

**FROM THEIR OWN PERSPECTIVE: PERCEPTIONS OF WOMEN ABOUT  
MODERN AND NATURAL/TRADITIONAL METHODS OF CONTRACEPTION  
IN KOFORIDUA AND ASOKORE IN THE EASTERN REGION OF GHANA**

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Cover photograph showing nurses inserting Norplant (a modern contraceptive method) beneath the skin of the upper arm of a client at a Family Planning clinic

Source: Fieldwork, June 2006

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I have come this far in my studies by the Grace of God.

## ABSTRACT

Population growth or increase comes about because of the interplay of the three main demographic variables namely fertility, mortality and migration. This growth can be high, low or stable and all these have implications for a country's socio-economic development and the standard of living of the people. With a current total fertility rate of 4.4, Ghana is still faced with the challenge of a high population growth rate. (Ghana Statistical Service et al 2004a) Since the 1960's the government of Ghana and other stakeholders have tried to come up with programs and campaigns to address the population question. This included the introduction of Family Planning and contraception into the country as a measure to reduce fertility rates and hence population growth. As at 2003 however Ghana's contraceptive prevalence rate was 25.2%, lower than that of many other countries in sub-Saharan Africa (Ghana Statistical Service et al 2004a)

The study therefore sought to know the perceptions and assessments women have about contraceptives and how that is contributing to the low usage of contraception in the country. Women formed the majority of the respondents of this study because they are the primary users of contraceptives. 20 married women (10 each) were selected from an urban and a peri-urban area in the Eastern Region of Ghana. Five of the women chosen were between the ages of 25-30 and the remaining five 40-45 years in each of the study areas. The region was chosen because it has a Contraceptive Prevalence Rate of 27% which is closer to the national average. Four spouses of the women were interviewed as well as family planning service providers in four pharmacies and a family planning clinic. The study was basically qualitative in nature and structured and semi-structured interview guides were used for the interviews. The structuration theory and the feminists' approaches of Gender and Development (GAD) and Women Culture and Development (WCD) were used in explaining the findings of the study.

The findings of the study revealed that most of the women had positive perceptions about both the natural and modern methods of contraception. They indicated how beneficial contraceptives are in controlling fertility rates. Many women especially those in the peri-urban area were however worried about the side effects of some of the modern methods. The study also revealed that there were more women using natural contraceptive methods in the urban area than in the peri-urban area. The main factors contributing to this is less education on the natural methods and the inability of women with relatively lower socio-economic status to negotiate with their husbands in order to adopt the methods effectively. Education was seen as the major factor to be considered in improving contraceptive usage in the country. It is most likely that contraceptive usage will improve if men are actively involved in family planning.

Some limitations of the study were that, the study made use of a small sample size because of its qualitative nature. A quantitative study with a large sample size will help for generalizations to be made. It would also have been interesting for one to investigate the topic along a rural/urban angle than the urban/peri-urban angle used in this study. Further studies could also include more males in the sample of the study.

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## **ABBREVIATIONS**

CPR	Contraceptive Prevalence Rate
GAD	Gender and Development
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
GSS	Ghana Statistical Service
IEC	Information Education and Communication
IPPF	International Planned Parenthood Federation
MOH	Ministry of Health
NGOs	Non-Governmental Organizations
NPC	National Population Council
NJMA	New Juaben Municipal Assembly
PPAG	Planned Parenthood Association of Ghana
RHFPU	Reproductive Health and Family Planning Unit
TFR	Total Fertility Rate
UN	United Nations
WCD	Women Culture and Development

# CHAPTER 1 GENERAL INTRODUCTION

## 1.1 Background

Population growth or increase comes about because of the interplay of the three main demographic variables namely fertility, mortality and migration. This growth can be high, low, constant or stable and all these have implications for a country's socio-economic development and hence the standard of living of the people. Demographically, Ghana can be said to be a country with a high population growth rate. With its current Total Fertility Rate (TFR) of 4.4 which is seen as an improvement upon that of previous years as reported by the 2003 Ghana Demographic and Health Survey, researchers and stakeholders are still of the view that the country has the potential to grow higher because of its large-based population. A look at the age structure of Ghana's population reveals that there is about 35 percent of the population within the ages of 0-14 years, 58.3 percent within the ages 15-64 years and 3.7 percent in the age of 64 and over. (Ghana Statistical Service 2002).

The rate of growth of the population continues to act as a serious impediment to the country's march towards economic modernization, sustainable development and eradication of poverty. Ghana's first post independence population census in 1960 counted about 6.7 million inhabitants. By 1970, the national census registered 8.5 million people and in 1984 a figure of 12.3 million was recorded from the national census. With the current growth rate of 3.2 percent, the country's population is projected to be around 35 million by 2025. (Ghana Statistical Service 2002) In Ghana it is estimated that there are more people living in rural areas than in urban areas. There are many people in Ghana who do not have access to some basic resources as water and electricity. Poverty is also seen as a consequence of population growth. If a country's population growth is not commensurate with available natural resources, it may affect its socio-economic development. For instance, Ghana's 1994 population policy was introduced to address some of the problems of population growth. It addressed some population problems as teenage pregnancy, pollution, degradation of the environment, high unemployment rate



and school drop out rate and other social vices as armed robbery, pick-pocketing and drug abuse.

With the awareness of the consequences of rapid population growth rate there has been global campaigns aimed at sensitizing people about the need for population reduction through family planning and contraceptive use. Contraceptive usage is seen as very critical in reducing every country's population growth rate.

Worldwide fertility rates have been declining and contraceptive use has been increasing for decades. Nevertheless, many women who want to stop having children or delay their next birth are not using contraception. Estimates suggest that less than half of the demand for family planning is being met in Sub-Saharan Africa. For couples who wish to delay or avoid a birth, the obstacles to contraceptive use often include a lack of knowledge about methods, where to obtain services and concerns about side effects of different methods.

The table below gives an idea of the Contraceptive Prevalence Rates of selected countries in Sub-Saharan Africa including Ghana.

**Table 1.1 Contraceptive Prevalence Rates of some countries in Sub-Saharan Africa**

Country	Year	CPR (%)	Source
Cote d'Ivoire	1981	2.9	World fertility Survey, Demographic and Health Survey (DHS)
Cote d'Ivoire	1994	11.4	
Cote d'Ivoire	1999	15.0	
Ghana	1988	12.9	Demographic and Health survey
Ghana	1993	20.3	
Ghana	1999	22.0	
Botswana	1984	27.8	National Fertility/family Planning/Health Survey
Botswana	1988	33.0	
Botswana	1996	47.6	
Zimbabwe	1989	43.1	DHS

Zimbabwe	1994	48.1	DHS
Zimbabwe	1999	53.5	
South Africa	1988	49.7	Research paper on publication (including UN publications, DHS
South Africa	1998	56.3	

Source: UN Population Division, Global Database on contraceptive prevalence

The data provided in the table above shows that over the years the Contraceptive Prevalence Rate (CPR) of Ghana compared with that of other Sub-Saharan African countries especially those in southern Africa is low. For instance compared with South Africa's CPR of 56.3 (1998) and that of Zimbabwe's 1999 figure of 53.5, that of Ghana was estimated at 22.0 in 1999. Ghana's most current CPR of 25% reported in 2003 is still very low compared to the figures of Southern African countries. The factors contributing to this are numerous. It may be due to lack of/inadequate knowledge about the methods, limited service provision centres and peoples concerns about the side effects of the different methods among others.

Since contraceptive usage is vital to reducing population growth in a country like Ghana, the government and other stakeholders have since the 1960's initiated programs and activities to reduce the rate of growth of the countries population. The reduction of fertility through contraception is promoted as a desirable policy solution to overpopulation. Thus, Ghana's population situation prompted the government, researchers and other stakeholders in the medical profession to introduce family planning methods and services into the country in the 1960s. The Ghanaian government has long shown interest in the population question. It was a co-sponsor of a resolution on population growth and economic development in the 1962-63 sessions of the United Nations (UN) general assembly and was the first Sub-Saharan African country to sign the World Leaders Declaration on Population in 1967 that called attention to the population question (Studies in Family Planning, 1969). In 1969, the government issued a general policy paper – "Population planning for National progress and prosperity that included provisions for family planning services" comprising the establishment of family planning units that will provide counseling on contraceptive knowledge and use. The government has also come out with two population policies which address solely the demographic

situation of the country. The first policy was promulgated in 1969 purposely to address the country's population question. One main objective of the policy was to reduce the population growth rate to 1.8% per annum by the year 2000. The establishment of the Planned Parenthood Association of Ghana (PPAG), an affiliate of the International Planned Parenthood Federation (IPPF) in 1966 marks the period of greater emphasis on Family Planning and also on maternal and child health.

A major component of family planning activities in the country among others has been to provide people with adequate knowledge on contraceptive methods and their use for birth control or avoidance of pregnancy. Onuoha and Timaeus (1995) argue that fertility reductions involve a sustained and usually irreversible decline in fertility, driven by the increasing use of contraception, sterilization and abortion to limit family size. Contraception permits spacing of births without risking spousal discord or the threat of violence associated with coital refusal. The study looks into the perception and experiences of women on contraceptive use as a possible measure to reduce fertility rates and hence population growth in an urban and peri-urban area in the country.

## **1.2 Problem statement**

In recent years many researchers have turned their attention to studies on contraceptive knowledge and use. This is a step in the right direction because many nations in Africa face the problem of high birth rates. Contraceptive use and availability help to prevent unwanted pregnancies, space births and again help couples to plan for the number of children they wish to have. The use of contraception by a woman can improve her reproductive health as well as the health of her children because she can space her births well.

Ghana like many other African countries is faced with the problem of high population growth rate. A decline in population can result when there is a substantial fall in both mortality and fertility rates. Demographers, health professionals and family planning experts are of the view that one major way by which the country can reduce its fertility is through the use of contraception. It is however disturbing and unfortunate that contraceptive use in Ghana as in many other African countries is low. Ghana's

contraceptive prevalence rate as reported by the 2003 Ghana Demographic and Health survey stands at 25 percent. Knowledge about contraception on the other hand is very high. Regarding knowledge about contraceptive methods it is almost universal in Ghana, with about 98 percent of all women and 99 percent of all men knowing at least one method of contraception. (Ghana Statistical Service et al, 2004a). The 2003 Ghana Demographic and Health Survey gives an account of the different contraceptive types known and used in Ghana. Contraceptive methods are grouped into two main categories: the modern and the traditional methods. Some of the modern methods include, male and female sterilization, the pill, the Intra Uterine Device, injectables, male and female condoms among others. The traditional methods are the rhythm or periodic abstinence and withdrawal methods. One other traditional method of contraception is abstinence. Schoenmaeckers (1981) asserts that abstinence is the preferred means of assuring long birth intervals because of people's traditional belief in the incompatibility of mother's milk with semen. His assertion was validated in a study on family planning conducted in Northern Ghana in 1999.

The proportion of married women using modern contraceptive methods is very low compared to other African countries as Mauritius, Kenya and Zimbabwe. The proportion of married women using modern contraception in these countries is 60 percent, 52 percent and 60 percent respectively. The figure for Ghana is 15 percent and there are only 5 percent of married women using the traditional methods. (Ghana Statistical Service et al 2004a). Gaisie reports that the breakdown of traditional fertility control mechanisms such as postpartum sexual abstinence due to modernization without a compensatory increase in modern contraceptive use has resulted in total fertility rate increasing in some parts of Ghana. (Gaisie 1981).

This research takes a look at the reasons for the low usage rate of contraception in Ghana in spite of the fact that there is universal knowledge of contraceptive methods by Ghanaians. The research is of further importance as contraceptive use does not only reduce fertility but also acts as a catalyst to control the spread of HIV/AIDS. The study examines the factors contributing to low contraceptive usage in the Eastern Region, specifically in Koforidua and Asokore. The contraceptive prevalence rate of the region is

27 percent which is around the national average. (Ghana Statistical Service et al, 2004a). The rate varies from region to region and even from place to place within individual regions. A critical analysis of why there is lower contraceptive usage in the country will yield a better result if one takes into account how peri-urban dwellers and urban dwellers may perceive contraceptive use. It is for this reason that the study takes a critical look into how women in Koforidua (an urban area) and Asokore (a peri-urban area) perceive contraceptive use.

### **1.3 Research objectives**

The primary objective of the study is to look at the factors promoting the use of modern and/or traditional method of contraception or both by women in Ghana.

Specifically, the study seeks to address the following,

- (i) To compare the perceptions and assessments about contraceptive use by married women aged 25-30 to that of older married women aged 40-45 years.
- (ii) To compare the differences in the perceptions of contraceptive use by these two groups of women (younger married women aged 25-30 and the elderly ones aged 40-45) in one peri-urban and one urban area.

### **1.4 Research questions**

The following research questions will serve as a guide to achieve the set objectives.

- (i) How do women perceive modern and traditional methods of contraception?
- (ii) Why do women use the traditional or modern methods of contraception or both methods of contraception?
- (iii) How do service providers disseminate information and knowledge on the use of modern and traditional methods of contraception to women and also how they make contraceptives available to women?
- (iv) What role do husbands and other household members play to influence a woman's choice of either modern or traditional method of contraception?

## **CHAPTER 2 THEORETICAL CHAPTER**

### **2.1 Introduction**

It is always important that a good research is linked to one or more theories or concepts. This is because different concepts and theories are used for choosing a methodological approach as well as for developing analytical tools for the research. There are a number of theories that have been put forward by health geographers and demographers that can be used to explain contraceptive use for birth control. In this study however, the following theories would be used to aid in the choice of the methodology and also in the analysis. They are the structuration theory and the Gender and Development (GAD) and Women Culture and Development (WCD) approaches advanced by feminist scholars. The significance of the theories to the study will also be explained.

### **2.2 Structuration theory**

The first approach or theory to be used is the structuration theory. The theory is one developed by geographers who sought to explain human geography as a voluntary discipline (in which events result from purely individual intentions) than explaining it deterministically (which tries to read off the specifics from general laws of capitalism) as argued by structural Marxists. Structuration theories have been explained by scholars as Bourdieu (1977), Bhaskar (1979) and Giddens (1979; 1984). Among these scholars it is the work of the British sociologist Anthony Giddens that has had the most profound influence on human geography. His theories were founded on a critique of the structural and interpretative sociologies that were connected to, but not synonymous with, the Marxist and humanist traditions that surfaced in the human geography of the early 1970's. (Cloke et al., 1991, P.93, cited in Holt-Jensen, 2000). Giddens explanation of the structuration theory is as follows. Giddens (1984) explains that he has tried to develop an ontology (a basis for understanding the world) of human society (concentrating on how to theorize human agency) and to consider the implications of this theorizing for the analysis of social institutions. Human agency to him refers to people's capabilities and their related activities or behaviours, but not to the agents themselves. Giddens theory

compared to that of structural Marxists, where agents are ruled by structures, he argues that structures are being created and recreated through human agency; the agents' position is central. The individual agent however has only an incomplete knowledge of either the empirical world or the 'mechanisms' (social rules) of the society that structure his or her actions.

In simple terms, Giddens argue that individuals are born into societies that entrap them with social structures, which both constrain and also enable them. While we live out our lives under the rules made by society, we are also reproducing these rules, but not necessarily in the same form.

There are some basic concepts spelt out in Giddens structuration theory. They include the concepts of structure, action, social rules and duality of structure.

Structures are sets of rules (constraints) and resources (capacities or possibilities) which exist only as memory traces, the organic basis of human knowledgeability and as instantiated in action (Giddens 1984). Simply put structures can be understood as rules and resources for action. In talking about structures as resources, a woman living in an urban area is likely to have access to a long term contraceptive method like tubal ligation or even Norplant than her counterpart in the rural area. This is because these methods can only be administered in well established Family planning units which may not be available in the rural or remote areas.

There is also the concept of action. Action according to Giddens represents the routine actions of daily life. Action is regarded as a continuous process rather than as a series of isolated single actions with specific intentions or aims. However skilled and competent agents may be, their knowledge is limited. As a result conditions of actions may remain unacknowledged and the consequences of action may be unintended. Agents are just as much influenced by the actions of others as they are by the rules and limitations of structures.

Social rules are implemented through the interaction of people with each other. Social rules also structure interaction, and the rules which structure interaction are themselves

reproduced by the process of interaction. Individuals in the society follow such rules consciously or unconsciously, depending on the degree to which they are self-evident to them. For instance many married women in both urban and peri-urban areas in Ghana will decide to use one form of contraception or another because of the massive sensitization programs in the country and the need for contraceptive usage to minimize fertility rates and hence population growth. A woman may however choose to use a contraceptive method because of other reasons.

Lastly, is the concept of duality of structure. From the theory we see that structures set the conditions of human actions, but they are also the results of human actions. Individuals are formed by society and its institutions, but they are skilled agents who direct their own lives through actions (agency).

Giddens idea is about the fact that structures influence individual behaviour, but behaviour can reciprocally influence structures. (Cloke et al. 1991, cited in Holt-Jensen 2000). In summary, structuration theory tells that both structures and agency/people influence each other and this leads to some structural changes in the society. The main criticism of this theory is that it does not give direct guidance on how to proceed in scientific investigations and for the absence of formal links between structuration theory and empirical studies.

This theory can however be applied to the study in the sense that contraceptive usage by women can be influenced by their personal reasons as well as by existing structures and institutions in the society. Women in this sense become the agents (human agency) and the structures can include available family planning units in an area constructed by the government or a Non Governmental Organizations, pharmaceutical shops where contraceptives are sold and the social structures comprising of the spouses of women, other family members and the entire society at large. The existence of a family planning unit or a pharmacy (structure) in one geographical area can perhaps influence how a woman will get access to contraceptives. Reciprocally, the individual concerns expressed by women (agents) who visit a family planning unit about the different contraceptive types (i.e. individual women's behaviours, perceptions and experiences) can influence



family planning experts to know which methods to advocate for or the best strategies to adopt to improve contraceptive usage.

Finally the theory will help to explain one research question which seeks to know where and how women receive information about the different contraceptive types and also how to use them. The various family planning service centres available in a society and the ease with which women utilize the services in the society will help answer the research question.

### **2.3 Theoretical approaches to women, gender and development**

A look at the different theories on gender and development can also provide good basis for this research. Gender is simply defined as the socially constructed roles of men and women in societies. There are five main theories that have been put forward to explain researches in gender and development as well as in other researches. The theories basically try to explain the inequalities that exist between men and women when one considers their productive and reproductive activities. In different societies in Africa, the assumption is that women should be actively involved in reproductive activities than productive activities.

Even though I will try to discuss briefly each of the different approaches, more emphasis will be placed on Gender and Development (GAD) and Women, Culture and Development (WCD) as they pose a greater influence on the study. This is because contraceptive use by women is highly dependent on the relationships that exist between men and women in society as explained by GAD. Secondly, the culture, values and norms of individual societies influences the productive and reproductive activities of men and women and this is embedded in the WCD approach.

Women in Development (WID) is mostly labeled as the first approach or theory used in studies on gender and development. It came into being in the early 1970s. The approach points to the fact that women are invisible and excluded in the development process. The approach calls for men and women to be treated equally in the working environment or in

production. The approach has been criticized among others as taking the existing gender relations between men and women for granted. It also did not theorize about how women were suppressed by men.

In view of the criticisms of WID, Women and Development (WAD) came into being in the late 1970s as a development upon the ideas of WID. WAD argues that women have always been part of the development process and that women are suppressed only when development is related to modernization. WAD has also been criticized for taking for granted the gendered division of labour that existed both at the household level and at the international level.

In the early 1980s, the ideas of Gender and Development (GAD) came to the forefront. GAD explains how women are suppressed in society on the basis of the gender relations between women and men. It is strongly believed that women's use of contraception and hence control over their bodies can to some extent be influenced by the role the women themselves play in reproduction but also their husbands reproductive rights as determined by the society has a greater influence. The gender relation between the man and the woman in the house is therefore a critical determinant of contraceptive use in the marriage.

Women, Culture and Development (WCD) approach is seen as the most recent approach compared to the others. This approach was developed by Bhavnani et al (2000). WCD compared to WID, WAD and GAD argues for one to consider the distinct cultures of individual regions as one studies gender relations between men and women. The approach also makes a distinction between the productive and reproductive roles played by men and women in a society. The approach can explain some aspects of the study because, contraceptive use by women in different societies can be better explained if we consider the roles and power relations between men and women regarding their reproductive lives. There may also be some values, customs, norms and other institutional arrangements in individual societies that may influence contraceptive use.

These theories (GAD and WCD) can best explain the question of the role played by husbands and other household members or the society to influence women's choice of contraception. The theories used in the study will serve as useful tools to help analyze the results qualitatively as the greater part of the response will be in narrative forms.

## **CHAPTER 3 METHODOLOGY OF THE STUDY**

### **3.1 Introduction**

Methodology is defined by Kitchin and Tate as a coherent set of rules and procedures which can be used to investigate a phenomenon or situation. (Kitchin and Tate, 2000).

In this section, I will mainly look at how to generate the data for my study and also the method of analysis. The chapter comprises the choice of methodology, sources of data, sampling procedure of respondents and the techniques of data analysis. This section will also provide a critical reflective analysis of the data collection process, the reliability and validity of the study and possible biases that may distort the result. The data generated from the study participants include that of their socio-demographic characteristics as well as their perceptions and experiences about contraceptive use.

### **3.2 Choice of Methodology**

There are two main methodological processes which are adopted in many geographical researches. They are the quantitative and qualitative methods. The choice of any research method is however based on the objective of the study. Kitchin and Tate (2000) argues that choosing a research method is not just a case of picking the one that seems the “easiest” but picking the most appropriate relative to the knowledge you require.

This study will mainly be qualitative in nature. Qualitative method is best suited for this research because it looks greatly into peoples own perceptions and assessments about a situation or a phenomena. Qualitative research gives a stronger consideration to the feelings, experiences, beliefs and attitudes that individuals have. (Gatrell, 2002). Minichiello et al (1995) assert that qualitative methods include approaches that seek to uncover the thoughts, perceptions and feelings experienced by informants. Baker (1999) also tells us that the findings of a qualitative study are presented not in numbers but solely in words. Those using qualitative methods do so because they seek a deeper understanding of human beliefs, values and actions and they do so from the standpoint of an equal partnership between the researcher and the researched. In view of the sensitivity

of my topic I had to approach my primary respondents with some sense of maturity and also used semi- structured open-ended interviews which allowed them to have the chance to share their experiences and to present other sub-topics or views with this flexible structure of the research instrument. I refer to the study as sensitive because questions on issues concerning people's reproductive lives are considered as mostly private in many parts of Ghana. Before approaching this specific theme, I began most of my interviews with a discussion about some general topics mostly about the communities they are living in or about a popular political discussion by the media. Kitchin and Tate classify the qualitative method into two main categories- Interviewing and observation. I adopted the two (different types of interviewing and non-participant observation) in order to get a better understanding of my research problem. The methods are appropriate for this study because the study seeks to know peoples perceptions and assessments about contraceptive use. The method will help to uncover the feelings and experiences of respondents about the topic under investigation.

### **3.3 Sources of data**

As in many other social science researches, the data for the study was sourced from primary and secondary sources. Primary data, however, constituted a greater proportion of the data used for the study. The primary data was collected from 20 married women and spouses of four of the women, 4 pharmaceutical attendants, a senior nursing officer and 4 mid-wives working in the family planning unit in Koforidua and finally the program officer (research) at the offices of the Planned Parenthood Association of Ghana in Accra. I employed the use of a semi-structured to structured interview guides to solicit for information from my respondents. The research instruments were used based on the type of informant and the nature of the information I was interested in collecting. I also sought for some literature and statistics on contraceptive usage from books and journals, articles and reports from libraries and offices of family planning experts in Koforidua and Accra. (This is further elaborated on in section 3.6).

### **3.4 PRIMARY DATA SOURCES**

#### ***3.4.1 Qualitative Interviews:***

The main source of data for the study was collected from primary sources. As has been mentioned earlier on the main data set for the study was sourced qualitatively. In this section I focus on the various types of interviews that were employed to generate data from my respondents. There were four main groups of respondents that I interviewed using three main different interview structures. I employed the use of a semi-structured interview guide for my primary respondents (married men and women) and the senior nursing officer at the family planning and reproductive health unit in Koforidua. (See interview guide in appendix). I used this type of interview in order to be able to give my respondents the room to elaborate further on their perceptions, assessments and experiences and to discuss in detail follow up questions. For the pharmaceutical attendants, I employed the use of a more structured open-ended interview guide. (See appendix). The interview with the research officer at the offices of PPAG was more of a conversation discussion without any strict format. (No interview guides).

Interviewing is said to be the most commonly used qualitative technique. Bauer and Gaskell (2000) define qualitative interviewing as interviews of a semi-structured type with a single respondent or a group of respondents. I employed the use of a semi-structured to structured open-ended interview guides to solicit for data from my respondents. Within a structured open-ended interview, the conversation is highly controlled by the interviewer and a series of open-ended questions are asked. Open-ended questions mean that the interviewee responses are not constrained to categories provided by the interviewer; respondents can give whatever answer they wish. It is hoped that open-ended questions better reflect a person's own thinking. This interview method is best suited for the topic because most of the married women (forming the majority of my respondents) had the chance to express their perceptions, feelings and experiences about contraceptive use. The use of a semi-structured interview also helps to increase the comparability of responses and ensure responses to all questions for every interviewee. It is also argued that the structured approach provides a natural basis of organization for analysis of data.

As with many other forms of interview, the structured open-ended interview has its own weaknesses. It is argued that because the interview is so highly structured and standardized, it allows little flexibility in relating the interviews to particular individuals or circumstances (i.e., it removes individuality).

Secondly the method may also constrain and limit the naturalness and relevance of questions and answers (i.e. the question might not be relevant to an interviewee but requires a response, and a particularly interesting response cannot be followed up in more detail). The semi-structured interview guide however allows for more flexible and open responses from respondents.

### ***3.4.2 Non-participant observation***

A well known technique in a qualitative study is observation. Observation is basically of two kinds- Participant observation and straight or non-participant observation. In participant observation the researcher seeks to observe events and the behaviour of people by taking part in the activity under study. Kitchin and Tate explain that in a non-participant observation process, the researcher is a visible and detached observer of a situation. Observation is important in qualitative studies as Walcott (1995) argues that in interviews “you get nosy” whilst in observation one watches as events unfold.

In view of the sensitive nature of my study, I chose to employ a straight observation method in order to help me to select relevant and useful respondents and to cross-check the validity of some of the responses from the interviews. Straight observation is classified into two main types by Kitchin and Tate. They are overt and covert observations. In covert observation, the researcher does not engage with the group under study and does not reveal to the group that they are being studied. In overt observation on the other hand, the researcher again does not engage with the group under study but makes no attempt to conceal fact of observation. Both forms of observation were employed in the study to the different respondents and at different settings.

On the field, I made some useful observations before and during the interviews. For instance before I began with my interviews I took time to visit my study areas just to

acquaint myself with the places, the people, their economic activities and most especially to observe some physical structures available for family planning services. During the period of my main field work I made the second observations. I employed the covert type of observation in the pharmacy shops I visited. This type of observation was used because I wanted to have a true idea of how the pharmaceutical attendants attend to their customers without them noticing that they are being observed. In employing the method I took a day each at Koforidua and Asokore to visit the different pharmaceutical shops I had earlier on visited to interview the attendants. At these visits, I observed the number and category of men and women who came to the shops to purchase contraceptives. I observed the various types that they request for. I also observed how the attendants demonstrate to their clients the different ways to use the various types of contraceptives. These observations took between 20 to 30 minutes.

Again, I visited the Family Planning and Reproductive Health unit at Koforidua on two occasions after my interviews. On my subsequent visits I was there purposely to collect some secondary data but took the opportunity to observe the activities of the nurses, midwives and doctors at the unit. On one occasion I observed a client complaining about the cost involved in purchasing the pills she has been taking daily. From this observation I realized that some women may find the costs involved in purchasing contraceptives expensive eventhough the mid-wife I spoke to was convinced that all the clients who come to the unit can afford every form of contraception they provide there. I also had the chance to witness how the nurses and midwives treat their clients with a high sense of hospitality and privacy as was said by the mid-wife I interviewed at the family planning unit. I again had the chance to witness how doctors and nurses provide their clients with the various contraceptive types from the very simple ones as pills and injections to a more complex one as the insertion of Norplant. Furthermore, I wanted to see if husbands (men) visited the unit alone or with their wives as was told by the family planning expert. Unfortunately, I did not see even a single man or one spouse accompanying his wife to the unit on the two occasions I was there. The type of observation at the family planning unit was the covert type since the nurses and their clients within the unit were not aware that they were being observed. I however employed the overt type of observation in order



to observe how the nurses administer norplant to their clients. On my visit I spent almost 3 hours at the unit as it took the senior nursing officer some time to get me the data I needed. Again the data was in the manual form so I had to spend some time writing out the ones relevant for my work. The condition here therefore gave me a nice opportunity to observe what goes on in the unit.

There wasn't much to observe about contraceptive knowledge and use as I interviewed the women and their husbands either in their homes or at their work places. However since I intentionally chose to interview men and women from two different geographical areas with different socio-economic and socio-cultural backgrounds, I took the opportunity to observe how these societal factors can influence women's choice of and use of contraception. Before the interviews, I observed the power relations between some couples in their homes as a basis to ascertain the level of negotiation in contraceptive usage among partners. For instance in one house at Asokore the man wanted to be present during the interview with his wife since he claims that he has the upper hand in their reproductive lives. In other homes, the husbands hurriedly excused us to have our interview conducted. Here the overt type of observation was employed as the respondents were aware that I was observing them.

The different types of observation employed here may influence the results in one way or the other. The covert type of observation will perhaps give a clearer picture of the phenomena under study or the attitudes of the respondents. The overt type on the other hand may provide some misleading conclusions. Many of the respondents may try to give answers that will please the interviewer. The covert type will also help the interviewer to do away with some in-built misconceptions about the group of people under study.

### ***3.4.3 Sampling of respondents***

In a qualitative study, the sample size is relatively small as the purpose of the study is to make more an in-depth analysis of the topic and not to study a representative sample of the population. In all I interviewed 28 primary respondents from two study areas

(Koforidua and Asokore) with different socio-economic and socio-cultural backgrounds. Koforidua is an urban area and the capital city of the Eastern Region whiles Asokore is a peri-urban area about 4kilometers from Koforidua in the same municipality. The socio-economic status and the socio-cultural environments are very different. Literacy rate and the purchasing power of the people are relatively high in Koforidua compared to Asokore. Many of the inhabitants in Koforidua work in governmental and Non-Governmental Organizations whiles the major occupation in Asokore is trading.

**Table 3.1 Number of primary respondents by type of respondents, sex and age in Koforidua and Asokore**

Location	Married women (25-30)	Married women (40-45)	Males (spouses) (25-30)	Males (spouses) (40-45)	Pharmacy attendants (Females)	Pharmacy Attendants (Males)	Total
Koforidua	5	5	1	1	1	1	14
Asokore	5	5	1	1	0	2	14
Total	10	10	2	2	1	3	28

Source: Fieldwork Koforidua and Asokore, 2006.

Primary data was sourced from 20 married women, 10 each from the two study areas (Koforidua and Asokore). In each of the study areas five of the women were between the ages of 25-30 and the remaining five between the ages of 40-45. These two groups of women were selected in order to ascertain how the lengths of their marriage and the number of children they already have may perhaps influence their choice of and use of contraception. The woman may also have different understandings of how the different contraceptive types work taking into consideration also how the cultural and traditional settings can influence their choice of contraception. In Koforidua I purposively selected civil servants living in four different suburbs with higher socio-economic status as my respondents. They were mostly teachers, nurses and others working in the local ministries. In Asokore, I made my fieldwork known to the inhabitants by attending a funeral ceremony in the community. According to the assemblyman of the community funeral grounds serve as the best place to get in touch with about 80 percent of the adults in the community. I managed to talk to the entire group and some of the women. During this event I selected four of my respondents. The four women scheduled appointments

with me to visit them in their homes for the interviews. The other six were selected randomly with special consideration to their socio-economic status. In addition two married men (spouses of selected women) one young, and one middle-aged from each of the study areas were interviewed separately on how they influence their wives use of contraception.

The selection of these respondents from the urban and peri-urban settings may probably help provide information about contraceptive knowledge, perception and use as it pertains in the two places. The perceptions and experiences of women may also differ with age. It is for this reason that women from two different age cohorts are chosen for the study. (See table 3.1). The table basically shows the primary respondents (men and women) in Koforidua and Asokore plus the pharmaceutical attendants. With the adoption of a semi-structured to structured interview methods these primary respondents were in the best position to answer some of the questions that the study seeks to ask. For instance the women themselves shared during the interview the knowledge they have about contraceptives, the types they use and the reasons for their choice of contraception. The men also provided some information concerning the role they play to influence contraceptive use by women. The ideas of these respondents will further be analyzed by support of the theories used in this study which have a bearing on the questions asked and answered.

It is worth noting that two of the respondents in Asokore refrained from being interviewed when they were told that I was going to record their responses. They were afraid that their voices will be heard on the radio stations or that they will appear in the newspapers. I therefore had to again purposively select two respondents to replace them. In Koforidua however, none of the respondents refrained from being interviewed.

Besides, there were semi-structured and structured interviews for the senior nursing officer at the family planning unit in Koforidua and two pharmaceutical attendants in each of the study areas respectively. These two groups of people seem to provide family planning services in many societies. The availability of these people in the society and

the manner in which they provide family planning services to women can influence contraceptive use. To answer the question of how women access the services of these people, these experts were interviewed. They were asked questions on how they disseminate information about contraception to women. Again they were asked if they were aware of any special concerns put forward by women about contraceptive use and how they addressed these concerns. Finally they were in a better position to come up with probable measures that can be taken to improve contraceptive use among women.

### **3.5 Conducting the interviews by the use of the semi-structured and structured interview guides**

In this study, I solicited for information from 24 primary informants in the two study areas, 4 pharmaceutical attendants and from 2 key informants (a senior nursing officer at the Family planning unit in Koforidua and the Program Officer- Research of PPAG). I employed the assistance of a male research assistant to help in interviewing the spouses of the married women to be interviewed. I chose to do this because there is the general belief that male respondents will feel more comfortable when being questioned by a male assistant in sensitive researches as mine. I took my time to go through my interview guide with him after which we both translated it into our local language (Twi).

I used a tape recorder to record the greater part of my interviews and also took some photographs with my respondents to show the differences in their socio-economic settings. I began with the women in Asokore and asked for two of their husbands for interviewing after which my assistant began with his male respondents. There were mostly three or four households in many of the houses I visited, but I was careful to select only one household in a house which had the socio-economic characteristics of the respondents I wanted. The interviews were mostly conducted in the twi as literacy rate is not very high in Asokore, and guided by extra privacy. Most of the women were interviewed either at their work places where they trade (mostly sellers) or in their kitchens (at home) in their husbands' absence. The men were interviewed in their homes as scheduled by. All of them were interviewed in twi. In conducting the interviews I began with a familiarization process where I discussed with them issues concerning the

work they were doing, about a political issue or about their community. The main interviews started after these discussions. By doing this I got many of my respondents to spare me a little of their time for the interviews. I interviewed all my respondents in isolated places. (in some cases under trees). Many of the interviews took between 35 minutes to 50 minutes. I had to make follow up visits to 4 of my female respondents as they were busy on my first visit and so we scheduled other appointment dates.

The situation was a little different in Koforidua. Most of the women interviewed were civil servants and so gave me appointments at their work places after I had visited them in their homes. Seven of the ten interviews with the women were conducted in English. The other three were conducted in the local language even though they also understood English. They preferred the local language because they believed that they could express themselves well and clearly when they speak *twi*. The men in Koforidua were however interviewed in their homes, and also under private conditions. The two men in Koforidua preferred to be interviewed in English whereas the other two in Asokore were interviewed with the local language.

Interviews with pharmaceutical attendants in Koforidua and Asokore were conducted by me in my local language. Each interview lasted for approximately 30 to 40 minutes.

Finally I conducted an interview with the senior nursing officer at the family planning unit of the Koforidua Regional Hospital. This interview was conducted in English and was treated with the fullest privacy since according to the senior nursing officer privacy to family planning issues is a guiding principle of the organization. The interview was conducted in her office with the door to her office closed. It was an elaborative interview as the senior nursing officer took her time to answer my questions and again patiently described all the activities that are undertaken in the unit. This interview lasted for almost one and a half hours. After the interview the nursing officer took me round the various offices and the theatre where they perform operations for some long term contraceptive methods like vasectomy, tubal ligation and norplant. This gave me the chance to take some photographs about the various activities of the unit.

### **3.6 SECONDARY DATA SOURCES**

Just as with quantitative studies, there are wide ranges of secondary data which one can utilize in qualitative studies. I therefore employed the use of some secondary data to supplement the information I had generated from my interviews and observation studies. I gathered some data on contraceptive knowledge and use from the Ghana Demographic and Health Surveys (GDHS) of 1998 and 2003. The GDHS provides information on contraceptive knowledge and use in all the regions in Ghana. It also shows the urban-rural disparities in contraceptive use in the country. It also provides some statistics on the different types of contraceptives that married women in the different individual regions use. I also sought for some literature on contraception in Ghana from books, journals, articles, magazines and newsletters from the offices of the PPAG and the family planning and the Reproductive Health Unit in Koforidua. In addition, I gathered some statistics on contraceptive usage in the New Juaban Municipality from the Family Planning unit in Koforidua. The data from the unit shows the trends in the use of the different contraceptive types by women who have visited the unit for a ten year period. (1995-2005). These statistics are however not specific to Koforidua and Asokore alone but for the entire New Juaben Municipal Assembly of which the study areas fall within.

Furthermore, I visited the University of Ghana Balme Library, the Regional Institute of Population Studies (RIPS)-Legon library and the School of Public Health Library, all at the University of Ghana to gather some information on contraception. Some of the relevant literatures I managed to get hold of include “Factors affecting contraceptive use in Ghana by Tawiah, (1997), “Child-spacing patterns and fertility differentials in Ghana by Gaisie S.K (1981) and Population and Development in Ghana by the Population Impact Project, University of Ghana (1994). I also gathered some data from published and unpublished dissertations and also got additional information from the internet.

The use of these secondary data may have some limitations. First the data may not be very current and specific to my study area. A typical example is the data from the GDHS. These surveys are conducted nationwide and this is done every five years. It provides among others data on contraceptive knowledge and use for the whole country and for the

individual regions in the country. The most current report was published in 2003. One can however compare the trend of a given phenomena from the different GDHS.

Secondly the data on contraceptive usage as reported by the family planning unit in Koforidua can give a clearer picture of contraceptive usage in Koforidua than in Asokore because of its location. Furthermore the data does not provide a specific picture of contraceptive usage in Koforidua and Asokore only since the unit provides its service to other communities within the New Juaban Municipality within which the two study areas are located. This problem is minimized to some extent when one considers some of the personal information on contraceptive use given by the head of the family planning unit in Koforidua. She reported that women from Koforidua form the greatest number of people who visit the unit. Experiences and judgements from several years of practicing from the head can partly compensate for lack of statistics at lower geographical levels like my study areas. In spite of the few limitations these secondary sources of data provide a relatively good picture of the situation as it pertains nation-wide and also can reasonably be relevant for more urban and peri-urban regions like Koforidua and Asokore. It can also help in explaining some of the responses given by the respondents.

### **3.7 Data processing and analysis**

The main research instruments used for data collection were semi-structured interview guide for the primary respondents and a family planning unit head and a structured guide for pharmaceutical attendants (See appendix). These guides were reviewed and translated into my local language (twi) before I administered it in the field. There are different approaches to the analysis of qualitative data, but qualitative data is mostly analysed as narratives. Dey (1993) argues that in spite of the differences in emphasis adopted in each of the approaches, the various approaches to qualitative analyses all seek to make sense of the data produced through categorizations and connections. In line with my set objectives and research questions, I have managed to come up with some broad headings to tackle in the analysis. Since I am faced with very rich data material from different types of interviews and responses, I will try to categorize and connect some of the linking responses I have transcribed.

The data will be analysed by taking into consideration the following headings or themes; contraceptive types used by women in the younger and older age groups, differences in contraceptives use among women living in peri-urban areas and that of their urban counter parts, perceptions and judgements about contraceptive use by married women aged 25-30 compared to those 40-45, spousal influence on contraceptive use by women and perceptions and judgements of service providers (at the pharmacies and family planning unit) about contraceptive use in the study areas. Finally I will look into the opinions of my male and female respondents, pharmaceutical attendants and family planning experts about some measures that can be taken to increase contraceptive use in the Eastern Region and in Ghana as a whole.

Data on the socio-demographic characteristics of the respondents and the data collected on contraceptive use in the New Juaben Municipality will however be represented in tables. Data collected from secondary sources will be used as reference framework and partly to explain some of the results. Secondary data also serve as good materials for comparing some ideas from the field that are similar to the theoretical approaches or empirical findings.

### **3.8 Reliability and validity of the study**

This section deals basically with how valid and reliable the study can be or about the trustworthiness of the study. Every good research project is characterized by a relatively high level of reliability and validity, even if these concepts are most widely used in quantitative approaches.

Validity concerns the soundness, legitimacy and relevance of a research theory and its investigation. (Kitchin and Tate, 2000). Silverman (1993), cited in Kitchin and Tate, 2000 argues that issues of validity and reliability apply just as much to qualitative-based studies as they do to quantitative based-studies. There is a number of validity issues that one needs to consider in ones research. They can however be classified under two main headings- validity that relates to theoretical issues and those that relate to practical issues.



Reliability is an issue related to validity. Reliability according to Kitchin and Tate refers to the repeatability or consistency of a finding.

In view of the sensitive nature of this study, and the fact that it delves to some extent into people's private lives, some respondents may have given "wrong", or distorted or expected answers to some of the sensitive questions. Newman (2000) asserts that when questions are sensitive respondents may try to present a positive image of themselves to researchers instead of giving "correct answers". In some instances, some women may have lied about the types of contraception they are using and how they felt comfortable with their choice of contraception. Perhaps some women did not provide correct information about how regular they use their choice of contraception. It is hoped that these imbalances could be partly corrected since the spouses of four of the women who were interviewed were also asked to give some information about the contraceptive types that their wives are using.

The type of validity relating to practice concern the soundness of the research strategies used in the empirical investigation and the integrity of the conclusions that can be drawn from a study. The main research instrument that was used to generate primary data for this study was a semi-structured to structured interview guides depending on the respondent. The simple and straight forward questions that were asked in the guide enabled the respondents to have the chance to express their individual perceptions judgements and experiences about contraceptive use. Before conducting the interview at Asokore, I had the chance to talk to most of the inhabitants of the community at a funeral ceremony. This gave me easy access to my respondents as most of the people I later on interviewed were present at the funeral grounds. Some of the respondents could have however given me very "favourable" answers which may be different from what is happening in reality since they had earlier on been informed about my mission and research work.

Furthermore, in conducting the interviews, I employed the assistance of a male research assistant to interview the spouses of four of the married women. In as much as it is generally believed that most female respondents feel comfortable when they are being

interviewed by their female counterparts, this was not the case in some of my interviews. I observed that some of the women working in the civil service in the urban area did not feel very comfortable sharing their experiences with me. Perhaps they would have felt very comfortable being interviewed by the male assistant. This can be attributed to the fact that most of them felt that I was in a better position (a female with higher level of education) to better understand their opinions and experiences which is within areas of the private sphere. The use of the male assistant to interview the males however was excellent according to his view. They were all very comfortable with the discussion and felt free to share their ideas and experiences.

Reliability as has been mentioned earlier on is related to validity. Reliability refers to the ability of an instrument to give consistent results over many tests. It may be difficult for one to argue that a research instrument will yield the same results or more richer or meager information when used and interpreted by different researchers and at different periods. This is because other researchers will interpret the information given by a research instrument based on their set objectives. It is therefore hoped that other researchers will come up with similar interpretations of the results if they are addressing similar research problems or objectives as in this study.

All the interviews conducted in this study were done under the highest level of privacy so that respondents will feel comfortable with their responses. I conducted most of the interviews myself including that of my key informants. It is with the male respondents that I employed the assistance of a male assistant. I think this strategy worked very well for me. Moreover I made several visits to the study areas and booked appointments with many of my informants before conducting the interviews. I also made some supplementary observations at all the places where I interviewed my respondents. This afforded me the chance to have a first hand knowledge about the judgements of my respondents and the activities of service providers. The greater part of the interviews was also done in my local language (Twi) which gave me the chance to explain my questions to the best understanding of my respondents.

With regards to my secondary data source, I managed to gather some qualitative and statistical data on contraception from some books and articles. This will serve as good

basis for explaining contraceptive knowledge and use in Ghana. In as much as there is a lot of literature and statistics on contraception for the different regions in Ghana including the Eastern Region I could not get any concrete statistical data showing trends in contraceptive use specific to my study areas. Nevertheless I got insight in the works of some friends which were relevant for my study.

On the whole, I think I managed to ask my respondents questions which address most of my research questions. I could however have given a better picture of the study if I could further minimize or control some of the limitations of the study.

I can therefore say with some degree of confidence that the study is trustworthy based on the manner in which I handled the data collection process and the information I managed to gather for this study. The study possesses the qualities of being reasonably valid and reliable taking into consideration the sensitive nature of the topic.

### **3.9 Limitations of the study**

This research work as compared to many other researches may have some possible limitations or biases. The following are some possible limitations.

The first one has to do with the selection of the respondents. The researcher may have been biased in the selection of respondents, especially with those living in the urban area. In order to ascertain the differences in contraceptive knowledge and use between women living in an urban area (Koforidua) with higher socio-economic status and environment and a peri-urban area (Asokore) with a relatively lower socio-economic status and environment, most of the respondents selected in the urban area were working in the civil service whereas the majority of those in the rural area were traders. Perhaps this is because most of the women living in Asokore engage in one form of trading or another and have no or lower levels of education. General literacy rate in Koforidua on the other hand is higher than in Asokore. This selection process may not provide a clear picture of the whole situation as we can have both categories of working women in both study areas who would have shared different perceptions and experiences. This selection was however done purposely to address the objectives of the study. There are however marked differences in the way of living of the people in the two study areas since

Asokore is a more homogenous society with mostly people from the Ashanti region who live a more traditional Ashanti life. Koforidua is inhabited by people from different regions of the country.

Secondly, the personality of the researcher may have in a way influenced the responses given by the respondents in the two study areas. In my data collection process, I observed that some of the women in the urban area did not feel very comfortable sharing their experiences about contraceptive use with me. This is because they realized that I am in a better position to understand their ideas or to read meanings into their responses. In view of this they would have given me wrong answers, “expected answers” or hidden some of their experiences and concerns from me. In Asokore (peri-urban area) however, many of the women were willing and comfortable to share their experiences and I realized some even went to the extent of exaggerating the side effects that they experienced/are experiencing from using some contraceptive types.

There were also two ethical considerations that may probably affect the results of the study. First, I had to take my time to explain further the purpose of my research to some of the respondents because they had some misconceptions about the study. Some of the women were particular about what the study will do to enhance their livelihoods. For instance, in Koforidua, a kindergarten school teacher with twelve children wanted to know if sometime later she will be provided with some assistance to help her cater for her children. I had to convince her that my study is purely academic but that it will possibly help the government and family planning experts to address the family planning needs of the community. Secondly, in Asokore some women were also not willing to be interviewed because of the use of the tape recorder. Those women probably could have provided me with some meaningful information but they were afraid that issues concerning their private lives will be published in the newspapers or their voices will be heard on radio stations.

Finally, the time allocated for the data collection period was woefully inadequate. This is because I had to make appointments with most of my respondents and key informants

within a couple of days before conducting the interviews. The key informants were mostly at meetings or were busy with other official assignments. Some of the respondents were also busy with work and had to schedule for other appointment dates.

In spite of the afore-mentioned limitations, I hope the responses I had from the respondents I managed to interview will help me to answer most of my research questions.

## **CHAPTER 4 THE STUDY AREA AND FAMILY PLANNING STRATEGIES IN GHANA**

### **4.1 Profile of Ghana**

Ghana is located in West Africa Gulf of Guinea and a few degrees north of the equator. The country is bounded on the north by Burkina Faso, on the east by Togo, on the south by the Atlantic Ocean and on the west by Cote d'Ivoire. Ghana has a total land area of about 238,538 square kilometer (92,100 square miles). The land of Ghana is relatively flat and the altitude is generally below 500 meters, with more than half of the country below 200 meters. The coastal area consists of plains and numerous lagoons near the estuaries of rivers. The 537-kilometres (334 miles) coastline is mostly a low sandy shore backed by plains and scrub and intersected by several rivers and streams, most of which are navigable only by canoe. Ghana is divided into 10 administrative regions which are sub divided into 110 districts. Accra is the capital city of the country with a population of approximately 3 million. Other larger cities include Kumasi, Cape Coast and Sekondi Takoradi.

Ghana is a country which is characterized by rapid population growth rate. Population growth, stabilization or decline is caused by the interplay of three demographic variables namely fertility, mortality and migration. Ghana's population has been increasing from census years to census years. The 1984 population census of Ghana estimated the country's population to be 12.3 million (Ghana Statistical Service 2002). That of 2000 gave a population figure of 18.9 million. The population as at 2000 was estimated to be 22 million.



**Figure 4.1 Map of Ghana showing the 10 regions and their capitals**

Source: [www.ghanaweb.biz/GHP/img/pics/42291028.gif](http://www.ghanaweb.biz/GHP/img/pics/42291028.gif)

Retrieved 20<sup>th</sup> March, 2007

## **4.2. Description of the Study Areas**

The study made use of 2 study areas, one an urban area, (Koforidua) and the other a peri urban area (Asokore). The subsequent paragraphs give a brief description of the study areas.

### **4.2.1 Description of Koforidua**

Koforidua is an urban town located in the Eastern Region of Ghana. It is the capital city of the region and the major town in the New Juaben Municipality (a local authority unit established in 1988). The region recorded a total population of 2,108,852 forming 11.5 percent of the total population of the country (Ghana Statistical Service, 2001).

It has the third highest population. The town itself has a total population of approximately 87,315 comprising of 42,099 males and 45,216 females (Ministry of Local Government and Rural Development, 2002).

The housing structures in Koforidua are mostly self-contained houses of detached or semi-detached types. These houses are mostly inhabited by different nuclear families. There are however a few compound houses located at the indigenous areas of Koforidua like Betom and Srodae. These houses normally have both people from nuclear and extended families occupying them.

Koforidua has a total land area of approximately 110 square kilometers. Its immediate bordering towns include Effiduase, Ada, Densu Agya, Okorase and Ntronan. (Fig 4.2) The capital town is sub-divided into several suburbs. Some of them include Betom, Oguaa, Srodae, Anlo Town and Atekyem. (Fig. 4.2)

The town is characterized by semi-deciduous rain-forest vegetation. It has two main climatic types- the rainy season and the dry season. The town receives average rainfalls of between 1200mm and 1700mm reaching its maximum during the two peak periods of May-June and September-October. The dry season is relatively short while humidity and temperatures are generally high ranging between 20 degree Celsius and 32 degree Celsius.

Like many other capital towns, most people in the working class in Koforidua are employed by the public and private service sectors in the town which include the banks, schools, insurance firms and the ministries. Other people also engage in large and small scale businesses. There are a few large scale poultry farming companies. People who engage in crop farming normally do it on small scale basis usually at their backyards and for subsistence purposes.

Koforidua also has the biggest and well equipped Regional hospital which serves the town and other towns and villages in the region. There is one other government hospital apart from the regional hospital. The town has 8 clinics, 1 Family Planning and Reproductive Health unit and 3 maternity homes. There are also a number of hotels, restaurants and guest houses in Koforidua for recreational purposes.

In terms of Education, Koforidua can boast of 1 private university, 1 polytechnic, 6 secondary schools and 73 basic schools.



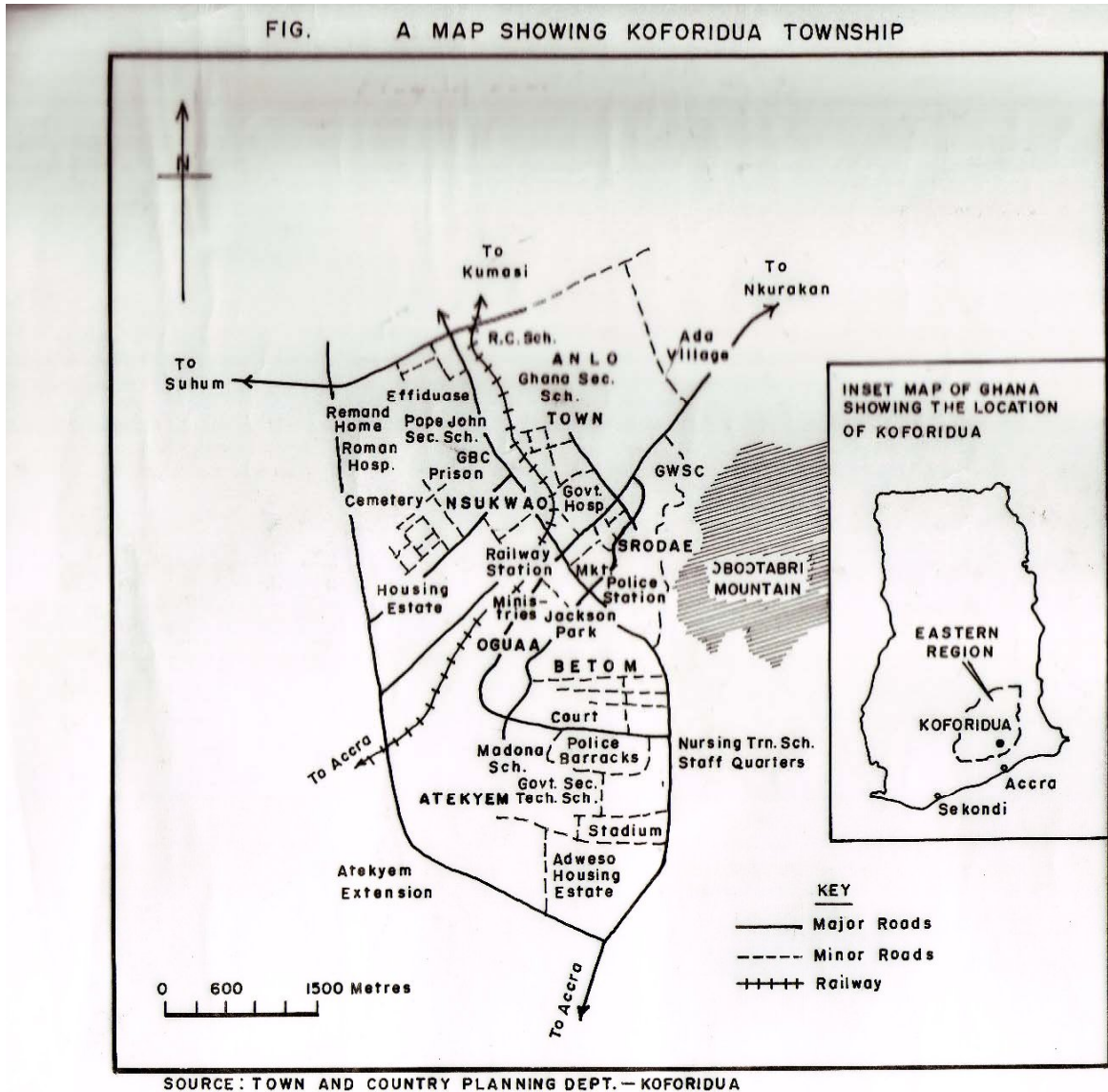


Figure 4.2 Map showing study area (Koforidua- urban town)

#### 4.2.2 Description of Asokore

Asokore is designated as a peri-urban area and also located within the New Juaben municipality in the Eastern Region. Asokore is bordered by other smaller towns as Oyoko, Jumapo, and Effiduase. The town is located about 4km from Koforidua. The town has similar climatic and vegetation characteristics as Koforidua. It has a very rich

soil type which is well suited for perennial tree crops and semi-perennial food crops such as cocoa, cassava, plantain, citrus and vegetables.

Asokore has a total population of approximately 10,086 comprising of 4,899 males and 5,169 females (Ministry of Local Government and Rural Development, 2002). About 80% of the people living in Asokore stay in compound houses. In the compound houses one can find about three or four nuclear families/households in the house or one big family made up of people of the nuclear and extended families. The housing system of Asokore makes the town look more traditional than Koforidua. The people of Asokore are also very particular about their traditional values and practices. This is very evident in how the people adhere to most of the traditional rules and norms of the society. A good example is about how almost the entire adult community of the town attends the funerals of their departed ones on weekends. The extent to which the family system influences women's use of contraception is more prevalent in Asokore than in Koforidua (This is explained further in chapters 6 and 7).

The major economic activities in Asokore are trading and farming. Perhaps this is because literacy rate in Asokore compared to Koforidua is generally low. Asokore however has some educational institutions. It can boast of 1 teacher training college, 2 secondary schools and 11 basic schools. Asokore has no hospitals, family planning unit and maternity homes but one clinic-Asokore Health Center.

FIG. A MAP SHOWING THE LOCATION OF ASOKORE AND KOFORIDUA IN THE NEW JUABEN MUNICIPALITY

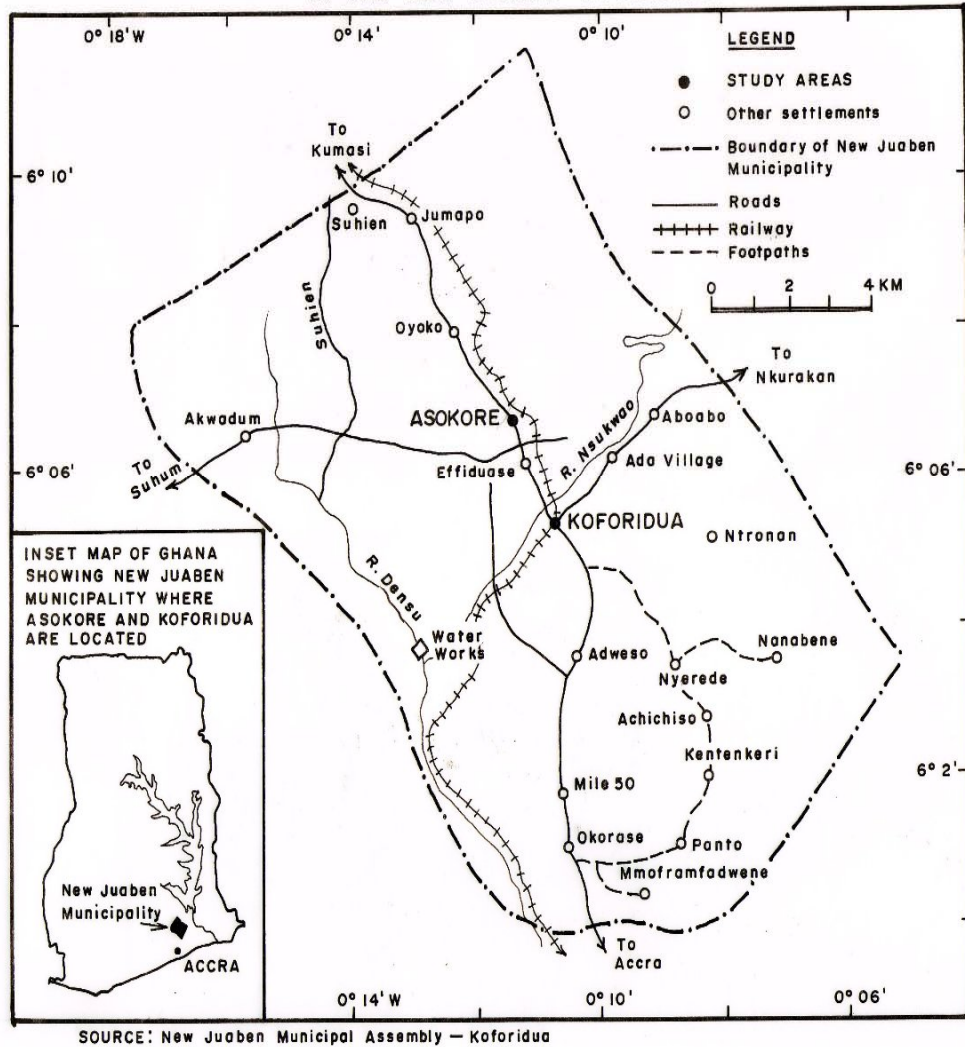


Figure 4.3 Map of Koforidua (urban area) and Asokore (peri-urban area)

### 4.3 Family Planning in Ghana

Family planning which is the conscious effort to determine the number and spacing of births, the right of individuals and couples to “freely and responsibly decide the number and spacing of their children and have the information, education and the means to do

so”, was first recognized as a human right in 1968, and over the past two decades has attained almost universal acceptance. (Planned Parenthood Association of Ghana 1967-1992, 25<sup>th</sup> Anniversary Report.)

In Ghana family planning owes its beginning to two private organizations. They are the Christian Council of Ghana and the Planned Parenthood Association of Ghana. These two organizations realized the need to undertake family planning activities in Ghana after a group of doctors and nurses had expressed concern about increasing maternal and child mortality cases in the 1960’s. (Owusu & Batse, 1991).

In line with the ideas of these two organizations being that individuals should have control over their reproductive lives and hence to control fertility levels, the government in the 1960s also showed great concern about the country’s population growth rate. The Ghanaian government was a co-sponsor of a resolution on population growth and economic development in the 1962-63 sessions of the United Nations (UN) General Assembly and was the first sub-Saharan country to sign the “World Leaders Declaration on Population” in 1967 that called attention to the population question. In 1969 Ghana issued a general policy paper, “Population Planning for National Progress and Prosperity”, which included provisions for family planning services.

Furthermore, the government in 1969 carried out a mass publicity and education campaign on family planning and during late 1970 sponsored an awareness week designed to encourage acceptance of family planning. Again, in line with the governments’ ambition to control its population growth rate, it issued a definitive policy on population in March 1969. The policy document affirmed the government’s commitment to adopt and implement appropriate strategies and programs to manage population growth in a manner consistent with government’s ultimate objective of accelerating the pace of economic modernization and improving the quality of life of Ghanaians. In 1994, the government issued a revised version of the 1969 policy document. This was done because the government realized that 25 years after the first policy was promulgated, the country’s rate of population growth still remained at an unacceptably high level, and the population factor continued to act as a serious

impediment to the country's march towards economic modernization, sustainable development and eradication of poverty.

There are a number of Governmental and Non-Governmental organizations (NGOs) in Ghana working on issues related to Reproduction and Family Planning. The National Population Council (NPC) is the major governmental body established in 1994 to advise government on population and related issues. This is the main body set up to see to the implementation of the aims and objectives of the 1994 population policy. The NPC works in collaboration with the Ministry of Health (MOH) the Ghana Health Service (GHS) and other NGOs. Some NGOs include the Planned Parenthood Association of Ghana (PPAG), Ghana Social Marketing Foundation (GSMF), Population Council and Family Health International (FHI).



**Figure 4.4 A sign post in front of the PPAG clinic in Accra showing services provided by the clinic.**

Planned Parenthood Association of Ghana (PPAG) is currently the leading NGO providing Sexual and Reproductive Health (SRH) in Ghana. The association was established on March 3<sup>rd</sup> 1967 as a Non-Governmental organization affiliated to the International Planned Parenthood Federation (IPPF). The Association has a long history of leadership in Family planning programs in Ghana and has pioneered many projects

including Family Life Education (FLE) for the youth, and the integration of family planning into community development projects.

The Association works to complement the efforts of government in providing healthcare and development for the nation.

#### **4.4 Contraceptive use in Ghana**

Knowledge about contraception is almost universal in Ghana. The 2003 Ghana Demographic and Health Survey (GDHS) report indicates that 98 percent of all women and 99 percent of all men know at least one modern method of contraception. The proportion of men and women who know about the traditional or natural methods are lower, perhaps this is because there isn't much education and publicity of the methods. 75 percent of the women interviewed knew about some traditional methods of contraception. With the above picture one would expect that contraceptive usage should be very high in Ghana. Ironically, this is not the case. Ghana's Contraceptive Prevalence Rate (CPR) among married women (which is relevant in this study) stands at 25 percent. (Ghana Statistical Service et al 2004). The 2003 GDHS shows that 15 percent of women use modern contraceptive methods while only 5 percent are using the traditional methods. Among the modern methods male condoms, pills and injectables are the most commonly used methods (4 % of each). Female sterilization, implants and Intra Uterine Devices (IUD) are used by 1 % each while female condoms foam/jelly and diaphragms are the least used modern methods (less than 1 % each). Of the traditional methods, periodic abstinence is the most commonly used (4 percent) while withdrawal is used by 1 percent. There are rural-urban disparities in contraceptive usage in Ghana. Women in urban areas are more likely to use contraceptive methods (31%) than their rural counterparts (21%).

A look at the trend in contraceptive usage among married women from 1988-2003 shows a steady increase in usage over the years. In spite of this steady increase the changes are not high enough to have a significant influence on Ghana's birth rates and hence population growth rate. The trend is represented in the table below.

**Table 4. 1 Trends in the use of specific Family Planning methods by married women aged 15-49 (in percentage)**

<b>Method</b>	<b>GDHS 1988</b>	<b>GDHS 1993</b>	<b>GDHS 1998</b>	<b>GDHS 2003</b>
<b>Any method</b>	12.9	20.0	22.0	25.2
<b>Any modern method</b>	5.2	10.1	13.3	18.7
Pill	1.8	3.2	3.9	5.5
IUD	0.5	0.9	0.7	0.9
Injectable	0.3	1.6	3.1	5.4
Diaphragm	1.3	1.2	0.9	0.5
Male condom	0.3	2.2	2.7	3.1
Female condom	u	u	u	0.1
Female sterilization	1.0	0.9	1.3	1.9
Implants	U	0.0	0.1	1.0
LAM	u	u	0.5	0.3
<b>Any traditional method</b>	7.7	10.1	8.7	6.5
Periodic abstinence	6.2	7.5	6.6	5.1
Withdrawal	0.9	2.1	1.5	0.8
Other	0.6	0.5	0.6	0.6

u= unknown

**Source:** Ghana Statistical Service (2004a)

From the table, one would observe that the rate of change in contraceptive usage between 1988 and 1993 (12.9 to 20.3) was far greater than the change from 1998 to 2003 (22.0 to 25.2). Probably the educational campaigns for contraceptive usage had declined during the 1998-2003 year period. There is also a considerable decline in the use of the traditional methods over the years. This is perhaps due to the fact that organizations who

campaign for the use of family planning services concentrate much on the modern methods neglecting that of the traditional or natural methods.

The proportion of women using contraception generally increases with increasing number of children. It is reported in the 2003 GDHS that 14% of women without children are currently using contraceptive methods, compared with 26% of women with five or more children. Contraceptive usage is however highest among women who have three or four children.

The pattern of current use of modern and traditional methods of contraception is generally similar across different subgroups (e.g. Married and unmarried) in the country. Use of both modern and traditional methods are more common in urban than rural areas, and increases with increasing education.

#### **4.5 Contraceptive use in the Eastern Region**

The Contraceptive Prevalence Rate (CPR) for the Eastern Region is 27 percent slightly higher than the national average of 25 percent (Ghana Statistical Service, 2004). This rate seems to be too low to bring down or stabilize the ever-increasing population of the region. The 2000 population and housing census report indicates that the region has the third highest population figure for the country. Again there is the need for an improvement in contraceptive usage in the region as it is noted to have the highest HIV/AIDS cases in the country. An increase use of condom for instance will help to reduce fertility and also prevent HIV/AIDS.

The CPR of the region has remained the same since 1998; however there have been changes in the use of the different modern and traditional methods as shown in the table below.



**Table 4. 2 Contraceptive use by married women in the Eastern Region for 1998 and 2003 (in percentages)**

<b>Method</b>	<b>1998</b>	<b>2003</b>
<b>Any method</b>	26.6	27.1
<b>Any modern method</b>	19.6	21.5
Pill	8.2	7.7
IUD	0.6	0.7
Injectable	4.1	4.2
Diaphragm/Foam/Jelly	1.3	0.6
Male condom	4.9	3.5
Female condom	0.0	0.3
Female sterilization	0.5	2.7
Male sterilization	0.0	0.0
Implants	0.0	1.5
*LAM	0.0	0.3
<b>Any traditional method</b>	7.0	5.6
Periodic abstinence	5.9	4.6
Withdrawal	0.9	1.0
*Other	0.3	0.0
Not currently using	73.4	72.9
Total	100.0	100.0

**Source:** Ghana Statistical Service et al, 1999 and 2004a

LAM= Lactational amenorrhoea method

Other= include the use of herbs and strong alcoholic drinks

The table shows that there has been a slight increase in modern contraceptive usage but a decline in the traditional methods from 1998 to 2003. It also shows that there has not been any significant increase in the use of the various methods but rather a decline in some of them. Over 70 percent of married women are also not using contraceptives as indicated in the table. With this picture of contraceptive usage in the region, one would argue that this study is a timely one as it seeks to address the reasons behind the lower usage of contraception by married women. The study will hopefully come up with

plausible measures that can be taken to improve contraceptive use in the Eastern Region and in Ghana at large.

#### 4.6 Contraceptive use in Koforidua and Asokore

A picture of contraceptive usage in Koforidua and Asokore is presented by statistics on contraceptive usage in the New Juaben Municipality. The two study areas form part of the municipality and the main family planning unit which keeps records of contraceptive usage in the municipality is located in Koforidua.

According to the head of the Reproductive health and Family Planning unit at Koforidua, the majority of contraceptive users who visit the unit come from Koforidua. A relatively lower proportion of women come from the smaller towns and villages surrounding Koforidua of which Asokore is one.

Contraceptive usage by women from 1995 to 2005 is shown in the table below.

**Table 4. 3 Contraceptive users (women) in the New Juaben Municipality (1995-2005)**

<b>Year</b>	<b>New Acceptors</b>	<b>Continuing Acceptors</b>	<b>Total</b>
1995	632	722	1354
1996	734	891	1625
1997	714	944	1658
1998	812	1078	1890
1999	1178	1772	2950
2000	1161	1812	2973
2001	2810	3247	6057
2002	5862	8282	14144
2003	10180	8922	19102
2004	7868	6163	14031
2005	4240	3677	7917

**Source:** Reproductive Health and Family Planning unit, Koforidua (2006)

There had been a tremendous increase in the number of contraceptive users until 2004 2005 when there was a decline. The decline among continuing users may be due mainly to the negative side effects of some of the methods.

The contraceptive type that most women in the municipality prefer to use is the “Depo”, an injection taken every three months to avoid any unwanted pregnancy.

## **CHAPTER 5 AVAILABILITY OF CONTRACEPTIVES IN GHANA AND THE STUDY AREAS**

### **5.1 Introduction:**

People will decide to use various types of contraceptives only if they have access to it and can afford it. The chapter takes a look at the availability of different contraceptive methods for use by both men and women. The chapter looks at contraceptive availability in Ghana as a country, in the Eastern Region where the study areas are located and its availability in the main study areas of this research.

### **5.2 Description of the various contraceptive types**

The first thing we usually think of when we consider ways to control fertility is contraception. Contraceptives are classified into different types by writers and family planning experts. This is done because classification makes it easier and simple to analyze phenomena. It is sometimes categorized into types meant for males or females, whether it is a permanent one, a long term, or short term one, whether it is a chemical type, natural type or surgical type and finally whether it is modern, natural or traditional. The short term contraceptive methods include the pill, male and female condoms, vaginal foaming tablets and the Emergency Contraceptive pill. The long term methods include Norplant, Intra-uterine device (IUD) and the injectables. The permanent methods are male sterilization (vasectomy) and female sterilization (Tubal Ligation).

In the 2003 GDHS, the different contraceptive methods are grouped under two main categories – the modern or traditional methods.

The modern methods include the pill, IUD, Injectables, male and female condoms, female sterilization, Diaphragm and Implants. The traditional ones are the periodic abstinence method and the withdrawal method. Data generated from my fieldwork, also shows that some people use herbs and strong alcoholic drinks as traditional forms of contraception. The head of the Reproductive Health and Family planning unit (RHFP unit) at Koforidua also made mention of other natural/traditional methods. She gave other examples as the Lactational Amenorrhoea Method (LAM), the ovulation method and the Basal Body Temperature method (BBT).

Weeks (1999) have also come up with a different classification of different contraceptive methods. He has divided contraceptive methods into three main categories, according to whether they are primarily female, male or couple methods and according to whether their action is primarily barrier, chemical, natural, or surgical.

This classification is presented in table 5.1.

**Table 5. 1 Contraceptive methods**

<b>Primary characteristics</b>	<b>Primary use</b>		
	<b>Female</b>	<b>Male</b>	<b>Couple</b>
<b>Barrier</b>	Diaphragm, cervical cap, Female condom, Vaginal sponge, Vaginal spermicides, IUD*	Condom	
<b>Chemical</b>			
<b>Pre-coital</b>	Pill, Mini-Pill, Implants, Injectables		
<b>Post-coital</b>	Morning-after pill or Emergency contraceptive pill		
<b>Natural (traditional)</b>	Breastfeeding	Withdrawal	Fertility awareness, oral/anal sex and other forms of incomplete intercourse
<b>Surgical</b>	Tubal Ligation	Vasectomy	

**Source:** Weeks 1999.

\*Intra-Uterine Device

The subsequent paragraphs give a brief description of the different contraceptive types as illustrated in the book by Weeks.

The diaphragm is a rubber disk that is inserted deep into the vagina and over the mouth of the uterus sometime before sexual intercourse.

The female condom is a lubricated polyurethane sheath that is inserted like a diaphragm into the vagina just before intercourse. The male condom on the other hand is a rubber or latex sheath inserted over the erect penis just before intercourse. The marketability of the male and female condoms is based not only on its protection against pregnancy, but also on its ability to permit a woman or man to limit his or her exposure to AIDS and other sexually transmitted diseases.

The Intra-uterine device (IUD) was first designed in 1909, but it was not widely manufactured and distributed until the 1960's. It is a small flexible device that is placed in the woman's womb through her vagina to prevent pregnancy. Although it comes in several different shapes and can be made of various materials, the IUD most commonly used is a nylon plastic coil. The IUD can prevent pregnancy for up to 10 years but can be taken out sooner by a trained health provider if the woman desires to become pregnant.

The oral contraceptive or the pill as it is popularly known is a compound of synthetic hormones that suppress ovulation by keeping the estrogen level high in a female. This prevents the pituitary gland from sending a signal to the ovaries to release an egg. The pill is taken by the woman everyday at the same time to prevent pregnancy. She continues to take the pill each day until she wishes to become pregnant. When she stops taking the pill, she can become pregnant again.

Norplant is a progestin-only implant developed by the Population Council in New York. It is one-eighth inch long silicone rubber capsule containing a small amount of levonorgestrel, a synthetic progestin. The capsule is implanted just beneath the skin of a woman's upper arm and releases a tiny amount of progestin every day for up to 5 years before needing to be replaced.

The Emergency contraceptive pill (ECP) or the "morning-after pill is one designed to avert pregnancy within a few days after intercourse. The commonest type currently

available on the Ghanaian market is the “Today’s contraceptive”. A single dose of this pill is taken 72 hours after an unprotected intercourse and a second dose taken 12 hours after the first dose was taken. This pill is normally taken in emergency cases and not recommended as a regular method of contraception.

Vasectomy is a permanent method of contraception for men who want to stop having children. It involves cutting and tying off the vasa deferens, which are the tubes leading from each testicle to the penis. The male continues to generate sperm, but they are unable to leave the testicle and are absorbed into the body. After vasectomy, a man can have sex just as before but he cannot make a woman pregnant.

The most popular permanent method of contraception for females is known as tubal ligation. It is of two kinds- minilaparotomy and laparoscopy. The methods are administered surgically. Minilaparotomy involves an incision just above the pubic hairline, through which a surgeon grasps the fallopian tubes and “ties” them off with rings or by some other method. Laparoscopy utilizes a smaller incision, through which a laparoscope (a tiny viewing device) is inserted to assist the surgeon to “tie” the tubes. In both cases, the result is that an egg is released normally, but it is prevented from entering the uterus, and sperm are prevented from reaching the egg. The menstrual cycle continues as usual, except that the egg produced is absorbed into the body. Biologically there is no effect on a woman’s sexual response, although psychologically the virtual absence of a reason to fear pregnancy probably enhances a woman’s sexuality.

Exclusive breastfeeding or Lactational amenorrhoea method (LAM) is known to be one natural method of contraception. In the 1980’s the practice was elevated to the status of a natural contraceptive, especially through the issuance of the so-called “Bellagio Consensus”. In 1988 a group of experts met in Bellagio, Italy, to review the evidence regarding the use of breastfeeding as a deliberate method of preventing conception. The consensus of the group was that the maximum birth spacing effect of breastfeeding is achieved when a mother “fully” or nearly fully breastfeeds and remains amenorrheic.

When these two conditions are fulfilled, breastfeeding provides more than 98 percent protection from pregnancy in the first six months. (Kennedy et al 1989).

Withdrawal method is an essentially male method of birth control. The effectiveness of the method is relatively limited. It is in fact, a form of incomplete intercourse (thus its formal name “coitus interruptus”) because it requires the male to withdraw his erect penis from his partner’s vagina just before ejaculation. The method leaves little room for error, especially since there may be an emission of semen just before ejaculation, but it is one of the more popular methods used historically and in present times for trying to control fertility

Periodic abstinence method is a very popular natural method of contraception. The method works with some degree of efficiency as a woman is able to observe some days within the menstrual cycle which are not “safe” for sex so as to avoid sexual intercourse. In a typical menstrual cycle of 28 days for instance, days 8 through 15 represent the time of the cycle when the chance of conception is greatest. Sperm can survive for several days in the uterus, so intercourse during the few days prior to ovulation (day 14 of the typical 28-day cycle) has the highest chance of producing a fertilized egg and thus conception. Since an unfertilized ovum dies very quickly, the risk of conception drops off quickly after ovulation.

### **5.3 Availability of contraceptives in Ghana**

Contraceptive use is possible only if the populace have access to them. In Ghana there are different kinds of modern and natural/traditional methods of contraceptives available to people. The modern methods that are available are categorized into short term methods, long term methods and permanent methods.

The short term methods include the male and female condoms, pill, vaginal foaming tablets and the Emergency contraceptive pill. These contraceptives are mostly available in most pharmaceutical shops and health centres in different parts of the country. In



recent times condoms are even made available in many hotels and restaurants in the cities. These types of contraceptives require simple directions in their administration. Pharmaceutical attendants and other health officials are able to administer them to customers. In most cases people who can read administer them themselves since they are mostly packaged with instructions for use. Among the different brands of condoms we have in the country are “Champion condoms”, “Panther condom”, “Rough rider”, “Aganzi”, “Gold circle”, “Rocket” and “Romantic”.

There is also the most popular emergency contraceptive pill known as the “Today’s contraceptive pill”.

The long term contraceptive types include the Norplant, the IUD and the injectables. Many women in the country prefer to use Depo-provera, a three-month injection which seems to be very effective. (Head of Family Planning unit, Koforidua). These types of contraceptives are available in the hospitals, clinics and Family planning centres. These contraceptives are mostly administered by nurses, midwives or gynecologists since it may require a minor operation or an injection which can only be done by a trained professional. The health centres where these contraceptive methods are available are skewed towards the urban areas. There are mostly few or no health centres in many rural and peri-urban areas for the provision of this service. The head of the Family planning unit in Koforidua confirmed this. She said

*“We have trained nurses and midwives who go to provide women in Asokore and other rural areas with information on contraceptives. They sometimes give out condoms and pills but for Norplant and other types that are administered surgically, the women are advised to visit this unit since the facility for the surgical operation is not available in those areas.”*

In Ghana, permanent methods of contraception are of two kinds- vasectomy for the males and tubal ligation for females. Both involve surgical operation in their administration. These methods are available only in the Regional and teaching hospitals like the Korle-

Bu teaching hospital, Komfo Anokye teaching hospital, Koforidua Regional hospital and the Ho Regional hospital.

Closely linked to the issue of the availability of contraception is the issue of affordability. Generally the prices for short term contraceptive methods are cheaper than long term methods. Within the two groups however, the prices differ for specific types of contraceptives. The prices of male condoms for instance as reported by pharmaceutical attendants interviewed range from a 100 cedis to 40,000 cedis, based on the size, colour, texture and thickness of the condom. A pharmaceutical attendant in Koforidua reported that some customers claim that there is more pleasure in the use of coloured and textured condoms than plain ones.

The long term methods of contraception can be cheaper or expensive depending on the financial stand of the individual. From my observation at the family planning unit in Koforidua, I realized that a woman was complaining about the cost involved in taking contraceptive pills everyday. Meanwhile the senior nursing officer I interviewed was convinced that all the contraceptive types they provide are highly subsidized and so everybody can afford.

The permanent methods of contraception (vasectomy and tubal ligation) are the most expensive among all the contraceptive types. Perhaps this is because they require surgical operation which can only be done by a doctor or a trained midwife. In Ghana there are very few people who have gone in for these methods. There may be several factors accounting for this but perhaps the fact that they can be undertaken in very few health centres may be a factor. The way people perceive and assess the choice of these methods of contraception from society to society may also be a factor. Aside the modern methods of contraception are the natural or traditional methods of contraception. In Ghana the most popular methods are the periodic abstinence method and the withdrawal method. (Ghana Statistical Service et al 2004). Other traditional methods that women use include the use of herbs and strong alcoholic drinks (information from fieldwork). Post-partum abstinence is also one traditional method which is widely known but less practiced.

Information on how best to adopt these methods are provided by health workers in most family planning units and hospitals. The senior nursing officer at the Family Planning unit in Koforidua attested to this. She said; “we provide our clients with information about all the different types of contraceptives be it modern or choose a method or traditional. After this, we give them the chance to choose a method that they deem suitable for them”.

#### **5.4 Availability of contraceptives in the Eastern Region**

The availability of contraceptives in the Eastern Region is not uniform across towns and villages within the region. Obviously men and women living in the cities would have better access to a variety of contraceptives than their rural counter parts. Many of the short term methods of contraception are available in almost all the pharmaceutical shops in the cities. Many of the pharmacies sell male condoms, female condoms, pills and the emergency contraceptive pill. There are a few or no pharmacies in some villages in the Region where people can purchase contraceptives. According to the senior nursing officer at the unit in Koforidua (the capital of the region) the unit trains nurses and midwives who visit most rural areas in the region to provide the people wish different kinds of contraceptives. Most of the long term and permanent forms of contraception are administered in the Regional hospital and in other private health centres located in the terms.

#### **5.5 Availability of contraceptives (modern and traditional) in Koforidua and Asokore**

As mentioned earlier on in the discussion of contraceptives available in the national and regional circles, the different types of contraceptives discussed about are also found in Koforidua and Asokore. The difference in contraceptive availability in the two areas is that whereas Koforidua is likely to have all types of contraceptives (short term or long term and permanent methods) available in the town, Asokore may not have.

From the observation made during the fieldwork process, I realized that many of the short term methods of contraception as the condoms, pills and the Emergency contraceptive pills were available at the pharmacies both in Koforidua and Asokore. The difference however was that there were more varied types of condoms available in the pharmacies in Koforidua than in Asokore. The female condom was scarcely seen in most of the pharmaceutical shops. It was only in one shop in Koforidua where I saw it available. The attendants claimed that most women do not patronize its use hence its scarcity. Most of the women I interviewed complained of the difficulty they encounter as they try to wear the female condom. The assessment of one woman in Asokore about the female condom is as follows:

*“I find it very difficult to wear it. I am also scared that it will get stuck in my vagina.”*

Aside the types of contraceptives available in almost all the pharmacies in Koforidua and Asokore, the different types of contraceptives be it long or short term, permanent or natural are available in the Reproductive Health and Family Planning (RHFP) unit located at the Koforidua Regional hospital. The head and senior nursing officer of the unit confirmed this. When asked about the different types of contraceptives they make available in the unit he said,

*“We have all kinds of contraceptives available here. We have the oral pills, injectables, IUD, Norplant, the sterilization methods (bilateral tubal ligation for the women and vasectomy for the men). We give out condoms and also the foaming tablets. We also talk about the natural methods to our clients. We talk about the Lactational Amenorrhoea method (LAM), the periodic abstinence method, the ovulation method, the basal body temperature method and even the withdrawal method”*

According to her the client have the right to information and so she and her staff always explain the different types of contraceptives to their clients for them to make a choice.

She again said that they provide their service to all men and women in the reproductive age whether married or not married.

She again informed me that the unit was established purposely to serve men and women within the New Juaben Municipality. Koforidua and Asokore are towns located within the municipality. She confirmed that women from Asokore and other nearby towns visit the centre for the different types of contraceptives. All things being equal however, women in Asokore are less likely to have access to the different contraceptive types than their counterparts in Koforidua.

The senior nursing officer also added that the RHFP unit also serves as a training centre for nurses, midwives and doctors in reproductive issues. They therefore have trained nurses and midwives who go to smaller towns as Asokore and nearby villages to provide the people with information on family planning and also make some of the short term contraceptive types available to them.

Finally she said, she makes sure that all the different types of contraceptives she has mentioned earlier on are available at all times for the clients and also for teaching purposes as the unit also serves as a teaching centre.

In recent times also male condoms are made available in most hotels and restaurants in both study areas.

As regards how affordable the different contraceptive types are, I was informed by the nursing officer that all the types are highly subsidized by the government and so most people can afford.

# CHAPTER 6 PERCEPTIONS OF WOMEN ABOUT MODERN AND NATURAL/TRADITIONAL METHODS OF CONTRACEPTION

## 6.1 Introduction

This section of the study provides analyses of the responses received from interviews conducted in the field. The study basically looked at the perceptions married women have about using modern and traditional/natural methods of contraception in Ghana. The perceptions and assessments women have about contraceptive usage will probably determine their willingness to use the various natural/traditional and modern methods of contraception. The study was undertaken purposely because Ghana is noted to be a country with a low contraceptive prevalence rate.

As mentioned in the methodology chapter, in this study, 20 married women and 4 of their spouses were interviewed. To ascertain aspects of urban/peri-urban disparity in the women's perceptions and assessment about the different contraceptive types, 10 women each were selected from one urban area and a peri-urban area in the Eastern region for the study. In each of the study areas five of the women were aged 25-30 and the remaining five 40-45 years. The views of the women that are analysed include the reasons for their use or non-use of the different modern and traditional contraceptive types and the influence of their spouses and family members on their choice of contraceptives. Furthermore, analyses would be made on how they receive information and counseling on contraception from service providers as pharmaceutical attendants, nurses and family planning experts in the next chapter.

The extent to which women in general in the two study areas are able to access the different contraceptive types will also be assessed. The information to be analysed will comprise of that collected from the women themselves analysed against that from pharmaceutical attendants and from the head of the Reproductive Health and Family Planning unit in Koforidua. The analyses place much emphasis on the differences in the perceptions and assessments of the women in the two age groups (25-30 and 40-45).

Secondly, the perceptions, assessments and use of contraception by these women is analysed by looking at the differences in the ideas of the young (25-30) women in Koforidua to that of their counterparts in Asokore and similarly for the women in the older age group (40-45) in the two areas.

## **6.2 What are the perceptions of women about modern and non-modern contraceptive methods?**

The following are some of the ways in which the women interviewed perceived modern contraceptive methods.

### ***6.2.1 Perceptions of women about modern contraceptive methods***

#### **Perceptions and assessments of younger women (25-30 years)**

The views of the women highlighted below shows how the women interviewed appreciate the benefits of the methods and also the dangers involved in using certain contraceptive types. Many of the women were much concerned about the side effects of some modern methods. The assessments of the younger married women are as follows.

*Modern contraceptives are convenient if we use them correctly*

*Modern contraceptives work effectively*

*The injection can give waist and abdominal pains*

*It is difficult to wear the female condom properly*

Some women also talked about the experiences of other women and this indicates that they themselves would not prefer to use the contraceptive types that the women complain about. The next three views are good examples.

*People grow very fat after going in for the Norplant*

*Some women experience excessive bleeding as a result of using the injection method*

*My sister experienced regular high body temperature and irregular menstruation after going in for the injection*

Other views expressed by women also tells that the manner in which service providers attend to their needs and the influence from their own societal norms and values can influence their choice of and use of contraception. These are few examples.

*There is the need for health personals to intensify education on modern contraceptive use. Sometimes people use the different methods wrongly branding the methods ineffective*

*Some women feel shy to purchase contraceptives from the pharmaceutical shops*

*Condom use has two benefits- protection against any unwanted pregnancy and HIV/AIDS*

*Condoms are in different varieties so one can choose from the most convenient one*

*Modern methods are best since they are administered by health professionals*

*It takes too long for one to conceive after she has stopped using a modern contraceptive*

*The Intra Uterine Device is very effective and has no side effects since it does not react with any hormones in the body*

#### **Perceptions and assessments of older women (40-45 years)**

The views /assessments of the older married women also point much to the side effects of the methods. There is comparatively little say about the good side of the methods. Perhaps these women have less understanding of how the modern methods work.

*Modern contraceptives are not good. They have many side effects*

*Modern contraceptives are not convenient at all. It can lead to the ceasure of ones menstruation at an early period.*

*Some say they have developed hypertension after using some pills*

*Some people have grown lean after using modern contraceptives*

*I have been taking the secure pills for five years and it has not given me any side effects*

*Some of the modern methods are not effective at all*

*Modern contraceptives are good but some religions do not accept their use*



## **6.2.2 Women's perceptions about traditional/natural (non-modern) contraceptive methods**

### **Perceptions and assessments of younger women (25-30 years)**

Married women in the younger age group basically talked about how they perceived the periodic abstinence method. They talked about the need to understand how the method works, co-operation from partners for better adoption of the method and the need for proper information provision on the methods. Here are excerpts.

*The periodic abstinence method is very convenient and effective. It has to do with knowing about your safe period*

*The periodic abstinence method will only work effectively if you have a spouse who will cooperate with you and discipline himself.*

*Non-modern methods are good but there is less information on them (information either from books and school etc)*

*The natural method is good but does not give room for frequent sexual activities for couples*

### **Perceptions and assessments of older women (40-45 years)**

Married women in the older age group also commented on their assessment of the periodic abstinence method. They however in addition made mention of the effectiveness of some herbs in preventing unwanted pregnancies. The following are some of their views.

*The periodic abstinence method has no side effects but it is not reliable*

*The use of herbal medicine is very effective for preventing unwanted pregnancies*

*There is the need for massive education on using natural contraceptives for all women in the reproductive age*

*Non-modern contraceptive has no side effects and there is little or no cost involved in their use*

*It does not cost anything to use the natural methods*

All the women who formed the sample of my study participants had knowledge about modern and traditional methods of contraception. All the women except one reported using contraceptives and in some cases also their spouses were using one, mostly the condom.

When the women were asked to give their opinions concerning the use of modern and non-modern contraceptive methods, the above views were expressed by the women.

From the above, we realize that the women preferred the use of both the traditional and modern methods irrespective of their place of residence but more women were using the natural method of contraception in Koforidua than in Asokore.

Based on a small sample used for this study however one cannot expect to reveal consistent structures regarding urban versus peri-urban/rural preferences of contraceptives used in preventing unwanted pregnancies.

Generally, married women in the younger age group (25-30) preferred to use the modern methods compared to the natural/traditional. The women were convinced that the modern methods are more efficient than the traditional ones. Others also preferred the modern methods because they think it is easily accessible, highly efficient and convenient to use. They also have better understanding of their usage perhaps because they have relatively higher levels of education than their older counterparts and so better understand how the contraceptives work. Some women in the age group of 40-45 years were also using the modern methods but the majority preferred to use the natural/traditional methods. Many of the women in Asokore for instance reported that they would prefer the natural methods if only their spouses would co-operate with them. This indicates that the younger couples can be more co-operative about their wives usage of contraceptives than the older spouses. A 42 year old teacher in Koforidua also reported that she has been using herbal medicine and occasionally the periodic abstinence method since she got married. Another Moslem woman aged 43 said she has stuck to the periodic abstinence method since she got married twenty years ago. She argued that the modern methods have many side effects and her religion also does not encourage modern contraceptive usage. This study, however, does not place much emphasis on how ones religion influences her choice of contraception.

In the case of the modern methods of contraception there were instances where some women experienced different side effects or no side effects at all upon using a particular contraceptive type. Most of the respondents using the periodic abstinence method mainly stressed that the effectiveness of the method rests upon discipline and commitment on the part of both partners. Nobody reported on any negative side effect of a natural form of contraception.

Four out of the ten women interviewed in Koforidua were using natural contraceptive methods whereas only one was using a natural method in Asokore. The women in Koforidua (whose socio-economic status is relatively higher) argued that they are able to use the periodic abstinence method because their spouses support their choice and are sometimes willing to use condoms when they are not in their “safe periods”. They also argued that the method can only be effective where a women can calculate very well the menstrual cycle to know when she is safe or not, and again for the partners to discipline themselves when the women is in her unsafe period. This may be the result of a more equal level of understanding and collaboration between them and their spouses which is influenced by their socio-economic status and their “modern” way of life.

Two of the women using the natural method were in the 40-45 age groups. One can therefore not give a firm conclusion about the age group which prefers natural contraception in Koforidua, but it was realized that the younger women (25-30) mostly preferred the modern methods. The five women using the modern method also talked about the negative side effects and in many instances they said they have consulted the FP unit in Koforidua for them to change the methods for them. Compared to Asokore two women aged 29 and 30 in Koforidua were using long term and permanent methods of contraceptives namely the Intra Uterine Device (IUD) and the Bilateral Tubal Ligation (BTL) respectively. From the answers they gave concerning why they have chosen the methods it was realized that these women better understood the benefits of the method to their reproductive lives after they have consulted doctors and nurses in a hospital. They also believed that the methods will not give them any negative side effects as the other modern forms of contraception. The other women using the modern methods of

contraception in Koforidua were of the view that they have tried to adjust to some of the negative side effects since they were informed about them.

When the head of the family planning unit in Koforidua was asked about why most of the modern contraceptives have negative side effects she had this to say:

*“Most of the modern contraceptives are hormonal in character. Hormonal contraceptives get into the blood stream before it works and so some side effects are bound to occur. Side effects are not medically harmful. Individuals are different biologically and so people react differently to the different modern contraceptives”.*

In Asokore on the other hand, 8 out of the 10 women interviewed were using modern contraceptives. They complained greatly about the negative side effects of the modern methods and some also talked about the fact that it sometimes failed them (i.e. they conceived even though they were on contraception). Deducing from the conversation with the family planning expert in Koforidua and relating her explanation about how the contraceptives should work and how the women in Asokore perceived it, one can conclude that most of the women either seek advice from their friends who are also ignorant or do not get a better understanding of how the methods work. For instance, the head of the unit informed me that, with the hormonal contraceptives it takes three to four weeks for one to conceive after she has stopped using them, but the women seemed not to understand.

It was also realized that some of the women in both study areas do not know the type of contraceptive method to use to either delay birth or prevent pregnancy in emergency cases. A pharmaceutical attendant in Koforidua reported a case where a woman wanted to purchase a wrong contraceptive type for an emergency case. He said;

*“A lady came to me and I asked of her need. She told me she’s had unprotected sex and would want to prevent pregnancy from occurring and so wants to purchase “Secure” (a pill). I advised her that secure is not for preventing pregnancy when you have already*

*had an unprotected sex. I therefore gave her the Emergency Contraceptive pill which works perfectly to prevent pregnancy from occurring within 72 hours after sex.”*

This tells that there is still the need for intensive education on how and when to use the different modern contraceptive types.

When I tried to ascertain why the women (both young and old) in Asokore (with a relatively lower socio-economic status) preferred to use the modern methods in spite of the side effects, some of the women lamented about the unwillingness of their husbands to use contraceptives and hence the need for them to protect themselves. Four of the women who expressed this concern were aged 40-45 years and two others in the younger age group (25-30). Automatically then it can be deduced that the husbands of the elderly women in Asokore are less co-operative with the family planning business. The women were aware that the natural methods had no or little negative side effects but works effectively only if their husbands will agree to discipline themselves. Some of them wished to have used the natural methods especially the periodic abstinence method but said their husbands will not co-operate with them. They also talked about the fact that they are not economically sound to take care of many children if they do not protect themselves with contraceptive methods that are more efficient and reliable.

The power relations existing between men and women as explained by feminists theorists in their gender and development approach which is been used in this study is evident here. This relation in which the woman is always seen as the subordinate (as evident among many women in Asokore with lower socio-economic status) needs to be deconstructed through empowering women so that they can also have control over many aspects of their lives including their reproductive lives. (See further explanation in chapter 8).

### **6.3 Contraceptive usage by women in Koforidua and Asokore**

Among the questions that were asked the women interviewed was about the type of contraceptive they have been using within the past two years. All except one of the

women interviewed reported not using or their spouse using a modern or traditional/natural method of contraception.

One objective of the study was to look at contraceptive use among younger married women aged 25-30 years compared to their older counterparts between the ages of 40-45 years. Among these women contraceptive usage was to be assessed according to the types used by the women living in the urban area and those living in the peri-urban area. As regards the differences in contraceptive usage between the two age groups under study, in all there were 7 women aged 25-30 using modern contraceptive methods compared to 6 women aged 40-45 years. With the natural/traditional methods, there were 3 women aged 25-30 using one type of natural method compared to 2 women in the older age group. One elderly woman was however combining one modern method with a natural method.

#### **Younger women in Koforidua**

Out of the 5 women interviewed in Koforidua, 2 were using solely natural methods of contraception and the remaining 3 were adopting modern contraceptive methods. The women using the natural method reported using the periodic abstinence method. One of them was 29 and the other 30 years. When the 30-years old teacher was asked about the effectiveness of the periodic abstinence method she said:

*“The method is very effective and convenient if you can calculate to know your “safe period”. It has helped me not to get pregnant anyhow, unless I want to have a child. This is the only method I have been using since I got married six years ago.”*

When the husband (a civil servant) of the same woman was interviewed he also confirmed that the periodic abstinence method is the only form of contraception they have been using. He said:

*“For us we use the natural method but with other drugs no. It is an effective method. It bothers on discipline. The two of you have to be much disciplined. At certain times no matter what you need not have an affair unless you are ready to have a baby?”*

From the views of the couple we can deduce that, the periodic abstinence method can work effectively for people who can calculate accurately the “safe” and “unsafe” periods within the menstrual cycle. It also needs a strong sense of discipline, commitment and understanding between partners on how best to regulate their sexual lives to make the method an effective one. The women’s adoption of the periodic abstinence method confirms the report of the 2003 GDHS which indicates the method as the first among the natural methods. This however brings to light that most women are ignorant of other natural methods as Lactational Amenorrhoea Method (LAM) and the Basal body temperature method mentioned by the head of the family planning unit in Koforidua.

The three women adopting the modern methods were using the IUD, BTL, and the “Depo-provera” injection. (Refer to chapter 5). The woman who had gone in for the BTL method however explained that she went in for the method for medical reasons, otherwise she would not have opted for such a permanent method of contraception. The same pattern almost pertains nation-wide as the Demographic and Health Survey (DHS) reports also indicate that many women only know about the periodic abstinence method. There is the need for better education on the other less popular natural methods since they may even be more efficient than the periodic abstinence method.

### **Younger women in Asokore**

All the five younger married women (25-30) interviewed in Asokore were using one type of contraceptive or another. Four of them were using modern methods and only one a natural method. Three of them were using contraceptive pills and injections. One woman aged 29 had gone in for the Norplant whilst the last aged 28, was adopting the periodic abstinence method. The woman using the periodic abstinence method however said that her husband occasionally uses the condom during her “unsafe” days.

In an attempt to ascertain the reasons why women in Asokore with relatively lower levels of education and income (mostly petty traders) preferred to use modern methods of contraception instead of the natural methods, I find this 30-year old trader’s reason interesting:

*“The modern methods are more effective than the traditional or natural ones. You know, our husbands would not want to use the condom and we cannot insist that they do. We therefore have to protect ourselves with modern contraceptives even though they have many side effects, so that we do not have many children. Many of our men neglect their children and they become a burden on us.”*

From this we see that the power relations between spouses in the home have a greater influence on the choice of contraception by women. The power dominance may depend partly on the education of the women and their overall status and the degree of view on gender issues along a “traditional-modern” axis. There are some women using different contraceptive types against their will and so would not encourage others to also go in for them. Men usually need to be educated to help their partners choose contraceptive types which are less harmful to their health. The low socio-economic standing of women may also force some women to choose certain types of contraceptives which the women themselves know can affect their health conditions. This pattern is most typical among the elderly women, but some younger women also face similar problems because of their lower socio-economic status.

### **Older women in Koforidua and Asokore**

The older married women (40-45 years) in Koforidua and Asokore were also using both modern and natural/traditional methods of contraception

In Koforidua, two of the women were using the injection and contraceptive pills. Two others were adopting the periodic abstinence method. One of them (aged 44) was combining two different types of the natural method. In addition to the periodic abstinence method she was using a herbal medicine prepared by a popular clinic located in the Volta Region of Ghana. She said she smeared the liquid on her naval before sex so as to prevent any pregnancy. According to her she has used the method for five years and it seems to be very effective. The last of the five women was combining a modern method with a natural one.



In Asokore on the other hand, 4 of the elderly women were using modern contraceptive methods whereas the other 1 woman was not using any form of contraception. The four women were either using the contraceptive pills or the injections. The woman who was not using any form of contraception was 41 years and a trader by profession. To her she wouldn't want to use any modern method of contraception because she has heard of the numerous side effects of the methods. With the natural methods she confessed that she was ignorant about most of them. She however recounts using a "home-made" herbal contraception made out of some herbs and hard liquor ("akpeteshie") during her youthful days. She was not very happy though that she is not using any form of contraception because of her health condition. She had already had five abortions and she did not want to have another one.

It is evident from the analysis that married women both young and old in Asokore are more likely to use modern contraception than natural/traditional ones compared to their counterparts in Koforidua. Most of the modern methods are available to the women as the town is located near Koforidua where different contraceptive types are available. This may not be the only reason as the majority of the women especially the elderly ones are compelled to use the modern methods since they have less power over their reproductive lives a situation arising as a result of their lower socio-economic status. Some would have otherwise opted for the natural methods if their socio-economic status is improved in which case they can be empowered to have better control over their reproductive lives.

#### **6.4 Why do women choose to use modern or natural/traditional contraceptive methods?**

We have realized from the previous section that all the women interviewed use one method of contraception or other. The question of why the women decide to use their choice of contraception need to be assessed.

Some of the views given by the women who have chosen to use one type of modern contraceptives or another include the following;

They consider how effective the methods are for preventing any unwanted pregnancy. They also consider the side effects of the method, the length of time that the method can protect them from any unwanted pregnancy and how accessible and affordable the methods are. The issue of affordability is however, not seen as a major factor since many of the short term modern methods which is highly patronized by the women are subsidized. Some women were also particular about using methods which can give them room for frequent sexual activity. Others were also of the view that there are a variety of them to choose from and as they have the choice to switch from one method to another to select the most convenient method. These responses were given by all the women irrespective of their age, place of residence or socio-economic status.

With the natural methods of contraception, the women were of the view that the methods have little or no side effects and also involve little or no cost involved in their usage.

A 30 year old women using the periodic abstinence method puts it this way;

*“The natural method will not give you any side effect because it is not a drug. Again it does not cost anything to use the method”* (It should be noted that contrary to this view, the use of the natural method can have a much greater cost-the risk of getting pregnant, than many of the modern methods).

Furthermore, the women were asked about why other women may not want to use their choice of contraceptives. With the modern methods most of women talked about the regular side effects as the number one reason.

A 30 year old woman in Koforidua using the IUD was particular about the inaccessible nature of some long term methods like hers in the rural areas. Others also were of the view that some women especially those with little or no education have pre-conceived ideas/perceptions about the methods and so would not use them. A 30 year old nurse in Koforidua said that some women will not use the methods simply because they cannot follow the instructions for their use as in the case of the pills which needs to be taken every day at a particular time. Again she said she was using the IUD which requires the user to keep herself neat to avoid any infections. She said some women cannot keep themselves neat at all times and so would not opt for her method. The use of the method requires that the user takes her bath at least twice a day to keep her private part neat to

avoid any form of vaginal disease which may render the IUD implanted in her womb infectious.

The majority of the women using the natural method (periodic abstinence method) were living in Koforidua. According to these women, some women would not choose their method primarily because they cannot calculate accurately the safe and unsafe periods of their menstrual cycle. Secondly one man married to one of the younger women who was interviewed also mentioned the need for discipline, commitment and understanding between partners for the effective adoption of the method.

The number of children a woman already had did not significantly determine her choice of contraception in both study areas and among the different age categories. Even though most of the women interviewed frowned upon barrenness, they regarded an overabundance of living children as something less than a blessing. A woman therefore wished to adopt one type of contraception or the other even if she has only one child.

# **CHAPTER 7 THE INFLUENCE OF THE FAMILY AND SERVICE PROVIDERS TO WOMEN'S USE OF CONTRACEPTION**

## **7.1 Introduction**

Contraceptive usage by women in many societies can be influenced by ones family members and also the manner in which they receive information from service providers. It is mostly argued that the man and sometimes family members from the extended family like grand-parents, uncles and aunties mostly have some influence on a couple's reproductive life. This section therefore analysis the extent to which husbands and other family members and also family planning service providers as pharmaceutical attendants, nurses and doctors positively or negatively influence women's use of contraception.

## **7.2 The role played by husbands and other family members in women's choice of contraception**

The family system of Ghana as it is with many other African countries is either the nuclear or the extended family system. The members of each family especially with the extended type can influence each other in making certain decisions concerning their lives. MacCormack (1982) and Patel (1994) argues that issues related to marriage and fertility are intimate, gendered and elicit intense interest from surrounding kin, community and state.

In this study, it was necessary for the researcher to ascertain the extent to which the husband and other family members as in-laws, aunties, uncles and grand-parents influence a woman's choice of and use of a particular type of contraceptive. Two spouses each of the women were interviewed in the two study areas in order to have some information about the husbands influence. The women were however asked questions that will answer for the influence of the significant others (aunties, in-laws etc).

All the four men interviewed from the two study areas were of the view that they encourage their wives to use one type of contraceptive or another. They however did not initiate the idea of their wives usage of contraception but encouraged them to use them after their wives had initiated the need for them to use contraceptives. Out of the four

men, there was only one man from Asokore who said he occasionally uses the condom. The other from Asokore (28 years) was of the view that it was the woman's duty to protect herself from any unwanted pregnancy. The other two men from Koforidua were also not using any form of contraception. The 30 years old man whose wife was adopting the periodic abstinence method said he prefers to stay out of sex when her wife is in her unsafe period than to use the condom.

Three women in Asokore reported that their in-laws occasionally told them to have their next child after a year or two years of having a child. One woman who had just given birth to her second child after the first one five years ago reported that the husband's mother was never in favour of her use of contraception, as she was always bothering her to have her second child.

The influence of these significant others in women's choice of contraception was not very significant in Koforidua. Most of the women reported that they come into contact with the members of the extended family occasionally and scarcely will they talk about matters concerning their reproductive lives with them.

Cleveland (1986) however reports on how some family members of rural inhabitants can influence the sexual lives of married people and hence their fertility levels. In his study conducted in Northern Ghana, he reports of how the sleeping arrangement of the people can serve as a barrier to frequent sexual activity. He said among many couples and even among younger couples who are expected to be sexually active, mothers, mothers-in-law and grandmothers often intervene to restrict sexual intercourse. Sleeping close to the daughter-in-law restrains her man from making sexual advances. Among the Kusasi people in Northern Ghana a woman would report the matter to a mother or a father and reprimand the man if he were observed not abstaining from sex or making advances without his wife's desire.

The head of the Reproductive Health and Family Planning Unit in Koforidua reiterated the need for family planning experts to place much emphasis on men's involvement in the Family planning business as they are still missing in discussions. She puts it this way:

*“Men are still missing in family planning activities; perhaps it is because they do not have a wide range of contraceptives to choose from. Much need to be done. For us here (talking about her organization), we have advised the women who visit the unit to convince their husbands to come with them, and we make sure that we treat the men with a high sense of cordiality”.*

This is a very important suggestion by the head of the family planning unit. Men in the Ghanaian society normally have a greater say in the number of children a couple wants to have and so they need to be greatly involved in family planning.

### **7.3 The role of pharmaceutical attendants in influencing women’s choice of and use of contraceptives**

The major contraceptive outlets apart from Family Planning centres and clinics are the pharmacies. The availability and accessibility of pharmaceutical shops is of much importance in accessing contraceptive usage among women.

In this study therefore, I visited two pharmacy shops each in the two study areas. When my respondents (all married women) were asked about what they consider before purchasing a type of contraceptive from a pharmacy, some gave the following answers. They said they consider the location of the shop, the types of contraceptives available, the manner in which the service provider attends to their needs and to remain anonymous to other clients in the pharmacy shop in that order.

In Asokore a woman complained that she always feels shy to purchase contraceptives since the attendants sometimes have their friends with them in the shop. She reported that she sometimes sends children to buy some contraceptive pills for her but the attendants would not sell it to them.

The plight of this woman shows that the attendants of some pharmacies may by their behaviour drive away potential users of contraceptives from purchasing different contraceptive types thereby contributing to the low usage rate of contraceptives. Some respondents in Asokore also reported that they sometimes have to travel to Koforidua to

purchase some kinds of contraceptives since the sellers in Asokore normally have very few types of contraceptives available in their shops.

A pharmaceutical attendant in Koforidua was also much concerned about the extent to which people feel shy when purchasing contraceptives. He said:

*“Most people feel very shy to purchase contraceptives. The greater proportion of people who purchase contraceptives here are married people and people who do not live in this neighbourhood. When the men want to buy condoms they ask, can I get some CD’s? Jokingly I sometimes respond to them that CD players are sold outside the pharmacy shops but just pick them and give it to them”.*

From this we realize that there is the need for much education to sensitize the populace to refrain from stigmatizing contraceptive usage. Perhaps pharmaceutical attendants also need to be taught to understand the language of their clients if that will help increase contraceptive usage. The attendant was also of the view that people are not able to express their concerns about the types of contraceptives they want to purchase since they always have many customers to attend to in their shops.

A 28 year-old woman in Asokore on the other hand was of the view that she really feels comfortable with an attendant in Asokore who has become a personal friend to her since he takes his time to attend to her anytime she goes to purchase her contraceptive pills. Compared to the situation in the pharmacy shops at Koforidua with regards to the number of people at the pharmacy shop at a time she said, it always happens that there are two or three of them at the shop at a time or even occasionally she doesn’t meet any customer when she goes there. This gives her the chance to feel free to express all her concerns when she visits the shop.

This tells that the location and the manner in which pharmacists attend to their clients also contribute much to their interest to use contraceptives. Perhaps experts can also look carefully into this as part of measures to improve contraceptive usage in most communities and in the country as a whole.

## **7.4 The role of family planning experts in influencing women's choice of and use of contraception**

Ghana, like many other countries in sub-Saharan Africa with a high population growth rate, has several governmental and non-governmental organizations established to address its population problem. As has been mentioned earlier on the Planned Parenthood Association of Ghana (PPAG) and other governmental ministries like the Ministry of Health, the Ghana Health Service and the Population Council are some major organizations which have special interest in Ghana's population question. The government in collaboration with the Planned Parenthood Association of Ghana has established some Reproductive Child Health and Family Planning Centres in most of the regional capitals and also in some selected districts.

The Reproductive Health and Family Planning unit located in Koforidua (Regional Hospital) is among the family planning units that have been established. On my visit to the place I observed the activities of the unit and also interviewed the head of the unit who was a senior nursing officer. The visit was necessary because the unit serves us the major family planning outlet for the inhabitants of Koforidua and other neighboring towns which include Asokore. The head of the unit informed me that most of their clients come from the Koforidua township. I therefore asked about how they are able to reach other people in the smaller towns and villages. This is the answer she gave me.

*“We have nurses and midwives who move out to provide our services to people in the remote areas. We even have nurses going to Densu Agya (a small village near Koforidua). This place also serves as a training centre so apart from the nurses and doctors you see here now; we train other nurses and midwives to go into family planning service provision.*

This shows that accessibility to family planning outlets may not be a major contributory factor to the low usage rate of contraceptives in Ghana and in the study areas. Some of the respondents interviewed in Asokore confirmed what the senior nursing officer said.



The head of the unit was, however, not impressed with the staff strength of the unit. She informed me that she was working with two nurses, three midwives and only one doctor (a gynecologist). She said the doctor and two of the midwives including herself are sometimes not available to attend to their clients when there are training programs for other nurses and midwives. This was something that I observed myself the first day I visited the unit. I was asked by the nurses there to go and come back the following day since the head was busy with a training program. Meanwhile there was a long cue of women in the unit waiting to be attended to by the two nurses I met.

The available staff in the family planning units may also contribute to the level of contraceptive usage by women. This is because as the head of the unit puts it, “the people who come here are not sick people who are eager for treatment”. Some people may therefore refuse to wait if they meet long cues in family planning units.

The relationship between the staff of the unit and their clients was however very cordial. Again I observed this myself and personally experienced it as the nurses gave me a warm welcome on my first and subsequent visits to the unit. Due to the cordial relationship between the staff of the unit and their clients, the head of the unit was convinced that her clients are able to express all their concerns about their reproductive lives and their choice of contraceptives when they visit the unit. She said they (her staff) are always willing to listen to their concerns and address them to their satisfaction.

Relating this to the structuration theory used in this study, the family planning unit serves as the structure and the clients the agent. According to the theory the structure can influence the agent and in the same way the agent can also influence the structure to alter the activities of the structure. In the case where the clients express their concerns to the family planning experts for them to address their concerns, the women’s behaviour (the agents) are influencing the services provided by the family planning unit (the structure) and so the family planning experts adjust their service provision to suit their clients.

Finally according to the head of the family planning unit, the unit had most of the contraceptive types available at all times from vasectomy to condoms. She said this was

so because as she had said earlier on the unit also serves as a training centre and so they use the different contraceptive types during their teaching sessions. The availability of different contraceptive types at the unit can therefore not be considered as a reason for the low usage rate of contraception in Koforidua and its surrounding towns.

## **7.5 Counseling and Information provision on Contraceptive use in Koforidua and Asokore**

It is of great importance for contraceptive users to have the necessary information on contraceptives so as to make an informed choice. In Ghana there are numerous public and private outlets where one can have access to information on contraception. Among them include many of the PPAG clinics, Family Planning and Reproductive Health centres and pharmaceutical shops. Many of the women who were interviewed attested to the fact that they received some information on contraception from Family Planning clinics when they went for ante-natal check-ups. Some had visited the Family Planning and reproductive health unit at Koforidua and others had also visited pharmacists to purchase contraceptives and also for more information on contraceptive use. Two women in Asokore and one in Koforidua said they had gained some knowledge on contraception from friends and from books respectively.

This study however is however interested in how family planning service providers disseminate information to their clients. It is believed that they may provide a more reliable and accurate information on contraceptive use and family planning to their clients.

The subsequent session therefore provides a tentative analysis of how experts in the Family Planning centres and pharmaceutical shops provide information about contraception to the populace.

### ***7.5.1 Information provision and counseling by family planning centres***

As part of the fieldwork process, I visited the Reproductive Health and Family planning unit in Koforidua located in the Regional hospital. The unit is the major family planning

centre which serves the reproductive needs of the people of Koforidua and other nearby towns including Asokore.

As part of the interview process with the head of the unit, I asked her to tell me much about how they provide information to their clients who visit the unit. Her answer is as follows:

*“When a client visits the unit we welcome her (since majority of our clients are females) cordially and after which take the background information of our client such as the name, age, place of residence, marital status and the number of children she has if any. This is mostly done after the client has informed us that she has come for some information on family planning and contraception. After this we proceed to the counseling process. We first provide counseling on reproductive health and Family planning which also includes contraceptive knowledge and use. This is done in a private place. We describe the various types of modern and traditional/natural methods of contraceptives we have here to our clients. We take our time to explain how each contraceptive type functions to prevent pregnancy, the length of time that a method can prevent pregnancy and the side effects and the warning signs of the different modern methods. We do this by having the different contraceptive types right in front of the client. We also use charts and other teaching aids made out of carved wood (e.g. the penis) to demonstrate how best to use some of the methods including the natural ones. After the counseling and teaching session we ask the client to make an informed choice. After the client has made a choice we examine her to see if she is deemed fit to use the type of contraceptive she has chosen. We do physical examination of her body, take her blood pressure and also take note of her past medical and gynecological history. If the client is not deemed fit for her choice of contraception we advise her to make a different choice”.*

The head of the unit was however of the view that in spite of the side effects of some of the modern methods the clients mostly refuse to understand that since most of the methods are hormonal based; they will definitely give some side effects at the beginning of usage. She also said some of the clients seem not to accept the way and manner in

which the various methods work. They are therefore coming to the unit with complains all the time. For instance she said, they advise their clients who use the injections and pills that it will take them some time to get pregnant after they have stopped with the contraceptives but the same people run to them to complain that they are not conceiving after a few days of stopping with the contraceptives. She also said some of the women especially those on the pills refuse to take them as prescribed and so sometimes get pregnant when taking the pills. The head of the unit said she and her staff are very willing to provide the necessary reproductive health information to their clients in the best way they can and so need the clients to co-operate with them by following any directives they give them.



**Figure 7. 1 Nurses inserting Norplant for a client at the Family Planning and Reproductive Health unit at Koforidua**

To buttress the discussion with the head of the unit at Koforidua, all the women in Koforidua and Asokore who said they had visited the unit confirmed what she said. They were however of the view that there is much emphasis on the modern methods than the natural/non-modern methods. One of the women said they only talk about the periodic abstinence method and tells them that the other methods need some level of advanced knowledge to adopt. I realized this was true as the head and senior nursing officer mentioned the Basal Body Temperature (BBT) method as one natural method which is very technical to adopt. She said some of the natural methods are very technical and so it is very difficult for most of their clients to know how to use them, even with those who have higher levels of education.

### **7.5.2 Information provision and counseling by pharmaceutical attendants**

The second main outlets for contraceptive service provision are the pharmacies. It was therefore necessary that the activities of pharmaceutical shops with respect to contraceptive provision were ascertained.

Four pharmaceutical shops were selected for the study, two in Koforidua and the other two in Asokore. It should be noted that the pharmaceutical shops in Koforidua were relatively bigger in size and had a variety of contraceptives to choose from as compared to Asokore. The pharmacists were asked series of questions about contraceptive provision to their clients. Of much importance however was the question of how the pharmaceutical attendants are able to provide the necessary information about contraceptives to their customers in order to help them make the necessary choice of contraceptives. The following are extracts of how the pharmacists disseminate information to their customers.



**Figure 7. 2** The picture shows a pharmaceutical attendant attending to a customer in Koforidua

#### **Koforidua pharmaceutical attendant 1**

*“There are many instances where people come and they have very little or no knowledge about the type of contraceptive they want and how to use them (ignorance). They hear about it on the radios and televisions and through friends but do not actually know how they work. Let me recount this special instance where I assisted a lady to have the right information about which contraceptive types to use at different times. It happened like this, a lady came to this shop and I asked of her plight. She told me she’s*

*had unprotected sex and would want to prevent pregnancy from occurring and so she wants secure (pill). I explained to her that secure is not for preventing pregnancy when you have already had unprotected sex. I therefore advised her to purchase the Emergency Contraceptive Pill (ECP) if the sexual act was done less than 72 hours ago. The pill works within 72 hours after sex. She was lucky the sexual act occurred 24 hours before she made the complain and so the ECP worked for her. I asked her to take the tablets in three courses. She was to start with 2 tablets and then another 2 tablets 12 hours after the first intake. She was to take the remaining 2 tablets, 12 hours again after the second intake”.*

### **Koforidua pharmaceutical attendant 2**

To the second pharmaceutical attendant, she said most of her customers already have knowledge about the different contraceptive types and so there have been a few cases where she explained the usage of some contraceptive types to her customers. She had this to say:

*“In a few cases I give people some directions about how to use Today’s” contraceptive since it is new in the system. Most people know how to use the different contraceptive types especially the condoms which is highly patronized in this pharmacy. There are also prescriptions on the boxes of most of the pills and so most women who buy them claim that they can read the instructions from the boxes”.*

### **Asokore pharmaceutical attendant 1**

The third pharmaceutical attendant in Asokore who happened to be a young gentleman of about 30 years also talked to me about how he disseminates information about contraception to his customers. He begins like this:

*“I sometimes provide some information about how to use the different contraceptive types to my customers. With “today’s” contraceptive for instance (which is a new*

*contraceptive type for the women), I tell them that the woman will insert one tablet 4-5 minutes before sex. One tablet works within one hour of sex. After one hour if the woman do not insert another tablet but continues with the sexual activity she may get pregnant. With the male condom people do not ask about how to wear it, I guess they already know how to wear it. I do not sell female condoms here. The women do not patronize it and you will make a loss if you decide to sell it. With the secure too (oral pill), I tell my customers that the woman takes one tablet everyday at a particular time of each day just after menstruation. She however does not take it during her menstruation days”.*

### **Asokore pharmaceutical attendant 2**

Finally the fourth pharmaceutical attendant from Asokore also tells his story.

*“There have been several instances where I have taught my customers how to use the different contraceptives types especially since the introduction of “Today’s” contraceptive this year. With Today’s contraceptive for instance, I tell my customers that the woman inserts one tablet 5 minutes before sex. The man should also wait for the penis to return to its normal size after sex before urinating in order to prevent any form of infection. Some of the tablets like Secure have the instructions for use on the box so I just read it out to my customers who cannot read it themselves. In most cases however I tell my customers how to use the different contraceptive types even if they do not ask”.*

The fact that all the attendants at the four pharmacies were able to illustrate how they disseminate information to their customers tells that many men and women can receive the necessary directions about how to use the different contraceptives if only they visit the pharmacies. One of the attendants informed me that the Ghana Association of Pharmacists (GAP) of which most pharmacists are members organize periodic meetings for them to update them about new contraceptive types and how best they can make the different types available to the populace. They therefore receive knowledge about the different contraceptives from time to time. It is therefore not surprising that all the attendants mentioned that the new Today’s contraceptive is on high demand in their

shops and three of them used it in illustrating the instances where they had provided some information to their customers.

Information provision about the natural contraceptive methods was however missing in all the pharmacies. The attendants were of the view that they disseminate information on the contraceptive types they have and sell in their shops which are mainly the modern types. The question of whether the pharmacies should start advocating for the natural/traditional methods in their shops is an issue to be addressed. There is also the question of how best they can do it. Since some women prefer highly the use of the natural methods and the pharmacies seem to be the commonest outlets for the different contraceptive types. It will be very necessary for Family Planning experts and pharmacists to consider how best they can provide information on the natural/traditional contraceptive types to their customers.



## **CHAPTER 8 SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENADCTIONS**

### **8.1 Introduction**

The study sought to look at the perceptions assessments and usage of modern and natural/traditional methods of contraception by women in Ghana. Here a summary of the findings that the study came across is presented. This is followed by a conclusion, then a section on how the findings are related to the theories used in the study. Finally there will be some recommendations on how best to improve contraceptive usage in Ghana and some areas that can be investigated by future researchers.

### **8.2 Summary of Findings**

It has been noted from the previous section that a major component of family planning activities is the introduction of modern and natural/traditional methods of contraception as a principal means to birth control.

To seek empirical evidence for the low contraceptive usage in the country, this study looked into the perceptions and assessments of women (who are the principal users of contraceptives) about contraceptives and how that is influencing their usage. Women in two age groups, 25-30 and 40-45 were interviewed from one urban area (Koforidua) and peri-urban area (Asokore) in the Eastern Region. The region has a CPR of 27 % which is close to the national average. Four men and Family planning service providers in pharmacies and Family planning clinics/centres were also interviewed.

The first research question addressed how women in two age groups (25-30 and 40-45) in the two different geographical areas (Koforidua and Asokore) under study perceived and assessed modern and natural/traditional contraceptive methods from their various experiences. It was realized from this study that almost all the women have positive assessments about the two major contraceptive types as they agree with the fact that it is helping many women to avoid any unwanted pregnancies and also spacing births which

will ultimately lead to a decline in the countries population. Most of them expressed how the different contraceptive types have helped them to avoid unwanted pregnancies. Their major concern was about the negative side effects of some of the modern methods. It is worth noting however that some of the women in Asokore were using different contraceptive types (sometimes against their will) because of economic reasons. They were much particular about the economic cost of catering for many children. This buttresses Caldwell's assertion that women are more inclined to limit their families than men. He argues that women would limit their families because they bear the biological burdens associated with frequent childbearing and operate in a socio-cultural and economic environment that makes high fertility beneficial for both men and women but places childbearing costs primarily on women. (Zulu et al 2003)

It was also evident from the field that women in Koforidua were using natural methods of contraception than modern ones compared to their counterparts in Asokore. Eight out of the ten women interviewed in Asokore were using modern methods of contraception. One would have expected the reverse of this pattern but it is otherwise in this study. Many other women in Asokore would have wished to use natural methods of contraception if their husbands would co-operate with them, since the usage of the periodic abstinence method for instance is based on commitment between spouses or partners.

The women adopting the natural/traditional methods were of the view that the methods have little or no side effects and again it involves little or no cost to use them. This assertion cannot be true at all times since the risk of getting pregnant when using a natural method is higher than when one is using a modern method. Many of the younger women (25-30 years) on the otherhand believed that the failure rate of some of the natural methods may be high since people may not get the right information from the right people on how to administer them. A case in point is the periodic abstinence method which requires that one should be smart to calculate accurately the "safe" and "unsafe" periods of the menstrual cycle for effective usage. To many of them, they prefer the modern methods which are easily available and are administered by professional health personnels in the hospitals and clinics.

Secondly, the study sought to answer the question of why women choose to use natural/traditional or modern contraceptive types or both. Married women, both young and old were willing to use both natural/traditional and modern contraceptive methods. With the modern methods there were some key factors that the women considered before making a choice on one type or another. These included how effective a contraceptive type is for preventing any unwanted pregnancy. Again they considered the side effects of the methods, the length of time that the method can protect them from any unwanted pregnancy and how accessible the methods are in that order. An interview with a pharmaceutical attendant in Koforidua showed that, many men and women may not use modern contraceptives because of the stigma the society attaches to contraceptive usage. The society has sometimes branded women who purchase contraceptives as promiscuous. Generally, also many people feel shy to purchase contraceptives and would not like their friends or peers to see them buy contraceptives. A case in point is where some men in Koforidua have re-named condoms as CDs so that when they are purchasing them in a pharmaceutical shop other customers would not realize it.

Eventhough, natural/traditional contraceptive methods are less publicized in the country; the study revealed that some women were adopting natural contraceptive methods. The commonest type mentioned was the periodic abstinence method. It is worth noting that there were more women using natural contraceptives in Koforidua than in Asokore. Many other women who were using modern contraceptive methods in the two study areas but most especially in Asokore wished that they change to the natural methods. They were however hindered by the fact that their husbands were not ready to co-operate with them because of their low socio-economic status. Again, with the periodic abstinence method for instance which involves some level of education or skill to calculate the safe period, some women advocated for proper education from health personnels for the proper usage of the method because some of them have lower levels of education.

It is also worth noting that in as much as the natural/traditional methods are highly preferred by the older folks; many other young women also wish to use the method. Generally, married women both young and old were willing to adopt the natural methods

of contraception because they perceive that the methods have little or no side effects and also involve little or no cost in their usage.

The third major consideration to contraceptive usage ascertained in this study was with how married women can access the different contraceptive types. The third research question was therefore posed to look into how family planning service providers disseminate knowledge and information about contraception to their customers. Two major groups of service providers were considered, they were pharmaceutical attendants in both Koforidua and Asokore and nurses and midwives in a Family Planning centre in Koforidua.

A visit to four pharmaceutical shops, two in Koforidua and two in Asokore revealed that many of the short term methods of contraception were available to both men and women. These included male condoms of different varieties, contraceptive pills, different contraceptive tablets for insertion and emergency contraceptive pills. The only difference was that the pharmacies in Koforidua had a more varied forms of the different contraceptive types than those in Asokore. The respondents in Asokore were however of the view that they normally travel to Koforidua to purchase the different types they needed, if not available in Asokore since Koforidua is not too far from Asokore. It can therefore be argued that access to contraceptives especially with the short term methods from pharmacies may not be a major reason why some women will not use contraceptives.

The attendants of the different pharmacies were asked to demonstrate how best they provide information on contraceptive usage to their customers. All the attendants were able to do this excellently and this can be due to the fact that the attendants receive periodic lessons and teachings on the various contraceptive types including newly introduced ones. Their only concern was that some of their customers do not go according to the instructions they give them and so sometimes come back to complain about the in-effectiveness of some of the methods. Some of the women in Koforidua on the otherhand complained that there are sometimes many customers in the pharmacy

shops and because of this they sometimes do not enjoy the necessary private atmosphere they need in order to talk about their reproductive needs to the pharmaceutical attendants.

The second group of service providers mentioned earlier on were nurses and midwives. The head of the Reproductive Health and Family Planning Unit at Koforidua who happened to be a senior nursing officer provided some information about how they provide contraceptive services to their clients. In the first place, an interview with her revealed that their customers have access to all the different types of contraceptives be it short or long term. The two major long term contraceptive methods (vasectomy for men and tubal ligation for women) which involve surgery are undertaken by the unit.

It was also realized from the field that the relationship between the nurses and midwives and their clients at the family planning unit was very cordial. The senior nursing officer informed me that as part of their information provision service, they counsel the women about all the contraceptive methods after which they leave it to them to make an informed choice. From this it can be deduced that one can always have the necessary information about contraception provided the person visits a family planning unit. The head was not happy about how men participate in their wives usage of contraception as she reported of very few men visiting the unit with their wives. She said that her unit is aimed at improving male participation in the family planning business. She and her staff therefore treat the few who come there with much attention and care so that the men themselves would encourage other men to be involved in family planning and hence contraceptive usage.

The final research question had to do with the role that men (husbands) and other family members play to influence women's usage of contraception. In the Ghanaian society, the man and sometimes other family members especially in-laws and grand-parents try to influence decisions couples make about their reproductive lives. The influence of the husband and these significant others in the family were more pronounced in Asokore than in Koforidua. This may be because Asokore has a relatively low socio-cultural and socio-economic setting than Koforidua. Many of the women interviewed in Asokore were

living in compound houses which is normally been occupied by three or four families or having several members of one big family comprising of members of the nuclear and extended families living together.

Some younger women interviewed therefore shared their experiences concerning their in-laws who were discouraging them from using contraception and pressurizing them for their grand-children. The situation was very different in Koforidua. Many of the women both young and old were living in nuclear homes with their husbands and their children. To them they are distant from their extended family members and so they do not see their influence on their choice of or usage of contraceptives.

It is generally argued that (men) husbands sometimes oppose to their wives usage of contraception. This assertion may not be true at all times since the case was different in this study. All the four men interviewed in this study supported their wives usage of contraception. There was only one man in Koforidua who was occasionally using the male condom, the others were not ready to use it but encouraged their wives to use contraceptives. This was the worry of some women in Asokore as they wanted their husbands to use condoms so that they can also stay out of contraceptives at certain times. The men however argue that they have very few choices of contraception and are less attended to when it comes to matters concerning family planning.

Some writers have however argued on the issue of why family planning and hence contraceptive usage is still female dominated. Watkins and Hodgson 1998; Watkins 1993, and Becker 1996 argue that family planning services are more focused on women, not only because most contraceptives are female based, but because the services are delivered through the existing Maternal and Child Health (MCH) programs, which are predominantly patronized by women.

### **8.3 Conclusion**

Ghana's Total Fertility Rates (TFR's) have been declining since the 1990's. (Ghana Statistical Service, 2004). The level of decline is however not very significant as to address the problem of population growth in the country which is seen as an impediment

to the country's development. Demographers are of the view that with the upsurge of the HIV/AIDS pandemic which has come to mar the improvements in mortality rates over the years, much needs to be done to decrease birth rates in order to control the growth of the population of the country.

A very vital tool that demographers and health personnels are using to reduce birth rates is contraception. Contraceptive knowledge is almost universal to the populace, from the youth to the aged. The rate at which people use contraceptives whether natural or modern is however low. (The Contraceptive Prevalence Rate as reported by the 2003 Ghana Demographic and Health Survey (GDHS) stands at 25.2 percent).

The study therefore tried to investigate the reasons for the low usage of both modern and natural/traditional contraceptive methods among married women in the younger age group of 25-30 and those aged 40-45 years. The women were selected from an urban and peri-urban area in the Eastern Region of Ghana.

It was realized from the study that in as much as many of the women appreciate the benefits of contraception for birth control, some of them were adopting methods against their will. This was common in Asokore (the peri-urban area). Comparatively, there were more women using natural methods of contraception in Koforidua (urban area) than in Asokore (peri-urban area). Some of the women in Asokore and even some in Koforidua, who were using modern methods wished to switch to the natural methods, if they could get the right information and education on how to adopt them and also had the support of their husbands. Some women in Asokore reported that it will be difficult for them to convince their husbands to abstain during their unsafe days when adopting the periodic abstinence method.

The most common natural method of contraception mentioned and used by the respondents was the periodic abstinence method. It was realized that there is little information available to women on how to adopt the method. All the women using the method in Asokore had information on them from friends. The women in Koforidua also

mentioned having read about the method from books. The information gained from friends can sometimes be misleading as compared to knowledge gained from health personnels. There is also the need for men or spouses to understand the mechanisms of the method so that they can co-operate with their wives to use the contraceptive type effectively.

In conclusion, it should be noted that, the ease with which an individual can use a contraceptive type of her choice will go a long way to improve the contraceptive prevalence rate of the country. The study ironically revealed that highly educated women living in the urban area preferred to use and were using natural methods of contraception than the modern methods which are widely publicized. Some women in Asokore especially those in the older age group wished to adopt the periodic abstinence method if they had the co-operation of their spouses. Co-operation here means that the men would use different kinds of condoms when their wives are in their “unsafe” days of the month or avoid any sexual activities during those days. Men should try to understand that their support is very much needed when it comes to matters concerning the reproductive life.

Burying all other considerations that should be taken into account to improve contraceptive usage in the country, health workers, scholars, the government, the contraceptive users themselves (men and women) and family planning experts need to put in place measures, aimed at increasing knowledge on natural/traditional contraceptive methods. This however does not suggest that there should be a shift in education on contraceptives from the modern to the natural/traditional. Education campaigns should aim at sensitizing the public on both methods.

#### **8.4 Relation of theories to the findings of the study**

In the third chapter of this study, two theories were selected and explained in detail to aid in the analysis of the study. They were the structuration theory and the approaches of Gender and Development (GAD) and Women Culture and Development (WCD) put forward by feminist scholars. The theories were selected based on the fact that they can



help in explaining the findings of this study. Giddens (1984) explains the structuration theory simply as how individuals born into societies are entrapped with social structures, which both constrain and enable them. Individuals (human agency) in one way or the other also influence the structures of the society to their benefit. The structures in the society as used in this study can be physical or social.

The physical structures that can influence women's choice of and use of contraception, include available family planning or reproductive health centres and pharmaceutical outlets. The social structures on the otherhand include influences from spouses and other family members especially those from the extended families. Socially, friends can also influence the decision by women to use contraceptives.

The study revealed that there was less influence from the physical structures available for family planning on women's choice of and use of contraception. In other words the availability of these structures does not contribute much to the lower usage rate of contraceptives by women. This was because there were pharmaceutical shops in both study areas where women can access the different modern methods of contraception at least the short term contraceptive types which were the most patronized. There was also a family planning unit at the General Hospital in Koforidua which provided services for both the inhabitants of Koforidua and other neighboring towns including Asokore. In the theory it is argued that structures influence individual behavior, but behavior can reciprocally influence structures (Cloke et al 1991, cited in Holt Jensen 2000). This assertion was realized in this study, as the senior nursing officer at the family planning unit and the pharmaceutical attendants in Koforidua reported of how the individual concerns of the women they serve have influenced the manner in which they provide their services. An example is that these service providers make sure that they always have the contraceptive types that are highly patronized by women available to them at all times.

The social structures on the otherhand may have much influence on the low usage rate of contraceptives in this study. The influence of husbands and friends was seen as critical in

the choices that women make on contraception. The study revealed that all the men interviewed encouraged their wives to use different contraceptive types but were mostly not willing to co-operate when they are to use some contraceptives themselves.

Again some of the women in Asokore, especially the older women had pre-conceived ideas about the different contraceptive types because of the experiences of their friends. They were therefore not willing to encourage other women to use contraceptives. These women mostly rely on the information they get from their friends. The friends of these women may not give them the right information since these friends may also be ignorant about how the different methods work. For instance, the head of the family planning unit in Koforidua elaborated on the fact that some modern contraceptives are hormonal based and so worked differently on different individuals. Some of the women interviewed in Asokore who were ignorant about this were not willing to even visit the family planning unit themselves because of the bad side effects that some of their friends had after visiting the unit.

Secondly, the approaches of Gender and Development (GAD) and Women Culture and Development (WCD) by feminist theorists were adopted in this study as earlier mentioned. These theoretical approaches simply try to explain the inequalities that exist between men and women when one considers their productive and reproductive roles. The approaches of Gender and Development and Women Culture and Development, best fit the explanation of the findings of this study because gender roles of men and women as explained by GAD cuts across decisions regarding their reproductive lives. The societal norms, values and cultures within the WCD approach also has much bearing on this study as the study made use of respondents from two geographical areas with different values and cultures.

In this study there were more women adopting natural contraceptive methods in Koforidua than in Asokore. These women had higher socio-economic status than those in Asokore. In Asokore women in both age groups under study, who wished to use the periodic abstinence method, were restricted because there is less negotiation between

them and their spouses concerning their reproductive lives partly because of their relatively lower socio-economic status. The gender roles that the society has assigned to women, which gives them less control over their reproductive lives, may be more pertinent in the peri-urban and rural areas as revealed by this study.

The study also showed that there was no woman in the younger age group (25-30), in Asokore or Koforidua who was adopting or wished to adopt the most traditional forms of contraception in the form of herbs and/or hard liquor and other herbal preparations sold in the market. The older married women especially in Asokore talked about how some herbs can also be effective contraceptive methods. Many younger women preferred to use modern contraceptive methods. The culture of contraceptive use is therefore changing even in peri-urban and rural areas from the traditional types with the introduction of modern methods.

Finally, it was realized from this study that friends and family members had little or no influence on women's choice of and use of different contraceptive types in Koforidua. These women mostly lived in their nuclear homes with their husbands and children and occasionally visit their family members. In Asokore, on the otherhand, most of the women lived within the same compound with members of the extended family as uncles, aunties, parents and in-laws. There is therefore some form of influence from these family members regarding the women's reproductive lives and hence choice of and usage of contraception.

## **8.5 The geographical dimension of the study**

This academic piece falls within the medical/health aspect of geographical studies. Gatrell (2002) argues in his book that ones "health" and geography are inextricably linked. Medical geographers basically undertake geographical analyses of health, diseases, mortality and health care. (Johnston et al 2000). There are different approaches to studies in health geography. Some researchers take to positivist epidemiology stand – point where they use statistical tools to measure variations in the occurrences of say diseases. A more recent approach involves studying the differences in health and health

care conditions in different places. Here one considers how the “culture” of different societies influences the health of the people of the society. In Gatrell’s book this recent approach is known as the post-structuralist approach.

In this study, the most recent approach in studies of health geography was adopted. The study tried to ascertain how the knowledge, perceptions and experiences women have about contraceptives affects their decisions to use them or encourage others to do so. The women were selected from two different geographical areas with distinct cultures. It was realized from the study that the different cultural beliefs and practices existing in rural/peri-urban areas could serve as a contributory factor to the low contraceptive prevalence rate of the country. It was realized that in as much as spouses in both study areas would encourage their wives to use contraceptives all of them were not ready to use the contraceptives themselves or sometimes do not agree to their wives choice of contraception.

In Asokore, it was evident that the living conditions of the women called for members of the extended family to have some influence on contraceptive usage among the women. Here, sometimes in-laws and grand-parents who live together in the same compound with the women discourage them from using contraceptives.

In Koforidua on the otherhand, the decision of a woman to use contraceptives is mostly taken by the woman and her husband. The members of the extended family have little or no influence here and there is much negotiation between the husband and the wife about the woman’s choice of contraception. This is partly due to the fact that generally, the women in Koforidua had higher socio-economic status than those in Asokore.

Culture is simply defined as a way of life. It is not a static phenomenon but a dynamic one. Because of its dynamic nature people adopt to new ways of life as societies change through time. This study has contributed to health/medical geography by emphasizing the importance of culture in women’s usage of health services. Modern contraceptives which are “foreign” in nature are being adopted in both urban and peri-urban areas in Ghana. Natural contraceptives are also being adopted in both areas. This may be due to the fact

that there is the diffusion of ideas about contraceptives across different geographical settings (e.g. from urban to peri-urban areas) resulting in people having revised attitudes about contraception.

## **8.6 Recommendations**

The aim of this study was to address the issue of the low contraceptive prevalence rate in Ghana and to come up with plausible measures to improve the situation. The respondents for this study came up with vital suggestions on improving contraceptive use in the country. The subsequent sections provide some of the suggestions of the respondents of the study and also the recommendations of the researcher.

### ***8.6.1 Recommendations on improving contraceptive usage***

#### ***8.6.1.1 Recommendations by women***

Women bear the risk of childbearing and in recent times sometimes carry the burden of looking after a child if the father decides to be irresponsible. The views of the women on contraception are therefore very vital to improving the contraceptive prevalence rates in different parts of the country. Many of the women expressed the need for a more intensified education on contraception. They tried to explain the different ways through which the populace should be educated. A married woman in the younger age group in Koforidua talked about the need for more advertisements about contraception on the radios and televisions. An older married woman, also in Koforidua reiterated the need for health officials to expand their Information Education and Communication (IEC) programs on contraception to the remotest parts of the country. To her those places need special attention since women there have the highest birth rates in the country. Still on education, a woman aged 28 years in Asokore also expressed the need for all women to share their knowledge about contraception with their peers and encourage them to also use contraceptives. Another woman in the older age group, also in Asokore, talked about the need for family planning experts to spread their messages in the churches, market places, work places and in the schools.

One of the younger married women in Koforidua expressed the need for parents to do away with shyness and talk about family planning and contraception to their female children who are of age. She said “*our society frowns upon discussions on sex and reproduction to the youth but we need to address this if we want to control our fertility rates.*”

Other women both in Koforidua and Asokore were much concerned about the need for women to utilize the services provided by the family planning clinics in the country. To them it is at these clinics that one can have the right information on the different contraceptive types.

For women to use the different contraceptive types with more efficiency, a woman in the younger age group in Asokore talked about the need for illiterate women to enroll in non-formal education classes so that they will understand better the technicalities involved in using the different contraceptive types.

A 30 year old woman in Koforidua also called on health personnels to put in place measures to get the men fully involved in family planning and contraceptive usage since they have the upper hand in reproductive matters in the family.

Lastly, regarding the negative side effects of some of the modern methods, some women mostly in Asokore suggested that, health personnels should try to administer the right contraceptive type to different individuals so as to minimize the side effects. There were also suggestions for the intensification of educational campaigns on the natural methods which have fewer side effects.

#### **8.6.1.2 Recommendations by men** **(Spouses in Koforidua)**

*Spouse 1: On how best to increase contraceptive usage in the country, men should be seriously targeted to receive education from family planning experts*

*Spouse 2: To improve contraceptive usage in Ghana, there is the need for people to do away with the ill-notions they have about contraceptives and seek for the right information from family planning experts.*

**(Spouses in Asokore)**

*Spouse 1: For an improvement in contraceptive usage in Ghana, there is the need for health personnels to encourage men to use the different brands of condoms.*

*Spouse 2: For more people to use contraceptives, there is the need for massive education campaigns through the media and by nurses and mid-wives in the different communities in the country.*

**8.6.1.3 Recommendations by pharmaceutical attendants**

**Pharmaceutical attendants in Koforidua**

*Pharmacist 1: For us to have a rise in contraceptive usage I advise that, the literate group should try to talk about sex education and contraception when they visit their illiterate and semi-literate families in the rural areas. You know in Ghana we regard sex and sex related issues as sacred and this is the reason why we have a high population.*

*Pharmacist 2: For more people to use contraceptives, the people need to be educated on the need to avoid shyness and visit the pharmacies to purchase their contraceptives and also to freely address their concerns when they visit the pharmacies.*

**Pharmaceutical attendants in Asokore**

*Pharmacist 1: For contraceptive usage to increase, rural education on contraception and family planning should be intensified by the Ministry of Health (MOH) and Non-Governmental Organizations (NGOs).*

*Pharmacist 2: To improve contraceptive usage in the country, I advise that the men should consider using condoms since it has two benefits, protection against unwanted pregnancies and HIV/AIDS.*

#### **8.6.1.4 Recommendation by family planning expert**

The following are some suggestions that were given by the head of the Reproductive Health and Family Planning Unit (RHFPU) at Koforidua on how best to improve contraceptive use in the country.

*There is the need for a more intensified education on contraceptive usage. The adolescent group is very high and they are at risk of getting pregnant, so education has to start early in the schools for the adolescents.*

*We also have to go to the churches eventhough some of the churches do not encourage discussions on contraception especially condom use.*

*Men, women and the youth have to develop the habit of utilizing the services provided at the family planning centres for the right information rather than relying on the ideas of friends.*

*I also encourage more women to visit the family planning unit for information on natural contraceptive methods. The usage of the natural methods is very practical and it takes a lot of time to teach people to understand how best to use them.*

*Finally, I advise our clients not to be reluctant to visit the unit and express their concerns about their choice of contraceptives. The nurses and mid-wives are always available to attend to them.*

In view of the findings that have come out of this study and also based on the recommendations given by women, men and the key service providers of contraception,



it is recommended that the status of women (who are the primary users of contraceptives) are improved in order that they will better appreciate contraceptive use. When the statuses of women are improved through education and empowerment they will have higher socio-economic statuses so that they can negotiate with their husbands to adopt contraceptive types that they find convenient to use. They will also be able to use the contraceptives in the right way so as to see the effectiveness of each contraceptive type.

There is also the need for the government and family planning organizations to put in place measures aimed at improving men's involvement in family planning in the country. The Ghanaian culture is fashioned in such a way that, the man being the head of the house mostly has a louder voice in matters of reproduction at home. Perhaps there is the need for the establishment of special family planning centres which will provide services solely to men.

Education on family planning and contraception is also very critical to improving contraceptive use in the country as has been mentioned earlier by the respondents of this study. There is the need for massive education on both modern and natural/traditional methods of contraception, since the modern methods are more popular than the natural ones. The television and radio stations are the best media channels that can be used. Family planning officers should target the churches, schools and market places where they can get large groups of people to talk to.

Since fertility rates are likely to be high in the remotest parts of the country, it is important that health personnels try as much as possible to reach all these areas with the message of family planning and contraceptive use.

For a more effective usage of the different contraceptive types by the illiterate group, there is the need for the government and Non-Governmental Organizations to set up educational centres at the local levels to provide non-formal education to the illiterate group. With some level of education, these people will appreciate the need to use contraceptives and also use them effectively.

## **8.7 Suggestions for future research**

This study focused on contraceptive usage by married women in an urban and peri-urban area. For one to better appreciate the disparity in contraceptive usage by rural and urban women, a study can be undertaken in a remote area or a village in the country to assess the situation there.

The youth who form the bulk of Ghana's population according to demographers have the highest tendency to influence future fertility rates and hence population growth of the country. It will therefore be important for future studies to investigate the perceptions, assessments and usage of contraception by the youth in the country.

This study was basically qualitative in nature with a small sample size. It was therefore difficult to make strict generalizations about the findings. Future studies can be quantitative in nature in which case some conclusions and generalizations can be drawn from the large sample used.

Several studies on contraception focus on women as the primary or sole respondents of the study. Since men play a major role in their wives reproductive lives in the Ghanaian society, future studies can investigate how men influence their wives or partners usage of contraception.

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# APPENDICES

## *Appendix 1*

### Interview Guide for Married women

#### **Demographic information**

1. Age of respondent
2. Occupation
3. How long have you been married?
4. How many children do you have?

#### **Knowledge about contraception**

5. Which types of contraceptive methods have you heard about?
6. How did you get to know about them?
7. Under what category will you place the different types you mentioned about earlier on? –Traditional and Modern.

#### **Contraceptive use, assessment and perceptions**

8. Which of these methods would you opt for if you were to use any of the methods- traditional or modern and why?
9. Have you used any of the types regularly in the last two years?
10. If yes, how convenient is the use of the contraceptive type?
11. Do you perceive that there may be other contraceptive types which may be more convenient than the one you are using?
12. How do you assess the effectiveness of your choice of contraception for birth control?
13. Do you find the type as one which is very comfortable to use or you experience some discomfort conditions when you use the contraceptive.
14. How accessible and affordable is your choice of contraception?
15. If no (to question 9), give reasons why you are not using any contraceptive method?



16. Did your husband or any other family member in any way influence your choice of contraception?

17. If yes, in what ways?

**Access to information on contraceptive use**

18. Where did you receive information and/or counseling about the contraceptive methods you use/used?

19. Were you introduced to traditional or modern methods of contraception?

20. Can you explain how the service provider demonstrated to you how to use the method?

21. Are there any special concerns you raised when you were introduced to the method?

22. Can you suggest some reasons why other women may not use different types of contraception?

23. In your opinion what can be done to improve the use of the methods?

## ***Appendix 2***

### **Interview guide for married men**

1. Which types of contraceptive methods have you heard about?
2. How did you get to know about them?
3. Under what category will you place the different types you mentioned about earlier on? –Traditional and Modern.
4. Has your wife been using any contraceptive type in the last two years?
5. Is your wife currently using any of the types? Please give reasons.
6. What has been your influence on your wife's usage of contraception?
7. What is going to be your reaction if your wife should use any contraceptive type without first informing you?
8. What in your opinion can husbands do to improve contraceptive use among their wives?

## ***Appendix 3***

### **Interview Guide for Pharmaceutical Attendants**

1. When did you start selling drugs?
2. Can you mention the different types of contraception you know of?
3. Which types do you sell here?
4. What are their prices?
5. Do you have women coming to purchase contraceptives?
6. What about men?
7. Which group of men and women normally comes to purchase contraceptives?
8. Which contraceptive types do they prefer most and do they buy it for themselves or for their spouses?
9. What are some reasons they give for their choice of contraceptives?
10. Do you provide them with information about the use of the methods?
11. If yes, can you demonstrate?
12. What are some of the concerns raised by women and men about the use of the various contraceptive types?
13. What do you think can be done to increase contraceptive use among women?

## **Appendix 4**

### **Interview Guide for Nurses/Midwives/Family planning expert**

1. For how long has the family planning unit been in operation?
2. Who are the people that the unit provides its services to?
3. How do you provide your target group with information on family planning?
4. What contraceptive methods do you provide information on and what is the cost involved, how accessible is it and what are the risks one may encounter in using them?
5. Do you have many women visiting the unit?
6. What contraceptive types do they prefer? Rank in order of preference 1, 2, 3 etc.
7. What are the concerns expressed by women when introduced to the various contraceptive types which may influence their choice of contraception?
8. How do you address their concerns?
9. What do you think are the factors that motivate or prevent women from patronizing your service?
10. What do you suggest can be done to motivate more women to utilize the service provided here?
11. How are you going to reach out to women in Asokore and other remote areas with information on contraception?
12. The contraceptive prevalence rate for the country is low. What do you think can be done to improve contraceptive usage in the country for a reduction in fertility?