

**ENSIGN COLLEGE OF PUBLIC HEALTH, KPONG,
EASTERN REGION, GHANA**

**FACTORS ASSOCIATED WITH USE FAMILY PLANNING SERVICES AMONG
FEMALES (15 – 49 YEARS) AT KPONE KATAMANSO MUNICIPALITY IN THE
GREATER ACCRA REGION OF GHANA**

BY

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DECLARATION

I declare that this dissertation was written by my effort through the support of my supervisor.

I, therefore, present it to Ensign Global College for the award of a Master in Public Health Degree.

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DEDICATION

I dedicate this dissertation first and foremost to Almighty Father for His divine protection and wisdom right from the beginning to this very point. A special dedication goes to my family (Boampong's). Special dedication also to the Ensign community for their relentless support and compassion towards me during programme study.

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DEFINITION OF TERMS

Family planning service -Voluntary decision and action taken to control the number of children.

Contraceptive prevalence rate: Percentage of women in the reproductive age who are using or whose partners are currently utilizing at least a contraceptive (WHO, 2015).

Contraceptive – A method/ commodity use to prevent pregnancy.

LIST OF ABBREVIATION

AIDS.....	Acquired Immune Deficiency Syndrome
CI.....	Confidence Interval
CPR.....	Contraceptive Prevalence Rate
DHS.....	Demographic and Health Survey
FHI.....	Family Health International
FP.....	Family Planning
GHS.....	Ghana Health Service
GSS.....	Ghana Statistical Service
HIV.....	Human Immune Deficiency Virus
IFPP.....	International Family Planning Perspective IPAFPP
IUDs.....	Inter-Uterine Devices
MOH.....	Ministry Of Health
SSA.....	Sub-Sahara Africa
STIs.....	Sexually Transmitted Infections
UNFPA.....	United Nations Fund for Population Activities
UNICEF.....	United Nations International Children and Educational Fund
WHO.....	World Health Organization

ABSTRACT

Background: Family planning deals with the services, policies, information, attitudes, practices and commodities, including contraceptives that gives women, men, couples and adolescents the ability to avoid unintended pregnancy and choose whether to have children or not. Access to contraceptives can also be inhibited by excessively restrictive medical criteria or provider bias against methods; these practices are often referred to as medical barriers. Unintended pregnancy remains a global public health problem and substantially higher in low- and middle-income regions. This study seeks to assess knowledge and attitude toward the use of family planning services among females towards family planning services.

Methodology: A cross-sectional design using quantitative method was employed. Two hundred and eighty-four females (15-49 years) were sampled and questionnaire administered. Descriptive analyses, chi-square test and logistics regression were done using Stata 17 edition program.

Result: the study found a statistically significant association between the respondents age, parity, educational and marital status and the use of family planning service. Favorable attitude toward family planning was 88% with 68.1% used of family planning services among the respondents.

Conclusion: Attitude toward family planning service was favorable in this study and use of contraceptive was above the national average. There is still the need for the government and other stake holders increase education on family planning services and to improve on awareness and utilization rate of family planning services.

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CHAPTER ONE

1.0 INTRODUCTION

1.1 Background of the Study

The World Health Organization (WHO) defines family planning service as “a way of thinking and living that is adopted voluntarily upon the basis of knowledge, attitude and responsible decisions by individuals and couples in order to promote health and welfare of family groups and thus contribute effectively to the social development of a country, planning of parenthood is an important and most significant aspect of it” (Park, 2011. Pg.443).

Report by the Guttmacher Institute 2014 stated that nearly 80 million unexpected pregnancy occur yearly in lower-and-middle income status countries including Sub-Saharan Africa. Of this number, 19% result in mostly unsafe abortion while a further 13% end up in maternal death (Guttmacher Institute, 2014). In addition, a recent report by Bawah et al., (2021) in their study found that almost seventy-five percent of unplanned pregnancies in middle- and lower-income countries happen in among females women not on any form of modern contraceptives, thus, a deliberate action was not taken to prevent unwanted pregnancy (Bawah et al., 2021). Between 2010 to 2014, an estimated 36 cases of abortion per 1,000 females occurred among females 15 to 44 years annually in developing countries including Africa (Singh, 2018).

Recent report suggest that Africa alone constituted 66.4% (196000/295000) of all maternal death globally (WHO, 2019). Interestingly, the report concluded that most of such maternal death are avoidable. Existing literature suggested that 33% of maternal deaths can be prevented by using contraception in women who are seeking to defer or stay postpartum (Ahmed, Li, Liu, & Tsui, 2012).

There exists a disparity in contraceptive acceptance in rural areas and urban areas. The rural areas are still lagging behind in most countries (WHO/UNFPA/UNICEF, 2012). Report by the GSS (2014) affirmed a three-percentage gap in fertility rate between the rural and urban areas in Ghana. Even within the urban areas, there exist a disparity among the urban poor and urban rich of about 5 % to 15 % in modern contraceptive prevalence (WHO, 2016). Conversely, other report indicates slow improvement in contraceptive use by females of low-income status (Mascarenhas et al., 2012). In view of this, the 2012 “family planning 2020” had the objective of providing information and materials on contraception to 120 million females especially adolescents by the year 2020.

Unplanned pregnancy is a major public health concern not to the individual but the society as a whole. Problems such as economic, educational, emotional and employment opportunities are some challenges that accompany unwanted pregnancy especially among the young women (Bawah et al., 2021). With a plethora of benefit on contraception use among women, there still exists barriers arising from the provider’s side (Tumlinson et al., 2013). Identifying and addressing these challenges would help improve the use of contraception by women in their reproductive age.

A recent study in Ethiopia on the use of contraception found that nearly 25% of the respondent believe using contraception predispose them to infertility resulting in 75% contraception use among the respondent (Kasa, Terekegn & Embiale, 2018). Despite the high knowledge of women on contraceptives, studies have documented that utilization of contraception is still low making the condition a serious challenge (Menhaden et al., 2012; Handady, Naseralla & Sakin, 2015). A 2019 report from the Democratic Republic of Congo found that shortage of some family planning commodity as seen as affecting the use of contraception (Kaniki, 2019).

1.2 Problem Statement

Induced abortion among women which result in maternal death and morbidity is estimated at 50 million worldwide (Singh, 2018). The WHO (2012) estimated that 536000 maternal related death occurred globally with almost fifty percent (50.0%) of this death occurring in Sub-Saharan Africa while 1% of this death occurred in developed and advance countries (WHO, 2012). In addition, almost 7 per 1,000 women in African in their reproductive age are treated for the complications of unsafe abortion while 1.6 million are treated for complications arising from unsafe abortion annually (Guttmacher, 2018).

Contraceptive uptake in Ghana has been inconsistent over the recent years. For example, the rate has fluctuated from 4.0% in the 1980s to 8.7% in 1999, then 1.6% in 2013 and recently 5.0% in 2016 according to report (GSS, 2014; UNPD, 2017; Modey, 2018). The various report also highlights unmet needs for contraception among the married women to be 32%. Again, as high as 60% of discontinuation of contraceptives is reported among users during subsequent visit to the provider (Modey, 2018). Reduced need for contraceptives, fear and experiences of side effects contributed to increased risks of discontinuation of contraceptive use compared to all other reasons cited.

Notwithstanding the drop in the Ghana's fertility rate over the years, the country still has a higher rate compared to other developed countries. Recent studies put Ghana's fertility rate at 3.9 per 1000 live birth in urban areas as compared to 4.7 per 1000 live birth in the rural areas (GSS, 2014), these rates are still higher than the 1.6 birth per 1000 per woman reported in the developed countries (UNDP, 2017). This rate calls for concern with respect to the available employment challenges confronting the country coupled with high poverty rate (GSS, 2014).

Access to and use of contraceptives are subduced by certain provider practices. Practices such as restrictive medical criteria and biases from providers against certain methods, collectively known as medical barriers. These medical barriers serve as impediment to quality care and subsequently, affect uptake of contraceptives (Tumlinson et al., 2013). More recently, Bawah et al., (2021) investigated the use, discontinuation and failure rate of contraceptives among women in Kumasi. The study found a discontinuation rate of up to 88,5% in the use of emergency contraception and 80.9% in condom use. Factors cited for discontinuation according to the researchers includes; husband disapproval, side effect of the method and infrequent sex (Bawah et al., 2021). Other studies reported lack information and communication on the method, lack of dignity to the client and misinformation on the part of the health workers as barriers to accessing family planning and other health delivery services (Bawah et al., 2021; Kaniki, 2019).

In view of the above challenges, this study seeks to identify factors associated with the use of family planning services at the Kpong-Katamanso Municipality.

1.3 Rationale of Study

The necessity for this study lies in the benefits of effective family planning services would provide. This study would provide basis for reviewing the services in schools, clinics, CHPS zones and hospitals in the municipality to ensure effective delivery.

Furthermore, the results of the study could lead to organizations of programs to revitalize family planning programs, sensitization on contraceptives and strengthening health programs that target effective contraceptive use.

1.4 Conceptual framework

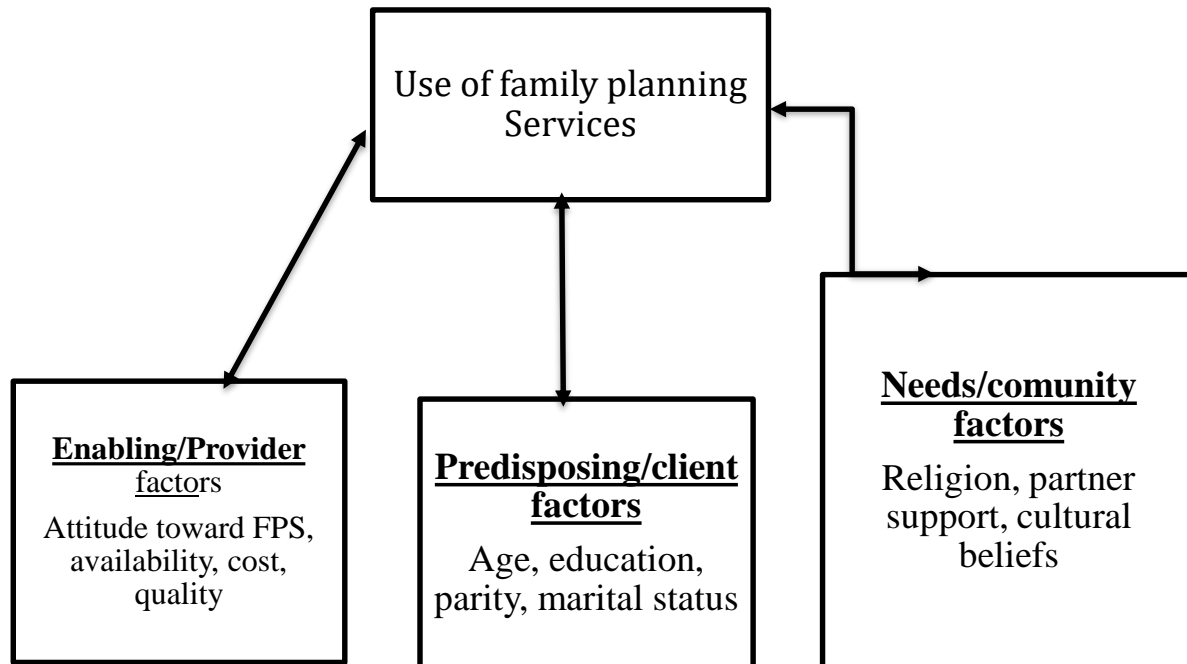


Figure 1.1 A conceptual framework adopted from *Yakob and Ncama (2016)*

Figure 1.1 above showing the conceptual framework that guide this study. Yakob and Ncama (2016) framework was used for the thesis. The conceptual framework indicates the three (3) main factors that determines the use of contraception. These are predisposing factors (client level factors), enabling factors (health care provider factors) and needs (community level factors). According to Yakob and Ncama (2016), the health care providers factors include attitude toward the client, delivery skill exhibited by the health care provider, quality of service, provider approach to service, and closeness of the service to the client. The needs or community factors that affect contraception use include religious belief of the client, partner support, and cultural beliefs and restrictions. The client related factors comprise of the age of the client, marital status, wealth

quintiles, educational level, parity and employment status. support from the spouse and access to the service.

The conceptual framework was adopted from Anderson's (1960) model. The framework was validated by Yakob and Ncama (2016) in their investigation of socio-ecological factors affecting access and acceptability of antiretroviral treatment (ART) in Ethiopia. Other recent studies that use this framework include Fuge, Tsourtous, and Miller (2022) in their study of factors link to the initiation of ART services in Sub-Saharan Africa.

1.5 Research Questions

1. What is the level of use of family planning services among females 15-49 years?
2. What is the attitude towards family planning services among females 15-49 years?
3. What is the level of knowledge about family planning services among females age 15-49 years?
4. What are the factors associated with the use of family planning services 15-49 years?

1.6 General Objective

The general objective of this study is to determine the knowledge and attitude towards family planning services among females (15 – 49years) in the Kpone Katamanso Municipality in the Greater Accra Region of Ghana.

1.7 Specific Objectives

1. To determine the use of family planning services among females 15-49 years.
2. To describe the attitude toward family planning service among females 15-49 years.

3. To assess the level of knowledge on family planning services among females age 15-49 years.
4. To investigate the factors associated with the use of family planning services among females 15-49 years.

1.8 Profile of the Study Area

The study was conducted at the Kpone-Katamanso in the Greater Accra Region. The municipality is 38 kilometers drive from Accra, national capital. The Kpone-Katamanso Municipality starts from Ghanaian's costal line in the south to the high the Akwapim mountains which shares boundaries with southern (Ningo-Prampam), East (Tema and Ashaiman), West (Adenta) and North (La-Nkwantanang Madina). The municipality was formerly part the Tema Metropolitan Assembly before its creation in 2012 with Legislative Instrument (LI) 2031. The municipality is made up of 18 elected assembly members and 11 government appointees. The GSS 2014 housing and population census put the municipality population at 109,864 representing 2.7 2.7 percent of the regions. The sex ratio of 94.5 means there are about 94 males to every 100 females in the district (GSS, 2014). Most of the inhabitants of the municipality engaged in petty trading and other commercial activities.

Four (4) area councils currently made up the Municipality. These are;

1. Kpone area council with comprises of Afienya, Laloi and Dingla
2. Kamsbeg area council with comprise of Kakasunanka, Nmlitsakpo, Sebrepor, Bethlehem and Gbetsile.
3. Onsbac which comprise of Oyibi, Nanoman, Saduase and Bawaleshie.
4. Zekas comprises of Zenu, Katamanso, Appolonia and Saasabi.

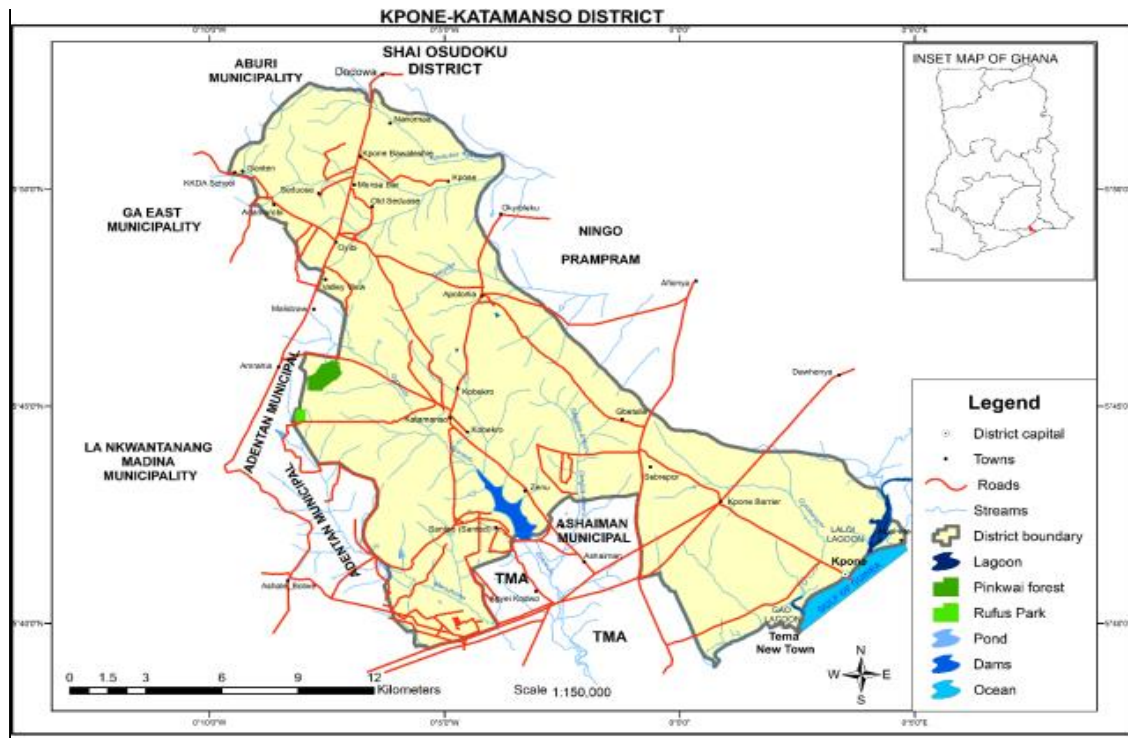


Figure 2 A map of Kpone Katamanso Municipality

1.9 Scope of Study

The study involved all females in their reproductive age within the Kpone Katamanso Municipality.

1.10 Organization of Report

The dissertation ordered in six chapters. The first chapter, looked at the statement of problem, background, conceptual framework, introduction, research questions, general objectives of the study, profile of study area, scope of study, and the study organization. The second is about the literature review is made up of overview of family planning in Ghana, types contraception, and the importance of contraception, knowledge and attitude concerning family planning services, factors influencing use of contraception. The chapter also considered the limitations and challenges to contraception access.

Chapter three is methodology and includes; study design, study site, data collection techniques, sampling, pre-testing, population, sampling, data handling, assumption, data analysis, ethical considerations, and limitations of the study.

Chapter four focus on the result of the study. Chapter five discusses the result under. It includes socio-demographic determinant of family planning services, knowledge on contraception, attitude toward contraception, and barriers to access to family planning service. Chapter six comprises of the summary, conclusion and recommendations.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

Literature review presents the review of related work from books, abstracts, articles, thesis and journals (Booth Sutton, & Papaioannou, 2016). This review outlined the concept of family planning, types of contraception, benefit of family planning, knowledge and attitude concerning family planning services, factors influencing contraception use. Finally, limitations and barriers to contraception use.

2.2 Overview Family Planning

There are varying definitions of family planning by different authors (The term family planning has varied definition by different authors (Woldemicael & Beaujot, 2011; Madhukumar & Pavithra, 2011). Whatever definition that is given, the central themes of family planning is birth spacing and prevention of unwanted and avoidable pregnancies. This definition provides the foundation for the first established birth control clinic in the 1982 which with theme “children by choice, not chance” (WHO, 2019). Bongaart et al., (2012) further adds that family planning helped both the mother and child live and improve their overall health by preventing unsafe abortion and its associated risk (Bongaarts et al., 2012). Family planning also helped individuals decide desired children they can cater for and the spacing of the children either through artificial, natural or voluntary sterilization (Bongaarts, Cleland, Townsend, Bertrant, & Gupta, 2012).

Williamson et al., (2011) further stated that, even though there has been great improvement over the year on women’s health to prevent unwanted pregnancies, couples are still not using contraceptives due to certain barriers such as preferred method not available, husband disapproval

provider attitude, undesirable effect and underlying health concerns of the woman (Williamson et., 2011).

Worldwide, 38% of all pregnancies are either unintended or accidental. Williamson et al., (2011) found that unplanned pregnancy presents a major social, health, and developmental challenges to the woman and family as a whole (Williamson et al., 2011). Unplanned pregnancy accounts for over 25 percent of 40 million pregnancies that occur yearly due to contraception failure, non-use and rape in some cases (Williamson et al., 2011). As a result of the above consequences, it's paramount and vital to thwart unplanned pregnancy through contraception provision including emergency contraception, comprehensive abortion care (CAC) and women empowerment to have control over their reproductive right and health (Ochako et., 2011).

Family planning is not new to the current generation. The ancient Egyptians used a mixture of honey and crocodile dung as spermicides and linen sheaths as male condoms to protect against STIs 3000 years ago (Wulifan & Bagah, 2015). Modern day contraception involves sexual practice, the use of chemical agents or devices purposely to avoid pregnancy (Darroch, Sedgh & Ba, 2011).

2.3 Family Planning in Ghana

In Ghana, the genesis of family planning is attributed to three (3) private organizations; Christian Council of Ghana, Marie Stopes Ghana and the Planned Parenthood Association of Ghana (PPAG). These three organizations realized the need to undertake family planning activities in Ghana after a group of doctors and nurses had expressed concern about increasing maternal and child mortality cases (Apusigah et al., 2011; Aryeetey & Hindin, 2010).

In an attempt to solve the concern raised by the above organization over increase maternal and child death and the need to control the rate of fertility in Ghana, the government also decided to show great concern about the country's population growth rate (Apusigah et al., 2011). The Ghanaian government was a co-sponsor of a resolution on population growth and economic development in the United Nations (UN) General Assembly and was the first Sub-Saharan country to sign the "World Leaders Declaration on Population" that called attention to the population question (Asante-Sarpong, 2012).

The 2014 annual report of the GHS and GSS categories FP methods into three main groups. Namely; short-term method which include condoms, pills, injectables and spermicides; long term methods include implants and intrauterine Device (IUD) and the permanents methods such as vasectomy and bilateral tubal ligation (BTL) (Ghana Statistical Service [GSS], 2014).

2.4 Types of Family Planning Methods

Family planning is achieved through use of contraceptive methods such as hormonal method, barrier method, pill contraceptives, intrauterine device, tubal ligation and natural methods (Freedman & Takeshita, 2015).

Hormonal method

This method contains hormones called estrogen and progestin that is able to inhibit conception in a woman. Examples of the hormonal method includes; pills, injections and implants. This method works by inhibiting eggs from been released from the ovary. It also thickens the uterine lining of the women and prevent fertilized eggs from implantation (Powell, 2012).

Barrier method

These methods work physically by preventing the sperm from entering the uterus thereby preventing pregnancy from occurring. Examples of barrier method include both the male and female condoms, diaphragms, cervical caps and contraceptives caps. This method has few side effects compared to the other method and do not alter the physiological state of the women (Seo et al., 2017). Qazi et al. (2019) found that condoms (85%) was most known method family planning methods use by the respondents.

Pill Contraceptive

The pill contraception is made up of synthetic hormone that defer ovulation by increasing the level of oestrogen. This stops the pituitary gland from sending a signal to the ovaries to release an egg (Regmi, 2010). The pill contraceptive is usually taken daily by the women to prevent pregnancy. It must be taken at the same time daily. A woman can become pregnant when she misses or forget a pill and engage in unprotective sex (Regmi, 2010).

Intra Uterine Devices (IUD)

It is a device that is inserted into the cervix through the vagina to inhibit conception. It is mostly made up of nylon plastic coil and has the ability to inhibit pregnancy for a maximum of ten (10) to twelve (12) years. Conception can occur when it is taken out (Seo, 2016). Intra Uterine Devices are of two major types which include:

Copper IUD: It releases a small amount of copper into the uterus, causing an inflammatory reaction that generally prevents sperm from reaching and fertilizing the egg. If fertilization of the egg does occur, the physical presence of the device prevents the fertilized egg from implanting

into the lining of the uterus. Copper IUDs may remain in the body for 12 years. A copper IUD is not recommended for women who may be pregnant, have pelvic infection, or had uterine perforation during previous IUD insertions. It also is not recommended for women who have cervical cancer or the uterus, unexplained vaginal bleeding, or pelvic tuberculosis (Lee, 2016).

Hormonal IUD: It releases a progestin hormone into the uterus released hormone causes thickening of the cervical mucus, inhibits sperm from reaching or fertilizing the egg, thins the uterine lining, and also may prevent the ovaries from releasing eggs. Hormonal IUDs can be used for up to 5 years (Lee, 2016).

Bilateral Tubal Ligation and Vasectomy

These methods are also known as permanent method. They usually involved surgical procedures that prevent the women or man from giving. This method is usually recommended for couples who do not desire more children. The method however does not affect the sexual activity of an individual (Gilbaugh, 2010). Tubal ligation involves cutting the women fallopian tube. This prevent the egg from reaching the uterus for implantation while vasectomy prevent sperms from reaching the cervix. It does not affect the sexual excitement or menstrual cycle of the women (Sangam, 2015).

Natural Family Planning Methods

These methods are also known as the traditional method. They do not involve any medication or device. These methods place much responsibility on the individual. Example includes Lactational Amenorrhea Method (LAM) and the fertility awareness method (Speroff & Darney, 2011).

Lactational Amenorrhea Method (exclusive breast feeding)

This method also known as exclusive breast feeding involving uninterrupted and exclusive breastfeeding after delivery for 6 months. This prevent the release of the ovary. One advantage of this method is that it is less expensive but only effective for 6 months after delivery (Speroff & Darney, 2011).

Fertility Awareness Method

This involves the women having sex during safe period during her menstrual cycle. This method places more responsibility on the women to monitor her menstrual cycle meticulously. Using a calandar, monitoring one's basal body temperature or changes in the cervical mucus are ways of detecting ones safe or unsafe period (Speroff & Darney, 2011).

Withdrawal Method

Also known as “coitus interruptus”. This method places the responsibility on the man. It involves withdrawing the penis from the vagina before ejaculation. Withdrawal method is an essentially male method of birth control. Its effectiveness is less in men un able to control their ejaculation (Asante-Sarpong, 2012). This method minor margin for error since emission of semen may occur but have been used before the discovery of modern contraceptive methods (Asante-Sarpong, 2012).

Periodic Abstinence Method

This involves complete abstinence from sexual activity during “unsafe” period of the months (Flynn & Bonnar, 2013). This method is based on the foundation that ovum have short life span in

the uterus if there are no sperm to fertilize. The risk of conception drops off quickly after ovulation (Flynn & Bonnar, 2013).

2.4.1 Importance of Family Planning

The importance of using contraception includes;

Preventing pregnancy-related health risks in women

A woman's ability to choose if and when to become pregnant has a direct impact on her health and well-being (Eguavoen, Odiagbe, & Obetoh, 2007). Using contraception allows couples to space childbirth and delay pregnancy. It also reduces the risk associated with early child birth among the adolescents. Older women with the risk of complication during delivery can also enjoy good sexual health with complications (Eguavoen et al., 2007). Again, family planning enables the women have the desired children she can cater for.

Reducing Infant Mortality

Use of contraception helps reduce the incidence of ill-timed pregnancies and births, which serve as a contributory factor to infant mortality and morbidity worldwide (Chuwa, 2012).

Helping to prevent HIV/AIDS

Family planning minimised the risk of acquiring sexual transmitted infections among women especially HIV/AIDS, resulting in fewer infected babies and orphans. For instance, both the male and female serve as dual protection against STDs, chlamydia, syphilis and prevent pregnancy at the same time (Chuwa, 2012).

Empower women to enhance their educational status.

Use of contraceptives enables the women make informed decision about their sexual right and health (Glasier et al., 2010). It also enhances the educational and employment opportunities of the woman. Again, couples with small family size can invest in them (Glasier et al., 2010).

Reducing Adolescent Pregnancies

Family planning use is important in the prevention of teenage pregnancy coupled with the complications associated with teenage pregnancy especially those in school (Glasier et al., 2012).

Slowing Population Growth

Family planning use serve as a means of controlling rapid population especially among the countries with high fertility rate, thus reducing the adverse effect of rapid population growth (Economic& Information, 2012).

2.5 Socio-demographic Factors associated with Family Planning Services.

The socio-demographic factors related to the client factors that influence the use of family planning service. These factors include age, gender, religious affiliation, cultural restrictions, marital status and employment status of the female.

The media, friends, relatives were revealed as the major source of information on family planning service in a study conducted in Ghana (Parr, 2013). Relatedly, Chaka and Kabagambe (2013) found that uneducated women had inadequate knowledge on family contraceptives and dislike the use of it. Participants low level of education and lack of exposure to contraception accounted for the outcome of the study. Chacko and Kabagambe (2013) further found that lack of access to information, limited availability, poor family planning services, inadequate numbers of skilled

service providers, poor communication skills on the part of service providers and unavailability of essential family planning commodities.

A study by Koroma et al., (2022) revealed that educated women are highly likely to use contraceptives than the uneducated. This might be due to the fact educated women could read and understand the side effect and also would like to pursue their employment opportunities. The study further found that women using contraceptives were between 15 and 34 years. Relatedly, Bawah et al., 2022 in their study found significant association between failure rate of contraceptives and the woman's age, educational level and marital status. The study again found that women within the age range of 20-29 years were more likely to discontinue using family planning method than younger women between 15-19 years.

In a cross-sectional study on male involvement in contraception involving 200 respondents (107 men and 93 women), Kwawukume, Laar and Abdulai (2022) found that only 67% had partner support in the form of encouragement, providing money for transport and assisting to the health facility. The study concluded that partner support has a monumental effect on the use of contraception (Kwawukume et al., 2022).

2.6 Knowledge and Use of contraception

Prevalence rate of contraceptives is determined by the number of women in their reproductive age who are on contraception or use any method at a given time to prevent pregnancy (WHO, 2013). According to the Ghana Health and Demographic Survey (GHDS) 2014, about one-third of Ghanaian men believe contraception is exclusively the responsibility of the female gender. For instance, a study by Wiafe (2015) on male involvement and support for partner on contraception use in Ghana found a 90% knowledge level but varied support to their partners. The study found

a 14% support from men on contraception. Other study has found only a small proportion of men believe that contraception is a shared responsibility (Kwawukume, Laar & Abdulai, 2022). A recent report by Wani et al., (2019) found that 57.4% of married women in their study had favorable attitude from their husbands toward family planning

In addition, Engelman (2012) in their quantitative found that there is an over reliance on female contraception, leading to the assumption that contraception is the role responsibility of women. This assertion has been proven wrong from various literature. The study concluded that men must get involved in their reproductive right of their partners (Engelman, 2012).

Consistent with the above, a study in Uganda male involvement in family planning revealed that men have inadequate knowledge on family planning methods and have the attitude that family planning service does not adequately meet the needs of men (Kaida et al., 2005). Most men in the study could also not explain how the various method worked. Poor communication among partners on contraception was found to be poor. It was also found that spousal communication about family planning issues is generally poor affecting men attitude toward contraception (Kaida et al., 2005)

Relatedly, a study in Kenya found that majority (75%) of rural men approved the use of contraception by their spouses, and could mention one modern contraception method and were able to access it at visiting mobile clinics (Muiga, 2014). This phenomenon of obtaining family planning service from mobile clinic rather than health centres could be attributed to unfriendly nature of the healthcare providers and uncondusive and poor reception men received at the health facility.

In a quantitative descriptive study involving 807 women in rural Jordan on the knowledge, attitude and practice toward family planning, Mahadeen et al., (2012), found that the concept of family planning was not well understood by women in the southern region of Jordan. Some women said that family planning meant spacing between births (36.9%) and others reported that it meant spacing between pregnancies (24.8%). The study however found that 8.7% of the women did not know what family planning was. The lack of adequate on family planning service could be attributed to the rural nature of the study. The study again found that 91.4% of the respondent knew at least one method of contraception, while 8.4% of the women did not know any methods (Mahadeen et al., 2012). The women in the study shown positive attitudes and knowledge about contraceptive use even though the prevalence of use of different methods highlight some educational needs among the women (Mahadeen et al., 2012).

In a study carried out in Ethiopia, Kasa et al., (2018), confirmed that 42.3% of the women had knowledge on contraception, 58.8% had favorable attitude, and 50.4% had good practice towards contraception. The study was however carried out among all women in their reproductive age irrespective of whether there were married or not, this may be responsible for their lower knowledge and attitude toward family planning. Contrary findings were reported in other studies in Ethiopia, Sudan and Tanzania were married women reported high level of knowledge and attitude toward family planning services (Tilahun et al., 2013; Handady et al., 2015; Lwelamira, Mnyamagola, & Msaki, 2012).

Consistent with the above study, Qazi et al., (2019) in their cross sectional study in India found that 80% women had positive attitude towards contraceptive usage, and expressed the desire to encourage others to patronize the family planning service. The study again found a 94% awareness level of family planning methods. Other studies have found high level of family planning service

awareness and acceptance among women in their reproductive age (Abasiattai et al., 2011; Tuladhar & Marahatta, 2008).

2.7 Factors Influencing the Utilization of Family Planning

Studies have revealed that the use of family planning service depends on several factors. Availability of the method, quality of the service, cost, and friendliness of the health workers has been reported as monumental factors (Bowling, 2014). Osubor, Fatusi & Chiwuzie adds that availability of health service such as postnatal and child welfare clinic and the nurses -patient-ratio affect a woman's decision to use family planning a method.

The 2014 GDHS revealed an increasing use of modern contraception among women of the higher educational ladder. The report again said women with at least secondary school level use contraception compared with married women no formal education (GDHS, 2014). Age and parity of the woman significantly influence a woman's decision to use contraceptives. For instance, Crissman et al., (2012) reported from their cross-sectional study that females in their 40 - 44-year group were more likely to use contraceptives than the 15 – 19-year age group. Again, women with no children are less likely to use contraceptive than those with 3-4 children (Crissman et al., 2012). In another study, Kanki (2019), investigated the “Factors influencing the use of modern contraceptive methods among rural women of child bearing age in the Democratic Republic of the Congo”, the study revealed frequent shortage of some contraceptives especially implants and injectables, distance to the health facility, and staff shortages were cited as some factors affecting the use of contraceptives. Unsurprisingly, only 14.3% of the respondents were using contraceptives at the time of the study. reasons cited for non-use of contraceptives include cultural beliefs, gender discrimination, husband disapproval and religious restrictions (Kanki, 2019).

Consistent with the above study, Najafi-Sharjabad et al., (2013) in their study found inadequate education, religious restrictions, fear of and lack of approval from husband as factors affect the use of contraceptives.

2.8 Unmet Needs to access Family Planning Services

The unmet need for family planning remains too high. This inequity is fueled by both a growing population, and a shortage of family planning services. In Africa, 24.2% of women of reproductive age have an unmet need for modern family planning (Goujon & Fuchs, 2013).

In Ghana, when comparing the results from the 1993 and the 2014 GDHS, access to family planning has decreased from 37% to 30% between the two surveys, while modern contraceptive use and percentage of demand satisfied have increased from 10% to 22% and from 18% to 39% respectively over the same period (GDHS, 2014).

Regions with high contraceptive use such as Asia, and Latin America, the levels of access to family planning are 10.2% and 10.7% respectively (Snow, Laski, & Mutumba, 2015). A study by Mahadeen et al. (2012) found that reasons for low access to family planning services include fertility-related reasons, unavailability of preferred methods, and inadequate knowledge. Less than 1% of the respondent reported opposition from their husband as a barrier to family planning service. Of noteworthy, the study did not report access challenge to family planning services (Mahadeen et al., 2012).

Qazi et al. (2019) in their cross-sectional study identified that 50% of the women were not having access to family planning services due inadequate knowledge, 13.8% due to pressure from husband, 12.5% due to desire for a male child, 11.3% thought it to be against religion, 6.2% due to non- availability as they were from rural area, 3.7% women not using any contraceptive methods

because of fear of side effects and 2.5% not using due to pressure from mother-in-law for a male child.

Some studies conducted outside Ghana have found a correlation between a woman education level and the use of contraceptives (Asfaw & Gashe, 2014; Asimwe, Ndugga, Mushomi, & Manyenye-Ntozi, 2014; Meskele & Mekonnen, 2014). The information a woman obtain concerning family planning service empowers emotionally and ultimately determines their attitude toward the use of the service (Çayan, 2009).

Again, low knowledge and poor attitude among healthcare providers have been cited as affecting access to family planning service in Bangladesh (Ugaz et al., 2016). As a result, Judge et al., (2011) recommends continuous training and refresher courses for health workers to help improve their knowledge and reduce inequality in family planning services.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Introduction

This chapter discusses the methodology which was used in this study. It covers the research design, study area, study population, sample and sampling procedure, instruments, data collection procedure and data analysis procedure.

3.2 Research Methods and Design

The main design employed for the study was a cross-sectional design. The study was quantitative in nature. A questionnaire was used to obtain data from the respondents. again, the study was descriptive in nature as it considered the knowledge and attitude of family planning services among females of ages (15-49 years). The design also employed the quantitative method of data collection which helps in addressing the research questions set for the study.

3.3 Data Collection Techniques and Tools

Data was collected by the use of a structured questionnaire design by the researcher based on the conceptual framework of the study. The questionnaire had both open-ended and closed ended questions. The questionnaire had four sections. Section A focused on the socio-demographic information of the respondents, Section B on their knowledge of family planning service while Section C elicited information on respondent attitude toward family planning service. The last section, section D provided information on factors associated with use of family planning services. The questionnaires were administered to selected respondents in their various homes or place of convenience.

Translation was done for respondents who could not read and write English language and their response entered. Privacy and confidentiality ensured by dealing with the respondents individually. Family planning providers' and health care nurses who provide reproductive health services in the Kpone Katamanso Municipality were selected as a research assistant to support the study by administering questionnaires. Three research assistants were trained in data collection for a day prior to data collection.

3.4 Study Population

Population is the entire number of people for a study. The study population for this study includes all women that are within the reproductive age of 15-49 years who were available at the time of the study. This age group was selected because it is considered the reproductive age group (women in their fertile age). Family planning providers' and health care nurses who provide reproductive health services in the Kpone Katamanso Municipality were selected to support the study by administering the questionnaires.

3.4.1 Inclusion Criteria

- i. Females in Kpone Katamanso aged 15-49.
- ii. Residents who consented to be enrolled in the study.

3.4.2 Exclusion Criteria

- i. Residents that are not in the age range of 15-49 years.
- ii. Residents who did not consent to the study.
- iii. Women who had done hysterectomy.
- iv. Non-resident of the municipality but present during the study were excluded from the study.

3.5 Study Variables

The variables for study was made up of dependent and independent variables. The dependent variables were use of family planning service.

The independent variables include the following;

- i. Socio-demographic characteristics example: age, marital status, educational level, employment Status, religion, and parity.
- ii. Knowledge about family planning services
- iii. Attitude toward family planning service.
- iv. Accessibility to family planning services.

3.6 Sampling

Respondents who qualified and met the specifications of the research was considered for the study.

A multi stage sampling method was used. There are four areas council in the Kpone Katamanso Municipality. These are Kpone, Kamsbeg, Onsbac and Zekas area councils. A simple random sampling was used to select one council area (Kpone) for the study. Kpone council area has number of communities and four were randomly selected for the study There was an equal allocation of participants within the four selected area councils. This was done by dividing the 284 participants equally among the four communities. Systematic sampling method was used to select households for the study and respondents were selected using simple random techniques from the household. Questionnaires were administered to the selected respondent who met the inclusion criteria.

Sample Size calculation

To determine an appropriate sample size for the study, sample size was calculated using the Cochran's formula as shown below;

$$n = \frac{Z^2 \times pq}{e^2}$$

Where,

n = sample size (Cochran, 1977)

Z = the z-score that corresponds with 95% confidence interval which is 1.96

p = Prevalence of contraceptive use in Ghana

q = 1-p

e = Margin of error set at 5% (0.05)

95% confidence interval and 5% margin of error was

Contraceptive prevalence rate of 21.5% in Ghana according Guure et al., (2019) was used for the study. used.

The sample size for the study was calculated as follows;

Therefore,

$$= \frac{(1.96)^2 \times (0.215 \times 0.78)}{(0.05)^2} \cong 257.6$$

A 10% non-respondent rate bringing total number to **284**. There was a proportional allocation of the sample size to the four selected communities. This was done by dividing the 284 participants among four communities selected within the Kpone council area based on the number of women in their reproductive age in each community.

3.7 Pretesting of Data Collection Tool

The questionnaire was pretested at the Afienya community of the Ningo-Prampram Municipality. The Afienya community was chosen because it shares boundary with Kpone Katamanso Municipality and has similar population dynamics to the study area. Corrections and modification to the questionnaire was done before data collection began. Result from the pretesting was not included in the main result. Twenty respondents were used for pretesting.

3.8 Data Handling

Data handling process is important in ensuring the integrity of research data since its addresses concerns related to confidentiality, security, and preservation of data collected. The questionnaires were cross-checked for completeness before the data entry. Incomplete questionnaires were sorted out and different respondents asked to complete it. Completed questionnaires were numbered before entry to reduce repetition of entry. All completed individual questionnaires were kept under lock and key. Again, multiple backup copies were created and stored multiple devices to ensure easy data recovery in case of emergencies.

3.9 Data Analysis

The analysis of data was based on the research questions set for the study. Data analysis was done using STATA version 17.0. Data was first entered into Microsoft Excel where cleansing and coding was done. Descriptive statistics was done using quantitative method. Bivariate analysis such as chi square test to test association between the variables. It was transferred into STATA for analysis. Descriptive statistic was presented in percentages, frequencies and charts. Chi-square was used to test associations between the covariates and the outcome variables.

3.10 Ethical Considerations

Clearance from Ensign Global College Ethical Review Committee was sought before data collection started. Also, administrative permission was sought from the community through the Assembly members, Unit committee members and elders. An oral informed consent form was sought from individuals after explaining the purpose of the research before undertaking the exercise and a signed consent form was obtained from participants. Assent form was obtained from parents of participants below the age of 18 years. Objectives of the research was discussed with them and assured anonymity and confidentiality of all information gathered. Participants were assured of the right to pull out of the research at any time without any consequences to them, their image and self-esteem. Respondents were assured of confidentiality as their person details were not made public to other respondents. Their personal details were not disclosed to other respondents.

3.11 Limitation of the study

A major limitation is that the cross-sectional survey design did not offer opportunities for probing further to get more understanding from the respondents. There may have been information bias due to the social stigma associated contraception use especially among younger respondents and participants' reluctance or inability to understand the questions.

3.12 Assumptions

It was assumed that the questionnaires for the study was correctly answered and there was no recall bias by the respondents.

CHAPTER FOUR

4.0 RESULTS

4.1 Introduction

This chapter presents the result of the study. The result is presented according to the objectives of the study. It is organized as follows; Socio-demographic data of the respondents, level of knowledge on family planning services, attitude toward family planning services and barriers to family planning services. Afterwards, inferential statistics was used to establish associations and strength of association between the outcome variable and independent variables.

4.2 Socio-Demographic Data of the Respondents

Table 4.1 Univariate analysis of Socio-demographic Characteristics of Study

Respondents

VARIABLES	FREQUENCY (284)	PERCENTAGE (%)
AGE		
15-20	27	9.5
21-30	97	34.2
31-40	131	46.1
41-49	29	10.1
PARITY		
ONE	78	27.7
TWO	146	51.3
THREE	50	17.3

FOUR	10	3.8
LEVEL OF EDUCATION		
Primary	17	6.2
JHS/Middle school	65	22.7
SHS	84	29.3
Tertiary	113	39.8
No formal education	5	1.7
OCCUPATIONAL STATUS		
Unemployed	19	6.6
Self-employed	88	30.7
Public servants	103	36.1
Private institution	24	8.3
Widow/Widower	52	18.1
RELIGIOUS AFFILIATION		
Christianity	190	66.4
Muslims	75	26.5
Traditionalist	16	5.9
None	3	1.1
MARITAL STATUS		
Single	71	25.2
Married	165	58.5
Divorced	18	6.38
Widowed	28	9.93

HUSBAND'S EDUCATIONAL LEVEL		
Primary	24	9.3
JHS	31	11.97
SHS	63	24.3
Tertiary	118	45.6
No formal education	21	8.11
ELECTORAL AREA OF RESPONDENTS		
Kpone/Dzooshi	42	14.8
Kpoiete	51	17.96
Saglemi	63	22.2
Shangai	101	35.6
Alata	27	9.5

Source: *field data, 2022*

Table 4.1 above indicates the demographic data of the respondents. Majority of the respondents 131 (46.1%) were between the age group of 31-49 years while few 27 (9.4%) were between 15-20 years. Most of the women 147 (51.7%) had two children while 11 (3.8%) had 4 children. With respect to respondents desired number of children, 214 (84%) said they desired 1-3 children. Most 114 (39.8%) had tertiary education and 84 (39.3%) had senior high school education. A further 65(22.7) had junior high education while 5 (1.75) had no formal education.

Again, with respect to the employment status of the respondents, most of the respondent 103 (36%) were public servant, 88 (30.7%) self-employed, 19 (6.6%) were unemployed while 24 (8.3%) were students. Most of the respondents 190 (66.4%) were Christians, 76 (26.5%) were Muslims while 17 (5.9%) professed to be traditionalist. Most of the women 165 (58.5%) were married, 71 (25.2%)

single and 28 (9.97%) were widowed. In terms of the educational history of the husbands of those married, 63 (24.3%) had senior high school education while most 118 (45.6) have tertiary education.

Most of the women 101 (35.6%) came from the Shangai electoral area, 63 (22.2%) from the Saglemi electoral area while 27 (9.5) were from the Alata electoral area.

4.3 Knowledge of Family Planning Service

Table 4.2 Knowledge of Respondents on Contraceptive Service

VARIABLE	FREQUENCY	PERCENTAGE
KNOWLEDGE OF CONTRACEPTIVE METHODS		
Yes	263	92.6
No	21	7.4
SOURCES OF KNOWLEDGE		
Health workers	212	74.7
Television	228	80.2
Radio	201	70.8
Friends	200	70.4
Family	120	42.2
METHODS OF CONTRACEPTIVES KNOWN		
Oral contraceptive Pills	211	74.3
Intrauterine Device	201	70.8
Injectables	180	63.4

Condoms	178	62.7
Diaphragm	98	34.5
Sterilization	86	30.2
Implants	100	35.2
Withdrawal	67	23.6
Periodic abstinence	37	13.02

Source: *field data, 2022*

Table 4.2 above indicating whether the respondent’s knowledge of family planning services. From the analysis, majority 263 (92.6%) have knowledge on family planning while 7.4% have no knowledge on family planning. All the women had heard of various methods for preventing pregnancies. Television (80.2%) accounted for the major sources of information followed by health workers (74.7%). Radio (70.8%), Friend (70.4%) while fifty two percent of the women said they receive information from their family.

When respondents were asked about the types of family planning methods known, oral contraceptive pills are known by 74.3 % of the respondents. Intrauterine device was known by 70.8% of the respondent. Injectables was known by 63.4% while condoms were known by 62.7% of the respondent. The least known methods were withdrawal (23.6%) and abstinence (13.02%) respectively.

4.4 Attitudes towards the use of family planning services

Table 4.3 Attitude toward Family planning service

Item	Attitude toward family planning services	Agree (%)	Disagree (%)	Mean (SD)
1	Large family size negatively affects economic conditions	167 (58.80)	117 (41.20)	3.63 (1.06)
2	Large family size earns the respect by my partner	114 (40.0)	170 (60.0)	3.62 (1.09)
3	Large family size earns the respect of the community	122 (43.0)	162 (57.00)	3.57 (1.12)
4	Large family size earns the respect by religious leaders	104 (36.62)	180 (63.38)	3.65 (1.11)
5	Large family size negatively affects maternal and child health	170 (59.9)	114 (40.14)	3.75 (1.04)
VARIABLE			Mean (Frequency)	Percentage
Favourable attitude			≥ 2.772 (250)	88.0
Unfavourable attitude			< 2.77291 (34)	12

These questions were itemized and score on a scale of 1 to 5. With item 1 and 5, neutral responses were treated as disagree and with respect to items 2,3, and 4 all neutral responses were treated as agree. The two responses were grouped together and results presented as follows.

On item one (1), majority of the respondents 167 (60.0%) disagree that large family size affects negatively economic conditions with a mean score of 3.63.

One item two (2) majority of the respondents 170 (60.7%) disagree that large family size earns the respect by my partner with a means score of 3.62.

On item three (3) majority of the respondents 162 (57.0%) disagree that large family size earns the respect of the community with a mean score of 3.57.

On item four (4) majority of the respondents 180 (63.4%) disagree that large family size earns the respect of religious leaders with a mean score of 3.65.

On item five (5) majority of the respondent 170 (59.9%) agree that large family size negatively affects maternal and child health with a mean score of 3.75.

The mean scores were divided into two. The mean score greater than 2.772 was considered a favourable attitude toward family planning and mean scores equal or less than 2.772 was considered unfavourable attitude toward family planning services.

4.5 Accessibility of Family Planning Services

Table 4.4 below indicating access to family planning services. 225 (83.0%) of the women had access to family planning services while 44 (17.0%) said they have no access to family planning service. When respondent was asked about the distance to the health facility, 136 (52%) said take them 30 minutes, 70 (27.1%) said it them 40 minutes while it takes 60 minutes for 42 (16.3%) to get to the health facility. In terms of the means of transport to the health facilities to access family planning services, majority of the respondents 112 (41.2%) said they walk to the health facility, 46 (17.2%) drive, 31 (11.7%) get a ride while 78 (29.2.0%) take a taxi or trotro to the health facility.

Again, 193 (75.1%) of the respondents said they can just walk in while 63 (24.9%) said they need prior appointment before going to the health facility. With respect to the affordability of the service, 178 (68.7%) of the respondent said it was affordable while 81 (31.35) said otherwise. In terms of the waiting time at the facility, it takes 109 (42.1%) 30 minutes, 36 (13.9%) 60 minutes while 66 (25.08%) of the respondents take 90 minutes.

Table 4.4: Access to Family Planning Services

VARIABLES	FREQUENCY	PERCENTAGE (%)
Access to health facility that renders family planning services?		
Yes	225	83.0
No	46	17.0
DISTANCE TO HEALTH FACILITY		
30 Minutes	136	52.71
40 Minutes	70	27.13
60 Minutes	42	16.28
80 Minutes	10	3.88
Means of transport to health facility		
Walking	112	41.95
Drive	46	17.23
Get a ride	31	11.61
Take a taxi	78	29.21
Do you need prior appointment		
I need appointment	63	24.9

I don't need appointment	193	75.1
Are family planning services affordable		
Yes	178	68.7
No	81	31.3
Waiting time at the health facility		
30 Minutes	109	42.1
60 Minutes	36	13.90
90 Minutes	66	25.5
120 Minutes	36	13.9
More than 120 Minutes	12	4.63

Source: *Field data, 2022*

4.6 Use of Family Planning Services

Table 4.5 Use of Family Planning Services

Variable	Frequencies	Percentages
HAVE YOU EVER USED ANY FORM OF CONTRACEPTIVES IN YOUR LIFE?		
YES	189	68.1
NO	86	31.2
FAMILY PLANNING METHOD USED		
Condoms	57	29.5
Intrauterine device	13	6.8
Oral contraceptives	22	11.4
Depo Provera	31	16.1
Morning Pills	16	8.3
Implants	8	4.2
Two or more methods	44	22.8

Table 4.4 above summarizing the use of family planning method respondents. 189 (68.1%) of the respondents have ever used or currently using family planning service while 86 (31.2%) have not use family planning service before. Most of the women 57 (29.5%) rely on condoms, 22 (11.4%) use oral contraceptives, 16 (8.3%) use morning pills, 13 (6.85) use intrauterine device while 44 (22.8) of the respondents were on two or more methods.

Figure 4.1: Use of Family Planning Services

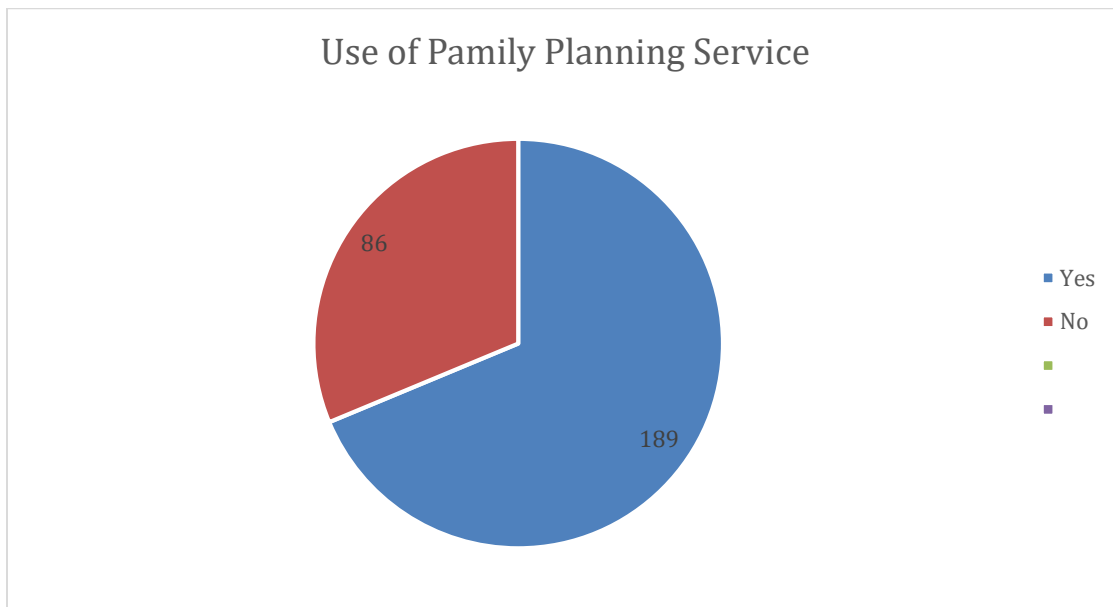


Figure 4.1 above indicating the utilization of contraceptives by the respondents. from the analysis, 189 (68.7%) have ever used any form of contraceptive while 31.2% of the respondent said they have not used any form of contraceptive before.

4.7 Bivariate Analysis (Chi-square) on socio-demographic factors and use of family planning services

Table 4.6 Bivariate Analysis of socio-demographic factors and use of family planning services

Variables	Use of family planning services		P-value
	Yes (%)	No (%)	
Age			
15-20	13 (52.0)	12 (48.0)	0.001*
21-30	56 (60.2)	37 (39.7)	
31-40	96 (75.0)	32 (25.0)	
41-49	24 (92.3)	2 (7.7)	
Parity			
No child	44 57.9	32 (42.1)	0.031*
1-2	101 67.3	49 (32.7)	
3-4	36 73.5	13 (26.5)	
Above 5	8 (100)	0	
Desired number of children			
1-3	156 (67.8)	74 (32.2)	0.381
Above 4	32 (72.7)	12 (27.3)	
Religious affiliation			
Christian	116 (63.7)	66 (36.3)	0.008*
Muslim	55 (73.3)	20 (26.7)	
Traditionalist	15 (100)	0	
Others	2 (100)	0	
Occupation			
Self employed	72 (62.5)	16 (18.2)	0.000*
Public servants	70 (68.0)	33 (32.0)	
Private institution	28 (58.3)	20 (41.7)	
Unemployed	5 (29.4)	12 (70.6)	
Students	13 (72.2)	5 (27.8)	
Level of education			
Primary	16 (88.9)	2 (11.1)	0.007
JHS	37 (57.8)	27 (42.2)	
SHS	60 (80.0)	15 (20.0)	
Tertiary	73 (64.0)	41 (36.0)	
No formal education	3 100	0	
Husband Educational level			
Primary	16 (66.7)	8 (33.3)	0.003*
JHS	21 (70)	9 (30)	
SHS	46 (80.7)	11 (19.3)	
Tertiary	72 (62.1)	44 (37.9)	

No formal education	20 (95.2)	1 (4.8)	
Others	0	2 (100)	
Marital status			
Single/co-habiting	50 (72.5)	1927.5	0.040*
Married	103 (64)	58 (46)	
Widowed	19 (76)	6 (24.0)	
Divorced/Separated	17 (94.4)	1 (5.6)	

Source: *field data, 2022* **statistically significant*

Table 4.6 above indicating a bivariate analysis of socio-demographic associated with the use of family planning service.

From the results, there was a strong statistically significant between age and use of family planning (P-value=0.001) with the age group 31-40 likely to use family planning than the other age ranged. Again, he numbers of times a respondent had given birth showed a significant association with the use of family planning method (P-value=0.031). religious affiliation of the respondents also shown a strong association with the use of family planning method (p-value=0.008).

Occupation, level of education, respondents husband level of education, and marital status of the respondents all showed significant association to the use of family planning service (P<0.05).

There was however no association between the desired number of children and use of family planning service.

4.8 Multivariate Analysis of Factors associated with use of Family Planning Services

Table 4.7 Multivariate analysis on Factors Associated with use of family planning service

Variable	Category	Unadjusted		Adjusted	
		P-Value	OR(CI)	P-Value	OR(CI)
Age	15-20	R	1	R	1
	21-30	0.46	1.3(0.5-3.39)	0.670	1.40 (0.29-6.8)
	31-40	0.023	2.7 (1.14-6.68)	0.078	4.35 (0.84-22.3)
	41-49	0.004	11.07 (2.14-57.20)	0.132	5.49 0.59-60.6)
Parity	None	R	1	R	1
	1-2	0.041	1.8 (1.02-3.29)	0.59	0.745 (0.25-2.19)
	3-4			0.807	1.17 (0.33-4.1)
Desired number of children	1-3	R	1	R	1
	Above 4	0.785	1.10 (0.55-2.2)	0.741	1.22 (0.37-4.00)
Religious affiliation	Christian	R	1	R	1
	Muslim	0.140	1.5 (0.86-2.8)	0.063	4.12 (0.92-18.4)
	Traditionalist	0.000	1.7 (1.29-2.37)		
Occupation	Self employed	R	1	R	1
	Public servants	0.031	0.47 (0.238-0.93)	0.012	0.117 (0.02-0.620)
	Private institution	0.004	0.31 (0.14-0.68)	0.542	0.588 (0.106-3.2)
	Unemployed	0.000	0.09 (0.028-0.29)	0.00	0.003 (0.002-0.06)
	Students	0.356	0.57 (0.18-1.85)	0.125	0.113 (0.012-1.02)
Educational level	Primary	R	1	R	1
	JHS	0.026	0.17 (0.36-0.808)	0.0020	0.041 (0.002-0.6)
	SHS	0.388	0.5 (0.103-2.41)	0.081	1.21 (0.08-18.3)
	Tertiary	0.005	0.22 (0.048-1.01)	0.017	0.257 (0.17-3.8)
Husband educational level	Primary	R	1	R	1
	JHS	0.793	1.16 (0.368-3.69)	0.332	3.7 (0.258-54.3)
	SHS	0.178	2.09 (0.71-6.11)	0.226	3.5 (0.45-27.26)
	Tertiary	0.671	0.818 (0.32-2.06)	0.799	1.2 (0.17-9.4)
	No formal education	0.038	10 (1.13-88)		
Marital status	Single/co-habiting	R	1	R	1
	Married	0.213	0.67 (0.363-1.25)	0.117	0,33(0,084-1.13))
	Widowed	0.732	1.20 (0.417-3.4)	0.29	0.29 (0.29-2.90)
	Divorced	0.079	6.45 (0.80-51.9)		
Attitude to family planning	Unfavourable	R	1	R	1
	Favourable	0.417	0.705 (0.30-1.64)	0.500	0.61 (0.15-2.5)

Access to family planning	YES NO	R 0.00	1 0.19 (0.099-0.38)	R 0.00	1 0.025 (0.0046-0.13)

Source: Field data, 2022 **statistically significant*

Table 4.7 above indicating the multivariate analysis of factors associated with family planning service. The multivariate analysis was done to determine the level of association between some independent variables and the use of family planning service.

In unadjusted model, respondent in the age range 31-40 are more likely to use family planning methods was 2.7 higher compared respondents in the age range 15-20 years (95% CI: 1.14-6.68).

Again, the respondents were more likely to use family planning service as their parity increase. Compared with respondents with zero parity, the odds of the respondents having access to family planning was 1.8 times higher more for respondents with 1-2 children (95% CI: 1.02-3.29).

In the adjusted odd ratio, compared with respondents with 1-2 children, the odds of the respondents using family planning service was 1.17 higher than those with 2-4 children (95% CI; 0.33-4.1). parity was significantly associated with access to family planning service.

Additionally, the crude or unadjusted odds ratio of respondents who were Muslims was 1.5 higher than Christians (95% CI: 0.86-2.8) while 4.12 higher on the adjusted ratio (95% CI 0.92-18.4).

On the educational level respondents in SHS were more 0.5 higher to use family planning service compared to respondents in primary school ((95% CI; 0.103-2.41). Compared to respondent with unfavourable attitude toward family planning service, the odds with those with favourable attitude were likely 0.705 higher than those with unfavourable attitude (95% CI: 0.30-1.64).

CHAPTER FIVE

5.0 DISCUSSION

5.1 Introduction

This study seeks to determine the factors associated with the use of family planning services among females (15 – 49years) in the Kpone Katamanso Municipality in the Greater Accra Region of Ghana. The discussion covers the summary of the results, and comparison of the result to the findings of previous studies.

5.2 Knowledge on Family Planning Services

Most women were aware of the availability of contraceptive method even though the region a low contraceptive prevalent rate. This study found 92.6% awareness level of family planning services. There was a significant relationship between age of the respondent and knowledge of family age was significantly associated with awareness. 100% of all the women between the age of 41-49 had knowledge on contraception. This could be due to the fact they might have attended antenatal care before and family planning are routine for such service. The study again found lower awareness level among 15-20 years' women. women 15-20 years less likely to be sexually active and this may account for their low knowledge of family planning services.

Health workers and television accounted for majority of the sources of information for the women in this study. Television accounted for 80.2%. This finding corresponds to the findings of Adjei et al., (2015) that television is major source of information for most Ghanaian women. Their study was however carried out in an urban area where access to television is easy. The role of health was also monumental as they were the sources of information for 74.7% of women. This might most likely occur during ANC. Even though this is commendable, the challenge is that women could

only be exposed to contraception information from health workers after their maiden pregnancy. Friends 70.4 % and family members with 42.2%.

Of noteworthy of reporting in this study, all participants had information on at least one contraceptive. A most recent study in hospitals and clinic centers in the rural Western Sierra Leone found a 100% knowledge on contraceptive methods among the women sampled (Koroma et al., 2022). The commonly mentioned methods include pills (74.3%), intrauterine device (70.8%), injectables (63.4%), condoms (62.7%), diaphragm, withdrawal method and abstinence. It was surprising that abstinence was the least known contraceptive method despite its wide usage. The study however found no statistical relation between the married status of the respondent and their knowledge of the various family planning methods (P -value=0.075). Knowledge.

5.3 Attitude toward Family Planning Services

From the study, there was a varied attitude of the respondents toward family planning. 58.8% of the respondents believe large families negatively affect their economic condition. Although women in our study had a positive attitude toward family planning services, the utilization was less than seventy percent of the respondents. The prevalence rate of the use of family planning services highlights some educational needs among the women. This study found 88.0% favourable attitude toward planning services among the selected respondents.

5.4 Accessibility of family planning services

This study found that access to family planning services was 83.0% which was quite encouraging. Again, the study found that 52.7% of those who have access to family planning services in a nearby facility said it takes them 30 minutes to the facility. Only 3.8% of the respondents that access

family planning service travelled for more than 80 minutes. The distance to access family planning service by respondent might be due to lack of government hospital in the municipality couple with the traffic situation in the municipality that is likely to cause delay. With respect to the means of transport to access family planning service, the study found that 41.9% of respondents walk. This finding is remarkable as it reduces the cost of accessing family planning service.

It was good to note that 75.1% of the did not need to make prior appointment but can just walk in and access service.

Again, in terms of the affordability of family planning service, 68.7% of in the study said the service was affordable. The affordability of the service was statistically significant with the parity of the woman even though majority of the respondent said the services was affordable. Women with 2-4 children were more likely to say the service was not affordable than those with no children. Again, marital status was not significantly associated with the affordability of the service (P-value=0.578). Married women were likely to say the service was affordable than the single and co-habiting. Again 39.8% of the respondent said the nurses were friendly while 14.2% of the respondent said the staff were not friendly.

5.5 Use of Family Planning Services

This study report a 68.1% utilization of contraceptives among the sampled participants despite a 92.6% knowledge of family planning services. This finding concurs with the assertion by Mendes et al., (2011) that knowledge of contraceptive method does not necessarily translate into usage of the method. This is higher than findings from a study in South Jordan that found 37% utilization rate of contraceptives (Mahadeen et al., 2012). This study was conducted among 29 villages while this current one is in the urban area. This might have affected the prevalent rate. Condoms

(29.5%), oral contraceptives (11.4), emergency contraceptives (18%) and intrauterine device (6.8%) were the commonly used contraceptive by the 68.1% who ever used any form of contraception. The condom is the most common, easily accessible, affordable and very easy to use and no wonder it was the most use contraception among the respondents. A quantitative study by Buxton and Hagan (2012) confirmed that women are more accustomed with condoms and oral pills. Contrary, Koroma et al., (2022) found the pill as the most use contraceptive with as much as two third of the respondents. This may be due to the perceived lack of education on other methods. The above findings contradict the finding of Yusuf and Yağma (2021) where majority of child bearing age women had inadequate or unvalidated knowledge on contraception. little or erroneous knowledge of family planning options.

From this current study, women who never used any contraceptives method was 31.0% of the respondents. Contrary existing studies Nayak et al., 2017 (11%) and Young et al., 1994 (8%) respectively, but comparable to the 38.2% found by Srivastava et., (2005).

5.6 Socio demographic factors associated with use of family planning services

Solanke (2017) contended that socio demographic factors such marital status, religious affiliation, age, educational level and parity, desired number of children have had significant influence on family planning service. This assertion was not different from this study. Age was significantly associated with contraception knowledge (P-value=0.008). Knowledge of contraceptive was more prevalent among women between the age of 41-49years than women age 15-20. It was not surprising that women nearing their menopausal age had better knowledge than younger women. Their exposure might be due to education received during childbirth. In a contrary finding, Solanke (2017) reported that women 18-25 had better knowledge on contraceptives. With respect to the

marital status of the respondents and knowledge of the various methods, the married and widowed had more knowledge than the single and co-habiting. The reason might be that older women might have used some of these methods during their life cycle.

Another socio-demographic characteristic highly correlated with contraception use was religion of the respondents. The study found that less Christians were likely to use family planning service than Muslims and traditionalists. This might be because Christians believe do not accept the use of contraception, it limits procreation according to what the bible teaches. From all indications, some religious beliefs forbid the use of contraceptives among its members. Health workers need to be cognisant of when dealing with the religious beliefs of their clients.

Marital status of the respondents was found to be significantly associated with use of contraception (P-value=0.040). In this present study, the single and co-habiting were highly likely to use contraceptives compared to the married. This might be due to the reason that most single and co-habiting people are not ready for child bearing and use the contraceptives as protection against pregnancy. Again, having children without being legally married is frowned upon in the Ghanaian society.

The study also found a strong correlation between the educational level of the respondent and contraception use (P-value=0.007). Women highly educated were found to be more likely to use contraception than those with less formal education. This concurs with a study in Ghana that revealed that education status of women is strongly associated with use of contraception. Educated women are more likely to postpone childbirth or space their children (Eliason et al., (2014). Again, Chaka and Kabagambe (2013) found that uneducated women had inadequate knowledge on family contraceptives and dislike the use of it. Contrary, Singh et al., (2014), argues education and knowledge is crucial in the sexual rights of women. The result further revealed that women

with tertiary educational level ever used less contraception than those with primary and senior high school education. This finding was difficult to explain.

Another socio demographic characteristics that was significantly associated with family planning used was occupation (P-value=0.00). The unemployed women were less likely to use contraceptives than the self-employed and public servants. Employed women would most likely be financially stable to be able to afford the cost on the contraception the less employed. On the flipside, Postlethwaite in his 2013 study found otherwise.

Finally, there was a relationship between parity and ever used of contraception (P-value0.031). Again, women with no children were less likely to use contraception than those with 2 or 3 children. This reason might be they were introduced to contraception during antenatal and post-natal education. Again, women with more children might use contraception to avoid pregnancy. This finding supports the claim by Vouking et al., (2014) that contraception is scarcely use by women with zero parity and not uncommon among women with multiple parity.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

The purpose of the study was identify the knowledge, socio-demographic characteristics associated with the use of family planning service. The study was conducted at the Kpone Katamanso Municipality in the Greater Accra Region involving 284 women between the age of 15-49 years. This age category was chosen because most women where in their reproductive age. STATA ver.17 was use to analysed the data.

The study discovered that knowledge level on contraception was 92.6% while utilization rate 68.7% among the selected participants was with oral pills, condoms and intrauterine device being the commonly use. Respondent sources of information on contraceptives include health workers, media and from friends. Finally, education level of the women, parity, marital status and age was significantly associated with the use of family planning service.

On the educational level respondents in SHS were more 0.5 more likely to use contraceptive compared to respondents in primary school ((95% CI; 0.103-2.41).

6.2 Recommendations

1. The government and other stake holders (Health Promotion Officers) should increase education on family planning services to improve on awareness and utilization rate.
2. The training institutions should increase intake of students that more health workers will take charge to reduce time spent at the facility.

3. Health workers needs in-service and re-fresher training on any update of family planning information to help educate women on the possible side effect/ management of the various contraceptive.
4. The NHIA should include all family planning commodities in the insurance list so people can freely access at every facility they find themselves.
5. The GHS and MoH should readily available Family Planning services should be made at all CHPS ZONES within the health sector to reduce the travel time.
6. More education on family planning services on the mass media (radio and television) by the GHS since this means form the majority of respondent's sources of information.
7. Further research on the knowledge of men of contraception since the husband education was significantly associated with family planning use.

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APPENDICES

APPENDIX I- INFORMED CONSENT

Appendix B: Participants Consent Certificate

Name of researcher: Larthey Joanna Anorkor

Project Title: Factors Associated with Use of Family Planning Services Among Females (15-49years) in the Kpone - Katamanso Municipality, Greater Accra Region of Ghana.

Duration /what is involved:

To achieve the objectives of this study, I will like to answer the questionnaire for me, because you are within the age range of 15-49 years.

If you agree to participate, you will be required to sign this consent form, and then answer the question in the questionnaire. To ensure participant confidentiality and privacy, the interview would be conducted by the trained research assistant. Participant name would not appear on the transcript and no identifying information would be included. The questionnaire would be kept in a locked cabinet for at least five years after study.

Potential Risks: This study is a minimal risk study. Your participation in the study is voluntary, and you are free to withdraw from the study at any point in the course of the study by just telling the researcher. However, if during the interview you become emotional as a result, the researcher will direct you to the specialist counsellor for support at no cost to you.

Benefits: There are no direct financial benefits to you as a participant since the study is self-funded by the researcher. However, it is hoped that the findings from this research would benefit the health profession in helping new graduate nurses in their transition to practice.

Costs: The cost of the study will be borne by the investigator solely. You will be visited at your workplaces or anyplace you decide, so you would not need to travel to incur transportation cost.

Compensation /Payment: You will not be compensated for participating in this study.

Confidentiality:

Confidentiality is essential; the researcher will safeguard participant's identities and responses from public disclosure. Confidentiality would be maintained by doing; No identifiable information about you will be collected. All identifiable information about you such as your name and signature on the consent form will be de-identified, labelled with a protected number and kept under lock and key for about five years. Only the researcher and his supervisors will have access to this information, your consent thus authorizes such access as and when necessary.

Voluntary participation/withdrawal:

The study is entirely voluntary and you have the right to decline. Your participation is also voluntary. You have the right to withdraw at any point in the process if you so wish and with no repercussion to you.

Outcome and Feedback: Data obtained from the participants will be analyzed and findings will be published for public consumption.

I have read through the foregoing information/the foregoing information has been read and interpreted to me and I fully understand all that has been explained to me about the objectives, benefits, risks and my right to withdraw from the study at any time without any consequences to me. I have been given opportunity to ask questions and have been answered satisfactory. I therefore agree to participate in the study.

Please confirm your participation by signing below.

Signature.....

Date.....

Research Assistant's name.....

Signature Date

QUESTIONNAIRE

Project Title: Factors Associated with the Use of Family Planning Service Among Females (15-49years) in the Kpone - Katamanso Municipality, Greater Accra Region.

Background of the study

My name is Lartey Joanna Anorkor. I am an MPH student of Ensign Global College. I am undertaking a research study on the topic “**Knowledge and Attitude towards Family Planning Services among Females (15 – 49years) at Kpone Katamanso Municipality in the Greater Accra Region of Ghana**”. The purpose of this study is to assess the knowledge and attitude toward contraceptive use in the Kpone Katamanso Municipality. This study is part of the requirements for the award of master of public health degree. I would like to seek your approval and permission to ask you some few questions on access to family planning.

Section A: Socio-Demographic data

1. Which of the following is your age range?

15-20 () 21-30 () 31-40 () 41-49 ()

2. Parity: How many children do you have? 0 () 1-2 () 2-4 () >5 ()

3. What is your desired ideal number of children? 1-3 () ≥ 4 ()

4. Religion; Christian () Muslim () Traditionalist () Others (state).....

5. Occupation: Self-employed () Public servant () Private Institution worker ()
Unemployed () Student ()`

6. What is your highest level of education?

Primary () JHS () SHS () Tertiary () No formal () Other.....

7. What is your husband’s highest level of education?

Primary () JHS () SHS () Tertiary () No formal () Other.....

8. What is your marital status?

Single/ Co- Habiting () Married () Widowed () Divorced/Separated ()

8. Where do you live?

Kpone /Dzooshi () Kpoiete () Saglemi () Shangai () Alata ()

SECTION B: Knowledge on Contraceptives

9. Have you heard of contraception? Yes () NO ()

10. Sources of knowledge on contraceptives (Tick the one that apply)

Source of information on contraceptives	Yes	No
Health workers		
Television		
Radio		
Friends		
Family		
Others		

11. Do you know any contraceptive method? () Yes No ()

12. Which of the following method of contraceptive know you know? (Tick the response that apply).

Contraceptives	Yes	No
Pills		
Intrauterine Device (IUD)		
Injectables		
Condoms		
Diaphragm		
Sterilization		
Implants		
Withdrawal method		
Periodic abstinence		

13. Have you ever used any form of contraceptives in your life? Yes () No ()

14. Which type of family planning method did you use /are you using?

Condom (___) IUD (___) Oral Contraceptives (___)

Depo Provera (___) Morning-after Pill (___) Implant () Tubal ligation ()

For questions 15- 19, please show the extent to which you agree or disagree with these statements

Statement	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
16. Large family size negatively affects economic conditions					
17. Large family size earns the respect by my partner					
18. Large family size earns the respect of the community					
19. Large family size earns the respect by religious leaders					
20. Large family size negatively affects maternal and child health					

Section C: Access to Family Planning.

21. Do you have a health facility in your area that renders Family Planning services?

Yes () No ()

22. How long does/did it take you to get to the facility? _____.

minutes () 40 minutes () 60 minutes () 80 minutes ()

23. How do you get there?

I walk (___) I drive (___) I get a ride from someone (___) I take the bus/trotro/ taxi (___) other

24. Do you have to make an appointment prior to coming to the family planning clinic or can you just walk in?

I have to make an appointment (___) I can walk in (___)

25. Could you make an appointment on the first try?

Yes (___) No (___)

26. In your view, are the family planning services affordable? Yes () No ()

27. Once in the clinic, how long do you have to wait before you are seen? (In minutes)

30 min () 60 min () 90 min () 120 min () >120 min ()

Facility related factors that affect access to family planning services.

Factors	Disagree	Somehow agree	Neutral	Agree
28. I find the waiting room comfortable				
29. I find the staff friendly				
30. I find the staff well trained				
31. I have enough privacy during my visit				
32. I feel that the main practitioner spends time to get to know me				
33. I feel I can discuss my concerns with the practitioner				
34. The practitioner tells me what to expect before the examination				
35. I feel that the use of the family planning method was clearly explained to me				
36. I was informed about possible side effects of the family planning method.				

APPENDIX IV: PERMISSION LETTER

Ensign Global College

Box 136

Akosombo

July 7, 2022

The District Director of Health Service

Kpone Katamanso

Accra.

Dear Sir,

PERMISSION TO ACCESS PARTICIPANT FOR A STUDY

I wish to apply for permission to access participants from your municipality for an academic study. I am a final year students of Ensign College of Public Health offering Master of Public Health (MPH) degree programme. My name is Lartey Joanna Anorkor. My index number is 217100202

As part of the requirement for the programme, I am writing a dissertation on “**Knowledge and Attitude towards Family Planning Services Among Females (15 – 49years) at Kpone Katamanso Municipality in the Greater Accra Region of Ghana**”

Attached is the ethical approval for the study and sample of my data collection tool.

Counting on your cooperation.

Thank you.

Yours faithfully

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Lartey Joanna Anorkor