) she is afraid to also use them."

A married woman in Mamponteng shared her experience on the side effect;

> *"I discussed it with my husband because he is the head of the family…I also discussed with friends to know how helpful it is…the discussion got me scared to use it*

because of the experiences shared by those who use it and those who have used it before…some people say that they do not menstruate after using it…others say they have irregular menstruation with large bleeding…others also complain they have blackout sometimes."

4.7.2 The people they discuss with? (Family member, friends, co-workers, spouse, co-habitant, etc.) equally matter

The interview with some of the participants alluded to the fact that, their close confidant either scare or encourage them to using contraceptives. The response cut across the two locations as neither the respondents from the urban nor the rural setting was exposed to being the influence.

|"Friends (they tell you not to do it because of the side effects, some complain they don't complain…there are no blood test to determine the type that will help you but they only allow you to choose the one that you want)."

"I discussed with my friends because I wanted to know their experiences too…I did not discuss it with my partner because my friends told me it was not good because of the side effects…I would have discussed with my partner if I was told it was good through the discussion I had with friends… I was affected by this discussion because I first wanted to use them but the discussion scared me from going ahead."

"I thought about it and decided to use it…after discussion with my friends I got to know that it is helpful and planned to use it…I got to know that it brings comfort and content. I am now using contraceptives… I discussed with my friends because they have been using contraceptives for a long time now…they were also giving birth when they were not ready and even some of their children are like twins because they were not properly spaced."

4.7.3 The nature and quality of the contraceptives matter

Others expressed concerns about nature and quality of the contraceptives. Key informants' interview put the concerns into perspective;

"My partner has used the male condom before but I don't like it because I was experiencing pain whenever he uses it…sometimes it is difficult to pause the act and put on the condom before you continue (the time to wear the condom disrupts the whole sexual act.)…you can also forget to wear the condom…the condom can also burst."

4.7.4Geographical accessibility and cost matter

Other participant's decision to use contraceptives had been the accessibility and affordability of these contraceptives. Key informants in the two communities shared their experiences on how easy and affordable contraceptives are in their localities.

"Sometimes I don't get the drug in one drug store and I will have to go to another drug store but at the end of the day I get some to buy… It is very affordable…I am able to buy anytime I want to."

4.7.5The culture of silence

Some of the respondents particularly women mentioned the culture of silence as a factor influencing the use of family planning methods. The account of a married woman in the urban setting summarized how culture of silence and the liberation has influenced contraceptive use among the people.

> *"It was very difficult for me to discuss contraceptives in some years ago because nobody wanted to discuss contraceptives and people were not ready to accept them. Now there has been education on contraceptives and people have become conscious of it. So now, I am comfortable to discuss contraceptives because everyone knows of it and also know the benefits."*

Another respondent also shared her view on this matter,

"oh it is very known to almost everyone because you always hear adverts on them on the television and radio"

4.7.6 Perception from the male counterpart

More males than females viewed contraception as the responsibility of women. The interview responses endorsed such findings:

> *"…I think it is the woman and the daughter who really need family planning…" (male respondent)…and "…What I know is that family planning is good for women and their daughters because they are closer to each other than the father so it is of more benefit to women and their daughters…."* (male respondent)

Similarly, a female respondent confirmed the findings above:

"My husband is also aware, everything depends on me the woman. As for the man…some of the men if you get pregnant he will ask you why you have become pregnant so quick. He will leave you and go for another woman because you are not attractive. And if you allow yourself he will have sex with you again".

Another married respondent shared her experiences;

"My husband has not been using any contraceptives and he has also not made any attempt to use them because everything depends on you the woman. The man does not care whether you get pregnant or not because when you get pregnant he does not experience the frustrations and pains that you go through and doesn't care…and it is only you who will carry the pregnancy. It all depends on you the woman, you have to protect yourself. It is you who have to get some drugs so you do not get frustrated with unplanned pregnancy."

4.7.7 Religion

Some religious beliefs of the people discourage some reproductive women from using contraceptives.

"I knew it was a sin to use contraceptives because the Bible is against that…I am aware that, as a married couple childbirth is a gift and no one should deny that from happening…my religion preaches against that…but I was giving birth too much and I was not able to cater for them…so I was ready to face any consequence that will arise out of the use of contraceptives."

4.8 The agents responsible for reproductive health education, service delivery, and information dissemination

My observation during data collection period even though it was not part of my data collection tools revealed that, various agents in the district are helping and being targeted by the health directorate to provide and improve reproductive health education, service delivery, and information dissemination. The various health institutions under the auspices of the Ministry of Health through the Ghana Health Services, the Ghana Education Service, traditional authorities, religious leaders, youth leaders, the Planned Parenthood Association of Ghana, the media (electronic), and the social and health committee of the Kwabre East District Assembly are all partnering in supporting reproductive health education and service delivery.

The Director of the District Health Directorate gave some of the way forward;

> *"the district and for that matter the government's immediate focus is to address high fertility…early child marriage and low school completion rates which have been found to be major contributors…we are collaborating with the Ghana Education Service, National Youth Authority, traditional authorities, religious leaders, youth leaders, the Planned Parenthood Association of Ghana and other reproductive health NGOs in the district as we suggest that promoting delayed sexual debut and early marriage through promoting completion of secondary education will lead to a reduction in the women fertility…the district assembly is pushing for the all to promote education of girls as a measure to reduce high fertility…the introduction of the free senior high schools in the country can help…"*

Similarly, the public health officer had this to say;

> *"I also recommend some initiatives to address cultural norms such as programs targeted to mothers-in-law and other well-wishers who usually put pressure on women to provide them with many grandchildren, as well as encouraging involvement of men in making decisions about family planning…even educated male graduates who should know better have been found to desire many children…I believe such a program when it reaches men through a workplace program or other platforms such as social events and groupings can help."*

4.9 Improving Family Planning through contraceptive use – the way forward

As a way of improving contraceptive use among the people, study participants provided various information they think could help to promote contraceptive use among women in the district.

"Education and awareness creation will help…It is very good to plan your family because now school fees is very expensive so it is better to give birth to 3 or 4 children or a number of children that you can take care of."

> *"the issue of money should be taken out…some people want to use contraceptives but if you ask them to pay any amount, they cannot afford so they will rather stay home and will not care whether they get pregnant or not…sensitization should also be made especially in schools…it is also important for family planning to be taught in schools…when family planning is inculcated in the young ones they will know that you have to be well prepared before you give birth…they will also know that*

teenage pregnancy will lead to premature ageing and frustration in life especially when the girl and boy are so young and still being fed by their parents."

"I think sex education should be encouraged in schools and parents can also help to educate their growing girls on contraceptives such as condoms."

4.10 Conclusion

This chapter has presented results of the data analyses. The data has been analyzed and the results presented in relation with the research questions. The results were presented in this manner to ensure that all research questions posed in this study are answered. The next chapter presents the discussion of the findings.

5 Chapter Five: Discussions

5.1 Introduction

This chapter discusses the results from the data analyzed in relation with relevant literature. The discussion is organized around the research questions.

5.2 Awareness of any contraceptives and modern methods

Responses to the awareness levels of contraceptive use revealed respondent's knowledge and understanding of family planning issues and in particular contraceptive use in the study locations. All the respondents showed high awareness levels as they have used and heard of some of the methods of contraceptives. Almost all the respondents demonstrated high knowledge of what contraceptives are about and what they are used for. This could be explained by number of factors including the demographic characteristics of the women such as age, marital status, and number of children, higher literacy rates and availability of contraceptives in these areas.

Women in urban areas are more likely to use contraceptive methods than their rural counterparts. This may be due to availability, accessibility and affordability of the contraceptive in the urban areas as compared to that of the rural areas.

5.3 The type(s) and specific brands(s) of contraceptives that people use most

Both traditional and modern methods of contraceptives were used by respondents in the study locations. For the traditional methods, the study revealed only the withdrawal method is practiced by the males.

Regarding the modern methods, Pills and injectable were the most currently used methods among married and sexually active unmarried women respectively, as per their own reports and those of their partners within the study communities. Respondents from a study in urban Mamponteng showed higher levels of use of pills among married women in contrast to the

current study, where injectable were the most prevalent. The reason for this situation may be largely due to their availability and publicity compared to other methods such as foam/jelly, diaphragm, IUDs, female condoms and emergency contraception, which are not usually advertised. For males however, the male condom was the most ever used method. The male condom was less popular in the female study population; however the sexually active unmarried females' current use was more than that of the married. Reasons such as lack of trust, wanting to become pregnant, stigma of associating condoms with HIV and STIs from prior prevention campaigns among others have been associated with community members avoiding condom use. It was observed that unmarried sexually active females used any, modern and traditional methods of contraception much more than married females in this surveyed population.

5.4 Sources of family planning (FP) Messages

Contraceptives in the surveyed population were accessed from diverse sources as documented in earlier studies. Among them are public medical facilities under the health ministry managed by the Ghana Health Service, non-governmental health institutions (private health facilities, pharmacy/chemical sellers) and other sources such as friends, relatives, social networking groups and media bodies. It was evident however that, most of the women patronize FP services especially contraceptives within health institutions such as hospitals, health centers, CHPS Compounds, clinics, possibly because the methods available require expertise from within such facilities significantly determining the source of service. The private sector, mostly chemical shops serve as sources of non-clinical contraceptives such as condoms and pills as shown in the current survey results. Just like previous studies, radio (mass media) was identified as the most popular FP dissemination means.

The current study identified other relevant and growing sources of FP message dissemination; this has been found to be social activities such as network groups and clubs, and visits to hairdresser's saloons. This can serve as a cheap means for FP messaging. Confirming previous studies, Cheng, 2011; Oye-Adeniran et al, 2006; Agha & Meekers, 2010; established that in most countries such as Taiwan, Pakistan among others mass media and social networks played important roles in disseminating contraceptive knowledge and that women transformed this knowledge into behavior - that is, contraceptive knowledge reduced fertility.

5.5 Perceptions on the effects of the use of contraceptives

The study revealed that contraceptive use has been helpful to users in many respects. Responses on the effects of contraceptives according to respondents are mainly contraceptive use as a way of reducing the number of unwanted pregnancies and abortions, maternal deaths from complications of pregnancy and childbirth. Other revelation on the benefits associated with contraceptives was also seen as improving overall health and wellbeing as well as health of mothers and children. Just like previous studies, various benefits are associated with the use of contraceptives by women such as fewer unintended pregnancies; fewer maternal and newborn deaths; and healthier mothers and children (Connor, 1968; Singh et al. 2009).

In this regard, contraceptive falls in the perspective of preventive innovations which according to Rogers (2002) are "new ideas that require action at one point in time in order to avoid unwanted consequences at some future time". Women in this current study use contraceptives or family planning methods basically to prevent pregnancy. The study revealed that they have trust that their use of contraceptives will keep them from pregnancies. They will not become pregnant unaware and give birth to large number of children that they cannot cater for. This idea or believe is a characteristic of preventive innovation. That is, observability which is the idea that the result of using an innovation can be seen by others, (Rogers 2002) may be said to have had impact on the acceptance and use of contraceptives by women in the current study.

The acceptance and use of contraceptives as some of the women alluded to has helped them space their birth. This does not only limit the number of children to have but has improved the health of these women. Prior to accepting and using contraceptives, the women indicated regular stress as a result of unexpected pregnancies they were confronted with. However, their stress has gone down due to family planning measures they have adopted and no longer give birth unexpectedly, and this goes a long way to improve the health of these women. The WHO (2012; 2013) confirmation of the results on woman's ability to space and limit pregnancies comprises. This subsequently provides a direct impact on their health and well-being as well as outcome of pregnancies.

The accounts of the women confirm financial savings as they accept and use contraceptives as a measure to family planning. Spacing birth gives women the time and health to work and

save money for the family. As the study revealed, most of the women are self-employed and therefore, frequent child birth means their businesses are put on hold during such periods and that deny them money as they are not able to serve their customers. Collaborating with findings by Singh et al. (2009) that, there are greater family savings and productivity; and better prospects for educating children, strengthening economies and reducing the pressure on natural resources in developing countries.

Again, this advantages of contraceptives use accounted in this current study highlights what Rogers (2002) calls 'relative advantage' that is, the rate at which an innovation is seen to be better than the idea it replaces (the positive accounts given by women to the use of contraceptives). This attribute of contraceptives may have had effect on the rate at which women accept to use contraceptives in this current study.

5.6 Factors influencing contraceptive use

The gap between knowledge and use may reflect the influence of a number of socio-cultural, environmental, contextual and religious factors that influence or hinder access to and acceptance of FP methods or contraceptives use. Some of these factors are the side effects of some of the contraceptives, poor education on the use of contraceptives, the culture of silence, geographical accessibility, cost and religion. Many studies in Sub-Sahara Africa show that there are many factors that inhibit the use of modern contraceptives among adolescents. These barriers include poor knowledge of contraceptive, fears and rumors about side effect, and unsupportive or negative influences of partners and family members (Williamson et al., 2009).

The fears and rumors about the side effects of using contraceptives put a barrier to effective use of contraceptives especially the new comers. As the results indicated, most of the respondents were discouraged to use contraceptives after hearing from their closets and confidants about the side effects of the contraceptives. Similarly, Rogers (2002) argued complexity as one of the attributes that influence the rate at which an innovation is accepted. In this current study the understanding on contraceptives that most of the women received from their friends and relatives influenced their decision to accept and use contraceptives.

The study also revealed the geographical accessibility and affordability of contraceptives in the study locations. This offered the people the opportunity to patronize contraceptive coupled with education received from various platforms. The ability of women to access contraceptives in their locality coupled with the affordable nature of contraceptives also influence the use of contraceptives as revealed in this study. Again, as the study highlights, women can buy any amount of the pills when needed. According to Rogers (2002) trialability, a characteristic of innovation is the rate at which an innovation can be experimented on a limited basis. This influences the rate of adoption of the innovation. This study also revealed that women can have access to the pills with a limited amount of money.

There was also the issue of influences of partners, friends and family members on the usage of contraceptives among the people. As the results showed, study participants discussed family planning issues with partners and friends who either encourage or put fear in them about contraceptive use.

Further, the culture of silence and the liberation has influence on contraceptive use as the current study revealed. Liberation of the culture of silence has contributed to the acceptance and use of contraceptives as the study revealed that some women now talk about contraceptives and uses them because according to them everybody knows about contraceptives. From the perspective of Roggers (2002), compatibility is 'the rate at which an innovation is seen to be consistent with existing values and norms of the society'. He argues that this attribute of innovation affects the rate of adoption and use of the innovation. The same situation is revealed in the current study whereby the rate at which contraceptives is being advertised and talked about in the society has affected its acceptance and use by women.

5.7 The agents responsible for reproductive health education, service delivery, and information dissemination

Various agents in the district are helping and being targeted by the health directorate to provide and improve reproductive health education, service delivery, and information dissemination. The various health institutions under the auspices of the Ministry of Health through the Ghana Health Services, the Ghana Education Service, traditional authorities,

religious leaders, youth leaders, the Planned Parenthood Association of Ghana, the media (electronic), and the social and health committee of the Kwabre East District Assembly are all partnering in supporting reproductive health education and service delivery.

Contraceptives distribution and sales are done by the government and the pharmaceutical companies in Ghana. Contraceptives distribution particularly those in the public health institutions including condoms in Ghana are mainly by the government of Ghana with United Nations Fund for Population Activities (UNFPA) being responsible for procurement. The Ministry of Health (MOH)/GHS dispense these contraceptives through the central medical stores to the regional stores, Planned Parenthood Association Ghana. (PPAG), Ghana Registered Midwives Association (GRMA) and Ghana Social Marketing Fund (GSMF). These associations and institutions in turn distribute to the clients through NGOs, private or public facilities. Apart from the government, some private importers procure contraceptives such as condoms and distribute directly to pharmacies/chemical sellers.

The institutions involved in reproductive health education, service delivery, and information dissemination also operate in the decentralized system of governance. At the national level, the Ministry of Health formulates policies and programs and implemented through the agents like the Ghana Health Service. The service operates through the national, regional and district levels. At the district level as the study revealed, the Kwabre East District Health Directorate leads the reproductive health education and service delivery. The office is the main institution that coordinates the health education in the district. The office supervises and monitors all public health institutions and therefore, ensures that these health centers and posts provide reproductive health issues such as family planning and counseling services in all the health centers.

Over the years, the media particularly the electronic (radio and television) networks have partnered the Ghana Health Service to promote health education in the country through local FM stations and community information centers at the rural areas. Programs are hosted by these media networks with experts who provide reproductive health education during the period of the program. During such programs, the listeners and viewers are given the chance to contribute through phone calls or text messages either to contribute or ask questions relating to the program.

Health education such as reproductive health is also promoted during social networking groups which is gaining currency in major towns and cities. As the extended family is gradually breaking down in towns and cities, residents in these areas are forming social clubs and network groups that provide social support for their members. Frequent and regular meetings are organized by members and during such meetings; they invite experts such as Medical doctors and seasoned health workers to educate members on pertinent health issues that affect members. Due to the high patronage of club or group members, the platform provides the ideal condition for the promotion of reproductive health education. Also, because group members share similar characteristics, there is effective interaction among members and experts invited.

5.8 Programs and policies on contraceptives

A number of policies and programs have been introduced in Ghana to increase the use of contraceptives. This includes:

5.8.1 Family planning 2020 commitment

Overview of the commitment

In 2017, the Government of Ghana committed to include Family Planning services and supply of family planning products in the country's national health insurance benefits package during the subsequent scheme review period. This was expected to make family planning services and products free at all public health facilities, and private health facilities that have subscribed to the national insurance scheme. There was also commitment to increase government's contribution to the buying of family planning supplies. Currently, the government directly secures about one quarter of all family planning supplies and has promised to increase this percentage to one third by the year 2020. Regarding programming and service delivery, the government has committed to increase the number of women who uses modern contraceptives from 1.46 million in 2015 to 1.93 million in 2020 by increasing the accessibility and availability of family planning services at all levels, "capacity building, improving contraceptive method mix, and increased demand for services". The government has also committed to support Sexual and Reproductive Health interventions in order to

increase the percentage of sexually active unmarried adolescent who are using contraceptives from current levels of 31.5 percent to 35.0 percent by 2020 (Government 2017).

This commitment was anticipated to improve access to family planning services through increasing the number of women and girls using modern contraceptive methods to 1.9 million by 2020. And to reduce teenage pregnancies and child marriages (Government 2017)

Policy & political commitments

In 2011, Ministry of Health and National Population Council in Ghana put in place millennium development goal 5 Acceleration Framework. Through this framework the country committed to make family planning services and its supplies free of charge everywhere within the country by including family planning services and supplies in the national health insurance benefits package (Government 2017)

Government's financial commitments

The government of Ghana committed to increase its contribution to the buying of family planning commodities. Before the year 2015, the government directly procured about one quarter of all family planning supplies. This percentage was expected to increase after 2015 (Government 2017).

Program and service delivery commitments

The program aimed to delivery family planning services through the following: "Use community-based nurses to deliver FP services in rural areas".; "Eliminate user fees for FP services in all public health facilities"; "Increase demand for FP, including advocacy and communications to improve male involvement"; "Improve workforce training and options for task shifting"; "Improve counselling and customer care; "Improve post-partum and post-abortion care"; "Offer expanded contraceptive choices including a wider range of long acting and permanent methods"; "Provide adolescent-friendly services for sexually active young people" (Government 2017).

There is another family planning program in Ghana which is specific to the emergency contraceptive (pill).

5.8.2 The emergency contraception Agenda.

This program supports the use of emergency contraceptives and has made it possible for public access of emergency contraceptives. The program involves: policies on emergency contraceptive, product availability, and access point of emergency contraceptives for women (Contraception 2013).

The policies:

"ESSENTIAL DRUG LIST": Through this policy Levonorgestrel 1.5 mg pills which has been specified for emergency contraceptive use appeared on the 2010 Essential Drug List.

"NATIONAL NORMS AND GUIDELINES"**:** In 1996 emergency contraceptive was introduced into Ghana's National Family Planning Program.

"PRESCRIPTION STATUS"**:** The policy has made it possible for emergency contraceptives to be purchased in most pharmacies and drug shops in Ghana without a prescription. Also, emergency contraceptive is available and can be obtained at the various family planning clinics run by the government throughout the country

"POST-RAPE CARE: There are no national policies/or protocols to guide post-rape care in Ghana (Contraception 2013).

Available product

"REGISTERED PRODUCTS"**:** There are now three main emergency contraceptive products registered and sold in Ghana: NorLevo, Postinor-2, and Pregnon.

"LOCALLY MANUFACTURED PRODUCTS"**:** There are no locally manufactured products of emergency contraceptives in Ghana.

"POOR QUALITY OR COUNTERFEIT EC PRODUCTS"**:** Reports indicate that counterfeit drugs are prevalent in Ghana. However, this situation is not limited to emergency contraceptives (Contraception 2013).

Access point of emergency contraceptives for women

EMERGENCY CONTRACEPTIVES IN THE COMMERCIAL SECTOR**:** Pharmacists in Ghana are permitted to sell approved emergency contraceptive products directly to women.

EMERGENCY CONTRACEPTIVES IN THE PUBLIC SECTOR**:** As I have already stated above, emergency contraceptives are also available in the public sector at the various clinics and hospitals and family planning centres run by the government (Contraception 2013).

5.9 Conclusion

This chapter has presented discussion of the research findings in relation to relevant literature. The discussion has been done based on the research questions. In this way, the chapter has served as the section where the research questions are answered. The next chapter presents the conclusions and recommendations.

6 Chapter Six: Conclusions and Recommendations

6.1 Introduction

This chapter presents the conclusion which is summary of the key findings that emerged from the result discussions and based on this, recommendations are made for improvement in reproductive health issues in the district.

The main goal of the study was to identify the pull and push factors in the acceptability and use of contraceptives among women in the Kwabre-east district of Ghana. The study was done by exploring factors influencing the acceptability and use of contraceptives among women. Two locations were chosen for this study; Mamponteng representing an urban area and Bremang also representing rural setting for the study. Based on the research questions, the methodological approach was qualitative case study. This research approach was deemed the most appropriate since the study sought to explore, understand, describe and interpret the phenomenon through the experiences, perceptions and perspectives from participants' standpoint. The study employed non-probability sampling techniques. Purposive and snowball sampling techniques were used to select the needed sample. In all, 20 respondents participated in the study including; women aged between 18-49 years (either married or unmarried), and men both married and unmarried. The main method of data collection was in-depth face-to-face interview. All the interviews were conducted in Ghanaian local dialect (Asanti Twi), audio recorded and transcribed into English for analysis. Results from the analysed data were presented by means of direct quotations.

6.2 Conclusions

The study revealed high levels of contraceptive use among the study participants. Almost all the study participants have knowledge in some of the types and brands of contraceptives and have at some points in their life used any methods of contraceptive indicating high level of knowledge of the use of contraception across the study locations.

Women use more of the modern methods of contraception than the traditional methods whiles males use the withdrawal method as a traditional method. Among the modern contraceptives, pills and injectables are the most used by women. The pattern of current use of modern and traditional methods of contraception is similar across subgroups. Use of both modern and traditional methods is more common in urban areas than rural areas and increases with level of education.

The results established that the health posts or centers dominated the sources of messages about contraceptives and its use among married women than male counterparts. Other sources included the media mostly electronic networks (both television and radio), friends, relatives, churches and other social groupings. Knowledge of Sources where family planning methods could be obtained was not difficult for most of the respondents as most respondents knew a place where they could obtain family planning services.

Increasing the number of trained community health care providers who provide a wider scope of services through the CHPS initiative has been extremely beneficial. Many rural women receive education, sensitization and general health care which hitherto, was a challenge has improved health care delivery to the people. Community Health Workers (CHWs), who are the lowest cadre of government-employed health workers, administer injectable contraceptives. The health workers can administer injectable contraceptives as well as implants and offer follow-up care to women with IUD.

The collective experience of these respondents demonstrates that Family Planning Programs (FP Programs) and contraceptives can play a key role in enabling couples access and use effective contraception, which empowers them to determine the timing and number of births that they would like to have.

The main factors influencing contraceptive use are based on socio-cultural, environmental, contextual and religious factors that influence or hinder access to and acceptance of FP methods. Some of these factors are the side effects of some of the contraceptives, poor education on the use of contraceptives, the culture of silence, geographical accessibility, cost and religion. Results of the study indicate that most reproductive women understand both factors that facilitate and inhibit contraceptive use as well as the level at which reproductive women use contraceptives. Being aware of these factors makes it easier to develop strategic

interventions to promote contraceptive use and help reduce the contraction of STIs and prevent unwanted pregnancies which may lead to abortion ad its negative implications.

The main agents spearheading reproductive health issues particularly family planning services in the district has been the various health institutions particularly health centers under the auspices of the Ministry of Health through the Ghana Health Services, and a lesser extent, the Ghana Education Service through schools. The media, particularly the radio (local FM stations) and television networks provide platform to discuss and promote women reproductive health.

Again, the study has highlighted some government programs and policies of family planning which are; the family planning 2020 commitment, and the emergency contraceptive agenda.

Based on these findings, this study concludes that more public health education alongside other interventions to increase contraceptive use among reproductive women who are sexually active is urgently needed. Going forward, findings from this study have depicted some essential shortfalls in the FP needs of the surveyed population that require action. It has also demonstrated some similarities and divergence from the FP picture within the district.

6.3 Recommendations

Based on the findings and conclusion drawn, I put forward the following recommendations for improvement in the use of contraceptives by reproductive women in the district and policy direction for the Ministry of Health and the Ghana Health Service as well as health related NGOs.

Provision of adequate staff strength and expertise

As majority of the study population would go to health facilities to access FP methods, policy makers should ensure that health facilities have adequate staff strength and expertise to provide such services. Health care providers should also make themselves accessible and provide satisfactory care to their clients. Family planning methods however, which does not require specific clinical expertise, should continue being made available in non-health institutions to increase access.

Use more of the electronic media for dissemination

Radio and television were also found to be an essential source of FP messages, as such program implementers should continue its use for dissemination of messages.

Use social networking groups for Family Planning message and information dissemination

Social activities have also shown a potential of enhancing message dissemination and should be considered as additional or alternate to radio to enhance information spread.

Strengthening institutions

The strategy to achieve high contraceptive use can include strengthening the institutional arrangements to deliver effective policy leadership for population and family planning, establishing a budget line for FP commodities, reforming youth friendly programs and taking them to scale, and increasing community access to long acting and permanent methods.

Accelerate and expand Primary Health Care Coverage

The study recommends to the District Health Service to accelerate and expand Primary Health Care Coverage in areas of the district. The Health Extension Program (HEP) can be the main vehicle for bringing key maternal, neonatal and child health interventions to the community. The package includes Family Planning services.

Research for evidence based decision making

The study recommends to District Health Service to improve Health Management Information System (HMIS), data reporting, research and dissemination to support decision making and to influence policy and program decisions.

Catch them young (Rational learning)

The study recommends to authorities to intensify sex education in schools and homes. This will mean family planning to be taught in schools…when family planning is inculcated in the young ones they will know that you have to be well prepared before you give birth…they will also know that teenage pregnancy will lead to premature ageing and frustration in life.

Galvanizing support from all corners

The study recommends to the District Health Service directorate to galvanize traditional (from traditional leaders), religious (churches and Muslims) and political (party leaders) will and commitment for Family Planning at top leadership and all levels of government, as this will increase its profile as a health and development priority, through evidence-based advocacy.

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Appendices

Appendix 1

Research guide for women acceptability and use of contraceptives research

Overall objective of the study

This study aims at exploring why some women in the Kwabre East district of Ghana are able to use contraceptives and why others are not able to use contraceptives in relation to pregnancies.

Specific objectives

1. To explore people's perceptions and knowledge on different types of contraceptives.

2. To find out the type(s) and specific type(s) of contraceptives that people use most.

3. To find out the perceptions that people have about the different types of contraceptives

4. To find out how and where women get access to contraceptives.

5. To find out how women get information concerning contraceptives.

6. To find out the agents responsible for reproductive health education, service delivery, and information dissemination

7. To find out the various family planning interventions by health care providers and NGOs involved in reproductive health

8. To find out government policies on reproductive health.

9. To make possible recommendations depending on the research findings.

Research questions

1. What are the various facilitators and barriers to the acceptability and use of contraceptives among women in the Kwabre East district of Ghana?

2. What type(s) of contraceptives do people use most?

3. According to the government policies who are the agents charged with the responsibility of reproductive health services delivery and how do women in the Kwabre East district of Ghana access these services?

4. Which individuals/ institutions are responsible for reproductive health education in Ghana and how is information regarding reproductive health communicated to women in the Kwabre East district of Ghana?

5. Are partners able to discuss issues pertaining to contraceptives?

6. Are women aware of the social, health, economic, and psychological consequences of unwanted pregnancies?

7. What are the various family planning interventions by health care providers and NGOs involved in reproductive health

8. What government policies on reproductive health are in place?

Expected outcome of the study

1. Provide insight on women perception on contraceptives and highlight the various facilitators and barriers to contraceptive use.

2. Provide insight on family planning interventions by health care providers involved in reproductive health and the extent to which they have contributed to enhancing women contraceptives acceptability and use.

3. Bring to light the various government policies on reproductive health and make recommendations on how women acceptability and use of contraceptives can be enhanced.

Demographic characteristics

1. Name

2. Sex

3. Age

4. Place of birth

5. Present place of residence

6. Education

7. Current occupation

8. Marital status (single, married, divorced, widow/widower, co-habitation)

9. Number of children (biological, adopted)

10. Contact address

Guidelines for married and unmarried women

1. Would you like to share with me what you know about contraceptives?

2. How did you get to know of contraceptives? (Mass media, partner, friends, family, co-worker, etc.)

a) How accessible is this medium of information to you?

b) When you first heard of contraceptives what did you do?

i) If you discussed it, who did you discuss with? (Probe: family member, friends, co-workers, spouse, co-habitant, etc.)

c) Why did you decide to discuss contraceptives with that person (s) or not discuss contraceptives with anyone? Explain?

d) How difficult was it for you to discuss contraceptives?

e) Were you in any way affected by this discussion? How? (Probe for: What kind of social, psychological, identity or stigma due to contraceptives).

f) How did you go about these challenges? (mention the various challenges if there are more than one challenge)

2. Do you use /have you used contraceptives before? (Probe: type of contraceptives).

a. How long have you been using contraceptives?

3. What specific brands do you use?

a. Can you tell me why you use this (these) types of contraceptives and brands?

(Probe further for relative advantage, compatibility, complexity, trialability, observability)

b. What about the other types of contraceptives (mention), have you use them before or not? (Probe: if yes, why did you stop using them. if no, why?)

4. In relation to your decision to use contraceptives which organizations, institutions and individuals have you and your sexual partner ever received some help from? (Probe: NGOs, health institutions, friends, family, co- workers etc.)

5. How did you know about the existence of this organization (s) and its services?

6. What kinds of service (s) have you and your sexual partner ever received from these different organizations or specifically organizations that are involved in contraceptives/family planning? (Probe: Referrals, economic, medical, etc.)

Probe:

a. How did you get access to this service? (mention the various services)

b. How often do/did you receive these services from these organization(s)?

c. To what extent have these services been helpful to you and your sexual partner? (Probe for: coping with stigma/ discrimination, health, economic, etc.). If they have not been helpful probe for reasons why).

7. What do you think will be the effects if you become pregnant when unprepared? (probe: psychological, social, economic, health impact) (for those using contraceptives to prevent pregnancies)

8. How do/did you take decision on contraceptives use? Probe: (decision by self, decision by partner, decision by other family members, doctor, etc.)

a) How does this decision affect your relationship with your partner and/or other family members?

b) How does it affect you psychologically?

c) Is the issue of contraceptives use only limited to you and your partner or extends to other family members?

d) How often do you discuss contraceptives issue with your partner?

Contraceptives Accessibility, information and education

9. From what avenues do you access contraceptives?

a) How well are you able to access contraceptives? (Probe: access to contraceptives any time you want)

b. Can you tell me how costly is it to get contraceptives? (for those who buy contraceptives)

10. How often do you receive information regarding contraceptives?

a) How is this information helpful to you?

11. Have you received education on contraceptives before or not? If yes, from which individual or organisation did you receive education from?

b) How did the education come about? (Self-request, arranged program, etc.).

12. Cultural Issues

a) What cultural dilemmas did you face or experience in your decision to use contraceptives?

b) How did you deal with the cultural norms that influences contraceptives use?

13. What kind of services do you need but you have not got them from any organization?

14. Are there people that you know who want to use contraceptives like you and who need help but are afraid to seek for such help? If yes why are they afraid?

Probe:

a. what advice do you give to them

15. Do you think that women who use contraceptives have similar experience and perceptions like you? If yes or No (explain).

Probe:

a. Have you ever shared your experiences with such women?

16. What kind of information do you think could help to promote contraceptive use among women? (Probe: free contraceptives, strengthen sex education in school, community involvement, financial benefit attached to contraceptives use, etc.).

Guide lines for married and unmarried men

1. What challenges do you face in relation to contraceptives (condom) use?

2. Can you tell me what you know about contraceptives?

3. What type of contraceptives have you used before?

a) What specific brand do you use? Why do you use this type and specific brand of contraceptive?

4. Which other types and brands of contraceptives have you used before and why did you stop using that types and/brands of contraceptives? (Probe 2&3: relative advantage, simplicity, compatibility, trialability, observability).

5. How do/did you take decision on contraceptives use? Probe: (decision by self, decision by partner, decision by other family members, etc.)

a) How does this decision affect your relationship with your partner and/or other family members?

b) Is the issue of contraceptives use only limited to you and your partner or extends to other family members?

c) How often do you discuss contraceptives issue with your partner?

6. Why did you decide to use contraceptives or why are you not using contraceptives? (Probe: family size, STDs unwanted pregnancies, etc)

7. Have you encountered unwanted pregnancy before?

a) If yes; what consequences/challenges did you face? (Probe for: psychological, social, economic, health etc.)

b) How was your relationship affected as a result of the unwanted pregnancy?

Probe based on the response:

i) The woman involved

ii) Woman's family members and friends

iii) Your family members and friends

iv) Other people in the community

d) How did you deal with the challenges you faced as a result of the unwanted pregnancy?

e) How do you feel about the way you have been handled in relation to the unwanted pregnancy? (Probe: whether you think you were not the cause of the unwanted pregnancy, the woman should have avoided it)

f) Do you feel sorry or guilt of the unwanted pregnancy? (EXPLAIN)

8. What are your needs in relation to contraceptives use? (Probe for: Economic, medical, psychological/counselling, social, etc.).

9. To what extent are you able to access these needs?

10. To what extent have the health institution, NGOS, family members and community been able to meet your needs? (Probe for: Economic, medical, Psychological, social, etc.)

11. Is there any service that you need but you have not received? (Explain)

12. Do you face any challenge in your decision to use contraceptives? (Probe for: their feelings, stigma, and social identity).

13. Cultural Issues

a) What cultural dilemmas did you face or experience in your decision to use contraceptives?

b) How did you deal with the cultural norms that influences contraceptives use?

14. In your opinion how and to what extent have you been helped so that you don't encounter unwanted pregnancy?

15. As a sexually active man, what advice would you give to other men, women and their families, community leaders, family planning institutions, and policy makers which you think are important in the prevention of unwanted pregnancies and to enhance contraceptives use?

Guide Lines for Health Providers

1. Generally what services do health providers provide in relation to contraceptives use? (Probe; medical, counselling, psycho-social support, referral to other institutions, NGOs, etc.).

2. What types (and brands) of contraceptives are commonly used by individuals? (Probe: types used by women, types used by men)

a) Why do you think individuals prefer to use these types (and brands) of contraceptives

3. Are these contraceptives prescribed to individuals or they are individuals' choices?

4. What are the advantages and disadvantages of using these contraceptives and contraceptives in general?

5. To what extent do individuals come to your health station for advice on contraceptives?

a) Which category of people seek for advice before using contraceptives? (Probe: gender, age, status, education, occupation, marital status etc).

b) What advantages do they gain over those who do not seek for any advice?

6. What reasons do individuals give for their decision to use contraceptives?

7. With your experience as health provider, which category of people do you think use contraceptives most and why?

a) Women: married, unmarried

b) Men: married, unmarried

8. What are the reasons why others do not use contraceptives? (Explain on category)

9. As a health provider, do you recommend contraceptives or not? Why?

10. What collaborations/partnerships do health providers/institutions have with the following?

a). NGOs,

b). Community leaders

11) What challenges do health providers experience in collaborating/working with the above mentioned organizations and actors? (Probe what has worked and not worked)

15. What kind of challenges do health providers face in relation to contraceptives? (Probe: lack of coordination/collaborations/referrals, cultural issues, lack of contraceptives commodities).

16. Cultural Issues

a) What cultural dilemmas did you face or experience in your decision to use contraceptives?

b) How did you deal with the cultural norms that influences contraceptives use?

Information delivery and education

17. As a health worker, what are your roles in relation to education on contraceptives, and information delivery?

18. How do you provide education and information on contraceptives to people?

(Probe: through mass media, at the health centre when necessary, social and religious gathering, schools, market places, etc.)

a) How accessible is the medium of communication to the target group?

b) How often do you provide education and information on contraceptives?

c) What is your primary and secondary target groups?

19. Do you think contraceptives are economically accessible? (Explain)

Guidelines for policy makers

1.What policies on reproductive health are in place?

2. Which of these policies are specifically on contraceptives?

a) What is the main target group for these policies and why?

b) What do the policies aim to achieve?

c) What methodology are you using to implement your policies to ensure that individuals are benefiting from them?

i) Which institutions/organisations and agents are mandated to execute the policies (NGOs, health workers, community leaders, etc.)

3. What kind of challenges do the institutions/organisations or agents experience in executing policies on contraceptives? (Probe: financial, lack of skills/competence, lack of human resources, cultural barriers, poor collaboration between various actors etc.)

4.If these challenges are known to you, how does the institution cope with the challenges highlighted above?

a. How do you address them?

5. In your view do you think that women benefit from these policies in reference to;

a) Acquiring education, and information on contraceptives?

b) Getting access to contraceptives?

6. If yes, how does the policies enhances women access to information, education, and use of contraceptives?

7. In all, how would you evaluate the policies on contraceptives/family planning?

a) To what extent has the goals of the policies been achieved?

b) What is lacking?

c) What needs to be done?

13. What interventions on contraceptives are in place? Those that are not done directly by you but by the hospitals.

14. What do you think the following actors need to do to enhance contraceptives use and/or reproductive health?

a) Policy makers

b) Health providers

c) NGOs

d) Community leaders

e) Individuals

Appendix 2

Request for participation in research project "women acceptability and use of contraceptives"

Background and Purpose

This study aims at exploring why some women in the Kwabre East district of Ghana are able to use contraceptives and why others are not able to use contraceptives in relation to pregnancies. The title of the research is 'The pull and push factors in the acceptability and use of contraceptives among women in the Kwabre-east district of Ghana.

This research is conducted as a partial fulfillment of the award of a master degree in International Social Welfare and Health Policy at the Oslo and Akershus University college of Applied Sciences.

You have been selected purposively for this research because your views are relevant in answering the research questions.

What does participation in the project imply?

This research is interview based and I am going to ask you questions based on the following:

Married and unmarried men and women

1. Demographic characteristics;

2. Knowledge on contraceptives and contraceptives use;

3. Contraceptives accessibility, information and education;

4. Cultural/social issues.

Health providers

1. Demographic characteristics;

2. Family planning services;

3. Information delivery and education.

Policy makers

1.Demographic characteristics;;

2. Perceptions on contraceptives

3. Contraceptives accessibility;

4. Policies on contraceptives.

The interview will last for approximately 60 minutes and audio recording will be taken.

What will happen to the information about you?

All personal data will be treated confidentially. Only I (the researcher), and my supervisor,will have access to the data, and a list of names will be stored separately from other data to ensure confidentiality and also, at no point will your name be mentioned in this research.

The research is scheduled for completion by May 2018 and all data will be destroyed after completion of the research

Voluntary participation

It is voluntary to participate in the project, and you can at any time choose to withdraw your consent without stating any reason. If you decide to withdraw, all your personal data will be made anonymous. If you would like to participate or if you have any questions concerning the project, please contact:

Esther M. E. Arhin

Mobile: +4791265712/ 0243026538

John David Kisuule

Mobile: +47 98059288

The study has been notified to the Data Protection Official for Research, NSD - Norwegian Centre for Research Data.

Consent for participation in the study

I have received information about the project and I am willing to participate

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(Signed by participant, date)