KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

COLLEGE OF HEALTH SCIENCES

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DEPARTMENT OF COMMUNITY HEALTH

FACTORS INFLUENCING WOMEN'S DECISION TO ADOPT FAMILY PLANNING METHODS, A CASE STUDY OF WOMEN AGED 15-39 YEARS IN EAST AKIM DISTRICT.

A THESIS DISSERTATION SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES, KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF PUBLIC HEALTH; POPULATION AND REPRODUCTIVE HEALTH

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DECLARATION

I declare that this thesis was written by my effort through the support of my supervisor. I therefore present it to the Department of Community Health of the School of Medical Sciences and the School of Graduate Studies for the award of Master in Public Health in Population and Reproductive Health.

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DEDICATION

I dedicate this write up to my husband Mr. Chrispa Anyomi and my children Eric, Abigail, Daniel for their support and all friends and relatives who contributed.

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DEFINITION OF TERMS

1. **Clients** were women in their fertility age and the adolescents who had children and practiced family planning.
2. **Decision** was the action taken by the women to adopt or stop using family planning.
3. **Adopt** refers to choosing a family planning method and use.

LIST OF ABBREVIATIONS

CPR……..Contraceptive Prevalence Rate

CRS……...Commercial Retail Services

CBS……...Community-Based Services

CHPS…….....Community-based Health and Preventive Services

GDHS……Ghana Demographic Health Survey

DMT……..Decision Making Tool

DFID……..Department for International Development

FP……...Family Planning

FGD…….....Focus Group Discussion

FPLM…….Family Planning Logistics Management

ICPD……...International Conference on Population Development

IUCD.....Intra Uterine Contraceptive Device

IFPP……..... International Family Planning Perspective.

JHU/PCS…….Johns Hopkins University/Population Communication Services

MOH…….. Ministry of Health

HED……Health Education Division

UNFPA……...United Nation Population Fund

USAID…….....United States Agency for International Development

WHO………World Health Organization

WIFA……Women in Fertility Age

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ABSTRACT

Family planning helps save women's and children's lives and preserves their health by reducing women's exposure to the health risks of childbirth and abortion and giving women more time to care for their children and themselves. Also all couples and individuals had the right to decide on the number and spacing of their children and to have access to the information, education and means to do so (UNFPA, 1999).

This study determines the factors that influenced the decision of women in their reproductive age between 15-39 years to adopt family planning. A cross-sectional descriptive study was conducted in three sub districts of East Akim district from August to November 2008. Two hundred women practicing or had ever practiced family planning and 30 providers were used for the study. The purpose of the study was to assess clients' satisfaction in FP method and services, to find out how client-provider interaction increase quality care, to find out the effectiveness in providers' supervision, identify logistic availability and how to improve FP policy.

Simple random sampling was used based on clinical attendance and home visit. The data techniques used were observation, check list, FGD among others. The result of the study showed that among the respondents, 76.0% were currently married or ever been married before and 23.0% were singles. About 89.5% had formal education.

Knowledge of family planning was universal as 97% of respondents had an idea about family planning, 62.0% attended clinic continuously, 29.0% ever discontinued while 9.0% defaulted. Fear of side effect was the major reason attributed for FP method switched or discontinuation and was also confirmed in the focus group discussion. Injectable was the commonest current family planning method used which constituted 60% with 30.0% using pills and the remaining methods recorded less than 10.0%. About 55.5% of respondents were satisfied with family planning method used. Half of the respondents represented 51.5% received support from husbands to practice family planning while 6.0% practiced FP without the awareness of their husband.

Statistically, alpha level of 0.05 at 95% confident interval, p=0.002, knowledge of family planning, age of the woman and husband support were all significant for a woman to

adopt FP. Other factors such as client satisfaction of method, clinical accessibility and waiting time less than 30 minutes with visit to the clinic at any time were also statistically significant.

It was found that supervision, information on side effect which was the main reason for stopping FP, logistics and FP policy needed to be improved.

Recommendations were made to the DHMT, the and the community members and the Government of Ghana to improve the FP policy and its implementation.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background Information

Family planning helps save women's and children's lives and preserves their health by preventing untimely and unwanted pregnancies. It helps in reducing women's exposure to the health risks of childbirth and abortion and giving women, who are often the sole caregivers, more time to care for their children and themselves. All couples and individuals had the right to decide freely and responsibly the number and spacing of their children and to have access to the information, education and means to do so (UNFPA, 1999).

Women are aware of family planning services and use an informed choice method globally. Unfortunately, one reason or another prevents them from using these methods and not attaining their desires. To respond to demand for contraceptives, a range of safe and effective modern methods of family planning approved by World Health Organization are available. The provision of family planning services required appropriately trained staff and a reliable supply of material and resources (WHO, 1999).

Since most family planning methods are used by the women, they have the right to confidentiality and privacy about their choice of methods. Therefore men being the decision-makers within the family unit need to be given the appropriate information and encouragement to take an active role in the family planning decision-making process with their wives. This helps to ensure that joint responsibility is taken for family planning decisions and it maximizes acceptability of the programme (UNFPA, 1999).

Some unmet needs for family planning by majority of women were unwanted pregnancies, unsafe abortion risks and deaths. Often these are related to satisfaction or dissatisfaction of accessibility to the location of clinics, appointment and waiting time, privacy, fee charging for family planning services, provider-client interaction

and communication on counseling, information and education on side effects, advantages and disadvantages on the methods.

On the other hand, supervision of managers and providers on availability of logistics such as suppliers, staff strength, knowledge and skills are needs to be assessed. These factors lead to client continuation or discontinuation of adopting family planning methods and use.

Moreover, recent Demography Health Survey in African countries has demonstrated the existence of high levels of unmet needs. For example, Ghana, Senegal and Togo had unmet needs over 30 percent. In other countries like Benin, Burkina Faso, and Cameroun, Cote d'voire, Guinea and Mali, the reported unmet need is between 20 and 30 percent.
Even though, 10 percent of situation where the Contraceptive Prevalence Rate (CPR) was accepted, women had felt needs of caring for at least two or at most three to four children (Policy Project, 2005).

Ten years after International Conference on Population and Development (ICPD), in Cairo (1994), it is estimated that there are nearly 39 million unintended pregnancies in Sub Saharan Africa (Global Health Council, 2004).

According to the Millennium Development Goal 5 which is improving the health of women, family planning has been accepted to promote good health among women and children. There is the need to increase family planning services so that by the year 2015, there will be universal access to full range of safe and reliable family planning methods. (Sai F.T., 2005).

1. 2 Problem statement

Family planning services has been available in Ghana for the past 40 years. However, achievements recorded had only been moderate in relation to the Millennium Development Goals and National Family Planning Policy.

In East Akim district, one woman out of every five of child bearing age was using contraceptive. Four out of every ten women who stated that they did wish to delay the next pregnancy were not using any effective method of family planning. According to the district profile, the contraceptive prevalence rate was 11.0% for 2006 and 13.0% for 2007. The acceptance rate of FP from 2004-2006 was 29.0% which was low.

For this reason, there was the need to find out what factors influence the use of contraceptive in order to meet the needs of women who practice FP and to promote acceptance rate.

Since the national population is growing at 2.7 percent annually, the population of Ghana could reach 31 million by the year 2015 and around 40 million by 2025. With the current family planning situation, the Millennium Development Goals would be is difficult to be achieved and the government's commitment to make Ghana a middle income state by the year 2015 would not be possible (Sai F.T., 2005).

Some of the factors which were inadequate logistics and human resources may be due to changes in donors and domestic government funding. This may have negative impact on sustainability of field work and clinics even though decentralization has been a positive influence. Other factors may be due to poor client-provider interaction which may affect information needed to enhance client's knowledge on side effect of the family planning method used.

This study set out to find the factors that influenced women in the reproductive age group in their decision making to adopt family planning method and use. The findings would assist the District Health Management Team

to improve measures of quality services to enhance continuity in family planning use.

1.3 Relevance of the Study

In East Akim district from 2004 to 2007, women who adopted family planning method were either continue to use it or discontinue within the same year due to client satisfaction or dissatisfaction of care and services.

Therefore, there is the need to find out the factors that influence the women decision making on adopting and continue using family planning method. The study findings would help the DHMT to improve on their strategic plans towards family planning services.

1.4 Research questions

1. What factors influence clients' satisfaction in using contraceptive?
2. How does client-provider relationship increase quality of care?
3. What factors affect effectiveness of supervision in family planning services?
4. What logistics are available to meet clients' needs?
5. What essential measures are necessary to motivate providers and improve their knowledge and skills?
6. What improvement in the family planning policy is needed to empower women in decision making to adopt family planning method and use?

1. 4 Objectives

Main Objectives: To assess factors that influence decision to adopt family planning methods and use.

Specific Objectives

1. To assess factors that influence clients' satisfaction accessing family planning.
2. To find out how client-provider interaction would increase quality care.
3. To find out the factors that affect effectiveness of supervision in family planning services.

4. To identify how available logistic would meet clients' needs.

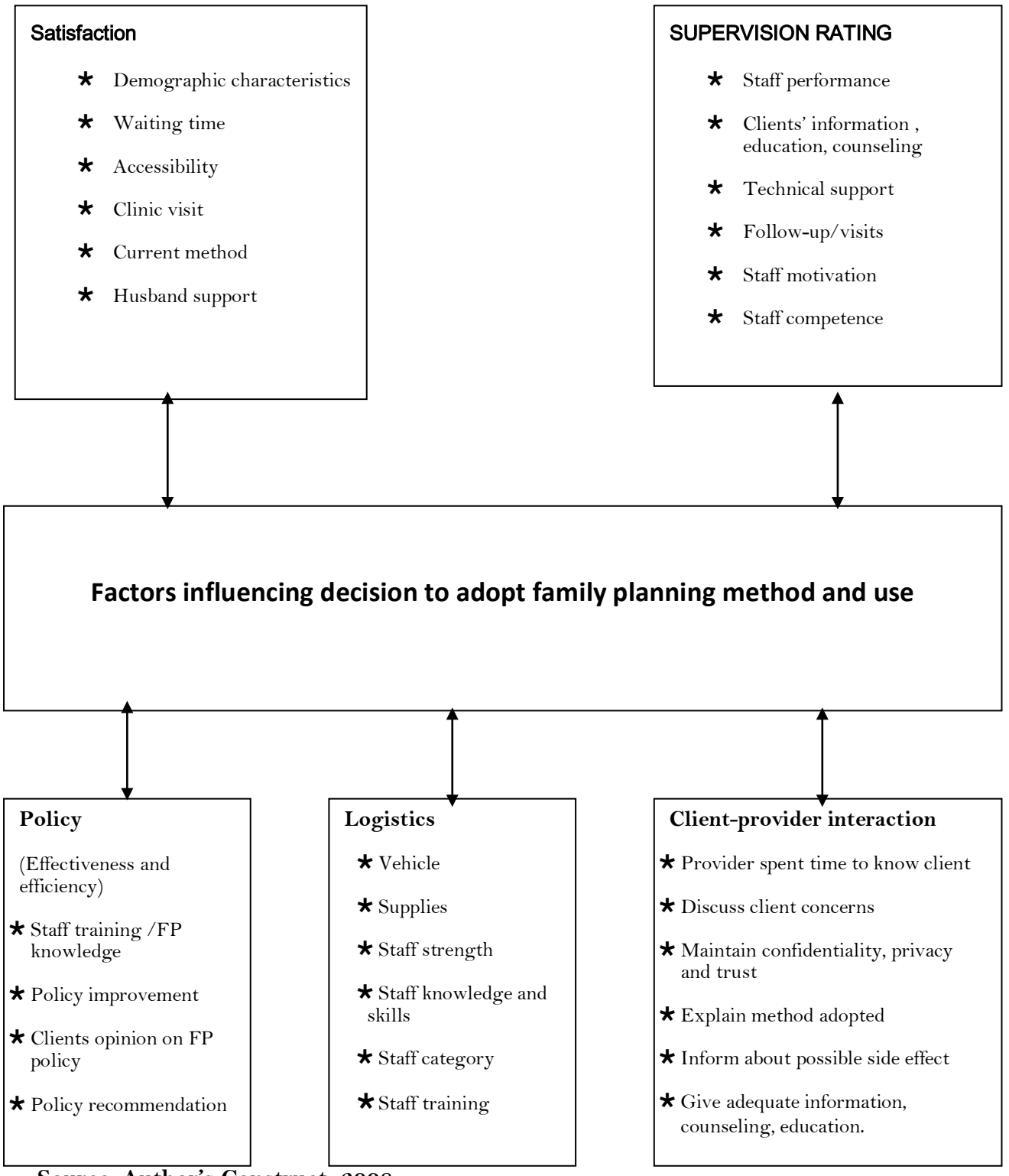
5. To identify how the family planning policy would be improved to empower women in decision making to adopt method and use.

1. 5 SCOPE OF THE RESEARCH

Persons living in the Tafo, Asafo and Apedwa communities at the time of the study were the reference population surveyed. The study considered respondents aged 15-39 who had delivered one and above and practiced family planning.

1. 6 Conceptual framework

FIGURE 1.1 Conceptual frameworks.



Source: Author's Construct, 2008.

CHAPTER TWO

2.0 LITERATURE REVIEW

Although, most women have knowledge of family planning, not all of them were willing to adopt a method or continue using it. These may be due to some factors that influence women's decision making to adopt family planning method.

2.1 Factors That Influencing Decision To Adopt Family Planning

Client's Satisfaction

According to Williams and others, (2000), client's satisfaction is the key to decision making to continue using methods and services. For all urban and rural women, it is very important that providers would be trustworthy, friendly, understanding, trained and competent in order to attract clients to utilize the clinic for services. In addition, lack of privacy and embarrassment by providers could create difficulties for clients attending family planning services (Williams et al., 2000).

Moreover, follow-up clients have been shown to express higher levels of satisfaction than first-time visitors. Reported satisfaction may be higher simply because the remaining clients are more willing to accept existing levels of quality care. Poor quality of service delivery could lead to such a decline in client, in that waiting time is no longer an issue (William et al, 2000).

Despite the fact that client-provider interaction might improve the rate of contraceptive adoption and effective use, research suggests that the amount of time is less important if information exchange is not focused on client's situation (Leon, et al, 2001).

A study in Jakarta and Ujung Pandang showed that more than two-thirds of 760 married women, aged 30 to 45 years discussed contraception with their husbands and adopted it because they saw family planning as a means to reduce the family's economic burden (Summer, 1998).

Demographic and socioeconomic information provided in the 1988 Ghana Demographic and Health Survey on current contraceptive use showed that,

currently married women aged 15–49 are the most predictors of current contraceptive use. This is followed by discussion of family planning with partner and level of education. As a policy measure, information, education and communication programmes on family planning should be intensified, particularly in rural areas. Female education, at least up to secondary level, should be given top priority (E. O. Tawiah .1997).

As postulated by Caldwell and McDonald (1981), education gives women greater power over many circumstances in decision making. Education also influences their health seeking behavior and also the utilization of health care services.

Even though the effect of education on fertility, contraceptive behavior and contraceptive method choice has been extensively researched in the family planning literature, the education levels completed by husbands and wives have been shown to be salient factors in determining the use of specific contraceptive methods (Bina Gubhaju, August 2008).

According Ezeh C. Alex, (1996), a Demographic Health Survey done in Ghana on the mean ideal family size for currently married women was higher than for unmarried women. This difference was significant in West Africa, ranging from about two children in Burkina Faso to more than four children in Niger and Senegal. In East and North Africa, no significant difference in fertility desire was found (Ezeh C. Alex, 1996).

Many women use contraceptive poorly. The reasons include personal feelings and beliefs; experiences with methods; fears about side effects; partner influences; cultural
values and norms; and problems in the contraceptive care system (Guttmacher Institute, April, 2008).

According to WHO, 2005, packages to satisfy the needs and preference of target population are the availability and accessibility of supply, proximity of clinic, short

appointment and waiting time to be attended to, privacy and low fee charging (WHO 2005).

In Lesotho, for example, the obstacle to contraceptive use included long distance and transportation cost to clinics site, lack of privacy, contraceptive shortage and restrictions imposed by providers on who could use certain methods (Tuoane et al., 2004).

Currently in Madagascar, a study done revealed that Norplant adoption rate was higher among women who were counseled on use of modern method of contraception and were more satisfied with it. Moreover, other study finding was that client's satisfaction in family planning method used and contraceptive supplies were the likelihood that women who adopt a method continue using it or switch methods when dissatisfied with the method adopted (Tapsoba, 1993.; Ali, 2001.; Ketende et al, 2003.; Ross J., et al, 1999.; Stephenson Tsui, 2002.; Thongand et al, 2002).

Although many contraceptive methods are available in Kenya, over the years the MOH has noticed that the national modern family planning methods had become dominated by contraceptive pills and injectables while proportion of contraceptive users choosing the IUCD has decreased significantly. Under utilization of the IUCD suggests that the full message about its advantages including safety, effectiveness, low cost, convenience, and possibility of long-term use is not getting through (DRH/MOH, Kenya, February 2003).

The 1998 Kenya Demographic and Health Survey (KDHS) conducted a study on information on contraceptive knowledge and use. Contraceptive practice in Kenya in the last 10 years showed that women initiate and stop contraceptive practice in response to changes in their own circumstances and in their social and health environment. They choose different methods at different points in their lives. Thus, the contraceptive prevalence and method at any given point in time is the result of series of decisions made by individual women to start contraceptive use, stop use, restart use, and to choose one method over another one (KDHS, 2001).

WHO also conducted project on policy and service delivery on contraceptive method which revealed the need to increase the range of contraceptive method and improve on user satisfaction. This enhanced program reputation and increased contraceptive prevalence which contribute to ultimate goal of reducing unwanted pregnancy (WHO, 1999).

Attention to education and family planning services is important. Introducing family planning knowledge in the society is preparation for parenthood. Research has concluded that these programs were most successful in ensuring behavioral change (IFPP, 1984).

Moreover in the case of financial support Bangladesh women were often totally dependent on their husbands so they were reluctant to use contraceptive because they thought their husbands might view family planning as an economic burden (Summer, 1998).

Although majority of women said their husbands or partners were usually involved in contraceptive discussions, the nature of the involvement varied. Some men were involved by supporting women's contraceptive decisions, other men used methods themselves, and others posed obstacles for women's use of family planning (Ann E. Biddlecom et al, 1997).

Client-Provider Interaction

According to Murphy E., and Steele C., 2002, client-provider interaction is treating individual well, providing client preferred method and giving individualised care and also educating the client**.** Using memory aids are also effective way to help clients understand the advantages and disadvantages of the method used**.** The client should know prevention of sexual transmitted infections and when to report the occurrence of any complication (Murphy et al., 2002).

Babalola and others study showed that, given information, education and communicate on family planning issues to family and friends aid to publicize services

as well as encouraging people to adopt contraceptive and increase the demand for quality care (Babalola et al., 2001).

Although population growth is the most fundamental problem that affects adversely the advancement of nations and the wellbeing of all peoples, the level of knowledge on modern contraceptive methods through mass and interpersonal communications could be one of the key strategies to increase the utilization rate (Adeyemi et al., 2001).

Furthermore, the World Health Organization has developed a Decision-Making Tool for Family Planning Clients and Providers (DMT) to improve the quality of family planning counseling. This educated new clients about the chosen method and clients did open up more about their situation and their wishes. This had a greater impact on sessions in which clients chose a new contraceptive method, as compared with visits by returning clients for a check-up or resupply (Kim et al, 2007).

A study was done in Nicaragua where communication was impacted in family planning by using decision making tools. It was shown that service providers who attended a training workshop on the DMT after the intervention increased their efforts to identify and responded to client needs. They involved clients in the decision-making process; screened them and educated new clients about their chosen method (Kim et al., 2007).

Studies had also found that counseling client on the possible side effect before they begin a method lowers discontinuation rates (Cotton et al 1992, Canto de Cetina et al, 2001).

Supervision

According to Wolff J.A., supervision and support to staff must be improved by staff performance, motivation and conflict management. Supervisors must develop performance and appraisal assessment systems to help set up a working standard (Wolff J.A., 1991).

A study on the effort of technical supervision and training supervisors on performance was conducted in Ghana on community–based distribution. It was found that training on technical supervision increased knowledge and skills. In a focus group discussion with the supervisors, transportation was identified as the biggest obstacle to carry out duties and inadequacy of supplies. The impact of the study was that, trained supervisors improved on their visits and addressed wide range of problems (Combary P., et al, 1999)

A research done in Zimbabwe assessed supervisors–providers interaction on performance and technical competence. However, the result was that supervisors failed to involve providers in problem identification and solving and paid little attention to clients input in the quality of services received. It was agreed by the local organization that supervisors could move from a hierarchical top to down approach to work as partners (Kim et al 2002).

However, assessments on performance of family planning programmes were identified as weak due to ineffective supervision. Therefore technical support and staff motivation could be improved through effective supervision (Simmons et al, 1987).

Other studies also conducted in Africa, Asia, and Latin America have shown that supervisors do not visit service delivery site regularly and do not remain long enough during visit (Ahmed et al, 1994.; Ashraf et al, 1996; Combary et al, 1999; Kim et al, 2006).

Logistics

Although majority of Pakistani women were familiar with family planning, the use of contraceptives remained low. Certain characteristics of family planning providers and health facilities were identified that affected women's initiation of contraception adoption. These helped program administrators to devise interventions to increase contraceptive use. Providers also began an awareness campaign of contraceptive needs of women with all levels of education and parity. Additionally, family planning facilities were improved and this also increased clients' contraceptive use by providing diversity in method choice, keeping offered methods in stock, displaying informational materials, and raising staff levels (Hamid S. et al., 2006).

Certain studies on supervision showed that supervisors frequently lack time and transport needed to visit remote clinics and these had effect on their duties. Therefore supervisors must be given directions concerning their job description to improve on their performance (Combary P., et al, 1999.; Loevinsohn et al., 1998).

Marie Stopes and others,(2002), find that the interest in family planning in women in their reproductive age is rising**,** but the demand for contraceptive supplies are limited by inefficient and poorly coordinated donors funding as well as inadequate logistics capacity in developing countries (Marie Stopes, et al., 2002)**.**

Further data from the 1998 Demography and Health Survey in Egypt revealed that health personnel trained in family planning lacked access to certain facilities needed for their services and this limited the range of availability of contraceptive and caused discontinuation (Egypt, DHS., 1998).

Other studies undertaken in Ghana and Guatemala suggested that higher system performance may result from keeping certain logistics management at both centralize and decentralize level of service delivery (Bossert T., et al., 2004)**.**

Despite good contraceptive coverage rates, recent studies in Iran have shown that, there should be focus on training programmes for care providers by giving priority to devise effective supervision. There are mechanisms and job training of senior

nursing and midwifery graduates which make them more competent in delivering basic family planning services (Shahidzadeh-Mahani A., et al., 2006).

According to Beith and others, (2006), policies can affect logistics function such that in some cases where family planning was integrated into other programs, its corresponding logistics system lost priority and moreover the program lacked political support. For example, in 2001, Peru began to integrate the family planning program into all other health programs. This integration process greatly compromised the family planning and contraceptive logistics system. Particularly, there was reduction in management staff and the merging of budgets, because the MOH had little commitment to taking over contraceptive supply chain management from an outside entity (Beith et al., 2006).

In September 1987, the Health Education Division of Ghana's Ministry of Health (MOH/HED) began a systematic family-planning on IEC project with funding from USAID and technical assistance from JHU/PCS. The goals of the project were to increase knowledge and improve attitudes toward family planning and promote contraceptive use among women of reproductive age. This enhanced family-planning counseling skills among MOH service providers (Lalla Touré ,1996).

Policy

According to Kols A.J. and Sherman F., to improve family planning programmes, there must be good maintenance and service quality, designed programmes by managers, control of day-to-day activities with supervision and monitoring (Kols A.J.; et al., 2001).

Other studies had showed that designing training programmes did not only improve performance of family planning providers and managers but also had favorable effect on outcomes such as client knowledge, compliance with return visits and contraceptive use (Halawa et al, 1995).

There have been laws developed over the past half century which have significantly improved adolescents' and women's access to essential sexual and reproductive health care. These regulations protect women's access to family planning services in publicly funded programs and constitutional right of privacy and confidentiality (English A, 2007).

For instance, in the United States there were problems of high unintended pregnancy and abortion; they focused on reducing barriers to contraception and improved opportunities to expand access. The ability to reduce unintended pregnancy depends on making family planning services available to all. A comprehensive approach requires policy change to improve funding for and access to family planning, to provide comprehensive sex education and to reduce insurance and religious barriers to contraceptives (Espey E., 2007).

According to Kim and others, (1996), campaigning on knowledge of family planning methods use also encouraged couples to communicate more about family planning and to decide jointly on a contraceptive method (Kim, et al., 1996).

For this reason the International Population Community has drawn attention towards how family planning programmes would work to attract and retain clients in developing countries (Betrand T.J., et al 1995).

Hence campaign has expanded to all areas through varieties of IEC material, media, and activities, including leaflets and booklets, motivational posters, national radio and television broadcasts, drama, a theme song, community audiovisual material, and community activities (Lalla Touré ,1996).

Attainment of success of family planning program in Zambia was to increase the prevalence of modern contraceptive use from 8.9% to 22.6%. Therefore projects done in Zambia incorporated a number of innovative strategies. These included involving the community by meetings with community leaders and traditional chiefs.

Efforts were made to move services beyond the clinic walls through community-based distribution (CBD) agents, commercial sales agents, and employer-based agents. These activities have had some success, but there is still a need to improve

access to family planning in rural areas through CBD and strengthened clinic services. CBD was an effective way to get services to rural populations, but it needs to be more widespread to have an impact

Hence in Bangladesh for example, changes in service delivery design from community-based distribution to clinic-based services to cut cost reduced field workers productivity and poor women's access to contraceptives ((Solo et al., 2005; Arends-Kuenning et al.; 2002).

Despite the increase in coverage to help sustain an efficient and continuous supply of contraceptives, various logistics functions negatively affected the supply chain throughout the planning and implementation process. Through careful planning, decision makers could help maintain a well-built logistics system that guarantees the availability of contraceptives to clients (Abramson Wendy et al, 2006).

According to Setty-Vernigopal and others, good logistics system ensured smooth distribution of contraceptive commodities and other supplies, so that at each service delivery point, there would be sufficient stock to meet clients' needs. Therefore, managers could use existing resources more efficiently by offering fewer or lower cost contraceptive method and ensuring that staff, equipment and facilities are fully utilized (Setty-Vernigopal et al, 2002; FPLM, 2002;

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study Method and design

A cross sectional descriptive study was done in three sub districts which were Tafo, Asafo and Apedwa. The study started from August 2008 and ended in November 2008 and involved 200 women of age between 15-39 years who practiced family planning and had one child and above. The women attended the community clinic and were interviewed or were visited at home.

3.2 Data Collection Techniques and Tools

The study techniques used were

- Questionnaire administration

- Observations

- Check list

The data collection tools used were

- Structured questionnaire administered to the service providers and the clients.

- Indirect observations were made on the providers' relationship with the clients.

- Secondary data was used by reviewing clinical attendance book.

- Focus group discussion was conducted to assess the clients' knowledge and decision making in preferred family planning method used and their willingness to continue.

- Check lists were used to rate clients' satisfaction on care given, clients'-providers' interaction and providers' opinion on service quality.

3.3 Study Population

The study populations were women who had practiced or were still practicing family planning and the service providers at the community clinics of Tafo, Asafo and Apedwa. The reference population were adolescents and women who had one child and above and those who had no child but practice family planning.

3. 4 Profile of the Study Area

East Akim District is one of the seventeen administrative districts of Eastern Region of Ghana. It is found in Akim Abuakwa and is bounded on the north by Atiwa district, north-west by Birim North, south by Suhum Kraboa- Coalta and south-west by Fanteakwa district, west by Birim South and West Akim districts. It has Kibi as its administrative and traditional capital which is about 56

kilometers from Koforidua, the regional capital. The district covers an area of 950 square kilometers.

East Akim has a population of 110,145 according to 2007 district annual report. The district has six sub districts namely Kibi, Tafo, Apedwa, Asafo, Bunso and Asiakwa. The district accommodates all types of ethnic groups. The major group is Akim and the minor tribes are Ewes, Dagartis, Krobos, Akwapim and Ashantis.
The economic activities in the district include farming, petty trading, small-scale industries and employment in the formal sector.

The district is under the political administration of the District Chief Exercutive, Presiding Member and Assembly Members forming the District Assembly. The paramount chief of East Akim Abuakwa Traditional area is Nana Amoatia Ofori Panin II with the seat at Kibi.

Some health problems in East Akim District are high mal-nutrition among children between six months to five years, low hemoglobin level of pregnant women especially after 36 weeks, high incidence of schistosomiasis. The contraceptive prevalence rate was 11 percent in 2006 and 13.3 percent in 2007. The acceptance rate of family planning from 2004-2006 was 29% and the couple year protection was 28.7%. The short term and long term acceptance rates were 21.2% and 0.54% respectively.

The municipal has forest vegetation and experiences rainy season from April to October and dry season start from November and ends in March in the following year. For the general infrastructure, the main Kumasi-Accra road is tarred and there are other feeder roads and pathways which lead to the smaller communities and villages. Source of water is pipe borne, bore-holes, wells and river Birim.

There are seven educational circuits with public and private schools from pre-school to the tertiary level. For health infrastructure, there are two hospitals at Kibi and Tafo, four health centers at Asafo, Apedwa, Bunso and Asiakwa. There are three

reproductive and child health (RCH) at Asafo, Apedwa and Bunso, eight 'CHPS' compound and twenty-three demarcated sites for 'CHPS' centers.

Table 3.1 SUB DISTRICTS POPULATION

Sub-Districts	2007 Population	Wifa 24 percent	Expected Pregnancy and Delivery
Kibi	**27,469**	**6318**	**1099**
Tafo	**35,742**	**8221**	**1430**
Apedwa	**12,753**	**2933**	**510**
Asafo	**11,647**	**2679**	**466**
Bunsu	**12,519**	**2879**	**501**
Asiakwa	**10,015**	**2303**	**401**
Total	**110,145**	**25333**	**4406**

Source: Annual Report 2007, East Akim Health Districts.

3.5 Sample Size Estimation

A study population of 230 was used. A sample size of 177 was estimated based on the contraceptive prevalence rate of 13.3% of the population of 25,333 women in fertility age according to 2007 annual report. A confidence level of 95% and error tolerance of 0.05% were used. An additional 23 clients were included based on 13% of the sample size estimated for margin of error, making up to a total of 200 respondents plus 30 providers who were also interviewed.

Using the formula $N=z^2pq / d^2$, where $q= (1—p)$ (Wayne, 2006)

N = Sample size

Z = Reliability coefficient which was 95% confidence level that majority of the population making decision in practicing family planning lie within this interval.

From statistical distribution table 95% = 1.96

P = Prevalence which was 13.3% of women using contraceptive method.

Pq = (0.133) (1- 0.133)

d = Error tolerance which was 0.05.

By substituting the values into the stated formula

$$N = \frac{(1.96)(1.96)(0.133)(1-0.133)}{(0.05)(0.05)}$$

$$= \frac{(3.8416)(0.133)(0.867)}{0.0025}$$

$$= \frac{0.44298}{0.0025}$$

$$= 177$$

N = 177 (Sample size estimated).

3.6 Study Method

Even though a sample size of one hundred and seventy-seven (177) respondents was calculated but a total of two hundred was used for margin of error. Questionnaire was used to obtain some demographic characteristics of respondents who practiced family planning and also used to obtain data related to quality of family planning services from the providers. Another set of interview questions was administered to appropriate staff who provided family planning services at the community clinics and the 'CHPS' centers.

Table *3.2* Table of Variables

VARIABLES	OPERATIONAL DEFINITION	INDICATORS	SCALE OF MEASURE-MENT	DATA COLLECTION TOOLS	EXPECTED OUT-COME

Satisfaction	Clients' perception of care and services	-Clients demographic characteristics - Accessibility - Waiting time -Clinic visits -Current FP method adopted -Husband support	Nominal/ Ordinal Nominal Nominal Nominal Nominal Nominal	Structured Questionnaire	High Accept-ability rate
Supervision	Managers and providers Effort in monitoring daily activities	-Information, education,-counseling -Follow-up/visits -Staff performance -Technical support -Staff motivation -Competency	Ordinal	-Indirect observation -Structured Questionnaire	Improve Supervision
Client- Provider interaction	Friendly Relationship	-Provider spent time to know client -Discuss client concerns -Maintain confidentiality, privacy and trust -Explain method adopted -Inform about possible side effect -Adequate information, counseling, education	Ordinal	Indirect Observation/ check list	Improve Inter-personal relation
Logistics	Available resources and working standard	-Vehicle, -Supplies, -Staff strength -Staff category -Up-grade of staff skills -Highest level of staff education -Training for FP capability	Ordinal	Structured Questionnaire	Increase
Improve policy	Effectiveness and efficiency of strategy	- Staff skills up-grade -Policy improvement -Clients opinion on FP policy -Policy recommendation	Ordinal	Structured Questionnaire	Improve Strategy

Source: Author's Construct, 2008.

3.7 Study Variables

The dependent variable was decision making.

The independent variables were:

- Satisfaction or dissatisfaction,

- Client's-provider's interaction,

- Supervision

- Logistics

- Improve policy

3.8 Sampling Techniques

Simple random sampling was used to select three sub-districts which were (Tafo, Asafo and Apedwa) out of the six in the district. The community clinics in Tafo, Asafo and Apedwa were used in addition to home visit to the communities of Bomponso, Agyaponma, Adonkwanta. Structured questionnaire were administered to 200 clients from the family planning clinic on daily basis and defaulters were followed up to their communities by tracing their addresses in the clinic registers until the sample size was achieved.

Structured questionnaire were given to 30 providers who worked at the community clinics and the CHPS centers in the three selected sub-districts to determine their supervision, logistics and the efficiency and effectiveness of the policy strategies for service quality

3.9 Pre-Test

The questionnaires were pre-tested at the community clinic at Asiakwa which is one of the sub-districts not included as a study site.

After the pre-test, the researcher found that:

-Some respondents were unwilling to answer questions about practicing family planning

-Some questions were particularly difficult to answer.

-A good number of questions were well understood by the respondents.

-The local dialect Twi was the main language well understood by the interviewers and the respondents.

The questionnaire was modified afterwards and used for the main study.

3.10 Data Collection Plan

At each of the three sub-districts selected one community health nurse was trained to understand the questionnaire and how to administer it to the respondents. Money was provided to the assistants to cover the day-to-day activities and any unexpected expenses. The necessary tools; pens, pencils and erasers were purchased well in advance of the survey. Completed questionnaires were entered into the software by the researcher on daily basis.

3.11 Data Handling and Analysis

The collection of data was done daily by researcher and assistants and recorded. Respondents were made to understand the questions before giving their responses. The data collected was compared for completeness, accuracy and relevance and stored electronically for confidentiality. Variables were categorized mostly into nominal scale of measurement and a few ordinal and the frequencies, percentages analyzed using EPI INFO version 8.0, 2008 and Excel.

Preliminary findings were discussed with the DHMT for their action.

3.12 Ethical Consideration

An introduction letter was sought from the District Director of Ghana Health Services for ethical clearance and support and a copy shown to respondents to gain their consent. Permission was also sought from the various assemblymen in the selected sub-districts by giving a copy of the introduction letter which explained the

purpose of the study and the benefits to the women. The questionnaire was confidential and anonymous and were processed and held safely. Confidentiality was ensured by respecting clients' right to privacy and information given. No information was passed on to anyone that could allow for the possibility of identifying persons completing the forms. As much as possible data and information were kept electronically.

3.13 Limitation of the Study

The challenges met during the study were time constrain and accessibility to the remote villages. Therefore not all the communities within the selected sub-districts were captured.

3.14 Assumptions

1. Current prevalence rate of family planning method adopted was 13.3%.
2 The calculated sample size was indeed representative of the current women in their reproductive age adopting family planning method and use.
3. All women had knowledge on family planning methods and uses.
4 External factors that could influence the study and were beyond control did not feature in the course of the study.

3.15 Expected Outcome

This study would help increase acceptability, improve supervision and client-provider interaction, increase logistics and improve policy strategies to achieve quality service and care.

CHAPTER FOUR

4.0 Results

The results were section one which involved the respondents and section two involved the providers

SECTION ONE

4.1 Clients' satisfaction

Among the sub-districts selected and communities were Asafo, Adonkwanta, Agyaponma, Apedwa, Tafo, Bonponso.

Table 4.1 Percentage distribution for Age of Respondents

Clients Age Group	Frequency	Percentage %
15-19	11	5.5
20-24	39	19.5
25-29	45	22.5
30-34	47	23.5
35-39	58	29.0
Total	**200**	**100.0**

Source: Field Data, 2008.

The percentage of the adolescents aged between 15-19 years was 5.5%. Women who were between 20-24 years represented not less than 19.5%, whereas 22.5% were respondents aged between 25-29 years. Those in the age group 30-34 years were 23.5% while 29.0% represented respondents aged between 35-39 years. The minimum age was 16 years and the maximum age was 39 years. The standard deviation for the ages was 6.28 and the mode of the age was 22 years.

Table 4.2 Percentage distribution for Level of education of Respondents

Level of education	Frequency	Percentage %
Elementary	17	8.5
JSS	110	55.0
Primary	26	13.0
SSS	23	11.5
Tertiary	4	2.0
Uneducated	19	9.5
Vocational	1	0.5
Total	**200**	**100.0**

Source: Field Data, 2008

For the level of education achieved, 8.5% completed elementary, 55.0% had JSS education, 13.0% had primary education, 11.5% had SSS education, 2.0% had tertiary education, 9.5% had no formal education, while 0.5% had vocational skills training.

Table 4.3 Percentage distribution for Marital Status

Marital status	Frequency	Percentage %
Divorced	5	2.5
Married	143	71.5
Separated	4	2.0
Single	46	23.0
Widow	2	1.0
Total	**200**	**100.0**

Source: Field Data, 2008

Among the respondents, 71.5% were married and less than 30.0% were either divorced, separated, single or widow.

Table 4.4 Percentage distribution for Respondents' Occupation

Client occupation	Frequency	Percentage %

Farming	26	13.0
Trading	110	55.0
Teaching	6	3.0
Seamstress	15	7.5
Hair dressing	22	11.0
Not working	21	10.5
Total	**200**	**100.0**

Source: Field Data, 2008

Majority of the respondents were petty traders which represented 55.0%, 13.0% were farmers, 3.0% were teachers, 7.5% were seamstresses and 11.0% were hair dressers while less than 10.5% were unemployed.

Table 4.5 Percentage distribution for Number of Children of Respondents

Number of children	Frequency	Percentage %
0	4	2.0
1	41	20.5
2	46	23.0
3	46	23.0
4	42	21.0
5	15	7.5
6	5	2.5
8	1	0.5
Total	**200**	**100.0**

Source: Field Data, 2008

From the result, 2.0% had no child, 20.5% had one child, 23.0% had two or three children respectively, 21.0% had four children each, 7.5% had five children, 2.5% had six children and 0.5% had eight children.

Factors Influencing Adoption of FP

4.1.1 Waiting Time

Table 4.6 Percentage distribution for Waiting Time

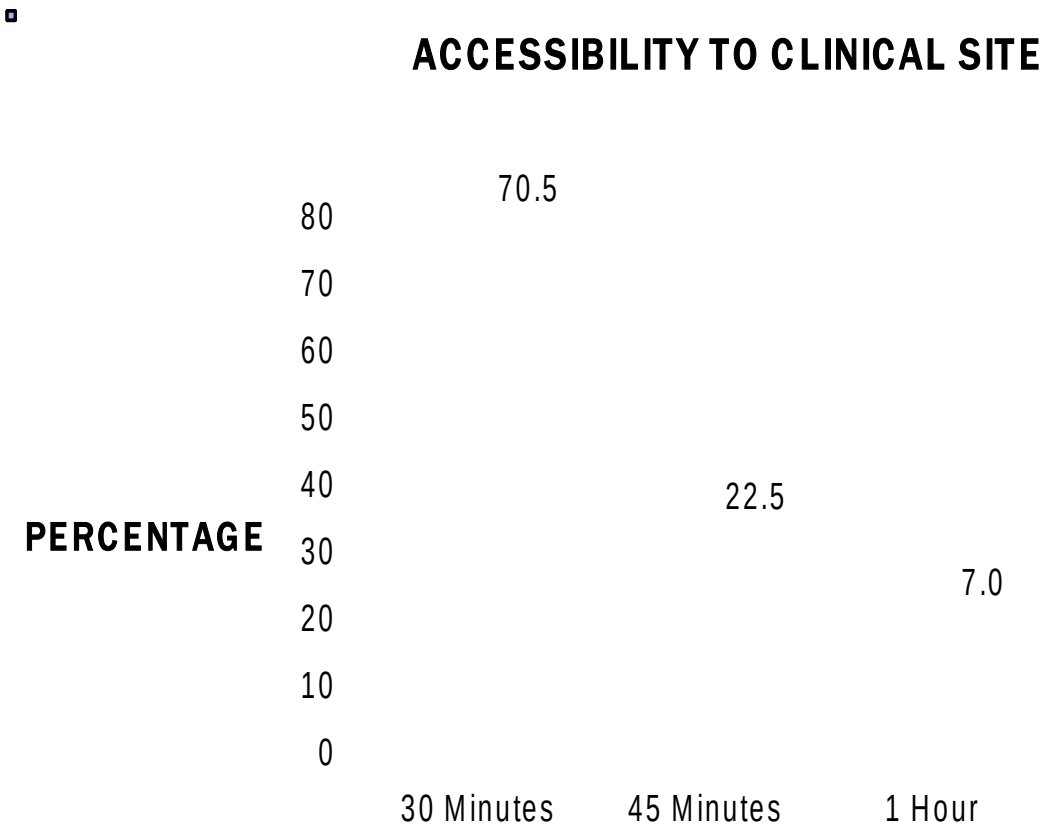
Waiting time	Frequency	Percentage %
Less than 1 hour	185	92.5
More than 1 hour	15	7.5
Total	**200**	**100.0**

Source: Field Data, 2008.

According to the result, 92.5% spent less than one hour at the clinic to be attended to while 7.5% spent more than one hour. Since over 90.0% of respondents spent less than one hour to be attended to, it was an improvement to increase FP acceptance rate.

4.1.3 Accessibility to Clinical site.

Figure: 4.1 Percentage distribution of Accessibility to Clinical site.

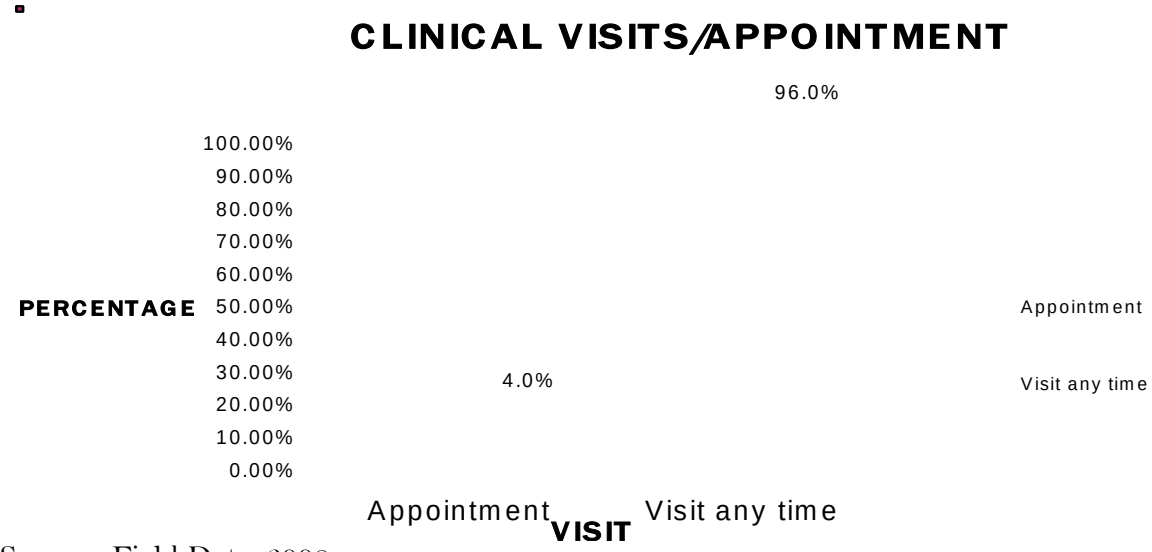


Source: Field Data, 2008.

According to the result, 70.5% of respondents had access to the FP clinic in 30 minutes, 22.5% accessed the clinic in 45minutes while 7.0% were able to access the clinic in one hour. Therefore majority accessing FP services in less than 30 minutes was good.

4.1.4 Clinic Visit for FP Respondents.

Figure: 4.2 Percentage distributions for Clinic visits

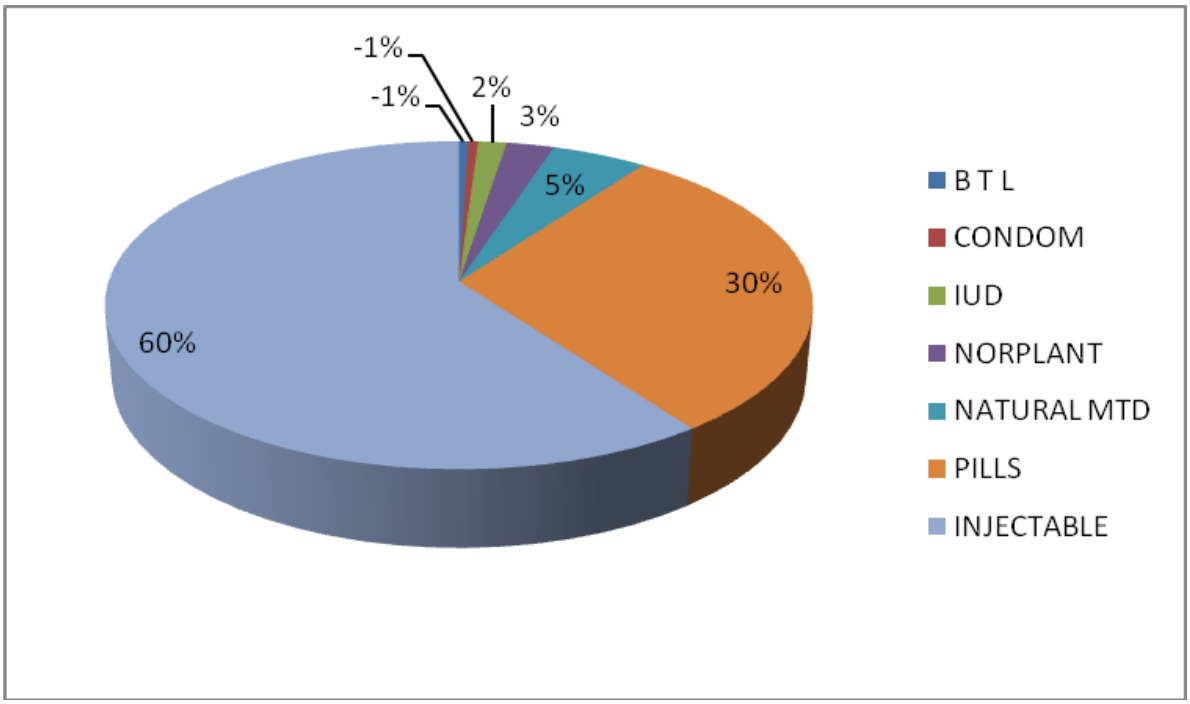


Source: Field Data, 2008.

According to the result, 4.0% of respondents visited the FP clinic by an appointment while 96.0% of respondents visited the clinic at any time. This was good since over 90.0% visited the clinic at any time could address the problem of discontinuation.

4.1.5 Current Family Planning Method Use

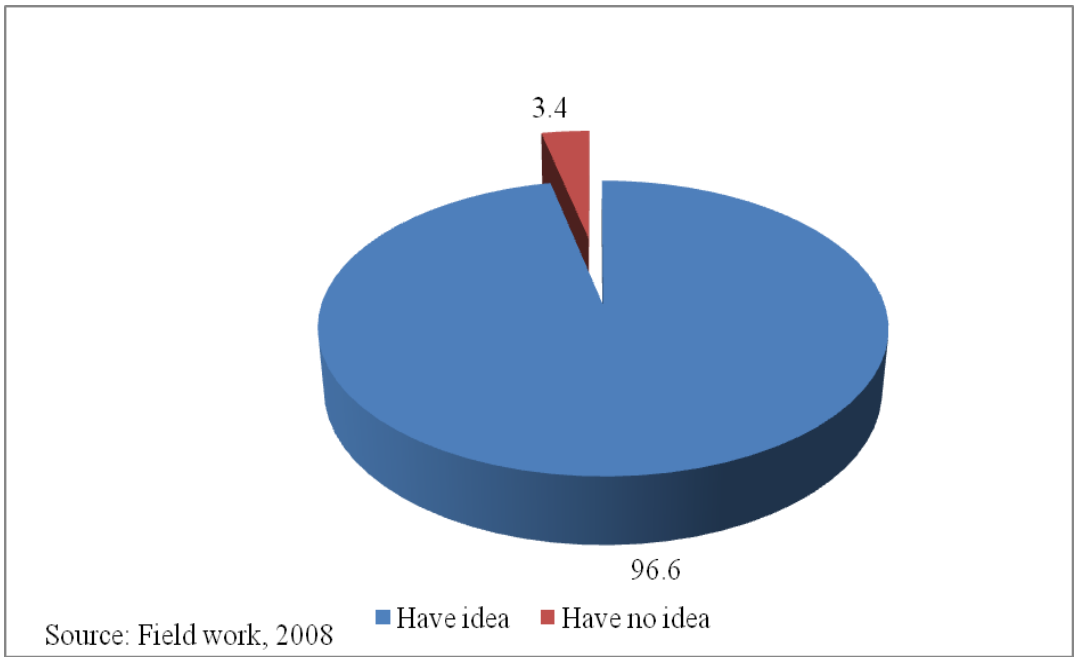
Figure: 4.3 Percentage distribution of Current Family Planning Method Use



Source: Field Data, 2008.

From the results 60.0% of respondents adopted injectable, followed by pills representing 30.0%. Respondents who adopted Norplant were 3.0%, 5.0% used natural method while 2.0% adopted IUCD and 1.0% used condom and BTL respectively. Since less than 10.0% of the women adopted Norplant, Natural method, IUCD and BTL, there was the need to increase information on these methods and train more providers on insertion of IUCD and Norplant.

Figure 4.4: Percentage distribution of respondents by knowledge of family planning



From the chart, 96.6% of respondents had knowledge on FP while 3.4% had no idea. Therefore, with over 90.0% respondents having knowledge on FP it could increase acceptability.

Table 4.7 Percentage distribution for Reasons for women stopping FP

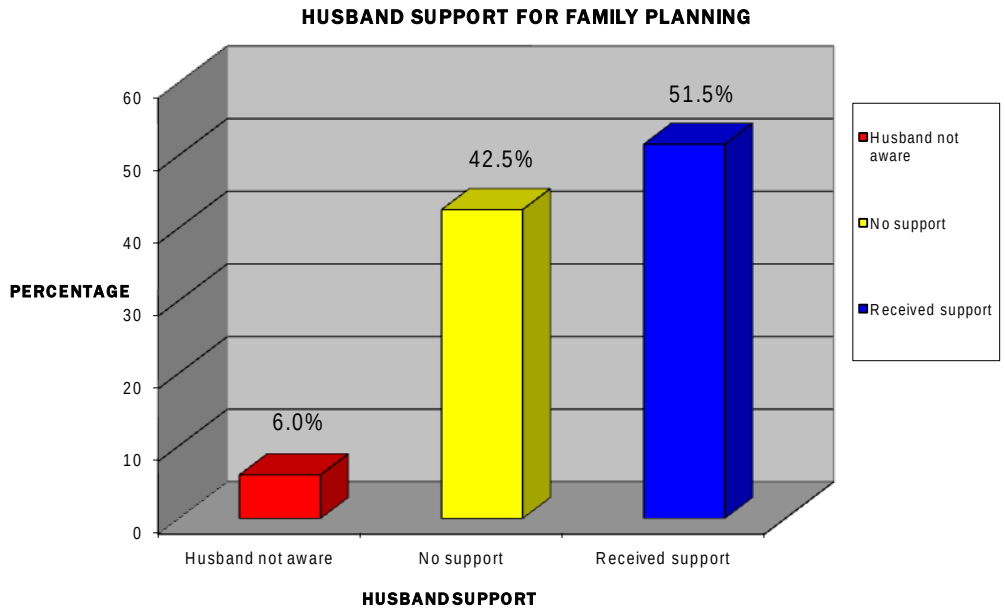
Reason for Stopping Method	Frequency	Percentage %
Divorce	1	0.5
Failure of method	2	1.0
Husband disagreed	2	1.0
Immigrant	1	0.5
Long distance	7	3.5
No privacy	1	0.5
Shortage of supply	5	2.5
Side effect	172	86.0
To have another child	9	4.5
Total	**200**	**100.0**

Source: Field Data, 2008.

According to the results, the main reason for women stopping FP method was side effects of the method used as 86.0% of the respondents gave their reports. This was followed by the need to have another child.

4.1.6 Husband Support to Respondents

Figure: 4. 5 Percentage distribution of Husband Support FP



Source: Field Data, 2008.

The result showed that 6.0% of respondents practiced FP without their husbands awareness, 42.5% of respondents had no support from their husband while 51.5% received support from their husband.

Table 4.8: Percentage distribution of willingness to Adopt FP Method

Clients Willingness to Adopt FP Method

Willingness to adopt FP method	Frequency	Percentage %
Willing	177	88.5
Unwilling	23	11.5
Total	**200**	**100.0**

Source: Field Data, 2008.

According to the results, 88.5% of respondents were willing to adopt FP method while 11.5% of respondents were unwilling to adopt a method. Therefore over 80.0% willing to adopt FP means acceptability could be increased.

Table 4.9 Percentage distribution of Client Satisfaction of FP Services

Clients' Satisfaction	Frequency	Percentage %
Dissatisfaction	6	3.0
Partially Satisfied	9	4.5
Very Satisfied	185	92.5
Total	**200**	**100.0**

Source: Field Data, 2008

From the result, about 3.0% of respondents were dissatisfied with FP services, 4.5% were partially satisfied while 92.5% were very satisfied.

Table4.10 Percentage distribution of Willingness, Somehow willing and Unwilling to Continue FP Method.

Method Continuation	Frequency	Percentage %
Willing	96	48.0
Somehow willing	85	42.5
Unwilling	19	9.5
Total	**200**	**100.0**

Source: Field Data, 2008

The results showed that, 48.0% of respondents were willing to continue with FP method, 42.5% were somehow willing while 9.5% were unwilling to continue method.

Comparing some demographic characteristics with willing or unwilling to adopt FP method.

Table 4.11: Percentage distribution of Relationship between mothers' age and adoption of FP method.

ADOPTION OF FP METHOD

AGE GROUPS	UNWILLING	WILLING	TOTAL
15-19	1, (0.5%)	10, (5.0%)	11
20-24	3, (1.5%)	36, (18.0%)	39
25-29	5, (2.5%)	40, (20.0%)	45
30-34	4, (2.0%)	43, (21.5%)	47
35-39	10, (5.0%)	48, (24.0%)	58
TOTAL	***23* (11.5)**	**177 (88.5%)**	**200**

Source: Field Data, 2008 $\Rightarrow \chi^2=16.528$; $p=0.035$

The results showed that 88.5% of respondents from all the various age groups were willing to adopt FP method with 24.0% of them being those aged between 35-39 years most willing to adopt FP method. From the results the willingness to adopt a method increased as the age group also increased. ie from 15-19 years to 35-39 years onwards.

Table 4.12: Percentage distribution of Relationship between Marital Status and Adoption of FP Method.

	ADOPTION OF FP METHOD		
MARITAL STATUS	**UNWILLING**	**WILLING**	**TOTAL**
DIVORCED	1, (0.5%)	4, (2.0%)	5
MARRIED	15, (7.5%)	128, (64%)	143
SEPERATED	0, (0.0%)	4, (2.0%)	4
SINGLE	6, (3.0%)	40, (20.0%)	46
WIDOW	1, (0.5%)	1, (0.5%)	2
TOTAL	**23, (11.5%)**	**177, (88.5%)**	**200**

Source: Field Data, 2008 $\Rightarrow^2$=9.217; p=0.324

There is no statistically significant association ($\Rightarrow^2$=9.217; p=0.324) between marital status and willingness to adopt family planning method. This showed that irrespective of the marital status, respondents were willing or not willing to adopt family planning method.

Table 4.13: Percentage distribution of Relationship between Husband Support and Adoption of FP Method.

	ADOPTION OF FP METHOD		
HUSBAND SUPPORT	**UNWILLING**	**WILLING**	**TOTAL**
No Support	15, (7.5%)	82, (41%)	97
Received Support	8, (4.0 %)	95, (47.5%)	103
TOTAL	**23(11.5%)**	**177(88.5%)**	**200**

Source: Field Data, 2008 $\Rightarrow^2$=6.377; p=0.382

The results showed that 47.5% of respondents who received support from their husband were willing to adopt FP method while 4.0% were unwilling and 41.0% of respondents who received no support from their husbands were also willing to adopt a method. The data showed no statistically significant association ($\Rightarrow^2$=6.377; p=0.382) between type of husband support and willingness to adopt family planning.

4.2 Client-provider interaction rating during clinical.

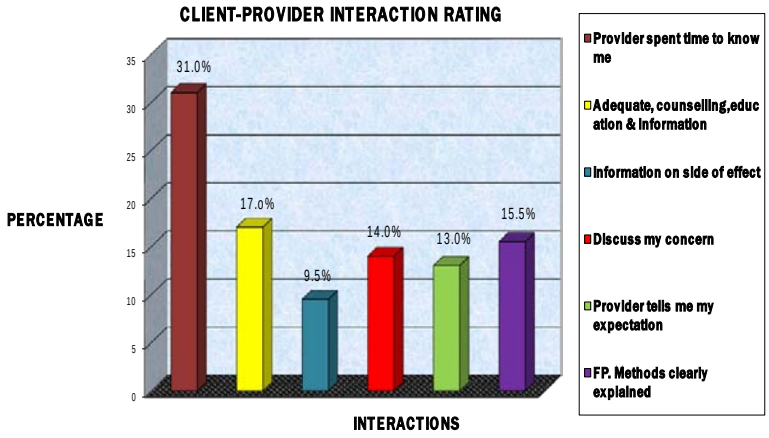
Table 4.14: Percentage distribution of Overall rating of client-provider interaction.

Over all rating on interaction	Frequency	Percentage %
Excellent	16	8.0
V. good	93	46.5
Good	81	40.5
Poor	10	5.0
Total	**200**	**100.0**

Source: Field Data, 2008.

The results showed that, excellence interactions between clients and the provider represented 8.0%, very good interaction was rated by 46.5%, 40.5% said it was good and 5.0% rated the interaction as poor. This was because 31.0% of respondents said providers spent time to know them, 17.0% said they had adequate counseling, education and information while 9.5% of respondents had information on side effect of method chosen, 14.0% said providers discussed their concern, 13.0% were told about their expectation on method and 15.5% had clear explanation on FP method. This was shown in Figure 4.6.

Figure: 4.6 Percentage distributions of Client-provider interactions rating during clinical.



Source: Field Data, 2008.

SECTION TWO

4.3 Supervision of Family Planning Providers

4.3.1 Supervision Rating

Table: 4.15 Percentage distribution of Supervision Rating

Supervision Rating	Frequency	Percentage %
Information, education, counseling	15	50.0
Staff performance	7	23.0
Follow -up visit	5	17.0
Technical support,	3	10.0
Total	**30**	**100.0**

Source: Field Data, 2008.

The results on supervision rating showed that information, education and counseling on FP method was 50.0%, staff performance was 23.0%, while follow-up visit was 17.0% and technical support was represented by 10.0%. About 50.0% supervision on IEC on method used by respondents was good to address the side effects but staff performance, follow-up visit and technical support could be improved.

4.3.2 Staff motivation

Table: 4.16 Percentage distribution of Staff motivation

Staff motivation	Frequency	Percentage%
Appraisal	10	33.30
Award given	5	16.70
Continue education	15	50.0
Total	**30**	**100.0**

Source: Field Data, 2008.

From the results, it showed that the staff valued to be motivated on continuing medical education to up-grade their knowledge more than giving them individual awards or appraisal.

4.3.3 Staff competence.

Table: 4.17 Percentage distributions for Staff Competence

Competence	Frequency	Percentage%
Excellence	4	13.0
very good	17	57.0
Good	9	30.0
Total	**30**	**100.0**

Source: Field Data, 2008.

According to the results for rating on staff competence, 13.0% represented those whose work was excellence, 57.0% were very good, while 30.0% were good. Therefore the staffs were competent in carrying out their duties.

4.4 Logistics

4.4.1 Rating of Logistics

Table: 4.18: Percentage distributions for Rating of Logistics

Rating Logistics	Number	Percentage %
Vehicle	5	16.7
Supply	25	83.7%
Total	**30**	**100.0**

Source: Field Data, 2008.

16.7% of service providers said they had vehicles to transport them for services delivery whereas 88.3% attributed the success of their work to the availability of supplies or FP commodities. Thus availability of transport was the major issue.

4.4.2 Staff Strength in some of the selected sub-districts of East Akim..

Table: 4.19 Percentage distribution of Staff Strength

Sub-Districts RH Unit	Staff Strength	Percent %
Asafo	5	16.70
Adonkwanta	2	6.70
Agyaponma	1	3.30
Apedwa	7	23.00
Tafo	13	43.30
Bonponso	2	7.00
Total	**30**	**100.0**

Source: Field Data, 2008.

From the results, staff strength for Tafo was 43.3% which was the highest, followed by Apedwa which represented 23.0% and Asafo was 16.7%. This meant more providers must be trained to render FP services.

4.4.3 Up-Grade of Staff Skills.

Table 4.20 Percentage distributions for Up-Grade of Staff Skills

Up- grade of staff skills	Frequency	Percentage %
Continue education	1	3.3
Workshop	29	96.7
Total	**30**	**100.0**

Source: From Field Work, 2008.

Over 90.0% of service providers up-graded their skills through workshops. However priority must also be given to continuing medical education.

4.4.4 Staff training

Table: 4.21 Percentage distributions for Staff training

FP training	Frequency	percentage %
Adequate	13	43.0
Inadequate	17	57.0
Total	**30**	**100.0**

Source: Field Data, 2008,

43.0% of service providers had adequate FP training while 57.0% had inadequate training. Since over 50.0% of staff had inadequate training in FP, training program for more staff should be considered.

4.5 Policy

4.5.1 Improved Policy

Table 4.22 Percentage distributions for Improved Policy

Improved Policy	Number	Percentage %
Info, educ , counsel (IEC)	3	10.0
Up-grade skills	7	23.3
Continuous education	10	33.3
Adequate logistics	8	26.7
Community-based services	2	6.7
Total	**30**	**100.0**

Source: Field Data, 2008.

From the results, improved policy according to the providers on IEC was 10.0%, up-grade of skills was 23.3%, continuous education was 33.3%, while logistics recorded 26.0% and CBS was represented by 6.7%. This showed that FP policy needs further improvement for quality services.

4.5.2 Period of Staff Up-Grade

Table: 4.23 Percentage distributions for Period of Staff Skill up-grade

Period of skills up –grade	Frequency	Percentage %

Five yearly	5	16.6
Every six months	13	43.3
Yearly	12	40.0
Total	**30**	**100.0**

Source: Field Data, 2008.

According to the results, 16.6% of the providers up-graded their skills every five years, 43.3% up-graded their skills every six months and 40.0% of the providers up-graded their skills on yearly basis. Thus a total of 83.3% service providers up-graded their skills at least on yearly basis.

4.5.3 Clients' opinion on family planning policy.

Table 4.24 Percentage distributions for Clients' opinion on family planning policy

Clients opinion on Family Planning Policy	Frequency	Percentage %
Campaign	93	46.5
Increase community FP program	26	13.0
Protect women's right	32	16.0
Regular advertisement	49	24.5
Total	**200**	**100.0**

Source: From Field Work, 2008.

The results showed that 46.0% of the respondents' opinion was to increase FP campaigns, 13.0% concerned was to increase community programmes, and 16.0% said the policy should intensify the protection for women's right to adopt FP while 24.5% opinion was on regular advertisement on FP.

4.5.4 Policy recommendation by providers

Table 4.25 Percentage distributions for Policy recommendation

Recommendation	Number	Percentage %
Reinforce women's right	4	13.3
Increase FP programs	15	50,0
Improve logistics	5	16.7
Increase skills up-grade	6	20.0
Total	**30**	**100.0**

Source: Field Data, 2008.

On providers recommendation on FP policy, 13.3% recommended that the policy should reinforce women's right to adopt FP, 50.0% said FP programs should be increased, 16.7% recommended the need to improve logistics while 20.0% said there should be intensification of up-grading skills.

CHAPTER FIVE

5.0 DISCUSSION

The discussions for this study were based on the results of the factors that influence decision making to adopt family planning method.

5.1 **Clients' Satisfaction**

Socio-economic and Demographic Characteristics of Respondents

The respondents whose age was between 15-19 years represented by 5.5%. Women who were between 20-24 years represented not less than 19.5%, whereas 22.5% were respondents aged between 25-29 years. Those in the age group 30-34 years were 23.5% and age 35-39 years were 29.0% and the highest to adopt FP. the minimum age was 16 years and the maximum age was 39 years. The mean age was 29.4 while the median age represented 30 years; the variance of the age was 39.6 represented 75.0% and was age 35 years. The standard deviation for the ages was 6.28 and the mode of the age was 22 years. This can be supported by a study in Jakarta and Ujung Pandang, which showed that more than two-thirds of 760 married women between age 30 to 45 years were the most to have adopted family planning (Summer, 1998).

Out of 200 respondents, 9.5% had no formal education, while 90.5% of majority had formal education. This contributed to the decision made to practice family planning to regulate their child bearing. This was supported by Caldwell and McDonald, (1981), that education had given women some level of independence and empowerment which had influenced their health seeking behavior and also the utilization of health care services (Caldwell et al., 1981).

According to Bina Gubhaju, the effect of education on fertility, contraceptive behavior and contraceptive method choice had been extensively researched in the family planning literature, the education levels completed by husbands and wives have been shown to be salient factors in determining the use of specific contraceptive methods (Bina Gubhaju, August 2008).

The data indicated that only 23.0% of the respondents had never been married before with the remaining either currently married or ever been married. Married respondents constituted the majority of 71.5% with about 2.5% divorced, 2.0%

separated, and the rest widowed. A study conducted by Biddlecom E Ann and others showed that majority of married women were usually involved in contraceptive discussions with their spouses and so adopted it (Biddlecom E. Ann et al., 1997).

The 1988 Ghana Demographic and Health Survey on current contraceptive use showed that, married women aged 15–49 are the most predictors of current contraceptive use. This is followed by discussion of family planning with partner and level of education. As a policy measure, information, education and communication programmes on family planning should be intensified, particularly in rural areas. Female education, at least up to secondary level, should be given top priority (Tawiah E. O., 1997).

Employment does not only give a woman some level of independence but also empowered them to utilize the health care services including reproductive health services. Utilization of reproductive health services such as family planning depends on affordability and distance to the facility. The employment status of women increases their ability to access the health services. The data indicates that almost 90% of the respondents were currently engaged in some economic activity for financial empowerment. Majority of the employed respondents were in the informal sector engaging in activities such as trading, farming, seamstress, hair dressing with relatively smaller proportion in the formal sector (civil servant, teaching, etc.). This was different from what pertained in Bangladesh, where women were often totally dependent on their husbands for financial support and therefore the men's views strongly influenced their contraceptive use. Women were reluctant to use contraception because they thought their husbands might view family planning as an economic burden (Summer, 1998).

The number of children or fertility among women practicing family planning should be relatively lower compared to the general population. The number of children for a woman was between 0 (no child) to 8 children. The analysis further revealed a mean number of children among the respondents to be 2.8 and a median of 3 children which was about 46.0% less than the national average fertility rate of 4.4. Only about

2.0% of the respondents did not have any child with about 10.5% of the respondents having more than 4 children.

According to Ezeh, 1996, the ideal family size was significant in West Africa, ranging from about two children in Burkina Faso to more than four children in Niger and Senegal. In East and North Africa, no significant difference in fertility desire was found (Ezeh Alex C., 1996).

Factors influencing the adoption of family planning method

There are other factors that influence and determine whether or not a woman will adopt a family planning method to control her fertility. Apart from the individual socio-economic and demographic factors, there are other external factors such as knowledge of family planning, the educational attainment, access to health facility that offers family planning services, waiting time at the clinic, current FP method use and husband support to adopt the method among other factors.

5.1.2 **Waiting time**

The waiting time by client before services has the potential to affect the adoption of family planning services. Table 4.6 showed that, 92.5% of the respondents spent less than an hour in waiting before receiving service. The remaining 7.5% waited more than one hour before receiving family planning service. This was confirmed by WHO, 2005, that packages to satisfy the needs and preference of target population are the availability and accessibility of supply, proximity of clinic, short appointment and waiting time to be attended to, privacy and low fee charging (WHO, 2005).

5.1.3 **Accessibility**

Adoption and utilization of any service or method will depend on how accessible the service is to the end user. The type of service satisfaction that the user derives from the service providers also plays a major role in increasing acceptance rate.

About 70.5% of respondents had access to the FP clinic in 30 minutes, 22.5% accessed the clinic in 45minutes while 7.0% were able to access the clinic in one hour,

depending on cost and availability of transportation. This may result in failure of method with a potential misconception and mistrust of the method. However in Lesotho, the obstacle to contraceptive use included long distance and transportation cost to clinics site, lack of privacy, contraceptive shortage and restrictions imposed by providers on who could use certain methods (Tuoane et al 2004).

5.1.4 **Clinic visits**

It was revealed in the study that, 4.0% of respondents visited the FP clinic by an appointment while 96.0% of respondents visited the clinic at any time. Those respondents given an appointment may be due to specific situational problems. Unlike the previous years where family planning clinics were held on specific days of once or twice within a week, now clinics were held daily throughout the working days. This was supported by WHO and JHUCCP. 2005, that short waiting time, accessibility to reach clinic on time**,** visit to the clinic at any time without an appointment were some of the factors which influenced clients' satisfaction to adopt family planning method. (WHO and JHUCCP, 2005).

5.1.4 **Current Method Used**

Knowledge of family planning was almost universal among the respondents. This was because 97.0% of the respondents had an idea of family planning with the remaining 3.0% having no idea about family planning. The percentage distribution of respondents by knowledge of family planning is shown in Figure 4.4.

A study conducted by International Family Planning Perspective. (IFPP, 1984), showed that education on family planning is important to enhance knowledge in the society and ensure behavioral change (IFPP, 1984).

The most family planning method adopted according to the result shown in Figure 4.3, was the injectables represented by 60.0% followed by pills represented 30.0%. Respondents who adopted Norplant (Jadel) were 3.0%, 5.0% used natural method while 2.0% adopted IUCD and 1.0% used condom and BTL respectively. It was realized that most of the service providers had not been trained in the insertion of IUCD and Norplants and moreover the cost was about five Ghana cedis, hence only

few clients who could afford and with an informed choice were referred to other sub district clinics for a trained nurse to render such services.

This was confirmed in 2003 by the Ministry of Health in Kenya, that although many contraceptive methods are available in Kenya, over the years the MOH noticed that the national modern family planning methods had become dominated by contraceptive pills and injectables while proportion of contraceptive users choosing the IUCD has decreased significantly. Under utilization of the IUCD suggests that the full message about its advantages including safety, effectiveness, low cost, convenience, and possibility of long-term use is not getting through (DRH/MOH, Kenya, February 2003).

Majority of the women adopting injectables was contrarily to a study done in Madagascar which also revealed that Norplant adoption rates were higher among women who were counseled on the use of modern method of contraception and were more satisfied with it (Tapsoba et al., 1993).

Among those who adopted FP method, 22.0% switched method while 81.0% reported for fear of side effect. While 91.0% said they would be able to recommend the method to other women because it had helped them for birth spacing and prevent unwanted pregnancy 9.0% said they would not recommend method because of side effect. This was supported with the focus group discussion held at Asafo sub district. A 35 year old mother of three from Adonkwanta said:

> *I was using the 3 months injection method and my menstruation stopped, I also experienced a high blood pressure but as soon as I stopped using it everything of mine came to normal* (FGD participant).

The main reasons for women stopping FP were attributed to side effect of the method use which represented 86.0%, while the remaining recorded divorce, failure of method, husband disagreement and long distance, no privacy and shortage of supply. Another mother of 30 years with two children narrated that:

> *My friend who was 37 years with four children went in for the 3 months injection and she bled profusely so she changed to the Pills and was better* (FGD participant).

A mother of 27 years from Akooko and had two children said:

> *I used the pills and had serious headache as a result of that, I have since stopped using it* (FGD participant).

Moreover, when the service providers were interviewed on the reasons why some clients stop the use of family planning, 63.0% confirmed that some reported to the clinic for unusual change in the health status while 37.0 attributed it to shortage of supplies.

This was also supported with a study on client's satisfaction in family planning method use that there was the likelihood that women who adopted a method would continue using it or switch methods when dissatisfied with the method adopted (Ali, 2001.; Ketende et al, 2003.; Ross et al, 1999.; Stephenson and Tsui, 2002.;Thongand et al, 2002).

It was also confirmed in 1998 Kenya Demographic and Health Survey (KDHS) that information on contraceptive knowledge and use in Kenya in the last 10 years has shown that women initiate and stop contraceptive practice in response to changes in their own circumstances and in their social and health environment. They choose different methods at different points in their lives. Thus, the contraceptive prevalence and method at any given point in time is the result of series of decisions made by individual women to start contraceptive use, stop use, restart use, and to choose one method over another one (KDHS, 2001).

WHO in 1999 confirmed that policy and service delivery on contraceptive method need to increase the range of contraceptive method and improve on user satisfaction. This enhanced program reputation and increased contraceptive prevalence which contribute to ultimate goal of reducing unwanted pregnancy (WHO, 1999).

5.1.5 **Husband Support**

Six percent of respondents practiced FP without their husbands awareness, 42.5% of respondents had no support from their husband while 51.5% received support from their husband. This is shown in Figure 4.6. This was supported by Biddlecom E Ann and others, 1997 that although majority of women said their husbands or partners were usually involved in contraceptive discussions, the nature of the involvement varied. Some men were involved by supporting women's contraceptive decisions, other men used methods themselves, and others posed obstacles for women's use of family planning (Biddlecom E. Ann, et a.l, 1997).

Comparing some demographic characteristics such as: Age of mothers, marital status, Husband support, with the willingness to adopt a method.

About 88.5% of respondents from various age groups were willing to adopt FP method and were graded as very satisfied. This consisted of 24.0% of respondents aged between 35-39 years most willing to adopt FP method and the least age group was represented by only 5.0%. This was confirmed in Table 4.11 that as the mothers' age increased from 20-39 years so was the percentage increased from 19.5% to 29.0%. The increased percentage to 29.0% corresponded to the acceptance rate of 29.0% family planning adoption by the women in their fertility age from 2004-2006 as confirmed in the district profile which was low.

All the respondents who were currently not married or married were willing to adopt family planning method. This was shown in Table 4.12, 64.0% of the respondents married were willing to adopt a method, 20.0% who were singles also adopted a method while the others who were divorced or separated represented by 2.0% and one widow were all willing. Less than 10.0% were unwilling to adopt FP method. There is no statistically significant association (χ^2=9.217; p=0.324) between marital status and willingness to adopt family planning method. This showed that irrespective of the marital status, respondent will be willing or not willing to adopt family planning method.

About 47.5% of respondents who received support from their husband were willing to adopt FP method while 4.0% were unwilling and 41.0% of respondents who

received no support from their husbands were also willing to adopt a method. This is shown in table 4.13. Less than 10.0% with husband support or not were unwilling. The data further showed no statistically significant association (χ^2=6.377; p=0.382) between type of husband support and willingness to adopt family planning.

About 92.5% of respondents were satisfied and willing to adopt FP method and less than 10.0% of respondents were dissatisfied or partially satisfied as shown in Table 4.9. There was significant link between satisfaction and family planning method used

The satisfaction of family planning method among respondents was also a feature of the FGD.

A 25 years old mother of three, FGD participant said:

> *I did the family planning on my own. I did not seek for an advice from my husband. He later got to know about it and he was comfortable with it (FGD participant).*

Another mother of one and aged 27years from Nkronso which is one of the rural communities said:

> *Initially, when I was coming to do the family planning my husband was against it because we had only one child at that time. I travelled to my mother's place and did it without his consent but my mother told him about it. He got angry but he later forgot about it. I however, developed a problem from the injection method I went for and had to stop. I got pregnant after I stopped using it (FGD participant).*

A mother of two and aged 24 years from Asafo said:

> *My husband asked me to go for the family planning but he did not go with me to the service center but I plan to take him there the next time that I will be going there (FGD participant).*

According to Biddlecom E. Ann and others, 1997, although majority of women said their husbands or partners were usually involved in contraceptive discussions, the nature of that involvement varied. Some men were involved by supporting women's

contraceptive decisions, other men used methods themselves, and others posed obstacles for women's use of family planning (Biddlecom E. Ann, et al., 1997).

About 3.0% of respondents were dissatisfied with the FP service, 4.5% were partially satisfied while 92.5% said they were satisfied with the services. Also 48.0% of respondents were willing to continue with FP method, 42.5% were somehow willing while 9.5% were unwilling to continue method. Those respondents who were somehow willing and unwilling to continue FP method attributed their reasons to side effects experienced as shown in Table 4.10.

The satisfaction in family planning method among respondents was also a feature of the FGD where some participants expressed high level of satisfaction of method use while others feared of side effects. Two mothers aged 38 years and 39 years with 4 and 5 children respectively said:

> *They had no problems using family planning. One had been using it for the past 10 years and the other for 5 years without any problem. They said the good and most important thing to do is to go in for the right method that will be good for one's body (FGD participant).*

Williams and others confirmed that client's satisfaction was the key to decision making to continue using methods and services. For all urban and rural women, it was very important that providers would be trustworthy, friendly, understanding, trained and competent in order to attract clients to utilize the clinic for services. In addition, lack of privacy and embarrassment by providers could create difficulties for clients attending family planning services (Williams et al., 2000).

Since some of the client defaulted, they found themselves of unwanted pregnancy. From the interview it client found that 64.0% of the respondents had an abortion. Out of this 38.0% had unintentional abortion while 28.0% had intentional abortion.
It had been realized that abortion can be prevented if providers focused on reducing barriers to contraception adoption and improving opportunities to expand access to family planning services. As done in the US, where there were problems of high unintended pregnancy and abortion, they found that the ability to reduce

unintended pregnancy depended on making family planning services available to all (Espey E., 2007).

Family planning services revealed that only 33.0% of respondents had knowledge on adolescent reproductive health and those who had knowledge, 24.0% knew of a separate day set for adolescents' family planning services. The separation of adults' services from the adolescents gave the opportunity for the adolescents to open up to the provider to discuss their concerns. The situation in the district revealed that because the waiting time was short and clients visit the clinic at any time, many clients were not seen waiting at the same time to be attended to, hence the separate day for adolescents' service was not effective.

5.2 **Client-provider interactions rating during clinical**

About 31.0% of respondents said providers spent time to know them, 17.0% said they had adequate counseling, education and information while 9.5% of respondents had information on side effect of method chosen, 14.0% said providers discussed their concern, 13.0% were told about their expectation on method and 15.5% had clear explanation on FP method. This is shown in Figure 4.6.

Studies by Murphy and others, (2002), concluded that client-provider interaction is treating individual well, providing client preferred method and giving individualize care and also educating the client. This would make the client to adopt a method and continue to use it. It is also good to give information, education and communicate on family planning issues to family and friends in order to publicize services but providers could encourage people to adopt contraceptive and increase the demand for quality care (Murphy E., et al., 2002; Babalola et al., 2001; Sharon et al., 2002).

Adeyemi and others in 2001 also confirmed that population growth is the most fundamental problem that affects adversely the advancement of nations and the wellbeing of all peoples, therefore, the level of knowledge on modern contraceptive methods through mass and interpersonal communications are the key strategies to increase the utilization rate (Adeyemi et al., 2001).

5.3 Supervision

5.3.1 Supervision rating on family planning

Supervision rating on information, education and counseling (IEC) in FP was 50.0%, staff performance was 23.0%, while follow-up visit was 17.0% and technical support was represented by 10.0%. This is shown in Table 4.15.

Staff Performance

Staff performance was rated to be 23.0%.Wolff found that supervision and support to staff must be improved by staff performance, motivation and conflict management. Supervisors must develop performance and appraisal assessment systems to help set up a working standard (Wolff J.A., 1991).

Information on family planning method, client education, counseling

IEC in FP was rated as 50.0%. This was supported with World Health Organization Decision-Making Tool for Family Planning Clients and Providers (DMT) to improve the quality of family planning counseling. The tool was used to educate new clients about the chosen method and therefore clients did open up about their situation and their wishes. This had a greater impact in Nicaragua where communication was impacted in family planning by using decision making tools through training workshops for service providers. The intervention increased their efforts to identify and respond to client needs. They involved clients in the decision-making process; screened them and educated new clients about their chosen method when clients chose a new contraceptive method, as compared with visits by returning clients for a check-up or resupply (Kim et al, 2007).

It was also found that counseling clients on the possible side effect before they begin a method lowers discontinuation rates (Cotton et al 1992, Canto de Cetina et al, 2001).

Staff Technical support

Technical support was low which was a barrier to service delivery. Studies conducted by Combary and others in 1999, in Ghana on community-based distribution found that training on technical supervision increased knowledge and

skills and that trained supervisors improved on their visits and address wide range of problems when they had adequate supplies of logistics (Combary P., et al, 1999).

Inadequate follow up visit contributed to discontinuation of FP use. William and others, (2000), found that follow–up or visiting the clients was not done regularly as providers complained of the means for transportation. Client dissatisfaction was due to lack of follow-up at the initial visit leading to discontinuation. Follow-up clients have been shown to express higher levels of satisfaction than first-time visitors (William et al, 2000).

5.3.2 Staff Motivation

Motivation was inadequate and providers representing 50.0% preferred continuing medical education. This is shown in Table 4.16. However, Simmons and others, confirmed that assessments on performance of family planning programs were poor due to ineffective supervision, but provider technical support and training in clinical to motivate staff and management of conflict could be improved through effective supervision (Simmons et al, 1987).

5.3.3 Staff Competence

Rating on staff competence, was 13.0% for excellence performance, 57.0% were very good, while 30.0% were good as shown in Table 4.17. It was supported with a study by Kim and others on supervisors-providers interaction conducted in Zimbabwe on performance and technical competence revealed that supervisors failed to involve providers in problem identification and solving hence, this affected input in the quality of service received by clients (Kim et al., 2002).

Moreover, Halawa and others, (1995), also found that, designing training programmes would improve performance of family planning providers and managers and also the outcomes would be such that knowledge would be impacted on clients (Halawa et al., 1995).

5.4 Logistics

5.4.1 **Rating of Resource Available**

Available logistics rated on vehicles was 16.7% while supply was 88.3%. This showed that there is available supply for all the clients at service point but vehicle to transport staff and supplies was not sufficient. This is shown in Table 4.18.

A study done by Hamid S., and others showed that majority of Pakistani women were familiar with family planning but the use of contraceptives remained low. It was revealed that certain characteristics of family planning providers and health facilities were identified that affected women's initiation of contraceptive adoption (Hamid S., et al., 2006).

Vehicle/Transport

Inadequate vehicle was another barrier to service delivery. Therefore studies done revealed that because supervisors frequently lack time and transport needed to visit remote clinics it had affected their duties as well as services in family planning to the needed women (Combary et al, 1999.; Loevinsohn et al, 1998).

Further study in 1998 Demography and Health Survey in Egypt also confirmed that smaller health personnel trained in family planning lacked access in terms of transport to facility and this limited the range of availability of contraceptive methods and caused discontinuation (Egypt, DHS., 1998).

Supplies

Sufficient supply of FP commodities was essential since shortage was some of the reason for discontinuation.

According to Marie Stopes and others, (2002), women in their reproductive age are growing and the interest in family planning is also rising**,** but the demand for contraceptive supplies was limited by inefficient and poorly coordinated donors funding as well as inadequate logistics capacity in developing countries (Marie Stopes, et al., 2002)**.**

5.4.2 **Staff strength**

Staff strength for Tafo was 43.3% which was the highest, followed by among Apedwa represented 23.0% and Asafo was 16.7%. The remaining recorded below 10.0%. This shown in Table 4.19. Asafo had two community health nurses assigned to work there, Agyaponma was also a CHPS center and a community under Asafo had only one community health nurse assigned there. Apedwa had seven staff including one community health midwife. Tafo had thirteen staff.

It was also noticed that most of the providers were the community health nurses who had inadequate training in family planning whereas the midwives were just a handfull.

Some studies done in Iran showed that training programmes were focused and there were mechanisms and job training of senior nursing and midwifery graduates which made them more competent in delivering basic family planning services (Shahidzadeh-Mahani A, 2006).

5.4.3 **Up-grade of staff skills**

Continuous education to up-grade staff skills was 3.3%, therefore priority must be given to continuing education. This is shown in Table 4.20. Even though organizing workshops was short term strategy to up-grade staff skills, continuing medical education to the higher level produced more competent staff for quality care and services.

Other studies undertaken in Ghana and Guatemala suggested that higher system performance may result from improving certain management functions in the health system (Bossert T., et al., 2004).

5.4.4 **Staff Training in Family planning**

About 43.0% of providers had adequate FP training while 57.0% had inadequate training as shown in Table 4.21. This was supported with a study done in September 1987 where Health Education Division of Ghana and Ghana's Ministry of Health (HED/MOH) began systematic project on training in family-planning on information, education and counseling (IEC). The goals of the project were to increase knowledge and improve attitudes toward family planning and promote

contraceptive use among women of reproductive age. This enhanced improved family-planning counseling skills among MOH service providers (Lalla Touré, 1996).

5.5 **Policy**

5.5.1 **Improvement**

There was not improvement on IEC, skill up-grade, continuous education, logistics and CBS. This showed that FP policy needs further improvement for quality services. This is shown in Table 4.22 and was supported by Kols A.J. and Sherman F., that to improve family planning programs, there must be good maintenance and service quality, managers must design programmes to control of day-to-day activities through supervision and monitoring, identify problems and find appropriate solution (Kols A.J.; et al., 2001).

5. 5.2 **Period of Staff Skill Up-Grade/Training**

This is shown in Table 4.23, that 16.6% of the providers up-grade their skills every five years, 43.3% up-grade their skills every six months and 40.0% up-grade their skills yearly. This is an improvement since a total of 83.3% staff up-graded their skills on yearly.

According to a study done by Halawa and others in 2006, designing training programmes did not only improve performance of family planning providers and managers but also had favorable effect on outcomes such as client knowledge, compliance with return visits and contraceptive use (Halawa et al, 1995).

According to Beith and others, 2006, logistic system can be affected by policy in cases where FP is integrated into other health programmes (Beith et al., 2006).

5.5.3 **Clients Opinion on Family Planning Programs**

Some respondents opinion on FP policy was to intensify campaign represented 46.0%, 13.0%, said there should be increased community-based programmes and those who wanted the policy to protect women's right to adopt FP and regular advertisement on FP represented 16.0% and 24.5% respectively. This is shown in Table 4.24.

According to English A., 2007, laws had been developed over the years which had significantly improved adolescents' and women's access to essential sexual and reproductive health care and also had the constitutional right of privacy and confidentiality (English A, 2007

Another study done by Lalla Touré in 1996 showed that campaign had been expanded to all areas through variety of IEC material, media, and activities, including leaflets and booklets for sending message across on family planning. Motivational posters, national radio and television broadcasts, drama, theme song, community audiovisual material, and community activities were other ways that messages were advertised (Lalla Touré, 1996).

According to Solo and others,2005, efforts were made to move services beyond the clinic walls through community-based distribution (CBD) agents, commercial sales agents and other activities which have had some success. But there was still a need to improve access to family planning in rural areas through CBD and strengthened clinic services. Therefore CBD was an effective way to get services to rural populations, but it needed to be more widespread to have an impact (Solo et al., 2005).

5.5.4 **Policy Recommendation by Providers.**

Providers' recommendation on FP policy showed that 13.3% recommended that the policy must reinforce women's right to adopt FP, 50.0% said FP programs must be increased, 16.7% recommended for the need to improve logistics while 20.0% said there should be increase in skills up-grade. This was supported with Abramson Wendy and others in a study on logistics that increase in coverage of FP programmes would help sustain an efficient and continuous supply of contraceptives. Hence through careful planning, decision makers could help maintain a well-built logistics system and policy that guarantees the availability of contraceptives to clients (Abramson Wendy et al, 2006).

Mitchell and others said managers could use existing resources more efficiently by offering fewer or lower cost contraceptive method and ensuring that staff, equipment and facilities are fully utilized (Mitchell et al, 1999).

CHAPTER SIX

6.0 **Conclusion and Recommendation**

6.1 **Conclusions**

The adoption and utilization of family planning services like any other health services is a phenomenon as it was influenced by many factors. Some of the factors were socio-economic and demographic. These were the age, educational attainment, marital status and husband support. However, there were other factors such as waiting time and accessibility to clinic less than 30 minutes, clinic visit at any time. Others were clients-provider interaction, supervision, logistics availability and government policy on family planning with addition to service providers' knowledge and attitude to service delivery and quality care.

Age was statistically significant determinant of willingness of respondent to adopt family planning. The data indicated across the age groups that, over half (88.5%) of the respondents were willing to adopt family planning method. Most respondents who showed the willingness to adopt FP method were those between age 35 and 39. Attention must be paid to the adolescent by increasing knowledge on FP and Adolescent reproductive Health facility to help them.

The data indicated that, knowledge of family planning; age of the woman; educational attainments were the significant determinants that influence women decision to adopt and used family planning. Satisfaction of family planning method which was significantly linked with waiting time and accessibility to service delivery point were two other major determinants that influence the adoption of family planning.

Rating client-provider interaction revealed provider spent time to know client, discussed client concern, client was able to tell provider her expectation. Others said family planning method was clearly explained to them including information on side effect, adequate counseling, education and information but most of the women switched method or stopped FP because of side effects.
From the FGD, it was clear that women were aware of the benefits of family planning through child spacing and preventing unwanted pregnancy. However, the lack of in-depth knowledge of side effects was the major barrier for adoption of family planning method among women. There was also evidence with significant association between adoption of family planning method and educational attainment of respondents.

Moreover, family planning users and service providers gave their opinion and recommendation for more improvement in logistics and FP policy.They wanted the effectiveness and efficiency in FP that provide highly effective supervision, protection and at the same time cause fewer side effects, cost less, and are easier to use.

For quality of care, supplies were improved but transport system must be improved to support service delivery. Most FP methods must undergo research and rigorous testing for safety and effectiveness and must obtain regulatory approvals before becoming available (Upadhyay U.D., 2005).

6.2 **Recommendation**

The key ideas are that policymakers, family planning managers, and logistics advisors could synthesize problems encountering family planning and consider helping sustain an efficient and continuous supply of contraceptives.

1. DHMT of East Akim District

Most contraceptive methods were designed for use by women, and as a result, most family planning programmes target their information, counseling and services to women of reproductive age. Health programmes and providers need to recognize that family planning is often a family decision.

Providers should look for ways to inform, involve and educate the relatives, who may have a tremendous influence on whether contraceptive should be used, when it begins, whether it continues, who uses contraception and what methods are used.
Women should be empowered to achieve higher educational level, reinforce and protect their right to be able to make decisions on their health care.

Interpersonal relationship should be improved between provider and clients. This would address client concerns and be able to assist in problem solving.
For good interaction to be established the provider needs to spend time to know clients and discuss concerns, tell clients expectations of family planning and explain side effect with adequate counseling, education and information.

Regular supervision and follow–up visits would help to identify clients' problems and find immediate solution.

Men should be involved to participate and support the women to practice family planning. Providers should take the responsibility to give the right counseling; education on method adopted. Adequate information on method chosen should be given to enhance acceptability and utilization of family planning services.

For waiting time to benefit client, other divisional therapy such as television at the waiting rooms could engage the clients' whiles waiting.
There should be equity of logistics to enhance efficient delivery of services. Equal opportunities should be given to providers to have training on counseling and family planning skills to deliver any preferred method chosen by clients.
Attention must be paid to the adolescents by increasing knowledge on FP and Adolescent Reproductive Health facility to help them.

2. **Community Members**

Men's involvement in discussion concerning women's decision making in adopting contraceptive method and use should be improved through adequate education, adverts and campaign with support.
Men must be encouraged to adopt the modern method such as vasectomy as a long-term method and regular use of condom for short-term.

3. **The Government of Ghana**

Improve outreach efforts by training local personnel in marketing techniques, public education, the use of the media and available transport to make time and duty easy for the providers.

Strengthen local institutions by improving management and administration and by training staff in methods such as Norplant and IUCD insertion to generate revenue.

The government should enhance the quality of local family planning services by up-grading the skills of staff and improve supervision and follow-up in such remote areas where reproductive health and methods of contraception are inadequate.

Donors fund should be increased with the government supports to make all methods available at any time at service points.

The logistic information system is expected to be integrated in the near future but the challenge would be to make contraceptive continue to be given the priority attention to make supply always available.

Moreover, there should be research into the modern contraceptive drugs and testing for safety and effectiveness.
There should be political commitment and support to increase training and motivation for providers.

Areas for Further Research

Other studies could be done on the following:

1. Reducing side effect of contraception for effective use.
2. Male involvement in contraceptive use.
3. Staff skill up-grade in contraceptive services and care.

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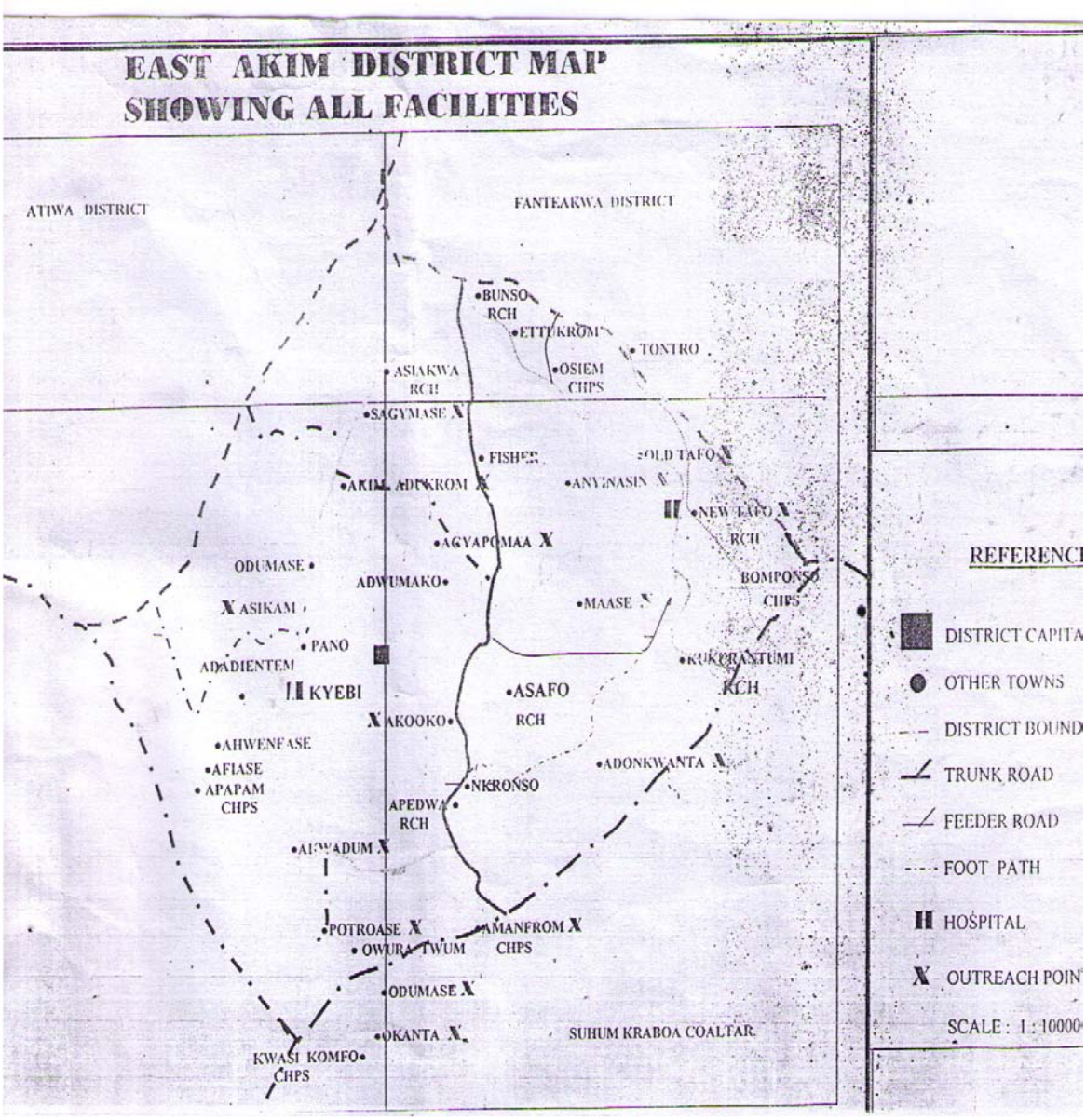
APPENDICES

Appendix A: MAP

1.1: Map of East Akim District



Appendix B: QUETIONAIRE 1

CLIENT'S DEMOGRAPHIC DATA

Dear respondent, I am a post graduate student from Kwame Nkrumah University Of Science and Technology, Department of Community Health. I need your consent concerning this study on factors influencing clients' decision making to adopt family planning method and use. I assure you that any information given will be kept confidential and action plan carry out for an appropriate intervention. Thank you.

Please write the appropriate figure in the box provided and CHOOSE ONLY ONE ANSWER.

Demographic Characteristics

Q1. Mothers' age

1.16-19

2.20-24

3. 25-29 ☐

4. 30-34

5. 35-39

Q2. Marital status

1. Married

2. Single ☐

3. Divorce

4. Separated

5. Widowed

Q3. Educational background (HIGHEST LEVEL ATTENDED)

1. Uneducated

2. Primary

3. JSS ☐

4. SSS

5. Tertiary

PLEASE TURN OVER

Q4. Occupation

1. Not working
2. Teaching ☐
3. Farming
4. Hair dressing
5. Seamstress
6. Others (state) ----------

Q5. Ethnicity

1. Akan
2. Ewe ☐
3. Ga / Adangme
4. Mole Dagomba

Q6.Number of children

1. None
2. One
3. Two ☐
4. Three
5. Above three (state) ----------

Q7. Ages of children. State -----, -----, ------, ------, ------, ------, ------, -----

Q8. Children Support

1. Wife alone
2. Husband alone ☐
3. Wife and husband
4. Guardian

Q9. Husband educational level (HIGHEST LEVEL ATTENDED)

1. Uneducated
2. Primary ☐
3. JSS
4. SSS

5. Tertiary

PLEASE TURN OVER

Q10. Husband Occupation

1. Trading
2. Teaching ☐
3. Farming
4. Driving
5. Others----------

CHOOSE ONLY ONE ANSWER.

Client's Family Planning Practice

Q11.Idea about family planning

1. Yes 2. No ☐

Q12. Ever practice family planning

1. Yes 2, No ☐

Q13. Period of practicing family planning

1. Less than 6 months ☐
2. Less than 1 year
3. Above 1 year
4. Others----------

Q14. What do you do to delay your pregnancy or child spacing?

1. Continue using family planning method
2. Not using any family planning method ☐

Q15.What is your reasons for visiting the family planning clinic?

1. Review ☐
2. Reporting side effect
3. Appointment
4. Others ……..

Q16. How long do you take to get to the clinic?

1. Less than 30 minutes ☐
2. 45minutes

3. 1hour

4. More than 1 hour

PLEASE TURN OVER

Q17. Current Family planning method use

1.Nil

2. Pills

3. Inject able

3. IUD

4. Norplant

5. Diaphragm

6. Female / male condoms

7. Natural method

Q18. Distance from clinical site

1. 30 minutes

2.45 minutes

3. Less than 1 hour

4. More than 1 hour

Q19. Do you visit the family planning clinic by

1. Booking/ appointment

2. Can just visit anytime

Q20. Clinical waiting time

1. Less than 1 hour

2. More than 1 hour

21. Are you willing to adopt a method?

1. Yes 2. No

Q22.Clinical Attendance

1. Continuous

2. Ever discontinued

3. Defaulter

Q23. Ever switched method

1.Yes 2.No ☐

PLEASE TURN OVER

Q23. Reasons for stopping family planning

1. Experienced side effect ☐
2. Long clinical distance ☐
3. Fee charging for services ☐
4. Long waiting time (more than 1 hour) ☐
5. No privacy/inadequate privacy ☐
6. Lost my clinical card ☐
7. Travelled more than 3 months ☐
8. Shortage /unavailable of supplies ☐
9. Transport fare more than 1 Ghana cedi ☐
10. Immigrant ☐

Q24. Clinical schedule

1. Monthly interval
2. Two monthly ☐
3. Three monthly
4. Yearly
5. Every five years
6. Every ten years

Q25. Are you satisfied with the family planning method you are using?

1. Yes
2. No ☐

Please write the appropriate figure UNDER the Very Satisfied, Partially satisfied, and Dissatisfied in the box provided

Q26. Client's satisfaction rating on care given

Very Satisfied Partially satisfied Dissatisfied

1. Comfortable waiting room
2. Providers friendliness
3. Practitioner/provider trust
4. Available supplies
5. Method adopted
6. Given counseling/education/information

PLEASE TURN OVER

Q27. Are you allowed to choose your own method?

1. Yes
2. No

Q28. Client's opinion on improving quality of service

1. No fee charging
2. Adequate supplies at service point
3. Good provider – client relations
4. Clinical days should be always available
5. Waiting time should not be more than 1 hour
6. Clinical hours extending from 8am to 5pm or otherwise
7. Increasing community-based services
8. Accessibility to clinic should be convenient

Q29. Are you willing to continue with the method you are using?

1. Willing
2. Somehow willing
3. Unwilling

Q30.Will you recommend the modern family planning methods used to friends/relatives?

1. Yes 2.No

Give your reasons----------

Q31. What do you think the government should do to improve family planning acceptance?

1. Protect women's right
2. Start family planning campaign
3. Regular coverage of family planning advertisement
4. Increase community family planning programmers

Please write the appropriate figure UNDER the Poorly, Good, Very Good, Excellence in the box provided.

PLEASE TURN OVER

Q32. Clients-provider interaction ratings

	Poorly	**Good**	**V. Good**	**Excellence,**
1.Provider spends enough time to get to know me	☐	☐	☐	☐
2. I can discuss my concern with the provider	☐	☐	☐	☐
3. Confidentiality, privacy and trust are maintained.	☐	☐	☐	☐
4. Provider tells me what to expect before physical examination is conducted.	☐	☐	☐	☐
5. I feel family planning method is clearly explained to my understanding.	☐	☐	☐	☐
6. I was informed about possible side effect of family planning methods.	☐	☐	☐	☐
7. I feel adequate counseling/ education and information is given.	☐	☐	☐	☐

Q33. Do you know any accessible Adolescents Reproductive Health Care?

1. Yes 2. No ☐

Q34. Do you have a separate day of family planning clinic for adolescents?

1. Yes 2. No ☐

Q35. .Do your husband support you to practice family planning?

1. Yes 2. No ☐

Q36. If yes, has your husband ever followed you to the family planning clinic?

1. Yes 2. No ☐

Q37. Do you know men can practice family planning?

1. Yes 2.No ☐

Q38. Do you know any of the men's family planning method?

1. Yes 2.No ☐ *PLEASE TURN OVER*

Q39. Which of the men's method do you know?

1. Vasectomy
2. Redrawal ☐
3. Condom

Q40. Have you ever had an abortion?

1.Yes 2. No ☐

Q41. If yes, was it

1. Intentional 2. Unintentional ☐

THANK YOU

Appendix C: QUETIONAIRE 2

STRUCTURED INTERVIEW

FOR DIRECTOR / PRACTITIONERS / PROVIDERS.

Dear respondent, I am a post graduate student from Kwame Nkrumah University Of Science and Technology, Department of Community Health. I need your consent concerning this study on factors influencing clients' decision making to adopt family plannining method and use. I assure all that any information given will be kept confidential and action plan carry out for an appropriate intervention. Thank you.

Please write the appropriate figure in the box provided and CHOOSE ONLY ONE ANSWER.

Q1.Providers Competence in Family Planning skills

1. Good
2. Very Good
3. Excellence

Q2. Family Planning training/motivation

1. Adequate
2. Inadequate

Please write the appropriate figure in front of the Poor, Good, Very Good, Excellence in the box provided

Q3. Professional supervision ratings

	Poor-1	Good-2	Very Good-3	Excellence-4
1. Counseling client				
2. Staff performance				
3. Client-education				
4. Information on method				
5. Technical support				
6. Fellow-up visit				

Q4. Have you been trained in Counseling?

1. Yes 2. No

Please write the appropriate figure UNDER the Good, Very Good, Excellence, Poor, in the box provided

PLEASE TURN OVER

Q5. Ratings on providers/ practitioner opinion on service quality

	Good	**Very Good**	**Excellence**	**Poor**
1.Counselling /information/educatio				
2. Client Satisfaction				

3. Client – Provider Relations
4. Confidentiality
5. Provision of Privacy
6. Regular Supervision
7. Able to identify side effect
8. Able to give explanation
9. Able to identify stock out/over
10. Availability of source of supplies
11. Adolescents' services

Q6.Main obstacles of client discontinuation of family planning practice

1. Location of clinic is inconvenient
2. Privacy and waiting time inconvenience
3. Experienced side effect of method use
4. Fee charging

Q7.Which of the methods mostly provided are available to the clients?

	Yes	**No**
1.Oral contraceptives		
2. Diaphragm		
3. Depo-Provera		
4. Emergency oral		
5.contraceptive		
6. Norplant		
7. Tubal Ligation		
8. IUD		
9. Vasectomy		

Q8. How do you assess supervision of clients?

1. Periodic survey
2. Occasional follow up
3. Regular visits/supervision

Q9. What categories of staff do you work at the family planning clinic?

1. Medical Officer ☐
2. Pharmacist ☐
3. Graduate Nurse ☐
4. General Nurse ☐
5. Registered midwife ☐
6. Enroll Nurse ☐
7. Community Health Nurse ☐
8. Community Health Midwife ☐
9. Health assistance ☐

Q10. Staff strength

1. Two
2. Three ☐
3. Four
4. Five
5. Others----------

Q11. What is the Staff relationship?

1. Weak
2. Cordial ☐

Q12.Do you work in Team?

1. Yes
2. No ☐

Q13. Staff educational level (HIGHEST LEVEL ATTENDED).

1. Elementary
2. JSS ☐
3. SSS
4. Tertiary

Q14.Do you have additional training/upgrade?

1. Workshop

PLEASE TURN OVER

2. Seminars ☐

3. Continue education

Q15. Improved Quality of care in family planning by

1. Up-grading skills ☐
2. Improving client provider relations ☐
3. Good interpersonal relations among staff ☐
4. Counseling and information/education ☐
5. Availability of supplies ☐
6. Adequate logistics ☐
7. Policy implementation should suit client and provider ☐
8. Regular supervision ☐
9. Home visit/follow up ☐
10. Community based services ☐
11. Clinic based services ☐
12. Combination of community/clinic based services ☐

Q16. In what ways do you think staff can be motivated?

1. Appraisal
2. Award given ☐
3. Opportunity to further education ☐
4. Decentralize authority to work
5. Organize get-together/ refreshment
6. Given bonus

Q17.Do clients have opportunity to ask question?

1. Often
2. Sometimes ☐
3. Not at all

Q18. How is provider – client interaction?

1. Strictly professional
2. Friendly ☐

PLEASE TURN OVER

Q19. What is client source of information?

1. Friends

2. Media
3. Campaign on family planning
4. Durbars
5. Talk at post natal clinic
6. Talk at antenatal clinic

Q20. Do clients complain on method use?

1. Often
2. Occasionally
3. Not at all

Q21.How often do staff upgrade their skills?

1. Every six months
2. Yearly
3. Two yearly
4. Five yearly

Q22.Clients continuity of care is by

1. Community base program
2. Voluntary workers distributing
3. Schedule for review
4. Advertisement of services

Q23. Clinical accessibility is

1. within community
2. Outskirt of town
3. Distance away from community

Please write the appropriate figure UNDER the Adequate, Inadequate, Moderate, in the box provided

Q24. Resources availability ratings

PLEASE TURN OVER

	Adequate	Inadequate	Moderate
1. Logistics/vehicle	☐	☐	☐
2. Supplies	☐	☐	☐

Q25. Recommendations on family planning implementation

1. Increase coverage/programs ☐
2. Improve incentives ☐
3. Improve logistics ☐
4. Increase motivation ☐
5. Increase programs for skill upgrade ☐
6. Reinforce women's right ☐
7. Increase donors fund ☐

Q26. Why clients are not adopting Family Planning?

1. Delay fertility ☐
2. Gives complication ☐
3. Services not free ☐
4. Fear of side effect ☐

THANK YOU

Appendix D:

FOCUS GROUP DISCUSSION GUIDE FOR FAMILY PLANING CLIENTS

Dear respondent, I am a post graduate student from Kwame Nkrumah University of Science and Technology, Department of Community Health. I need your consent concerning this study on factors influencing clients' decision making to adopt family planning method and use. I assure all that any information given will be kept confidential and action plan carry out for an appropriate intervention. Thank you.

Region: Eastern
District: East Akim
Place: Asafo
Number of participants: 12
Date: October 2008
Start time: 11am
Moderator: Josephine Anyomi
Time end: 12pm

A.CLIENTS SATISFACTION IN FAMILY PLANNING

Q1.What do you think are the problems facing clients during family planning services?

Q2.What is your impression about the chosen method?

Q3.Do you have any preference to the family planning method and if yes, why?

B. CLIENTS OPINION ON THE QUALITY OF CARE GIVEN

Q4.How can the family planning services be improved to increase acceptability rate?

Q5.What is your impression about providers' attitude?

Q6.How do the community-based services and clinical-based services benefit clients?

C.RECOMMENDATION/SUGGESTIONS FROM THE CLIENTS

Q7.Do you have any suggestion for the government policy on family planning practice?

Q8.Any recommendation to friends, relatives and the government?

Q9.Do you have any suggestion for supporting the health providers to enable them carry out effective services?

D.HUSBANDS' CONTRIBUTION IN FAMILY PLANNING PRACTICE

Q10.Do the husbands support the women to practice family planning?

Q11.How can family planning practice benefit women?

THANK YOU

Appendix E: FGD – Family Planning

Question: What are the difficulties that people who use family planning go through?

Response:

> *I was using the 3 months injection method and my menstruation stopped, I also experienced a high blood pressure but as soon as I stopped using it everything of mine came to normal. I have 3 children as at now.*
>
> *My friend went in for the 3 months injection and it made her bleed profusely.*
>
> *I used the pills and had serious headache as a result of that. I have since stopped using it. I have four children.*
>
> *I went in for the 3 months injection and as a result I do not experience my menstruation again and this has become a source of worry for me.*
> *My sister went in for the 3 months injection and she bled profusely.*

Some education on family planning from questioner to respondents:

We do family planning because we do not want the eggs women lay at the end of every month to meet the man's sperms to develop into pregnancy. Usually, most of the family planning methods taken by women either destroys or prevent women

from laying eggs. In such a situation it is usually not possible for the woman to menstruate because the very egg that has to burst for the woman to see her menstrual period is not laid at all. It is therefore normal if women do not menstruate when using some family planning methods.

Question: Those of you who went in for family planning, did it work for you?

Response:

It was not good for me because I developed a lot of reaction from it

It helped me to delay my birth

Question: You usually go for family planning services from health facilities, so when you develop problems why don't you report it to the health facilities?

Response: *When I had the headache as a result of the usage of the pill, I immediately stopped taking it and the problem stopped.*

Question: What can we do to help women to use family planning services or what can we do to improve family planning services?

Response: *Recommend the method use to friends and relatives*

Why don't the nurses choose the method of family planning that will be good for us?

Questioner's response: *There is something in family planning we call informed choice, and so usually the methods that people use are their own choice. The duty of the nurses is to explain the various methods to you and allow the individuals t make their own choice.*

Respondent question: Sometimes when a woman delivers it can take about one month before the person will see her menstruation again. Can we factor this into family planning education?

Questioner's response: *Whatever that happens with regards to an individual's*
menstrual cycle after child birth depends on the individual's hormones.

Question: What do the nurses tell about family planning?

Response:

The nurses educated me on the 3 months injection and that it protect me from pregnancy for three months. I told them I have ever used that method and it wasn't good for me so thy changed it and gave me the one month injection one.

Respondent question: Can you take the three month injection if the one month injection is not available?

Questioner's response: Yes you can because they all perform the same function with months being the only difference.

Question: Family planning services were formally based in health facilities. Presently we want to bring the services closer to you in your communities. Which of these two methods of service delivery do you think will be good for you?

Response:

If it is in our community it will be accessible by everybody because currently some people are not using it because of the distance they have to travel for the service.
If it is in the community it will help because usually the delay that some users may make in the renewal of their method as a result of the distance of the health facility and the consequences this could bring can be eliminated.

Question: What can you tell your friends or family members about family planning?

Response:

Family planning is good and should be use to protect young girls who cannot abstain from sex from teenage pregnancy.
School children should be educated well on family planning and government should make a law that will make it possible to provide school girls who cannot abstain from sex with family planning services.
Family planning will protect young from getting pregnant and also save them from abortion.
Some say they have problems using family planning. I have been using it for the past 10 years without any problem. It is a good thing and most important thing to do is go in for the right method that will be good for your body.

Question: If you take the cost of abortion and that of family planning, which one will you prefer?

Response: We will prefer family planning

Question: What can you do to help the nurses in educating the public about family planning?

Response:

We shall talk to them about the various methods, the symptoms that may show up and explain to them that it is normal and that they could change them method anytime they see it not to be good for them.
We shall also help to educate all young ladies who cannot abstain from sex to use family planning.

Respondent Question: A woman who was using family planning after having six children from her first marriage later got remarried at the age of 45 but could not pregnant for her new husband. Is this the cause of the family planning?

Questioner's Response: The family planning is not the cause. Her age is major factor in this situation and she may be currently experiencing menopause.

Question: What help do your husbands give you in family planning?

Response:

I did the family planning on my own. I did not seek for an advice from my husband. He later got to know about it and he is comfortable with it.
Initially, when I was coming to do it my husband was against it because we had only one child at that time. I travelled to my mothers place and did it without his consent but my mother told him about it. He got angry over it but he later forgot about it. I however, develop a problem from the injection method I went for and had to stop. I got pregnant after I stopped using it.
My husband asked me to go for it. He did not go with me to the service center but I plan to take him there the next I'm going there.

Question: What benefit do women get out of family planning?

Response:

It helps in child spacing
It can safe women's life from pregnancy death

Question: What advise can we give to ourselves and other women?

Response: If you tell somebody that family planning can protect her from unwanted pregnancy and she refuses to use any family planning method, what can we do?

Questioner's response: It is good to explain family planning methods to other in details and usually use yourself as an example and the benefits you have derived from family planning.

Respondent Question*: Is using family planning something disgraceful? Usually women who use it tend to hide it from other.*

It is not disgraceful and there is no point for people to do that.

END