

Original Research Article

Factors Influencing the Utilisation of Family Planning contraceptives among Men and Women in the Ho Municipality of Ghana

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ABSTRACT

Objective: The aim of this study was to investigate factors influencing contraceptive use among men and women in the Ho Municipality in the Volta Region, Ghana.

Materials and Methods: This study was a cross-sectional survey. A total of 340 respondents, men and women were randomly selected from the sub-municipalities in Ho for the study. The tool for data collection included structured questionnaires. Data were collected on socio-demographics and barriers to contraceptives use. Data were analyzed using SPSS version 15.0 software. The Chi-square test was used to determine the statistical association ($P < 0.05$) of demographic characteristics and the utilisation of family planning contraceptives

Findings: The results show that the socio-demographic characteristics of respondents associated with contraceptives use were age ($P = 0.04$), educational status ($P = 0.05$), religious denomination ($P = 0.02$) and marital status ($P = 0.03$). Also, the barriers to contraceptives use in this study included partner's disapproval, religious and cultural beliefs, poor quality of service and poor attitudes of health workers, side effects of some contraceptives, lack of means of transport, lack of sexual satisfaction when using contraceptives and forgetfulness to use contraceptives during sexual intercourse.

Conclusion: In conclusion, there is the need for nurses and other health workers to continuously educate people about the importance of contraceptives use in order to disabuse the misconceptions people hold about contraception. It is also important for family planning services providers to extend services to both men and women in the reproductive age in the Ho municipality.

Key words: Factors, Influencing, Contraceptive Use, Men and Women.

INTRODUCTION

The right to life and health is a basic human right and therefore, all should be guaranteed the right to a healthy reproductive life. Reproductive life implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce, and the freedom to decide if, when, and how often to do so. Implicit in this are the rights of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and the right to appropriate health care

services that enable women to safely go through pregnancy and childbirth.^[1]

Modern contraceptives allow individuals and couples to anticipate and attain their desired number of children, and to space and time their births. Pregnancy should be by choice not by chance. The ability to decide freely and responsibly the number and spacing of one's children is recognized internationally as a human right.^[2] This is achieved through the use of contraceptive methods and the treatment of involuntary infertility. The World Health Organization indicated that two-thirds

(2/3) of unplanned pregnancies in developing countries occur among women who do not use any method of contraception at all. [3]

Research studies suggest that effective contraceptive uptake prevents an estimated 2.7 million infant and maternal deaths and the loss of 60 million of healthy life in a year. [4,5] Moreover, investing in family planning as a component of good reproductive health has social and economic benefits for global development goals. However, despite persistent advocacy urging the use of modern contraceptive methods for family planning, the fertility rates in most sub-Saharan African countries still remain unacceptably high, mostly due to poor uptake of contraception because of cultural, economic and political barriers. [6,7]

According to Adusu, unplanned pregnancies are common in Ghana. [8] The study states that more than 16 % of all pregnancies that occur in Ghana are unplanned while 24% were mistimed (wanted later). He found out that for every five pregnancies that occur in the Ho municipality in the Volta Region of Ghana, three were unplanned. The 2008 Ghana Demographic and Health Survey (GDHS), reveals that higher risk sexual intercourse is very common among the youngest age group (15-24) of both sexes. [9] The survey noted that 52% of women aged 15-24 years and 86% of men in the same group engage in risky sexual intercourse, and a little less than one-third 28% of women and less than half 46% of men aged 15-49 years used modern contraceptives during their higher risk sex intercourse.

Politically, socially, economically and culturally both local and national authorities have accepted to investigate the barriers to contraceptive use in Ghana. In the Ho Municipality, the picture of modern contraceptives use is not the best. Over a 3-year period (2005-2007), the records on modern contraceptives use reduced steadily. [10] This was despite the increase in the target populations. The modern contraceptives use in the year 2005 was

62% when the population of women in their reproductive age (WRA) was 36,225. Contraceptives use reduced to 55% the following year and in 2007, with a target population of 37,690, contraceptives use reduced to 30%. [10] Though this figure in the Ho Municipality exceeds that of the figures of similar townships in the country, the Municipal Health Directorate is worried about the gradual decline in contraceptives use. While extensive studies have been conducted on unsafe abortion in the Ho Municipality, little has been done to determine the factors influencing contraceptives use among residents of the Ho Municipality in the Volta Region, Ghana.

Research Objectives

1. To identify the socio-demographic factors that influence family planning contraceptives use among women and men in Ho Municipality.
2. To determine the barriers to contraceptive use among women in the Ho Municipality

MATERIALS AND METHODS

Study Design

A cross-sectional study design was used in this study to determine the extent of factors influencing the utilisation of family planning contraceptives among men and women in the Ho municipality.

Description of Study Site

Ho is one of the fifteen-political/administrative districts in the Volta Region of Ho Municipality Ghana. It is located in the middle zone of the Region. The Municipality, formerly a district which was made up of six sub-districts had two of its sub-districts- Adaklu and Kpetoe-Ziope carved out to make the new Adaklu-Anyigbe District. The municipality has since then been made up of four sub-municipalities namely Ho Shia, Kpedze Vane, Abutia and Tsito sub-municipalities. Ho Municipality is bordered on the north by the Hohoe District, west by Asuogyaman District, east and south-east by Adaklu-Anyigbe District, north-west by South Dayi

District and north-east by the Republic of Togo. Although the land area covered by the municipality has not yet been clearly demarcated, together with Adaklu-Anyigbe, they cover an area of about 2,564 square kilometers with Ho Municipality operating with an estimated population of 160, 493 with an annual growth rate of 1.9 percent. Ho town doubles as the Municipal Capital and the Regional Capital of the Volta Region.

There have been Adolescent Health Services going on in the municipality, precisely, Tsito Health Centre and Ho Reproductive and Child Health (RCH) Unit. Patronage is no more encouraging. In an effort to revamp the Adolescent Health Service in the municipality, Community Health Nurses (CHNs) were taken through the health policy, so as to make their facilities more adolescent friendly and to report on activities carried out in their various catchment areas. The Municipal Health Directorate (MHD) in collaboration with a Non-Governmental Organization has set up a center known as Health Outreach and Peer Education (HOPE) Centre at VORADEP Village in Ho. In addition to the above, the MHD has outlined a series of activities to reach out to the adolescents in the municipality and to sensitize them on the Adolescent Health Policy. Pathfinder International has earmarked Tsito Health Center (H/C) and Council Hall RCH Unit for upgrading into an adolescent health facility and a budget proposal has been forwarded to them awaiting their response.

Study Population

The survey population is comprised of women in their reproductive age (15-49 years) and men aged between 15-65 years and above, who were sexually active and were willing to participate in the study were selected from communities in the Ho Municipality for this study.

Data Collection Techniques and Tools

A structured questionnaire was used to collect data from respondents. Three hundred and forty (340) individuals aged 15-49 years for women and 15-65+ years

for men were interviewed to elicit information on respondents' socio-demographic characteristics and barriers to contraceptives use. Background characteristics of the respondents recorded included the age, residence, and ethnicity of the respondents. The questionnaire consisted of 18 items, each of which was worded in a short statement and was structured on nine (9) dimensions; awareness of contraceptive, preference for a method, number of children living, contraceptive use, accessibility and availability of contraceptive, partner's influence of contraceptives use, staff attitude at service units and misconceptions of contraceptives use.

Study Variables

In this study, the dependent variable is contraceptive use. The independent variables are background factors including age, sex, level of education, wealth, misconceptions, distance of client to the health facility, availability of the methods preferred. The dependent variable was the use of family planning contraceptives

Sampling Techniques and Sample Size

Multistage sampling technique was used in selecting the respondents for the study. The Municipality is composed of four sub-municipalities and each has between seven (7) and twelve (12) towns and villages. The sampling covered the four sub-municipalities: Tsito, Abutia, K/Vane and Ho/Shia. Systematic sampling was used in selecting the communities in the four sub-municipalities. On the main road through a sub-municipality, every other community was selected on the basis of fair systematic sampling. In each community, every other household was then selected, starting from the one nearest to the interviewer and all men 15-65 years and women 15-49 years in their reproductive years were interviewed.

Sample Size

A sample size of 340 was used for the quantitative data. The sample size was calculated as follows: The size was arrived at by using the Magnani Robert formula, $n = \frac{Z^2 pq}{d^2}$, where n = sample size, Z^2 =

reliability coefficient, P = population proportion (parameter), $q = 1-p$ and d = width (CI) / margin of error. Given $p = 0.3$, $q = 1-0.3 = 0.7$, $z = 1.96$ and $d = 0.05$,
 $n = z^2 pq / d^2$
 $= 1.96^2 * (0.3) (0.7) / 0.05^2$
 $= 3.8416 * 0.21 / 0.0025$
 $= 322.7$
 $n \sim 323$

Adding 5% (n) as non-response rate makes $n = 339 \sim 340$.

The above formula is from Magnani Robert's sampling guide (1997).

Four research assistants were trained to assist in the data collection. Topics discussed during the training included how to conduct an interview and how to obtain valid answers from the respondents since contraception is a sensitive issue.

Pre- Testing

In order to ensure the validity and reliability of the study instruments and to identify potential problems in the proposed study as well as to give the research assistants some practice, pre-testing of research instruments was conducted in Dzodze which was not part of the study area. This was useful in testing the suitability of the questionnaires, and corrections were made where necessary.

Data Analysis

Completed questionnaires were checked for errors in the field immediately after collection to ensure completeness. Since this was a learning situation, the principal investigator also took part in the data collection. Data was analyzed using the Statistical Package for the Social Sciences (SPSS) version 15.0 software. Data were presented graphically by the use of tables and graphs. Individual variables were described using frequency distribution tables and bar charts and relationships and associations established by using the chi square test. Gender was the basis of comparison. The chi-square test for trend was used to measure the association between study variables and the corresponding p-values were reported.

Ethical Consideration

Ethical clearance was obtained from Ethics Committee Board (Committee on Human Research Publication and Ethics) of Kwame Nkrumah University of Science and Technology. Administrative approval was obtained from the Ho Municipal Assembly and the Ghana Health Service (Ho). The respondents were not required to state their names. Participants were informed about the study and about their right to refuse to participate in the survey. Strict privacy was ensured and respondents were reassured that their views and identity would remain confidential. The respondents gave their verbal consent before they were enrolled in the study.

RESULTS

Background Characteristics of Respondents

The results showed that the average age of the men was 28.06 years ($SD=7.28$) while that of the women was 30.41 years ($SD=8.12$). The difference between the ages of the groups was statistically significant ($p=0.04$). Whereas 52.2% of the men lived in an urban area, 46.7% of the women lived in the same area. The dominant ethnic group was Ewe; 73.3% and 69.2% of men and women respectively. The religious background of the respondent showed that 88.2% and 85.2% of men and women respectively were Christians. Nearly seven percent (6.8%) of the men and 9.5% of the women had had no education. Among the men and women, 52.8% and 52.7% respectively were married. Eighty percent (80.7%) of the men and 81.7% of the women said they earned a regular income. The type of occupation engaged in by the respondents included the civil service, trading, farming, and artisanship. Eighteen percent (18.0%) and 19.5% of men and women respectively were students. On the rating of the economic status, 63.4% of the men were ranked in the middle class as against 58.6% of the women. However, 4.3% of the men and 6.5% of the women were rated core poor on the socio-economic

scale; they earned little and were not able to provide for 2 meals a day for their family.

Table 1: Background characteristics of respondents

Variables	Men (161) n (%)	Women (169) n (%)
Age (years)		
- <20	15 (9.3)	19 (11.2)
- 20 - 24	37 (23.0)	30 (17.8)
- 25 - 29	51 (31.7)	32 (18.9)
- 30 - 34	24 (14.9)	34 (20.1)
- 35 - 39	18 (11.2)	23 (13.6)
- 40 - 44	12 (7.5)	20 (11.8)
- 45 +	4 (2.5)	11 (6.5)
Residence		
- Urban	84 (52.2)	79 (46.7)
- Peri-urban	23 (14.3)	27 (16.0)
- Urban slum	12 (7.5)	16 (9.5)
- Rural	42 (26.1)	47 (27.8)
Ethnicity		
- Ashanti	10 (6.2)	10 (5.9)
- Other Akan	8 (5.0)	15 (8.9)
- Ewe	118 (73.3)	117 (69.2)
- Ga/Adangme	12 (7.5)	10 (5.9)
- Guan	9 (5.6)	10 (5.9)
- Tribes from the three northern regions	4 (2.5)	7 (4.1)
Religion		
- Christianity	142 (88.2)	144 (85.2)
- Islam	9 (5.6)	15 (8.9)
- Traditionalist	7 (4.3)	6 (3.6)
- Spiritualist	3 (1.9)	4 (2.4)
Education		
- None	11 (6.8)	16 (9.5)
- Primary	15 (9.3)	18 (10.7)
- JHS	41 (25.5)	35 (20.7)
- SHS	24 (14.9)	32 (18.9)
- Tertiary	70 (43.5)	68 (40.3)
Marital status		
- Married	85 (52.8)	89 (52.7)
- Cohabiting	17 (10.6)	10 (5.9)
- Divorced/Widowed	5 (3.1)	13 (7.7)
- Single	54 (33.5)	57 (33.7)
Earn regular income		
- Yes	130 (80.7)	138 (81.7)
- No	31 (20.3)	31 (19.3)
Occupation		
- Civil servants	39 (24.2)	42 (24.8)
- Traders	28 (17.4)	28 (16.6)
- Farmers	27 (16.8)	23 (13.6)
- Artisans	38 (23.5)	42 (24.9)
- Students	29 (18.0)	33 (19.5)
Economic status		
- Core poor	7 (4.3)	11 (6.5)
- Poor	38 (23.6)	38 (22.5)
- Middle class	102 (63.4)	99 (58.6)
- Rich	11 (6.8)	12 (7.1)
- Very rich	3 (1.9)	9 (5.3)

Socio-Demographic and Economic Characteristics of Respondents and Its Association with Current Use of Contraceptives

Table 2: Socio-demographic and economic characteristics of respondents that influence current use of contraceptives

Variables	Men (78) n (%)	Women (77) n (%)	Chi square (p-value)
Age (years)			12.7 (0.04)
- <20	7 (9.0)	5 (6.5)	
- 20 - 24	25 (32.1)	14 (18.2)	
- 25 - 29	23 (29.5)	18 (23.4)	
- 30 - 34	17 (21.8)	22 (28.6)	
- 35 - 39	6 (7.7)	12 (15.6)	
- 40 - 44	0 (0.0)	4 (5.2)	
- 45 +	0 (0.0)	2 (2.6)	
Residence			4.11 (0.25)
- Urban	49 (62.8)	48 (62.8)	
- Peri-urban	13 (16.7)	7 (9.1)	
- Urban slum	3 (3.8)	8 (10.4)	
- Rural	13 (16.7)	14 (18.2)	
Ethnicity			2.55 (0.77)
- Ashanti	8 (10.3)	8 (10.4)	
- Other Akan	3 (3.8)	6 (7.8)	
- Ewe	53 (67.9)	53 (68.8)	
- Ga/Adangme	8 (10.3)	5 (6.5)	
- Guan	4 (5.1)	2 (2.6)	
- Northerner related	2 (2.6)	3 (3.9)	
Religion			3.21 (0.02)
- Christianity	74 (94.8)	69 (89.6)	
- Islam	3 (3.8)	4 (5.2)	
- Traditionalist	0 (0.0)	1 (1.3)	
- Spiritualist	1 (1.3)	3 (3.9)	
Education			4.66 (0.05)
- None	5 (6.4)	4 (5.2)	
- Primary	4 (5.1)	11 (14.3)	
- JHS	18 (23.1)	15 (19.5)	
- SHS	11 (14.1)	11 (14.3)	
- Tertiary	40 (51.3)	36 (46.8)	
Marital status			4.18 (0.03)
- Married	13 (16.7)	6 (7.8)	
- Cohabiting	1 (1.2)	1 (1.3)	
- Divorced/Widowed	0 (0.0)	1 (1.3)	
- Single	64 (82.1)	69 (89.6)	

The study identified the demographic characteristics of men and women that are associated with contraceptive use. A Chi-Square test was carried out to identify the demographic characteristics of women associated with family planning contraceptive use. The demographic characteristics of respondents identified by this study to be significantly associated (p-values<0.05) with contraceptive use were age, education, and religion. However, Ethnicity, marital status, occupation and residential area were not significantly associated (p-values>0.05) with contraceptive use. Out of the 78 men who were currently using contraceptives, 61.6% were aged 20 - 29 years as compared with 42.6% of the women in the same age group were also currently using contraceptives. There was a significant

difference ($p=0.04$) in the variation in the ages of the men and women in terms of contraceptive use. There were no differences of the current users in terms of residency of the sexes ($p=0.25$), ethnicity ($p=0.77$), religious affiliation ($p=0.02$), education level ($p=0.05$) and marital status ($p=0.03$). It was evident that working for an income ($p=0.38$); type of occupation ($p=0.37$) and economic status rating ($p=0.72$) did not vary statistically relative to the men and women who were currently using contraceptives.

Barriers to Contraceptive Use among Women and Men

The study identified the major reasons why women do not use family planning contraceptives. These reasons are presented in a ranking order from the most important barrier to the least important barrier. These include partner's disapproval 20 (26.0), religious and cultural beliefs 16 (21.0), poor quality of service and poor attitudes of health workers 15 (19.5), side effects of some contraceptives 12 (16.0), lack of means of transport 7 (9.1), lack of sexual satisfaction when using contraceptive 5 (6.5) and forgetfulness to use contraceptives during sexual intercourse 2 (3.0). The results are shown in Table 3 below.

Table 3: Barriers to contraceptive use among women and men

Barrier	n (%)	Rank
Partner did not approve contraceptive use	20 (26.0)	1 st
My religion does not allow the use of contraceptives	16 (21.0)	2 nd
Poor quality of service and poor attitudes of health workers	15(19.5)	3 rd
Because of the side effects of some contraceptives	12 (16.0)	4 th
Lack of means of transport,	7 (9.1)	5 th
Lack of sexual satisfaction when using contraceptives	5(6.5)	6 th
I usually forget to use contraceptives during sexual intercourse	2 (3.0)	7 th
Total	77(100.0)	

Method-Related Factors that Discourage Contraceptive-Use

The side effects (51.3%) and excessive bleeding (41.4%) and barrenness (32%) were identified by current users of contraceptives as key method-related factors that affect the use of contraceptives. The rest of the reasons are presented in figure 1 below.

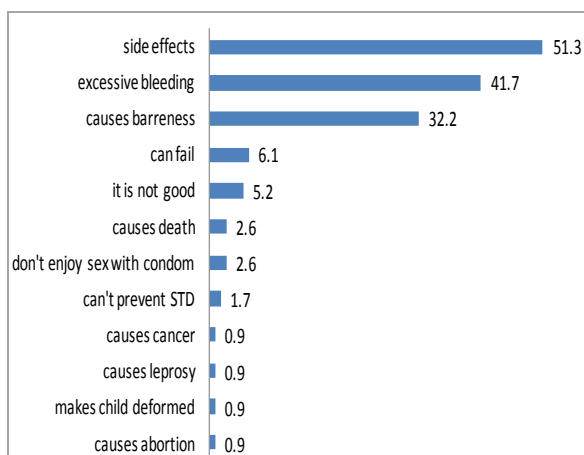


Figure 1: Method-related factors that discourage contraceptive-use

DISCUSSION

The main objective of the study was to identify factors that influence contraceptives use among men and women in the Ho municipality of the Volta Region of Ghana. The decision to use or not to use contraception is a complex web and it is influenced by many factors.

Socio-Demographic Factors that Influence Contraceptive Use between Men and Women

The first objective of this report was to identify the demographic characteristics of women that are significantly associated with family planning contraceptive use. In this study, the results showed that age, religious denomination, educational status, and marital status of respondents were the socio-demographic factors influencing contraceptive use among men and women in the Ho municipality. However, Ethnicity, occupation, and residential area were not significantly associated with contraceptive use.

The result of this study show age of respondents was an influencing factor in contraceptive use between men and women as the age of respondents was statistically significant ($p = 0.04$) to contraceptive use. This finding suggests that there is an association between age and current contraceptive use even though among all the ages, 24-29 years were the highest users of contraceptives. The finding of this study is consistent with 2008 GDHS, which established a relationship between an increase in age and contraceptive use even though this was not measured to establish any causality. [11] This means that as men and women advances in age, there is the high possibility of them using family planning contraceptives. Adult men and women between the ages of 24 and 29 years are sexually active and more likely to be aware of the importance of contraception and would make attempt to use contraceptives than men and women who are younger than 24 or older than 40years.

Consistent with previous literature, educational attainment has an effect on contraceptive use. The increase in the level of education is expected to be matched by an increase in contraceptive use. According to the Ghana Maternal Health Survey 2007, education has a direct relationship with the use of contraceptives. [11] The GDHS 2008 reports similar findings in the use of contraceptive methods which suggest that contraceptive use increases with increasing level of education. [9] Also, the findings of this study confirm a study conducted by Achana, et al. on spatial and socio-demographic determinants of contraceptive use in the Upper East Region of Ghana. [12] Their study showed that educational status of respondents was significantly associated with contraceptive use. This is however, not surprising because a considerable amount of evidence abound in Africa and elsewhere on the powerful effects of formal education on female empowerment, reproductive health, child and maternal health. Formal education is particularly noted to be a strong predictor of contraceptive use. [13,14]

This finding implies that men and women who attain a high level of education are more likely to understand the importance of contraceptive use and would use them as compared to men and women who are less educated or have no formal education at all. This also explains the reason why in Ghana, like other developing countries, men and women who have no formal education deliver many children than those men and women who have attained higher level of education. There is a great deal of evidence which suggests that age and education influence knowledge about sex and contraception and that these variables in turn influence contraceptive use. [15]

Another factor which influenced family planning contraceptive use in this study was a religious denomination. Religion was shown to be significantly associated with contraceptive use. This finding is similar to results found in several other studies conducted in Ghana and elsewhere. For instance, study conducted in rural Western Kenya to investigate women's attitudes towards receiving family planning services from community health workers found that non-Catholics showed higher acceptance of family planning services than the Catholic women. [16] The Roman Catholic Church by their religious beliefs does not allow their church members to use modern contraceptives. This finding is not surprising because the majority of the participants were predominantly Catholics. This finding, however, contradicts a study conducted in the United Kingdom which showed that Roman Catholic Church members do not pay attention to their leaders who say they should not use contraceptives. [16]

Further, the results of this study showed that marital status is also a significant determinant of contraceptive use. This finding of this study is consistent with previous studies conducted in Ghana and elsewhere. According to the findings of a study conducted in Ghana, married women and men were more likely to use

contraception than non-married men and women.^[17] This may reflect true differences in contraceptive use between men and women. Married men and women are more likely to use contraceptive for the purpose of spacing births since failure to use family planning contraceptive can result in early pregnancy after delivering. Most cultures in Ghana like any other African countries, see it morally right to allow married couples to use contraceptives to space their childbirths than women or girls who are not married. Societal stigmatization regarding the use of contraceptives has often scared men and women who are not married from using contraceptives. This finding implies that health workers especially family planning nurses need to educate all women to disabuse the thinking of women and men that the use family planning contraceptives are for only married couple.

Barriers to Contraceptive Use among Women and Men

This study identified several barriers/reasons why men and women do not use family planning contraceptives. The results showed that the barriers to contraceptive use from the perspectives of women included religion do not allow the use of contraceptives, poor quality of service and poor attitudes of health workers, because of the side effects of some contraceptives; partner does not approve contraceptive use and lack of means of transport. These findings have also been reported by several researchers in Ghana and in Uganda.^[12,18-20] According to Apanga & Adam, one of the major reasons cited for not using service included husbands opposition against their wives using family planning contraceptives.^[4] The finding of this study also confirms a study conducted in Malawi, which found that one of the main factors that discouraged women from using modern family planning methods was husband's disapproval.^[21] This may be because of the authority that men have over household decisions and the high regard that wives have of their husbands, which is the case in most

cultures. This is a major constraint as women in Ghana, especially the Volta region of Ghana, where the study was conducted cannot take decisions regarding reproductive health without the approval of their husbands who are regarded as the heads of the family.

Also, religious and cultural beliefs were cited as one of the major barriers to contraceptive use among women in this study. These findings are consistent with a study conducted in Ghana, which indicates that the Ghanaian culture places a high value on large families and especially male children, and therefore, there is a lack of support for women's use of birth control. Women, therefore, exercises little control over their reproduction and experience multiple pregnancies.^[19] In some Christian religions, particularly the Roman Catholic Church, they do not encourage their members to use modern contraceptives. This may largely explain why some women do not use family planning contraceptives in this study. Further, poor quality of service and poor attitudes of health workers as well as the lacks of means of transport were also mentioned as barriers to contraceptive use in this study. A number of studies, including ones conducted in Ghana, have identified poor infrastructure, in competence of healthcare professionals, delays in receiving appropriate care at health facilities, non-availability of medical supplies such as drugs, lack of specialists, inadequate referral systems, and the attitudes of healthcare professionals factors contributing to poor quality health service.^[22,23] These factors translate into the loss of the public's confidence in the healthcare systems in developing countries.

Additionally, the side effects and excessive bleeding were identified as key method-related factors that affect the use of contraceptives. These findings are consistent with what previous research studies reported that women who have ever experienced bleeding as a result of using a particular contraceptive would always hold the perception that using contraceptive

would lead to excessive bleeding. [21,14,16] This perception has made some women not to use any contraceptives even if that contraceptive would not cause any bleeding. Misconceptions about contraceptive use have not assisted the translation of good knowledge of contraceptives into high usage. Hodgson et al. reports that women often rejected using the contraceptive because of their poor attitudes towards its perceived side effects. [24] Respondents expressed fears that using contraceptive would make them barren. Others complained of side effects such as excessive bleeding, contraceptive failure, causing of cancer, deforming children, and causing deaths in women. The findings of this study suggest that there is a high perception among the discussants that contraceptives use such as condom causes reduction in sexual satisfaction, and an individual's decision to use a condom can be influenced by the extent to which he thinks condom use influences his sexual satisfaction.

CONCLUSION

In conclusions, we found in this study that the socio-demographic characteristics of respondents associated with contraceptive use were age, educational status, religious denomination and marital status. This study show that the barriers to contraceptive use from the perspectives of women included partner's disapproval of contraceptive use, religious and cultural beliefs, poor quality of service and poor attitudes of health workers, the side effects of some contraceptives, partner's lack of means of transport, lack of satisfaction in sexual intercourse when using contraceptive, poor quality of service and poor attitudes of health workers, and forgetfulness to use contraceptives during sexual intercourse were also mentioned as the reasons for not using contraceptives. We recommended that there is the need to continuously educate people about the importance of contraceptive use in order to disabuse the misconceptions people hold about contraception. It is also important for

family planning services providers to extend services to both men and women in the reproductive age in the Ho Municipality.

Implication of Findings for Practice

The findings of this study provide implications for nursing practice, nursing education, and nursing inquiry. The findings of this study call for nurses, especially reproductive health nurses, to adopt strategies in educating men and women about the importance of contraceptive use in order to disabuse the misconceptions regarding contraceptive use. It also calls for nurses to provide culturally competent and sensitive care in a respectful and caring manner. Interpersonal communication skill should be emphasized at the nursing administration level to improve nurse-client relationships in reproductive health care services.

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