

Factors Influencing Family Planning Uptake Among Women of Reproductive Age in the Sefwi Akontombra District of Western North Region, Ghana

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ABSTRACT

➤ **Background:**

Some of the highest infant mortality rates in the world can be attributed to poorly scheduled and closely spaced pregnancies and births. The danger of death and ill health is higher for the offspring of moms who pass away after giving birth closely. High fertility rates mean people are not spacing their births which can lead to high mortality rates. When mortalities are high, people tend to give birth frequently to replace the lost children and this comes with several complications because, frequent deliveries put the woman at risk of mortality both at younger age and at older age. Malnutrition of under-five children can also be as result of low birth spacing. It has been discovered that using family planning services in underdeveloped nations can prevent unplanned births and lower mother and infant mortality. Family planning use, however, is still uncommon in the majority of poor nations.

➤ **General Objectives:**

In the Sefwi Akontombra district, this study looked to see what factors affected the use of family planning by women of reproductive age.

➤ **Methodology:**

In the Sefwi Akontombra District in the Western North region of Ghana, a descriptive cross-sectional methodology was utilized to evaluate the characteristics related with family planning uptake among women of Reproductive Age (15-49 years). Data were entered into SPSS version 22.0 and analyzed after 285 study participants were chosen using a multi-stage sampling procedure in each of the five subdistricts. The investigation made use of the chi-square test, multinomial logistic regression, and descriptive statistics.

➤ **Study Outcome:**

This study explored factors affecting family planning uptake and recommendations made to help in improving the family planning uptake in the district.

Keywords:- *Factors Family Planning Influencing Reproductive Age Sefwi Akontombra Uptake Women.*

CHAPTER ONE INTRODUCTION

In all aspects pertaining to the reproductive system and to its activities and processes, reproductive health is a condition of whole physical, mental, and social well-being and not only the absence of disease or infirmity (Brody, 2020). Having a fulfilling and safe sexual life, being able to reproduce, and having the choice to choose if, when, and how often to do so are all indicators of reproductive health (Leete, 2000).

The expansion of family planning (FP) programs has had numerous positive effects on health outcomes, opening doors for the eradication of poverty and the empowerment of women. A notable reduction of 32% of all maternal fatalities and 10% of all child deaths has been achieved because to FP programs. Additionally, these programs advance gender equity and women's empowerment, and within that context, they work to raise the overall standard of female primary education. In the last four decades, FP programs have boosted the contraceptive prevalence rate (CPR) from 10% to 60% globally and significantly decreased the fertility rate in low- and middle-income nations from 6 to 3 children per woman (Memon et al.,2022).

The SDGs 3.7 and 5.6 include family planning as one of the goals for achieving universal access to sexual and reproductive health (Organization, 2016).

In addition, family planning aids individuals or couples in avoiding unintended pregnancies, controlling the time of births relative to the parents' ages, and deciding the number of children to have in the family (Kavanaugh & Anderson, 2013). The success of each pregnancy as well as a woman's health and wellbeing directly depend on her ability to space and restrict pregnancies (Organization, 2016).

The package of sexual and reproductive health includes family planning as a fundamental element. A fundamental prerequisite for women's health is fertility that is chosen, not born out of circumstance (Organization, 2019b). In order to be deemed in a "state of complete physical, mental, and social well-being," as stated in the WHO constitution, a woman must be able to regulate and control her fertility (Fathalla & Fathalla, 2017).

Contraceptive methods have been categorized either as a traditional or modern method in most world Fertility surveys. The modern sources include Oral pills: These are systematically steroid hormones. There are two (2) types which are the combined oral contraceptive (COCs) and progestin – oral pills (Akbar, 2020).

Injectable Contraceptive: This is also a hormonal based contraceptive which is injected every three months and one month to prevent pregnancy.

Male and female sterilization: Sometimes called surgical is often desired when the desired family size has been achieved. Intra Uterine Device (IUDs) is also small flexible devices made from metal and or plastic which are placed in the uterus (Minett, 2017). It works by inhibiting sperm migration, interferes with ovum transport and fertilization. The traditional ones are the periodic and post-partum sexual abstinence, rhythm or calendar and withdrawal methods (Rossier & Corker, 2017). Governments and Non-Governmental Organizations in Ghana have made conscious efforts to promote the use of contraception through billboards, radio and television advertisements, social workers, and local opinion leaders (Quarry & Ramirez, 2013). After Kenya in 1965, Ghana adopted a comprehensive population program in March 1969, becoming the second country in sub-Saharan Africa to do so (Frankema & Jerven, 2014).

When Edith Gates of the Pathfinders Fund visited the then-Gold Coast in 1952 to gather information, systematic family planning was first implemented in Ghana (EK, 2018). They highlighted that a family planning committee was established to coordinate her work as a result of her efforts in April 1960. The Christian Association (YMCA) Hall in Accra then established a family advice center in 1961; it is now a family planning facility (EK, 2018). In 1964, in association with private physician Dr. Joy Nicholas, a second centre was established in Kumasi. With the goal of lowering the population growth rate from above 3% in 1969 to 2.5% in 1985 and 1.7% by the year 2000, the Ghana National Family Planning Program (GNFPP) was established in May 1970 to provide family planning services to couples (EK, 2018).

Following its introduction, the Ghana Family Planning Program saw widespread cooperation from the MOH, the PPAG, the Christian Council of Ghana, and other organizations (EK, 2018). However, the basic goals have not been realized. We rather witness the doubling of population growth barely after every 15 years. There is therefore the need to really look understand why population growth rate is still high leading to the doubling of population growth barely after every 15 years.

➤ *Problem Statement*

214 million women of reproductive age in developing nations who want to prevent conception, according to estimates from 2017, do not use a modern method of contraception (Nyarko, 2020). The use of condoms and other family planning tools can aid

in reducing the spread of sexually transmitted diseases like HIV. Abortion, especially dangerous abortion, is less necessary when family planning and contraception are used (Organization, 2019a).

The right of people to choose their own child-bearing strategy is strengthened by family planning. Family planning and contraception prevents mother and child fatalities by preventing unplanned pregnancies (Bailey, 2013).

Pregnancies can be delayed in young women at higher risk of health issues and early childbirth-related death when they are spaced apart. Unwanted pregnancies are avoided, especially in older and younger women who have higher pregnancy-related risks. There is evidence to support an increased risk of maternal death for mothers with more than four (4) children (“Maternal Mortality Fact Sheet, Maternal Health,” 2015). Family planning lessens the need for risky abortion by lowering the rate of unplanned pregnancies. Some of the highest infant mortality rates in the world are caused by poorly scheduled and closely spaced pregnancies and births. The risk of death and ill health is higher for the offspring of women who pass away during childbirth (Cacciatore, 2013). High fertility rates mean people are not spacing their births which leads to high mortality rates and when mortalities are high, people tend to give birth more often to replace the lost children which comes with several complications. Frequent deliveries put the woman at risk of mortality both at younger age and at older age. Malnutrition under five can also be a result of low birth spacing among women of reproductive age.

When family planning is properly used, there is a lower risk of unwanted births among women with HIV, which reduces the number of orphans and babies who are infected. Additionally, condoms for both sexes offer dual protection against STIs including HIV and unplanned pregnancies (Malarek, 2011). In comparison to kids with many siblings, those with fewer siblings typically stay in school longer. Preterm births or new-borns with low birth weights are more common in adolescent pregnancies. Higher rates of new-born mortality are observed among children born to teenagers. When a teen girl becomes pregnant, many of them are forced to leave school. For them as individuals, their families, and their communities, this has long-term repercussions.

Sefwi Akontombra district’s localities are completely rural with no urban settlements with their major occupation being cocoa farming and children are a major labour force hence parents turn to give birth to more children to strengthen their labour force (Botchway & Madjitey, 2014). As a result of optimal birth spacing, it is also known that couples with lower fertility rates provide better maternal and child health, as well as making money and other economic benefits more accessible to their families and the community as a whole. Therefore, concerted policy initiatives are required to lower fertility rates.

The prevalence of contraception among Ghanaian women of reproductive age (ages 15–49) was 30.80 as of 2017 according to the Demographic and Health Surveys (DHSs) and Multiple Indicator Cluster Surveys (MICSs) (Ghana Statistical Service, 2018). Its highest value over the past 37 years was 34.70 in 2015, while its lowest value was 9.50 in 1980 (Ghana Statistical Service, 2018).

During the 2019 annual performance review in the Sefwi Akontombra district, it was revealed that 17.4% and 21.5% were recorded as family planning prevalent rates for the years 2018 and 2019 respectively as against a national target of 30% (Awortwi, 2019).

The Sefwi Akontombra district recorded 14.3% and 13.4% prevalence of teenage pregnancy for 2018 and 2019 as against a national target of 20.0% according to the 2019 annual reports (Awortwi, 2019).

This study therefore sought to establish the elements that influence the use of family planning by women between the ages of 15 and 49 who are in reproductive life in the Sefwi Akontombra District of Western North Region of Ghana and recommended effective ways to improve the situation.

➤ *Main Objective*

Finding the parameters linked to family planning uptake among women of reproductive age in the research area was the study's main goal.

➤ *Specific Study's Objectives*

The specific objectives of the study include the following.

- *To determine how much knowledge there is about using contraceptives among women of reproductive age.*
- *To evaluate the district's use of contraception prevalence.*
- *To investigate the different drivers that encourage women of reproductive age to use family planning services in the area.*
- *To discover the many factors that deter women from seeking family planning services in the area.*

➤ *Research Question*

- *To what extent are women of reproductive age aware of the use of contraception?*
- *How common is the use of contraception among women in the district who are of reproductive age?*
- *What factors influence reproductive-age women's decisions to use the district's family planning services?*
- *For what reasons are family planning services in the district not used by women of reproductive age?*

➤ *Expected Outcomes of the Study*

It was expected that factors associated with family planning uptake among women of reproductive age in Sefwi Akontombra District would be established. The study was able to assess participants' level of knowledge on the potential effects of not using contraceptives.

➤ *Justification of the Study*

The study's findings were valuable for developing policies and planning initiatives aimed at increasing the district's utilization of family planning services. There are numerous family planning options available, but people can choose. The study's findings therefore provided health authorities with information on the favoured techniques of their clients, allowing them to devote more resources to marketing those family planning services.

CHAPTER TWO

MATERIALS AND METHODS

➤ *Introduction*

This chapter examines the methodology of the study, including the steps used for data collecting, collation, analysis, and the use of various statistical methods.

➤ *Study Area*

In the North-Eastern corner of the Western Region, between Latitudes 60 and 60 30' N and Longitudes 20 45' and 20 15' W, is the Akontombra district. Sefwi Wiawso District and Juabeso District to the north, Aowin Suaman to the south-east, and Wassa Amenfi to the south-west form its eastern boundaries. Akontombra, which is 69.0 kilometers from Sefwi Wiawso, is approximately at the westernmost edge of the area. A second-class (gravel-paved) road connects them.

It has a 1,111 square kilometer total land area. The distances from Takoradi, the capital of the Western Regional Region, and Accra, the nation's capital, are 440 km and 271 km, respectively, via the Asankragwa and Ayamfuri roads (Botchway & Madjitey, 2014).

The district formerly had 110 communities until the beginning of 2013 when administratively, Aowin district took over three of the communities with a CHPS compound. The district currently therefore has 107 communities.

Akontombra district shares boundaries to the north east with Sefwi Wiawso, to the South East with Wassa Amenfi West. To the South is Suaman district whilst that of the South- west is Aowin District. It also shares boundaries with Bodi district to the North.

The population of Sefwi Akontombra District, according to the Population and Housing Census, is 110,730, representing 3.5 percent of the region's total population. Males make up 52.8% of the population while females make up 47.2%. Children under one (1) year constitute 4%, under five constitute 20%, and WIFA is 24% thus 26,576 (Awortwi, 2021). The Total Fertility Rate for the district is 3.6 births per woman. Akontombra is a rural area with a general Fertility Rate of 113 births per 1,000 women aged 15-49 years (Botchway & Madjitey, 2014). This fertility rate justifies the low prevalence of contraceptive use in the district which is 21.5% (Awortwi, 2021). Since no studies has been conducted on contraceptive use in the district yet, it is therefore necessary to conduct this study in the district to find out the factors that contribute to uptake of family planning.

There are no urban areas in any of the District's villages. There are 26,984 households spread over the District's five (5) subdistricts. The district has a total of 27 healthcare facilities. There are two (2) health centers, twenty-two (22) CHPS Zones that are operational and have their own grounds, one (1) private hospital, and two (2) maternity homes. There are 112 men for every 100 females in the district. The district has a young population (46.6%), which shows a broad base demographic pyramid that tapers down with a tiny number of elderly people (4.1%) who are 60 years of age and more. For the District as a whole, the age dependence ratio is 82.8. 26 births per 1,000 people is the crude birth rate (CBR). In the district, there are 3.8 fatalities for per 1,000 people (Botchway & Madjitey, 2014). There are 17,592 households in the district, with 81,883 people living in them.

In the district, 4.7 people live in each household on average. Children make up the majority of the household population, accounting for 46.9% of all occupants. About 13.2 percent are married couples.

39.6% of the households in the district are nuclear families, which consist of the head, spouse(s), and children. The Akan/Sefwi, who make up around 61.2 percent of the population, are the majority ethnic group in the District. The Mole-Dagbani, Ga-Dangme, Ewe, and Guan are further minority groups (Botchway & Madjitey, 2014). In the district, Christianity is the most popular religion (76.7%). Islam, which accounts for 16.6% of the population, is the second most popular religion after Christianity. Traditionalists and other groups make up 6.7%.

Agribusiness is practiced by about 86.6 percent of families in the district. 99.3% of the households in the district are involved in crop cultivation. 0.2 percent of homes engage in fish farming. The district's most prevalent livestock farming activity is poultry (chicken) (Botchway & Madjitey, 2014).

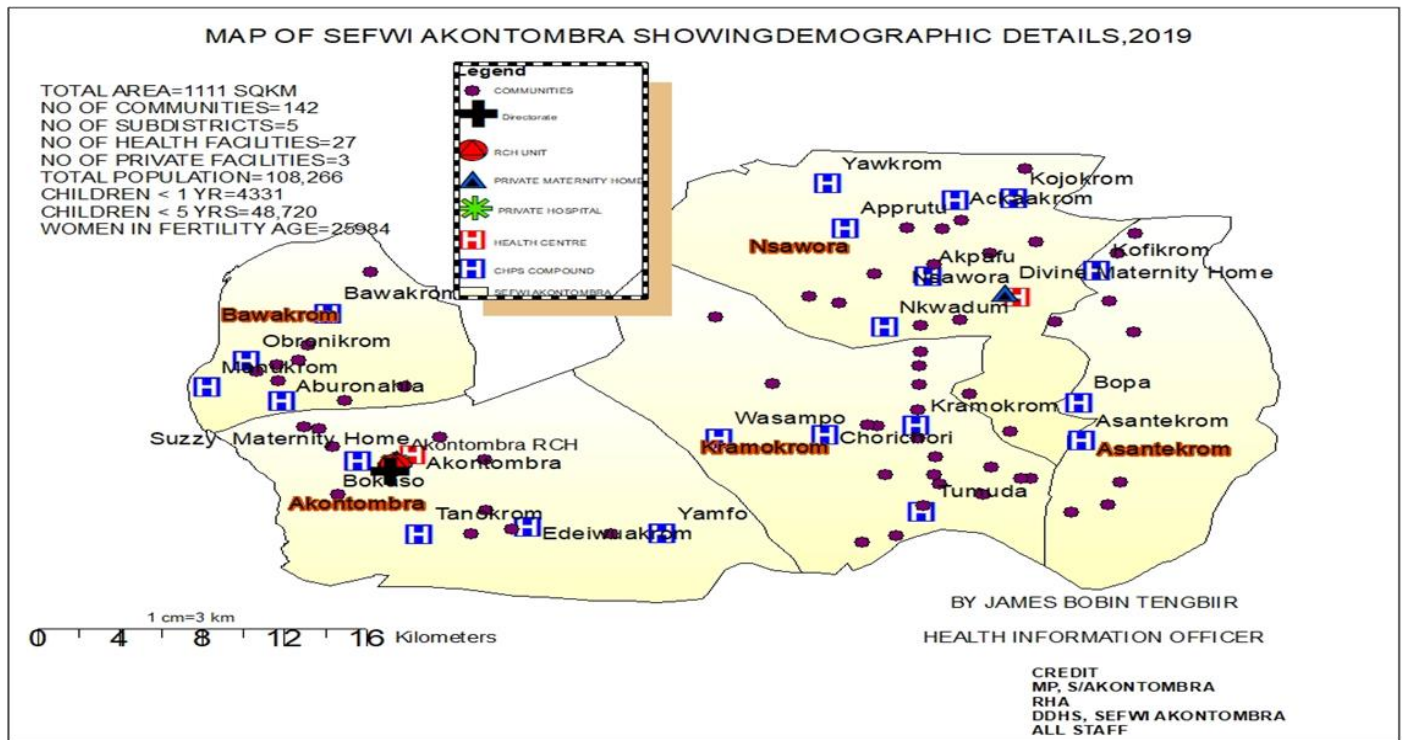


Fig 1 District Map
Source: (Bobin, 2021)

➤ *Study Design*

In the Sefwi Akontombra District in the Western North region of Ghana, a descriptive cross-sectional methodology was utilized to evaluate the characteristics related with family planning uptake among Women of Reproductive Age (15-49 years).

➤ *Study Participants*

The study's participants were women who had reached reproductive age (15–49) and were long-term inhabitants of Ghana's Western North Region's Sefwi Akontombra area.

➤ *Criteria for Inclusion and Exclusion*

In this study, all women who had lived in the district for at least six months and were between the ages of 15 and 49 were included. Women over 49 and under 15 were once again excluded from the study. Similar exclusion criteria applied to women who had been in the area for less than six months, as well as to women who refused to participate in the study.

➤ *Sample Size*

The Cochran formula was used to determine a sample size (Tips, 2019).

$$n = \frac{Z^2 pq}{d^2} = n_0 \frac{Z^2 pq}{e^2}$$

Where:

- n0 is the sample size
- d is the accepted margin of error for proportion being estimated
- The intended degree of precision, or the margin of error, is e, which is equal to 5% or 0.05.
- p is the (estimated) proportion of an attribute that is present in a population thus 21.5% prevalence of contraceptive use in the district.
- q is 1 – prevalence.
- The z-value can be discovered in a Z table (the standard tables give us Z values of 1.96 with a 95% confidence level)

$$n = \frac{(1.96)^2 \times (0.22) \times (1-0.22)}{(0.05)^2}$$

$$n = (1.96)^2 \times (0.215) \times (1-0.215) / (0.05)^2$$

$$n = 259.3464 = 259$$

Using 10% non-response rate, Sample size $(n) \times$ non-response rate = 259×0.1

Therefore, sample size = $25.9 + 259 = 285$

➤ *Sampling Technique*

The study participants were chosen using a multi-stage sampling method. The study covered all five of the district's sub-districts. Two (2) settlements in each sub-district were chosen by simple random sampling. The odds of selection were the same for all communities. Two (2) localities were chosen at random from a list of all the names of the communities in each sub-district by a person who was not aware of the research.

Each family was given a number, and a sampling interval (n) was calculated and used to choose the first household in each chosen neighbourhood. Next, selection was made for every (nth) family in the same manner. All female residents who were willing to participate were interviewed inside each chosen household, ranging in age from 15 to 49 (WIFA). 285 people were questioned using this methodical random procedure.

➤ *Instruments*

Research instrument was adopted from other similar studies based on the research questions and the objective of the study. The questionnaire was also based on the background variables and the main variables under study. The research questionnaires were administered using the face-to-face approach.

The questionnaires were divided into four parts. The first part being the socio-demographics whilst the second part being the awareness and usage of family planning services. The third part of the questionnaire provided various reasons that motivates women to access family planning services and the fourth part asked questions on various reasons that discourages women from using the service. The questionnaires were administered in a language that participants understood and were comfortable to respond.

➤ *Pretesting*

The instrument was pretested at Kalo, a community in the Suaman district among women of reproductive age. Kalo had similar characteristics as the Sefwi Akontombra District. Modifications were made in the instrument after the pretesting before the final study was conducted. After the pre-test, a Cronbach's alpha value of 0.7-0.9 was discovered as the instrument's dependability.

➤ *Data Collection Procedure*

On Kobo collect, deployed questionnaires were used to gather the data. The researcher and skilled data gatherers assembled the information. These data gatherers were instructed by the researcher. Two data collectors were chosen for each sub-district, for a total of ten data collectors. The data collectors were informed of the data collection's goals. During the training, each person was given a copy of the instrument and each question item was discussed. The intended purpose of each item was discussed. Any ambiguity or misconception was clarified during the training. Data collectors were also taken through the technique they needed to employ in the collection of the data. Role play and demonstrations were used for the training. Data collectors were made to collect data from 5 volunteers under the direct observation of the researcher.

➤ *Data Analysis*

All data were extracted into an excel file, cleaned, double-checked, and then entered into SPSS version 22.0 for analysis. The threshold for statistical significance was set at P 0.05. utilizing the chi-squared test, the relationship between the binary outcome of utilizing family planning services (yes or no) and independent categorical variables such marital status, age, religion, parity, and educational level was examined. The impact of independent variables such marital status, age, religion, parity, and educational level on the adoption of family planning services was examined using a multinomial logistic regression model with the outcome of individuals who had utilized family planning services. Various factors that encouraged respondents to seek family planning services as well as factors that led certain respondents to refrain from doing so were reported using descriptive summary statistics. (Apanga & Adam, 2015).

➤ *Ethical Consideration*

This study was approved by the Committee on Ethical Review, Publication and Ethics (CHRPE) of the University of Health and Allied Sciences, Ghana.

The community entry was done through the District Director of Health/Sub-District head to the chiefs and elders and requested their consent before the questionnaires were administered because sexual reproductive concerns are highly important and sensitive. Additionally, the respondents' and their spouses' permission were requested, and they were assured of the confidentiality of their answers. The purpose of the study was explained to respondents in that regard. Informed written consent

was sought from women participants who are 15-49 years. Participants who gave their consent to participate only were interviewed. They were allowed to either stop or withdraw from the study at any time if they wanted to freely without any cost or coercion. There was no compensation for participants in this study. Privacy and confidentiality of information was assured by keeping the collected data under lock and key. Participants of this study had no personal benefit. However, the results of this study informed recommendations that equipped stakeholders for effective decision making to improve upon family planning education and skills to improve the health of women of reproductive age.

There were no risks associated with participants, taking part of this study, but they were asked some questions that made them felt uncomfortable.

➤ *Participant's Right*

The study's participants were informed that their participation was entirely voluntary. They also have the right to decline participation or leave the study at any time.

➤ *Potential Risks/Benefits*

Participants were duly informed that there was not going to be any personal benefit i.e. remunerations for participating in the study. In spite of that, their participation was going to help inform policy makers as well as stakeholders within the district to create and put into action initiatives and policies to improve healthcare utilization in the Sefwi Akontombra District, the Region and the Nation as a whole.

➤ *Informed Consent*

Participants in the study gave their informed consent before taking part.

The study's methodology was thoroughly explained to the participant in language they could easily understand. And were made aware that they have the choice to opt out of the study or decline an answer to question if they found it uncomfortable.

➤ *Privacy/Confidentiality*

To preserve privacy, every interview was done in a comfortable setting without the presence of outsiders. Additionally, to lessen the likelihood of linking the information collected to respondents, identifying numbers rather than names were utilized. This was done to protect the participants' privacy and identities.

➤ *Data Storage*

It was made clear to participants that the researcher would be the only one to utilize the coded questionnaires, and that they would be kept private.

CHAPTER THREE RESULT / FINDING

➤ *Socio-Demographic Characteristic of Correspondents*

The study involved a total of 285 participants aged between 15-49 years who resided in Sefwi Akontombra for at least six months prior to the data collection. The finding indicated that majority of the respondents were between the age group of 20-24 years (42.8%) with a mean of 25.8 years. About 76.5% of the respondents had their parity between one and two conceptions or parity. Also, most of the respondents were from Akontombra (22.1%) followed by Kramokrom (13.3%) and Nsawora (13.0%). The highest educational level attained by the respondents were basic education (JHS) (28.4%). 21.4% of respondents had no formal education. More than half (53.7%) of the study respondents were married with (29.1%) being single. The study recorded (48.1%) of its respondents being unemployed with (29.1%) employed to the private sector. Moreover, Christianity dominated as the highest recorded religion (79.3%) with traditionalist being the least (1.4%). (42.1%) of respondents had their religion supporting the use of family planning services. Marital status and geographical location where family planning services were located significantly influenced the utilization of the family planning service with P-values of ($X^2=11.685$, P-value = 0.020) and ($X^2=20.145$, P-value =0.017) respectively. Details can be found in table 1 below.

Table 1 Association between Socio-Demographic Characteristics and the Utilization of Family Planning Services

Characteristics	Frequency (N=258)	Percent (%)	Chi- square (X^2)	P-value
Age (Years), Mean \pm SD	3.05 \pm SD 1.53			
Age groups (Years)			3.723	0.714
15-19	32	11.2		
20-24	122	42.8		
25-29	7	2.5		
30-39	72	25.3		
40-44	5	1.8		
45-49	9	3.2		
Parity			0.004	0.998
0	49	17.2		
1-2	218	76.5		
Above 3	18	6.3		
Name of Community			20.145	0.017**
Akwakan	15	5.3		
Aburonehia	34	11.9		
Akontombra	63	22.1		
Besibema	15	5.3		
Bokaso	21	7.5		
Bronikrom	23	8.1		
Fawokabra	13	4.6		
Kofikrom	26	9.1		
Kramokrom	38	13.3		
Nsawora	37	13.0		
Level of education			2.998	0.392
No formal education	61	21.4		
Basic education (Primary)	53	18.6		
Basic education (JHS)	81	28.4		
Second cycle / Vocational	53	18.6		
Tertiary	37	13.0		
Marital Status			11.685	0.020**
Single	83	29.1		
Married	153	53.7		
Cohabiting	28	9.8		
Divorced	12	4.2		
Separated	9	3.2		
Employment status				
Unemployed	137	48.1	0.695	0.875
Employed (Public sector)	44	15.4		
Employed (Private sector)	83	29.1		
Others	21	7.4		
Religious background			2.174	0.337

Christian	226	79.3		
Islam	55	19.3		
Traditionalist	4	1.4		
Does your religion support Family planning			3.481	0.175
Yes	120	42.1		
No	87	30.5		
Don't know	78	27.4		

SD: Standard Deviation, (%) represents row percentage, **p<0.05

➤ *Knowledge and Awareness Level and its Association with Family Planning Utilization Services*

The results of the study revealed that 98.9% of the respondents have heard of or were aware of the existence of the family planning service. Most of this information were obtained from health workers (60.6%) with (29.4%) from friends and relatives. Also, 93.2% of the respondents who had knowledge about family planning were in known of the modern methods of the family. The fact that respondents were aware of the existence and the methods of family planning types alone significantly influenced the utilization of the family planning services. ($X^2=6.161$, P-value = 0.013) and ($X^2=19.534$, P-value =0.001) respectively. Details can be found in tablet 2 and 3 below.

Table 2 Knowledge and Awareness level of Respondents on Family Planning Services

Characteristics	Frequency (N=285)	Percent (%)
Awareness level		
Yes	282	98.9
No	3	1.1
Source of information		
Health workers	171	60.6
Friends/ relative	83	29.4
Media	28	10.0
Knowledge level on types of methods		
Knows none	11	4.0
Knows traditional methods	8	2.8
Knows modern methods	263	93.2

(%) Represents Row Percentage, **p<0.05

Table 3 Association between the Awareness Level of Respondent and the Utilization of Family Planning Services

Characteristics	Frequency	Percent (%)	Chi-square(X^2)	P-value
Awareness level			6.161	0.013**
Yes	282	98.9		
No	3	1.1		
Sources of information			1.448	0.485
Health worker	171	60.6		
Friends/relative	83	29.4		
Media	28	10.0		
Knowledge on the types of FP methods			19.534	0.001**
Knows none	11	4.0		
Knows traditional	8	2.8		
Knows modern	263	93.2		

(%) Represents Row Percentage, **P<0.05

➤ *Prevalence of Family Planning Utilization Services in the Sefwi Akontombra District*

The results of the study showed that 67% of the respondents have ever gone for the family planning service with last 6 months. Also, 65.6% were currently using the family planning methods as at the time of data collection. Moreover, the most common methods that the respondents were using included the injectable (63.1%) and the Pills (24.1%). Details can be found on table 4 below.

Table 4 Prevalence of Family Planning Utilization Services in the Sefwi Akontombra District

Characteristics	Frequency (N=285)	Percent (%)
Ever gone for FP services within last 6 months		
Yes	191	67
No	94	33
Currently using any contraceptive method		

Yes	187	65.6
No	98	34.4
Which method are you currently using		
Intra-Uterine Device	11	5.9
Injectable	118	63.1
Pills	45	24.1
Condom	13	6.9

(%) Represents Row Percentage, **P<0.05

➤ *Accessibility to Family Planning Services and how it Affects the Utilization of Family Planning Services*

The study indicated that 49.2% of the respondents reside close to the facilities where the family planning services are rendered. About 67.9% of the respondents indicated that family planning services are located within the facility premises while only 13.4% indicated the family planning services being away from the facility premises. Most (41.2%) of the respondents stated that, it is easy to get family planning centre roughly between 10 to 30 minutes (37.4%) and was mostly by foot (72.7%). Moreover, most respondents described the transportation fare to the site as affordable (47.1%). The distance respondents cover to access family planning services significantly affected the utilization of the service ($X^2 = 9.128$, P-value = 0.003) though most people were not affected by the distance (50.8%). It is important to note that, majority of the respondents (90.9%) were made the pay to access the family planning services though (33.7%) of them described it as being affordable, it significantly affected the utilization of the family planning services in the Akontombra district ($X^2 = 39.912$, P-value = 0.001). Details can be found in table 5 below.

Table 5 Accessibility to Family Planning Services and how it Affects the Utilization of Family Planning Services

Characteristics	Frequency (N=187)	Percent (%)	Chi-square(X^2)	P-value
Closeness of residence to the facility			2.623	0.105
Yes	92	49.2		
No	95	50.8		
Where is FP service located			1.204	0.548
Within the facility premises	127	67.9		
Close to the facility	35	18.7		
Far from the facility	25	13.4		
Means of transportation to the FP centre			0.371	0.831
By foot	136	72.7		
By public transport	39	20.9		
By private transport	12	6.4		
How easy is it to get to the FP centre			1.536	0.674
Very easy	63	33.7		
Easy	77	41.2		
Difficult	38	20.3		
Very difficult	9	4.8		
Time taken to get to the facility			3.897	0.147
Less than 10 minutes	60	32.1		
Between 10-30 minutes	70	37.4		
Above 30 minutes	57	30.5		
Transport fare to FP centre			3.396	0.334
Cheap	61	32.6		
Affordable	88	47.1		
Expensive	30	16.0		
Very expensive	8	4.3		
Effects of distance of FP utilization			9.128	0.003**
Yes	92	49.2		
No	95	50.8		
Payment of Fee for utilizing the FP service			39.912	0.001**
Yes	170	90.9		
No	17	9.1		
Describe the amount you have to pay			1.980	0.576
Cheap	80	42.8		
Affordable	63	33.7		

Expensive	31	16.6	
Very expensive	13	6.9	

(%) Represent Percentage, **P<0.05

➤ *Service Provider Factors to Family Planning Utilization*

The way health services are rendered in a facility goes a long way to affect its utilization. The current study shows that (94.1%) of the respondents were satisfied with the reception given them and 56.1% describe the whole service given as satisfactory when they go to access the service. This significantly affected the uptake of the family planning services with ($X^2 = 59.277$, P-value = 0.001) and ($X^2 = 63.488$, P-value = 0.001) respectively. (58.8%) and (85.0%) of the respondent respectively said there was the presence of waiting time and area. Majority (86.1%) of the respondents said they were able to discuss their problem with the service providers very well. (97.3%) of them said they were able to discuss the side effects or any service related problems with their service providers. This goes a long way to affect the utilization of the family planning service in the Sefwi Akontombra district with ($X^2 = 9.128$, P-value = 0.003) and ($X^2 = 70.402$, P-value = 0.001) respectively. Details can be found in table 6 below.

Table 6 Service Provider Factors to Family Planning Utilization

Characteristics	Frequency (N=187)	Percent (%)	Chi-square(X^2)	P-value
Satisfaction with the reception			59.277	0.001**
Yes	176	94.1		
No	11	5.9		
Presence of awaiting time			0.215	0.643
Yes	110	58.8		
No	77	41.2		
Presence of waiting area			1.689	0.194
Yes	159	85.0		
No	28	15.0		
Ability to discuss problem with service provider			1.436	0.774
Very well	161	86.1		
Not well	23	12.3		
Poorly	3	1.6		
You would describe the service as being satisfaction			63.488	0.001**
Yes	105	56.1		
No	82	43.9		
Best describe your service provider			40.391	0.001**
Friendly and up to date on FP issues	184	98.4		
Indifferent	3	1.6		
Discussion about possible side effects with your method			9.128	0.003**
Yes	182	97.3		
No	5	2.7		
Discussion on what to do when you experience any problem			70.402	0.001**
Yes	182	97.3		
No	5	2.7		

(%) Represent Percentage, **P<0.05

➤ *Women Autonomy or Empowerment and its Effects on the Utilization of Family Planning Services*

The study results indicated that, (78.9%) and (72.6%) of the participants had the power to respectively negotiate safer sex or refuse sex if their partner is known to have had STD. Most of the participants' refuse sex on the basis of ill health (51%) whiles (4%) indicated menstruating as a condition for refusing sex. (33.7%) of the participant have the right to always spend their own money. However, majority of the participants (54.7%) have the right to spend their own money sometimes. More than half (60.4%) of the participants do not have negative thought about family with only 39.6% having negative thought about family planning. The commonest among the negative thought included the fact that it can make one infertile (78.8%). This negative thought about family planning significantly affect the utilization of the services with ($X^2 = 20.853$, P-value = 0.001). Details can be found in table 7 below.

Table 7 Women Autonomy or Empowerment and its Effects on the Utilization Family Planning Services

Characteristics	Frequency (N=285)	Percent (%)	Chi-square(X ²)	P-value
Power to negotiate safer sex if your partner has STD			1.693	0.193
Yes	225	78.9		
No	60	21.1		
Power to refuse sex			0.006	0.983
Yes	207	72.6		
No	78	27.4		
Condition for which one refuse sex			6.244	0.100
Menstrual pain	9	4		
Ill health	106	51		
Tiredness	33	16		
Not being in a good mood	59	29		
How often do you spend your own money			4.032	0.258
Always	96	33.7		
Sometimes	156	54.7		
Often	28	9.8		
Never	5	1.8		
Negative thought about FP			20.853	0.001**
Yes	113	39.6		
No	172	60.4		
If yes, what are some of them			5.735	0.125
It makes you infertile	89	78.8		
It can kill	4	3.5		
Others	20	17.7		

(%) Represents Row Percentage, **P<0.05

➤ *Household Decision Making Processes and their Effects on the Utilization of Skilled Delivery Services*

The finding of this study indicated that (76.1%) of the participants were allowed to take part in the decision-making processes and the commonest amongst them included daily purchases in the house (36.2%) and their children's education (24.2%). When it comes to decision on how family income is spent, 43.5% said it is both the wife and husband that decide. Household decision making process in this study did not necessarily have influence on the update of family planning service with P-value > 0.05. Details can be found in table 8 below.

Table 8 Household Decision Making Processes and their Effects on the Utilization of Skilled Delivery Services

Characteristics	Frequency (N=285)	Percent (%)	Chi-square(X ²)	P-value
Taking part in decision making processes			0.178	0.673
Yes	217	76.1		
No	68	23.9		
Which household matters do you partake as a wife			2.162	0.706
Large house expenditure	33	15.2		
Daily purchase	78	36.2		
Children education	53	24.2		
Household expenditure	33	15.2		
Others	20	9.2		
Who makes decision on how to spend the family income			3.232	0.199
Husband	56	19.6		
Both husband and wife	124	43.5		
Wife	105	36.8		

➤ *Husband's Support and its Effects on the Utilization of Family Planning Services*

Husband approval and influence on the use of contraceptive as well frequent engagement in conversation on family planning usage significantly affect the utilization of the family planning services. The study indicated that, 71.2% of the participants had their husband approval on the use of contraceptives, while 56.8% of them had their partner's influence on the use of family planning services. 25.6 of the respondents indicated they never talked about family planning for the past one year while 25.6% had a talked on family planning with their partner at least once a year. Most (72.3%) of the respondents had discussed with their partner the number of children to have. About 68.4% of the partner agreed to the number of children they discussed with their wives or partners. Most of the respondents (50.2%) agreed to have between 2 to 3 children. However, deciding on the number of

children to have is important factors in family planning but it did not have any positive relationship with the uptake of family planning service in the current study with P-value > 0.05.

Table 9 Husband's Support and its Effects on the Utilization of Family Planning Services

Characteristics	Frequency (N=285)	Percent (%)	Chi-square(X ²)	P-value
Husband's approval on the use contraceptives			9.295	0.002**
Yes	203	71.2		
No	82	28.8		
Partners influence on the use of FP services			3.574	0.059**
Yes	162	56.8		
No	123	43.2		
How often does you and your partner talk of FP for past 1 year			22.806	0.001**
At least once a month	73	25.6		
Between 3 to 6 month	68	23.9		
Once a year	71	24.9		
Never	73	25.6		
Does the partner discuss the number of children to have			2.025	0.155
Yes	206	72.3		
No	79	27.7		
How many children have you agreed to have			0.466	0.796
One child	4	1.4		
Between 2 to 3 children	143	50.2		
Four children	138	48.4		
Does your partner likes the idea of same no. of children you would like to have			0.127	0.721
Yes	195	68.4		
No	90	31.6		

(%) Represents Row Percentage, **P<0.05

➤ *Multinomial Logistic Regression of the Factors Affecting the Utilization of Family Planning Services in Sefwi Akontombra District*

Table 10 below present summary logistic regression of the significant factors affecting the utilization of family planning services in the Sefwi Akontombra District. From the finding of the study, Geographical location (community) of respondents and marital status significantly influenced the utilization of family planning service. A respondent who stays in Atwakan, Akontombra, Bokaso and Kofikrom is 7 times, 3 times, 4 times and 8 times respectively more likely to utilize the family planning service as compared to a respondent who stay in Nsawora. (AOR = 7.22, 95% CL 1.69-30.81, AOR = 3.39, 95% CL 1.19-12.31, AOR = 4.13, 95% CL 1.04 -16.37 & AOR=8.25, 95% CL 2.27-30.01). Similarly, the same thing applies to Aburonehia, Bronikrom and Kramokrom. Moreover, a respondent who is single or married was 78.4% and 78.5% less likely to utilize the family planning service as compared to respondents who was separated (AOR = 0.216, 95% CL 0.05-0.93, AOR = 0.215, 95% CL 0.05-0.89).

Also, awareness level and knowledge of the types of family planning methods had a positive association on the use of family planning service. A respondent who was aware of the existence of family planning service is 1.3 times more likely to utilize the service as compared to someone who was not aware (AOR=1.31, 95% CL 0.34-1.32). Moreover, a respondent who knows the modern types of family planning methods is 24 times likely to utilize the family planning methods that someone who does not know any of the methods (AOR= 24.17, 95% CL 3.04 -191.95).

The finding of the study indicated that, distance to access family planning services, payment of money (fees) for utilizing the service significantly affected the utilization of family planning services. A respondent who is affected by distance is 28.2% less likely to utilize the family planning service as compared to someone who is not affected (AOR= 0.718, 95% CL 0.43 -1.42). Also, a person who pays before accessing the family planning service is 97.9% less likely to utilize the family planning service as compared to someone who does not pay anything (AOR= 0.021, 95% CL 0.003 – 0.134).

Service providers' contribution to healthcare service cannot be overlooked. The finding of the current study indicated that, reception of service providers, attitude of service providers, discussing with services providers any service related problems and side effect of the drugs significantly affected utilization of family planning service. It indicated that respondents who were satisfied with the reception of the service providers were 29 times more likely to utilize the family planning service as compared to those who were not satisfied (AOR= 29.26, 95% CL 9.64 – 88.84). Also, service providers who were friendly and up to date on family planning issues were 2 times more likely to attract respondents (customers) as compared to those who were indifferent

(AOR= 1.80, 95% CL 1.32 – 1.79). Moreover, the service providers who were opened to clients to discuss side effect of the family planning drugs and what to do when there was any side effect or any problems were 2 times and 50 times respectively more likely to attract respondents to utilize the family services than those who had benefited from such services (AOR= 1.65, 95% CL 1.62 – 1.64 & AOR= 50.03, 95% CL 13.59 – 185.22). Respondents who had a negative thought about family planning usage and services were 69.1% less likely to utilize the family planning service than those who had positive thought (AOR= 0.31, 95% CL 0.19 – 0.52).

The role of a husband in a service delivery cannot be over looked. The finding of the study indicated that, husband’s approval and influence of the use of the family planning services significantly affected the utilization of family planning services. Respondents who had the husband’s approval and influence on the usage of family planning services were 2 times respectively more likely to utilize the service than those without the husband’s approval and influence (AOR= 2.27, 95% CL 1.33 – 3.86 & AOR= 1.61, 95% CL 0.98 – 2.66). Moreover, those who between one months to one year, have their husband spoken to them about family planning service were 3 to 6 times respectively more likely to utilize the family planning service than those who were not (AOR= 3.44, 95% CL 1.49 – 7.89, AOR= 6.49, 95% CL 2.88 – 14.55 & AOR= 3.02, 95% CL 1.31 – 6.94). Details can be found in table 10 below.

Table 10 Multinomial Logistic Regression of the Factors Affecting the Utilization of Family Planning Services in Sefwi Akontombra District

Predictive Variables	P-value	AOR	95% Confidence Interval	
			Lower Bound	Upper Bound
SOCIO-DEMOGRAPHIC FACTORS				
Name of community				
Nsawora	REF			
Akwakan	0.008**	7.219	1.691	30.808
Aburonehia	0.003**	6.513	1.887	22.484
Akontombra	0.024**	3.387	1.196	12.307
Besibema	0.386	2.062	0.402	10.596
Bokaso	0.044**	4.125	1.039	16.370
Bronikrom	0.003**	7.562	2.017	28.349
Fawokabra	0.664	1.500	0.241	9.345
Kofikrom	0.001**	8.250	2.268	30.013
Kramokrom	0.035**	3.808	1.099	13.195
Marital status				
Separated	REF			
Single	0.040**	0.216	0.050	0.931
Married	0.035**	0.215	0.052	0.897
Cohabiting	0.077**	0.237	0.048	1.169
Divorced	1.000	1.000	0.160	6.255
KNOWLEDGE AND AWARENESS LEVEL				
Aware of existence of FP services				
No	REF			
Yes	0.001**	1.314	0.341	1.314
Aware of the types of FP methods				
Knows None	REF			
Knows modern methods	0.003**	24.156	3.040	191.951
Knows traditional methods	0.221	2.416	0.589	9.905
ACCESSIBILITY OF FP SERVICES				
Effects of distance on FP utilization				
No	REF			
Yes	0.000**	0.718	0.434	1.418
Payment of fees for accessing FP services				
No	REF			
Yes	0.001**	0.021	0.003	0.134
SERVICE PROVIDER FACTOR TO UTILIZING FP SERVICES				
Satisfaction with the reception given				
No	REF			

Yes	0.001**	29.256	9.635	88.838
Satisfaction with the service provided				
No	REF			
Yes	0.001	1.257	0.268	1.257
Attitude of the service provider				
Indifferent	REF			
Friendly and up to date on FP issues	0.001	1.80	1.321	1.793
Discussion of the possible side effect with clients				
No	REF			
Yes	0.00	1.654	1.626	1.1.640
Discussion on what to do if you encounter any problem or side effect				
No	REF			
Yes	0.003**	50.033	13.588	184.227
WOMEN AUTONOMY				
Negative thought about family planning services				
No	REF			
Yes	0.020**	0.309	0.185	0.517
HUSBAND'S SUPPORT				
Does the husband approve to the use of contraceptive?				
No	REF			
Yes	0.003**	2.267	1.332	3.860
Partners influencing your willingness to use FP soon after birth				
No	REF			
Yes	0.060**	1.614	0.981	2.655
Often times the husband talk to wife about FP				
Never	REF			
Between 3-6 months	0.004**	3.436	1.495	7.898
At least once a month	0.001**	6.485	2.881	14.551
Once a year	0.011**	3.019	1.314	6.937

CHAPTER FOUR DISCUSSIONS

➤ *Socio-Demographic Characteristic of Correspondents*

This study indicated that majority of the respondents were between the age group of 20-24 years (42.8%). This is similar but lower than the study conducted by (Eliason et al., 2014) and (Beson, Appiah, & Adomah-Afari, 2018) where most of the participants were between the age group of 20-29 years. Also, the highest educational level attained by the correspondents were basic education (JHS) (28.4%). This is similar to the study conducted by (Beson et al., 2018) but different from another cross-sectional study conducted in the Kintampo of Ghana, where majority (37.9%) of the participant had no basic education (Nettey et al., 2015). The current study indicated that 76.5% of the respondents had between one to two conceptions. This is similar but higher than the study conducted by (Beson et al., 2018) where most of the participants (68%) had had between 1 and 3 conceptions. Moreover, it was noted that more than half (53.7%) of the study respondent were married. This is lower than the study conducted by (Fedrick, Mkingule, Mtae & Kigadye, 2019) and (Beson et al., 2018) where 89.7% and (67%) respectively of the respondent were married. Moreover, a respondent who is single or married was 78.4% and 78.5% less likely to utilize the family planning service as compared to respondents who was separated (AOR = 0.216, 95% CL 0.05-0.93, AOR = 0.215, 95% CL 0.05-0.89). This is in line with the study conducted in Ga-East that being married remained significantly associated with ever use of a modern contraceptive method, with married women being more than twice as likely to have ever used modern contraception compared with unmarried women (Aryeetey et al., 2010). The study recorded (48.1%) of its respondents being unemployed with (29.1%) employed to the private sector. This contradict with the study conducted by (Fedrick et al., 2019) where more than (60%) of its participant were peasant, 4.4% were employed and 18.8% were into petty business. Moreover, Christianity dominated as the highest recorded region (79.3%). This is similar but lower than the study conducted by (Beson et al., 2018) where (87%) of its respondent were Christians.

➤ *Knowledge and Awareness Level and its Association with Family Planning Utilization Services*

The findings of the study suggests that knowledge of modern family planning methods is very high (98.9%). This is similar but lower than the purposive sampling study conducted in the Ga East District where awareness level was (99.7%) (Beson et al., 2018). It was however higher than the study conducted (Eliason et al., 2014) and (Beson et al., 2018) which recorded awareness level to be 91.5% and 98% respectively. According to the current study, respondent who was aware of the existence of family planning service is 1.3 times more likely to utilize the service as compared to someone who was not aware (AOR=1.31, 95% CL 0.34-1.32). Moreover, a respondent who knows the modern types of family planning methods is 24 times likely to utilize the family planning methods that someone who does not know any of the methods (AOR= 24.17, 95% CL 3.04 -191.95). Health workers (60%) were the main source of family planning information in the Sefwi Akontombra district followed by friends and relatives (29.1%). This correspond to the study conducted by (Eliason et al., 2014) but opposite to the study conducted by (Beson et al., 2018) and (Nettey et al., 2015) where their major source of information were newspaper/magazines and radio (50.4%) respectively. The fact that respondents were aware of the existence and the methods of family planning types alone significantly influenced the utilization of the family planning services. ($\chi^2 = 6.161$, P-value = 0.013) and ($\chi^2 = 19.534$, P-value = 0.001) respectively.

➤ *Prevalence of Family Planning Utilization Services in the Sefwi Akontombra District*

The study reported that (67%) of the respondents have ever gone for the family planning service with last 6 months. This is directly proportional or equal to a purposive sampling study conducted in Ga East District, where ever Modern Contraception usage among Women was indicated to be (67%) (Aryeetey et al., 2010). The prevalence recorded in the current study is higher than the study conducted by (Beson et al., 2018) and (Nettey et al., 2015) where prevalence was recorded to be 21% and 55% respectively. Moreover, the commonest methods that the respondents were using included the injectable (63.1%) and the Pills (24.1%). This is similar but lower than the cross-sectional study conducted at Ledzokuku Krevor municipality in the greater Accra region of Ghana injectable 64.5% and pills (61.8%) was the most known modern method of family planning (Beson et al., 2018).

➤ *Accessibility to Family Planning Services and How it Affects the Utilization of Family Planning Services*

The finding of the study shows that 49.2% of the respondents reside close to the facilities where family planning services are rendered with 67.9% indicating that family planning services are located within the facility. The study indicated that, distance to access family planning services significantly affected the utilization of family planning services. A respondent who is affected by distance is 28.2% less likely to utilize the family planning service as compared to someone who is not affected (AOR= 0.718, 95% CL 0.43 -1.42). This is in line with the cross-sectional study conducted by (Beson et al., 2018) which also indicated that residing in close proximity to FP service delivery points is significantly associated with utilization of family planning as compared to those far (Fedrick et al., 2019). Our current study stated that most of the respondent (41.2%) have easy access family planning centre roughly between 10 to 30 minutes (37.4%) and was mostly by foot (72.7%). This still conform with the assumption of another study, that respondent who lived beyond walking distance of health facilities with family planning clinics (more than 2 kilometres) were significantly less likely to use modern contraceptives compared to those who lived within 2 kilometres of health facilities (Fedrick et al., 2019). Another cross-sectional study conducted in the Nkwanta district of Ghana affirmed that, respondents who stayed less than 5 km away were more 4 times likely to utilize family planning services than those where stay away from 5 km (Eliason et al., 2014). Moreover, payment of money (fees) for utilizing the service significantly affected the

utilization of family planning services. Also, a person who pays before accessing the family planning service is 97.9% less likely to utilize the family planning service as compared to someone who does not pay anything (AOR= 0.021, 95% CL 0.003 – 0.134). It is important to note that, majority of the respondents (90.9%) in the current study were made the pay to access the family planning services though (33.7%) of them described it as being affordable. This significantly affected the utilization of the family planning services in the Akontombra district. It was further proven that, a person who pays before accessing the family planning service is 97.9% less likely to utilize the family planning service as compared to someone who does not pay anything (AOR= 0.021, 95% CL 0.003 – 0.134). It significantly affected the utilization of the family planning services in the Akontombra district ($X^2=39.912$, P-value = 0.001). The percent among those who pay for service to access family was higher than purposive sampling study conducted in Ga-East which report Fewer than 5 percent of respondents pay cost of service as a barrier to accessing family planning services (Aryeetey et al., 2010).

➤ *Service Provider Factors to Family Planning Utilization*

The way health services are rendered in a facility goes a long way to affect its utilization. The current study shows that (94.1%) of the respondents were satisfy with the reception given them and 56.1% described the whole service given as satisfactory when they go to access the service. The study indicated that, reception of service providers, attitude of service providers, discussing with services providers any service related problems and side effect of the drugs significantly affected utilization of family planning service. It shows that respondents who were satisfied with the reception of the service providers were 29 times more likely to utilize the family planning service as compared to those who were not satisfied (AOR= 29.26, 95% CL 9.64 – 88.84). Also, service providers who were had good attitude, friendly and up to date on family planning issues were 2 times more likely to attract respondents (customers) as compared to those who were indifferent (AOR= 1.80, 95% CL 1.32 – 1.79). The current study indicated that (58.8%) of the respondents attested to the presence of waiting time. This is higher than the purposive study conducted at Ga-East district where 23% of respondents stated long waiting hours as main service related barriers to family planning service related factor. Eliason et al., 2014 confirmed in their study that, favourable opening hours (five hours or more) of the facilities and distance to health facilities influenced the use of modern contraceptives. It significantly increased odds of modern family planning use compared to non-favourable opening hours (Eliason et al., 2014). Majority the respondents (86.1%) said they were able to discuss the side effects or any service related problems with their service providers. This goes a long way to affect the utilization of the family planning service in the Sefwi Akontombra district with ($X^2 =70.402$, P-value =0.001).

➤ *Women Autonomy, Household Decision Making Processes and its Effects on the Utilization Family Planning Services*

The finding of this study indicated that (76.1%) of the participants were allowed to take part in the decision-making processes on daily purchases in the house (36.1%) and their children's education (24.6%). This negative thought about family planning significantly affects the utilization of the services with ($X^2=20.853$, P-value =0.001). The study indicated that, more than half (60.4%) of the participants have do not have negative thought about family planning with only 39.6% having negative thought about family planning. It further shows that respondents who had a negative thought about family planning usage and services were 69.1% less likely to utilize the family planning service than those who had positive thought (AOR= 0.31, 95% CL 0.19 – 0.52). This is in line with the multivariate logistic regression analysis conducted by (Asiedu et al., 2020) which revealed that, respondent with negative thoughts about the use of modern contraceptives were 61% less likely to utilize the family planning services (AOR = 0.39; 95% CI = 0.21–0.75) (Asiedu et al., 2020). (31.2%) of the respondent believed that family planning can make one infertile. The percentages recorded was higher than the study conducted by (Aryeetey et al., 2010) where only 8% of the respondent had the view that family planning could lead to barrenness.

➤ *Husband's Support and its Effects on the Utilization of Family Planning Services*

Spousal communication between a husband and wife has been found to be a prime indicator of the extent of knowledge and acceptance of family planning practices that couples will be willing to adopt and use (Akafuah & Sossou, 2008). The finding of the study indicated that, husband's approval and influence of the use of the family planning services significantly affected the utilization of family planning services. The study indicated that, (71.2%) of the participants had their husband approval on the use of contraceptives, this was supported by a study conducted in Burkina Faso where husband approval to contraceptive usage have been documented as method-related reasons for non-use of modern contraceptives among women with unmet needs (Adebowale et al., 2014).

Also, (56.8%) of respondent in the current study had their partner's influence on the use of family planning services. This is lower than the study conducted by (Aryeetey et al., 2010) where most users (73 %) indicated that their decision to use contraception were influenced by their partner. (Beson et al., 2018) also added that women who received partner support reported high prevalence (34%) of use of modern contraceptives (Beson et al., 2018). It shows that, respondents who had the husband's approval and influence on the usage of family planning services were 2 times respectively more likely to utilize the service than those without the husband's approval and influence (AOR= 2.27, 95% CL 1.33 – 3.86 & AOR= 1.61, 95% CL 0.98 – 2.66). This was linked to the cross-sectional study conducted in Nkwanta District of Ghana where women whose partners approved of modern family planning were 4 times more likely to use modern family planning than those whose partners did not approve (OR = 4.33, 95% C.I 2.55-7.36) (Eliason et al., 2014).

Notwithstanding, the study shows that between (23% - 25.6%) of the respondent has had a talk with their partners on family planning either once a month, between 3 to 6 months or once a year. Those who frequently discuss family planning with their partners were 3 to 6 times respectively more likely to utilize the family planning service than those who were not (AOR= 3.44, 95% CL 1.49 – 7.89, AOR= 6.49, 95% CL 2.88 – 14.55 & AOR= 3.02, 95% CL 1.31 – 6.94). This was in line with multivariate analyses conducted by (Eliason et al., 2014) where, women who discussed modern family planning with their partners were 5 times more likely to use modern family planning methods compared to those who did not discuss with their partners (OR = 4.67, 95% C.I 2.88-7.58) (Eliason et al., 2014).

CHAPTER FIVE CONCLUSION

This study was to investigate factors that contribute to family planning uptake among Women of Reproductive Age in the Sefwi Akontombra District of the Western North Region.

The study shows that the educational programmes organized by policy makers to create awareness on contraceptives were very effective. It has further revealed that most of the respondents obtained their information from health workers.

The utilization level of contraceptive was below the knowledge level. This could be as a result of the perceived negative taught associated with the use of contraceptive or some negative beliefs people have on contraceptive.

The finding of the study revealed the role men or husbands play in the uptake of family planning, however most of our educations on family planning do not capture men as their targets.

The study also shows that despite the education on family planning there are still some myth or beliefs people have on the use of the contraceptive which if not addressed, is likely to be a barrier or a factor to prevent or reduce the use of contraceptives.

RECOMMENDATION

The purpose of this study was for academic purpose and to come out with the following recommendations which would go a long way to benefit policy makers, in the Ghana health service and the entire population.

First, the health education and promotion programmes should target men in the society since they influence the uptake of family planning methods.

Secondly, the health education and promotion programmes should be regularized and integrated into routine activities.

Thirdly, family planning providers should have time to clarify any misconceptions and negative beliefs people might have on contraception especially when clients or first users come for counselling.

Again, the Directorate should liaise with Marie Stopes for commodities and run free family planning services campaign in the communities since accessibility and cost has significant influence on the uptake of family planning.

The Directorate can also identify and train community influencers, who will be advocating for uptake of family planning in the communities.

Finally, even though most people are aware of contraceptives there should be an intensification of educational and promotional programmes particularly to address the issue of side-effects perceived to be associated with the use of contraceptives.

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