UNIVERSITY OF MEDIA ARTS AND COMMUNICATION-INSTITUTE OF JOURNALISM (UNIMAC-IJ, SCHOOL OF GRADUATE STUDIES (SoGS)

TOPIC: LEVEL OF PATRONAGE OF FAMILY PLANNING METHODS AMONG MARRIED WOMEN - A STUDY OF AWOSHIE- MARKET COMMUNITY

BY

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A DISSERTATION SUBMITTED TO UNIVERSITY OF MEDIA, ARTS AND COMMUNICATION, INSTITUTE OF JOURNALISM (UNIMAC-IJ); IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF ARTS (MA) DEGREE IN DEVELOPMENT COMMUNICATION

3RD DECEMBER 2025

CANDIDATE'S DECLARATION

I hereby declare that this dissertation is the result of my own original research and has not been previously submitted for a degree at this or any other university. All sources of information have been duly acknowledged through complete references.

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	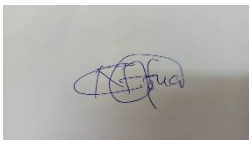	
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SUPERVISOR'S CERTIFICATION

We have read and hereby certify that this dissertation meets the standards and requirements for approval by the University of Media Arts and Communication - Institute of Journalism (UniMAC-IJ).

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DEDICATION

This study is dedicated to my dear mother, Stella Oye Mills and brother, Emmanuel Nyarko whose support enabled me to successfully complete this work.

ACKNOWLEDGEMENTS

I wish to express my deep gratitude to Madam Beatrice Asamani Savage and Mr Joseph Baffoe, the Head of Editorial and Head of Administration at the Ghana News Agency respectively for their approval and permission to embark on this academic journey.

My heartfelt appreciation goes to my supervisor, Dr Daniel Odoom, for the continuous encouragement, expert guidance, insights, constructive feedback and patience offered at every step of this work. Your guidance strengthened the quality of this research.

I am very grateful to the Management and Staff of the Family Planning Unit of the Anyaa Polyclinic, Community Health workers at Awoshie Zongo and Traditional Leaders especially the Queen Mother of Anyaa, Naa Dedei Chabitiale II and opinion leaders of the Awoshie-Market community for granting me access and needed support during the data-collection process without any bureaucratic processes.

Special thanks also go to Madam Rebecca Aku Bortey, the Awoshie-Market Queen and Madam Dianah Larteokor Anum, member of the Awoshie-market Traders Association for their immense assistance.

Appreciation also goes to all respondents within the Awoshie-Market enclave and other key informants whose willingness to participate made this study possible. Your openness and shared experiences provided the foundation upon which the findings of this research were built.

To all my lecturers at the School of Graduate Studies and Research (SoGSaR), I say a big thank you for the knowledge impacted in me throughout my study.

I am also indebted to my Sub editors, especially Madam Lydia Kuukua Asamoah for her assistance in helping me get the needed finances to support my studies. Your contribution is deeply valued and sincerely acknowledged.

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LIST OF ABBREVIATIONS

Abbreviation		Meaning
AMA	-	Accra Metropolitan Assembly
CHW	-	Community Health Worker
COC	-	Combined Oral Contraceptive
CPR	-	Contraceptive Prevalence Rate
DOI	-	Diffusion of Innovations Theory
ECP	-	Emergency Contraceptive Pills
FP	-	Family Planning
GHS	-	Ghana Health Service
GSS	-	Ghana Statistical Service
HBM	-	Health Belief Model
IUD	-	Intrauterine Device
LARC	-	Long-Acting Reversible Contraceptive
LNG-IUD	-	Levonorgestrel-Releasing Intrauterine System
POP	-	Progestin-Only Pill
SDG	-	Sustainable Development Goal

SPSS - Statistical Package for the Social Sciences

TPB - Theory of Planned Behaviour

UNDP - United Nations Development Programme

UNFPA - United Nations Population Fund

UNICEF - United Nations Children's Fund

UNIMAC - University of Media, Arts and Communication

WHO - World Health Organization

ABSTRACT

Family planning (FP) is a foundation of public health. It is key to reducing maternal mortality, a means to empower women and foster sustainable development. Despite high awareness of modern contraceptive methods in Ghana, its patronage among married women, particularly in urban-poor communities, remains critically low. This study explored the level of patronage and its determinants among married women in the Awoshie-Market community within the Greater Accra Region.

Adopting a Convergent Parallel Mixed-Methods Design, the study used a combination of a quantitative cross-sectional survey of 101 married women with qualitative key informant interviews involving 10 health workers and community leaders. Data was analysed using Descriptive and Inferential statistics (SPSS) for the Quantitative Data and Thematic Analysis for the Qualitative Data.

The study revealed a significant difference between awareness and practice - while awareness of methods such as pills was high, only 56.4% had ever used a modern method. The primary barriers were not demographic but socio-relational and perceptual. Fear of side effects was the most significant barrier (72.3% in agreement), followed by spousal disapproval (62.4%). Pervasive misconceptions, including beliefs that FP causes infertility (49.5%) and health issues (67.3%), were amplified by peer networks and religious interpretations. Logistic regression confirmed that demographic factors were poor predictors of use underscoring the dominance of social dynamics.

The study concludes that the low patronage of FP in Awoshie-Market is fundamentally an "awareness-acceptance gap" driven by misinformation, gender power imbalances, and systemic service barriers. To bridge this gap, it is recommended that policymakers and

practitioners implement multi-faceted interventions which must include strengthening male involvement initiatives; deploying targeted communication in local languages to dispel myths; training healthcare providers in client-centred care; ensuring reliable commodity supply and strategically engage community leaders as FP ambassadors.

This evidence-based approach is necessary to increase FP uptake and achieve related Sustainable Development Goals (SDGs) in peri-urban Ghana.

Key words:

Family Planning, Contraceptives, uptake, married women, methods, market, usage, patronage

CHAPTER ONE

INTRODUCTION

1.1 Background of Study

Population dynamics greatly impacts the course of national development. Although a youthful population offers demographic dividends through an expanded labour force, rapid population growth worsens poverty, strains infrastructure, and hampers sustainable development (United Nations Development Programme [UNDP], 2024). Ghana exemplifies this paradox: its population is growing at 2.3 percent annually (Ghana Statistical Service [GSS], 2024), outperforming economic growth, which the World Bank (2024) estimates at 2.9 percent GDP growth for 2024, thereby crippling public service delivery. Urban centres such as Accra face severe overcrowding, with youth unemployment currently at 42 percent and primary school classrooms averaging seventy-five pupils to one teacher (World Bank, 2024). The Awoshie-Market community, located within the Anyaa-Sowutuom Constituency, mirrors these challenges, struggling with housing shortages, sanitation crises, and overburdened healthcare facilities (Accra Metropolitan Assembly [AMA], 2024).

Overpopulation in Ghana is driven by persistently high fertility rates (3.8 births per woman), early marriages (18% of females marry before age 18), and low modern contraceptive use (only 25% among married women) (GSS, 2024). Cultural preferences for large families, religious restrictions, and gender inequities further limit family planning (FP) access, perpetuating cycles of intergenerational poverty (Odoi et al., 2023). Consequently, national resources are diverted from productive investments to crisis management, undermining progress toward Sustainable Development Goals (SDGs) 1 (No Poverty) and 4 (Quality Education) (UNDP, 2024). Family planning offers a scientifically validated modern solutions and methods that enables females birth spacing and limitation, reducing maternal mortality by 30% and deaths of children under the age of five years old by 25% (Ahmed et al., 2022).

These includes short, long term and emergency hormonal methods/procedures, barrier methods, Long-Term Reversible Contraceptives (LARCs), Irreversible/Permanent Procedures and Traditional/Natural Methods.

Hormonal methods of family planning prevent pregnancy by employing artificial versions of the human hormones' oestrogen and progestin (progesterone) to alter a female's natural menstrual cycle. These comes in either short or medium to long term usage. These methods primarily work by suppressing Ovulation to prevent the release of an egg from the ovaries, thicken Cervical Mucus thus making it difficult for sperm to enter the uterus to fertilize the egg, others work to thin the lining of the uterus (known as the Endometrium). This causes it to be less receptive to a fertilized egg embedding on the uterine wall.

Combined Oral Contraceptives (COCs) - Also known as the "The Pill". These are Tablets that contain both synthetic oestrogen and a progestin and is taken orally. That is, one pill daily at approximately the same time each day. Most packs are designed for a twenty-one-day active pill/seven-day placebo pill cycle or a 24-day active/four-day placebo cycle, during which withdrawal bleeding occurs. Continuous or extended-cycle formulations (i.e., where active pills are taken for longer periods) are also available to reduce or eliminate periods (WHO, 2018).

Progestin-Only Pills (POPs) – Also referred to as "The Minipill". Unlike the COCs, these are tablets that contain only a progestin hormone. The Minipill is also orally administered by taking one pill daily at the same time every day (i.e., within a three-hour window for most types, though more modernised POPs have a 12-hour window) for maximum results. There are no placebo pills; active pills are taken continuously, and irregular flow of blood or staining is common (Odoi et al., 2021).

Injectables – These are progestin-only contraception administered to the veins with the help of a hypodermic syringe or through an intravenous procedure. These types of contraceptives are administered by certified healthcare providers every eight weeks or eleven to thirteen weeks depending on the type of injectable used. This procedure can be taught to the female to do herself (Burke et al., 2017).

Contraceptive Implant - These are tiny, flexible rods or capsules that contain only a progestin hormone (mainly levonorgestrel). They are inserted under the skin, usually at the inner part of the upper arm by a trained healthcare provider in a minor surgical procedure with less or no anaesthetic. These long-term reversible methods of contraception provide a highly effective protection for between three to five years (depending on the type used). Its removal requires a trained provider (Ochako et al., 2015).

Contraceptive Patch -This is a thin adhesive patch that is worn on the skin of the female. It releases synthetic oestrogen and progestin continuously that helps prevent unwanted pregnancy. The patch is applied to clean, dry skin usually around the buttocks, abdomen, upper outer arm, or upper torso once a week for three consecutive weeks, followed by a patch-free week during which withdrawal bleeding occurs. This type is strictly administered on prescription with its availability in Ghana and the rest of Africa very limited (CDC, 2020).

Vaginal Ring: This is a flexible, transparent ring inserted into the vagina. It releases synthetic oestrogen and progestin continuously to prevent unplanned and unwanted pregnancies. The ring is inserted by the female and left in place for 3 weeks after which it is removed for a 1-week ring-free break during which withdrawal bleeding occurs. A new ring is inserted soon after the break. Like the patch, this type also requires prescription and its availability in Ghana/Africa is limited (WHO, 2018).

Emergency Contraceptive Pills (ECPs) – These are high-dose hormonal pills which either contain progestin-only [levonorgestrel] or combined oestrogen-progestin synthetic hormone, or ulipristal acetate [UPA] which is a progesterone receptor modulator. It is taken immediately after unprotected intercourse to prevent pregnancy.

These pills are most effective within 72 to 120 hours (5 days) after sexual intercourse. They work by delaying or hindering ovulation. However, they are not meant for regular use. Access to such contraceptives as well as its awareness in Ghana/Africa though improving, still faces some challenges (Ghana Health Service [GHS], 2020).

The Barrier methods prevent sperms from the male from swimming to fertilise the egg in the female. The devices captured under this method act as physical or chemical barriers at various points within the reproductive tract.

The Male Condom - A small thin oily rubber-like sack usually manufactured from latex, polyurethan, or polyisoprene. It is worn over the erected penis, leaving a nip tip to collect semen. These are worn before sexual intercourse to prevent contact between spermatozoa in males and eggs in females. Condoms provides significant protection against Sexually Transmitted Infections (STIs) such as Human Immuno-Virus (HIV), and Gonorrhoea (WHO, 2018; ARFH, 2012).

Female Condom – This is a small soft, loose-fitting sack with flexible rings at both ends usually manufactured out of nitrile or polyurethane. The female squeezes the inner ring and then inserts into the birth canal (vagina) whiles leaving the outer ring to cover the vulva before sexual intercourse. The condom provides a lining that prevents spermatozoa from reaching the eggs to fertilise it. Just like the male condom, the female one also provides significant protection against STIs (WHO, 2018; MIIRAP, 2011).

Diaphragm – This is a shallow, dome-shaped cup with a flexible rim that is fitted over the cervix inside the vagina. This device, made from silicone is inserted up to 6 hours before intercourse and often used together with spermicide for maximum effectiveness. Requires reapplication of spermicide for each additional act of intercourse while the diaphragm is in place. It must be washed and stored after removal (Ghana Health Service [GHS], 2020; WHO, 2018).

Cervical Cap – This is a small, thimble-shaped silicone cup that is fitted comfortably over the cervix alone by a certified healthcare provider. Like the diaphragm, this cervix-fitting device must be used together with spermicide and fitted several hours before sexual intercourse for maximum results. Its availability is limited globally, including in Ghana and the rest of the continent (WHO, 2018).

Spermicides – These are chemical agents (most commonly nonoxynol-9) that are inserted deeply into the vagina using an applicator or finger to incapacitate sperms. It comes in the form of foaming tablets, creams, gels, films, suppositories. It is usually blended with barrier methods such as diaphragms or caps. However, it can also be used alone. Spermicides unlike condoms, does not protect against STIs and HIV (WHO, 2018; ARFH, 2012).

Contraceptive Sponge – It is a soft, disposable polyurethane foam sponge that contains spermicide. This sponge is moistened with water to activate the spermicide before insertion to cover the cervix 24 hours before intercourse. It is removed by pulling the loop attached to the sponge. According to Trussell et al (2018), it releases spermicide such as nonoxynol-9 while acting as a physical barrier at the same time. Its availability in Africa is very limited.

Long-Term Reversible Contraceptives (LARCs) are highly effective birth control methods that provide contraception for an extended period (usually more than a year) after a single intervention and are quickly reversible to fertility upon removal. These devices require minimal

user adherence after correct placement. They are the Intrauterine Devices (IUDs) and Subdermal Implants.

Inter-Uterine Devices – They are small, flexible, T-shaped devices that are inserted into the uterus by a trained healthcare provider and come in two different models:

Copper-Bearing IUD: (Cu-IUD) which has a copper wire coiled around the stem and sometimes the arms. This type does not contain hormones. The copper ions create an inflammatory reaction in the uterus that is toxic to sperm and eggs thus preventing fertilization. The device is ideally inserted shortly after menstruation and anytime pregnancy is reasonably excluded (Jacobstein, 2018). Copper-Bearing IUDs can protect a female from pregnancy from five to 10 plus years, depending on the specific model (e.g., the TCu-380A has been proven to be effective for at least 12 years) (WHO, 2018).

Levonorgestrel-Releasing Intra-uterine System (LNG-IUD): Unlike the Cu-IUD, this type contains a progestin hormone that is stored in a reservoir on the stem that is released slowly into the uterus. The primary mechanism of this type is the thickening of cervical mucus that creates a barrier to sperm entry. It also thins the innermost lining of the uterus, making it unsuitable for conception to occur. It partially suppresses ovulation (especially in the first year of insertion). (Hubacher et al., 2017).

Subdermal Implants – These are small, flexible rods or tubes containing a progestin hormone (etonogestrel or levonorgestrel) that are inserted just under the skin of the inner upper arm by a trained healthcare provider. Modern examples include Jadelle, Sino-implant, and Implanon NXT. This device releases progestin steadily into the bloodstream which prevents ovulation, thickens the cervical mucus and thins the innermost lining layer of the uterus. It can protect the female user for up to five years. Like the IUDs, fertility returns rapidly after its removal (Ochako et al., 2015; WHO, 2018).

Irreversible or permanent contraceptive procedures (widely known as sterilization) are surgical procedures intended to permanently prevent pregnancy. This is done by blocking or cutting the reproductive tubes that carry eggs (as in women) or sperms (as in men). These procedures are usually permanent, and reversal is very complex, expensive, often unsuccessful or not guaranteed. Worldwide, these procedures are only recommended couples and individuals who are convinced they do not want any children at all or will not want any more children in the future. This type of sterilisation comes in two different forms. The male sterilisation otherwise known as vasectomy and female sterilisation widely known as Tubal ligation/Obstruction.

Female Sterilization (Tubal Ligation / Tubal Obstruction) - A surgical procedure that blocks, cuts, seals, clips, or removes segments of both fallopian tubes. This is done to prevent the egg from traveling down the tube to meet sperm and prevents sperms from reaching the egg. Can be performed shortly after vaginal or caesarean delivery, often through a small incision near the umbilicus. The procedure is more common and convenient. The procedure can also be done at any time where there is an absence of pregnancy.

Male Sterilization (Vasectomy) - A minor surgical procedure that cuts or blocks both vas deferens (i.e., the tubes that carry sperm from the testes to the urethra). This prevents sperm from being present in the ejaculated semen. This procedure does not hinder testosterone production, sex drive, and ejaculation volume (WHO, 2018).

Traditional/Natural Procedures -Traditional or natural family planning (NFP) methods involve the tracking of fertility signs or the modification of sexual behaviour to avoid pregnancy during fertile periods. These methods do not involve physical devices, artificial hormonal interventions or surgery. Its effectiveness is highly dependent on user knowledge, consistency and correct application. Generally, they have higher failure rates compared to modern methods of contraception (WHO, 2018; Manortey et al., 2020).

The Withdrawal Method (or Coitus Interruptus) involves the removal of the penis from the vagina before ejaculation during sexual intercourse. The aim is to prevent sperms from entering the vagina. This method relies entirely on the husband's ability to detect impending ejaculation and withdraw immediately and completely before any semen is released into the vagina. This method requires significant self-control and experience on the part of the male partner or (husband) Manortey et al (2020). Effectiveness of this method ranges from low to moderate whilst perfect use failure rate is around 4% per year. However, typical use failure rate is high (20% per year) according to WHO (2018) due to the difficulty in timing withdrawal correctly and the potential for sperm in pre-ejaculated fluids.

Calendar-Based/Rhythm Methods – Also known as Fertility Awareness-Based Methods (FABMs), this method estimates the fertile window of the female's menstrual cycle based on her past cycle lengths to identify days when pregnancy is likely to occur. It estimates the fertile window around ovulation (i.e., when an egg is released). According to Arevalo et al (2002) & Kabagenyi et al (2016) this type requires regular cycles and consistent tracking.

Lactational Amenorrhea Method (LAM) – Also called Prolonged breastfeeding, this is a temporary natural method of contraception based on the natural infertility that occurs when a woman is exclusively or nearly exclusively breastfeeding an infant under six months old and has not resumed menstruation. With this method, frequent, intense suckling suppresses ovulation by inhibiting hormones that cause egg to be released. Amenorrhea (i.e., the absence of menstruation) is a key indicator that ovulation is likely suppressed. This method has high results only when there is a very high commitment to breastfeeding in the first 6 months after birth (Kennedy et al., 1996; Gebeyehu et al., 2022).

Effectiveness often plummets if this criterion is not strictly followed or abandoned. Its effectiveness is dependent entirely on the users accurate understanding and proper tracking.

High Failure Rates are significantly higher for habitual users of this method. (Manortey et al., 2020).

The situation at Awoshie-Market

Despite Ghana's 2020 commitments on family planning and free contraceptive policies, patronage remains critically low in urban-poor enclaves such as the Awoshie-Market community. Misinformation (e.g., "contraceptives causes cancer or bareness"), religious stigma and prohibitions, cultural influences, spousal opposition, and limited family planning services perpetuate low adoption (Biney, 2021; Gyimah et al., 2023). Awoshie context—marked by migrant populations, patriarchal norms, and scarce health infrastructure propels the demand for urgent investigation to align FP services with community realities.

1.2 Problem Statement

Family planning (FP) remains a critical yet underachieved public health priority in Ghana, with significant disparities in contraceptive uptake across different regions and communities. Despite national efforts to improve reproductive health services Ghana's contraceptive prevalence rate (CPR) among married women remains critically low at 27 percent (Ghana Statistical Service [GSS], 2024), which is far below the West African average of 36 percent and the SDG target of 50 percent by 2030 (United Nations Population Fund [UNFPA], 2024). The Awoshie-Market community exemplifies this crisis: while 85 percent of women demonstrate awareness of family planning (FP), only 22 percent use modern methods (Accra Metropolitan Assembly [AMA], 2024). This disparity mirrors findings from similar urban poor communities in Ghana, such as Ashaiman, where FP knowledge failed to translate into usage due to structural and sociocultural barriers (Adjei et al., 2023).

Three key factors that perpetuate this gap, as is evident by recent previous studies are cultural and religious barriers, systemic failures and gender inequity (Twumasi-Ankrah et al., 2024).

The Ghana Health Service (GHS, 2024) reported stockouts of contraceptives in 70 percent of clinics in Greater Accra, with only 15 percent of providers offering counselling in local dialects (e.g., Ga or Twi). This aligns with a 2024 study in Odorkor (a community adjacent to Awoshie), where stockouts reduced FP uptake by 40 percent. Odoi et al. (2023) documented that 78 percent of reproductive decisions in Ghana are male dominated. In Awoshie, preliminary data shows that 62 percent of women require spousal consent to access Family Planning services (Accra Metropolitan Assembly [AMA], 2024), mirroring findings from Tamale, where male resistance accounted for 55 percent of non-use (Alhassan et al., 2023).

The consequences are severe in Awoshie's whose fertility rate (4.2 births per woman) exceeds that of the national average of 3.8 per woman (GSS, 2024), exacerbating poverty and maternal mortality (451 deaths/100,000 live births) (GHS, 2024). Without targeted interventions, Ghana's SDG 3 (health) and 5 (gender equality) targets will remain unachieved.

Existing research such as the one done by Osei et al. (2023) focused on rural areas and generalized urban data, neglecting local disparities in communities such as Awoshie-Market. This study will provide community-specific evidence to guide FP programs in Accra's underserved enclaves, update outdated data with current insights on post-COVID-19 FP challenges and address the male involvement gap by exploring spousal dynamics, an understudied area in urban Ghana (Agyei et al., 2024).

1.3 Research Aim

To examine the determinants of low family planning patronage among married women in Awoshie-Market community and propose evidence-based strategies for improving contraceptive acceptance.

1.4 Research Objectives

1. To examine the level of awareness of family planning methods among married women in Awoshie.

2. To ascertain perception about family planning methods among married women in Awoshie.

3. To identify the social, economic, religious and cultural factors influencing married women's decision on family planning methods.

4. To explore ways of increasing family planning acceptance among married women in Awoshie.

1.5 Research Questions

1. What is the level of awareness of family planning methods among married women in Awoshie?

2. What perception do married women in Awoshie have about family planning methods?

3. What are the social, economic, religious and cultural factors influencing married women's decision on family planning methods?

4. What strategies can help in increasing family planning acceptance among married women in Awoshie?

1.6 Significance of the Study

The significance of this study on the topic: “Level of Patronage of Family Planning Methods Among Married Women – A Study of Awoshie-Market Community” lies in its potential to influence health communication strategies, public policy, and socio-cultural understanding of reproductive health practices in peri-urban communities in Ghana. Family planning remains a foundation for reducing maternal mortality, improving the health of women and support

economic stability in households (Cleland et al., 2012). Yet, despite widespread awareness campaigns, uptake remains inconsistent due to a combination of cultural norms, misinformation, and inadequate communication approaches (Anarfi, 2003).

This study is particularly important in the context of Awoshie-Market, a rapidly urbanizing community where population growth places immense pressure on health and social services. Understanding the socio-demographic effects and communication channels that influence family planning decisions among married women provides serious insight for development communicators. It enables the design of culturally appropriate messages and the selection of effective media platforms to reach target audiences.

Moreover, the findings can inform local health institutions, such as the Ghana Health Service, Non-Governmental Organisations (NGOs), and other stakeholders on how to effectively tailor their family planning programs. By identifying gaps in knowledge, communication inefficiencies, and community-specific barriers, the study will provide evidence-based recommendations for improving family planning outreach and acceptance (World Health Organization, 2018).

Academically, this research will contribute to the body of literature on reproductive health communication in sub-Saharan Africa and addresses the intersection between communication, gender roles, and health behaviours, thus offering a holistic framework for future interventions. Eventually, the study emphasises the pivotal role that development communication plays in achieving Sustainable Development Goals (SDGs), particularly Goal three on good health and well-being and Goal five on gender equality.

1.7 Scope of the Study

This study focuses on examining the level of patronage of family planning methods among married women residing in the Awoshie-Market community, a peri-urban settlement in the

Greater Accra Region of Ghana. The study specifically explores the types of family planning methods known and used, factors influencing the adoption or non-adoption of these methods, and the role of development communication in shaping attitudes and behaviours toward family planning.

The research covers married women between the ages of 18 to 49 years, recognizing this group as the most active reproductive demographic according to global reproductive health standards (Ghana Statistical Service [GSS], 2023). The study investigates how communication strategies such as interpersonal, community-based, mass media, and digital platforms affect knowledge, attitudes, and decisions regarding family planning. Additionally, the study examines how socio-cultural factors such as religious beliefs, spousal influence, economic status, and educational background intersect with communication in shaping reproductive health decisions.

Geographically, the study is restricted to the Awoshie-Market community due to its dense population, active market economy, and observable variation in health-seeking behaviour, making it an ideal microcosm for assessing family planning trends in similar urbanised communities. Data collection methods include structured questionnaires, key informant interviews with health workers, and focus group discussions with the community's women.

The study does not include unmarried women or men, as its primary interest is understanding family planning choices within the context of marriage and household decision-making. It also does not assess the clinical effectiveness of family planning methods, but rather the communication dynamics and behavioural responses surrounding their use.

Ultimately, the scope provides a focused yet comprehensive lens for understanding how development communication can enhance the acceptance of family planning services and inform policy and programme interventions within urban-poor Ghanaian communities.

1.8 Limitations of the Study

Despite the relevance and potential contribution of this study on the Level of Patronage of Family Planning Methods Among Married Women in the Awoshie-Market Community, certain limitations must be acknowledged, which may influence the interpretation and application of the findings.

First, the social desirability bias presents a significant limitation. Given the cultural and religious sensitivities surrounding reproductive health and contraception issues in many Ghanaian communities, participants may alter their responses to align with what they perceived to be socially acceptable. This could lead to underreporting of negative attitudes or non-use of family planning methods (Amo-Adjei & Darteh, 2023).

Secondly, the generalizability of the findings is limited. Awoshie-Market is a unique peri-urban setting with specific socio-economic and demographic characteristics. Therefore, conclusions drawn may not be applicable to rural communities or other urban areas with different cultural or infrastructural contexts. The study's findings should thus be interpreted as community-specific, rather than representative of the broader Ghanaian population.

Moreover, resource constraints, especially funding and time limitations may influence the study design. The sample size was restricted to 50 married women, which may limit the statistical power and robustness of the findings. While efforts will be made to ensure diverse representation within the community, a larger sample would provide more comprehensive insights (GSS, 2023).

Lastly, the study focuses solely on female respondents, and as such, the perspectives of male partners are not directly captured. While women's reports may reflect their partners' influence, indirect inferences about male attitudes toward family planning may not fully represent men's own views, which are crucial in decision-making processes within marriage (UNFPA, 2024).

Future studies on the subject should consider mixed-gender participation, larger samples, and expanded geographical coverage to enrich understanding and policy relevance.

1.9 Organisation of the Study

This research is structured into five interrelated chapters, each serving a different purpose in presenting a comprehensive analysis of the Level of Patronage of Family Planning Methods Among Married Women in the Awoshie-Market Community through a development communication lens.

Chapter One presents the study by giving the background, statement of the problem, research objectives, research questions, significance of the study, scope, limitations, and organization of the study. It establishes the rationale for exploring family planning patronage and sets the tone for the research.

Chapter Two presents a detailed review of relevant literature, including theoretical frameworks such as the Health Belief Model and Diffusion of Innovations Theory, a review of the key concepts and issues, as well as empirical studies on family planning at global, regional, and national levels. A conceptual framework is developed to guide the study's analysis (WHO, 2024) and finally s chapter summary and lessons learnt.

Chapter Three outlines the methodology, detailing the research design, target population, sampling techniques, data collection instruments, and data analysis procedures. Ethical considerations are also addressed (GHS, 2023).

Chapter Four presents the findings and discussion, using descriptive and thematic analysis to interpret data in line with the research objectives.

Chapter Five concludes the study by summarizing key findings, draw conclusions, and offer recommendations for policy, community-based communication strategies, and future research.

1.10 Chapter Summary

This chapter establishes the critical link between population growth, development, and family planning in Ghana, with a focus on Awoshie-Market's unique challenges. It articulates the study's aim to dissect barricades to the patronage of family planning and will propose actionable solutions. The objectives, aims, research questions, scope, significance and limitations provide a roadmap for investigation, underscoring its significance for policy, practice, and gender equity in urban areas of Ghana.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

Family planning remains a critical public health intervention globally, particularly in low- and middle-income countries where population growth outpaces infrastructural and socio-economic development. In Ghana, despite high awareness of modern contraceptive methods among women of reproductive age, actual utilization rates remain low, especially in peri-urban communities such as Awoshie-Market. This gap between knowledge and practice reflects a complex interaction of individual, socio-cultural, religious, economic, and systemic barriers hindering effective family planning adoption. The study, titled "Level of Patronage of Family Planning Methods Among Married Women – A Study of Awoshie-Market Community", pursues these multifaceted factors through a robust literature review grounded in relevant theoretical frameworks, empirical studies, and conceptual analyses. It adopts the Health Belief Model, Theory of Planned Behaviour, and Diffusion of Innovations Theory to provide a multidimensional understanding of contraceptive behaviours and contextual realities shaping them in Ghana's urban-poor settings. By critically synthesizing global, continental, and local perspectives, the study identifies key elements and gaps that inform actionable strategies for improving family planning patronage among married women in the focus community.

2.1 Theoretical Framework

Understanding the low patronage of family planning (FP) methods among married women in the Awoshie-Market community requires a multi-dimensional theoretical lens. The study adopts a three-way theoretical framework that comprises of the Health Belief Model (HBM), the Diffusion of Innovations Theory (DOI), and the Theory of Planned Behaviour (TPB). Together, these theories offer explanation to individual perceptions, community-level

influences, and broader sociocultural dynamics and systemic influences that shape contraceptive behaviour.

2.1.1 The Health Belief Model (HBM)

Developed in the 1950s by social psychologists Hochbaum, Rosenstock, and Kegels at the U.S. Public Health Service (Rosenstock, 1974), the Health Belief Model was originally created to explain the low uptake of tuberculosis screening. The theory, has since been widely applied to diverse health behaviours, including contraceptive use (Champion & Skinner, 2021). The HBM postulates that, health behaviours are determined by individual beliefs about health conditions and the perceived benefits as opposed to barriers of taking preventive action. The theory covers six key concepts. These are:

i) Perceived Susceptibility – The belief about the likelihood of experiencing a health issue.

ii) Perceived Severity – The belief about the seriousness of the consequences.

iii) Perceived Benefits – The belief that a specific action will reduce susceptibility or severity.

iv) Perceived Barriers – It is the belief about the tangible and psychological costs of the action.

v) Cues to Action – These are the triggers that prompts engagement in health-promoting behaviours.

vi) Self-Efficacy – The confidence in one's ability to act (Rosenstock et al., 1988).

The philosophical argument of this theory rests on the view of rational choice which suggests that individuals make health decisions by considering risks and benefits (Becker, 1974) yet, critics of this theory also argue that it downplays emotional, social, and structural factors (Janz & Becker, 1984).

In relation to the situation at Awoshie-Market, married women's decisions about family planning use may reflect these constructs. Many are aware of their susceptibility to unplanned

pregnancies and understand the severe consequences, including financial stress and health risks (GHS, 2024) but, perceived barriers such as fears of infertility, stigma, spousal/family opposition or divine punishment often overshadow perceived benefits (Gyimah et al., 2023). Social myths, e.g., "contraceptives cause obesity", further intensify these barriers. Additionally, limited cues to action (e.g., few FP counselling sessions offered in local languages) and poor self-efficacy hinder its adoption. The theory throws the light on how interventions in Awoshie must address risk perception, dismiss all myths, and build confidence through culturally sensitive counselling and community education.

2.1.2 Diffusion of Innovations Theory (DOI)

The theory was introduced by Everett Rogers in 1962 with continuous refinements concluding in his seminal book's 5th edition (Rogers, 2003). The Diffusion of Innovations (DOI) theory emerged from rural sociological studies that observed how agricultural innovations was spread among farmers. This was later extended to health innovations such as family planning methods.

The theory explains how new ideas and practices spread through social systems over time. It highlights five innovation traits that affect adoption. These are:

i. Relative Advantage - Which explains the degree to which an innovation is perceived as better.
ii. Compatibility - This trait explains whether the innovation is in alignment with existing values, experiences, and needs.
iii. Complexity - This trait explains the perceived difficulty in understanding and using the innovation.
iv. Trialability - Explains the capacity to experiment with the innovation before adopting it fully.

v. Observability - This explains the visibility of the innovation's results to others (Rogers, 2003).

Aside the arguments above, communication channels and opinion leaders within a social system also play fundamental roles in adoption.

Philosophically, DOI theory assumes that adoption is a social process that is influenced by network dynamics and cultural settings (Greenhalgh et al., 2004). Unlike individual-focused theories such as the HBM, DOI emphasise collective behaviour change through diffusion mechanisms. In urban settings such as Awoshie-Market, Long-Acting Reversible Contraceptives (LARCs) such as IUDs offer clear relative advantages including effectiveness, cost savings, and convenience, yet compatibility with cultural and religious norms remains low. For instance, LARCs are often viewed as foreign or morally questionable (Biney, 2021; WHO, 2018). Complexities such as fears about painful insertions or side effects may reduce the willingness to adopt (Ochako et al., 2015). The low trialability of LARCs as insertion requires commitment and low observability of benefits (due to the private nature of family planning use) further impedes diffusion. In all, the DOI theory underscores the importance of engaging community leaders (e.g., Pastors, Imams and Market Queens) as change agents. If these opinion leaders endorse family planning, adoption could increase; if not, they may reinforce resistance.

2.1.3 Theory of Planned Behaviour (TPB)

The Theory of Planned Behaviour was developed by Icek Ajzen in 1985 but was refined in 1991. This model builds upon the Theory of Reasoned Action by Ajzen & Fishbein (1980). This theory introduces perceived behavioural control as a key factor in determining intention and behaviour; recognizing that, external constraints often limit individuals' ability to act on

intentions. The arguments put forward by this theory is that behavioural intention is the strongest predictor of behaviour and is influenced by the following tenets:

i) Attitudes toward the behaviour – positive or negative evaluations of the behaviour.
ii) Subjective Norms – These Include the perceived social pressure to perform or not to perform the behaviour.
iii) Perceived Behavioural Control – This explains the perceived ease or difficulty of performing the behaviour.

The philosophical foundations of this theory lie in the social cognitive theory that emphasises agency and rational decision-making within social contexts. Nonetheless, critics argue that it insufficiently addresses emotional and habitual influences (Sniehotta et al., 2014).

In relation to the study, many women express positive attitudes toward FP for birth spacing and health benefits (Adjei et al., 2023) but subjective norms often conflict these. Social expectations for large families and male-dominated decision-making on reproduction impose strong restraints. A recent study found that 78 percent of reproductive decisions in Greater Accra are controlled by men (Odoi et al., 2023). Perceived behavioural control is also limited due to poverty, distance to clinics, shortages (affecting 70 percent of FP clinics), and counselling offered in non-local languages (GHS, 2024). Partner disapproval or fear of violence further diminishes women's sense of action. The TPB highlights how even strong intentions to use contraceptives may not translate into behaviour unless structural and social barriers are addressed. Collectively, these three theories provide a multi-level analytical lens.

The Health Belief Model explains how individual perceptions of risk and benefits shape family planning decisions whilst the Diffusion of Innovations (DOI) captures how innovations such as LARCs spread (or fail to) via Awoshie's social networks. The Theory of Planned Behaviours (TPB), on the other hand, show how attitudes, norms, and perceptions interact to influence

contraceptive use. By integrating these perspectives, the study identifies actionable levers that address misinformation (HBM), engaging opinion leaders (DOI), and empowering women against restrictive norms and encourage men to be interested in the family planning affair of their female partners (TPB) in a bid to improve the patronage of modern family planning methods.

2.2 Review of Concepts and Key Issues

The review of key concepts and key issues positions the study of family-planning patronage among married women within Ghana's rapid urbanization, growing unmet need for contraception, and the intersectional influence of awareness, perceptions, and socio-economic-cultural-religious determinants. It derives from materials predominantly published between 2016–2024, including Ghana Statistical Service demographic data, UNDP, UNICEF reports, Ghana Health Service technical bulletins and reports, peer-reviewed Ghanaian and comparative African and global studies.

2.2.1 Family Planning and National Development

Family planning remains an essential part of economic and infrastructure development, public health and sustainable urban planning and management in Ghana. The review of key concepts and key issues synthesizes literature from key national, continental and international sources published predominantly between 2016–2024, addressing issues of demographics, barriers, program effectiveness, policy responses, and comparative perspectives. The goal of this review is to provide a complete understanding of the current state of family planning in Ghana, particularly in urban settings like such as Accra—while situating it within broader developmental objectives. The review seeks to identify robust findings, methodological strengths, and critical gaps that requires further attention.

This review proceeds through seven thematic sections. These are demographic context and urban pressures, barriers to contraceptive acceptance, the impact and effectiveness of family planning programs, provider and consumer experiences, policy frameworks and implementation, comparative insights, program innovations, synthesis, gaps and future directions. The World Bank's Ghana Economic Update 2023 and Economic Outlook 2024 draw attention to persistent urban poverty, glaring income inequality, and limited formal employment as conditions that interact with reproductive behaviour. Poor urban women often face financial barriers to accessing contraception; a challenge further compounded by socio-cultural constraints, health infrastructure gaps, and limited public funding for reproductive health outreaches. Also, UNICEF's State of the World's Children 2023 report, focuses on urban health disparities, noting that, slum communities in Accra have a higher unmet contraceptive needs and lower antenatal care coverage than wealthier and middle-class neighbourhoods. Addressing inequities in infrastructure and public services has become a necessary requirement for enhancing family planning use.

The data, as espoused by the World Bank and UNICEF, reveals how females from disadvantaged background tend to be vulnerable to uncontrolled or unmanaged reproduction perpetuated by socio-cultural rudiments and poverty. This is a challenge which needs to be addressed in other to bridge the developmental gap between the rich and the poor.

2.2.2 Awareness of Family Planning Methods

Awareness refers to the knowledge of the various types of family planning methods such as pills, injectables, implants, etcetera as well as its availability, side effects, eligibility, and sources. On the national scale, over 80 percent of women know at least one modern method and awareness is similarly high in Awoshie (GHS, 2024) however, this does not translate into usage which is only pegged at 22 percent (AMA, 2024**).** This is due to the discrepancies in

Awareness and Usage. A critical issue in family planning (FP) discourse, especially in urban-poor communities such as Awoshie-Market, is the differences between awareness and actual usage. This irony, often termed as the "awareness–acceptance gap" (Adjei, Mensah, & Asante, 2023), underscores the limited impact of FP awareness campaigns that do not translate into behavioural change. According to the Ghana Health Service (GHS, 2024), over 80 percent of Ghanaian women are aware of at least one modern contraceptive method. However, only 25 percent of married women nationally, and just 22 percent in the Awoshie community report active use of modern methods (Accra Metropolitan Assembly [AMA], 2024).

This gap arises not merely from knowledge deficits but from deeply entrenched socio-cultural, religious, economic, and systemic factors that suppress uptake. In Awoshie, many women are aware of injectables, implants, pills, among others, but lack the enabling environment to act on this knowledge due to spousal resistance, social stigma, or logistical hurdles such as language barriers during counselling (GHS, 2024). Therefore, the problem is not informational but rather behavioural and structural, requiring a multifaceted response that addresses both belief systems and institutional delivery.

2.2.3 Knowledge-Practice Gap

Other key issues identified by Adjei, Mensah & Asante (2023) in their study titled: “The knowledge–practice paradox: Awareness versus actual use of contraceptives in urban Ghana” is the “Knowledge–practice gap”. Adjei et al. (2023), documented an irregularity in which women in Accra were knowledgeable about the different contraceptive methods but failed to apply that knowledge due to fear of side effects, partner refusal, or concerns over future fertility whilst Biney (2021) in his exploration of community attitudes in a peri-urban Accra locality, found that, women often negotiated contraceptive use secretly due to patriarchal expectations. “They don’t even know I go to the clinic,” is a common buzzword and this demonstrated

autonomy yet concealed vulnerability. According to their studies, the "knowledge–practice paradox" arises when high awareness coexists with strong negative beliefs. Their findings expose how their knowledge about modern contraceptives does not necessarily translate into patronage due to perceived fear and repercussions associated with the use of modern contraception including those perpetuated by the patriarchal system.

2.2.4 Perceptions about Family Planning

This concept dwells on the beliefs, fears, attitudes and value judgements women have about family planning methods. This includes perceived efficacy, side effects, fertility consequences, morality, and social acceptability. The findings from Adjei et al. (2023), Gyimah et al. (2023) and Nukpe et al. (2023) highlighted the persistent misconceptions surrounding modern contraceptive use such as infertility or womb damage. Their studies show how religion frames these perceptions about family planning as an "interference of divine will". The issue raised included Myth-laden rumours in market networks, stigma, low trust in providers or methods and anticipation of social sanctions.

WHO's Global Handbook for Providers (2022) and Communicating Family Planning handbook (2024) provided standardized tools for quality assurance and community engagement. The Ghana Health Service (GHS) has localised many of WHOS's materials, conducting provider training workshops and developing promotional content aimed at demystifying contraceptive methods such as implants, injectables, and intrauterine devices (IUDs).

Burke et al. (2017) addressed the Sayana Press - an intravenous injectable introduced into the countries of Uganda and Senegal, demonstrating its acceptability among Community Health Workers (CHWs) and clinic-based providers. While the use context differs, their findings on

decentralizing contraceptive administration were pertinent to Ghana, where CHWs were underutilized.

Acceptability Studies conducted by Aziato, Kyei, & Deku (2016) provided a Ghanaian context to sterilization. Whilst female sterilization acceptance remains low, the study revealed how urban women who chose sterilization value its permanence, cost-effectiveness, and emotional relief after completing childbearing whilst Hubacher et al. (2017) illustrated barriers to IUD acceptance in Nairobi, Kenya as the result of misconceptions, provider hesitancy, and absence of trained personnel in low-resource settings. The parallels with Ghana are clear: provider training and acceptance are very essential to expanding the method mix.

2.2.5 Social, Economic, Religious, and Cultural elements

The Accra Metropolitan Assembly's (AMA) report (2024) and Odoi et al., (2023) in their study: "Male involvement in family planning decisions in urban Ghana published in the Journal of Gender & Society" cited Gender norms, male decision-making, spousal consent and mother-in-law pressure as some of the social factors influencing the patronage level of modern family planning methods. Their studies were corroborated in the AMA (2024) report which stated that, 62 percent of women needed the approval of their husbands before patronising modern contraceptives. Often, their male partners discouraged use. Their studies highlight how male involvement in family planning remains minimal, despite its recognised importance.

Odoi, Amoako-Sakyi, & Boah (2023), further, explored male engagement, revealing that, those men often perceived contraception as solely the duty of females hence rarely escorted their female partners to clinics. The study revealed how some men discouraged usage based on fears of promiscuity, mistrust, or misconceptions about the side effects. Moreover, the UNFPA's 2024 policy brief on male involvement argued that, engaging men in modern family planning decisions was therapeutically sound. However, patriarchal gender norms and limited targeted

interventions meant male involvement was stagnant. The findings of Odoi et al (2024) and UNFPA (2024) sheds light on the need for specialised male-partner-cantered family planning initiatives to improve the rate of family planning uptake in the country.

On economic reasons, the World Bank Report (2023) pointed to poverty, informal income, cost of services and opportunity cost of clinic visits as some of the reasons constraining poor urban women from accessing modern family planning methods.

When it comes to religion, two parallel studies done by Nukpe et al. (2023) & Amo-Adjei & Darteh (2023) titled: “Religion, Myths, and Contraceptive Behaviour in Ghanaian Communities” published in the Journal of Biosocial Science and African Journal of Reproductive Health, illuminated the powerful role of religion and culture in shaping contraceptive behaviours. Common themes running through, included beliefs discouraging artificial contraception, concerns over premarital sex, infertility myths, and fatalism regarding childbearing. Their qualitative work underline how religious teachings could influence both men and women, endorsing natural fertility regulation over modern methods of contraceptives. Amo-Adjei & Darteh (2023) further validated their findings at a national level; their quantitative survey revealed that, women with conservative religious beliefs showed significantly lower usage rates of modern contraception.

Similarly, Adjei, Mensah, & Asante (2023) described the "knowledge–practice paradox" - urban women often have accurate information about family planning but faced pressure from family, especially from religious leaders and older family members against its use. Their study highlights how religion reinforce beliefs that “contraception is sinful”, sparking a greater need to engage religious bodies and figures in family planning programmes, campaigns and efforts to disabuse the negative perceptions surrounding modern contraception and its adoption.

In Awoshie-Market, religion functions both as a moral compass and a social control mechanism. According to Nukpe, Darteh, and Ahinkorah (2023), certain conservative Christian and Islamic sects and believers of typical African traditional tenets believe and teach that, using contraceptives is against divine will, as it interferes with procreation. The belief that "children are gifts from God" is prevalent, and many women fear spiritual repercussions for using artificial methods. Additionally, cultural expectations for large families, especially among first wives in polygamous marriages, further discourage FP use, as children are seen as sources of labour, social status, and future economic insurance (Odoi, Amoako-Sakyi, & Boah, 2023). Addressing these barriers requires not just medical information but also religious and cultural literacy among health professionals as well as collaborations with religious leaders, traditional rulers, market queens, local influencers among others because, they are crucial to reframe FP from being seen as anti-faith and family to being pro-family health.

Cultural Undertones - A study by Ugandan researchers, Kabagenyi et al. (2016) titled: "Traditional and Modern Contraceptive Coexistence in Uganda" as part of the MIIRAP Project Report, pointed to polygamous traditions, the importance of fertility for status and old-age support and secrecy around contraceptives as key determinants to family planning patronage and identified how those modern methods could coexist with traditional methods. Their studies brought out the need for stakeholders involved in family planning initiatives to encourage the use of modern contraceptive methods alongside traditional methods.

2.2.6 Service Delivery and Systemic Barriers

Gyimah, Appiah, & Okyere (2023) research work: "Service-level barriers to contraceptive uptake in Greater Accra", identified several pragmatic and service-level barriers. These were: clinic hours clashing with working schedules, long waits, inconsistent supply chains, provider bias, and confidentiality concerns. Users reported being turned away for minimal shortages or

being subjected to negative attitudes. This meant that, even well-informed individuals could be discouraged from accessing services due to poor quality of service delivery. Their discoveries exposed how poor health care provider-patient relationship and quality in-service delivery as well as shortages of family-planning tools affects mass family planning patronage even amongst well-informed individuals of society.

Other studies such as the Ghana Health Service's (GHS) Family Planning Technical Bulletin of 2023 and the National Family Planning Programme Report 2023 to 2024 outlined a national contraceptive prevalence rate (CPR) of 28 percent, which is below the 30 to 35 percent target. These publications unveiled ambitious plans and performance-based funding for district providers, community health worker-led outreach, post-delivery family planning integration, and adolescent-targeted initiatives. The Ghana Health Service technical bulletin detailed progress in access to commodities such as implants and injectables, while stacking outreach activities such as mobile clinics and school-based sessions; against logistics challenges, especially in urban fringes such as Awoshie-Market. The above data from the GHS and the National Family Planning Programme report of 2023-24 shed light on the need to revise National Strategies and Service Delivery to meet family planning threshold.

Nonetheless, the AMA's 2024 Infrastructure Development Report and Annual Action Plan proposed the integration of reproductive health into a wider urban service delivery. The strategy included the allocation of land for clinics in underserved areas and the coordination with GHS in other to enhance family planning outreach. However, AMA's focus was on infrastructure over service quality, indicating a fragmented approach to health planning whilst the National Reproductive Health Service Policy and Standards (GHS Family Health Division, 2020) offered a framework for delivering family planning in Ghana. This included provider training, quality assurance, and integrated service packages. Yet, assessments suggested

insufficient funding, limited provider oversight, and weak accountability systems hinder translation into effective practice.

The research conducted by AMA and the GHS family Health Division (2020) highlights a serious disconnect between infrastructural expansion and service quality which is an issue directly relevant to the study as mere proximity to clinics may not necessarily translate into utilization if systemic gaps in service delivery, provider engagement, and trust continues to remain unaddressed whilst Jacobstein (2018), in his study, outlined the rapid increase in the use of implants across Africa, noting that their discretion, reversibility, and multi-year coverage make them well-suited to urban users. Ghana has mirrored this trend, with implants now comprising 35 percent of contraceptive method acceptance according to the 2024 GHS performance report.

The above researchers in their synthesisation of regional and global research, underline Ghana's measurable strides in contraceptive uptake, particularly with implants and persistent provider limitations, socio-cultural fears, and partner dynamics which are all indicators that continue to undermine informed choices and equitable access across board.

Strategies for Communication and Community Engagement

Traditional messaging versus participatory approaches – The World Health Organization and UNICEF recommend interactive community engagement on family planning issues through trusted opinion leaders such as market queens, religious and traditional leaders, community radio stations and dramatizations to enable education and campaign efforts to get to the population, particularly women to patronise modern contraceptive methods. (WHO, 2024; UNICEF, 2023). However, the poor regulation of these communication mediums, Anarfi (2003), argues in his study: "Community-based communication for family planning: Lessons from Ghana" can lead to mixed or contradictory messages. The above highlights the need for

a streamlined engagement of these stakeholders for accurate dissemination of information to achieve desired results on family planning patronage.

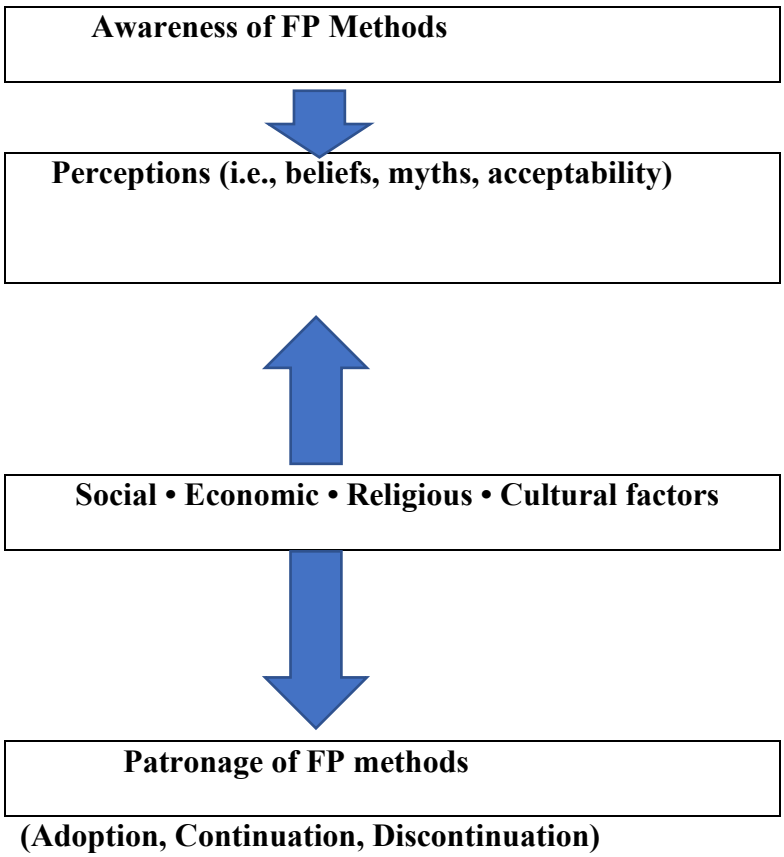
Demographic trends, urbanization & consequence for FP in Awoshie-Market

The preliminary report of the country's 2024 Population and Housing Census done by the Ghana Statistical Service (GSS) outlined a population of approximately 34.5 million, with an urbanization rate of 57 percent; an increase from 55 percent in 2020. Rapid urbanization, especially in Greater Accra, including Awoshie has put a strain on infrastructure, as indicated in the AMA Metropolitan Development Report and Annual Action Plan of 2024, which highlighted deficiencies in water, sanitation, transportation, and health services. Moreover, urban congestion exacerbated disparities in health access, including reproductive health services. The United Nations Development Programme's (UNDP) National Human Development Report 2024 emphasised that, high population growth, if left unmanaged, will undermine gains in education, health, and income. The report recommends scaling family planning services alongside infrastructural development to ensure sustainable urban living standards. The above data from AMA and UNDP clearly indicates how rapid population growth have an impact on the development, quality and distribution of social amenities and services in urban settings such as Awoshie and the need for population control to ensure sustainability, inclusion and improve the quality of life.

Simplified linkages between study objectives and key Issues

Objective	Independent variables	Mediating factors/perception	Dependent variable: patronage (use)
Awareness	**Level of exposure to Family Planning information via clinic contacts, media or community outreach**	**Understanding of method benefits, risks, misconceptions**	**Actual uptake and continuation rates**
Perceptions	**Religious beliefs, myth exposure, social norms, spousal attitudes**	**Perceived acceptability, fear of side effects, stigma**	**Decision to adopt or reject Family Planning methods**
Social-economic-religious-cultural factors	**Household income; husband's consent; religious affiliation; traditional norms**	**Power dynamics, autonomy, financial access**	**Use or non-use of family planning methods**

2.2.7 Conceptual Framework Diagram establishing linkages



NB: Arrows indicate how awareness has a direct effect on perceptions stemming from the social-economic-religious-cultural factors that shape both awareness (through access and exposure) and perceptions (beliefs, norms), and all variables influence the outcome i.e. the actual use of methods.

2.2.8 The importance of focusing on Awoshie-Market include:

a. The availability of limited studies that focus on urban fringe communities such as Awoshie-Market hence the study's heavy reliance on international, regional, national studies.

b. The study found limited male-focused interventions, language barrier, trust, and community leader roles understudied, especially in local settings. This study will examine awareness,

perceptions, and contextual factors; linking them in a framework that predicts patronage**.** The study will fill local evidence gaps, especially on cultural/religious dynamics in Awoshie, men's roles, and provider-client communication in Ga/Twi languages.

2.3 Empirical Review

Family planning (FP) worldwide remains a serious public health intervention for improving maternal and child health, empowering women, and achieving sustainable development goals (SDGs). Numerous studies done empirically on the global, continental and within the Ghanaian setting, have examined factors of FP acceptance thus revealing complex connections of individual, socio-cultural, systemic, and gender-related factors. This section critically synthesizes these studies and highlights their relevance to the current investigation of the patronage of FP among married women within the Awoshie-Market enclave; a peri-urban community with distinct socio-economic and cultural dynamics.

2.3.1 Global Perspectives on Family Planning Patronage

FP utilization worldwide over the past decades has significantly improved however, gaps in terms of access and usage persist. The phenomenon is evident, especially in low and middle-income countries (LMICs). Ahmed et al. (2022) using demographic and health survey (DHS) data from fifty-seven countries published as part of his studies titled: "Maternal Deaths Averted by Contraceptive Use: An analysis of 57 low- and middle-income countries" published in the Lancet Global Health, 10(3), stated that, 77 percent of females within the ages of reproduction in high-income countries, reported using a modern contraceptive method as compared to only 40 percent in sub-Saharan Africa. The study identified the level of female education level, household wealth, and urban residence as strong predictors of modern contraceptive patronage.

On a similar note, a global review by Benova et al. (2021) under the title: "Family Planning Service Readiness in low- and middle-income countries: A systematic review". PLOS

Medicine, p.18(6), emphasised on the role of health system readiness in FP interest noting that, shortages or non-existence of FP commodities, poor provider training, and lack of adolescent-friendly services were some of the causative factors that reduced accessibility and trust in FP services.

The World Health Organization (WHO, 2022) made mention of the myths and misconceptions about side effects of contraceptives (e.g., using them causes infertility and cancer) which it stated, remained a global barrier, particularly in regions where peer networks and social media spread misinformation.

2.3.2 Experiential Evidence from Africa

In Africa, Family Planning acceptance differs considerably across regions and countries because of cultural, religious, and systemic factors. A study in South Africa done by Mothiba and Moabi (2023) published under the name: "Determinants of family planning use in Johannesburg: A cross-sectional study" which was published in the African Journal of Primary Health Care & Family Medicine, p.15(1), revealed that, while 85 percent of women in urban Johannesburg were aware of modern contraceptive methods, only 52 percent has regularly used them. The fear of its side effects, male partner disapproval, and long waiting periods at clinics were named as key barriers to the low patronage. Their findings shed light on how misconceptions on FP, nature of service delivery at health centres and partner interference continue to influence the adoption of modern contraception by females in intimate relationships.

Adebowale et al. (2022), in Nigeria examined rural and urban differences in contraceptive use among married women. Their study, which employed multilevel logistic regression on Nigeria DHS data, found that, urban women were 1.7 times more likely to opt for modern methods of contraception than their rural counterparts. However, cultural pressure to prove one's fertility

early in marriage proved to be a major limitation in the uptake of FP even among urban residents.

In Kenya, Obare and Kabiru (2023) in their studies, explored gender norms and Family Planning (FP) utilization in informal settlements where they reported that, male dominance in reproductive decision-making was a hinderance to women's autonomy in reproductive decision-making. The study reveals that, 63 percent of respondents indicated that their husbands had the final say on contraceptive use. Their research sparks the need for an encouraged male-involvement in the interventions that seeks to increase the patronage of FP services. However, in Ethiopia, the investigations of Gebre and Tadesse (2024) on FP service delivery challenges in peri-urban areas, found that 48 percent of clinics experienced regular shortages of injectables and implants, leading many women to revert to traditional methods which has very low rates of effectiveness.

2.3.3 Family Planning Patronage in Ghana

Within Ghana, recent studies provide nuanced insights into factors influencing FP utilization. Adjei et al. (2023) who conducted a cross-sectional survey that involved 400 urban women in Accra found that, whereas 90 percent of respondents were aware of at least one modern method, only 25 percent reported regular use. Barriers to the adoption of these modern methods included the fear of side effects, spousal opposition, and inconsistent health worker communication. Their studies concluded that, awareness alone is not enough guarantee for adoption of modern contraception methods unless it is paired with supportive social and service structures.

The Ghana Demographic and Health Survey (GSS, 2024) confirmed the patterns nationally. Women with secondary or a higher education were three times more likely to use modern contraceptives compared to their less educated counterparts. Their data underlined the role of education, literacy, and informed decision-making.

Gyimah et al. (2023), who conducted qualitative interviews with sixty women in Accra's slums, found that 68 percent avoided hormonal methods due to fears of infertility, weight gain, and cancer. His findings revealed how peer narratives, misinformation and wrong perceptions amplified these fears, thus creating formidable barriers to contraceptive use.

Biney (2021) who employed focus group discussions in Mamprobi and Ashaiman to explore sociocultural influences stated how many women preferred traditional methods (e.g., withdrawal) over modern one's contraception due to fears of barrenness and cultural pressure to maintain fertility for lineage continuity. Community elders often discouraged FP as they perceived it as a threat to family legacy. This research shows how culture has a great influence over whether a woman will opt for modern contraception or not.

Similarly, in the Northern part of Ghana, Nukpe et al. (2023) survey of 400 women on religious influences revealed hoe Pentecostal and Muslim women were 40 percent less likely to use modern contraceptives compared to their non-religious peers. Their research highlighted doctrinal prohibitions that framed FP as "divine interference." However, in communities where religious leaders supported modern methods, there was a significant increase in adoption.

As for Odoi et al. (2023), who used a mixed-methods study across Greater Accra, reported that, male dominance in reproductive decision-making was present in 78 percent of households. Women feared partner disapproval or violence which discouraged clinic visits even where services were free.

2.3.4 Systemic and Gender-Based Barriers

GHS (2024) identified systemic barriers, such as stockouts in 70% of urban clinics and counselling predominantly offered in English or Akan, excluding Ga-speaking communities. These service delivery gaps contributed to a 40% decline in clinic-based FP visits.

Findings from Adjei et al. (2023) research found that, women with spousal support were three times more likely to use modern family planning methods. This study also highlighted the critical role of male involvement.

2.3.5 Method-Specific Challenges and Traditional Practices

Jacobstein (2018), in a multi-country analysis, observed that Long-Acting Reversible Contraceptives (LARCs), though highly effective, remained underutilized in Africa due to misconceptions. In Uganda for example, myths about IUDs "migrating to the lungs" deterred adoption. In Kenya, Ochako et al. (2015) found that only 12 percent of young women used implants or IUDs due to such fears and social stigma.

Manortey et al. (2020) reported that 33 percent of women in Ashaiman relied on the withdrawal method, despite its failure rate of 20 percent whilst Gebeyehu et al. (2022) in Ethiopia found that 45 percent of breastfeeding mothers used the Lactational Amenorrhea Method (LAM), but 61 percent practiced it incorrectly which raised the fears and risk of unintended pregnancies.

2.3.6 Male Engagement and Culturally Tailored Communication

The report of UNFPA (2024), stated how the involvement men in Family Planning (FP) counselling in Tamale increased acceptance rates by 30 percent. This underscored the effectiveness of gender-inclusive strategies. The 2023 UNICEF report confirmed the power of culturally sensitive communication when it stated how radio dramas in local dialects help improved FP knowledge by 50 percent among women in Kumasi slums.

2.3.7 Identified gaps in cited studies

While the above studies illuminated national and regional trends, they largely overlooked peri-urban communities such as Awoshie-Market characterized by migrant populations, market-driven economies, and hybrid cultural norms. Most existing research focused on either rural or

urban contexts, leaving urban-poor enclaves underexplored. The study addresses this gap by examining how individual, socio-cultural, and systemic factors cross to influence FP patronage among married women in Awoshie-Market.

2.5 Conceptual Framework

The conceptual framework for this study synthesizes insights from the Health Belief Model (HBM), the Theory of Planned Behaviour (TPB), and the Diffusion of Innovations (DOI) theory to examine factors influencing the patronage of family planning (FP) methods among married women in the Awoshie-Market community. This multi-level framework identifies four interrelated domains that interact to shape FP behaviours. These are:

Individual-Level Determinants

At the individual level, key constructs of the HBM such as perceived susceptibility to unintended pregnancies, perceived benefits of family planning (e.g., improved maternal health and economic stability), perceived barriers (e.g., fear of side effects, myths, and misinformation), and self-efficacy (confidence in using contraceptives) are central (Champion & Skinner, 2021). Additionally, educational attainment and prior experience with family planning are seen as modifying factors that may enhance or hinder acceptance (GSS, 2024).

Interpersonal and Socio-Cultural Influences

This domain incorporates elements of subjective norms from TPB, focusing on spousal approval, peer influence, and broader community norms regarding contraceptive use (Ajzen, 2020). 2.3.7 Identified gaps in the cited studies

While the above studies illuminated national and regional trends, they largely overlooked peri-urban communities such as Awoshie-Market characterized by migrant populations, market-driven economies, and hybrid cultural norms. Most existing research focused on either rural or

urban contexts, leaving urban-poor enclaves underexplored. The study addresses this gap by examining how individual, socio-cultural, and systemic factors cross to influence FP patronage among married women in Awoshie-Market.

2.6 Chapter Summary and Lessons Learnt

This chapter reviewed relevant theoretical models, conceptual issues, and empirical evidence to understand the patronage of family planning methods in urban-peri-urban contexts like Awoshie. The integration of HBM, TPB, and DOI provided a robust lens for examining individual, social, and systemic determinants of FP use. Key concepts such as knowledge-use gaps, gender dynamics, religious influences, health system barriers, and communication channels were critically explored.

Empirical studies consistently revealed that, high awareness does not automatically translate into high contraceptive uptake, as socio-cultural norms, misinformation, male dominance in decision-making, and health system weaknesses remain significant barriers (Biney, 2021; Aziato et al., 2016; Ahmed et al., 2022). Lessons from the literature underline the need for culturally sensitive, gender-inclusive, and community-driven methods to scale up FP acceptance and utilization.

Furthermore, a gap in localized research focusing on peri-urban underserved communities in Ghana was identified. Most studies tend to generalize findings across urban and rural populations without adequate consideration of peri-urban peculiarities. This study therefore contributes unique, context-specific insights that can inform national family planning policies, targeted health communication strategies, and advocacy efforts for reproductive justice.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter outlines the research methodology employed to investigate the level of patronage of family planning methods among married women in the Awoshie-Market community. It serves as a blueprint for how the research is systematically conducted, detailing the strategies used for data collection, analysis, and interpretation to address the study's objectives and research questions. Given the complex and culturally entrenched nature of family planning within the Ghanaian context, a comprehensive and integrated research approach is essential.

The study adopts a Convergent Parallel Mixed Methods Design, which combines both quantitative and qualitative techniques simultaneously. This design facilitates the simultaneous collection of statistical data and in-depth qualitative insights, allowing for a more nuanced understanding of the factors influencing family planning patronage. The quantitative strand involves a descriptive cross-sectional survey, which captures measurable data on awareness, perceptions, and usage patterns. In parallel, the qualitative component utilizes key informant interviews to explore deeper social, cultural, and institutional dynamics affecting decision-making.

The chapter further describes the study setting which is Awoshie-Market - a peri-urban community with diverse populations and reproductive health challenges. Details are provided on the study population, sampling procedures, data collection tools, and methods of analysis. Measures to ensure the reliability, validity, and ethical integrity of the study are also discussed. Altogether, this methodological framework supports a robust investigation capable of informing targeted family planning interventions and policies in urban and peri-urban Ghanaian communities.

3.1 Research Approach

This study adopts a mixed method approach (i.e., a quantitative research approach complemented by qualitative elements). The quantitative dimension allows for the collection of numerical data on the level of awareness, perceptions, and socio-cultural factors influencing family planning (FP) patronage, while the qualitative component employs key informant interviews to explore underlying perceptions and cultural dynamics in-depth. This approach, Creswell & Creswell (2018) argue, is justified because it provides a robust understanding of both measurable patterns and nuanced social realities within the Awoshie-Market community.

3.2 Research Design

This study adopts a Convergent Parallel Mixed Methods Design, one of the core mixed methods frameworks described by Creswell and Plano Clark (2018). In this design, both quantitative and qualitative data are collected simultaneously, independently analysed, and then merged during interpretation. The rationale for this design lies in the study's objective to not only quantify the level and determinants of family planning patronage among married women but also explore the cultural, social, and institutional contexts influencing such behaviours. The quantitative component utilizes a descriptive cross-sectional survey to measure awareness levels, socio-demographic characteristics, and patterns of family planning utilization. The qualitative strand involves key informant interviews to delve deeper into community beliefs, healthcare system challenges, and cultural norms affecting family planning decisions. The integration of both aspects during the interpretation phase provides a holistic understanding and allows the researcher to triangulate the findings for validity. This approach enhances the study's explanatory power, particularly in a socially complex setting such as Awoshie-Market where numbers alone do not capture the full picture of reproductive health behaviours.

3.3 Study Setting

The study is conducted within the Awoshie-Market community, located within the Anyaa-Sowutuom Constituency in the Greater Accra Region. Awoshie-Market, a suburb of the greater Awoshie town, is identified as a densely populated peri-urban area with diverse ethnicities, high fertility rates, and limited access to healthcare services (Accra Metropolitan Assembly [AMA], 2024). Its socio-economic dynamics make it an ideal setting for investigating family planning behaviours in poor urban areas.

3.4 Study Population

The study population includes married women between the ages of 18 to those above 54 years old residing in Awoshie-Market. This demographic of choice consists of women in their reproductive years, who are most likely to need family planning services (Ghana Statistical Service [GSS], 2024).

3.5 Sample and Sampling Techniques

A sample size of 101 married women is selected using stratified random sampling, which is used to divide the population into smaller subgroups. In the case of this research, the stratification is created based on age groups, specifically from 18- 25 years, 25–34 years, 35-44 years, 45-54 years and those above 54 years. This technique ensures fair representation across all the reproductive ages. Within each level, participants are randomly selected from households using a systematic sampling technique with a defined interval calculated from the total estimated number of households.

Additionally, purposive sampling is used for qualitative interviews with healthcare providers and community leaders to explore institutional and cultural influences (Tongco, 2007). The sample size determination is informed by Cochran's formula—a method that suits large populations and when there is an estimated proportion.

3.6 Data Collection Instruments

The instruments for data collection include a structured questionnaire and a key informant interview guide. The structured questionnaire is used to gather quantitative data on the independent and dependent variables such as demographics, awareness, perceptions, and family planning (FP) utilization patterns. It includes both closed-ended and Likert-scale items (allowing respondents to rate items), adapted from validated tools such as the Demographic and Health Surveys (DHS) and Ghana Health Service FP modules (GHS, 2024). The key informant interview guide is used to gather information from healthcare workers and community leaders to explore systemic and socio-cultural barriers affecting FP acceptance.

3.7 Reliability and Validity

To ensure reliability, the questionnaire undergoes a pilot-test in a similar peri-urban community e.g., Anyaa, involving ten percent of the sample size. Validity is ensured through expert reviews by public health and reproductive health specialists. Construct validity is enhanced by aligning the instruments with the Health Belief Model, Theory of Planned Behaviours, and Diffusion of Innovation theoretical paradigms.

3.8 Data Collection Procedure

Data collection takes place over a month, with the help of research assistants fluent in English, Ga, and Twi to curtail language barriers. After obtaining informed consent, questionnaires are administered face-to-face to married women in their households and workplaces. Key informant interviews are conducted privately at secluded places and in homes to encourage honest responses.

3.9 Data Handling, Processing and Analysis

All quantitative data are processed using SPSS and cleaned for inconsistencies. Descriptive statistics such as frequencies, means, and percentages are used to describe demographic characteristics and FP patronage levels. Inferential statistics, such as chi-square tests and

logistic regression, are used to assess associations between socio-demographic factors and FP utilization. On the other hand, qualitative data from interviews are transcribed verbatim and analysed thematically. Emerging themes are mapped to the study's conceptual framework to provide explanatory insights.

3.10 Ethical Considerations

The Ghana Health Service and that of the UNIMAC's Ethical Review Committee is contacted for approval. Informed written and verbal consent is obtained from all participants, while confidentiality is enhanced by removing all identifiers from datasets and coding all responses. Additionally, voluntary participation is emphasized, as participants and respondents are informed of their right to withdraw without consequences. Minimization of harm is ensured by carefully framing sensitive questions. Support referrals are provided for participants needing reproductive health services.

3.11 Chapter Summary

This chapter outlines the methodological approach for examining family planning patronage among married women in Awoshie-Market. It describes the research design, population, sampling techniques, data collection instruments, reliability and validity measures, data collection and analysis procedures, as well as ethical safeguards. Together, these elements form a comprehensive approach to generate actionable insights for enhancing family planning acceptance and utilization in peri-urban Ghana.

CHAPTER FOUR

PRESENTATION AND ANALYSIS OF FINDINGS

4.0 Introduction

This chapter presents a comprehensive analysis of the data collected for the study on the "Level of Patronage of Family Planning Methods Among Married Women in the Awoshie-Market Community." Faithful to the convergent parallel mixed-methods design, the chapter integrates quantitative data from 101 survey respondents with qualitative insights from 10 key informant interviews. The presentation is structured to address the core research objectives: assessing awareness and patronage levels, examining perceptions and misconceptions, identifying key influencing factors, and exploring strategies for improvement. Through the triangulation of statistical trends with lived experiences and community perspectives, this chapter provides a multi-layered understanding of the determinants driving family-planning decisions among the study population, moving beyond mere description to explain the underlying socio-cultural and relational dynamics

4.1 Quantitative Data Analysis

Table 1 presents the age distribution of the respondents. The age distribution indicates that most respondents were within the economically active reproductive age group of 35–44 years (47%), followed by those aged 25–34 years (24%). Only one percent were below 25 years, suggesting that family-planning patronage in Awoshie-Market is dominated by mature, married women. This pattern implies that awareness and use of family-planning methods are likely informed by prior marital and reproductive experience rather than youthful experimentation. The dominance of women in their mid-thirties also reflects the market community’s demographic profile, where trading and household management overlap**.**

Table 1: Age distribution of the respondents

Characteristic	Category	Frequency (n)	Percentage (%)
Age Group	25-34 years	29	28.7%
	35-44 years	46	45.5%
	45-54 years	20	19.8%
	Below 25 years	3	3 .0%
	Above 54 years	3	3.0%
Total		**101**	**100**

Education, as displayed in table 2 play a critical role in reproductive decision-making. A large majority (71.3%) of respondents had tertiary education, while only 6.9% and 5.0% reported basic or no formal education respectively. This high literacy rate suggests that respondents are more likely to access and understand reproductive-health information disseminated through formal media and health institutions. It also indicates that education may enhance autonomy and confidence in choosing appropriate family-planning options.

Table 2: Educational levels of Respondents

Characteristic	Category	Frequency(n)	Percentage (%)
Level of Education	Tertiary Education	72	71.3%
	Secondary Education	17	16.8%
	Basic Education	7	6.9%
	No formal education	5	5.0%
Total		**101**	**100**

Occupationally, 31.7 percent of the women are employed in the public sector, followed by 29.7 percent who are self-employed and 34.7 percent in the private sector as captured in Table 3. This occupational spread demonstrates that the Awoshie-Market community hosts both formal and informal income earners, implying diverse access to health insurance and workplace-based information sources. The strong representation of private and public sector workers may partly explain the high awareness levels of modern family-planning methods observed in the study.

Table 3: Occupational distribution of respondents (N = 101)

Characteristic	Category	Frequency (n)	Percentage (%)
Occupation	Employed in Private Sector	35	34.7%
	Employed in Public Sector	32	31.7%
	Self-employed	30	29.7%
	Unemployed	4	4.0%
Total		**101**	**100**

In Table 4, more than half (63.4%) of respondents' report having one or two children, while 27.7 percent had three or four children. Only a few respondents indicated having more than five children. This finding suggests that fertility preferences among married women in Awoshie-Market community are shifting toward smaller family sizes, consistent with national demographic trends. It also implies that family-planning adoption is increasingly seen as a means of maintaining manageable household sizes and economic stability.

Table 4: Number of children of respondents

Characteristic	Category	Frequency (n)	Percentage (%)
Number of Children	1-2	64	63.4%
	3-4	28	27.7%
	No child	6	5.9%
	5 or more	3	3.0%
Total		**101**	**100**

In Table 5, Christian women represent 79.2% of the sample, with Muslims constituting 20.8%. The significance of this distribution is highlighted in the study's inferential analysis, which shows a statistically significant association between religion and FP use. This aligns with empirical findings that religious interpretation and not just affiliation in play a critical role in shaping FP acceptance. In Awoshie-Market, varying doctrines continue to influence whether women perceive FP as permissible, bad, or morally questionable.

Table 5: Religious affiliation of respondents (N = 101)

Characteristic	Category	Frequency(n)	Percentage (%)
Religious Affiliation	Christian	80	79.2%
	Muslim	21	20.8%
	Traditionalist	0	0.0%
Total		**101**	**100**

Awareness of Family Planning Methods

Table 6 indicates that health facilities (64.4%) and television (43.6%) are the primary sources of information about FP. This is followed by family/friends (38.6%). This aligns with the research objective concerning awareness, confirming that access to FP information is widespread. However, the importance of interpersonal sources also highlights a pathway for misinformation, explaining why misconceptions persist despite high awareness. This supports realistic concerns about community-level myths overriding medically accurate information.

Table 6: Sources of Information about Family Planning (Multiple responses allowed)

Source of Information	Frequency	Percentage (%)
Health facility/clinic	65	64.4%
TV	44	43.6%
Friends/Family	39	38.6%

Social media	37	36.6%
Radio	29	28.7%
Community health workers	27	26.7%
Religious Leaders	14	13.9%
Other	1	1.0%

Table 7 displays a high awareness score for pills (mean 4.5), female condoms, and emergency contraceptive pills (both mean score 4.4) respectively. However, methods such as diaphragms/spermicides remain poorly known (mean 3.3). The pattern reflects the national trend where commonly advertised or widely available methods dominate knowledge. The findings support the study's first objective by revealing that awareness is high but unevenly distributed thus creating gaps that contribute to inconsistent or inappropriate method selection.

Table 7: Awareness Levels of Modern Family Planning Methods (Awareness was measured on a 5-point Likert scale analysis categories were collapsed & mean score calculated for each method).

Method	Very Highly/Highly Aware (%)	Moderately Aware (%)	Lowly/Very Lowly Aware (%)	Mean Score (1-5)
Pills	84.2%	7.9%	7.9%	4.5

Female Condom	82.2%	9.9%	7.9%	4.4
Emergency Contraceptive Pills	80.2%	10.9%	8.9%	4.4
IUD	79.2%	11.9%	8.9%	4.3
Injectables	75.2%	13.9%	10.9%	4.2
Sterilization	69.3%	16.8%	13.9%	4.0
Implants	68.3%	18.8%	12.9%	4.0
Diaphragms/Spermicides	49.5%	22.8%	27.7%	3.3

Perceptions about Modern Family Planning

Although 56.4% of women in Table 8 have ever used a modern FP method, 43.6% have never used any. The data illustrated by this table clearly demonstrates the awareness–usage gap which is a key empirical issue identified in the literature. It confirms that high knowledge does not automatically translate into patronage. Factors such as fear of side effects, myths about infertility, and husband/family disapproval remain powerful restrictions despite widespread availability of information.

Table 8: Usage of family planning Method

Issue	Response	Frequency(n)	Percentage (%)
Ever Used a Modern Method	Yes	57	56.4%
	No	44	43.6%
Total		**101**	**100**

Table 9 reveals a mixed perception profile: while 37.6 % of women hold positive views (with concerns) and 21.8% very positive perceptions, 11.9% and 5.0% hold negative and very negative perceptions respectively. The data is rooted in fears about side effects, infertility, and cultural beliefs. These findings align with empirical evidence that perceptions, particularly negative ones are a major predictor of non-usage. This directly supports the second research objective concerning how perception influences patronage.

Table 9: Perception of family planning

Response	Category	Frequency(n)	Percentage (%)
Perception	Very Positive	22	21.8%

	Positive (with concerns)	38	37.6%
	Neutral	24	23.8%
	Negative (side effects/myths)	12	11.9%
	Very Negative	5	5.0%
Total		**101**	

Table10 identifies widespread misconceptions, with 56.4% holding at least one and 73.3% acknowledging that myths hinder FP acceptance. Misbeliefs about infertility (49.5%), excessive bleeding (66.3%), and weight gain (61.4%) continue to shape behaviour irrespective of educational level. This confirms empirical findings that misconceptions are strong, socially transmitted, and deeply rooted in community discourse. This data highlights a key barrier to FP acceptance.

Table10: Prevalence of Misconceptions

Issues	Yes	No
1. Hold any misconceptions (Q12)	56.4%	43.6%
2. Do Misconceptions hinder acceptance (Q13)	73.3%	26.7%
3. Causes infertility (Q14)	49.5%	50.5%
4. Causes health issues (Q15)	67.3%	32.7%
5. Causes cancer (Q16)	31.7%	68.3%
6. Causes weight gain (Q17)	61.4%	38.6%
7. Causes excessive bleeding (Q18)	66.3%	33.7%
8. Causes barrenness (Q19)	43.6%	56.4%
9. Goes against religious beliefs (Q20)	37.6%	62.4%
10. Goes against cultural beliefs (Q21)	40.6%	59.4%

Findings in Table 11 illustrates an overwhelming 81.2% (strongly agree + agree) acknowledge the benefits of FP. This signifies strong conceptual support – a sharp contrast with the lower levels of actual usage. This contradiction reinforces the knowledge–practice paradox. i.e. women understand the benefits but remain apprehensive due to perceived risks and socio-cultural pressures.

Table 11: Belief in the Benefits of Family Planning (N=101)

Response	Frequency	Percentage (%)
Strongly Agree	18	17.8%
Agree	64	63.4%
Neutral	12	11.9%
Disagree	5	5.0%
Strongly Disagree	2	2.0%
Total	**101**	**100%**

Factors influencing Family Planning use among married women

Table 12 shows Side effects (72.3%) and husband/family disapproval (62.4%) emerge as the strongest barriers to FP use. Financial concerns and difficulty understanding usage instructions also exhibit high rates. These findings directly support objective three by identifying socio-cultural, economic, and relational causes of behaviour. They highlight that FP decisions in Awoshie-Market are not just individual choices but negotiated within households and influenced by fear-based narratives.

Table 12: Factors influencing Family Planning Use

Issues	Agree (%)	Neutral (%)	Disagree (%)	Mean Score (1-3)
Side Effects	72.3%	17.8%	9.9%	2.6

Husband/Family disapproval	62.4%	22.8%	14.9%	2.5
Financial factors	58.4%	23.8%	17.8%	2.4
Knowledge of the use	57.4%	25.7%	16.8%	2.4
Religious reasons	49.5%	26.7%	23.8%	2.3
Cultural beliefs	46.5%	28.7%	24.8%	2.2
Desire to get pregnant	33.7%	31.7%	34.7%	2.0

Table 13 report moderate to strong support carrying the greatest percentage 63.3% of respondents, but nearly one-quarter experience low or very low support. This variation demonstrates the unpredictable nature of household dynamics, with some families encouraging FP while others resist or stigmatize it thus reflects the gender-power imbalance emphasized in empirical literature.

Table 13: Family Support for FP

Issue	Response	Frequency (n)	Percentage (%)
Level of Family Support	Very Strong Support	12	11.9%
	Strong Support	26	25.7%
	Moderate Support	38	37.6%
	Low Support	19	18.8%
	Very Low Support	6	5.9%
Total		**101**	**100%**

About 25.7% in table 14 report direct family resistance. This aligns with qualitative evidence that spousal opposition and extended-family influence remain key obstacles. Resistance also connects to cultural expectations about fertility, gender roles, and religious teachings.

Table 14: Resistance to family planning (N=101)

Response	Category	Frequency (n)	Percentage (%)
Faced Family Resistance	No	75	74.3%
	Yes	26	25.7%
Total		**101**	**100%**

Strategies for Increasing Family Planning usage among married women

In table 15, strategies with the strongest endorsement include free FP services and training & deployment of more community health workers (mean 4.6). Mobile clinics, male involvement, and localized education also recorded high support. These findings directly address objective four and reflect community-preferred interventions. Lower support for religious-leader endorsements (mean 4.0) suggests mixed trust in faith-based messaging about FP.

Table15: Suggestions for Improving Acceptance of Family-Planning Methods

Suggested Strategy	Strongly Agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Strongly Disagree (%)	Mean Score (1-5)
Free and accessible contraception services	68.3%	22.8%	5.0%	2.0%	2.0%	4.6
Training & deployment of more community health	64.4%	22.0%	4.7%	7.9%	1.0%	4.6

workers						
Use of mobile clinics & outreach services	59.4%	27.7%	9.9%	1.0%	2.0%	4.5
Male involvement in campaigns	54.5%	30.6%	10.9%	2.0%	2.0%	4.5
More education in local languages	49.5%	34.7%	10.9%	3.0%	2.0%	4.4
Integration with maternal & child health clinics	49.5%	33.7%	12.9%	2.0%	2.0%	4.4
Introduction of culturally appropriate media campaigns	45.5%	34.7%	15.8%	2.0%	2.0%	4.3
Peer education programs	41.6%	36.6%	16.8%	3.0%	2.0%	4.3
Incentive programs for couples	36.6%	36.7%	20.8%	4.0%	2.0%	4.2

Religious leader endorsements	29.7%	37.6%	23.8%	5.0%	3.9%	4.0

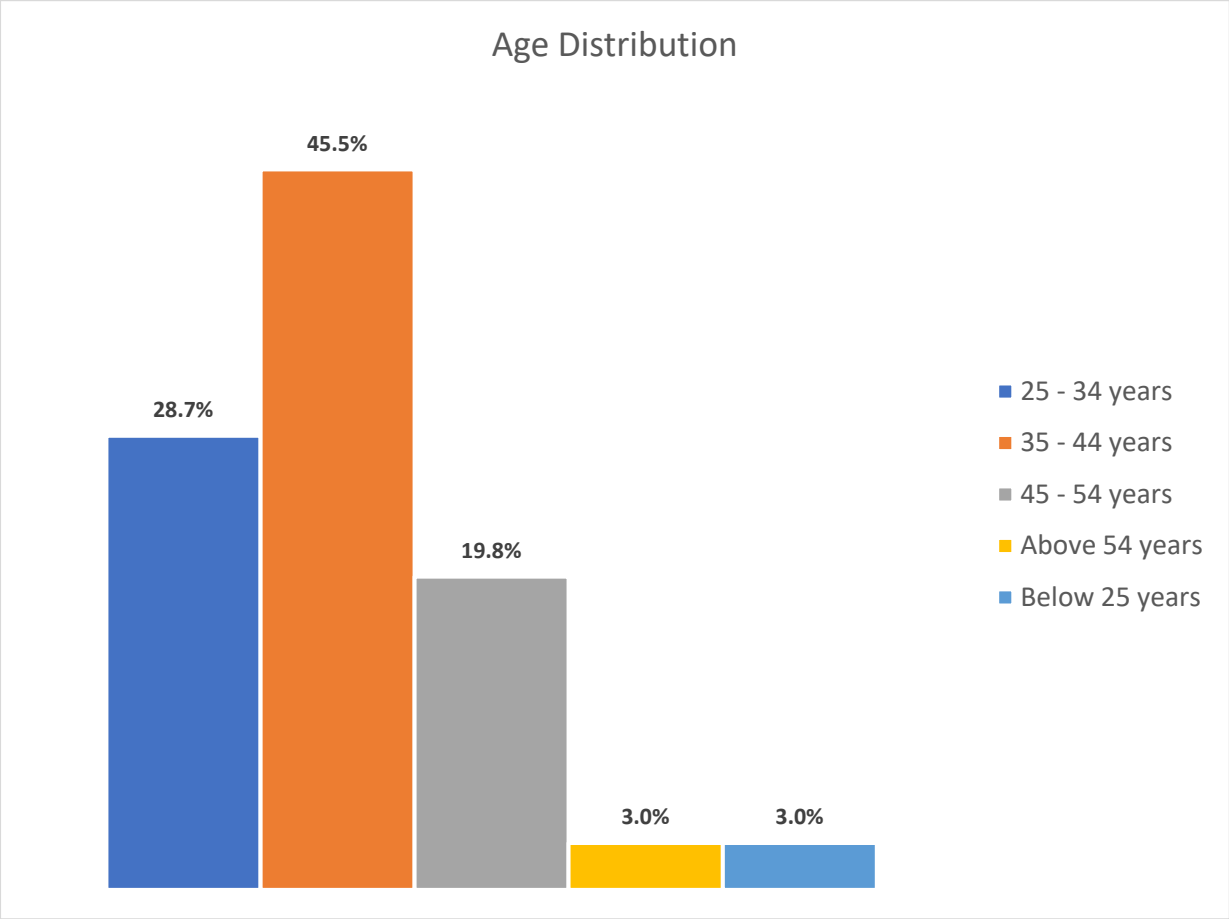
Table 16 illustrates 85.1% of respondents willing to recommend FP to other married women. The finding demonstrates a high potential for peer-driven advocacy. This shows that even women who may not currently use FP themselves still recognize its importance and are prepared to promote it. This is an important insight for designing community-based communication strategies.

Table: 16 Willingness to Recommend Family Planning (N=101)

Response	Frequency	Percentage (%)
Yes	86	85.1%
No	15	14.9%
Total	**101**	**100**

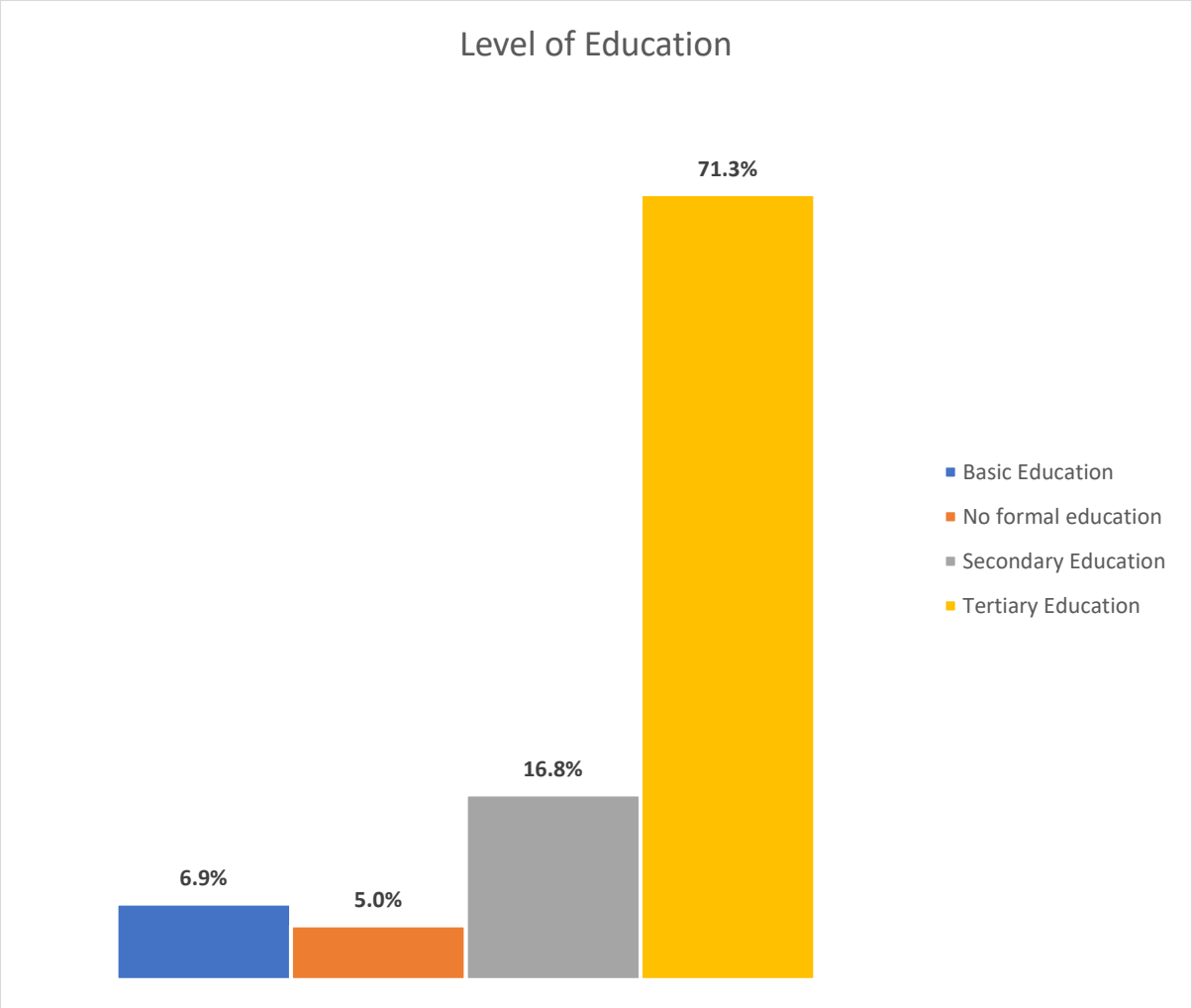
CHARTS SHOWING DATA DISTRIBUTION

Figure 1: Age Distribution of Respondents



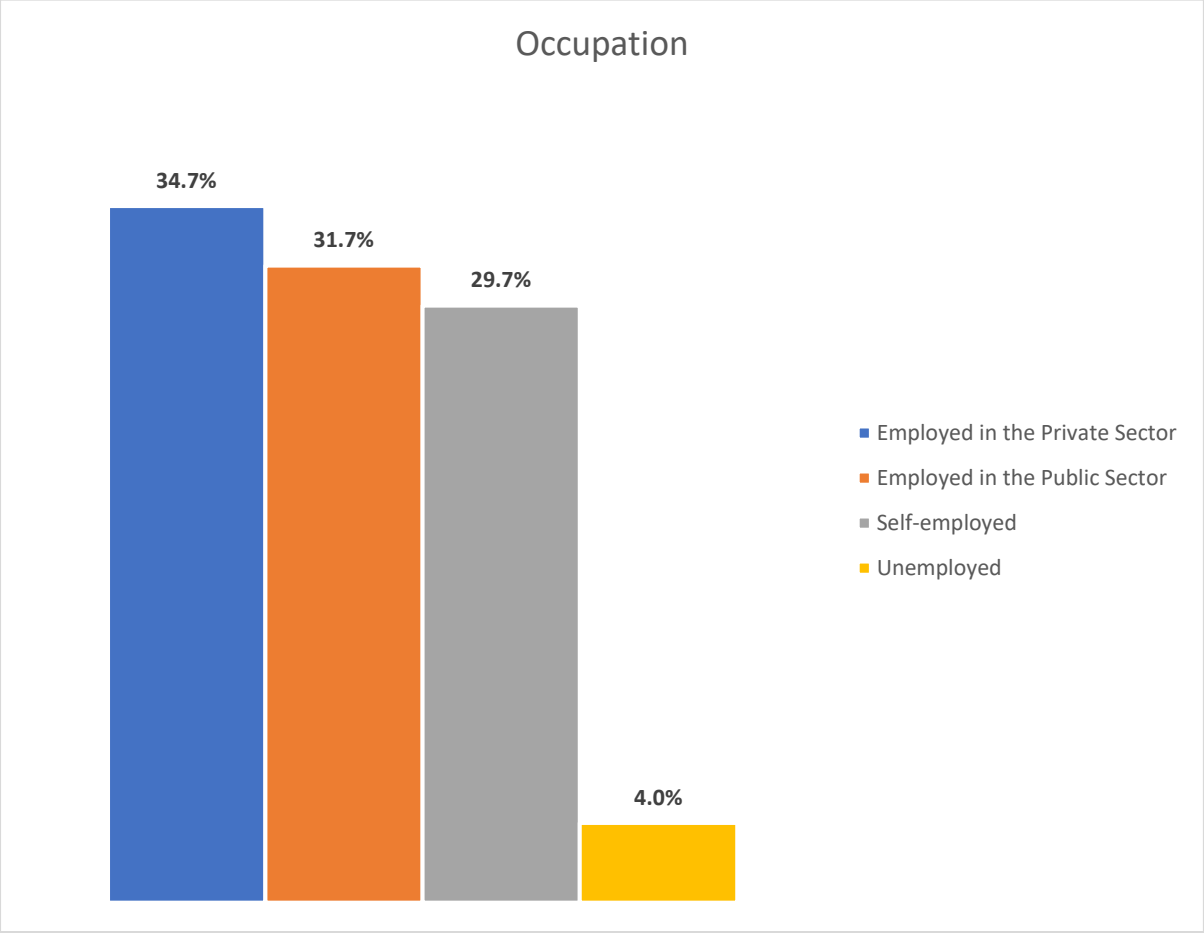
The chart illustrates the age distribution of the 101 respondents. It shows that the majority (45.5%) were within the 35-44 age bracket, indicating the study successfully captured women in their prime reproductive years.

Figure 2: Level of Education



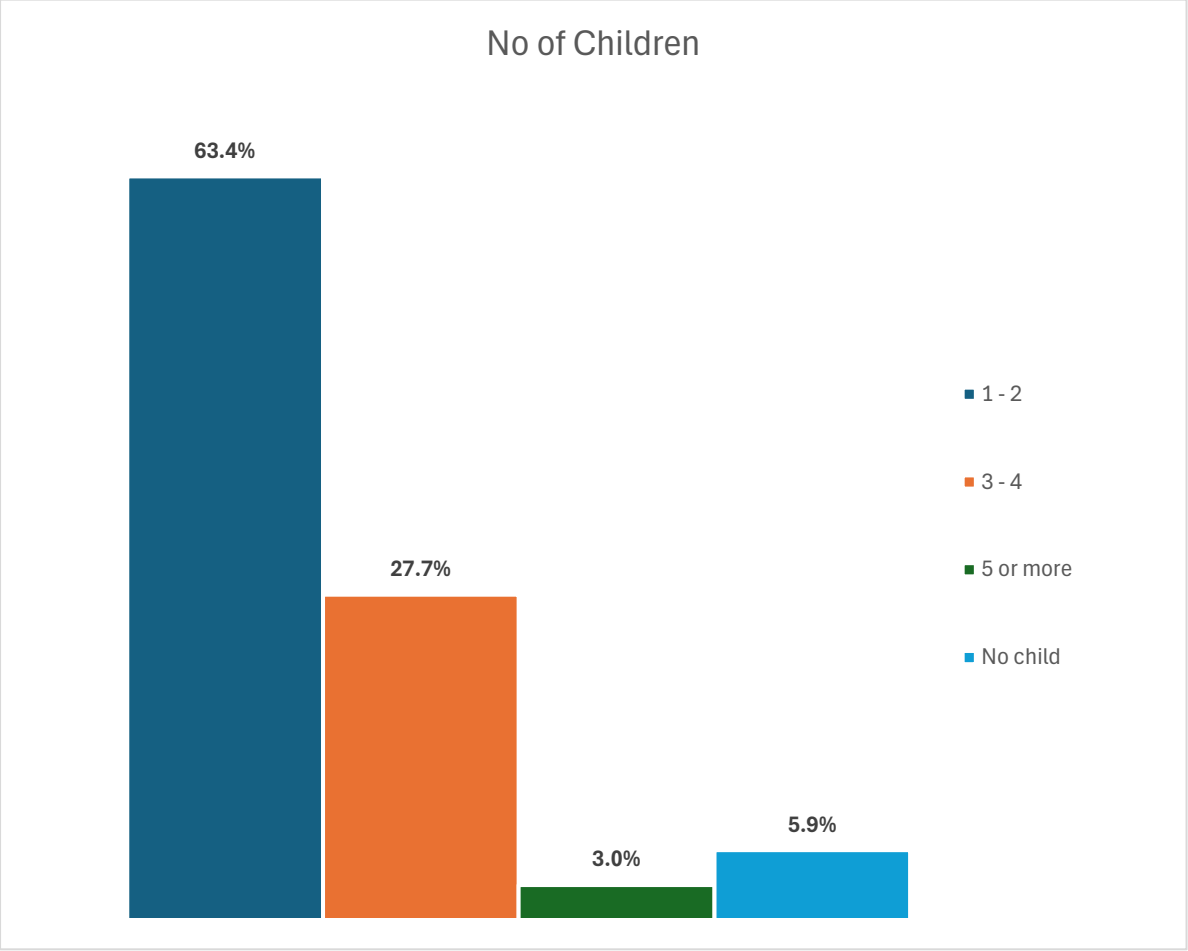
The chart presents the educational attainment of the sample. A significant majority (71.3%) had tertiary education, suggesting a sample with high potential health literacy.

Figure 3: Occupation of Respondents



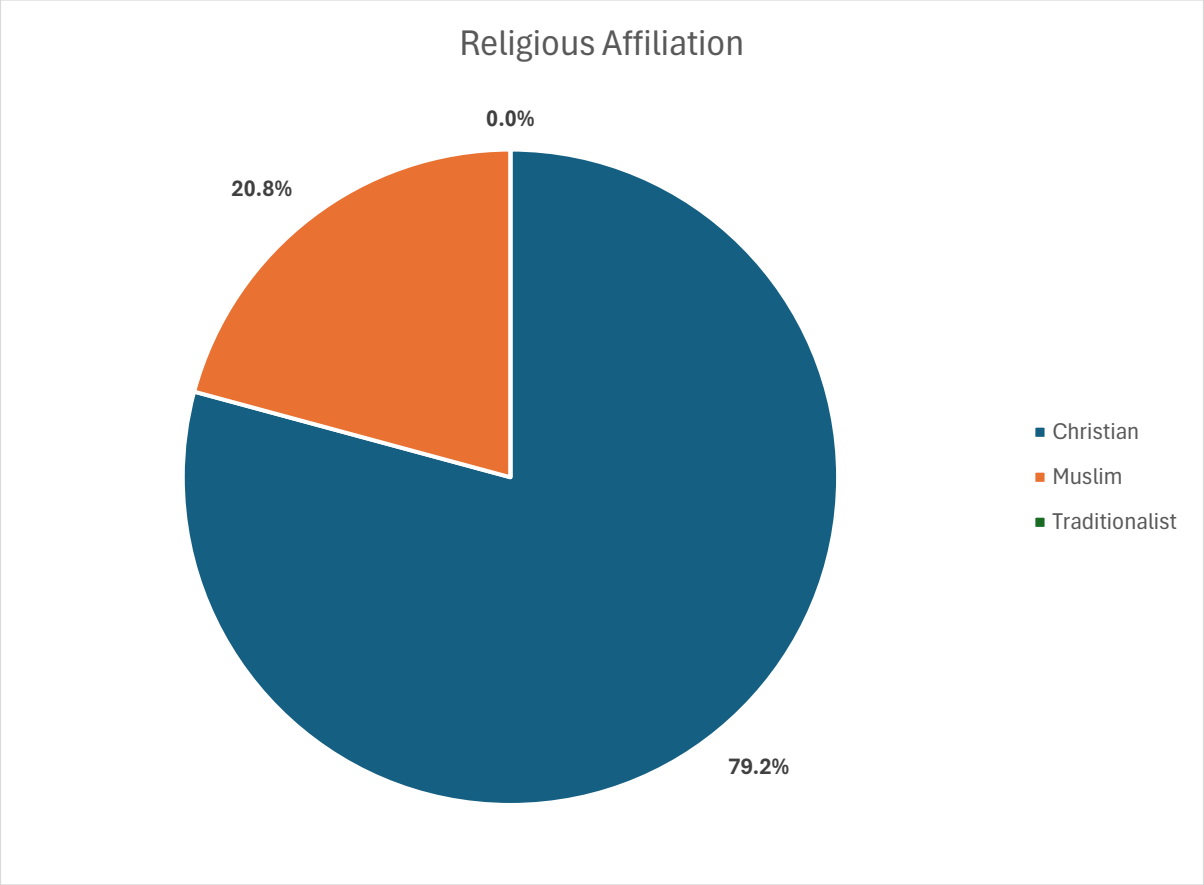
The chart outlines the occupational status of respondents. The distribution was relatively balanced among private sector employment (34.7%), public sector (31.7%), and self-employment (29.7%), reflecting an economically active sample.

Figure 4: Number of respondents' children



The chart displays the parity of the respondents. Most women (63.4%) had 1-2 children, indicating a trend towards smaller family sizes within the sample.

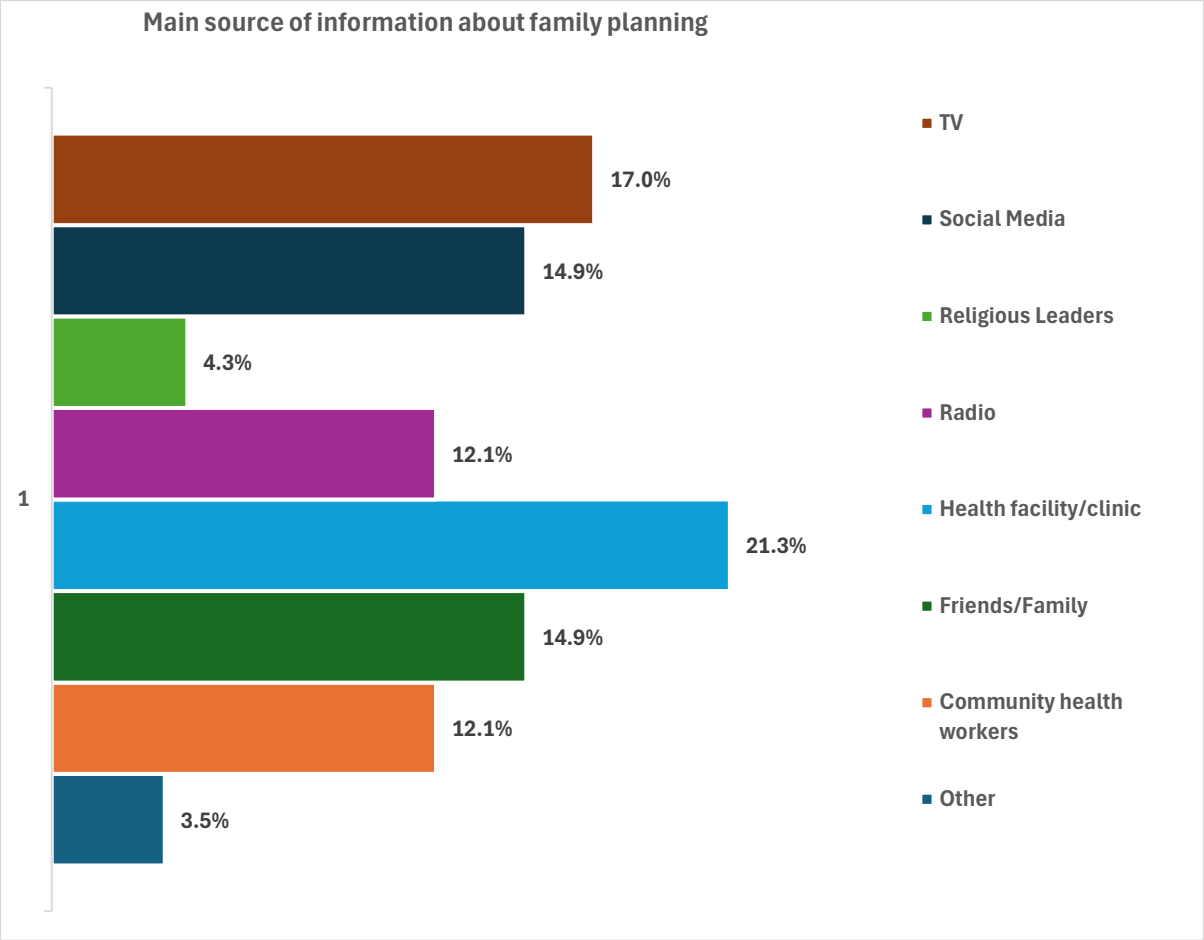
Figure 5: Religious Affiliation of Respondents



The chart details the religious affiliation of participants, with Christianity being the dominant faith (79.2%), followed by Islam (20.8%).

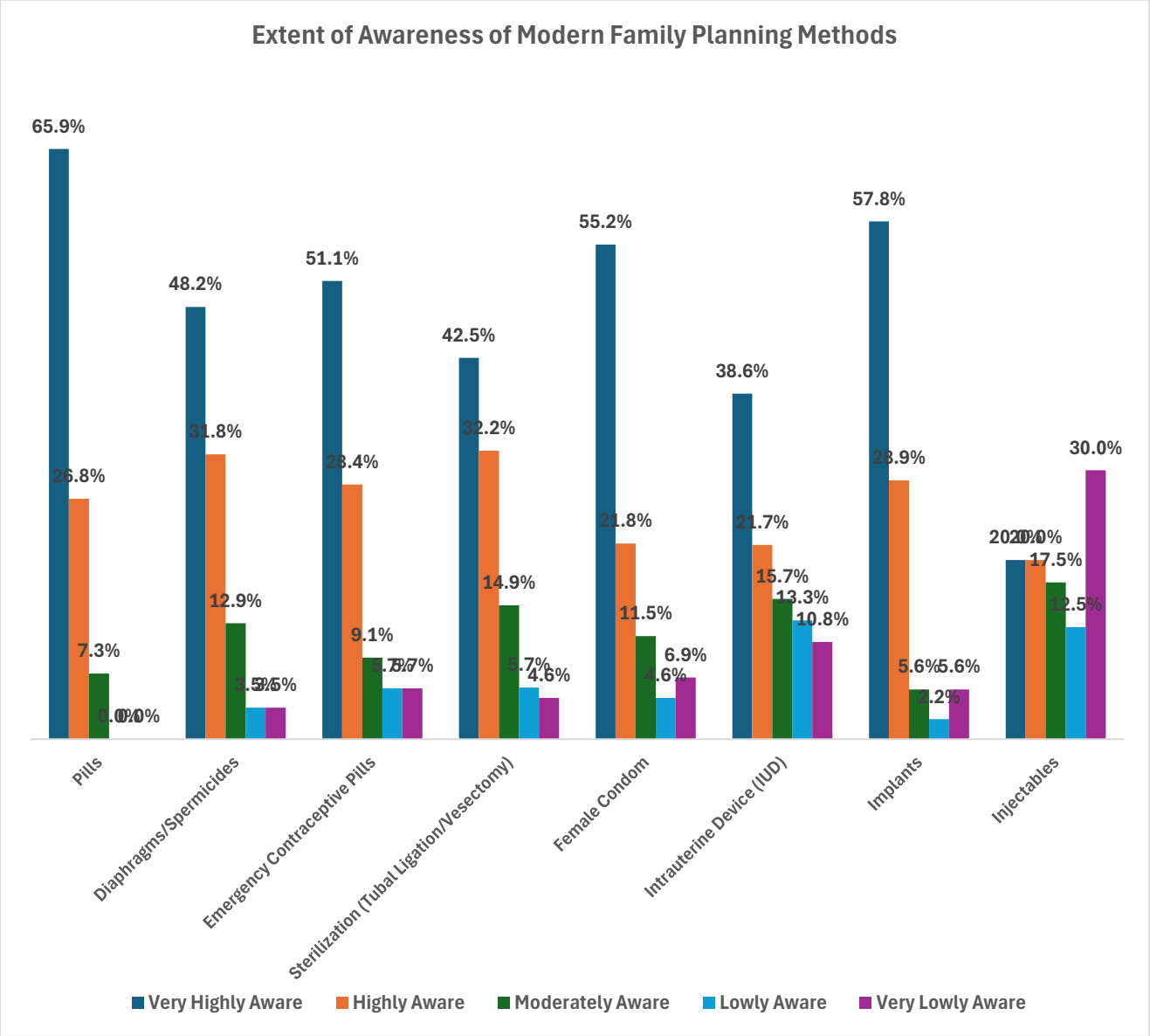
Figure 6: Awareness of Modern Family planning Methods

Sources of Information about Family Planning (Multiple responses)



The chart details the primary sources of information about family planning, with health facilities (64.4%) and television (43.6%) being the most cited. Interpersonal sources like friends/family (38.6%) and social media (36.6%) were also significant.

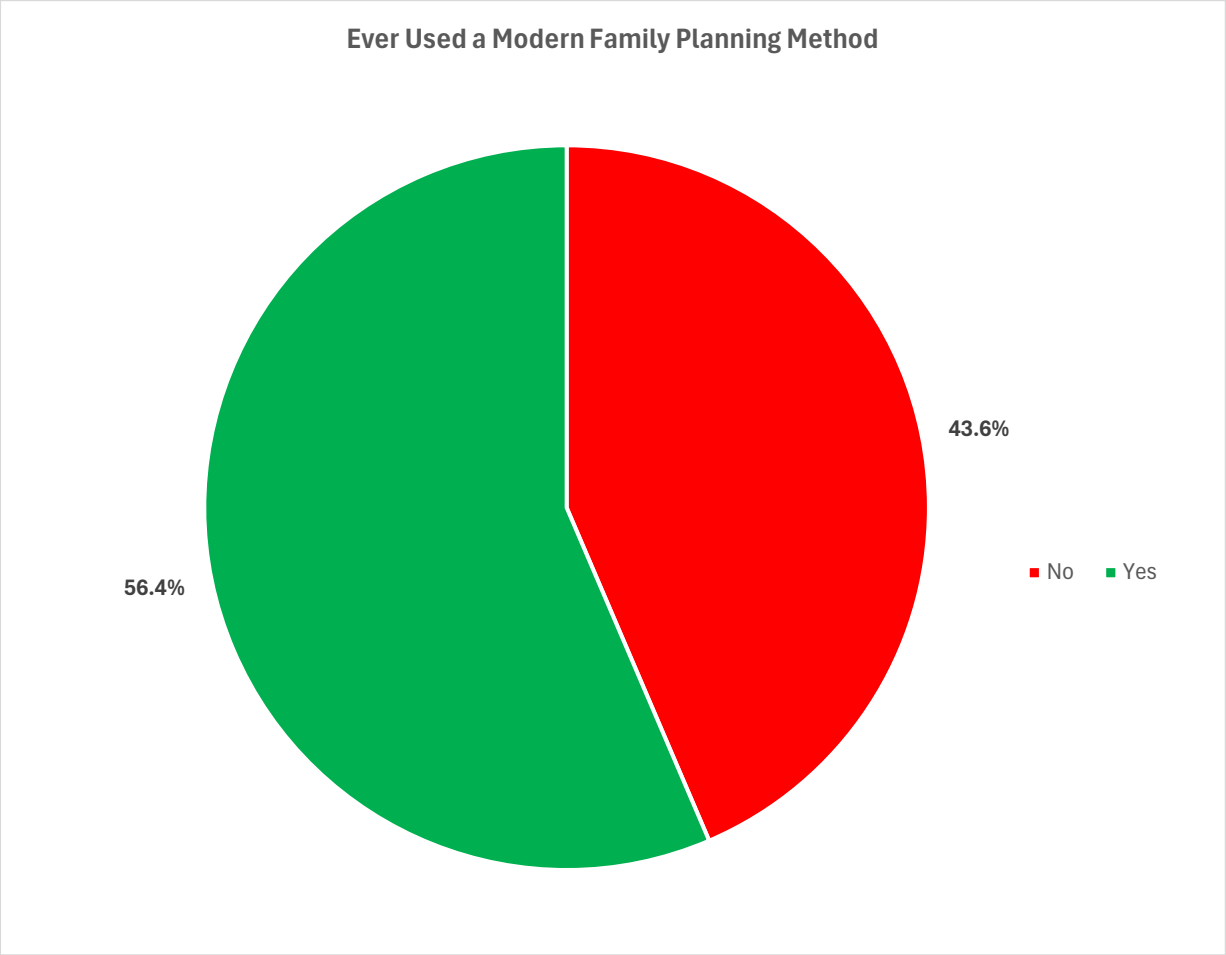
Figure 7: Five-point Likert scale on the extent of awareness on Modern FP methods



This chart analyses awareness levels of specific modern family planning methods on a 5-point Likert scale. Pills had the highest mean awareness score (4.5), while awareness was lowest for diaphragms/spermicides (mean=3.3), highlighting a knowledge gap for less common methods.

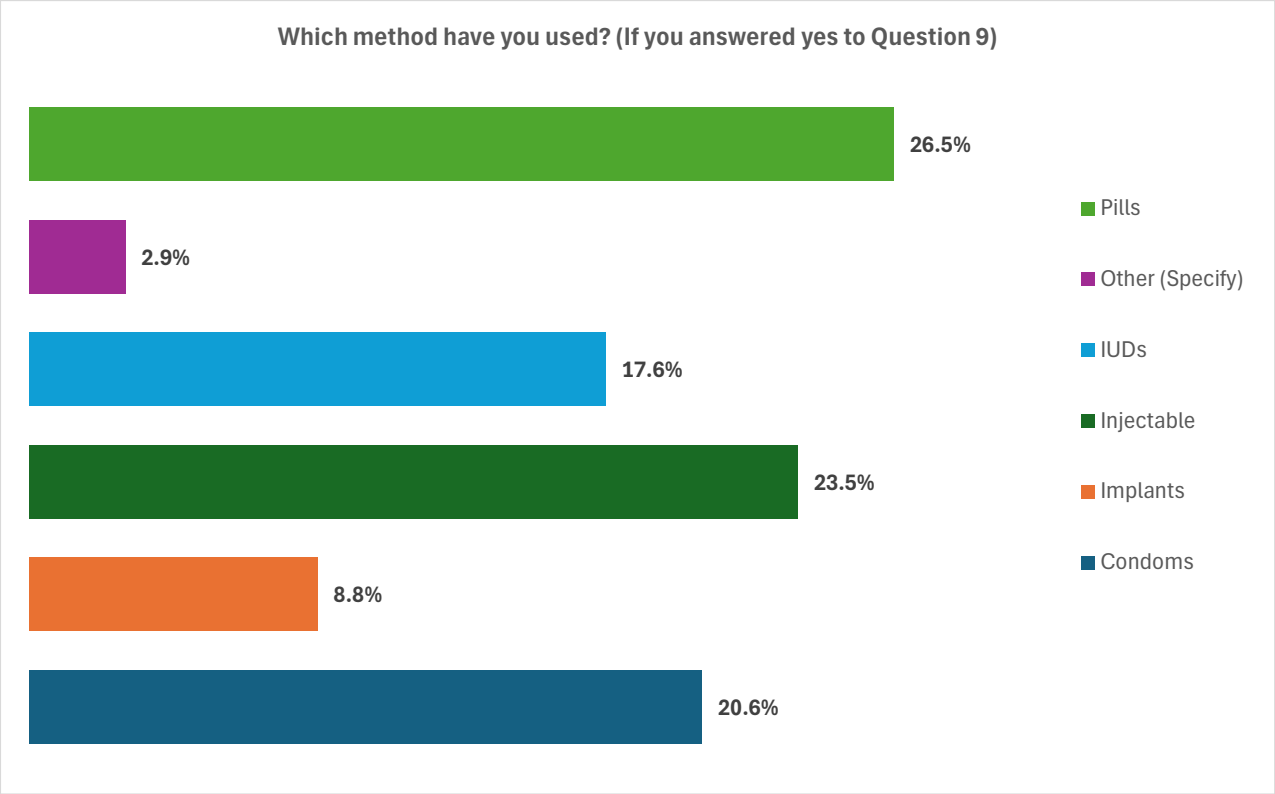
Figure 8: Perception about Family Planning

Ever used a Modern Family Planning Method?



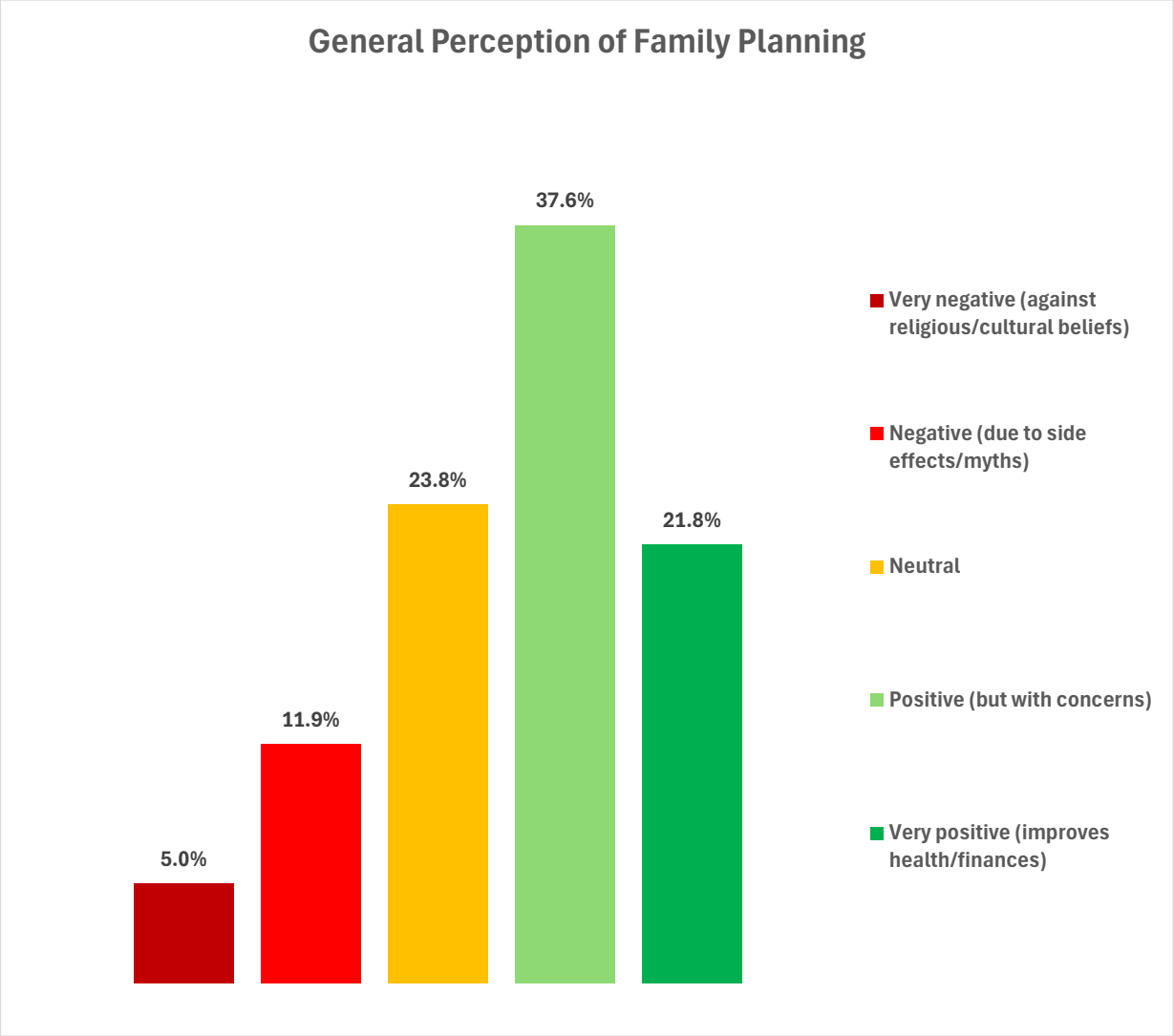
The chart contrasts awareness with practice, showing that while awareness was high, only 56.4% of respondents had ever used a modern family planning method.

Figure 9: The method used (Those who answered Q9)



The chart is a follow-up to respondents who answered question 9. It states the actual family planning methods used. The highest used modern contraceptive was the pills (26.5%) this was followed by the injectable with 23.5% and female condoms with 20.6 percent

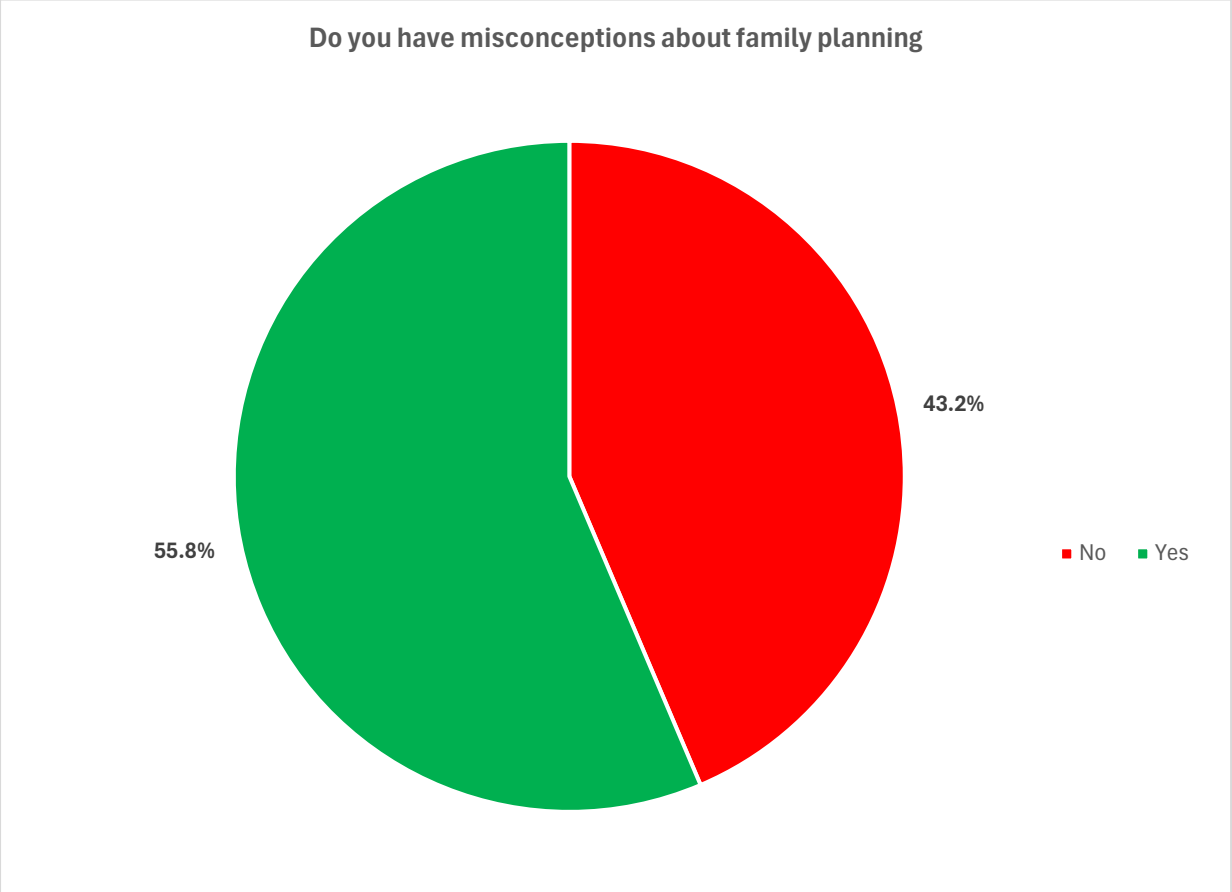
Figure 10: General Perception about Family Planning



This chart shows general perception of modern family planning methods. While a significant number (37.6%) held positive views, 11.9% held negative views primarily due to fears of side effects and myths.

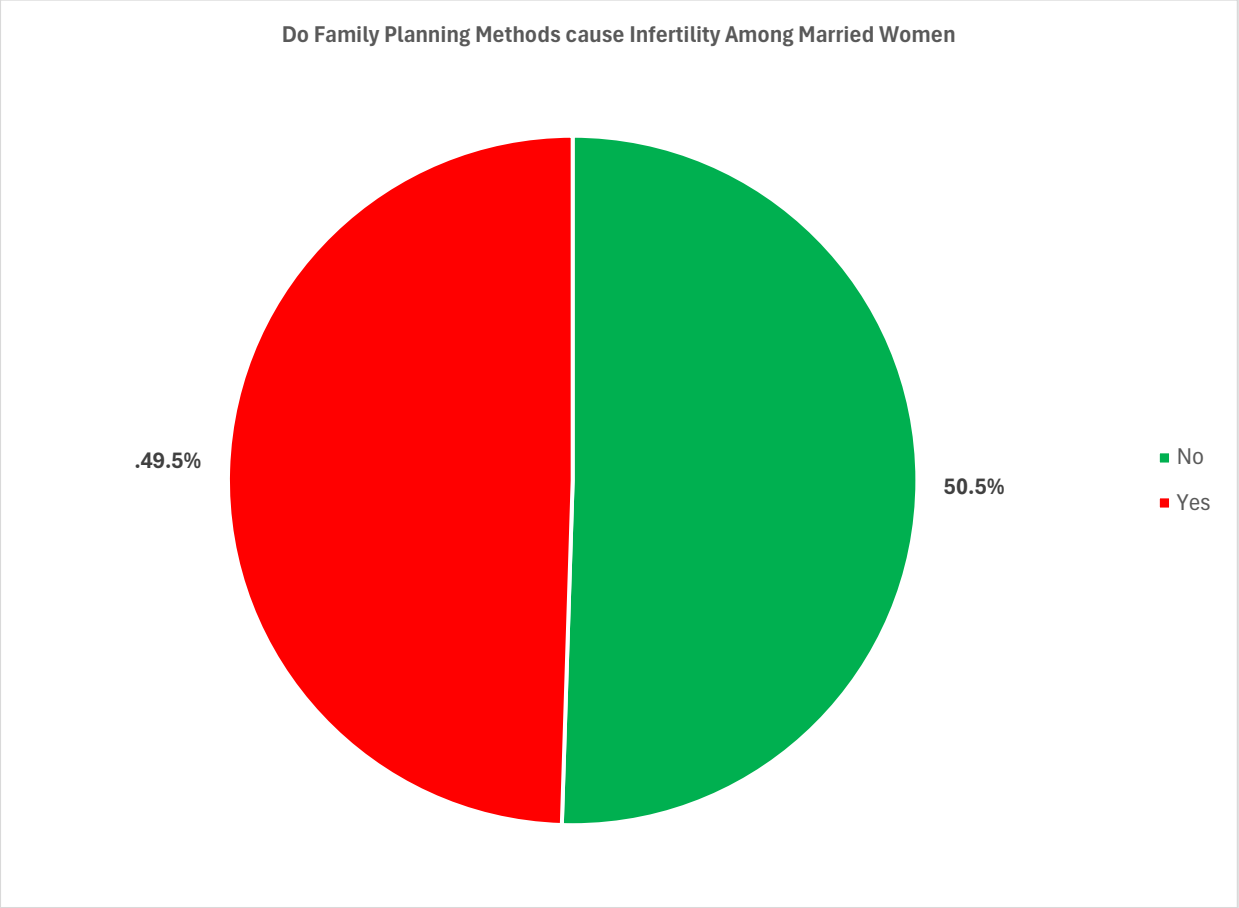
Figure 11: The following charts quantify the prevalence of specific misconceptions about FP

(Q12) Chart showing whether respondents have misconceptions about Family Planning



(Q12) The chart above depicts that, despite a high awareness level, majority of respondents (55.8%) still had misconceptions about family planning.

Figure 12: (Q14) Misconception of FP causes infertility



(Q14) The chart shows only a little over half of respondents (50.5 percent) who do not believe that Family Planning causes infertility while nearly half of respondents (49.5%) believe the opposite.

Figure 13: (Q15) Family planning causes health issues

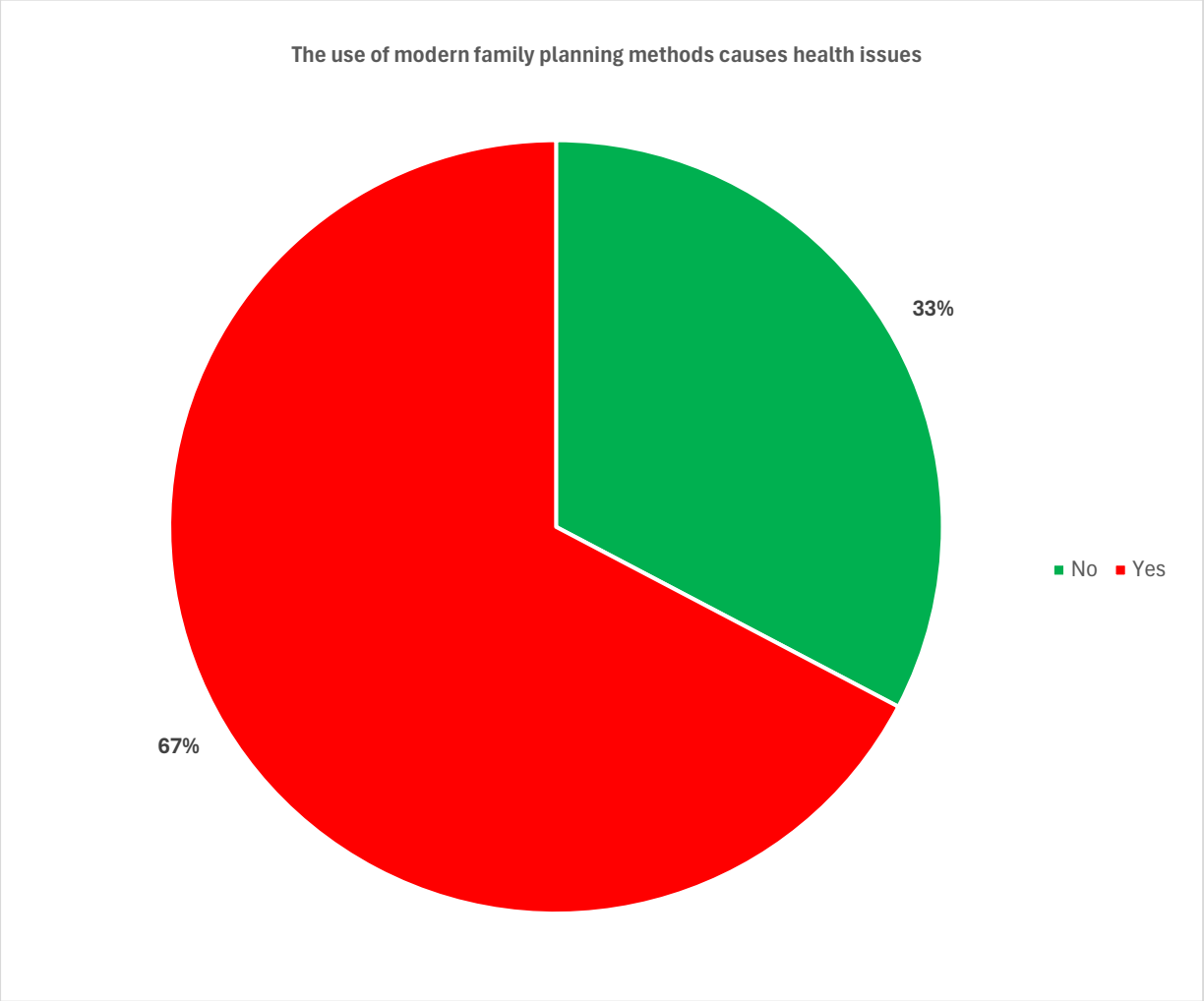
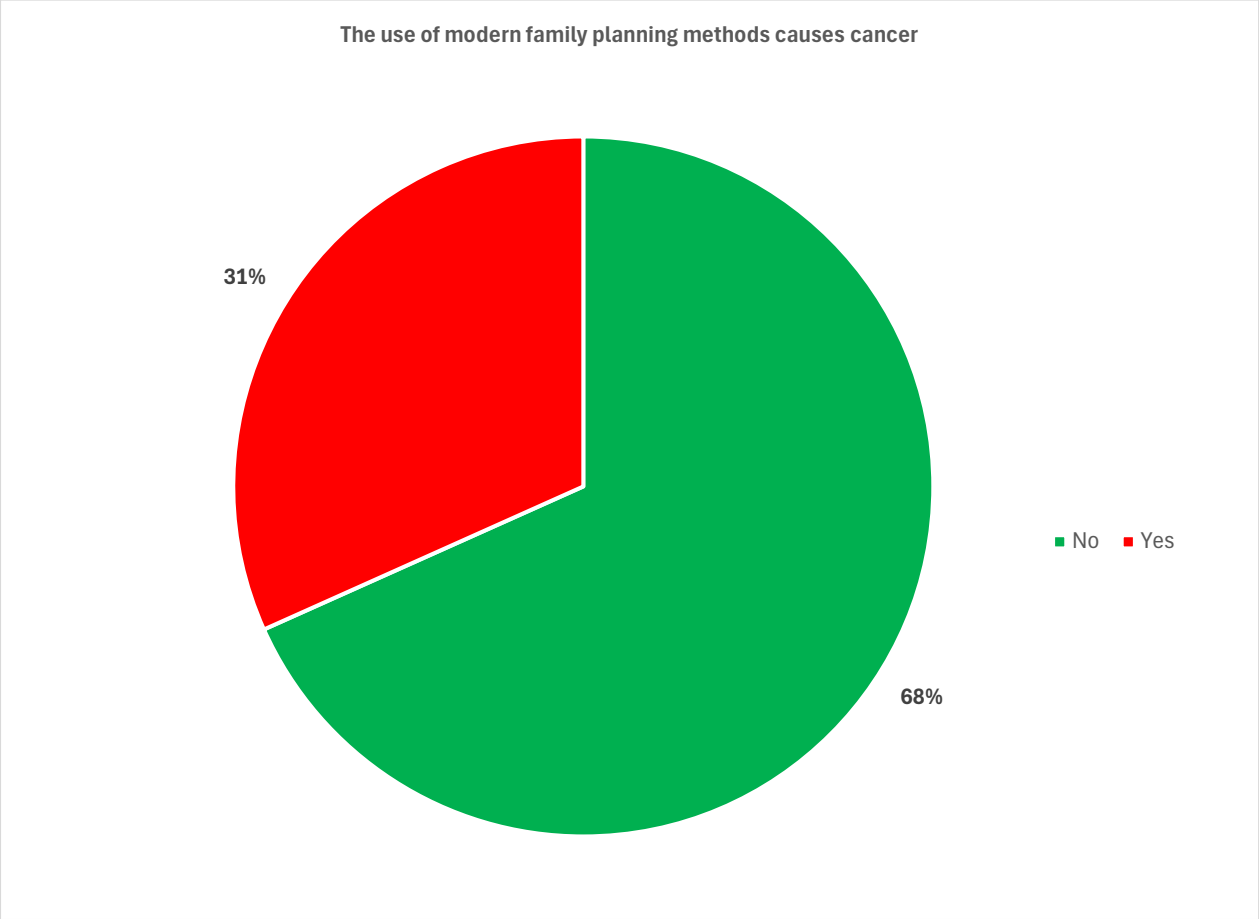


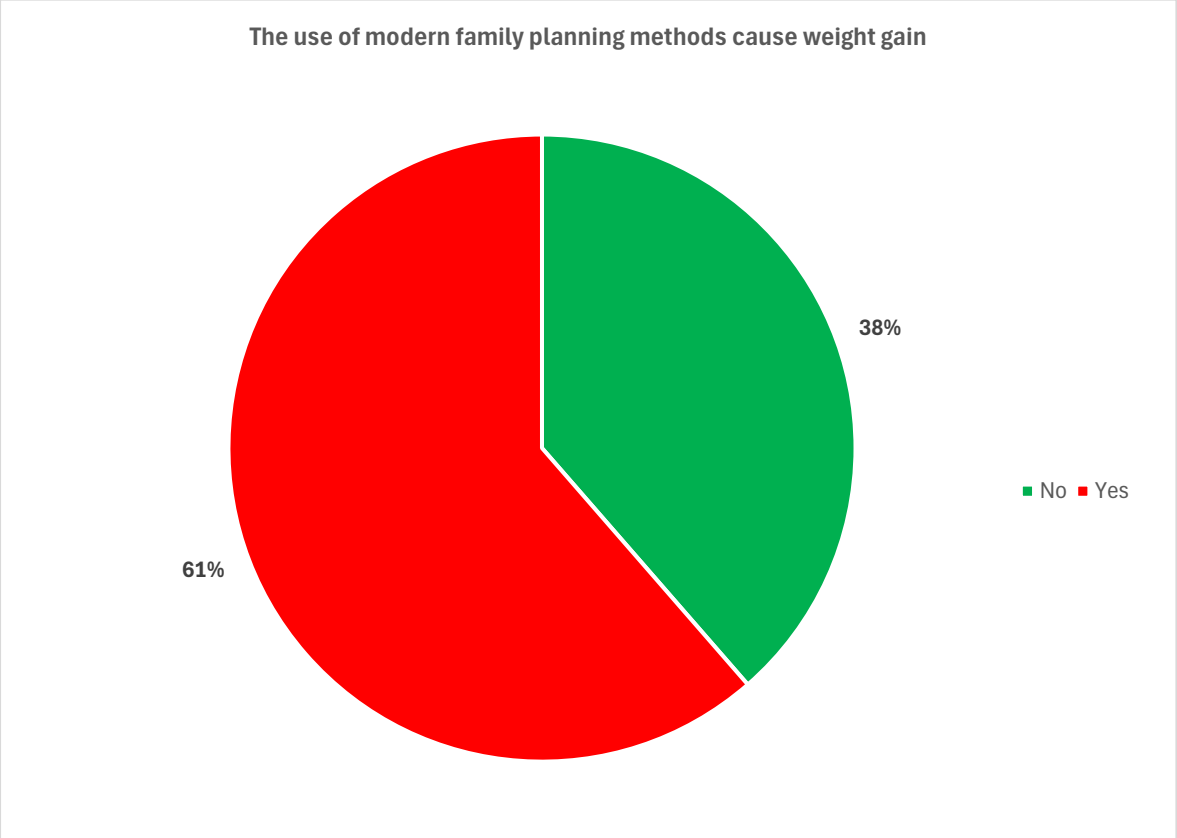
Chart on (Q15) shows that majority of respondents (67%) believe FP causes health issues such as side effects. More than a quarter (33%) admitted to no health issues.

Figure 14: (Q16) Misconception on family planning causes cancer



(Q16) Majority (68%) of respondents rejected the misconception of FP causes cancer. Nonetheless, more than a quarter had the belief that that one could get cancer from using a modern family planning method.

Figure 15: (Q17) Family planning causes weight gain



Most respondents for Q17 (61%) believe FP causes weight gain. However, a significant portion of respondents (38%) do not have this misconception.

Figure 16: (Q19) Modern family planning methods cause bareness

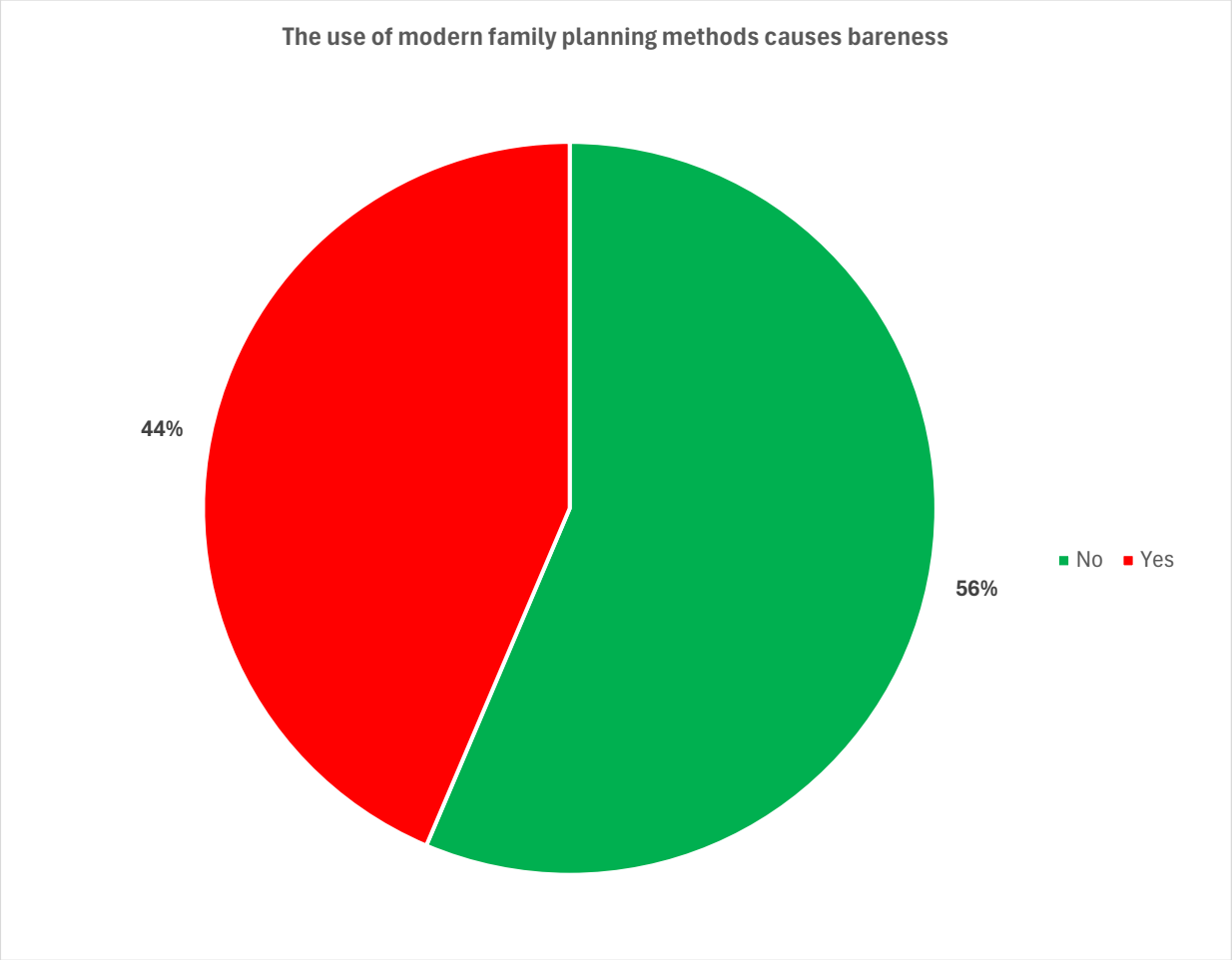
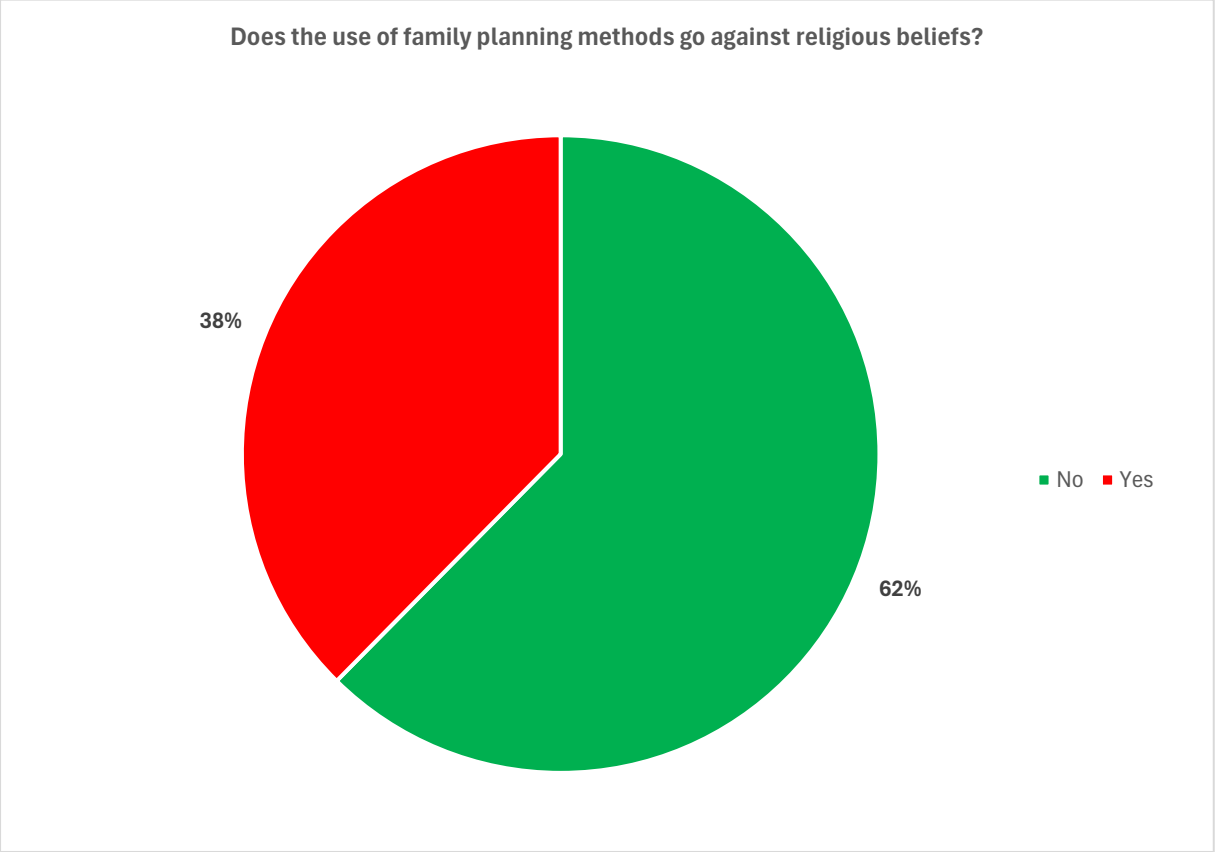


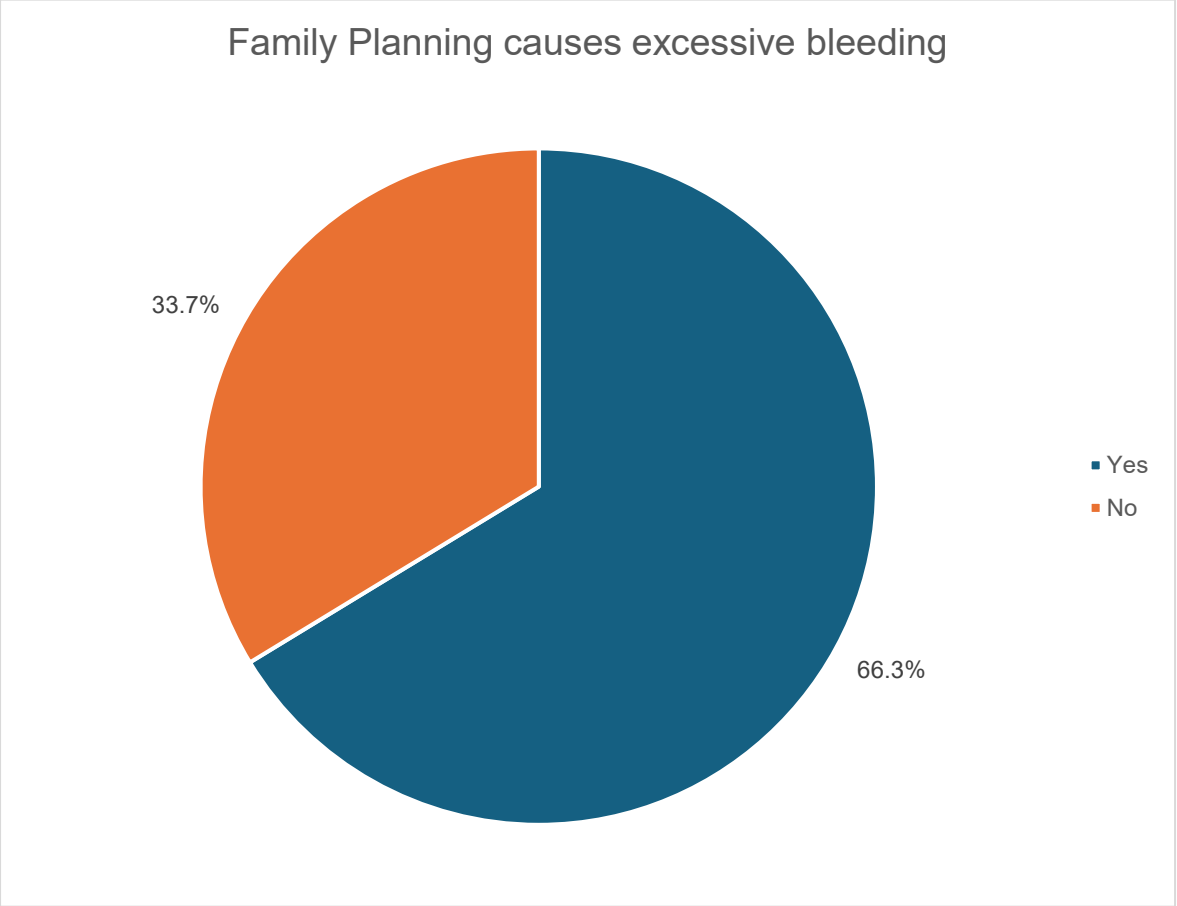
Chart in (Q19) shows more than a third (44%) of respondents held the belief of FP was a cause of bareness though half (56%) did not associate with this misconception.

Figure 17: (Q20) Family planning goes against Religious Beliefs



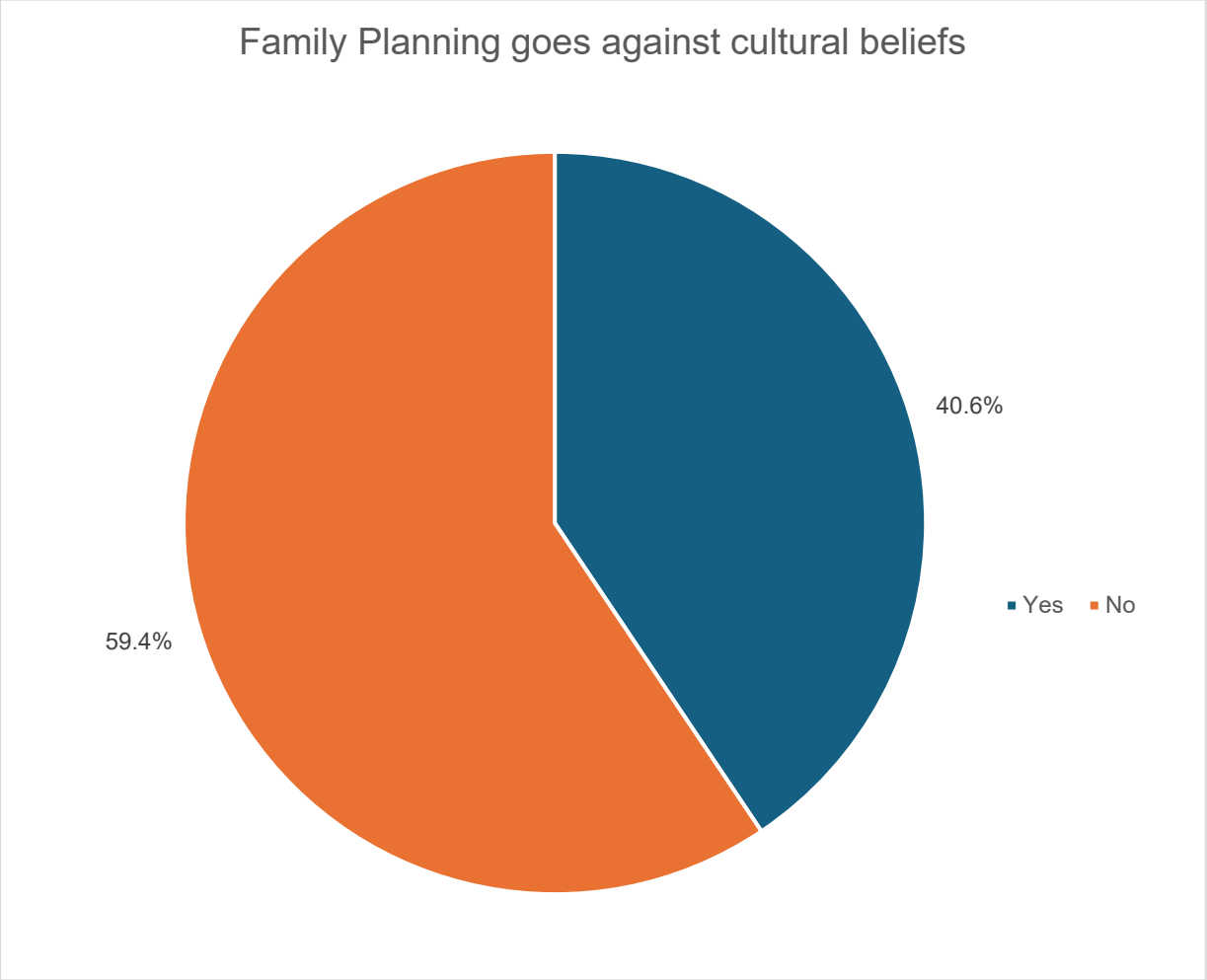
The chart on (Q20) shows that though modern FP does not go against religious beliefs of most respondents (62%), it did contradict the response of a third (38%) of all married women surveyed.

Figure 18: (Q18) FP causes excessive bleeding



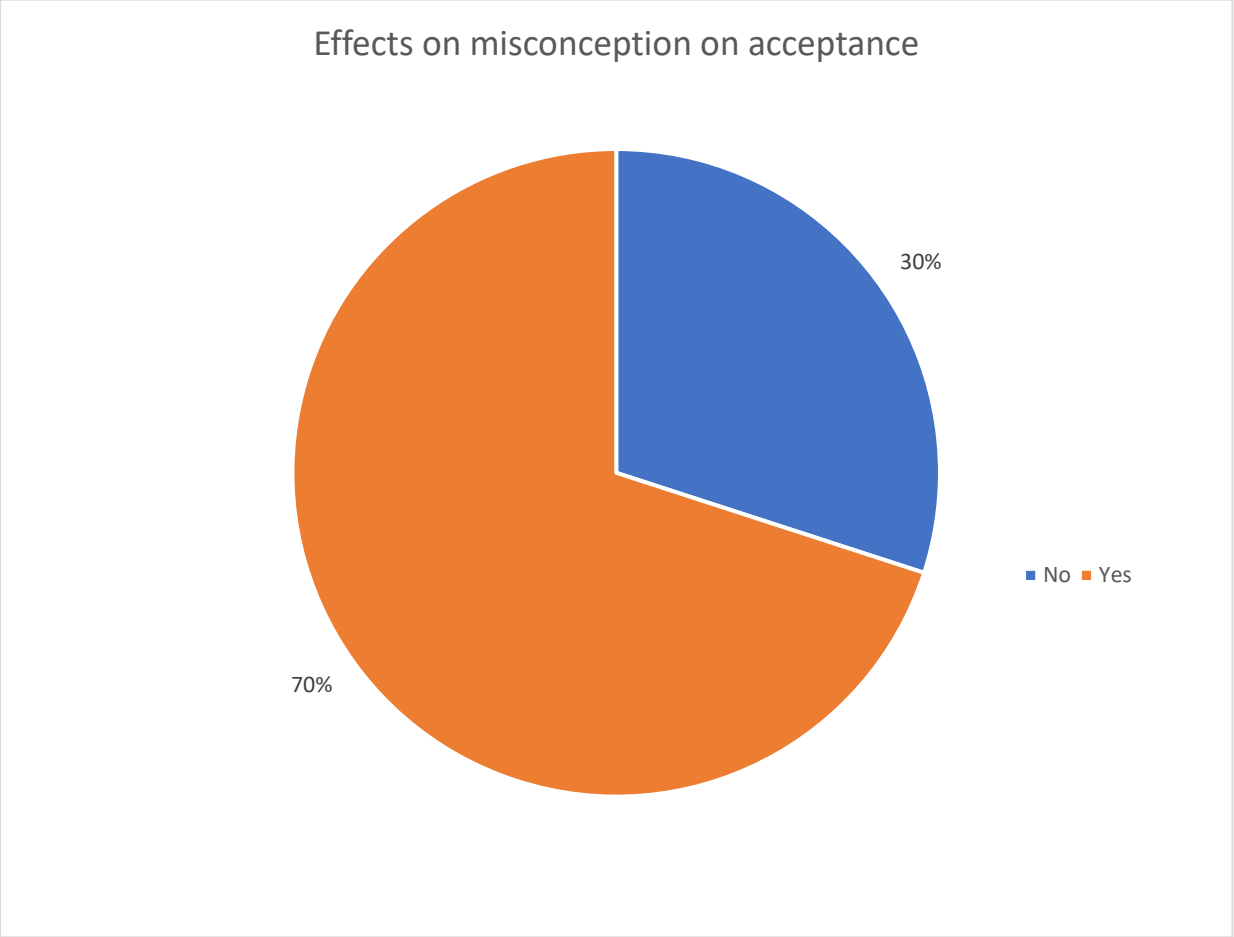
Most respondents for (Q18) (66.3%) agreed that modern family planning causes excessive bleeding while a third did not have any such misconception.

Figure 19: (Q21) FP is against cultural beliefs



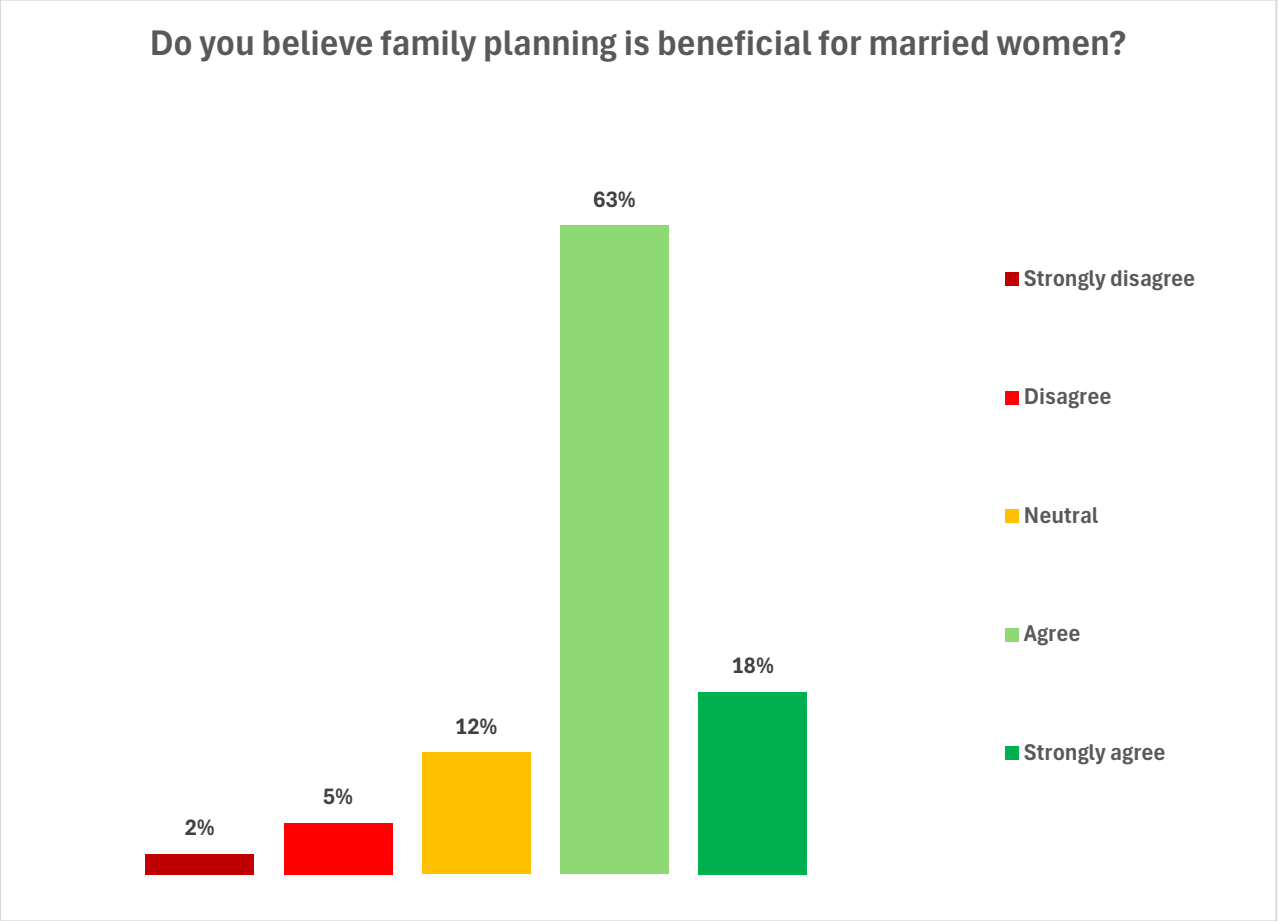
More than half of all respondents for (Q21) believe that modern FP does not go contrary to their cultural beliefs. However, a significant portion believe FP is anti-culture.

Figure: 20 (Q13) Misconception affects acceptance



Most married women surveyed on (Q13) (70%) believed that misconceptions on FP hindered its general acceptance.

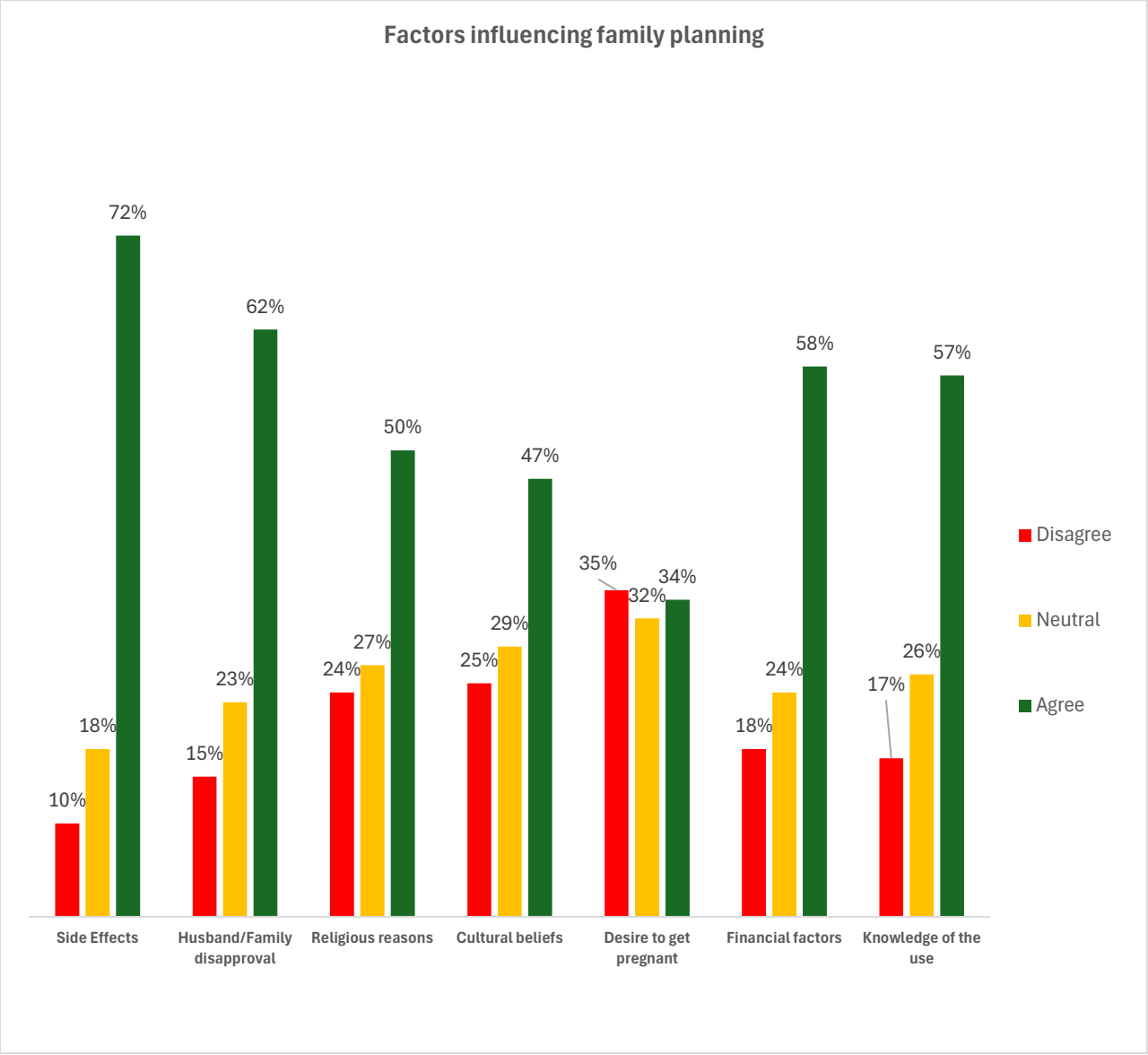
Figure 21: Belief that Family planning benefits married women



The chart demonstrates theoretical support for family planning, with an overwhelming 63% and 18% of respondents agreeing or strongly agreeing that it is beneficial.

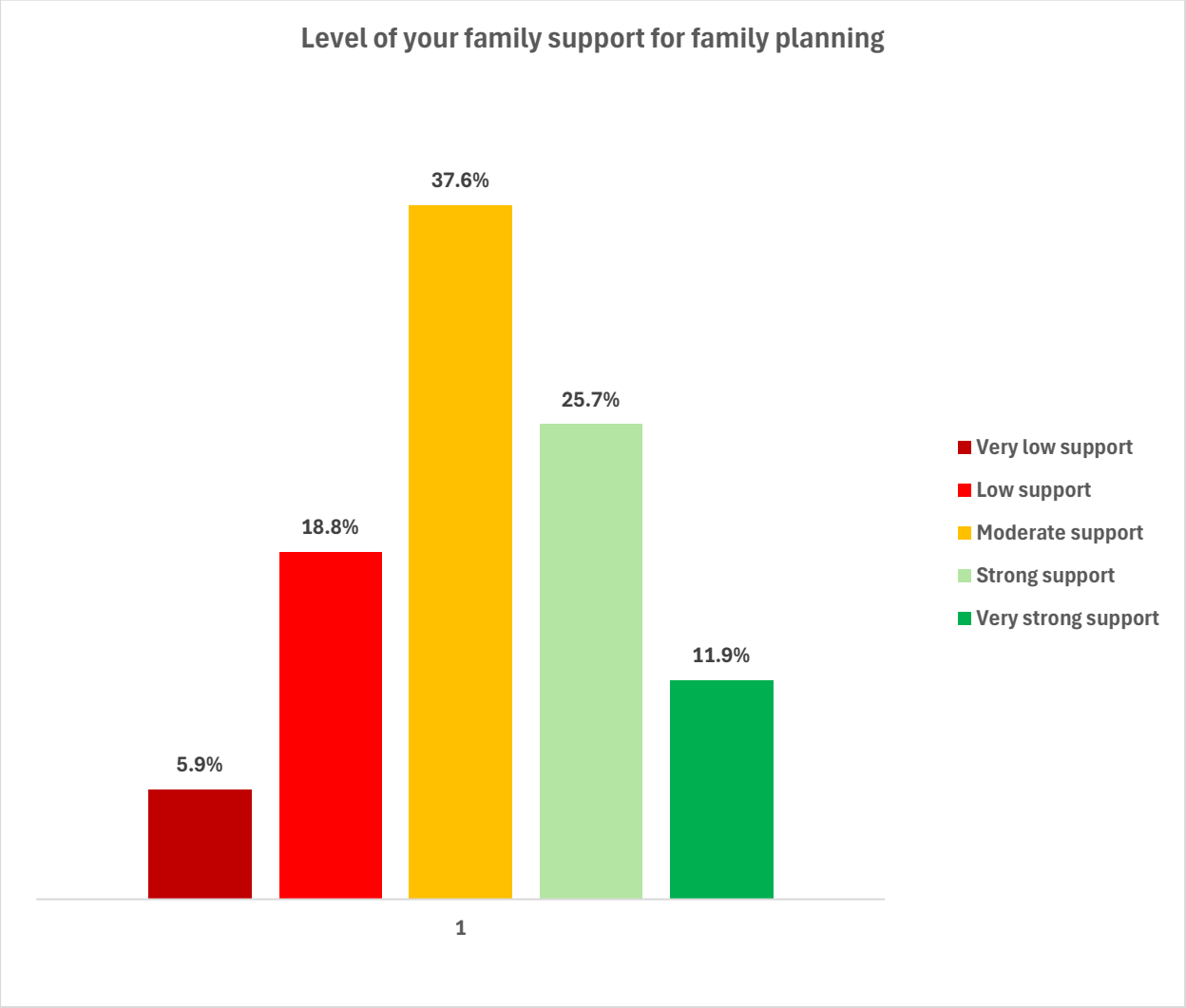
Figure 22: Factors influencing family planning use among married women

Likert scale on factors that influence FP use



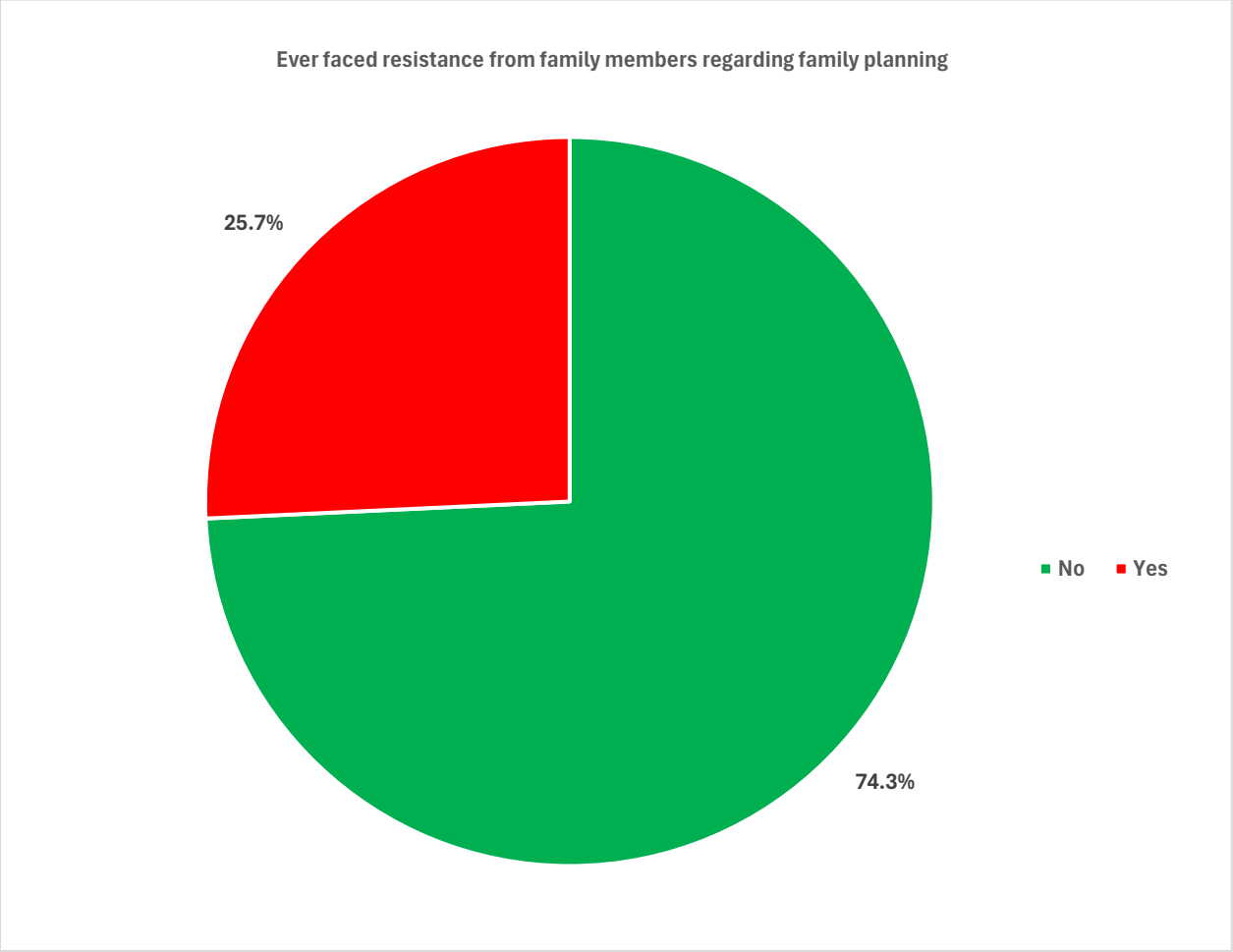
This Chart ranks as factors influencing family planning using on a Likert scale. Side effects (72% agreement) and husband/family disapproval (62%) were the most significant barriers.

Figure 23: Level of family support for FP



The chart describes level of family support for family planning, which was mostly moderate (37.6%) to strong support (25.7%) though nearly a quarter reported low or very low support.

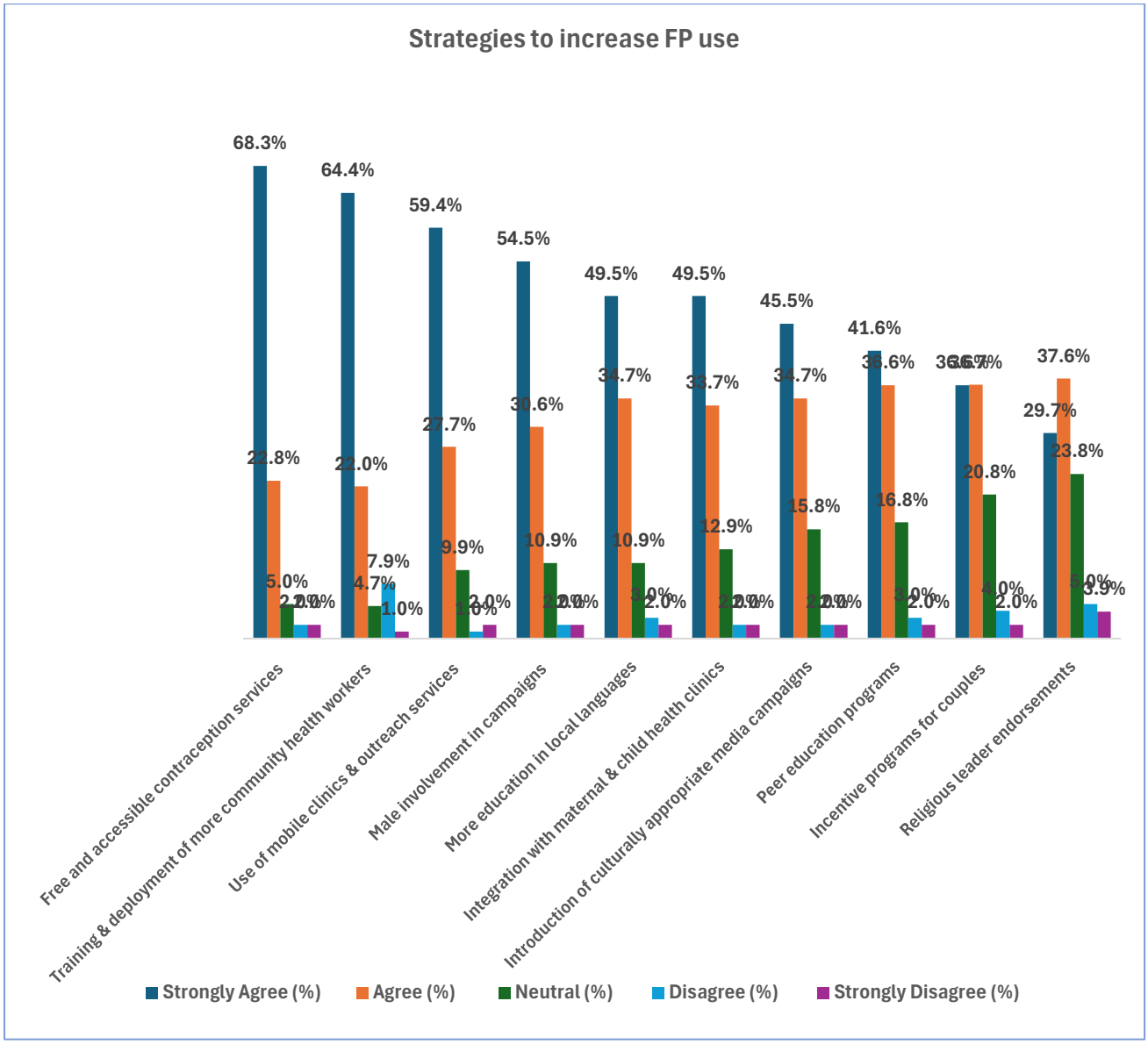
Figure 24: Resistance from family members on FP



The chart shows that over a quarter of respondents (25.7%) faced direct resistance from family members whilst majority (74.3%) did not face any such resistance regarding family planning use.

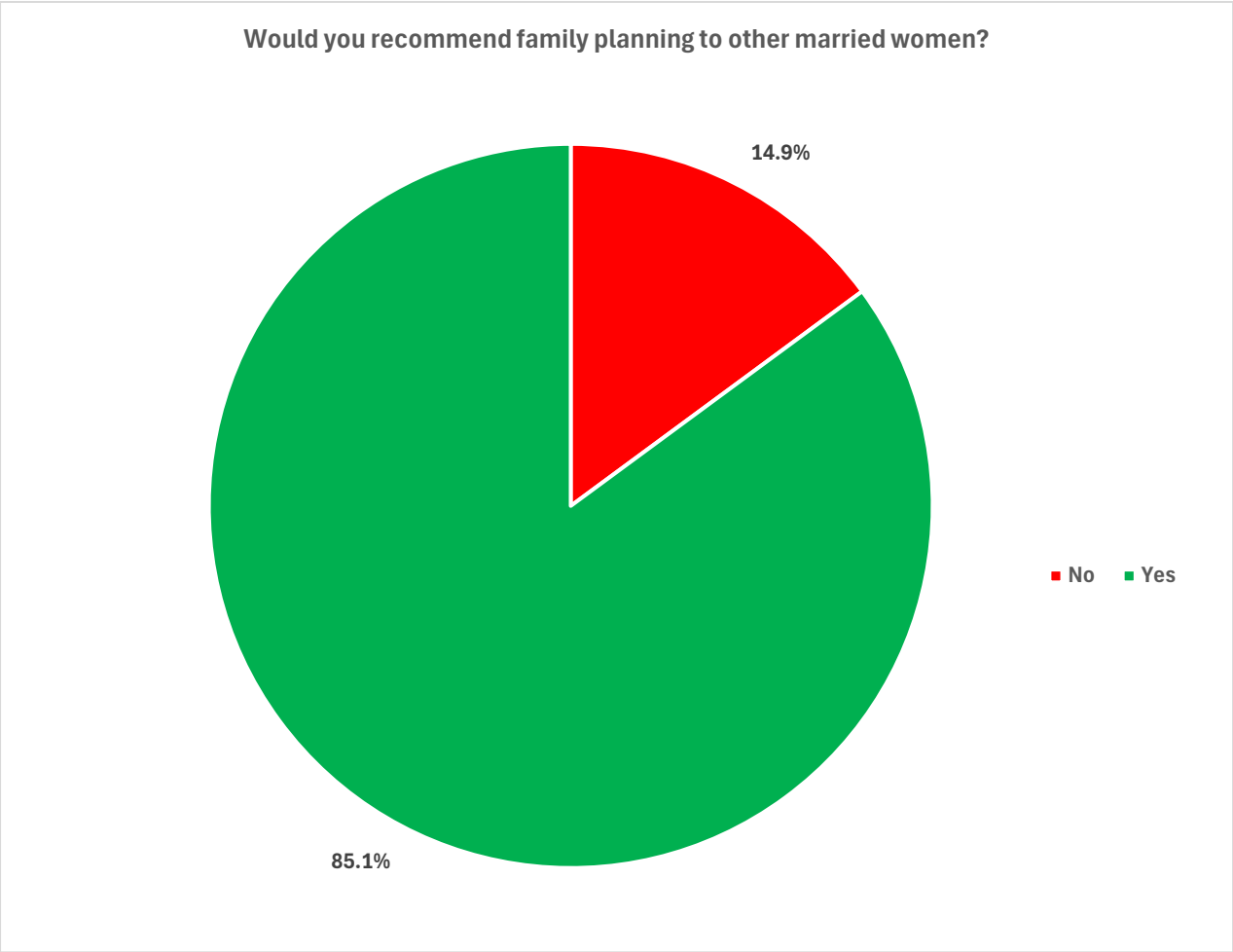
Suggestions for Improving Family Planning Acceptance

Figure 25: Strategies which could increase family panning usage in Awoshie-Market



This chart presents the level of agreement with suggested strategies for increasing family planning uptake on a 5-point Likert scale. Providing free services and training more community health workers (both mean=4.6) were the most strongly recommended strategies.

Figure 26: Data showing whether respondents will recommend FP to other married women



This chart shows a strong willingness among respondents (85.1%) to recommend family planning to others, indicating potential for peer-led advocacy.

4.2 Summary of Inferential Tests

Statistical tests revealed that religion had a significant association with the ever-use of family planning ($\chi^2 = 7.72$, $p = 0.005$). However, age group and education level were not statistically significant predictors. A logistic regression model confirmed that demographic variables like age, education, and number of children were poor predictors of use, explaining only 8.6% of the variance (Cox & Snell $R^2 = 0.086$). This underscores that non-demographic factors—such as social, cultural, and relational dynamics—play a more decisive role in family planning patronage in this community.

Table 1.1

Test	Statistic	df	p-value	Interpretation
χ^2 (Ever Used × Religion)	7.72	1	0.005	Significant
ANOVA (Ever Used by Age group)	F = 1.97	—	0.105	Not significant
Pearson r (Education vs Ever Used)	r = 0.063	—	0.531	Not significant

The table summarizes key inferential tests. It confirms a significant association between religion and FP use ($\chi^2 = 7.72$, $p = 0.005$), while age and education showed no significant relationship with usage.

Table 1.2 Logistic Regression Predicting Ever Use of Modern Family-Planning Method (N = 89)

-2 Log Likelihood	114.028
Cox & Snell R^2	0.086
Nagelkerke R^2	NA

Model χ^2 (df) & p-value	7.989 (5), p = 0.157

Variable	B (log-odds)	SE(B)	Z	P	Exp(B)	95% CI Lower	95% CI Upper
Const	-0.3789	1.2939	-0.293	0.770	0.685	0.054	8.647
Education cat	0.0828	0.3960	0.209	0.834	1.086	0.500	2.361
Num Children	0.0805	0.2245	0.359	0.720	1.084	0.698	1.683
age_35-44 years	0.7056	0.5936	1.189	0.235	2.025	0.633	6.482
age_45-54 years	0.2076	0.7064	0.294	0.769	1.231	0.308	4.914
age_55+ years	-1.4113	0.9596	-1.471	0.141	0.244	0.037	1.599

This model confirms that the included demographic variables (age, education, number of children) are poor predictors of family planning use, explaining only 8.6% of the variance (Cox & Snell $R^2 = 0.086$).

a) Converged Results and Meta-Inferences

The convergent parallel mixed-methods design combined quantitative survey data from the 101 married women in the sample with qualitative insights from the 10 key informant interviews. The integration of both data strands provides a multi-faceted understanding of the patterns and determinants of family-planning (FP) use within the studied population of married women in the Awoshie-Market community.

i) Areas of Convergence (Agreements) - Both the quantitative and qualitative data from this study revealed a consistent pattern: while awareness of modern FP methods is high among the 101 respondents, actual usage is moderate (56.4%) and is hindered by a common set of barriers.

The quantitative data disclosed that many respondents held misconceptions (56.4%), which was directly corroborated by qualitative accounts describing widespread myths linking contraceptives to infertility and health issues. Furthermore, both data sources identified fear of side effects and spousal disapproval as the most significant barriers to use, underscoring their primary influence on FP decisions within this sample.

ii) Areas of Divergence (Contradictions) - A notable divergence emerged regarding the influence of religion. The quantitative analysis of the 101 respondents indicated a statistically significant association between religious affiliation and FP use ($\chi^2 = 7.72$, $p = 0.005$). However, the qualitative interviews provided essential context, revealing that religious influence is not monolithic. Key informants explained that interpretations vary, with some leaders supporting FP for child spacing and others discouraging it. Thus, while the quantitative data flagged religion as a significant variable, the qualitative insights clarified that its impact is conditional and mediated by local leadership and interpretation, rather than being a straightforward barrier.

iii) Meta-Inferences - The integration of data from the 101 survey respondents and 10 key informants leads to the overarching conclusion that FP patronage in this community is not primarily limited by a lack of knowledge but by a complex interplay of social and relational dynamics. The decision to use FP occurs at the intersection of partner relations, peer influence, and personal experiences with side effects, all within a context where religious and cultural norms are actively interpreted and negotiated. Therefore, improving FP uptake requires strategies that move beyond information dissemination to address these deeply embedded social and interpersonal factors.

b) Trustworthiness and Assumptions

i) Qualitative Trustworthiness - The credibility of the qualitative findings was established through triangulation, gathering perspectives from a diverse range of 10 key informants,

including healthcare workers, religious leaders, and community figures. Member checking and verbatim transcription were employed to enhance the accuracy of the data. Dependability was ensured through a systematic process of thematic analysis. To support transferability, thick, contextual descriptions of the Awoshie-Market community were provided, allowing for judgments about the applicability of these insights to similar settings. Confirmability was maintained by documenting the analytic process and supporting themes with direct quotations from the informants.

ii) Quantitative Assumptions and Diagnostics - The quantitative analysis operated on the assumption that the sample of 101 married women was representative of the broader population of married women in the Awoshie-Market community. The statistical tests applied, including ANOVA and logistic regression, relied on assumptions of normality, independence, and homoscedasticity, which were assessed and deemed acceptable for this dataset. For categorical variables, non-parametric chi-square tests were used to minimize potential violations of distributional assumptions. Model diagnostics for the logistic regression, such as the non-significant model chi-square ($p = 0.157$), confirmed the model's adequacy, though the low explanatory power (Cox & Snell $R^2 = 0.086$) accurately reflects that the included demographic variables alone are poor predictors of FP use for this sample. This underscores the importance of the qualitative data in explaining the larger share of variance in FP behaviour.

4.3 Thematic Analysis of Qualitative Data

4.3.1 Awareness and Knowledge of Family Planning Methods

Findings indicate a high level of general awareness of modern family planning methods among married women within the Awoshie-Market community. All participants consistently reported that women in the community are knowledgeable about the existence of modern contraceptives.

A healthcare worker confirmed this, stating, "So for in Awoshie community, a lot of married women know about modern family planning Methods. Many know the types of contraceptives that we have around" (Participant 2, Healthcare Worker). This sentiment was echoed by the Market Queen, who noted that many married market traders were aware of "at least one modern method especially Pills, injectables and IUDs" (Participant 1, Market Queen).

However, this general awareness often lacks depth and is frequently intertwined with misinformation. While women know the names of methods, their understanding of how they work, their side effects, and their eligibility is often mediated by peer testimonies and myths. A community health nurse from Awoshie Zongo elaborated on a common misconception: "Most of the women there complained about not menstruating at all when they started taking the injectables. Some even discontinued use because they believed that the cessation of menstruation was because the drug was destroying their ovaries. Other women in the community believed the modern family planning methods especially the injectables were the cause of fibroid but this is not true" (Participant 8, Community Health Nurse).

Regarding the most discussed methods, injectables (specifically the three-month Depo-Provera) were overwhelmingly cited as the most preferred and requested. The primary reason for this preference, as identified by multiple respondents, is its discretion. Women choose injectables to conceal their use, especially from unsupportive husbands and family. A health worker explained, "They like that because that one, when you come into the family planning unit and they inject you, no one will know about it... But with the others such as the implants which can be felt on the arm though under the skin and the IUD which can shift if improperly inserted thus can make their husbands may ask many questions when they realise it" (Participant 2, Senior Nurse, Family Planning Unit). This highlights a critical finding: method choice is not solely based on medical efficacy but is a strategic decision influenced by social and relational dynamics.

4.3.2 Perceptions, Misconceptions, and their Impact on Patronage

Perceptions about family planning are a significant determinant of patronage, often acting as a more powerful influence than factual knowledge. Several pervasive misconceptions emerged from the data.

The most recurrent myth is the belief that modern contraceptives cause infertility. Medical personnel stated, "Yeah, most of them really think Using family planning probably when you decide to become pregnant again, it takes a while Like it's prone to infertility" (Participant 5, Medical Personnel). This fear of permanent loss of fertility discourages initiation and promotes early discontinuation.

Other common misconceptions include the belief that contraceptives cause fibroids, cancer, and other health complications like excessive weight gain and hypertension. As one health worker summarised, "Others who said, because like when they do the long method... they might not even get pregnant again when they do it" (Participant 2, Healthcare Worker). These perceptions are fuelled and sustained by powerful peer networks. The Market Queen confirmed this, noting that women are often afraid to visit the clinic "because of their peers' testimonies and perceptions about family planning" (Participant 1, Market Queen).

The role of religion in shaping perceptions is dualistic. For some, it provides a moral justification for rejecting FP. The Christian Minister noted that some congregants believe scripture mandates them to "multiply and fill the earth," and thus, "to curtail the number of children... is not that simple" (Participant 9, Christian Minister). Conversely, other religious interpretations support FP. The Muslim Sheikh authoritatively clarified that "family planning in Islam is not haram. It means that it is halal," provided it is for spacing children and not for preventing them permanently, and is based on mutual spousal consent (Participant 4, Sheikh

Adjei). This indicates that religious doctrine itself can be ambiguous, and its interpretation by local leaders significantly influences community perceptions.

4.3.3 Barriers to Family Planning Patronage

The analysis identified a complex web of barriers that impede the uptake and continued use of family planning services. These can be categorized into socio-cultural, structural, and gender-related barriers.

i) Socio-Cultural and Religious Barriers – While direct cultural prohibitions were less frequently cited, the preference for large families as a source of status and security persists. A healthcare worker noted, "Some traditional men want to have plenty of children. Because, when they have children, it's like they are men for having numerous children" (Participant 6, Healthcare Worker). Religious doctrine, as previously mentioned, can also be a barrier, particularly in conservative denominations where FP is framed as "interfering with divine will" (Participant 9, Christian Minister).

ii) Male Partner Influence and Gender Dynamics - This emerged as the most significant barrier. Male involvement is characterised by a spectrum from active opposition to passive or active support, with opposition being more commonly reported. Many women use contraceptives secretly to avoid spousal conflict. A health worker reported, "Most of them, when they do their implants... their husband has been dragging them back to the facility for us to remove it for them" (Participant 8, Community Health Nurse). The Christian Minister shared an extreme case where a husband threatened divorce after his wife adopted FP without his consent (Participant 9, Christian Minister).

However, a positive shift was also noted, linked to economic pressures. The Market Queen observed "rising testimonies of husbands encouraging wives... to opt for modern family

planning methods due to current economic situations" (Participant 1, Market Queen). This suggests that economic rationality can, at times, override cultural preferences for large families.

iii) Side Effects and Method-Related Concerns - The experience of, or fear of, side effects is a major reason for discontinuation. Commonly reported issues include irregular bleeding, weight gain, and dizziness. A healthcare worker stated simply, "Usually it comes with the side effects" (Respondent 5, Medical Personnel). For Muslim women, prolonged bleeding or spotting presents a unique barrier as it affects their ability to perform religious rituals. The Community Health Nurse from the Zongo community explained, "They can't pray five times a day... So, since you are menstruating, you don't have to go to mosques and pray. So that is what is causing the problem here" (Participant 8, Community Health Nurse).

iv) Structural and Service Delivery Barriers - While some health workers reported consistent commodity supply, others cited periodic stockouts. One health worker admitted, "for the past three months... we are not having commodities, so the women come in, and we tell them they should go back" (Participant 2, Healthcare Worker). Another critical service barrier is the attitude of some healthcare providers. The Political Party Women's Wing Leader explicitly cited the "negative attitudes of some medical staff at the Anyaa polyclinic" as a factor discouraging women from accessing services (Participant 7, Political Leader).

4.3.4 Strategies for Improving Family Planning Acceptance

Participants proposed several evidence-based strategies to enhance FP acceptance and usage, which align with development communication principles.

a) Intensified and Targeted Education and Awareness Campaigns - There was a unanimous call for more education to demystify FP and counter misinformation. Participants suggested this should be conducted in local languages and through diverse channels, including churches, mosques, schools, and community gatherings. A medical professional recommended "moving

from church to church to make them family planning awareness" (Participant 5, Medical Personnel). The Christian Minister proposed innovative use of social media algorithms to target married women with short, informative videos on platforms like Facebook and TikTok (Participant 9, Christian Minister). The Market Queen advocated for a media blitz akin to the COVID-19 campaign, stating it should be conducted *"vigorously just as it was done for covid-19 pandemic era in 2020" (Participant 1, Market Queen).

b) Strategic Engagement of Community and Religious Leaders - Involving opinion leaders is considered crucial for building trust and legitimacy. The Healthcare Worker (Participant, 2) suggested that involving leaders as stakeholders in FP campaigns would be effective because "the community members really listen to them." The Sheikh (Participant, 4) recommended equipping religious leaders with both religious and medical knowledge on FP so they can effectively counsel their congregations. The Queen Mother of Anyaa confirmed their active involvement, stating that traditional authorities are already engaged in FP education "during traditional gatherings and festivities such as Homowo" (Participant 10, Queen Mother).

c) Male Involvement Initiatives - A recurring recommendation was the need for male-targeted interventions. The Sheikh (Participant, 4) asserted that "if the men really accept the methods, I think it will be easier for the women to embrace it." The Christian Minister (Participant, 9) suggested targeting male-dominated spaces and groups like taxi drivers and barbers with FP messages in local dialects.

d) Improved Service Delivery and Provider Attitudes - To address structural barriers, informants recommended making services more user-friendly. This includes ensuring consistent commodity supply, offering free or highly subsidised services—"if it is free, maybe if the person is encouraged, they would accept it" (Participant 4, Sheikh Adjei)—and improving healthcare providers' attitudes. The Market Queen urged health personnel to "be patient

enough... to educate clients, willing to answer every question, clear doubts and misconceptions" (Participant 1, Market Queen).

e) Expanding the Target Audience - The Queen Mother introduced a critical perspective, advocating for programs to expand beyond married couples to include young, unmarried girls in Senior High Schools to mitigate teenage pregnancy, noting that "many of these age group are increasingly becoming sexually active" (Participant 10, Queen Mother)

4.4 Discussion of Key Findings

This section provides an in-depth discussion of the study's key findings, interpreting them through the lens of the established research objectives, the integrated theoretical framework (Health Belief Model, Theory of Planned Behaviour, and Diffusion of Innovations) and existing empirical literature. The convergent parallel mixed-methods design of this study yields a rich, multi-layered understanding of the determinants of family planning (FP) patronage among married women in Awoshie-Market area thus revealing not only “what” the patterns are but also portray “why” they continue.

4.4.1 Discussion of Objective One: Level of Awareness of Family Planning Methods

The first objective sought to examine the level of awareness of FP methods among married women in Awoshie. The quantitative data clearly demonstrates a high level of general awareness, with methods like pills (mean score=4.5/5), female condoms (4.4), and emergency contraceptive pills (4.4) being widely recognised. This finding aligns with national and regional data indicating that over 80% of Ghanaian women know at least one modern method (Ghana Health Service [GHS], 2024). The primary sources of information which is the health facilities (64.4%), television (43.6%), and social networks (friends/family: 38.6%) all suggest that both formal health systems and informal communication channels are effective channels for the dissemination of basic FP information.

However, the qualitative data crucially unpacks this high awareness, revealing a significant "awareness-acceptance gap" (Adjei et al., 2023). The thematic analysis reveals that awareness is often superficial and heavily contaminated with misinformation. For example, while women know the name "injectable," their understanding of its mechanism is often mediated by widespread myths, such as the belief that it causes fibroids or destroys ovaries, as reported by a Community Health Nurse. This finding resonates with the "knowledge-practice paradox" identified by Adjei et al. (2023), where high awareness coexists with strong negative beliefs. The superficial nature of awareness is further evidenced by the low knowledge of less common methods like diaphragms/spermicides (mean score=3.3), indicating that awareness campaigns have successfully promoted a narrow range of methods while leaving gaps in comprehensive contraceptive knowledge.

From a theoretical perspective, the Health Belief Model (HBM) posits that knowledge is a modifying factor, but not a direct driver, of behaviour (Champion & Skinner, 2021). This study's findings strongly support this: high awareness (knowledge) has not sufficiently motivated action because it has not effectively addressed the perceived barriers and threats. The data suggests that awareness campaigns have successfully achieved the "knowledge" stage in the Diffusion of Innovations (DOI) theory but have stumbled at influencing the "persuasion" stage, where individuals form a positive or negative attitude towards the innovation (Rogers, 2003). The qualitative findings show that the persuasion stage is dominated by peer testimonies and myths rather than clinical proof.

4.4.2 Discussion of Objective Two: Perception about Family Planning Methods

The second objective is aimed at ascertaining perceptions about FP methods. Quantitatively, perceptions were carefully positive, with 59.4% holding positive or very positive views, yet a significant 40.6% were neutral or negative. The qualitative data provides the narrative behind

these numbers, identifying a landscape of perception dominated by fear and suspicion. The most formidable perceptual barriers are the deeply entrenched fears of infertility, health issues (e.g., fibroids), and side effects like weight gain and excessive bleeding.

These perceptions are not formed in a vacuum but are socially constructed and reinforced through powerful interpersonal networks. As the Market Queen indicated, women are often afraid due to the “perceptions” and "testimonies” of their peers." This aligns with the concept of "subjective norms" in the Theory of Planned Behaviour (TPB), which refers to the perceived social pressure to perform or not perform a behaviour (Ajzen, 2020). In Awoshie-Market, the subjective norm, particularly among female peer groups, often carries a negative perception of modern contraceptives.

The role of religion in shaping perceptions is nuanced. While the quantitative data showed a significant association between religion and FP use ($\chi^2 = 7.72$, $p = 0.005$), the qualitative insights clarify that religious doctrine itself can be ambiguous. The interview with the Sheikh, who stated that FP is "halal" for spacing, contrasts with the Christian Minister's account of congregants who view it as contravening the command to "multiply." This demonstrates that it is not merely religious affiliation, but the “interpretation” and “emphasis of religious leaders—the opinion leaders in the DOI framework—that critically shape community perceptions (Rogers, 2003).

The perceived barriers construct of the HBM is overwhelmingly activated in this context. The fear of side effects (a perceived barrier) is so potent that it overrides the perceived benefits of FP, such as economic stability and improved maternal health. The finding that 72.3% of respondents agreed that side effects are a barrier, and 73.3% acknowledged that misconceptions hinder acceptance, directly reflects the power of these perceived threats to health and fertility, consistent with studies by Gyimah et al. (2023) and Biney (2021).

4.4.3 Discussion of Objective Three: Factors Influencing Decision on Family Planning

The third objective was to identify the social, economic, religious, and cultural factors influencing FP decisions. The mixed-methods data converge to paint a picture where interpersonal and systemic factors are more decisive than individual knowledge or demographics. The logistic regression model's low explanatory power (Cox & Snell R^2 = 0.086) powerfully underscores that demographic variables like age and education are poor predictors of use in this community. Instead, the salient factors are relational and systemic.

The most significant factor emerging from both data strands is male partner influence. Quantitatively, "husband/family disapproval" was the second most agreed-upon barrier (62.4%). Qualitatively, this is vividly illustrated by reports of men dragging their wives to clinics for implant removal and threats of divorce. This finding strongly validates the work of Odoi et al. (2023), who documented male dominance in 78% of reproductive decisions in Ghana. This aligns with the "subjective norms" of the TPB, where the most important reference i.e. the husband applies his immense impact. The practice of covert use of contraceptives, particularly discreet methods like injectables, is a strategic response by women to navigate this lack of "perceived behavioural control" over their reproductive health, a core construct of the TPB (Ajzen, 2020).

Beyond gender dynamics, systemic failures in service delivery act as critical barriers. Stockouts of commodities, reported qualitatively by health workers, directly erode access and trust. Furthermore, the negative attitudes of some healthcare providers, as cited by the Political Leader, constitute a significant structural barrier. This finding is consistent with Gyimah et al. (2023), who identified provider bias and poor patient-provider relationships as key service-level barriers in Greater Accra. When women muster the courage to seek services, encountering stockouts or hostile providers reinforces perceived barriers and diminishes self-efficacy.

Economic factors (58.4% agreement) and religious reasons (49.5%) also play a role. The qualitative data, however, revealed an interesting counter-narrative: the Market Queen observed that current economic hardships are leading some men to actively support FP, indicating that economic pressure can sometimes override cultural preferences for large families. This suggests that framing FP as a tool for economic empowerment could enhance its "relative advantage," a key attribute for adoption in the DOI theory (Rogers, 2003).

4.4.4 Discussion of Objective Four: Strategies for Increasing Family Planning Acceptance

The final objective explored strategies to increase FP acceptance. The proposed strategies from respondents and informants collectively advocate for a multi-faceted, communication-centric approach that directly addresses the identified barriers, aligning perfectly with development communication principles.

The top-rated quantitative strategies which is the provision of free and accessible services (mean=4.6) and the training more community health workers (mean=4.6) are direct responses to the structural and financial barriers. On the qualitative side, the call for improved provider attitudes and consistent commodity supply further underscores the need to strengthen the health system. This echoes recommendations from the World Health Organization (2018) on ensuring service readiness and quality.

The strong endorsement for "male involvement in campaigns" (mean=4.5) is a direct and logical response to the finding that spousal disapproval is a primary barrier. This strategy seeks to alter the "subjective norms" by making men part of the solution, an approach supported by Odoi et al. (2023). Likewise, the call for more education in local languages and a culturally appropriate media campaigns aims to deepen shallow awareness and counter misinformation at the community level thus facilitating the "persuasion" stage in the DOI process.

The strategic engagement of religious and community leaders, while having a slightly lower mean score (4.0), was emphasized qualitatively as crucial for building legitimacy and trust. As the Sheikh recommended, equipping these "opinion leaders" with accurate information allows them to become agents of change, potentially reframing FP from a foreign imposition to a pro-family health practice. This leverages the core tenet of DOI theory which says that diffusion is most effective through respected, homophile individuals within a social system (Rogers, 2003). The Queen Mother's suggestion to expand FP education to unmarried adolescents is a forward-thinking strategy that recognizes the need for early, self-protective education, addressing future needs beyond the current study population.

In conclusion, the discussion of these four objectives, informed by the mixed-methods data, reveals that the challenge of low FP patronage in Awoshie-Market is not a simple problem of information deficit. It is a complex issue rooted in a nexus of gendered power relations, culturally embedded misconceptions, and systemic health service failures. The integrated HBM, TPB, and DOI framework provides a strong explanation: women perceive high barriers and low behavioural control, within subjective norms that are often unsupportive, and where the innovation of modern FP has not been effectively communicated and legitimized by trusted community channels. Therefore, the path forward requires integrated interventions that concurrently empower women, engage men and leaders, improve service quality, and deploy culturally intelligent communication to reshape perceptions and social norms around family planning.

4.5 Summary

This chapter has presented, analysed, and integrated findings from both quantitative and qualitative strands of the study. The convergence of results demonstrates that while awareness of modern FP methods is high among married women in Awoshie-Market, actual usage is

constrained by socio-cultural beliefs, partner approval, misconceptions, and systemic barriers. The mixed-methods approach revealed the interplay between measurable trends and lived experiences, emphasizing that behavioural and relational factors are as critical as access and information.

The next chapter (Chapter Five) will interpret these findings within the frameworks of the Health Belief Model, Diffusion of Innovations Theory, and Theory of Planned Behaviour, drawing connections between observed patterns and theoretical expectations. It will further discuss implications for policy, community engagement, and communication strategies aimed at improving family-planning patronage among married women in Awoshie-Market

4.6 Conclusion

The analysis presented in this chapter culminates in a clear and nuanced understanding of family planning patronage in Awoshie-Market. The convergent mixed-methods approach was instrumental in revealing that high awareness of modern methods does not directly translate to high usage. The central finding is the awareness-acceptance gap, where knowledge is mediated and often negated by a powerful undercurrent of misconceptions, fear of side effects, and significant spousal influence.

The quantitative data precisely quantified this gap, the prevalence of myths, and the primary barriers, while the inferential statistics decisively shifted focus away from demographics to more complex predictors. The qualitative narratives gave voice to these numbers, exposing the strategic, and often secretive, ways women navigate reproductive decisions within constraining social and gender dynamics.

The meta-inference drawn from this integration is that the challenge is not one of information deficit but one of socio-relational acceptance. Therefore, improving patronage requires a paradigm shift from mere information dissemination to targeted development communication

strategies that actively involve men, empower women, collaborate with trusted community and religious leaders, and simultaneously address systemic health service failures to rebuild trust and reduce perceived barriers. The following chapter will translate these critical findings into actionable recommendations and a concluding summary for the entire study.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter presents the final section of the research study, providing a summary of the whole research, from the foundational problems to the key findings. It joins the major conclusions drawn from the integrated analysis of both quantitative and qualitative data, addressing the research objectives and questions that guided the study. Moreover, this chapter translates the empirical insights into actionable recommendations directed at policymakers, healthcare providers, development communicators, and community stakeholders. Finally, it advocates productive avenues for future research to build upon the findings of this study. The aim of this chapter is to link the gap between research and practice, offering a clear, evidence-based pathway for improving family planning patronage and reproductive health outcomes among married women in Awoshie-Market and similar peri-urban communities in Ghana.

5.1 Summary of the Study

The study was motivated by the persistent gap between high awareness and low usage of modern family planning (FP) methods in Ghana, a paradox acutely observed in urban-poor enclaves like the Awoshie-Market community. The research was anchored on the topic: "Level of Patronage of Family Planning Methods Among Married Women – A Study of Awoshie-Market Community." The prime objective was to examine what determines low family planning patronage among married women in Awoshie-Market and recommend evidence-based strategies for improving contraceptive acceptance. With the four objectives serving as guidance, the study sought to:

1. Examine the level of awareness of FP methods.

2. Ascertain perceptions about FP methods.

3. Identify the social, economic, religious, and cultural factors influencing FP decisions.

4. Explore ways of increasing FP acceptance.

A convergent parallel mixed-methods design was employed, concurrently collecting quantitative data from 101 married women via a structured survey and qualitative data from 10 key informants via in-depth interviews. The study was supported by an integrated theoretical framework combining the Health Belief Model (HBM), the Theory of Planned Behaviour (TPB), and the Diffusion of Innovations (DOI) theory, which provided a multi-dimensional lens for analysing data.

Key findings, detailed in Chapter Four, revealed a significant disconnect between knowledge and practice. While awareness of modern methods was high (e.g., Pills: 4.5/5 mean score), actual usage was only 56.4%. This "awareness-acceptance gap" was primarily driven by persistent misconceptions (56.4% of respondents held at least one misconception), an overwhelming fear of side effects (the top barrier at 72.3% agreement), and considerable spousal disapproval (62.4% agreement). Inferential statistics confirmed that demographic variables such as age and education were poor predictors of FP use, highlighting the greater influence of socio-relational and systemic factors. Qualitative insights enriched these findings, exposing the deep-seated myths about infertility and health risks, the strategic use of discreet methods to navigate male opposition, and the critical role of service delivery issues like commodity stockouts and provider attitudes.

5.2 Key Findings

The analysis yielded the following key findings, structured according to the research objectives:

1. Level of Awareness - There is a high level of superficial awareness of common modern FP methods (pills, injectables, condoms) among married women in Awoshie-Market, primarily sourced from health facilities and television. However, this awareness is narrow, corrupted with misinformation, and marked by significant knowledge gaps concerning less common methods like diaphragms and spermicides.

2. Perceptions about Family Planning - Perceptions are cautiously positive but are heavily overshadowed by deep-seated fears and misconceptions. The most potent myths include the belief that FP causes infertility, fibroids, cancer, excessive bleeding, and weight gain. These perceptions are socially constructed and reinforced through powerful peer networks and varying interpretations of religious doctrines.

3. Influencing Factors - The decision to use FP is predominantly influenced by a complex interplay of socio-relational and systemic factors, rather than individual demographics.

Socio-Cultural - Male partner influence is the most significant social barrier, with many women requiring spousal consent or using methods secretly in other to avoid conflict.

4. Religion - Religious affiliation has a significant association with use however, its impact is facilitated by the interpretations of local religious leaders, with some supportive and others discouraging.

5. Economic: Financial constraints are a barrier, but economic pressures are also beginning to motivate some men to support FP for smaller family sizes.

6. Service Delivery Challenges - Periodic stockouts of commodities and negative attitudes from some healthcare providers, further hinder access and trust.

7. Strategies for Improvement - Respondents strongly endorsed multi-faceted strategies which includes:

i) Providing free and accessible services as well as training more community health workers.

ii) Actively involving men in FP campaigns and education.

iii) Conducting intensified and culturally appropriate education in local languages to dispel myths.

iv) Strategically engaging religious and community leaders as advocates and legitimizers of FP.

v) Improving service delivery by ensuring reliable supply of modern FP products and fostering positive provider attitudes.

5.3 Conclusion

Established on the synthesis of the study's findings, the following conclusions are drawn:

i) The primary challenge to family planning patronage in Awoshie-Market is not a lack of information but a crisis of acceptance, characterized by an "awareness-acceptance gap."

ii) The fear of side effects and pervasive misconceptions act as a more powerful deterrent to FP use than factual knowledge acts as an enabler.

iii) Male dominance in reproductive decision-making is a pivotal factor, often forcing women into either clandestine use or a complete non-usage of contraceptives, thus severely limiting their reproductive independence.

iv) The influence of religion and culture is not absolute but is interpreted and enforced by local opinion leaders (clerics, traditional leaders), making their engagement crucial for shifting social norms.

v) Systemic weaknesses in the health service delivery chain, such as stockouts and poor client-provider interactions, exacerbate perceived barriers and erode trust in the public health system.

vi)A singular approach is ineffective. Improving FP patronage requires an integrated, development communication-driven strategy that simultaneously empowers women, engages men and leaders, improves service quality, and deploys targeted communication to reshape perceptions.

5.4 Recommendations

To address identified barriers and enhance family planning patronage within the Awoshie-Market community the following evidence-based recommendations are proposed:

a) Policy guidance from the Ghana Health Service, Ministry of Health and Accra Metropolitan Assembly

1. Integrate Male Engagement into FP Policy: Develop and fund national and metropolitan policies that mandate and outline strategies for male-inclusive FP programming, such as creating "male-friendly" corners in health facilities and conducting outreach in male-dominated spaces.

2. Decentralize and Strengthen Logistics: Policy should prioritize and fund robust, decentralized supply chain systems to eliminate perennial stockouts of contraceptives at the community level, particularly in peri-urban clinics.

3. Incentivize Community-Based Health Workers: Formalize and provide sustainable incentives for Community Health Workers (CHWs) and volunteers to serve as the primary link

for FP education, referral, and even distribution of certain methods within hard-to-reach communities.

b) Recommendations for Practice (Healthcare Providers, NGOs, Development Communicators)

1. Implement targeted myth-busting campaigns - Health promotion units and Non-Governmental Organisations (NGOs) should design communication campaigns that directly address the top misconceptions such as infertility, fibroids and weight gain using testimonials from satisfied users, clear infographics, and messages delivered in Ga, Twi, Ewe and the likes through local radio outlets and social media.

2. Build Capacity of Opinion Leaders - Organize regular sensitization workshops for religious leaders (Pastors, Imams) and traditional authorities particularly Queen Mothers and Assembly Members on the health and economic benefits of FP, equipping them with both theological and medical arguments to support informed spousal dialogue.

3. Revamp Interpersonal Communication at health facilities - Train healthcare providers on client-centred counselling and positive attitude. This includes ensuring counselling is conducted in the client's preferred language and creating a non-judgmental atmosphere that encourages questions and addresses fears.

4) Promotion of a wider method options – campaigns and education should move beyond the heavy promotion of only injectables and pills. Actively educate women about the full range of methods, especially Long-Acting Reversible Contraceptives (LARCs) like implants and IUDs, emphasizing their efficacy, convenience, and subtle nature.

c) Recommendations for Future Research

1) Specific Studies of Husbands/Male partners - Future research should directly investigate the knowledge, attitudes, and specific concerns of husbands in Awoshie-Market community regarding family planning to design more effective male engagement interventions.

2) Longitudinal Study on method discontinuation - A follow-up study should be done to track women who initiate a modern FP method to understand the specific reasons and triggers for discontinuation. This would provide deeper insights for improving continuation rates.

3) Expanded Geographical Scope – A similar mixed-methods research should be repeated in other peri-urban communities across different regions of Ghana to compare determinants and develop a more nuanced national strategy.

5.5 Contribution to Knowledge

The study makes significant contributions to the body of knowledge because it:

1. It provides community-specific, contemporary evidence on the determinants of FP patronage in Awoshie-Market community, a peri-urban enclave that has been play down in existing research, which often generalizes urban data or focuses on rural settings.

2. By employing a convergent parallel mixed-methods design, the study offers a more universal and nuanced understanding of the FP landscape, demonstrating the critical value of integrating statistical trends with lived experiences.

3. The study successfully operationalizes an integrated theoretical framework (HBM, TPB, DOI) to explain FP behaviour, demonstrating how individual perceptions, social norms, and innovation dynamics interact to influence health decisions in a Ghanaian context.

4. It highlights economic pressure as an emerging promoter for male support of FP, an outcome that offers a new and pragmatic angle for framing FP messages to men.

5. The research underscores the critical role of development communication as the thread that binds technical FP solutions with community acceptance, emphasising that communication is not just about messaging but about facilitating dialogue, building trust, and engaging social systems.

REFERENCES

Accra Metropolitan Assembly. (2024). Annual Action Plan 2024. Accra, Ghana: Author.

Adjei, P., Mensah, K., & Asante, R. (2023). Knowledge versus practice: The family planning paradox in urban Ghana. Journal of Health, Population and Nutrition, 41(1), 12.

Ahmed, S., Li, Q., Liu, L., & Tsui, A. O. (2022). Maternal deaths averted by contraceptive use: An analysis of 172 countries. The Lancet Global Health, 10(2), e227–e235.

Ajzen, I. (2020). The theory of planned behavior: Frequently asked questions. Human Behavior and Emerging Technologies, 2(4), 314–324.

Ajzen, I., & Fishbein, M. (1980). Understanding attitudes and predicting social behaviour. Prentice Hall.

Amo-Adjei, J., & Darteh, E. K. M. (2023). Understanding barriers to modern contraceptive use in Ghana. African Population Studies, 37(1), 1–14.

Anarfi, J. K. (2003). Reproductive health in urban Ghana: Policies, programs and research issues. Institute of Statistical, Social and Economic Research.

Arevalo, M., Jennings, V., & Sinai, I. (2002). Efficacy of a new method of family planning: The Standard Days Method. Contraception, 65(5), 333–338.

Association for Reproductive and Family Health (ARFH). (2012). Knowledge and utilization of spermicides among women of reproductive age in selected states in Nigeria. ARFH Publications.

Aziato, L., Kyei, A. A., & Deku, G. (2016). Experiences and reasons for accepting or declining female sterilization among Ghanaian women. International Journal of Women's Health, 8, 31–39.

Becker, M. H. (1974). The health belief model and personal health behaviour. Health Education Monographs, 2(4), 324–508.

Benova, L., Dennis, M. L., & Campbell, O. M. R. (2021). Family planning service readiness in low- and middle-income countries: A systematic review. PLOS Medicine, 18(6), e1003649.

Biney, A. A. E. (2021). Community perspectives on family planning in Ghana. Journal of Health Research, 15(2), 45–60.

Burke, H. M., Mueller, M. P., Packer, C., Perry, B., Bufumbo, L., Mbengue, D., … & Gilles, K. (2017). Provider acceptability of Sayana Press: Results from community health workers and clinic-based providers in Uganda and Senegal. Contraception, 95(1), 87–93.

Centers for Disease Control and Prevention (CDC). (2020). US medical eligibility criteria for contraceptive use, 2016. MMWR Recommendations and Reports, 65(No. RR-3).

Champion, V. L., & Skinner, C. S. (2021). The health belief model. In K. Glanz, B. K. Rimer, & K. Viswanath (Eds.), Health behaviour: Theory, research, and practice (6th ed., pp. 75–94). Jossey-Bass.

Cleland, J., Conde-Agudelo, A., Peterson, H., Ross, J., & Tsui, A. (2012). Contraception and health. The Lancet, 380(9837), 149–156.

Creswell, J. W., & Creswell, J. D. (2018). Research design: Qualitative, quantitative, and mixed methods approach (5th ed.). SAGE Publications.

Creswell, J. W., & Plano Clark, V. L. (2018). Designing and conducting mixed methods research (3rd ed.). SAGE Publications.

Ghana Health Service (GHS). (2023). National family planning programme report.

Ghana Health Service (GHS). (2024). National family planning performance report 2023–2024.

Ghana Health Service (GHS), Family Health Division. (2020). National reproductive health service policy and standards (4th ed.).

Ghana Statistical Service (GSS). (2023). Ghana Demographic and Health Survey 2022: Key indicators report.

Ghana Statistical Service (GSS). (2024). Ghana Demographic and Health Survey 2024: Key indicators report.

Ghana Statistical Service (GSS). (2024). Ghana 2024 population and housing census: Preliminary report.

Ghana Statistical Service (GSS), Ghana Health Service (GHS), & ICF International. (2015). Ghana Demographic and Health Survey 2014.

Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: Systematic review and recommendations. Milbank Quarterly, 82(4), 581–629.

Gyimah, A. A., Appiah, Y., & Okyere, J. (2023). Barriers to contraceptive use in urban Ghana: A qualitative study. PLOS Global Public Health, 3(4), e0001589.

Hubacher, D., Olawo, A., Manduku, C., & Kiarie, J. (2017). Factors associated with uptake of the levonorgestrel-releasing intrauterine system among women presenting for contraception in Nairobi, Kenya. Contraception, 96(3), 187–192.

Jacobstein, R. (2018). Liftoff: The blossoming of contraceptive implant use in Africa. Global Health: Science and Practice, 6(4), 694–710.

Kabagenyi, A., Jennings, L., Reid, A., Nalwadda, G., Ntozi, J., & Atuyambe, L. (2016). Use of traditional and modern family planning methods in Uganda: A comparative analysis. Journal of Biosocial Science, 48(5), 613–632.

Kennedy, K. I., Rivera, R., & McNeilly, A. S. (1996). Consensus statement on the use of breastfeeding as a family planning method. Contraception, 39(1), 1–13.

Manortey, S., Boateng, J., & Addai, E. (2020). Traditional family planning practices among women in Ashaiman, Ghana. African Health Sciences, 20(4), 1851–1861.

MIIRAP. (2011). Increasing access to female condoms in Uganda: Lessons learned from the Female Condom Project (2007–2011). Ministry of Health Uganda & PATH.

Mothiba, T. M., & Moabi, R. D. (2023). Determinants of family planning use in Johannesburg: A cross-sectional study. African Journal of Primary Health Care & Family Medicine, 15(1), e1–e8.

Nukpe, E., Darteh, E. K., & Ahinkorah, B. O. (2023). Religious barriers to family planning in Ghana. Journal of Biosocial Science, 55(1), 168–182.

Nukpe, E., Daketsey, A., & Baku, E. (2023). Religious and cultural barriers to contraceptive use in urban Ghana. African Journal of Reproductive Health, 27(2), 34–47.

Obare, F., & Kabiru, C. W. (2023). Gender norms and family planning use in Kenyan informal settlements. Social Science & Medicine, 310, 115307.

Ochako, R., Mbondo, M., Aloo, S., Kaimenyi, S., Thompson, R., Temmerman, M., & Kays, M. (2015). Barriers to modern contraceptive methods uptake among young women in Kenya: A qualitative study. BMC Public Health, 15, 118.

Odoi, A., Amoako-Sakyi, D., & Boah, M. (2023). Male involvement in family planning in Ghana. Culture, Health & Sexuality, 25(1), 1–17.

Ojule, J. D., Oriji, V. K., & Georgewill, K. N. (2010). Knowledge, attitude and practice of vasectomy as a method of contraception amongst married men in Port Harcourt, Nigeria. Nigerian Journal of Medicine, 19(4), 428–431.

Peterson, H. B., Xia, Z., Hughes, J. M., Wilcox, L. S., Taylor, L. R., & Trussell, J. (1996). The risk of pregnancy after tubal sterilization: Findings from the U.S. Collaborative Review of Sterilization. American Journal of Obstetrics and Gynecology, 174(4), 1161–1170.

Rogers, E. M. (2003). Diffusion of innovations (5th ed.). Free Press.

Rosenstock, I. M. (1974). Historical origins of the health belief model. Health Education Monographs, 2(4), 328–335.

Setia, M. S. (2016). Methodology Series Module 3: Cross-sectional Studies. Indian Journal of Dermatology, 61(3), 261–264.

Tavakol, M., & Dennick, R. (2011). Making sense of Cronbach's alpha. International Journal of Medical Education, 2, 53–55.

Tongco, M. D. C. (2007). Purposive sampling as a tool for informant selection. Ethnobotany Research and Applications, 5, 147–158.

APPENDIX

Questionnaire

Target Respondents: Married Women within Awoshie-Market Community

Topic: Level of Patronage of Family Planning Methods Among Married Women – A Study of Awoshie-Market Community

Introduction

This questionnaire forms part of an academic research project being conducted by a postgraduate student at the University of Media, Arts and Communication (UniMAC), Accra–Ghana. The aim of the study is to examine the level of awareness, perceptions, and factors influencing the patronage of family planning methods among married women in the Awoshie-Market community, as well as to identify strategies for improving acceptance.

Your participation in this study is voluntary. You have the right to refuse to answer any question or to withdraw from the study at any time without facing any penalty. There are no risks associated with participating in this research. **The information you provide will be kept strictly confidential and used only for academic purposes. Your responses will be held in anonymity (i.e., no names or personal identifiers will be recorded).**

The questionnaire will take approximately 15 minutes to complete. By proceeding to answer the questions, you are providing your informed consent to participate in the study. If you have any questions or concerns about the research, you may contact the researcher before or during your participation.

Thank you for taking time to partake in this important study.

Instructions:

Please answer all questions honestly. Your responses will remain confidential.

Tick (✓) the appropriate box or write your answer where applicable.

Section A

1. Demographic Information

Age Group:

☐ Below 25 years

☐ 25–34 years

☐ 35–44 years

☐ 45-54 years

☐ Above 54 years

2. What is your Level of Education?

☐ No formal education

☐ Basic Education

☐ Secondary Education

☐ Tertiary Education

3. Your Occupation

☐ Unemployed

☐ Self-employed

☐ Employed in the Public Sector

☐ Employed in the Private Sector

4. How many children do you have?

☐ No child

☐ 1–2

☐ 3–4

☐ 5 or more

5. What is your Religious Affiliation?

☐ Christian

☐ Muslim

☐ Traditionalist

☐ Other (specify): _____

Section B: Awareness of Family Planning Methods

6. Are you aware of any modern family planning methods?

☐ Yes

☐ No → If No, skip to Section C.

7. What is your main source of information about family planning (Tick all that apply)

☐ Health facility/clinic

☐ Radio

☐ TV

☐ Friends/Family

☐ Religious Leaders

☐ Community health workers

☐ Social Media

☐ Other (specify): _____

8. The following are types of modern methods commonly used by people. To what extent are you aware of these types of modern family planning methods using a scale of 1 to 5, where 5=Very Highly Aware (VHA), 4=Highly Aware (HA), 3=Moderately Aware (MA), 2=Lowly Aware (LA), and 1 =Very Lowly Aware (VLA)?

Type of Family Panning Method	**VHA**	**HA**	**MA**	**LA**	**VLA**
Pills					
Injectables (e.g., Depo-Provera)					
Implants (e.g., Jadelle)					
Intrauterine Device (IUD)					
Female condoms					
Sterilization (Tubal ligation/Vasectomy)					
Emergency Contraceptive Pills e.g., Postinor Two					

Diaphragms/spermicides					

Section C: Perceptions About Family Planning

9. Have you ever used a modern family planning method?

☐ Yes

☐ No

10. If yes to question 9, which method(s) have you used? (Tick all that apply)

☐ Pills

☐ Injectables

☐ Implants

☐ IUD

☐ Condoms

☐ Other (specify): _____

11. How do you generally perceive family planning?

☐ Very positive (improves health/finances)

☐ Positive (but with concerns)

☐ Neutral

☐ Negative (due to side effects/myths)

☐ Very negative (against religious/cultural beliefs)

12. Do you have any misconceptions about family planning?

Yes ☐ No ☐

13. Do misconceptions about family planning hinder its acceptance among married women?

Yes ☐ No ☐

14. Family planning methods cause infertility among married women.

Yes ☐ No ☐

15. The use of modern family planning methods causes health issues.

Yes ☐ No ☐

16. The use of modern family planning methods causes cancer

☐ Yes No ☐

17. The use of modern family planning methods causes weight gain

☐ Yes No ☐

18. The use of modern family planning methods causes excessive bleeding

☐ Yes No ☐

19. The use of modern family planning methods causes bareness

☐ Yes No ☐

20. Does the use of modern family planning methods go against religious beliefs?

Yes ☐ No ☐

21. Does the use of modern family planning methods go against cultural beliefs?

Yes ☐ No ☐

22. Do you believe family planning is beneficial for married women?

☐ Strongly agree

☐ Agree

☐ Neutral

☐ Disagree

☐ Strongly disagree

Section D

Factors Influencing Family Planning Use Among Married Women

23. The following are factors influencing family planning use among married women. Please, indicate whether or not you agree to these factors as influencing your use of family planning methods using a scale of 1 to 3, where 3=Agree (A), 2=Neutral (N), 1=Disagree (D).

Factors influencing family planning use	A	N	D
Side effects			
Husband/family disapproval			
Religious reasons			
Cultural beliefs			
Desire to get pregnant			
Financial factors			
Knowledge of the use			

24. What is the level of your family's support for family planning?

☐ Very strong support

☐ Strong support

☐ Moderate support

☐ Low support

☐ Very low support

25. Have you ever faced resistance from family members regarding family planning?

☐ Yes

☐ No

Section E: Suggestions for Improving Family Planning Acceptance

26. The following are strategies which could increase family planning usage in Awoshie-Market? Please, indicate whether or not you agree to these strategies to improve the use of family planning methods using a scale of 1to 5, where 5= Strongly Agree (SA), 4= Agree (A), 3= Neutral (N), 2= Disagree (D) and 1= Strongly Disagree (SD)

Suggestions for Improving Family Planning Acceptance	**SA**	**A**	**N**	**D**	**SD**
More education in local languages					
Male involvement in campaigns					
Free and accessible contraception services					
Religious leader endorsements					
Peer education programs					
Training and deployment of more community health workers to provide					

family planning services.					
Incentive programs for couples who adopt family planning methods.					
Integration of family planning services with maternal and child health clinics.					
Use of mobile clinics and outreach services in marketplaces and densely populated areas.					
Introduction of culturally appropriate drama and media campaigns (radio, TV, social media) to promote family planning.					

27. Would you recommend family planning to other married women?

☐ Yes

☐ No

THANK YOU.

INFORMANT INTERVIEW GUIDE

Target: Healthcare providers and community leaders.

Objective: To explore systemic, cultural, religious, and institutional factors influencing family planning awareness, perceptions, and usage among married women in Awoshie-Market, and to identify practical strategies to enhance acceptance.

Research Topic:

Level of Patronage of Family Planning Methods Among Married Women – A Study of Awoshie-Market Community

Introduction:

This interview forms part of an academic research project conducted by a postgraduate student at the University of Media, Arts and Communication (UniMAC), Accra. The study seeks to explore systemic, cultural, and institutional factors influencing family planning usage among married women in the Awoshie-Market community, with the aim of identifying effective strategies to increase acceptance and utilisation.

Your participation is entirely voluntary. You may decline to answer any question or withdraw from the interview at any point without consequence. The interview is expected to last 45 minutes. With your consent, the discussion may be audio-recorded for accuracy, but all recordings and notes will be kept secure and confidential. Your name or identity will not appear in any report, publication, or presentation of the findings; only aggregated or anonymised information will be utilised.

There are no direct personal benefits to you for participating, but your insights will contribute to improving family planning programs in the community. There are also no anticipated risks beyond the sharing of your professional or community perspectives.

By agreeing to proceed, you are giving your informed consent to take part in this interview. Should you have any questions before, during, or after the interview, you are encouraged to ask the researcher.

Thank you for your valuable contribution to this research.

Section A: Awareness and Perceptions

1. How would you describe the current level of awareness of modern family planning methods among married women in Awoshie-Market?

Explore: Are women generally knowledgeable about available options (pills, injectables, implants, IUD, etc.)?

2. Which family planning methods do you think are most discussed or requested by women?

Explore: Which methods are least preferred and why?

3. What are some common myths or misconceptions you have heard about family planning in this community?

Explore: How do these misconceptions affect acceptance and usage?

Section B: Barriers to Use

4. In your opinion, what are the main reasons married women avoid or discontinue the use of family planning?

Explore: Religious beliefs? Husband's disapproval? Side effects? Financial concerns?

5. How does male involvement influence family planning decisions?

Explore: Do men usually support or oppose family planning? Do men accompany their wives to clinics? Are there any male-focused educational initiatives?

6. Are there any cultural or traditional beliefs in the Awoshie-Market community that discourage family planning?

Explore: How strong is the influence of these beliefs on decision-making?

7. What service delivery challenges do healthcare providers face when offering family planning services?

Explore: Issues like stockouts, language barriers, cost, stigma, or staff attitudes?

Section C: Strategies for Improvement

8. From your experience, which strategies or programs have been successful in increasing family planning awareness and usage in Awoshie?

Explore: Health education, peer programs, media campaigns, religious leader involvement?

9. How can religious and community leaders contribute more effectively to family planning education and acceptance?

10. What new policy or program interventions would you recommend improving the uptake of family planning among married women in this community?

Explore: Free services, male involvement campaigns, education in local languages?

11. Do you have any additional comments or suggestions on how family planning acceptance can be improved in Awoshie-Market?

Closing

Thank you for your time and valuable insights.