

UNIVERSITY OF CAPE COAST

FACTORS AFFECTING UTILIZATION OF CONTRACEPTIVES AMONG
MARRIED WOMEN IN NORTH GONJA DISTRICT OF GHANA: A
QUALITATIVE STUDY

ABDUL AZIZ ADAM

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QUALITATIVE STUDY

BY

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Thesis submitted to the School of Nursing and Midwifery of the College of
Health and Allied Sciences, University of Cape Coast, in partial fulfilment of
the requirements for the award of Master of Nursing Degree.

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DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature..... Date.....

Name: Abdul Aziz Adam

Supervisors' Declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Principal Supervisor's Signature Date.....

Name: Prof. Akwasi Kumi-Kyereme

Co-Supervisor's Signature..... Date.....

Name: Dr. Mate P. Siakwa

ABSTRACT

In Ghana, fertility rates continue to vary widely; ranging from 2.5 children per woman in the Greater Accra region to 6.8 children in the Northern Region. Moreover, the use of any contraceptive method is highest among women in the Volta Region (32%) and lowest among women in the Northern Region (11%). Using a qualitative explorative descriptive design, this study explores the factors affecting contraceptive utilization among married women in the reproductive age group (15 – 49 years), through in-depth interviews in the North Gonja District. The data collected was analyzed by means of thematic analysis. This included construction of a thematic framework, coding, editing and categorization of available data as well as the creation of sub-themes. The study revealed that there is limited knowledge and a general lack of understanding about contraceptives among the married women who were interviewed. The result also suggested that male domination and social stigma are some of the factors affecting the utilization of contraceptives. In view of this, it is recommended that Ghana should develop some educational and counselling techniques to educate the public to help debunk the social stigma in the community. Besides, the study recommends an effective development and implementation of male-involvement contraceptive initiatives to address men's negative beliefs regarding contraceptive services.

KEY WORDS

Factors

Utilization

Contraceptives

Women

Ghana

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DEDICATION

To my lovely wife Hajia. Rahama Abdul Aziz and my beautiful daughter Miss Zahra Daliri Abdul Aziz as well as my handsome son Abdul Aziz Aadel Tipagya

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CHAPTER ONE

INTRODUCTION

Background to the Study

Population explosion is the major contemporary issue in this part of the world. The alarming increase in the world population poses certain crucial economic, political and social problems in almost all spheres of life and in all sectors of the human race. In addition to the depletion of environmental resources and the impact of global climate change, most developing countries realize the implication of rapid population growth on the socio- economic status and welfare of the people (Yunus, 2006).

With the human population exceeding 7 billion and the food and energy prices rising, the longstanding question of the adverse consequences of expanding populations in the developing world and rising consumption everywhere is commanding the attention of scientists and policymakers. In addition to the depletion of environmental resources and the impact of global climate change, other potential adverse effects of rapid population growth and high fertility include poor health among women and children, slow economic growth and widespread poverty, and political instability in countries with large numbers of unemployed young people (John, 2012).

Family planning has been defined (WHO, 2015) as allowing people to attain their desired number of children and determine the spacing of pregnancies. It is achieved through the use of contraceptive methods and the (treatment of infertility). Thus, researchers have discovered that the same pill used to prevent pregnancy can actually help a woman conceive. The study found that a two-week intervention treatment using a standard low-dose birth

control pill can help time egg harvesting, making the in Vitro Fertilization (IVF) process more convenient for both doctor and patient. While the previous definition focuses on limiting the size of the family, the 2009 Collins English Dictionary (Collins,2009), specifies the use of contraceptives when defining family planning as the control of the number of children in a family and the intervals between them, especially by the use of contraceptives. The Medical Dictionary (Marriam, 2007) on the other hand adds a sense of intention and determination to the two previous definitions by stating that family planning is intended to determine the number and spacing of one's children through effective methods of birth control.

The World Health Organization (WHO, 2006), issued a recommendation that, after a live birth, the interval before attempting the next pregnancy should be at least 24 months, and at least six months after a miscarriage or induced abortion, in order to reduce the risk of adverse maternal, perinatal, and infant outcomes (Healthy Timing and spacing of pregnancy) .

Contraceptive use in the United States is virtually universal among women of reproductive age: virtually all women of reproductive age in 2006–2010 who had ever had sexual intercourse have used at least one contraceptive method at some point in their lifetime (99%, or 53 million women aged 15–44), including 88% who have used a highly effective, reversible method such as birth control pills, an injectable method, a contraceptive patch, or an intrauterine device (Daniels, Mosher, & Jones, 2013). In 2002, 90% had ever had a partner who used the male condom, 82% had ever used the oral

contraceptive pill, and 56% had ever had a partner who used withdrawal (Michael, 2012).

Modern contraceptive methods constitute most contraceptive use. Modern contraceptives method are contraceptives that are based on scientific knowledge of the process of conception. Globally in 2015, 57% of married or in-union women of reproductive age used a modern method of family planning, constituting 90% of contraceptive users. Traditional contraceptive methods are contraceptives which are prescribed or supplied by traditional healers or methods used traditionally in specific cultures without any prescription. When users of traditional methods are counted as having an unmet need for family planning, 18% of married or in-union women worldwide are estimated to have had an unmet need for modern methods in 2015 (United Nations, 2015).

The modern contraceptive prevalence rates (that is, the proportion of women of reproductive age who are using a modern contraceptive method, vary widely across the African region. Among women of reproductive age, Contraceptive Prevalence Rate (CPRs) for modern methods ranges from 1.2% in Somalia to 60.3% in South Africa. Countries in Southern Africa reported the highest levels of contraceptive use, followed by countries in East Africa. With a few exceptions, West and Central African countries report very low rates of family planning use. Some of the lowest contraceptive prevalence rates in the world exist in these two sub regions of Africa (United Nations, 2009).

Sub Saharan African countries by and large are characterized by high fertility and correspondingly high rates of population growth for the

foreseeable future. Most countries in the region will grow by 100-300% by 2050 and in total, the population of the region will double over the next 45 years. The main driver of high fertility (5 children per woman) in most countries is a persistent demand for large numbers of children, as expressed by women responding to questions about desired child bearing. Fertility would decline only if women had no undesired childbearing, that is, if greater access to quality family planning services respond to unmet needs (Levin, 2009).

Since the 1960s, alongside efforts to increase levels of education and improve health conditions, the main policy response to rapid population growth has been the implementation of voluntary family planning programs that provide information about and access to contraception. This policy has permitted women and men to control their reproductive lives and avoid unwanted childbearing. The choice of voluntary family planning programs as the principal policy to reduce fertility has been based largely on the documentation of a substantial level of unwanted childbearing and an unsatisfied demand for contraception (John, 2012).

Although there has been a marginal improvements in infrastructure and consumable items needed for family planning services delivery in many parts of Ghana, the Ghana Health Service Survey (GHSS) in 2012 also noted many barriers to the utilization of family planning. According to the GHSS, (2012), these barriers include frequent periods of contraceptives being out of stock at the facility level, limited provider skills, limited use of educational tools, and limited number of methods. Low contraceptive use is attributed to a number of barriers acting at policy, facility, district, community and individual levels

(Benefo, 2005). Within individual level, knowledge of family planning services and methods is crucial (Bamikale & Casterline, 2010).

Whereas evidence from a number of researches around the world reveal a near universal knowledge on family planning methods among the women of the reproductive age, this has not translated into increased utilization of these methods in the North Gonja District in the Northern Region of Ghana. Low usage of family planning services and methods has been widely attributed to the negative attitude towards the use of modern contraceptives (Addai, 2009). Specifically, approval/disapproval of the modern methods by self and partner, fear of harmful effects on health and low levels of education (Benefo, 2005), have been identified to influence the use of modern family planning methods in Ghana, and for that matter the North Gonja District.

Religions vary widely in their views on the ethics of birth control. Some religious sect accepts Natural Family Planning. Natural Family Planning is the use of calendar or rhythm of a woman's menstrual cycle to time sexual intercourse with the aim of preventing conception. The Roman Catholic Church accepts only Natural Family Planning and only for serious reasons, while Protestants maintain a wide range of views from allowing none to very lenient. In Islam, contraceptives are allowed if they do not threaten health, although their use is discouraged by some. Hindus may use both natural and artificial contraceptives; however they are against any other contraceptive method that works after fertilization. A common Buddhist view of birth control is that preventing conception is ethically acceptable, while intervening after conception has occurred or may have occurred is not. A number of

nations today are experiencing population decline. Growing female participation in the work force and greater numbers of women going into further education has led to many women delaying or deciding against having children, or to not have as many. In Eastern Europe and Russia, natality fell abruptly after the end of the Soviet Union. The World Bank issued a report predicting that between 2007 and 2027 the populations of Georgia and Ukraine will decrease by 17% and 24% respectively (Agyei, 2014).

People's control over their sexual lives and choices is in turn shaped by gender-related values and norms defining masculinity and femininity. These culturally-defined gender values and norms evolve through a process of socialisation starting from an early stage of infancy (Agyei, 2014). Studies have suggested that greater gender equality may encourage women's autonomy and may facilitate the uptake of contraception because of increased female participation in decision making (Hakim, Mumtaz & Salway, 2003). However, it has not been set as a prerequisite for widespread adoption of contraceptives (Amin & Ahmed, 1998).

Empirical review on the effect of decision-making patterns on contraceptive use often does not distinguish between women participating in decisions and controlling them and account for the effects of common decision-making patterns within the community. This strong effect of normative decision-making patterns within the community is net of individual education and community education, both of which had strong and significant effects. Less traditional gender roles as measured by normative decision-making patterns seem to support more innovative fertility behavior. Community decision-making patterns matter importantly for contraceptive use

in this low contraceptive prevalence setting and the need to be assessed elsewhere. Furthermore, women's influence is inadequately measured where joint decision-making and wife-dominated decision-making are considered together (Agyei, 2014). When a couple's most fundamental assumptions of a faith are dissimilar to those of the health care provider, medical recommendations may be made that are not consistent with the couple's religious or cultural values. Health care providers in culturally diverse nations must understand the possible influences of culture and religion on a couple's willingness to use contraception, and they should be familiar with a range of contraceptive options in order to address such situations in the most appropriate ways.

Statement of the Problem

Many sub-Saharan African countries have high rates of unmet need for family planning (FP) and low rates of contraceptive use (Westoff, 2001). Individuals and couples who want to limit their fertility are often unable to obtain the Family Planning methods they need due to numerous barriers (Campbell, Nuriye & Malcolm, 2006). The lack of understanding surrounding what influences Family Planning use and how decision-making takes place in families has led to the inability of policy and programs to focus on the factors that are most important to helping people control their fertility (Campbell, Malcolm & Nuriye, 2006).

The data compiled from the 2010 Census questionnaires yielded a population of 24,658,823. The figure represents an increase of 30.4% over the 2000 census population of 18,912,079. The annual average intercensal growth rate is 2.5% (Ghana Statistical Service, 2012). The Total Fertility Rate (TFR)

for Ghana is 4.2 children per woman, a slight increase from 4.0 children per woman in the 2008 Ghana Demographic and Health Survey (GDHS) (GDHS, 2014). In recognising such lowering of fertility rate at the time when traditional methods of birth postponement, spacing and abstinence are on the decline, it will require an increase in Contraceptive Prevalence Rate (CPR) to 28% by 2010 and to 50% by 2020 (National Population Policy, 1994). According to the United Nations, Department of economic and Social Affairs (2016), Ghana's Contraceptive Prevalence Rates for 2013, 2014 and 2015 were 25.6%, 27.6% and 34.7% respectively.

The GDHS (2014), observed that the current use of any method is 23% among all women, 27% among currently married women, and 45% among sexually active unmarried women and a large number of women have an unmet need for family planning as the acceptor rate for family planning services remains low. It is on this note that the Ghana Health Service argues that the lives of mothers and children will be improved and maternal mortality reduced if the family planning acceptor rate is improved (Apanga & Adam, 2015). One of the main targets of the 1994 revised National Population Policy was to reduce the total fertility rate from 5.5 to 5.0 children per woman by the year 2000, to 4.0 by 2010, and to 3.0 by 2020 (NPC1994). With a TFR of 4.0 in 2008, Ghana achieved its fertility target two years before the target year of 2010. However, with the slight increase in fertility reported in the 2014 GDHS, more needs to be done to reach the TFR target of 3.0 children per woman by the year 2020 (Statistical service Ghana, 2015).

Similarly, by region, GDHS 2014 observed that the current use of any method is highest among women in Volta (32 %) and lowest among women in

Northern (11%)(Statistical service Ghana, 2015) and the North Gonja district, specifically the Northern Region (NR) of Ghana, is not spared from this predicament as the utilization of contraceptive methods also remains low. The Northern region offers a virtually free and a highly subsidized family planning services to clients in most of the health facilities in the region. Despite the provision of virtually free family planning services, the region reported 16.7% family planning acceptor rate in 2013, 19.4% in 2014 and 18.5% in 2015, which is below the national family planning acceptor target rate of 34.5%.

The regional annual health report showed a consistent decrease in family planning acceptor rate of the North Gonja district in 2013 to 2015 with an acceptor rate of 16.3% in 2013, 9.3% in 2014 and 6.7% in 2015 respectively (Amadu, 2015). Despite the ready availability of Family Planning methods and high contraceptive knowledge, the use of Family Planning methods remains low. The factors people assign to non-utilization of contraceptive has not been well established. These are important issues to be addressed so as to enhance further contraceptive use and lower fertility levels in Ghana and most especially in the North Gonja districts. This study therefore, sought to explore the factors affecting the Utilization of Contraceptives among married women of reproductive age (15-49 years) in North Gonja District.

Objectives of the Study

The main objective of this study is to explore the factors that affect contraceptive utilization among married women in the reproductive age group (15 – 49 years) in the North Gonja District.

The specific objectives are to:

1. Explore how the extend of knowledge of married women on contraceptives affect contraceptive utilization.
2. Explain how husbands' approval and spousal communication influence the use of contraceptives among married women in North Gonja district.
3. Investigate how cultural, social and religious factors affect married women's decisions on contraceptive utilization
4. Explore how access to contraceptives influences contraceptive uptake among married women in the North Gonja district.

Research Questions

1. How does married women's knowledge affect contraceptives utilization?
2. How does husbands' approval and spousal communication influence the use of contraceptives among married women in the North Gonja district?
3. How does cultural, social and religious factors affect married women's decisions on contraceptive utilization?
4. How does access to contraceptives influence contraceptive uptake by married women in the North Gonja district?

Significance of the Study

This study will help understand the socio – demographic, the socio – cultural, religious as well as access issues that affect the use of contraceptives by married women. The findings of the study may help in developing new approaches for increasing the use of contraceptives among married women. The research will help to generate ideas for reducing women's negative

perceptions and husbands' attitudes toward the use of contraceptives. The recommendations that will be made at the end of this study may play a vital role towards improving the effective use of contraceptives and family planning services, and thereby contribute towards the sustainable development goals by ensuring good health and promoting well-being for all ages to achieve gender equality and empower women and girls by the year 2030.

Delimitation

This study will focus on the factors affecting the utilization of contraceptives among married women in the reproductive age of 15-49 years in the North Gonja district. The findings of the study will be limited to the age bracket, 15-49 and not the entire women population, and therefore will not account for those who are outside the age limit.

Limitation of the Study

The results of the sample survey might differ from the complete census which could give a more accurate picture of the characteristics of the population instead of using a few respondents to generalize for the entire population. All the possible confounders might not be known from this study. There are many factors related to the practice of family planning, however, this study will not cover all determinants. The basic factors such as, cultural, religious, knowledge level, accessibility, and husbands' approval will only be the centre of focus. There was a language barrier as the women interviewed were only conversant with the local language, which is Gonja. This was overcome by prior recruitment of research assistants who could speak the language since this challenge was observed during pre-testing of the tools. In North Gonja, like in other patriarchal societies, contraceptive use is considered

a sensitive matter that the user (women) would not want her spouse/ partner to be aware of. Consequently, it is likely that some users of contraceptives might have concealed the truth about their uptake of contraceptives.

Additionally, as with all qualitative studies, one limitation of the study was the representativeness of the sample. This is because, to ensure rich and detailed data was obtained on the views, feelings, beliefs and experiences of married women about contraceptives, the researcher employed a non-probability purposive sampling technique by recruiting only participants who had a wealth of information to share about contraceptives. As a result, the findings 'replicability is limited to groups that share the same characteristics as the sample of this study. Another limitation stems from biases of the researcher, which may have affected the findings. This awareness allowed the researcher to ensure that frequent discussions about the coding and the subsequent development of themes took place between the researcher and his principal supervisor to avoid the influence of preconceived ideas and biases. The researchers biases and preconceived ideas or prejudices were also bracketed before the study started; this means they were noted down up front in the researcher's field journal.

The last limitation encountered by the researcher was financial and transportation constraints. This is because, although the North Gonja district is within the Northern region, it is considered as overseas due to its inaccessibility as a result of the district being cut off from the rest of the region at the peak of the raining season by the White Volta and also, one has to cross the White Volta by manually powered canoe before getting access to the district. The dispersed nature of the sub-districts and the inaccessible road

network could not make it possible for one to travel to the sub-districts by car, but had to rely on jungle motor bikes from the district health directorate to help the researcher to locate participants in their widely dispersed locations.

Definition of Terms

- Family Planning: A program to regulate the number and spacing of children in a family through the practice of contraception or other methods of birth control.
- Contraceptive Prevalence rate: Is the proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time.
- Contraceptives: Agents that are used to prevent the occurrence of pregnancy other than abstinence.
- Modern contraceptives method: Contraceptives that are based on scientific knowledge of the process of conception
- Natural contraceptives method: The use of calendar or rhythm of a woman's menstrual cycle to time sexual intercourse with the aim of preventing conception
- Traditional contraceptive methods: Contraceptives which are prescribed or supplied by traditional healers or methods used traditionally in specific cultures without any prescription
- Total Fertility Rate: It is a common measure of current fertility and is defined as the number of children a woman would have by the end of her childbearing years

- Unmet contraceptive need: Unmet contraceptive need is the proportion of fecund women who wish to space their next birth or to limit childbearing altogether but are not using contraception

Organization of the Study

This study is organized into five chapters. The first Chapter presents the introductory framework of the study that include, background to the study, statement of the problem, purpose of the study, objectives, research questions, significance of the study, delimitation ,limitation of the study and the definition of terms. This is followed by Chapter Two, which focuses on literature review in which empirical context of the study is laid out. Chapter Three discusses the methodology employed in the study. It also contains general background of the study area, research design, population, sampling and sampling size, method of data acquisition and instrument used. Chapter Four deals with presentation and analysis of data. Also discussed are findings against the evidence presented in the empirical literature. Finally in Chapter Five, a summary of the major findings of the research, conclusions, recommendations and areas for further research are presented.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This study sought to explore the factors that may affect contraceptives utilization among married women in the reproductive age group (15 – 49 years). This chapter is devoted to an overview of the literature related to the study. This will allow readers to gain an in-depth knowledge and understanding of the many facets of the concept of contraception in contemporary literature. A comprehensive literature search was conducted using three search engines: PubMed, Google Scholar and available data base from Wiley Online Library. Search terms include: “family planning Ghana”, “family planning,” “factors affecting contraceptive utilization,” “contraceptive use among Ghanaian women,” “birth control methods,” and “family size Ghana”. The review will briefly look at the thematic concepts, based on knowledge of married women on contraceptives, how cultural, social and religious factors influence married women’s decisions on contraceptive utilization, the extent to which husbands’ approvals, and spousal communication influence the use of contraceptives among married women in the North Gonja district and how access to contraceptives influence contraceptive uptake among married women in the North Gonja district.

Knowledge about Contraceptives

Ignorance about contraception is by definition an absolute barrier to the adoption of these methods. In order to use a method, women must be aware of its existence and they must know how to use it and where to obtain supplies. Knowledge of at least one modern method is widespread in Asia and

Latin America, but less so in sub-Saharan Africa (Westoff Charles & Bankole, 1995). Knowledge of multiple methods is often limited and incomplete, and erroneous information about where to obtain methods and how to use them is common (Robey, Ross, & Bhushan, 1996).

Several studies have shown that knowledge of modern contraceptive methods is an essential determinant of contraceptive usage (Caldwell, & Caldwell, 2007). Women who are well informed about the benefits of family planning tend to use it. However, the degree of contraceptive knowledge and practice still vary in time and space and from one social group to the other whether the method is modern or traditional (United Nations, 1996).

According to Gupta and Simon (1996) and Shane (1997), many peoples acceptance of family planning methods is directly related to knowledge of contraceptives among the eligible couples. At present, world fertility surveys confirmed a very high proportion of women; thus, three out of four in every country knew at least one modern method (United Nations, 1996). There is evidence for a direct link between knowledge about contraceptives and its usage. Recent world surveys based on estimates from developing countries have revealed that higher knowledge of modern contraceptives and their source is related to higher utilization and vice versa (Casterline&Sinding,2000). Despite these associations, however, misconceptions about different modern contraceptives in these parts of the developing world may lead to low approval of a method. Regarding this, Khalifa (1988), in her study in Sudan has confirmed that, inspite of a high level of knowledge of vasectomies, approval was low due to misconceptions. In addition, Gupta and Simon (1996), have also reported that many women

have misconceptions of various types about different modern contraceptives, mainly about modern contraceptives repercussions on their health. For instance, 32 and 22 percent of women in India did not accept IUCD and pills respectively; and also a significant figure in Mexico believe these pills cause nervousness and cancer. Hence, such perceived after-effects and misconceptions might prevent women and men from adopting those modern contraceptives (Simeon, 2002).

In a study conducted in the Kwazulu Province in South Africa, Family planning clients are usually not provided with detailed information on family planning methods so that they can make an informed decision (Ngom, & Binka, 2002). The findings of a study conducted in the Eastern Democratic Republic of Congo by Mathe, Kasonia and Maliro (2011) showed that the overall family planning knowledge of women in the city of Butembo, Eastern Democratic Republic of Congo, is very high; teenage mothers have little knowledge of family planning; women's perception of family planning is also very good. However, the use of modern contraception is very low.

A number of studies considered knowledge about family planning as a crucial factor which affects family planning utilization. However, the participants in a study conducted by Ahmed, Boutros Shokai, Hassan Abduelkhair and Yahia Boshra (2015), possessed good knowledge about family planning even though they do not like to use family planning products. Another study conducted in Dar Alsaam-Sudan to identify factors of low utilization of family planning services in some developing countries including Sudan showed that women do not like to use family planning even if they possessed a good knowledge about it (Umbeli, Mukhtar & Abusalab, 2005).

Furthermore, a study by Eltomy, Saboula and Hussein (2013) in Egypt indicates a majority of the non- users of Family Planning and the women who had discontinued use said they intended to have children and intended to use Family Planning methods in the future. These findings presented a disconnection between what the women want and what they really do. This could be a result of many Egyptian women having a greater control over their reproductive decisions, but they lack the knowledge and hence need proper counselling. This finding emphasizes the lack of essential knowledge about Family Planning and these women need specific attention and more information to promote their safety and to avoid unintended pregnancies. This result is supported by Ali and Cleland (1999), who emphasized that this age group (15-49years) lacks reassurance about which methods promote overall safety and reduce risks. Hassanein (1998), reported that 39% of women in his study were married at the age of 20–24 years and never used Family Planning services. Women who indicated that they are not using contraception because they do not know about contraceptive methods could be unfamiliar with specific methods of contraception or could lack an awareness of the concept of family planning or fertility control (World Health Organization, 2004).

In a qualitative study conducted by Sibongile, Miyonga and Kiconco (2016) on family planning providers perspectives on the barriers to contraceptive use in the Kaliro and Iganga district of Eastern Central Uganda showed that all the participants reported that there was inadequate community awareness about family planning services. The lack of awareness was attributed to the lack of access to information, and this posed a barrier to the use of family planning services. A study in Nigeria showed that women who

had knowledge of modern contraception were 67% more likely to have an unmet need to limit childbearing, relative to women who had no knowledge of modern contraceptive methods (Austin, 2015). The pattern of reasons that women cite reveal considerable variation across regions and among countries. Lack of information is much more important in Latin America and sub-Saharan Africa than in other regions (Busbhan, 1997).

A study conducted in the capital city of Ghana by Hodogbe and Badu-Nyarko in (2015) on the knowledge and practices of family planning among female basic school teachers portrayed that, knowledge/awareness about family planning is associated with the extent of the practice of family planning. The study only focused on female teachers who are literate and also reside in the capital city and are exposed to the media campaign of family planning and also can gain access to other vital information on family planning to inform practice, hence, the correlation of the findings with regard to knowledge and practice. However, a comparative, rural, non-educated female population and an urban female educated population could have revealed other findings.

A study conducted in Ghana at the Nkwanta district by Eliason et al., (2014) seemed to suggest that knowledge of modern family planning methods is very high among both cases and controls as a little over 90% of them had knowledge of at least one modern contraceptive method. This result confirms what is reported in the Ghana Demographic and Health Survey (GDHS)(Ghana Statistical Service, 2009) that about 98% of all women aged 15–49 years know at least one modern method of contraception as well as the 2014 GDHS, which indicates knowledge of contraception has been universal

in Ghana. The high level of knowledge could be attributed to the successful dissemination of family planning messages, mainly through the mass media. In essence, modern methods are more widely known than traditional methods; almost all women (99 percent) know of a modern method, compared with 85 percent who know of a traditional method. Among modern methods, the male condom (96 percent), injectables (92 percent), the pill (91 percent), and female condoms (87 percent) are the most commonly known modern methods among women (Statistical service Ghana, 2015). However, another study by Hindin, Mcgough and Adanu, (2014), conducted in Ghana, indicates that women lack knowledge about how modern contraceptive methods work as well as basic reproductive biology. Consequently, women need reliable sources of information.

It has been reported that behaviour change goes through the following stages: knowledge, approval, intention, use, and advocacy (Sedgh et al., 2007). Such findings could explain why women's intention reflects their ability to respond to health education sessions about contraception according to whether their needs are met (Eltomy et al., 2013).

Husbands' Approval and Spouse Communication

Communication of spouses about the fertility and family planning decision making has been one of the controversial discussions in this area of research. Lack of communication between wives and husbands creates barriers to contraception use (Casterline & Sinding, 2000). These barriers come into existence because either wives frequently misperceive their husbands' attitudes or husbands are more strongly opposed to contraception than their

wives (Biddlecom, 1998). The absence of spousal communication also appears to be an important contributing factor to unmet needs.

A comparative pattern of husband-wife communication in the last 12 months between women with unmet needs and those who use contraceptives revealed that women with unmet need communicate less frequently with their husbands about family planning. This gap is crucial, since many women who think that their husbands disapprove of contraceptive use may not have discussed the issue with them. Many women think that their husbands disapprove of family planning when, in fact, the husbands do approve. In Tanzania, for example, 45% of married women either did not know about their husbands' views (23%) or thought their husbands disapproved of family planning (22%) when in fact their husbands did approve (Busbhan, 1997).

A study conducted in Pakistan by Azmat et al., (2015), shows the lack of spousal communication and its negative impact on reproductive health behaviors. Between couples, partners do not share information with each other openly and this finding also coincides with existing literature that indicates that there is a greater need for spousal communication. Along with the communication lag between husband and wife, husband and mother-in-law imposed their religious sensibilities and acted as social constraints (Mahmood & Ringheim, 1997).

In a study conducted in South Sudan by Ahmed et al., (2015), it was indicated generally that women reported the decision regarding the utilization of family planning services as one of their concerns and that men may not have any actions regarding that but, actually, men are the dominant decision makers. That is so because women assume responsibility for their children and

it is women who suffer during pregnancy and labor and men may not share that. Some women said that their husbands do not want them to use family planning services because the men feared for their wives' health from side effects of contraceptive pills. Other reasons are due to the fact that some men simply wanted more children than the women did. In general, men either controlled women's utilization of contraceptives or women used contraceptives secretly. Men and some women reported that the decision to use family planning methods should be with men because they pay dowry to marry a woman, and they pay for all her expenses and that of the family.

This study conducted by Ahmed et al., (2015) revealed that the decision making process regarding utilization of family planning services, is influenced by the decision maker in the family. Men are dominant in this process, but some women call for change by giving them a chance to be partners in the decision making process. Women argue that since they spend all their times in childbearing activities, they should have the right to make choices. In reviewing the literature, it showed that men play the dominant role in decision making processes regarding certain women's issues such as family planning.

Traditionally, the community listens to men and not women. Women cannot do anything without their husbands' permission. It is common knowledge among men and women that the community is supporting male superiority regarding all life matters including women's affairs such as the use of Family Planning methods. Male dominance and male opposition to the use of contraceptives was also seen as a major barrier in Burundi and Northern Uganda. This was reported in the study of the perception of determinants of

utilization of maternal and reproductive health services (Chi, Bulage -Urdal et al., 2015).

In a community based comparative cross sectional survey conducted in Ethiopia by Eshete and Adissu (2017), they showed nearly half (53.3%) of the women had a discussion on contraceptive methods with their husbands in the total sample. Urban women (61.2%) had a better discussion on contraceptive methods with their husbands compared to rural women (45.5%). Similarly, urban women (60.0%) received better cooperation from their husbands compared to rural women (44.9%). Around 15.9% of urban and 7.2% of rural women also got support from their relatives. A study conducted in Uganda has shown that engaging men in communication regarding family planning was perceived by some as inappropriate and destructive. Given the social expectations for men to earn income for their families, use of men's limited time and mental preoccupation to discuss family planning was considered unduly burdensome (Rutaremwana et al., 2015).

A qualitative study conducted by Sibongile et al., (2016) on providers' perspectives on the barriers to contraceptive use in Kaliro and Iganga district, Eastern Central Uganda, established that the health workers cited lack of partner and family support as a barrier to family planning use. Most men were reportedly against their wives' use of contraceptives because they wanted many children and had fertility concerns if their wives used contraceptives. The study also found a high level of spousal communication among participants who were educated, Christian and in monogamous relationships regarding issues such as the number of children they wanted to have and also the use of contraceptives.

In addition, the data showed that when women are involved with making their own health decisions, they are significantly more likely to demand contraception to space pregnancies. Studies have shown that in many instances, decisions around family size and fertility, in the Nigerian context, fall outside of a woman's domain (Kahansim,2013). Interventions aimed to improve women's empowerment, particularly with reference to their own health, have been shown to increase women's uptake of contraception in the urban Nigerian context (Corroon et al., 2014). A case study regarding gender norms and decision-making in Tanzania reported a similar situation in which almost all men and women discussed family planning, but a gender inequality was still present in the execution of decisions with family planning; the final decision maker being the male (Schuler, Rottach & Mukiri, 2011). These findings suggest that communication between couples does not imply an equal status between husband and wife.

A comparison of the husbands' approval reveals greater differences in several countries. For example, in Kenya, only 58% of women with unmet needs reported that their husbands approved of family planning. The corresponding figure for contraceptive users is 86%. These differences persist even after controlling for background characteristics of the respondents such as education, age, and the area of residence. This finding implies that husbands' approval is one of the key factors contributing to unmet need. A study in Nigeria by Eko, Osonwa, Osuchukwu, and Offiong, (2013), has shown that most of the respondents had favourable attitude towards contraception. About 70.8% of respondents felt husbands should be involved in family planning decisions and this is imperative because men's approval

and decisions making has been said to be very vital in utilizing family planning and this further stresses the need to carry men along in family planning campaigns.

Furthermore, Tizazu (1994), in his study in south Ethiopia, Dalle Woreda, has also indicated that inter-spousal communication is related to higher level of family planning (contraceptive usage) and duration of use for women whose husbands approve use was found one and a half times higher than their counterparts. According to Piotrow and Rimon (1997), many family planning managers have seen men as obstacles to women's use of contraception due to power differentials, conflicting gender roles, and lack of economic resources. According to them, these factors have prevented many women from effectively negotiating the use of contraceptives and safer-sex practices with their male partners. 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 (Sharan & Valente, 2002).

A study conducted in Dunkwa-on-Offin, which is located in the Upper Denkyira District of Ghana, by Akafuah and Sossou (2008) revealed that participants in this study were involved in discussions about their interspousal communication patterns concerning family planning. According to most of the participants, the discussion of the number of children a couple should have is considered a taboo and culturally unacceptable. Participants believe that children are gifts from God and their numbers should not be negotiated. However, Interspousal communication was found to be more common among participants who were Christian and those in monogamous relationships. In a

case control study conducted in the Nkwanta district of Ghana by Eliason et al., (2014), it was indicated that women who discussed modern family planning with their partners were 4.67 times more likely to use modern family planning methods compared to those who did not discuss with their partners. Furthermore, women whose partners approved of modern family planning were 4.33 times more likely to use modern family planning than those whose partners did not approve.

Social, Cultural and Religious Factors

The principles of informed choice focuses on the individual; however, it also influences a range of outside factors such as: social, economic and cultural norms, gender roles, social networks, religious and local beliefs (Bosveld, 1998). To a large extent, these community norms determine individual child-bearing preferences and sexual and reproductive behaviour. It is usually thought that community and culture affect a person's attitudes towards family planning, desire for sex of children, preferences about family size, family pressures to have children and whether or not family planning accords with customs and religious beliefs (Dixon-Muller, 1999;Greenwell, 1996).

Community norms also reflect how much autonomy individuals have in making family planning decisions. The larger the differences in reproductive intentions within a community, the more likelier that community norms support individual choices (Bosveld, 1998;Dixon-Muller, 1999). Household and community influences can be so powerful that they can obscure the line between individual desires and community norms. For instance, in some culture, many women reject contraception because bearing

and raising children is the path to respect and dignity in the society (Barnett & Stein, 2000; Cherkaoui, 2000). In certain countries, most women use contraception because having small families is the norm (Lutz, 2003; Mkangi, 2001). People are often unaware that such norms influence their choices. In other cases, they are particularly aware. For example, young people often decide not to seek family planning because they do not want their parents or other adults to know that they are sexually active, while many fear ridicule, disapproval and hostile attitude from service providers and others around (Jejebhoy, 2004).

A person's social environment usually has more influence on family planning decisions that influence the attributes of specific contraceptives. In Kenya, for example, when new clients were asked to give a single reason for their choice of a specific family planning method, most cited the attitudes of their spouse or their peers, or their religious values (Kim, Kols & Mudieke, 1998). As a women gain more autonomy, they are better able to claim their rights as individuals including the right to act and protect their own reproductive health (Heise, Ellesberge & Gottemoeller, 1999). People choose contraceptive methods that are commonly used in their community because they know that it is socially acceptable to do so, and they tend to know more about these methods (Rogers & Kincaid, 2000; Valente, 1995).

Many women use the same family planning methods that others in their social network use. A 1998 study in urban Nigeria found that the more widely used method was the one that was popular in other cities and villages (Entwisle, Rindfuss, Guilkey, Chamrathirong, Curran, & Sawangdee, 1999). The entire community may be encouraged to use one type of contraceptive

based on the choices of early contraceptive users, rather than individual needs (Potter, 1999).

Social norms as well as health system factors were also identified as stymieing men's participation in reproductive health services. Men and women highlighted gender norms which assigned the role of child-bearing and child-rearing to women. Matters relating to fertility and birth planning were also considered to be within this domain (Kabagenyi, Ndugga, Wandera, & Kwagala, 2014). In a study conducted by Azmat et al., (2012) in Pakistan, mothers-in-law and husbands (emerge as a main social barrier affecting Family Planning decision making) and women are bound by social pressure for fertility. In a study conducted by Lanre (2011), in southwest Nigeria, it was observed that the socio-economic status of the couples of Southwest Nigeria, their religions, their cultural norms and their educational status did not significantly influence their choice of family planning. However, there are significant influences in the involvement of partners on the choices of family planning in Southwest Nigeria.

Furthermore, women often may not reveal the real reasons because of embarrassment, politeness, or other cultural constraints and instead substitute what they regard as more acceptable responses (Bongaarts & Bruce, 1995; Casterline, Perez, & Biddlecom, 1997; Nag, 1984). These limitations notwithstanding, the responses do provide some indication of the factors that prevent women from practicing family planning even when they wish not to become pregnant (Busbhan, 1997). A study conducted in Egypt by Eltomy et al., (2013), found out that cultural barriers were the most significant barriers to future use of contraception, followed by reproductive and demographic

barriers. In a study conducted in Pakistan by Hameed et al., (2014), it was asserted that the ages of women were directly linked with that of their husbands and the number of children. Thus, higher decision-making power increased with age and may be attributed to the cultural norm whereby a newly-married woman is expected to perform household duties under the supervision of her husband, or even the mother-in-law, who is the primary decision-maker (Dali, Thapa & Shrestha, 1992).

In a study by Ieda (2012), he showed that another factor that affects reproductive behaviour is religion. The participants in the study were either Muslims or Ethiopian Orthodox Christians, and in general they saw children as gifts from God, and many claimed that people must receive all what God gives them. Moreover, many thought that God decided the number of children and the timing of pregnancies, and that controlling this by using contraceptives was regarded as a sin. Therefore, some participants used contraceptives secretly or without really talking about it, because they were afraid of religious punishment by God or community members. The study therefore suggested that religion has a direct impact on contraceptive use, and that religion tend to create an anti-contraceptive atmosphere or at least cause frustration and ambivalence among potential users.

A study that explored reasons for low contraceptive use among young people in Uganda reported a similar situation (Nalwadda, Mirembe. Byamugisha. & Faxelid, 2010). The churches in the area were highly pronatalistic and the messages given from these churches were perceived as key obstacles to the use of contraceptives and contradictory to what partners, parents, teachers, cultural leaders and health workers were saying. The

position of the churches on this issue therefore seemed to put young people in a dilemma (Nalwadda, Mirembe, Byamugisha & Faxelid, 2010), creating the same type of ambivalence and frustrations as seen in our study. Also, a study by Ieda (2012), showed that the anti-contraceptive atmosphere set by religious leaders went against the wider community's views and general acceptance of using contraceptives causing frustration and ambivalent community members.

Religion also had an influence on gender norms. Muslim female participants tended to say that according to their religion "wives should follow their husbands' opinion", and we may say that religious norms support an unbalanced gender relationship, Also an educator in sociology, studied the influence of religion on fertility among different religions. He claims that religion is linked with other social characteristics and proximate determinants, such as level of education, type of residence, marriage age, contraceptive use and divorce (Heaton, 2011). In other words, single factors such as "gender norms" and "religious norms" can be related to and shape each other. Further, what influences people's perception and behavior related to reproductive behaviour can be influenced by different "modifying" factors, such as level of education, and must be viewed holistically (Ieda, 2012).

Some religions, such as Catholicism, have restrictions on contraception based on the belief that it is God's will to bring children into the world. According to Dixon-Muller (1999), religious believers or observers might choose to avoid certain methods of family planning, such as birth control pills, in an effort to live their lives according to the teachings of their religion (Lanre, 2011). Though it is not investigated much in Ghana, studies in different countries confirmed that religion has a profound influence on contraceptive

use and fertility pattern. To mention some few, a survey for contraceptive use in 1975 in India for Bangalore state has found that 15.6% of Hindus and 12.5% of Muslims were using modern contraceptives, and Muslims were found many fewer to Hindus in the adoption of both sterilization and other temporary methods for Bangalore and all other states in all social groups in the nation (Srikantan, 1993).

According to Roysten and Armstrong (1989), the Roman Catholic Church's opposition to intercourse with protection and Jewish law opposed to sterilization considering it to be a surgical impairment of reproductive organs and hence " deliberate interference with the natural practice of generation ", can also profoundly influence their followers. However, as Srikantan (1993) argues, religions like Islam, Hinduism, the Orthodox and Protestant Christian denominations have no spiritual basis for opposing family planning, but they might still discourage it subliminally in their teachings (Simeon, 2002).

Casterline and colleagues (Casterline, Perez & Biddlecom, 1995) reached this conclusion in their in-depth study in the Philippines that, religious opposition to contraceptive use is not a major reason for unmet needs in most countries.. In Bangladesh, Nigeria, Pakistan, and Senegal, however, survey data suggest that perceived religious opposition discourages some women from adopting contraception. In these countries, more than 10% of women with unmet needs do not intend to use contraceptives because of religious reasons. In Egypt and Bangladesh, women with unmet needs are more likely to think that religion is against contraceptive use than women who use contraceptives (Busbhan, 1997).

Wealthy women had two times higher odds of using modern contraceptives than poor married women. Married women who lived in rural areas had 30% lower odds of using modern contraceptives than urban married women. Educated women had better odds of using modern contraceptive methods than uneducated married women. Age had an inverse association with the use of modern contraceptive methods. Older married women had lower odds of using modern contraceptive methods than younger married women. Muslim married women had 30% lesser odds of using modern contraceptive methods than Christians. Women who had worked or been employed had a 30% lower odds of using modern contraceptives compared to married women who had no employment history. The number of living children a woman had was significantly associated with the use of modern contraceptive methods. A woman who had at least one child had higher odds of using modern contraceptives than a woman who had no children. Women who had polygamous marriages were by half less likely to use modern contraceptive methods than women in monogamous marriages (Lakew, Reda, Tamene, Benedict, & Deribe, 2013).

According to Saw (1989), spouses with better education, urban residence and paid work in non-agricultural sectors are more likely exposed to family planning information and, hence, develop a positive attitude towards it. In addition (Mahmood & Ringheim, 1997) have indicated that, better education, urban residence and paid labour in non-agricultural activities are associated with positive attitudes towards contraceptives and higher inter-spousal communication on family planning and higher contraceptive usage (Simeon, 2002).

Access to Contraceptives

Access to Family Planning services is an important determinant of contraceptive use. It is widely accepted that family planning services are essential to fertility decline. The proximate determinant of ongoing fertility decline in the developing world has been the widespread adoption of contraception. In Vietnam, the ease of obtaining contraceptives has been shown to be an important factor in the success of family planning programs. The level of awareness of a range of contraceptive methods provides a rough measure of the availability of family planning information in the country. In countries where people have more exposure to family planning messages on radio and television, people are aware of more methods (Ngom, & Binka 2002). There are two symbiotic drivers of contraceptive uptake: supply and demand. Although generating demand is critical in the uptake of contraception, it cannot happen in a context where the system cannot ensure a consistent supply of affordable and acceptable methods. There is an existing demand for contraceptives to space and limit fertility among currently married women that is not being met (Austin, 2015).

According to Bandarage (1997) and studies by others, large segments of the population concentrated in rural areas in developing countries face considerable difficulty in obtaining low-cost, high quality family planning services (Simeon, 2002). The rural people lack both knowledge to range of methods, accessibility and where to get them. Regarding women's knowledge of sources of supplies of modern contraceptives, studies by Mahmood & Ringheim (1997), confirmed that it is a strong predictor of contraceptive use. Furthermore, studies by Shelton et al, (1999), on the underlying reasons for

the rise of contraceptive prevalence in many developing countries in the 1990s, found that intensive community based distribution projects of modern contraceptives to be the major source of knowledge: where to get and how to use, in the period mentioned. Studies by Roysten and Armstrong (1989) in Mexico, South Korea, Bangladesh, Thailand and Philippines also confirmed that the closer a woman lived to a source the more likely she was to use contraceptives.

A study conducted by Lanre (2011) in southwest Nigeria has revealed in the findings that both upper and lower class levels, and rural and urban areas, have equal chances to the accessibility, affordability and availability of family planning services. In a comparative study on the availability of modern contraceptives in public and private health facilities in a peri-urban community in Ghana by Adjei et al., (2015) in the Ga East municipality of Ghana, it was indicated that for the private health facilities such as pharmacies and licensed chemical stores, the combined oral contraceptives, the emergency contraceptives and the male condoms were the most available contraceptives compared with other modern contraceptives such as injectable and long acting reversible contraceptives. The most available modern contraceptive in the public health facilities was the injectable and it was the only method available in all the public hospitals and clinics (100 %) in the municipality. The study only looked at providers' view on the availability of contraceptives without the views of the ultimate end user.

Bongaarts (2014), recently reiterated that dissemination of knowledge on the benefits and availability of contraceptive methods will not only lead to higher uptake among those who want to limit their fertility, but might also

change the attitudes (or willingness) of the ones that had not considered limiting the number of their off-springs before. The rural people lack both knowledge of a range of methods, availability and where to get them. Regarding women's knowledge of sources of supplies of modern contraceptives, studies by Mahmood and Ringheim (1997), confirmed that it is a strong predictor of contraceptive use.

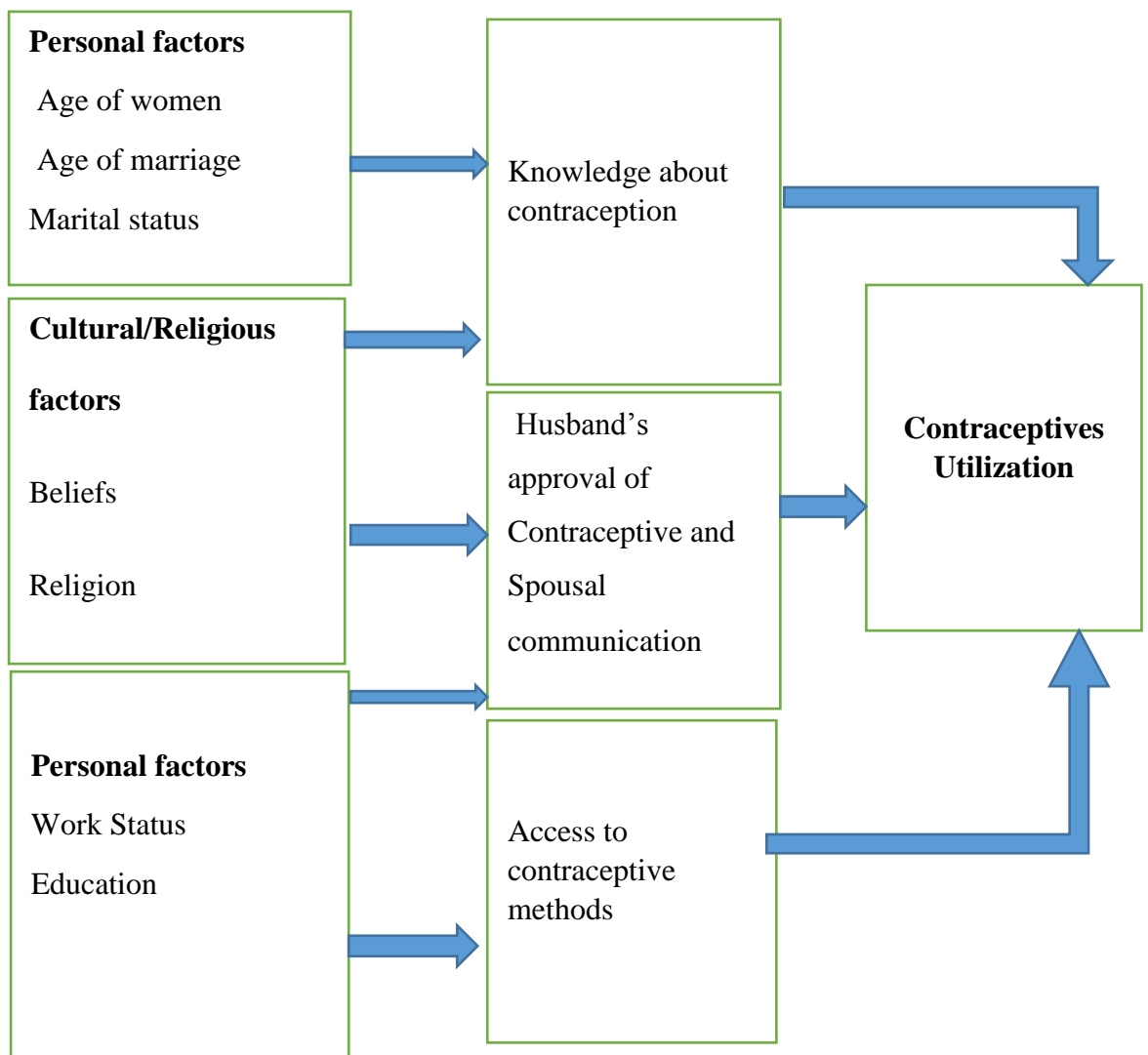
Conceptual Framework

The conceptual framework considers factors that determine whether a married woman will use contraception or not. First, a woman must be able to access knowledge upon which she should then form perceptions regarding accessibility and availability of a contraceptive method if she is to make a decision on her fertility regulation and contraceptive utilization. Second, the decision making process is influenced by motivation. The drive to regulate one's fertility is influenced by the socio-economic status of the individual, their culture/social and religious family life cycle. The use of any contraceptive method depends on the person's knowledge of the different contraceptive methods available and the willingness of both spouses to participate in the Family Planning program. The costs related to availability (geographical and physical, qualitative and cognitive aspects of availability), and cost related to social, cultural and familial disapproval of family planning (disapproval of family, religion and customs) influence contraceptive utilization.

A person's intention to behave in a particular way and his/her behavior depends upon two sets of factors: personal and social influences. Personal factors includes age of women and the individual's own positive or negative

evaluation of the behavior, while social includes religion, husbands' approval of the use of contraception and spousal communication as well as the accessibility of contraceptives. These influence the effect of an individuals' attitudes on one's behavior, hence, influences contraceptive utilization

Diagrammatic Conceptual framework: Use of Contraceptive Methods among Women.



Source: Adapted from Kaushik's model (Kaushik, 1999)

Chapter Summary

In summary, the literature identified and adapted Kaushik's conceptual model (Kaushik, 1999) which served as the conceptual model for the study. Some constructs of the model relevant to the study were adopted. Such were; personal factors which are demographic factors and delineates factors affecting contraceptive utilization. Personal factors include the individual's own positive or negative evaluation of the behavior, which deals with the knowledge about contraception. Empirical review was also done to explore research findings on knowledge about contraception on the domain of "what does contraception mean and knowledge of any method and of any modern method". The literature reviewed revealed that most of the research findings indicated excellent knowledge among participants. This was a good finding because knowledge in most cases aid in utilization of contraceptives and was related to this research which sought to explore the knowledge of married women on contraception.

Further empirical review of literature on Husbands' approval and spousal communication about contraception/family planning indicated that most of the participants of the studies reviewed demonstrated poor spousal communication and husband approval of contraception use. This was not a good finding because in most cases, poor or lack of spousal communication had led to husbands' disapproval and non-utilization of contraceptives. The review was also related to the study, in that, the study sought to explain the extent to which husbands' approval, and spousal communication influenced the use of contraceptive methods among married women.

Also, literature was reviewed to investigate how cultural, social and religious factors influenced married women's decisions on contraceptive utilization. The reviewed showed that most cultural, social and religious factors had more influence on family planning decisions and contraceptive usage. Literature was also reviewed on the effects of personal and social factors such as age of women, age of marriage, total living children, child loss, work status (income), standard of living, education and exposure to mass media. All the literature reviewed in this section indicated that, the personal and social factors indicated above had effects on married women contraceptive utilization.

The review also explored the literature on how access to contraceptives influence the contraceptive uptake of married women. Most of the reviewed studies showed that accessibility of contraceptives will lead to higher uptake among those who want to limit their fertility. The review was in tandem with one of the research objectives which seeks to understand how access to contraceptives influence contraceptive uptake among married women.

CHAPTER THREE

METHODOLOGY

Introduction

This chapter entails the various techniques that were employed by the researcher to collect the needed data for the study. It highlights the research design, population, sample and sampling procedure, instrument, pretesting of instrument, reliability of the instrument, data collection procedure, ethical issues and data analysis.

Research Design

The study employed a qualitative explorative descriptive design. Qualitative research is a naturalistic and interpretive inquiry. It involves the study of individuals or groups in their natural settings, attempting to make sense of phenomena in terms of the meanings the individuals/groups bring to them (Bassett, 2004; Creswell, 2007; Howitt, 2010). The purpose of this qualitative descriptive study was to explore, describe, and understand the factors affecting contraceptive uptake among married women. According to Kim, Sefcik, Bradway, (2016), Qualitative descriptive is a term that is widely used to describe qualitative studies of health care and nursing-related phenomena. A qualitative description design is particularly relevant where information is required directly from those experiencing the phenomenon under investigation and where time and resources are limited. This study aims at exploring, describing, and understanding of married women's opinion on the factors affecting utilization of contraceptive methods. It also seeks to explore how married women's knowledge influences their decisions related to contraceptive methods utilization. Qualitative description is a label used in

qualitative research for studies that are descriptive in nature. This genre is particularly common in qualitative studies of health care and nursing-related phenomena (Polit , & Beck, 2009; 2014).

Qualitative description has been identified as important and appropriate for research questions focused on discovering who, what, and where of events or experiences and on gaining insights from informants about phenomenon. Qualitative description is a suitable goal when a straight description of a phenomenon is desired or information is sought to develop and refine interventions (Neergaard , Olesen, Andersen, & Sondergaard, 2009; Sullivan-Bolyai , Bova , & Harper, 2005). Therefore, qualitative explorative descriptive design is the most appropriate design in exploring the factors affecting utilization of contraceptive methods among married women of reproductive age (15-49 years) in the North Gonja District.

Study Setting

The study was carried out in the North Gonja district, in the Northern Region of Ghana. The North Gonja District is located in the western part of the Northern Region of Ghana. It shares boundaries with West Gonja and Wa East districts to the West, Tolon District to the East, Mamprugu Moagduri and Kumbungu districts to the North and Central Gonja to the South. The district has a total land mass of about 4,845.5sq km representing 6.9 percent of the total land size of the Northern Region. It was selected for the study based on two criteria: (1) Socio-cultural diversity [existence of two main ethnic groups Gonjas and Tamplumas in the area], (2) low acceptance of family planning methods. The population is 51,696 and the main economic activities include farming, fishing and cloth (smock) weaving. The place is as

well noted for its natural iodised salt mining, which attracts tourist to the area. Some of the major events that bring home most of the sons and daughters of the area include the Damba and Smock weaving (Kutumbi) festivals, which are celebrated annually. The district has four sub districts namely Bawena, Daboya, Lingbinsi and Mankarigu sub district. The district has no hospital but contains one polyclinic (referral) facility in Daboya, three (3) public (governmental) health centres/clinics in Bawena, Lingbinsi and Mankarigu. The district has no private health facility. The study was conducted in the four (4) sub districts. The total number of women in their reproductive age found in the four sub district were 12,149 (Haruna, 2015).

Study Population

The target population has to do with all married women in the reproductive age (15-49 years) in the district. The study population that was used for the study is the sample of women in their reproductive age (15-49 years) in the district.

Sample Size and Sampling Techniques

The sample size for the study was dependent on data saturation. According to Houghton, Casey, Shaw and Murphy, (2013), saturation is achieved when new emerging data or themes are not forthcoming. The sampling technique that was employed in the study was the purposive non-probability sampling technique. This technique allowed sufficient recruitment of participants who met the inclusion criteria for the study. According to Creswell (2007), “purposive sampling entails the researcher selecting participants and sites that can purposefully inform an understanding of the research problem and central to the phenomenon of the study”. Sharan (2002)

also notes that, since qualitative inquiry seeks to understand the meaning of a phenomenon from the perspectives of the participants, it is important to select a sample from which the most can be learned.

The four sub districts namely: Bawena, Daboya, Lingbinsi and Mankarigu, were used for the study. The four sub districts represented peri – urban (Daboya) and rural areas (Bawena, Lingbinsi and Manarigu) respectively. From each districts, one ward was selected and from each ward one village was further selected; and from the village one street/hamlet was then selected as the study area. With the help of local leaders, the researcher employed purposive sampling to obtain sixteen (16) women aged between 15 and 49 for the face-to-face semi-structured interview.

Four (4) participants were then selected from each sub district who were within the age brackets and were married. This was done with the help of the local leaders of each respective area. Purposive sampling for variation enabled us to hear different opinions on the study subject. Within each sub district, a list of locations and sub-locations were generated, and one sub-location in each sub district was randomly selected and further smaller villages were randomly selected where respondents were screened and recruited for meeting the eligibility criteria. The field-based recruiters/local leaders assisted with identifying the women within the villages. A landmark within the villages was randomly selected, and field recruiters/local leaders visited households in a predetermined direction. Each fifth house- hold was approached to see if they had an eligible respondent. No more than one respondent per household was recruited, and if there was more than one eligible woman the youngest were chosen because the youngest always faces greater challenges with

decision making process in their reproductive health. This process was repeated until the sample of women reached saturation. The recruiters/local leaders then set a date for the interviewer to return to conduct the interview.

Data Collection Method

Data for the study was collected mainly through in-depth interviews. The interviews were conducted with the aid of an interview guide, which was developed based on the objectives of the study, the research questions, literature review and the constructs of the study. Since the purpose of the study was to explore the factors affecting utilization of contraceptive methods among married women of reproductive age (15-49 years) in the North Gonja District, interview was the best data collection method in gaining such an understanding. Before the actual data collection, a pilot study was conducted with two participants to determine if there were flaws with the semi-structured interview guide and to make the necessary corrections if any. The researcher did serve as the main instrument for gathering data in the study with his assistants. The researcher used flexible open ended questions and intentional silence during the interview to allow participants to express their thoughts.

The researcher also visited participants at their residences to familiarize himself with them and to consolidate the rapport building process a week to the interview. Again, the researcher started each interview with less sensitive questions before graduating to the sensitive ones and responses were probed or redirected where necessary during the interview to ensure rich and detailed responses were obtained from participants which were geared towards the fulfilment of the objectives. The interview guide was drafted in English and translated in Gonja/Tampluma and Dagbani. Interviews were then

conducted in Gonja/Tampluma and Dagbani by trained and highly experienced qualitative research assistants who has for the pass years engage themselves in UNICEF and WHO organizations research projects. The interviews were recorded on an audio-tape with permission from the participants to ensure that every aspect of the data is captured for analysis in order to fulfill the objectives. Lastly, the researcher took field notes of all non-verbal communications during the data collection process to enhance understanding of the data.

Data Collection Instrument

A self- developed interview guide was used as the study instrument. The interview guide contained five (5) sections with thirteen (13) open-ended questions which were developed based on the objectives of the study and the research questions. The interviews were conducted with the aid of a semi structured interview guide, which was developed based on the objectives of the study, the research questions, literature review and the construct of the study. Interview was the best data collection method because a semi-structured interview is flexible, supplemental questions will be added for each specific interview. This semi-structured interview format provided open-ended questions through which to explore multiple perspectives regarding contraception while ensuring that standard topics were covered to allow for comparisons.

Semi-structured interviews were conducted in order to examine the subjects' experiences and individual opinions of contraceptive usage. All the interviews were conducted by the researcher and his assistants. The interviewing was based on the use of an interview guide, which is a written list

of open-ended questions and topics that need to be covered, sometimes in a particular order (Bernard, 2002). Using an interview guide makes it possible to have some control of what you want from an interview, for example, that certain topics are covered, but there is still space for the researcher and the participant to follow new leads (Bernard, 2002). In-depth interviews were selected given the sensitivity of discussing sexual activity among married people; one-on-one sessions offered participants the chance to speak more freely and offered the interviewer the opportunity to probe factors affecting contraceptive use.

Another advantage of doing individual interviews is that the researcher can pay close attention to each participant. For instance, if a participant does not understand the meaning of the question or the researcher feels that he/she does not answer fully, the researcher can then ask the question in a different way or probe her (Bernard, 2002). On the other hand, an individual interview is reactive in the way that the information given from a participant depends on the relation between the researcher and the participant.

The research assistants and I were aware of this and actively paid attention to this aspect by being careful in relation to how we spoke and how we behaved. In particular interest to us were the participants' body language and signs that indicated whether or not they felt comfortable with the situation and the questions being posed. The interviews were recorded on an audio-tape with permission from the participants to ensure that every aspect of the data was captured for analysis. This is to determine if there were flaws with the semi-structured interview guide and to make the necessary corrections if any.

The researcher did serve as the main instrument for gathering data in the study.

Data Collection Procedure

The researcher used qualitative method of data collection. Single interviews were conducted to ensure privacy and avoid influence from others so as to elicit in-depth responses from respondents. The researcher conducted the interviews using an interview guide. The respondents were informed about the study and after their concerns were addressed, the researcher conducted reliable and valid copies of the interview guide to the proportionate respondents' in the four (4) sub-districts. Mostly, probing questions such as what?, why? and how? were used during the various sessions. The process continued until a saturation level was achieved (no new information or codes will be present).

The sessions were conducted at participants' convenience of time and place. Where necessary, the interview guide was transliterated into Dagbani or Gonja/Tampulima (local dialects) during the interview sessions. The researcher ensured the transliteration of the interview guide was done by another person who spoke and wrote this language to ensure accuracy of transliteration. The interviews lasted for approximately 30 to 45 minutes and were recorded on an audio-tape with permission from the participants. One interview was executed each day and the entire interview days lasted sixteen days. This facilitated reflection on, and consolidation of, emerging issues for further questioning and to ensure that every aspect of the data was captured for analysis. Participants were informed they had the right not to respond to

questions that were considered sensitive enough to unearth unpleasant memories during the interview session.

The researcher started each interview with general and less sensitive questions before asking the more sensitive ones. The researcher also used flexible open ended questions and intentional silence during the interviews to allow participants to express their thoughts. Again, the participants were encouraged to freely express themselves and each participant was asked to reflect on her experiences and on opinion with contraceptive use. Also, responses were probed or redirected where necessary during the interview to ensure rich and detailed responses were obtained from participants. The researcher took field notes of all non-verbal communications during the data collection process to enhance understanding of the data and to help in analysis. Lastly, a pilot study was conducted with two participants to determine if there were flaws with the semi-structured interview guide and to make the necessary corrections before the actual data collection.

Pre-Testing of Instrument

Pre-testing of the data collection instrument refers to testing the instrument prior to the actual collection of data (Polit & Beck 2008). A pre-test of the interview guide was done among two married women of age 22years and 20years respectively, who were within the reproductive age (15-49years) in Buipe community, which had the same characteristics of the study setting. The sessions were conducted at the participants' convenience of time and place, with each interview session lasting for about thirty (30) minutes to forty five (45) minutes. One interview was executed each day. This facilitates reflection on, and consolidation of emerging issues for further questioning.

The pre-test was done in order to assess the appropriateness and suitability of the questions and to find out whether the respondents understood the questions as intended, as well as their willingness to answer the questions. This helped the researcher to modify the language of some of the questions and also added it to the component. The pretest revealed that more probes need to be added to elicit more insightful responses from respondents. This led to the modification of the instrument which was used for the final research. The interview guide was drafted in English and translated in Gonja/Tampluma and Dagbani. Interviews were done in Gonja or Tampluma or Dagbani by the researchers depending on which of the languages the respondent was fluent in.

Ethical Considerations

Ethical clearance for this research was obtained from the University of Cape Coast Institutional Review Board (UCCIRB) with Ethical Clearance ID: (UCCIRB/CHAS/2017/19). The researcher also sought approval from authorities of the North Gonja District Health Directorate to conduct the study at the North Gonja District, with an introductory letter from the School of Nursing, University of Cape Coast. The authorities at the North Gonja District Health Directorate approved use of the study setting by issuing a certificate of authorization to the researcher, see (appendix A). All measures to maintain human rights including informed consent; the right to participate in the study, right to privacy and confidentiality and right to prevent from any type of harm was taken into consideration. In terms of confidentiality, the respondents were assured that the information will not be disclosed to anyone who is not directly involved in the study.

All Participants were informed about the objectives of the study and that their participation will be on voluntarism and none rock-solid for participation. For voluntary participation, the respondents were fully informed and volunteered to participate in the study after explaining the purpose of the study – for academic purpose only. It was clearly clarified that the information to be provided whether orally or in writing were for research purposes and will be strictly confidential. Local leaders in each of the sub districts were also invited to review and approve the study.

Anonymity, privacy and confidentiality were ensured during the interview. The respondents were promised that they will remain anonymous throughout the study, that is, their names/address will not be written on the questionnaire too. Consent were obtained from each participant for participation in the study. They were also informed that participation were voluntary and they had the right to withdraw from the study even after they had participated. Subjects were made comfortable and protected from any physical and mental harm in the course of the data collection. Initial findings of the study were presented to the district.

Inclusion Criteria

The criteria for inclusion in the study was all women, 15-49 years, of reproductive age and who were married and lived within the North Gonja district as well as willing to participate in the study and able to give informed consent.

Exclusion Criteria

The following people were not included in the study: a) women who were below the age of 15 years and above 49 years, b) women within the

reproductive age 15-49 years and were not married, c) women who were deaf and dumb, married or not married, d) women who were within the reproductive years 15-49, married and were not residing in the district, e) women who were unwilling to participate in the study, f) women who were with health /mental condition rendering it impossible to obtain informed consent or perform interview g) women who were too sick to give consent or to be interviewed.

Training of Research Assistant

Four people were recruited to serve as research assistants in the data collection process. These four research assistants were trained on the process and procedures of the data collection, how to probe and to ask flexible questions during the data collections stage. This was easily comprehended due to their previous similar engagement by UNICEF and WHO in the district. These four research assistants were added to the principal researcher to be five in number. Each of them was assigned to each of the sub districts in the data collection process to ensure confirmation, congruence and validation of data.

Data Analysis

All of the interviews were recorded with an audio recorder and transcribed verbatim. The interviews were either conducted in Gonja /Tampulima and or Dagbani depending on the language the respondent was fluent in. It was later translated to English. Because of time limitations, the research assistants were simultaneously translating and transcribing the interviews. Through this process, in order to increase our understanding and limit sources of misunderstanding, we did discuss the meaning of certain words and sentences used by the participants, as there might be different

possible interpretations. Many were used to confirm not only the linguistic meaning of the words/sentences but also the interpretation of them. Interview results were stored in electronic files. There was a list of the sessions conducted with the file names for each session. There was also a final notes from each of the sessions. Each of these files were included in the session notes as well as the background and impressions information.

Finally, there was a project file that included information about the status of the research data. For a complex project involving transcription, this file was a spreadsheet that included columns recording the date the session occurred, whether the transcription was complete, who was reviewing the transcription and whether the review was complete, the name of the primary and secondary coders and whether the coding had been completed, among others. This file included information regarding the interviewer and note-taker and the status of the notes.

According to Sharan (2002), data analysis is simultaneous with data collection in qualitative research. Sharan (2002) further notes that, simultaneous data collection and analysis allows the researcher to make adjustments along the way and to test emerging concepts, themes and categories against subsequent data. To achieve this, data from the study were analysed concurrently with data collection using thematic content analysis. The researcher begun analysing the data with the first interview and on the grounds on each selected sub district and compared in line with selected variables. Thematic content analysis is a method of identifying, analysing and reporting patterns/themes within the data. It organises and describes the data set in rich detail (Braun & Clarke, 2006). It has also been introduced as a

qualitative descriptive method that provides core skills to researchers for conducting many other forms of qualitative analysis. In this respect, qualitative researchers should become more familiar with thematic content analysis as an independent and a reliable qualitative approach to analysis. Braun, & Clarke, (2006), suggest that it is the first qualitative method that should be learned as it provides core skills that will be useful for conducting many other kinds of analysis. A further advantage, particularly from the perspective of learning and teaching, is that it is a Method rather than a methodology (Braun, & Clarke, 2006; Clarke, & Braun, 2013). This means that, unlike many qualitative methodologies, it is not tied to a particular epistemological or Theoretical perspective. This makes it a very flexible method, a considerable advantage given the diversity of work in learning and teaching.

According to Braun, & Clarke, (2006) thematic content analysis entails familiarising with data , generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report.

Interviews were transcribed and translated into English. The data were coded using a set of pre- set codes based on the discussion guide as well as emergent themes. The thematic coding framework was then applied to assess all interview transcripts. The analysis looked for patterns and associations on the emerging themes, focusing on the factors affecting utilizations of contraceptive methods uptake.

Quotations from the study participants were used to characterize emerging issues and themes. Each printed transcript was read and reread many times to gain a sense of the whole and to get familiarised with the content of

the transcript. While the transcripts were read, the researcher searched for similar ideas, thoughts and words within the data and these made up the codes. Identified codes were written against the lines of the transcripts where the codes were found in the right margin, created on the printed transcripts. Each transcript was handled in this same manner, and new codes that emerged during the process were added until all the transcripts were coded. Following the coding, all information belonging to a code were copied and pasted in separately labelled Microsoft word files in a computer. Subsequently, the entire codes were jotted on a piece of paper to form a long list of codes and the relationships between the codes were analysed and similar codes grouped into themes and sub-themes. After the themes were formed, they were reviewed but one theme was collapsed because there was not enough data to support it. Meanwhile, the researcher reached consensus with his supervisor during the coding process and some codes were moved to appropriate files.

Data Management

The researcher manually managed the data that was generated from the study. In managing the data, each participant was assigned a code (001 to 016) in the order of recruitment into the study. Pseudo names were later used to replace the codes. Also, the interviews that were conducted in Dagbani, Gonja and Tampilima (local language) were transcribed verbatim to English language by a person fluent in both Dagbani and English, Gonja and English and Tampilima and English languages respectively. The researcher explained the need to maintain confidentiality to the translator. Again, the interview materials (tape and transcripts) were separated from the demographic information sheets of participants and were kept under lock and key in the

researcher's custody. Only the researcher and his supervisors had access to them. The transcripts will be kept for five years following completion of the study and if they are needed for further analysis, ethical clearance will be obtained.

Methodological Rigour

Rigour in qualitative studies has to do with the ability to determine whether the findings of a study actually represent the participants' voices and can be trusted. Creswell (2007), defines rigour to mean the researcher validating the accuracy of the accounts using one or more of the procedures for validation, such as member checking, triangulation of sources of data, or using peer or external auditors of the accounts. A number of concepts have been cited in qualitative literature as the major criteria for establishing trustworthiness in qualitative research. They include credibility, transferability/fittingness, mdependability, and confirmability (Kumar, 2011).The researcher ensured trustworthiness in the study using the above criteria.

According to Trochim and Donnelly (2007), 'credibility involves establishing that the results of qualitative research are credible or believable from the perspective of the participant in the research'. As qualitative research studies explore perceptions, experiences, feelings and beliefs of people, it is believed that the respondents are the best judges to determine whether or not the research findings have been able to reflect their opinions and feelings accurately. Hence, credibility, which is synonymous to validity in quantitative research, is judged by the extent of respondent concordance whereby you take your findings to those who participated in your research for confirmation,

congruence, validation and approval. The higher the outcome of these, the higher the validity of the study. To achieve credibility in the study, the researcher purposefully recruited participants that met the inclusion criteria and who could provide in-depth information on their perceptions, experiences, feelings and beliefs about contraception. The researcher also spent sufficient time in the field to gain a fuller and deeper understanding of participants' 'perceptions, experiences, feelings and beliefs with contraceptive usage. Credibility was further enhanced in the study through member-checking. According to Houghton, Casey, Shaw and Murphy (2013), member-checking involves allowing participants to read the transcripts of their interviews to ensure that these have been accurately recorded and are therefore credible. Transcripts of the interview were taken back. Also contraception perceptions, experiences, feelings and beliefs to the participants were explained to them in the local dialects for comments and verifications before conclusions were drawn from the data.

Transferability refers to the degree to which the results of qualitative research can be generalized or transferred to other contexts or settings (Trochim & Donnelly, 2007). Though it is very difficult to establish transferability primarily because of the approach you adopt in qualitative research, to some extent this can be achieved if you extensively and thoroughly describe the process you adopted for others to follow and replicate. Transferability was achieved in the study through vivid description of the research setting and by employing a sample size large enough to yield data saturation. Additionally, the researcher outlined detailed and thick description of field experiences and transcripts of the study in order to give explicit

accounts of how conclusions were drawn from the study. Finally, analysis of the transcribed data has been kept for reference purposes. This will provide the means for other researchers to transfer the conclusions of the study to other similar settings.

Dependability in the framework suggested by Guba, and Lincoln, (2008) is very similar to the concept of reliability in quantitative research: 'It is concerned with whether we would obtain the same results if we could observe the same thing twice'(Trochim & Donnelly, 2007). Again, as qualitative research advocates flexibility and freedom, it may be difficult to establish unless you keep an extensive and detailed record of the processes for others to replicate to ascertain the level of dependability. In achieving dependability in the study, the researcher maintained an audit trail by giving a transparent and in-depth description of the research design, background of participants and the methods used in collecting and analyzing the data. The researcher also employed the services of another researcher not involved in the study to examine and make comments on the processes and findings of the study. The purpose was to evaluate the accuracy and assess whether or not the findings, interpretations and conclusions were actually supported by the data.

Confirmability refers to the degree to which the results could be confirmed or corroborated by others (Trochim & Donnelly, 2007). Confirmability is also similar to reliability in quantitative research. It is only possible if both researchers follow the process in an identical manner for the results to be compared. It also refers to the researchers' ability to demonstrate that the data represent the participants' responses and not the researcher's biases or viewpoints. In ensuring conformability, the researcher ensured that

the findings of the study reflected the participants' experiences and not the researcher's. This was achieved by the researcher reflecting on his own biases and prejudices and bracketing and controlling them before the data was collected. To further ensure confirmability in the study, the researcher provided rich quotes from the participants that depicted each emerging theme and provided in-depth description of how interpretations and conclusions were drawn from the study.

Chapter Summary

The study employed a qualitative exploratory descriptive design approach. It was conducted on a sample of 16 married women within the reproductive age (15-49years) in the North Gonja district. The sample size for the study was dependent on data saturation. A purposive sampling technique was used to select the participant. Four (4) participants were selected from each sub-district that is within the age brackets and were married. This was done with the help of the local leaders of each respective area. Purposive sampling for variation did enable us to hear different opinions on the study subject. Data was collected using a self-developed face-to-face semi-structured interviews, with the aid of an interview guide which was developed based on the objectives of the study, which was also in turn derived from the constructs of the model that informs the study. To achieve credibility (Validity) in the study, the researcher purposefully recruited participants that met the inclusion criteria and who could provide in-depth information on their perceptions, experiences, feelings and beliefs about contraception.

The researcher also spent sufficient time in the field to gain a fuller and deeper understanding of participants' perceptions, experiences, feelings and

beliefs with contraception. Credibility (Validity) was further enhanced in the study through member-checking. Member-checking involves allowing participants to read the transcripts of their interviews to ensure that these have been accurately recorded and are therefore credible. Transcripts of the interview were taken back. Also, contraceptive perceptions, experiences, feelings and beliefs of the participants were explained to them in the local dialect for comments and verifications before conclusions were drawn from the data.

In achieving dependability (Reliability) in the study, the researcher maintained an audit trail by giving a transparent and in-depth description of the research design, background of the participants and the methods used in collecting and analyzing the data. The researcher also employed the services of another researcher not involved in the study to examine and make comments on the processes and findings of the study. The purpose was to evaluate the accuracy and assess whether or not the findings, interpretations and conclusions were actually supported by the data. Data obtained from the study were analyzed using thematic content analysis.

The findings of the study may not be generalizable to other districts because the study was conducted at North Gonja and hence the findings could be peculiar to only the North Gonja district. The researcher, being a nurse, could have influenced the responses of participants (social desirability bias). However, this was avoided as much as possible by pre-testing the interview guide and allowing the participants to give their opinions, views and experiences without any prejudices on the subject matter.

Additionally, funding difficulties, inaccessible roads and the limited time for this study were limiting factors in the entire research work. Furthermore, the study employed a qualitative interpretive phenomenological design. Qualitative research is a naturalistic and interpretive inquiry: It involves the study of individuals or groups in their natural settings, attempting to make sense of phenomena in terms of the meanings the individuals/groups bring to them and data collected at one point in time. As such, in-depth meanings of answers as well as further clarification of answers were sought from participants.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

This chapter presents and discusses the findings of the data generated from participants on their perceptions, experiences, feelings and beliefs about contraception. The findings and discussion of the study are presented under the constructs of the conceptual model and the objectives of the study. The study sought to explore the factors affecting utilization of contraceptives among married women of reproductive age (15-49 years) in the North Gonja District. The study employed a qualitative exploratory descriptive design. A sample size of 16 was used for the study which was dependent on data saturation. A purposive non-probability sampling technique was used to draw all the 16 married women aged 15-49 years for the study.

Data for the study were collected mainly through in-depth interviews, with the aid of a semi structured interview guide, which was developed based on the objectives of the study, the research questions and literature review. Using thematic content analysis, six major themes emerged from the data collected with their corresponding sub-themes. The chapter will first highlight the demographic characteristics of participants in the study. This will be followed by a presentation of the themes identified and the discussion of the results.

Results

Demographic Characteristics of Participants

The study sample was 16 married women between the ages of 15-49 years. Six of the participants were in their twenties, seven were in their thirties and three were in their forties. With their levels of education, two of the participants had tertiary education and six had secondary education. With the remaining eight, six had no formal education while two had primary education. Four of the participants were Christians and the rest were Muslims. Ten out of the sixteen participants had never used any contraceptive method before, four were current users and two had ever used (former users) a contraceptive method before. In all, the number of children that the participants had ranged from one to six.

In relation to their occupation, two of the participants were public servants and six were self-employed. One was a house wife and the remaining seven were unemployed. Majority of the participants (seven) belonged to the Tampilima ethnic group while five participants belonged to the Gonja ethnic group. Four were from different tribes; One Mamprusi, One Bulsa, One Fulani and One Kassin. All participants could speak Dagbani aside their native language. Participants' life experiences with contraceptives ranged between six months and five years. Their residential locations varied between peri - urban and rural settlements in and around the North Gonja District.

In the ensuing sections, the identified themes and their corresponding sub-themes are discussed (Table 1). The presentation of findings via the main themes and sub themes are supported by verbatim quotations from the

interview transcripts. The main themes include; knowledge on contraceptives, gender relations, cultural issues, social issues and availability of resources.

Table 1: Themes and Sub-Themes from Transcribed Data

NUMBER	MAIN THEME	SUB-THEMES
1.	Knowledge on contraceptives	<ul style="list-style-type: none"> • knowledge of contraceptive methods • Source of information • Misperception about contraceptives
2.	Gender relations	<ul style="list-style-type: none"> • Couples communication • Spousal disapproval • Male domination
3.	Cultural issues	<ul style="list-style-type: none"> • Preference for large families • Family pressure • Children as supporter of parents • Children as successors
4.	Social Issues	<ul style="list-style-type: none"> • Social stigma • Shyness
5.	Religious Belief	<ul style="list-style-type: none"> • Religious ambivalence
6.	Availability of resources	<ul style="list-style-type: none"> • Access to contraceptives • Non availability of certain contraceptives • Inadequate human resource capacity

Knowledge on Contraceptives

The three most commonly reported (either spontaneously or when probed) by the married women interviewed on their knowledge about contraceptives were knowledge of contraceptive methods and how it works, misinformation and misperceptions about contraceptive methods and their sources of information.

Knowledge of Contraceptive Methods

There were varying degrees of knowledge observed in the study. Generally, twelve (12) out of the sixteen (16) participants demonstrated

inadequate awareness about contraceptive methods and a general lack of understanding about the appropriate use of contraceptives, how it works and its effectiveness. This was expressed as follows:

“I only hear people mentioning contraceptives contraceptives. I can't mention the name of one. I don't really know how it is use and how it works but I've heard about it. I don't know that much about it”. (Non User, rural)

Another woman share similar sentiment and she opined:

“I heard there is something like tablets I have not seen or taken it but i heard of it and that you take it and it will accumulate in your body before it will work. They say is colour, colours then you follow it and take it. I don't really know how that works but I've heard about it. I don't know that much. Actual I have not taken any before I only heard it from people”. (Non user. peri-urban)

However, while recognising that some of these knowledge gaps are common to all married women, some women demonstrated high degrees of knowledge about contraceptive methods, it appropriate use and its effectiveness. Four (4) out of the sixteen respondents in the study were familiar with one to three contraceptive methods. Among current and former users, the ones which were personally familiarized and used appropriately were with the pills, injectable and the implants. As one of the participant pointed out:

“I know the pills, injectable and the implant .The pills is taken one tablets a day.it should not be skip or missed per day when you do miss taken it in a day, then you take it in the morning and evening for that days own .if you remembers in the evening for not taking it then you

take two tablets in the evening. If it so happened that you forgets to takes it for more than two days then you have to change a sachets. For the injection it is taken every three months or monthly. The implant is done for three years". (User, peri-urban)

Another married woman opined:

"The little thing that I know is about the injection, implant and pills. The injection are of two types there is one you take monthly and the other is taken every three month whiles the pills is taken daily starting from the yellow pills to the red pills and when you forget of taken it in a day and you remembers the next day then you take it immediately .whiles the implant is taken for every three years.

She continued to say:

"When I took the implant it really disturb me a lot I was fallen sick always and when I get my menses it does not stop at all. when I changed to the injection I realized that it was still the same with regards to the menses not stopping when it comes and it always make me fall sick and disturbs me a lot. i again changed to the pills(tablets) and it was far better for me as I was not fallen sick and my menses not flowing excessively and it stops for some few days. The pills is good for me it does not disturb me". (User, rural)

Sources of information

Married women received both true and false information from a variety of sources, including friends, family and the society. Out of the sixteen (16) participants interviewed, twelve (12) reported that they got know of contraceptives through family and friend. This was expressed as follows;

“My friend first talked to me about contraceptives. She said when she wanted to use contraceptives she was introduced to the pills and she used the pills. That’s what made me try it”. (User, Rural)

Another woman pointed out as follows;

“It was my mother who talked to me about contraceptives she said she once used the pills. But that if I want to use any I should go to the clinic and see the midwife.” (Non User, Peri-Urban)

Another woman shared similar sentiment and she commented:

“I heard of contraceptives within the community here .it was been discussed by fellow women, they were talking about the injectable and that it is taken every three months in the clinic.it was the only one I heard them talk about. I have not taken any since”. (Non User, Rural)

While family, friends and society can be trusted sources of information, sometimes this casual information sharing can perpetuate misinformation. A thirty year old married woman echoed

“.....because am not educated on contraceptives and also I have not been to school to read things about it. I always hear friends mention them and don’t know anything about them and can’t even mention any one .they even say that if before you go in for contraception they will test your blood to see which one will be good for you before they give you, and that if your blood does not matched well with any one and you use it, it won’t work or you will become infertile”. (Non User, rural)

Another woman narrated:

“In our community here people say when you use contraceptive and later you stop and want to give birth

that you will never become pregnant neither for you talking of giving birth”.(Non User, peri-urban)

However, according to the four (4) users of contraceptives out of the sixteen participants, friends and family were major sources of information and influence. This was expressed as follows:

“I was told about contraceptives by my friend and she advised me to go in for the implant that will make me space my children well because I have five children and one died and my husband still want more children. Also any time I become pregnant I will not feel well for some time till the pregnancy is quite advance.so I was like is a good idea and I went to the clinic and did it for three years”.(User, rural)

A thirty year old woman remarked as follows:

“I got know contraceptives through my late mother who was a nurse. My mum had influence me greatly about contraceptives. So when I gave birth to my third born and I was having difficulties I discussed it with my husband and we went to the hospital to see the family planning nurse and she further counsel me about it and I chose the pills”.(User, peri-urban)

Misperceptions about Contraceptives

Almost all the respondents reported misperceptions about contraceptives and their effectiveness. In general, interviewees demonstrated a high sense of misperception about contraceptives. Out of the sixteen (16) participants interviewed, ten (10) insinuated that contraceptive usage is associated with birth defects or abnormalities. As one woman stated:

“I heard that when you use contraceptives especially the implant and IUD and later gives birth, the children will

not be strong and they will have problems with some of their body part. So am scarred to use those methods it is only the injection I am using and when I give birth after stopping the injection I give birth normal without the baby having any deformity". (User, rural)

Another woman shared similar sentiment, she said:

"You hear some people say that when you use contraceptives for some time in the future you won't give birth to normal children again".(Non User, peri-urban)

However, some of the respondents were also of the view that contraceptives could disrupt the natural processes of the body and create harm. Out of the sixteen (16) participants interviewed, ten (10) insinuated that contraceptive could disrupt the natural processes of menstruation. One woman commented:

"I hear some of the contraceptives makes the woman not to have her menses. If you are a woman and you are not menstruating later you will fall sick because of that. Because you are not in your menopause and the dirty blood will not come out it will go and accumulate somewhere and later cause you a disease in which you might not know it is the cause".(Non User, rural)

Another woman echoed:

"Some say the most common problem some of the contraceptive have that I hear is causing a woman not to menstruate when taking them it worries my mind because if you are not in your menopause and you do not menstruate it means you are retaining dirt and that

will cause you a disease like fibroid”.(Non User, peri-urban)

Furthermore, most of the respondents reported misperceptions concerning a particular contraceptive intake. They associated the injectable contraceptive with potential changes in weight gain. Out of the sixteen (16) participants interviewed, nine (9) insinuated that the injectable contraceptive causes weight gain. This was expressed as follows:

“I know a lady who is using the injectable and she has grown very fat and big meanwhile she is a young lady and now she looks like a grown up lady meanwhile she is a young lady”. (Non user, rural)

Another respondent pointed out:

“In our community here when a woman is growing fat people say you are using contraceptive methods”. (Non user, peri-urban)

Gender Relations

One of the expectations was that husbands would communicate and offer support to their wives in various ways towards their contraceptive decisions. However, from the discussion, almost all that is out of the sixteen (16) participants interviewed, thirteen (13) of the women reported that their husbands were unable to play these expected roles for several reasons. The three most commonly reported issues were couples' communication, spousal disapproval and male domination.

Couple Communication

Communication among the couples is important in contraceptive usage and decision- making on the number of children a couple wants to have, as well as the reproductive health issues and the biological lives of couples. In

the study setting, most of the respondents that is out of the sixteen (16) participants interviewed, ten (10) indicated that there was no communication among them on the use of contraceptives. This was expressed as follows:

“In this community couples do not discuss contraceptive use. This is because if the husband does not discuss it with the wife, then the woman sometimes fear to start such discussion”. (Non user, rural).

Another woman shared similar sentiment and she said:

“I can’t discuss contraceptives issues or the number of children to have with my partner because he is the breadwinner of the family and the decision maker of the house and apart from that children are a blessing from Allah, and knows what they will eat and will provide for his creatures”. (Non User, per-urban)

Furthermore, the findings showed that some people believe that discussing contraceptive issues with their partners was not that important. It was difficult for some women to engineer discussions, as they perceived that men largely made key family decisions. One woman commented:

“I do not discuss contraceptive issues with my husband because he thinks it is not important and think that contraception is women issues, that is why I don’t discuss it with him”.(User , rural)

Another woman opined:

“If the head of the family that is my husband, does not start any discussion on contraceptives I can’t because he is the breadwinner of the family, decision maker, including the number of children to have and the use of contraceptives”.(Non user, rural)

However, some of the participants expressed different perceptions by indicating they talk about contraceptives with their husbands that is out of the sixteen (16) participants interviewed, four (4) indicated that. One woman said:

“It is very easy to communicate with my husband. If am chatting with my husband is like am chatting with my best friend or brother.my husband is friendly and very open, I talk to him as and when I want to and he always listen to me. I discussed contraceptives use with my husband and number of children to have so that we can take good care of them”. (User, rural)

Another woman echoed:

“I easily communicate with my husband on any matter including contraceptive use .when I had the admission to go to school and was thinking about going in for contraception I talked to him we discussed it and we agreed”.(User, per-urban).

Spousal Disapproval

The participants cited lack of spousal approval as a factor that militates against the use of contraceptives. Most women reportedly, that is out of the sixteen (16) participants interviewed, twelve (12) stated that their husbands were not in support of their use of contraceptives because they wanted many children. One woman stated:

“My husband want many children and this makes him stop us from taking up contraceptives”. (Non Users, rural)

Another woman shares similar sentiment:

“For me my man does not want to hear any concerning family planning or contraception because he want many children”. (Non user, peri-urban)

However, some of the participants reportedly that is out of the sixteen (16) participants interviewed, ten (10) stated that their husbands were not in support of their use of contraceptives because they had fertility concerns regarding the usage of contraceptives. This was expressed as follows:

“My husband is of the view that if a woman uses contraception and after sometime she want to give birth the woman cannot become pregnant so he won’t allow me to take up contraception”.(Non User, peri- urban)

Another woman echoed:

“When I was told about contraceptives by my friend and I decided to use contraceptives I went to the Daboya for the implant, because I knew my husband would not support the idea and later when he discovered that am using contraceptives he instructed me to go and discontinued it and that it might make me not to give birth if I continue to use it”. (User, rural)

Male Domination

The findings show that out of the sixteen (16) participants interviewed, thirteen (13) participants were of the view that, traditionally, men are the heads of households and decision-makers in all issues in these respects. Men decide on contraceptive use, the number of children and the general decisions in the family. Also, the findings showed that since men were the decision-makers, they were expected to initiate discussions on contraception. Men were cited as the sole providers for their family needs. Women were not considered decision-makers, but implementers of what had been decided by men, without questioning the decisions. As one woman commented:

“My husband told me he is the head of the family and that whatever he likes I should also like it and follow it.

He said, he does not want me to use contraceptives because he wants many children.

She continued:

“.....and the problem is that when I am pregnant I won't be myself till the pregnancy is advanced and whenever I give birth it won't be long and I will conceive again .meanwhile I gave birth to five and one died leaving four .so my friend advise me to go in for contraception and because I did not want my husband to know I went to Daboya because here in Bawena the nurses are his friends and they might inform him.so I went in for the implant as this can take for so long before I go to the clinic again. Unfortunately he detected it and during that period I was sick and he alluded my sickness to it and told me to remove it which was against my wish and I went and remove it”.(User, rural)

Similar view was shared by another woman and she states:

“The man is the head of the family in our tradition and he decides on everything including decision to use contraceptives. So he is one who has the final say whether you should go in for contraception or not, when you go in without his consent then it means you have disobeyed your husband. Right now am not been able to conceive he thinks am doing contraception and I told him that am not using any contraceptive methods”.(Non user, peri-urban)

Another commented:

“My husband is the one in control of the family he decides on the number of children to have. If you talk about contraceptive use he will ask you that, are you the one who feeds the children? Or whether you are the one paying the children school fees?” .(Non User, rural)

Cultural Issues

Regarding this major theme, the participants shared their experiences on the various cultural challenges they faced as regards contraceptives uptake. Four sub-themes emerged under this major theme. These were preference for large families, family pressure, children as supporter of parents and children as successors.

Preference for Large Families

Most of the women, that is out of the sixteen (16) participants interviewed, twelve (12) reported a general preference for large families in the community as a factor that affect contraceptive usage. Commonly cited reasons were that in case of tragedies like death of children, the practice of encouraging large families will ensure some are alive. Those who had less would have none if calamity befell their children. One woman commented:

“I like more children and my husband also likes more children, this is because if you give birth to let say two children and you say you won’t give birth again and God forbid one dies of malaria and the other dies of cholera, then you will be left with no child. That is why is good to give birth plenty”. (Non User, rural)

Another married woman pointed out:

“I and my husband’s prefer many children because if we give birth to one and he or she dies. But I told him that it would not be good to give birth to many children and at the end of the day you cannot take care of them by sending them to school or when a child is sick and you cannot afford the medical bills. I suggested to him for me to go in for contraceptives and he accepted. However any time we need a child I will stop the

injection and become pregnant and after delivery I continue". (User, peri-urban)

Similarly, childbearing was seen as a race against the biological clock for women. These women wanted to have their required number of children before reaching their menopausal stage and hence stayed away from contraceptives. One married woman echoed:

"Hmmm for a woman when you marry you just have to give birth to all the children in your womb or else you will soon get your menopause and your time for giving birth will be over. Men don't have time limit for bringing forth children but women have". (Non User, peri-urban)

Another married woman pointed out

"Now a day I hear some women get their menopause in their late thirties because of that it is important we give birth to these our many children before your menopause surprise you". (Non User, rural)

Family Pressure

Most of the women, that is out of the sixteen (16) participants interviewed, ten (10) also indicated that the pressure from immediate and extended family members, as well as the older community members who believed in large numbers of children, promoted this within the community. Furthermore, their in-laws were regarded as desiring many children, and if this was not fulfilled, they put a lot of pressure on the men to marry other wives. This fear ushered them into giving up and rejecting contraceptives. One married woman commented:

".....immediately after school my mother was always asking me why am I not giving birth because I have finished the school, that we are only five and not many

and I do not also want to give birth to many children. The old people they want us to give birth to plenty children. Also, my mother in-law always asked me why I have finished school and do not want to be pregnant".
(User, peri-urban)

Another shared a similar sentiment and said:

"In this community if you are using contraceptives and you are not giving birth there is pressure from in-laws, friends and the elderly in the community asking your husband to marry even if it is a consensual agreement between you and him to use contraceptives". (Non User, rural)

Children as Supporters of Parents

Generally, that is out of the sixteen (16) participants interviewed, eleven (11) participants expected their children to support their parents, and mentioned having children meant getting support both at a younger age and at a later age in life. When the children are young, parents expected them to help with daily work, for instance, farming for male children, and fetching water for female children. The role of children in daily work was thus important, as more helping hands in the house and on the farm alleviated pressure from the parents. Parents also received support from their children when they became older and frail. One woman from the interview said:

"My husband has three wives am the youngest and the male children helps their father in the farm and that brings a lot of food to the house. The females helps their mothers in cooking and fetching water". (Non User, rural)

Another married woman said:

"if you become old and you can't fend for yourself the children will take care of you when you are sick, feed

you and provide everything for you”.(Non User, peri-urban)

Children as Successors

The respondents also indicated the importance of children as successors. Out of the sixteen (16) participants interviewed, ten (10) were of the view that if the parents passed away without having children, their properties, including chieftaincy title, houses, farmlands, and livestock can easily be taken by others. One of the respondents said:

“In our culture giving birth to so many children is link with prestige and honor and the man will seat back and be contend that when he dies he will have children to ascend to his throne if he is chief or from a royal family take over his”.(Non User, rural)

Another woman shared similar sentiments. She remarked:

“When couples give birth to children they nurture them to take over from their parent the family fortune, house, farm land and properties after their demise. As to perpetuate their family business or occupation”. (User, peri-urban)

As the above comment, married women referred to their disappearance after their death by having no children and also mentioned the fear of being forgotten by others after their death if they did not have any children. Having children was one of the essential factors of gaining respect in the community. Furthermore, children played important practical and symbolic roles as supporters and successors and this importance is related to the fear of the disappearance of one’s legacy and lineage after the death.

Social Issues

Regarding this major theme, the participants shared their experiences on the various social challenges they faced regarding contraceptive uptake. The two most commonly reported social issues by participants either spontaneously or when probed were social stigma and shyness.

Social Stigma

Generally, Out of the sixteen (16) participants interviewed, thirteen (13) participants expressed worry and fear following the stereotypical nature of members in the society with regard to the usage of contraceptives. Some of the participants were of the view that when people get to know a person uses contraceptives, she is singled out and discussed in social gathering. As a woman pointed out:

“In this community when a woman uses contraceptives and the people within the community get to know they talk about you, point fingers at you and makes you feel uncomfortable as if you have done something wrong or kill somebody. This makes most women not to use contraceptives despite them having the need for it”.
(User, rural)

Another woman remarked:

“People will talk about and look at me in the community when I begin to use contraceptive and they get to know. This is why I cannot go in for contraception”. (Non user, peri-urban)

Women also shared concerns raised by their spouses or partners on the use of contraceptives. This, according to them echoed their own concerns about the social outcomes. Male partners raised concerns that the usage of

contraceptives results in social stereotyping. Generally, women fear the society, their husbands and being noticed by the society for buying contraceptives and as a result, they tend to acquire them from the nearby communities to ensure confidentiality on this. One woman said:

“Our husbands want more children and the society because of that if you are using contraceptives it looks as if you have done something wrong they even “eye you”.”(Non User, peri-urban)

Another respondent remarked that:

“...and because my husband did not want contraceptive use I secretly went to Daboya to do the implant so that people will not see me and tell him.”(User, rural)

Shyness

Most of the participants in the study that is out of the sixteen (16) participants interviewed, ten (10) verbalized their inability to discuss basic reproductive concerns including contraceptive issues with health volunteers, nurses or anyone else because of shyness. As a result, most of the participants do not seek support from family members, friends, spouses and nurses to be able to utilize these contraceptive methods and other reproductive facilities in their communities. A thirty year old woman had the following to share:

“I once asked my fellow woman why she is not considering using contraceptives because she give birth most often and has six children now she said she feel shy. She said that how can you go to the clinic and tell madam that you are coming for contraception just like that, me I can’t.”(User, peri-urban)

Another woman shared similar sentiments. She commented:

“In Bawena here most women feel shy to come to the clinic to take up contraceptives”. (User, rural)

Religious Beliefs

Religious beliefs is an important factor that influences every human attitude, behavior and decision making. The participants commonly expressed ambivalence when religion was brought up in the discussion with regard to contraceptives.

Religious Ambivalence

Generally, out of the sixteen (16) participants interviewed, twelve (12) of the respondents expressed ambivalence when religion was brought up in relation to contraceptives. When the respondents were asked about contraception from a devotees' position, they tended to express negative attitudes and the importance of following religious interpretations. The people living in the area were either Christians or Muslims. The respondents were of the view that their religion actually prohibited contraceptives, or that contraceptive use was accepted but seen in a negative way by religious leaders as well as the teachings in the Bible or the Quran. The common reason mentioned by many participants was that children were gifts from God and people must receive everything God gave them. A respondent from one of the interviews said:

“God created us to procreate and it should be followed and children are gift and blessing from God .so using contraceptives and not giving birth means you are not following God”.(Non User, rural).

The respondents claiming this view thought that if one was taking contraceptives, they were committing a sin. One of the participants from one interview remarked:

“I did not know the Islamic ruling on contraceptive use when I was using contraception .I stopped using contraceptives when I began attending Islamic studies, I asked God for forgiveness.” .(User, rural)

Most of the Muslim, out of the twelve (12) participants Muslims interviewed, ten (10) respondents said that even if people in the “community” increasingly allowed the use of contraceptives, their religion did not allow it. They stated that God was the one who decided everything from conception to death, and subsequently, it is wrong to interfere in these processes. A participant from one of the interviews plainly stated:

“Islam encourages us to have many children and the Prophet Mohammed (S.A.W) orders us to have many children so that on the day of judgement he will use his ummah (followers) to show to Allah and it will be an honour and pride for him”

She continued:

“Allah also stated in the Quran that food, drink, wealth and everything needed by any being given birth to would be taken care of by he Allah”. (Non User, peri-urban).

Due to this type of interpretation, two (2) Muslim participants reported that they closely followed the writings in the Quran and thus never used contraceptives. However, among the Muslim participants, there were four (4) who claimed that Islam does not forbid contraceptive usage but prohibits

abortion. She subsequently reported that they were living in agreement with what was written in religious texts on the topic. This was expressed as follows:

“Islam does not prohibit any thing that prevent conception but prohibit anything that remove conceptual matter or abortion”. (Non User, rural)

A participant shares the same idea, and continued the argument that Islam supported contraceptives based on the idea that it was necessary. One woman remarked:

“Our religion Islam permit contraceptives use if it is necessary and permitted, if it is necessary by the married woman to use it to help her delay or prevent pregnancy or for a purpose but not for non-married women to use it for promiscuity. If it is recommended also by a qualified medical practioner and the method is permissible for instance the scholars say Islam prohibit the permanent method thus tubal ligation and sterilization.”(Non User, per-urban).

Some of the Christian participants, that is two (2) out of the four (4) said that their religion and the Bible did not mention contraception and contraceptive usage, but they still thought that controlling birth was a sin and not desired by God. On the other hand, some of the participants in one of the interviews readily discussed the positive acceptance of contraceptive usage by her Church. One of the participants claimed that the religion does not prohibit the use of contraceptives. One woman commented:

“Our church encourages us to use contraceptives, they even organises talks on it for the women in the church, that why I am using the injectable and it is ok for me.”(User, rural)

A Muslim participants said they felt the need to consult their religious leaders because they did not know whether using contraceptives were acceptable or not, considering the challenges they faced due to having many children. One Muslim participant said:

“I asked a religious leader about contraception, the religious leader just told me that it was not good to have too many children and could not meet their needs, without actually verbalizing anything related to contraceptive use”.(Non User, rural)

Availability of Resources

Availability of resources was yet another major theme that emerged from the data. Three sub-themes that emerged under this theme were access to contraceptives, non-availability of certain methods and inadequate human resource capacity.

Access to Contraceptives

Generally, out of the sixteen (16) participants interviewed, nine (9) respondents reported that the pills, implant and the injectable (the monthly and the three monthly) were the most accessible ones in the clinics in the entire districts. The pills were the only method that they could find in the Licensed Chemical Store (LCS).The other methods such as IUD, Patch, Diaphragm, Sponge, spermicide, Female Condom, Cervical Cap and the ring were not accessible. The respondents indicated that the pills, the injectable and the implant many a time is not available at the clinic and hence, the staff will tell you to come for it in due course. One woman said:

“The pills and the injectable are the ones in the clinic and the pills and the injections are sometimes not there,

because of that I always take the three months injection so that it will take time for me to come. Whenever I come and it is not there madam will tell me when to come and it will be there at the time she said you should come". (User, rural).

Another woman shares similar sentiments. She said:

"I use to take the three month injection but because of it bleeding problem I changed to the pills .but most at times I will come to the clinic for it and it will not be there then I will go to the drug store and buy. Now a days I just go to the drug store to buy". (User, rural)

Another woman remarked:

"Now a days when you go to the clinic and you ask of the one they put in your arm(implant) the clinic people say is not there". (User, peri-urban)

Non Availability of certain Contraceptives

The most commonly reported methods by all users were the pills, the injection or the implant. Most respondents, that is twelve (12) out of the sixteen (16) reported that with the exception of the pills, the injectables and the implants, which were reported to be found in the clinic, the other methods such as IUD, Patch, Diaphragm, Sponge, spermicide, Female Condom, Cervical Cap and the ring methods were non-accessible and difficult to obtain. One respondent commented:

"The other methods you are mentioning like the IUD, diaphragm, sponge and the rest. It is not in this community, it is not in the clinic either and for one to get them it will be difficult. So we always use what is there and is working for us".(User, rural)

Another woman remarked:

“If you choose or want any method apart from the pills and the injectable in this community you won’t get it. The clinics don’t even have them they only have the pills and the injectable. Some time ago, the Norplant was there in the clinics but now it is not there any longer”.
(User, peri-urban)

Inadequate Human Resource Capacity

Most of the respondents that is out of the sixteen (16) participants interviewed, ten (10) reported that the clinics in the district lacked qualified personnel to offer some of the contraceptive services such as IUDs and permanent methods that require skilled personnel to execute. The facilities in the district had constrained human resource capacity since the facilities had mostly few registered general Nurses and Midwives.

Majority of them are Nurse Assistants who did a short nursing certificate course of about 2years. They mainly helped with bedside nursing such as wound dressing, bathing patients, preparing trolleys for procedures, and immunizations. They also offered health education and carried out patient observations. Others who had some training in family planning also dispensed oral contraceptives. One facility had a Nurse Practitioner who could insert IUDs, but could not offer permanent methods due to a policy that stated that this can only be done by doctors. A Nurse Practitioner had a diploma or degree in clinical and community medicine and headed lower level health facilities with the capacity to conduct deliveries, prescribe for basic ailments, and perform minor surgeries. They also provided all contraceptive methods except the permanent voluntary surgical methods. One of the respondent in the

interviews reiterated that the lack of qualified staff to offer permanent methods was hindering access in the community. She said:

“The IUDs and the permanent methods are not in this community here mankarigu, they are not available in the clinics too due to that we are not able to access those methods”. (Non user, rural)

Another woman opined:

“I doubt whether the Nurses here can implant the IUD and or do the permanent method. I hear it requires some level of training to do them and we only have Prescribers, Midwives, Nurses and Nurse Assistant .we do not have a doctor to do tubal ligation and IUDs. They need doctors to do them and they are not available if you want those methods you go to tamale“. (User, peri-urban)

Discussion of Key Findings

The discussion is organized and presented around the research questions and the conceptual framework of the study. The findings are evaluated with reference to empirical evidence in the area of contraception. This allowed for the drawing of sound conclusions and recommendations. The main themes that emerged from the data were knowledge on contraceptives, gender relations, cultural issues, social issues, religious beliefs, and availability of resources. This section presents and discusses the key findings in relation to existing literature. References to existing literature are made throughout the discussion in order to situate the findings within the context of knowledge. Among other key findings, results from this study revealed that married women had limited knowledge and a general lack of understanding about contraceptives. It further revealed that factors such as, male domination,

preference for large families, social stigma and religious ambivalence are major factors affecting married women regarding contraceptive usage. Finally, the study identified non availability of certain contraceptives as a key factor militating against contraceptive usage. These findings are expected to help illumine the understanding of the factors affecting the utilization of contraceptives among married women and to help improve the quality of life and the general well-being of married women. These findings are expanded in the ensuing discussion.

Knowledge of Contraceptives

Concerning the knowledge of married women on contraceptives. The findings revealed that there is a limited knowledge and a general lack of understanding on contraceptives among married women in the community. These findings agree with the findings of other researchers who examined the barriers and facilitators to implementing a patient-centered model of contraceptive provision in community health centers in the United States of America (Politi et al., 2016).

Knowledge on contraceptives is the key to choosing a contraceptive method and in practicing it. All participants of this study were able to mention or were aware of at least one contraceptive method. In line with the above, previous studies have identified mentioning or awareness of at least one modern contraceptives as the most prevailing knowledge on different contraceptive methods among women (Gebremariam & Addissie, 2014; Hodogbe & Badu-Nyarko, 2015). Also, previous studies have also corroborated these findings as evident in a case control study conducted in Ghana at the Nkwanta district by Eliason et al., (2014), which found that

concerning both cases and controls, a little over 90% of women had knowledge of at least one modern contraceptive method. This result confirms what is reported in the Ghana Demographic and Health Survey (GDHS)(Ghana Statistical Service, 2009) that about 98% of all women aged 15–49 years know at least one modern method of contraception as well as the 2014 GDHS which indicates knowledge of contraception is universal in Ghana (Statistical service Ghana, 2015). Despite the awareness of at least the knowledge of one method, married women do not like to use them. This finding emphasizes the lack of essential knowledge about contraceptives and that these women need specific attention and more information to promote contraceptive use.

Male Domination

Gender relations are pervasive, but also dynamic and evolve over time. Gender inequality in reproductive decision-making is a key ingredient within the social brackets of reproductive health decision making processes. Studies show that couples often disagree about the desirability of pregnancy and the use of contraceptives (Jessica & Michelle, 2007;Shah, 1974). When this disagreement happens in a situation of male authority, husbands' opinions about these issues over ride women's opinions and decision, even though the women often are bound to implement the decisions made on these matters. In some cases, husbands fear that if they approve of contraceptives and allow their wives to use them, they would lose their role as heads of their families or they might lose face in their communities (Mosha et al., 2013 ; Rutenberg & Watkins, 1997).

Generally, participants reported that the decision to use contraceptives should be with men because they are head of the families and they pay for all their expenses and those of the families. Traditionally, the community listens to men and not to women. Women cannot do anything without their husbands' permission. It is not uncommon among men and women in the North Gonja district that the community supports male superiority regarding all aspects of life including women's affairs such as the use of contraceptives. Male dominance and male opposition to the use of contraceptives were also seen as a major barrier in Burundi and Northern Uganda. This was reported in the study of the perception of determinants of utilization of maternal and reproductive health services (Chi , Bulage -Urdal et al., 2015). This study revealed that the decision making process regarding utilization of contraceptives is influenced by the head of the family. Men are dominant in this process.

Preference for Large Families

Regarding cultural issues, the participants stated a number of related factors that hindered their contraceptive utilization. Preference for large families was identified as the most common reported factor. The cultural milieu of the northern part of Ghana is more pronatalistic and patriarchal compared to those in the South. Generally, participants indicated that there is that general preferences of large families. Having children was an essential issue for the married people that we interviewed, and one of the most important reasons was the perceived value of children to the family and the community. In this study, participants were of the view that having children as an eventual means of getting support when they got older. This however gave

them the opportunities to improve their living conditions. The essence of having many children were intrinsically related to the life span of individuals living in the district, which is heavily dependent on manual labour. This was in line with the findings of a study conducted in Ethiopia to explore Perceptions and behaviour related to family planning in a rural area in the Oromia region (Ieda, 2012).

Social Stigma

Findings from the study revealed that married women had social issues militating against the use of contraceptives. Among the social issues, social stigma, was the most reported problem. Findings of this study revealed that users of contraceptives were stigmatized in the North Gonja district. The pronatalistic nature of the society and the husbands' preference of large families made the phenomenon of contraceptives utilization stereotypical with its attendant stigmatization within the society. These findings are in line with that of Ahmed et al., (2015), who found that social stigma was consider as one of the factors that affect utilization of family planning in south Sudan. Most of the respondent said contraceptive use is socially not acceptable, and people want more children for agriculture and other work purposes. Those with negative perception regarding the utilization of contraceptives are mainly in rural areas.

Most of the married women in North Gonja district singly handly carry heavy responsibilities which include caring duties for their children, husbands, as well as household duties. In most African countries, including Ghana, and specifically the North Gonja district, married women are burdened by childbearing and caring responsibilities. Some respondents expressed

positive perception regarding contraceptives and the wish to use contraceptives, but due to negative social perception and unacceptability of contraceptives make married women tend to shy away from these contraceptives. Generally, women fear the society and their husbands. This is in tandem with studies conducted by Ahmed et al., (2015) in south Sudan.

Religious Ambivalence

This study also revealed that religious beliefs of married women in the North Gonja district set an atmosphere of ambivalence with regard to the acceptability of contraceptive usage in their religions. Also, religious leaders set an anti-contraceptives atmosphere in the district. However, due to the significance of religion in peoples' life and the significant roles religious leaders play in the society, also bearing in mind the potential punishment from God and criticism from religious peers due to the use of contraceptives, many of these women are mentally defeated and coerced to abandon the use of these methods.

Most, of the participants that is twelve (12) out of the sixteen in this study were Muslims and four (4) were Christians, and in general they saw children as gifts from God, as they claimed that people must receive all what God gives. Moreover, many thought that God decided the number of children and the timing of pregnancies, and that controlling this by using contraceptives was regarded as a sin. Therefore, some participants used contraceptives secretly or without really talking about it, because they were afraid of religious punishment from God or community members. The study therefore suggests that religion has a direct impact on contraceptive use, and that religion tend to create an anti-contraceptive atmosphere or at least cause frustration and

ambivalence among potential users. A study that explored reasons for low contraceptive usage among young people in Uganda and Ethiopia reported a similar situation (Ieda, 2012 ; Nalwadda, Mirembe, Byamugisha & Faxelid, 2010)

If the decision of using contraceptives was somehow accepted on a personal level but frowned upon by religious peers or family members, the solution could be to use contraceptives secretly. Even though some participants sounded positive about the decision of using contraceptives, it was obvious that among the majority, religious thoughts caused a certain level of ambivalence. We also found, however, that some, despite being religious, interpreted the use of contraceptives in a different way. Sarkar (2008), who studied reproductive biology, found that the use of contraceptives is approved by some Muslims because the Islamic faith underlines that children have a right to education and future security; this entails that the number of children in a family may have to be limited, and birth control subsequently allowed (Sarkar, 2008). This is similar to some of the views among participants in our study, and the finding therefore suggests that it could be important to focus on the diversity within a religion (Ieda, 2012).

Religion also had an influence on gender norms. Muslim female participants frequently said that in their religion, “wives should follow their husbands’ opinion”, and we may say that religious norms support an unbalanced gender relationship. Heaton (2011), an educator in sociology, has studied the influence of religion on fertility among different religions. He claims that religion is linked with other social characteristics and proximate determinants, such as level of education, type of residence, marriage age,

contraceptive use and divorce. In other words, single factors such as “gender norms” and “religious norms” can be related to and shape each other. Further, what influences people’s perception and behavior on contraceptive behaviour can be influenced by different “modifying” factors, such as level of education, and this must be viewed holistically (Ieda, 2012).

Non Availability of certain Contraceptives

Regarding availability of resources, the participants stated a number of resource constraint factors that hindered their uptake of contraceptives. The most commonly reported were access to contraceptives and non-availability of certain contraceptives. The findings of the study revealed that three categories of contraceptive methods were identified namely, the combined oral contraceptives, injectables and implants. Availability appeared to influence use. Most women perceived over-the -counter methods as accessible and easy to get, hence, Two (2) former users and four (4) current users of contraceptives in this study were either using pills, injectables or had ever used any of the afore mentioned methods. They further indicated that the pills and the injectables are the most accessible in the district, which sometimes run out of stock when they visit the clinics to access them.

However, it was also observed by participants that the other methods are not in the districts, most especially the permanent and long acting contraceptives. It was further observed by participants that the pills is the only method that users could get from licensed chemical stores in the district. This finding is congruent with studies by Hong, Amanua & Miller (2006), who found that the most available methods of contraceptives in Ghana are the pills, the injectables and the male condoms. Findings from this study however

indicate that the injectable is only available to women who patronize public health facilities but not to those who patronize private health facilities like licensed chemical stores. This is corroborated by Adjei et al., (2015) in their study which found out that injectables might be available only to women who patronize public health facilities but not to those who patronize private health facilities like LCS and pharmacies.

In general, the respondents indicated that they cannot find long acting reversible contraceptive (LARC) methods such as the copper IUDs and the permanent methods in the clinics and the Licensed Chemical Stores in the district, making it inaccessible to prospective users. These findings are in line with the findings of Adjei et al.,(2015) in their study which found out that availability of long acting reversible contraceptive (LARC).Methods such as the implants and the copper IUDs in this study were low with only 7 out of the 51 health facilities (14 %) having them in stock. None of the chemical shops and pharmacies sampled had these LARC methods. The IUD was also not available in any of the health facilities surveyed.

The study also revealed that most of the participants attributed the non-accessibility of the long acting reversible contraceptives (LARC) methods such as the copper IUDs and the permanent methods in the clinics to inadequate human resource capacity to insert and carry out some of these procedures, as insertion of these methods can only be done in health facilities with trained providers. These findings are congruent with the findings of a qualitative study by Sibongile et al. (2016),which found that inadequate human resource capacity is a barrier to family planning use. The findings in this study highlight a growing challenge observed by Aryeetey, Kotoh and

Hindin (2008), in which it was made apparent that awareness of LARC methods in the Ga East municipality was low. It lends credence to the growing perception that this is one of the key factors that need to be addressed in order to increase the utilization of contraceptives in Ghana and in particular the public health facilities (Aryeetey, Kotoh & Hindin, 2008; Adjei et al., 2015; Ministry of Health (MOH), 2009).

It was further observed that participants identified pills as the most accessible contraceptive particularly in licensed chemical stores in the district. This is in concordance with the Ghana Demographic and Health Survey (Ghana Statistical Service (GSS), Ghana Health Service (GHS) & ICF Macro., 2009) and a study finding by Adjei et al., (2015) , which reported that “secure” is the most popular brand of contraceptive pills in Ghana.

Chapter Summary

The above findings were based on data generated from interviews on the perceptions, experiences, feelings, beliefs and opinions of married women on the factors that affect contraceptive utilization among married women in the North Gonja district. A total of 16 participants participated in the study .The findings were more revealing and brought to bear the multifactorial nature of contraceptive utilization and the enormous challenges that married women face with their contraceptive decision making and utilization. Most of the participants, that is twelve (12) out of the sixteen (16) had limited knowledge and did not have a general understanding about contraceptives despite their ability to mention at least one contraceptive method. Misperceptions about contraceptives were quite ripe in the district as a result of married women mainly relying on peers, family and other community

members as their main source of information, and their perceptions also heavily influenced their decision to use or otherwise.

The most flagged factor that militated against the use of contraceptives was religious beliefs, which seemed to produce an atmosphere of ambivalence and frustration and made it difficult for people to initiate and continue the use of contraceptives. This was followed by gender related factors which viewed the male gender as a domineering one over married women while not being self-motivated to support women to use contraception. Social factors such as social stigma and shyness played a critical role in shaping the thinking of women about contraception, thereby influencing them greatly in their contraceptive decision making processes.

The old age cultural predilection for many children still hinders the uptake of contraceptives with the perception of giving birth to so many children borne out of succession, support and the prestige and honor that accompanied the life span of parents. It was also found that, access to contraceptives affect utilization. It was observed that all former and current users had used or are using either the pills, the injection or the implant, which are the methods reported to be readily accessible in the district.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

The study sought to explore the factors affecting utilization of contraceptives among married women of reproductive age (15-49 years) in the North Gonja District. This study was expected to provide empirical evidence on the factors that affect utilization of contraceptives among married women, resulting in recommendations to policy makers, health professionals, donors, family planning campaigners and management of health institutions on the ways to improve contraceptive usage. To meet this overall objective, the study set out to answer four questions. The specific questions were:

1. How does married women's knowledge affect contraceptive utilization?
2. How does husbands' approval, and spousal communication influence the use of contraceptive methods among married women in the North Gonja district?
3. How does cultural, social and religious factors affect married women's decisions on contraceptive utilization?
4. How does access to contraceptive methods influence contraceptive uptake of married women in the North Gonja district?

A qualitative cross sectional survey of 16 married women of reproductive age (15-49 years) in the North Gonja District was undertaken, using an in-depth interview with the aid of a semi structured interview guide to collect the data in June 2017. A final sample size of 16 was used for the study which was dependent on data saturation or when new themes were not

forthcoming. A purposive non-probability sampling technique was used to draw all the sixteen married women aged 15-49 years for the study. Using thematic content analysis, six major themes emerged from the data collected with their corresponding sub-themes.

Participants of the study were drawn from the four sub- districts namely Bawena, Daboya, Lingbinsi and Mankarigu, of the North Gonja district. Four participants were then selected from each sub -district who were within the age brackets and were married. In general, twelve (12) of the participants were Muslim and four of the participants were Christians. With their levels of education, two of the participants had tertiary education while six had secondary education. With the remaining eight, six had no formal education and two had primary education. Ten out of the sixteen participants had never used any contraceptive method before, four were current users and two had ever used a contraceptive method before. In all, the number of children that each of the participants had, ranged from one to six.

In relation to their occupation, two of the participants were public servants and six were self-employed. One was a house wife and the remaining seven were unemployed. Seven (7) of the participants belonged to the Tampilima ethnic group with five (5) participants belonging to the Gonja ethnic group. Four were from different tribes; Mamprusi, Bulsa, Fulani and Kassin. All participants who belonged to the various tribes could speak Dagbani aside their native languages. Participants' life experiences with contraceptives ranged between six months and five years of usage. Their residential locations varied between peri -urban and rural settlements in and around the North Gonja District.

Summary of Key Findings

In general, twelve (12) out of the sixteen (16) women interviewed, reportedly stated that their husbands were against their use of contraceptives because they wanted many children and had fertility concerns if they used it. Generally, participants reported that the decision to use contraceptives should be with men because they pay dowry to marry a woman, and they pay for all her expenses and that of the family. Traditionally, the community listens to men and not to women. Women cannot do anything without their husbands' permission. It is not uncommon among men and women in the North Gonja district that the community will support male superiority in all spheres of life including women's affairs such as the use of contraceptives. Male dominance and male opposition to the use of contraceptives were also seen as a major factor militating against contraceptives usage in the North Gonja district.

It was also found that, participants indicated that the cultural milieu of their communities is more pronatalistic, due to the fact that their culture places a lot of value on children and child bearing as it views children as supporters of parents and successors of parental lineage. It was further observed that, participants faced a varying degree of social issues, with the profound one being social stigma. Further findings in this study revealed that religious ambivalence among married women in the North Gonja district sets an atmosphere of ambiguity and ambivalence with regard to the acceptability of contraceptive usage in their religion. Religion was also found to have an influence on gender norms. Muslim female participants said that according to their religion, "wives should follow their husbands' opinion", and we may say that religious norms support an unbalanced gender relation.

Furthermore, participants of the study expressed a varying degree of availability of resources within the district. The profound resource constraint factor that was reported by participants were, access to contraceptives, and non-availability of certain contraceptives. In general, participants reported that access to a wide range of contraceptives and non-availability of certain contraceptives militated against the use of these contraceptives.

Conclusions

Understanding factors that affect contraceptive use among married women aged 15 to 49 years is a critical step to improving contraceptive usage within and among this population. Based on the key findings in this study, it can be concluded that married women in the North Gonja district have limited knowledge and a general lack of understanding about contraceptives.

In light of this study, it is clear that there are numerous factors that affect contraceptive utilization among married women. Many of the factors that have been identified as factors in this study include: knowledge of contraceptives, male domination, preference for large families, social stigma, religious ambivalence and non-availability of certain contraceptives were previously identified in other studies as factors affecting contraceptive utilization. However, this study has proven that it is not accurate enough to say knowledge of modern family planning methods is very high or knowledge of contraception is universal. This is because knowledge about contraceptives is limited to name mentioning. This finding emphasizes the lack of essential knowledge about contraceptives and these women need specific attention and more tailored information to promote contraceptive use. Public health messages and health providers can help women in this age group by reviewing

their fertility risks, as well as all contraceptive methods and their associated educational information.

What has also become apparent in this study is that certain factors, if prompted or ensured, may lead to an increase in utilization of contraceptives among married women. These include increased male involvement in the education about contraceptives. Overall, the findings revealed that there is low usage of contraceptives in the communities owing to social determinants and beliefs among married women. Sociocultural factors influence contraceptive use by exaggerating misperception. The data from this study highlights the social nature of beliefs and behaviours around contraception. The decision to use or not is primarily influenced by others from within the society, whose views and perceptions are often more important than an individual's own. Women need reliable sources of information and better access to contraceptives as well as well-trained providers who can address their concerns. There is the need to increase community sensitization efforts to create demand. In the long term, it will be important to build the capacities of clinical officers to offer long-term methods in order to increase the availability of contraceptive method options.

Recommendations

Ministry of Health

1. The Ministry of Health should institute and implement an effective male-involvement family planning initiative to address men's negative beliefs regarding contraceptive services. Since husbands' influence are still key factors affecting contraceptives use.

District Health Management

1. Formation of lobby groups to enhance cultural change, awareness creation and counselling as well as strengthen capacity of religious leaders, by providing them with knowledge on contraception and providing guidance on key messages they can incorporate in their sermons by advocating for use of contraceptives in their communities.
2. The District Health Directorate should develop community and interpersonal education projects and counseling techniques to debunk social stigma as well as to address underlying socio-cultural norms over time.
3. The District Health Directorate and facility managers should ensure that facilities have adequate stocks and offer a variety of methods for new users and users who want to switch methods.

Implications for Nursing

1. The findings of the study revealed that, participants were not given proper health education on contraceptives and nurses being educators, should develop educational programmes and materials for women and families to help them understand the nature of contraceptives, its benefits to families and mothers, appropriate use and as well as potential side effect in order to diffuse misperceptions about contraceptive. Again, there is the need for an in-service training and sensitization workshop for nurses and other health professionals to sensitize them on contraceptives. This would help nurses recognize the

need to educate women and families on contraceptives in the North Gonja district.

2. It was further observed that, Non availability of certain contraceptive methods and inadequate human resource capacity mitigated against the use of contraceptives. Nurses and Midwives as advocates for clients should campaign for government to provide adequate human resource capacity and adequate contraceptive methods to enhance access to a wide range of contraceptive methods.

Suggestions for Further Research

I recommend that further studies should be conducted in the following identified areas to get a better understanding of the factors affecting utilization of contraceptives in Ghana and elsewhere:

1. Anthropological research to examine the sociocultural and religious norms that underlie contraceptive use, to help develop programmes that can target the sociocultural and religious factors militating against contraceptive use in Ghana.
2. A qualitative research on the psychometric aspect of couples' use of contraceptives, to obtain a more thorough understanding of couple dynamics.
3. A qualitative study to examine women and their male partners as a dyad to identify the extent to which women's desires to use contraception are linked to their male partners' awareness and support of contraceptives.

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APPENDIX A
List of Demographic Data

NO	Pseudo names	Age	No of Children	Ethnicity	Religion	Level of Education	Employment Status	Contraceptives User Status
1	Daliri (001)	26yr	2	Tampulima	Moslem	Secondary	Self Employed	Non User
2	Memuna (002)	38yrs	1	Tampulima	Moslem	Secondary	Self Employed	Non User
3	Sala (003)	22yrs	1	Gonja	Moslem	Secondary	Self Employed	User
4	Afsa (004)	30yrs	3	Tampulima	Moslem	Primary	Self Employed	Non User
5	Rahi (005)	35yrs	3	Tampulima	Christian	No formal education	Unemployed	Non User
6	Azara (006)	36yrs	4	Tampulima	Moslem	Primary	Unemployed	Former User
7	Rafi (007)	29yrs	2	Mamprusi	Moslem	Tertiary	Public servant	Non User
8	Suut (008)	42yrs	4	Gonja	Moslem	No formal education	House wife	User
9	Naziha (009)	33yrs	2	Gonja	Moslem	No formal education	Unemployed	Non User
10	Habiba (010)	39yrs	2	Gonja	Moslem	No formal education	Unemployed	Non User
11	Getrude (011)	24yrs	3	Tampulima	Christian	Tertiary	Public servant	Non User
12	Sedi (012)	36yrs	5	Kassin	Christian	Secondary	Self Employed	User
13	Murijana(013)	40yrs	4	Tampulima	Moslem	Secondary	Self Employed	User
14	Fouzia (014)	28yrs	2	Gonja	Moslem	Secondary	Self Employed	Non User
15	Maltiti (015)	22yrs	6	Fulani	Moslem	No formal education	Unemployed	Former User
16	Stella (016)	45yrs	6	Bulsa	Christian	No formal education	Unemployed	Non User

APPENDIX B

UNIVERSITY OF CAPE COAST

INSTITUTIONAL REVIEW BOARD SECRETARIAT

TEL: 03321-33172/3 / 0207355653/ 0244207814

C/O Directorate of Research, Innovation and Consultancy

E-MAIL: irb@ucc.edu.gh

OUR REF: UCC/IRB/A/2016/128

YOUR REF:

OMB NO: 0990-0279

IORG #: IORG0009096



29TH MAY, 2017

Mr Abdul Aziz Adam
School of Nursing and Midwifery
University of Cape Coast

Dear Mr Adam

ETHICAL CLEARANCE –ID :(UCCIRB/CHAS/2017/19)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted **Provisional Approval** for the implementation of your research protocol titled ‘ **Factors Affecting Utilization of Contraceptive methods among married women of reproductive age (15-49) years in the North Gonja District: A Qualitative Study.**’

This approval requires that you submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research. The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

Please note that any modification of the project must be submitted to the UCCIRB for review and approval before its implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol.

Yours faithfully.

Samuel Asiedu Owusu
Administrator

.....
ADMINISTRATOR
INSTITUTIONAL REVIEW BOARD
UNIVERSITY OF CAPE COAST
Date:.....

APPENDIX C

OUR CORE VALUES:

1. People-Centered
2. Professionalism
3. Team work
4. Innovation
5. Discipline
6. Integrity



District Health Directorate
P.O. BOX
NORTH GONJA,
DABOYA

12th APRIL, 2017

Tel: 0201999501/0243684828

*My Ref No:GHS/NR/NGD/
Your Ref No:*

The Dean of Students
College of Health and Allied Sciences
School of Nursing and Midwifery
University of Cape Coast

Dear sir/ Madam

**APPROVAL TO DO RESEARCH IN THE DISTRICT: RE: MR. ABDUL AZIZ ADAM –
ID NUMBER SN/MNS/15/0007**

Reference to your request with Reference number SNM/R/2/Vol.2/233 dated the 30th March, 2017 introducing the above named Post Graduate student of the School of Nursing and Midwifery, to conduct a research in the district on the topic: Factors affecting utilization of contraceptives methods among married women of reproductive age (15-49) years in the North Gonja District; approval is hereby given for the research to be carried out by the student.

Thank you
Yours faithfully

A handwritten signature in blue ink, appearing to read 'Abukari Alhassan', is written over a horizontal line.

Abukari Alhassan

DDHS - NGD

**APPENDIX D
INFORMATION SHEET**

UNIVERSITY OF CAPE COAST

**SCHOOL OF NURSING AND MIDWIFERY
MASTER OF NURSING**

Title of Study; Factors Affecting Utilization of Contraceptives among married women of reproductive age (15-49) years in North Gonja District: A Qualitative Study

Principal Investigator: Abdul Aziz Adam

Qualification: Bachelor of Science in Nursing, Registered General Nursing (Diploma)

Specialty: General Nursing

Department: Tamale Teaching Hospital

Postal Address: Post Office Box 16 Tamale- N/R

Telephone: 0242106723/0201509622

Email address: abdulazizadam386@yahoo.com

Title of the research: Factors Affecting Utilization of Contraceptives among married women of reproductive age (15-49) years in North Gonja District: A Qualitative Study.

Objective: To explain the factors affecting utilization of contraceptive methods among married women of reproductive age (15-49) years in North Gonja District

Duration: The expected duration of this interaction process will last for 40-60 minutes.

Participants: You are being invited to take part in this interview because we feel that your experience and opinion about the factors affecting utilization of

contraceptives methods among married women will contribute much to this discussion.

Potential Risks: There is no foreseen risk by being participating in this study.

Confidentiality: All the information that you give would be kept confidential and private. Only the principal investigator and interviewer would have access to the information, and you are not mentioned (indicated) by name and won't be accessible to third party. Your name won't register on the question sheet so that you will not be identified.

Benefits: No financial benefits are related with this study. But by participating in this study, you will acquire or increase your understanding and knowledge with regards to contraceptives it usage and importance as well as it benefits. Your honest response to the questions can make the study to achieve its objective.

You are kindly requested to respond voluntarily. You can also choose not to participate in this study or if you become uncomfortable during the study, you will be allowed to leave the study at any time. You will be interviewed, where you cannot understand, the researcher or his assistance will help you to understand. The interview or discussion would be recorded by the researcher for analysis. At any time if you have questions, you can contact me by using the following addresses.

Name of the principal Investigator: Abdul Aziz Adam, 024216723/020159622

I here with declare that:

- The objectives of this study are explained to me and are clear.
- The contents of the consent are verified to me to participate in the study.

I understand that participation in this study is completely voluntary and that I may withdraw at any time without giving reasons. I agree to participate in this study to be interviewed, provided my privacy is guaranteed. When signing this consent form to participate in the study, I promise to answer honestly to all reasonable questions and not provide any false information or in any other way purposely to mislead the researcher.

Signature of the participant _____ date _____

Signature of the investigator _____ date _____

**APPENDIX E
CONSENT FORM**

I want to thank you for taking the time to meet with me today. My name is Abdul Aziz Adam I'm from University of Cape Coast and I would like to talk to you about your experiences, opinions and perspective about family planning and for that matter contraception. Specifically, as a major component of family planning and one of the components of our overall family planning program. Evaluating your opinion, experience and perspectives with regards to the factors affecting utilization of contraceptives methods among married women will be a capture lessons that can be used in future interventions. The interview should take less than an hour. I will be taping the session because I don't want to miss any of your comments.

Although I will be taking some notes during the session, I can't possibly write fast enough to get it all down. Because we are on tape, please be sure to speak up so that we do not miss your comments. All responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our study does not identify you as the respondent. Remember, you do not have to talk about anything you do not want to and you may end the interview at any time.

Are there any questions about what I have just explained?

Are you willing to participate in this interview?

Interviewee

Witness

Date

**APPENDIX F
INTERVIEW GUIDE**

Selection criteria: Married women, aged 15-49, who have never used modern methods of contraception or have used and reside in North Gonja district.

I will start by explaining the ground rules as follows:

Before we start I would like to remind you that there are no right or wrong answers in this discussion. We are interested in knowing what you think, so please feel free to be frank and to share your point of view. It is very important that we hear your opinion.

Background Information

Code Number.....

Please tell me about yourself?

1. Age: 15-29 () 30-39 () 40-49 ()
2. Ethnicity
3. Nationality
4. Marital Status
5. Number of Children if Any
6. Religion
7. Occupation
8. Level of Education
9. Languages Spoken
10. What is your ideal family size/composition?
11. What is your current family size/composition?
12. How many children do you want to have?

Probe:

Why?

Knowledge on Contraception and use

A. Please kindly tell me about contraception?

Probe:

B. What kind of contraceptive methods do you know? OR mention the contraceptives methods you know?

C. What do you know about these methods?

Probe: Efficacy? Characteristics? Usage? Perceptions?

D. For each of the method talked about please kindly share with me its side effects.

Probe:

E. From whom or where did you get your contraceptives information?

F. Which contraceptive method or methods have you ever used?

G. If you have never used any contraceptives, please kindly share with me the reason for not using any contraceptives?

Probe:

H. Were your expectations met with regards to the method or methods used?

Probe: Efficacy /experience/side effects?

I. How did you come to choose this mode of contraception?

Probe:

Any reason(s) for this specific choice?

J. Have you ever changed your contraceptive method?

Probe: any reason for the change of method?

K. Which contraceptive method are you currently using?

Probe:

Any reason(s) for this specific choice?

L. How do your knowledge on contraception influences your decision to use or not to use contraception?

Probe:

M. What barriers did you encounter during your contraceptive decision making process to use contraception? Please explain.

N. Please kindly share with me your experiences with the method or methods you have ever used?

Probe:

O. What challenges did you encounter in your contraceptive decision making process?

Please explain

Husband's approval and spouse communication about contraception

A. Is it easy to communicate about contraception with your husband?

Probe:

C. Have you ever discussed contraceptive use with your husband?

D. What was the result of the discussion?

E. How did you make the decision to use these methods?

Probe:

G. Please can you share with me how your spouse communication has affected your contraceptive decision?

Probe:

H. Please can you share with me how your spouse approval has affected your contraceptive decision?

Probe:

Cultural, social and religious factors about contraception

- A. Do you believe some women or women face social pressures/barriers regarding contraception? If yes, describe them.
- B. How do your social background influence your contraceptive decision, to use or not to use?

Probe:

- C. How do your societal norms influences your decision to use or not to use contraception?

Probe:

- D. How does your cultural background influenced your contraceptive decision to use or not to use contraception?

Probe:

- E. How does cultural norm influences your contraceptive decision to use contraception?

Probe:

- F. How do your religious background influences your contraceptive decision to use or not to use contraception?

Probe:

- G. How does your religious doctrine influences your decision to use or not to use contraception?

Probe:

- H. Please kindly share with me any social norm/cultural norm or religious quotation encouraging the use of contraception?

- I. Please kindly share with me any social norm/cultural norm or religious quotation prohibiting the use of contraception?

Probe:

Accessibility to contraceptive methods

- A. Which contraceptives method are accessible to you in this community?

Probes:

- B. Which contraceptive methods are mostly available in this community?

- C. Which contraceptive methods are mostly used in this community?

Probe:

- D. Why is it the method used frequently?

Probe:

- E. How do you access contraceptives methods?

Probe:

- F. Where do you normally get your contraceptive method?

Probe;

- G. How far is the access point to your home?

Probe:

- H. which methods are available in these access point?

Probe:

- I. What things or reason might influence a woman's decision to use contraceptives methods?

- J. What things or reason might influence a woman's decision not to use contraceptives methods?

- K. Please can you share with me how access to some contraceptive methods has affected your contraceptive decision, to use or not to use?

Probe:

Why are not able to access some contraceptives?

Closing key comments

Is there anything more you would like to add?

Do you have any questions for me?

Is there anything that I haven't asked that you would like to tell me about?

Thank you for your cooperation.