Formulation and Implementation of Reproductive Health Policies in Ghana: Analysis of the Views of Key Community Leaders and State Technocrats

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Abstract

This qualitative study evaluated the views of ten elites concerning their roles and views in the formulation and implementation of reproductive health (RH) policies in Ghana. The elites comprised of politicians, State policy technocrats, community leaders including a Traditional Chief; the group of elites also included representatives from all three major religions in Ghana: African traditional religions, Christianity and Islam. The results of the study indicated both positive and negative impacts of RH policies on the improvement of the economic welfare of individuals and small owner businesses. A major finding was the role of awareness in the acceptability of RH policies related to the birth control (BC) methods and products and contraceptives. The influence of the affordability of BC products and contraceptives was a common point of agreement of the ten elite people. The limited numbers of proper family planning clinics and specialist clinics in Ghana were seen to be a hindrance towards the acceptance of RH policies related to the use of BC products and contraceptives. The elites agreed that the Ghanaian society was a conservative one and this presented a general difficulty concerning the discussion of family planning and sexual matters. While there was a consensus on the role of awareness in increasing the acceptance and use of BC products and contraceptives, there was some disagreement of the proper role of non-governmental organizations, including religious organizations, in creating awareness of BC products and contraceptives in the community.

Keywords: birth control products, contraceptives, elites, family planning, Ghana, reproductive health policies, technocrats

1. Introduction and Problem Statement

1.1 Background

Reproductive Health (RH) Care is about the provision of cost-effective health services encompassing various aspects of human reproduction. It covers health promotion, prevention and maternal core services, such as safe motherhood, and adolescent reproductive health. The absence of effective RH policies has been suggested to be a factor affecting the quality of reproductive health services and the quality of health of women in their child-bearing ages (refer to the works of Chavane et al., 2017; Kyilleh et al., 2018; Apanga and Awoonor-Williams, 2018; Kriel et al., 2019). The quality of health of women inevitably affects their productivity and economic welfare and their contribution to the development of a nation.

Several factors have been noted to influence the acceptance of RH policies by women and these include the fact that many married women lack confidence to approach RH facilities based on lack of approval by their partners due to perceptions of infidelity arising from suspicions emanating from their husbands and spouses (Hindin et al., 2013). The role of men in the acceptance of RH policies and the use of birth control methods is a noticeable gap because it has received scant attention in the empirical literature even though a sexual relationship between men and women is the normal source of pregnancies. While women have the biological carrying capacity in producing children, men can produce a very large number of children based on having sex with as many women as they can find for sexual relationships.

In developing framework for a new reproductive health paradigm, researchers such as Kriel et al. (2019) and Gopal et al. (2020) draw attention to the absence of men from previous reproductive health initiatives and the need to incorporate men into emerging programs. This point of view is also supported by earlier works of Mundigo (2000),

Hawkes and Hart (2000) and Starbird et al. (2016). Men are important actors who influence both positively and negatively the reproductive health outcomes of women and children.

The ongoing challenge to RH framework is how to characterize men's possible influences and areas of impact on women's health. The 1994 International Conference on Population Development (ICPD) Program of Action explicitly calls for the inclusion of men in women's reproductive health programs through three awareness areas. These are (1) the promotion of men's use of contraceptives through increased education and distribution; (2) the involvement of men in roles supportive of women's sexual and reproductive decisions, especially contraception; and (3) the encouragement of men's responsible sexual practices to prevent and control sexually-transmitted infections (Basu, 1996).

1.2 Problem Statement

There has been increasing recognition that RH policies that led to good reproductive health also results in personal economic and social welfare of an individual (sometimes called empowerment) (for example, refer to Canning and Schultz, 2012; John et al., 2014; Starbird et al., 2016; Chavane et al., 2017; Apanga & Awoonor-Williams, 2018; Thaci & Foster, 2018; Gopal et al., 2020).

The formulation and implementation of RH policies require the participation of State agencies in a leading role and also the extensive participation of Community leaders and individual men and women for the successful uptake of policies. RH policies in the Western context are often not appropriate to the settings and circumstances of indigenous African societies because they lack relevant application to much of the population who have been brought up in societies that have different cultural values from those in Western societies. Further, the common equalization of gender with women without the inclusion of men fails to analyze and comprehend the considerable interactions of important political economy variables, such as ethnicity, race, and connections to political power structures, on both income-based and non-income-based measures of human well-being.

Much of empirical research works have focused on the important role of individuals, especially women, on factors influencing their decisions to accept and use BC products and contraceptives. These factors have been identified to include age, cultural beliefs, education, location, marital status and the quality of health systems and services (Crissman et al., 2012; Malalu et al., 2014; Sedgh et al., 2016; de Silva & Tenreyro, 2017; Beson et al., 2018). However, in the formulation, development and implementation of RH policies in developing countries, the key actors are the elites, specifically politicians, State technocrats and policy shapers, and Community leaders, such as Chiefs and religious leaders. Yet, the literature is limited with regards to the role of these elites in the actual formulation and development of RH policies in developing countries such as Ghana. The important role and contributions of elite persons in the formulation and implementation of RH policies are missing from the empirical literature; this gap needs to be addressed, as is being undertaken in this study. The views of elites are also important to understand the limited impact of RH policies despite large amounts of monies and resources invested in such policies in developing countries.

The main objective of this study was to ascertain the roles and views of elite people directly involved in the development, formulation and implementation of RH policies in Ghana. The remainder of the paper is organized as follows: the next section deals with a discussion of the review of the literature. This is followed by the methodology of the study, the results of the analysis and conclusions and recommendations.

2. Literature Review

2.1 Definition of RH

The nomenclature "reproductive health" was first introduced and adopted at the Cairo International Conference on Population and Development (ICPD) in 1994 (Basu, 1996). The ICPD heralded a major diversion in knowledge, thinking and approach to population matters. Hitherto, the core population issues were the actual numbers of people living on the Planet, population control, and family planning. The Conference expanded the concept of population much wider to include fertility control, birth control practices, general livelihood of women, early-life events such as puberty, reproductive maturation and function, nutritional impacts and life-cycle patterns.

The Conference defined RH as a state of complete physical, mental and social wellbeing. Thus, RH is not merely the absence and avoidance of disease, or infirmity, but includes all issues concerning the reproductive system, its functions and processes. Following the Conference, eight recurring issues involving RH have been identified. These are (1) adolescent health, (2) maternal health, (3) contraception, (4) sexually-transmitted infections, (5) abortions, (6) female genital mutilation, (7) child marriage, and (8) forced and non-consensual marriage.

2.2 Benefits of RH

RH is important for the current generation of people because it also includes the prevention and treatment of sexually-transmitted diseases and infections such as HIV/AIDS (Government of Ghana Ministry of Health, 2015; 2018; Basu, 1996). The importance of RH is also because its incorporation into a country's health care system facilitates the detection, diagnosis, and treatment of other diseases. In addition, the study of RH practices brings more awareness about safe sexual practices and birth control methods in adults and children.

RH policies have benefits, which include improving family and community wellbeing, promoting economic and financial empowerment, savings of lives of women and children through improved maternal delivery methods. Other benefits of RH policies include a controlled population growth rate that allows society to make adequate plans to safeguard the welfare of the current generation without sacrificing the needs of future generations.

2.3 RH as Human Right and a Business Issue

Investing in RH allows women and men to have opportunities for education, training and employment that eventually benefit their families, their communities and the nation. A key factor is that women make up more than half of the world's workforce. In fact, many women expect their employers to provide benefits such as maternal leave and will not accept jobs where such health benefits are unavailable. Clearly, comprehensive RH benefits is a business issue. Companies both large and small can gain competitive advantage by providing RH related benefits for their employees and communicating any changes to their employees; hence companies can no longer be on the sideline of RH development and associated programmes (Hammann, 2020). Recognizing the value that gender diversity brings to performance and profitability of businesses, many companies around the world have invested millions of dollars to attract, develop and retain female employees including managers (Alpern, 2021).

The right to reproductive health is recognized as a distinct human right and not as a subcomponent of the right to health (Gable, 2011). Likewise, RH rights interact with and influence the attainment of many other human rights. Framed as a distinct human right, the right to RH grants individuals a specific claim to all aspects of human rights and obligates States and Territories to respect, protect, and fulfil RH right. Thus, understanding of the right to RH bolsters RH outcomes and the rights of women and men to make more informed reproductive decisions.

But the articulation of the right to health, that is the absence of disease, is weaker from the perspective of protecting the general health of women and men. This research study puts greater emphasis on women RH issues because a woman's life undergoes increased risk through the process of pregnancy, an additional health risk which men do not go through. Therefore, the right to health is not confined to healthcare. On the contrary, it embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life and extend to the underlying determinants of health. These determinants include:

1. Availability of adequate resources, integral to health, including sanitations, safe and potable drinking water, functional health services, trained healthcare professionals, and access to essential social amenities.
2. Access to health facilities eliminates barriers to goods and services, if these barriers are imposed through economic, geographic, physical or informational means.
3. Acceptability of goods and services must be adequate, according to cultural traditions and standards of medical ethics.
4. Goods and services must adhere to levels of quality consistent with ethical and scientific standards.

2.4 Reproductive Health Services and Systems

Reproductive health care is the provision of basic cost-effective health services. Health services cover health promotion, prevention and maternal core issues such as safe motherhood, adolescent reproductive health. Some progress has been made in reproductive health services in Ghana such as improvement in the family planning and maternal health indicators. For example, awareness of birth control methods especially contraceptives are high in Ghana. According to the 2003 Ghana Demographic and Health Survey (GDHS), about 98 percent of women and about 99% of men were aware of at least one method of birth control (Ghana Statistical Service, 2004; Government of Ghana Ministry of Health, 2015; 2018).

The maternal mortality ratio in Ghana fell from 760 per 100,000 live births in 1990 to 319 per 100,000 live births in 2015 (World Health Organization, 2016). However, the speed of decline in maternal mortality was slow; hence, the country could not achieve the United Nations Millennium Development Goal target of 190 per 100,000 live births in 2015. This inability is partly due to the relatively higher maternal mortality in rural areas as compared to urban areas related to the 74% and 43% skilled birth attendance, respectively (Apanga & Awoonor-Williams, 2018).

De Silva and Tenrenyro (2017) argue that a reason for lack of penetration of FP policies and RH programs in developing countries is the use of the clinic-based approach. The clinic based approach refers to the use of already existing health facilities as the means to reach women of child bearing age for offering family planning advice. This method of implementation misses out on women who do not utilize or have access to healthcare facilities. Similar observations were made by Barber (2007) who conducted a study on contraceptive use in Mexico, and Anaman and Okai (2016) at Abokobi, Accra, Ghana.

Hardee et al. (2016) suggest that while family planning serves the health and economic needs of both males and females, family planning programs implemented by governments and health services around the world focused on females. Women focused approach reinforces societies' gender biases of leaving the burden of reproductive health care to women. These biases do not encourage the adoption of family planning methods as males usually do not take decisions in favor of family planning (Kraft et al., 2014). This is as a result of the lack of funding to prospect for new forms of male contraceptives. In spite of funding difficulties, Hardee et al. (2016) observe that when family planning programs adopt gender accommodating and transformative elements, as well as focusing on males as users of family planning choice, the adoption rates in both males and females tend to increase. This view is also shared by Dalaba et al. (2016).

The rate of availability of health infrastructure and degree of access to the facility influence family planning and acceptability of RH policies. Pathak et al. (2000) showed that the place of residence – either rural or urban - affects how easily one can get access to contraceptives. Accessibility differences exist due to the relatively high availability of health facilities in urban areas compared to rural areas. Barber (2007) suggests that when women have access to family planning facilities, they have a higher probability of taking up family planning methods and practices. Nair et al. (2019) support the view of Barber (2007) but added that inadequate privacy and space for counseling within health centers affects contraceptive use among clients, and also affects the output of the health workers in providing quality services to their clients.

2.5 Family Planning and RH Policies Around the World

From the literature, the researcher observed three main views of family planning (FP) and RH policies; the coercive or authoritarian; the liberal or consensus driven; and informal FP and RH policies (Robinson & Ross, 2007). A fourth view of FP and RP exists, which may be labeled as traditional being derived from traditional cultural practices. The fourth view is often lumped together with the informal category.

Some scholars such as Bovill and Leppard (2006) argue that population policies around the world are driven and sponsored by developed countries and international organizations. These entities impose their thoughts and ideas of population control on poor nations without considering local circumstances; and, therefore, create a source of disagreement. For these reasons, population control policies are divided to two distinct policies of coercive and informal policies. Although the coercive and informal policies seem to differ in modes of implementation, both are flexible as they allow for periodic reviews to ensure the rights of individuals are maintained while at the same time ensuring population control.

In developed countries where some form of consensus on family planning exists, some scholars such as Womack (2000) indicate that some kind of coerciveness is incorporated in the implementation process to ensure conformity and compliance. Womack (2000) argued that the United Kingdom, government mounts pressure on its citizens to make them adhere to social norms that encourage small family sizes by using tools such as social pressure and incentives to encourage people to get sterilized. Similarly, Correa and Reichmann (1994) report of how the governments of the United States, Philippines and South Africa also use incentives to control the birth rates of poor people.

In China and Peru, coercive and arbitrary measures were adopted by the respective governments to ensure compliance. On the other hand, in the implementation of the mild form of coercive FP and RH policies in countries such as Singapore, governments incentivize families who comply with these policies. However, the Chinese RH policy, which is the most studied by scholars, was described as extremist, as it did not allow couples to take personalized informed decisions on their own family planning choices (Whyte et al., 2015). Under the one-child policy of China, couples who wanted to have children sought government approval. Government enacted laws to penalize couples who broke the law (Zhang, 2017).

Although some scholars have discredited the Chinese one-child policy, Zhang (2017) further argued that the implementation of the policy was not arbitrary because the policy considered differences in rural requirements for more children and also considered the needs of ethnic minorities for having more children. However, China has since

2016, formally implemented a two-child policy that is much more flexible by incorporating inputs from stakeholders in order to bring the population of China out of below replacement levels (Feng, Gu, & Cai, 2016). The new Chinese population policy was adopted to correct information and misconceptions about the earlier one-child policy in the minds of the Chinese public and also to assist couples to make informed decisions on their family sizes and reproductive health (Feng et al., 2016).

2.6 Gaps Identified in the Literature Review

The researcher identified several gaps in the literature which were used as inputs in the interview of the elites responsible for the formulation and implementation of RH policies in Ghana. There are four major gaps identified in the literature. First, there is limited information of the effects and consequences of RH policies and practices, including use of birth control methods and products, on businesses and general consumer behaviour. Second, while access, use of health facilities and access to mass media have been advanced by several scholars to influence decisions to use birth control products and contraceptives, awareness as a driving factor is an underlying issue affecting these decisions. Emphasis on education in the form of awareness and advocacy is scanty; researchers often fail to fully recognize the different levels of education as important factors influencing the acceptance and use of birth control products and contraceptives.

Third, while the use of birth control products and contraceptives, as a life-style choice in many Western countries, is prevalent in the literature, in developing countries, the choice of these products is strongly influenced by demographic patterns, cultural factors, religion and traditions. The literature on RH, emanating from scholars based in Western countries, fails to adequately recognize these links. This failure is particularly associated with the inadequate attention paid to issues involving both male and females in family planning services in developing countries. Fourth, the literature on RH policies in developing countries pays little attention to the role of men in RH policy formulation and practices; generally the role of men is understated in the reviewed literature. Discussions at RH meetings and conferences, and research outputs especially those linked to journal publications, have focused on the role of women without acknowledging the key roles men play in causing pregnancies, and the support they provide to females in the acceptance of RH policies related to the use of birth control products and contraceptives.

3. Methodology

3.1 Introduction

This section of the paper deals with the views of elites responsible for the formulation, development and implementation of RH policies in Ghana. A select group of elites were interviewed to elicit responses related to the formulation, development and implementation of RH policies in Ghana with emphasis on the use of birth control products and contraceptives. Non-random probability sampling procedures were used to select the elites for this study and these sampling procedures are discussed in next section.

3.2 Non-probability Sampling Methods

Sampling methods fall into two groups: probability sampling methods and non-sampling methods (Anaman, 2014; Creswell, 2014; Babbie, 2020). For qualitative RH studies, non-probability sampling methods are generally used as the researcher is interested more in the elites who actually formulate and develop RH policies rather than the masses of people who use RH policies. Non-probability sampling methods are of four main types. The first type is convenience sampling, which covers participants who are accessible to the researcher and are not required to be randomly selected. As such results of the analysis of the data are not generalizable. The second type is voluntary response and this deals with people who volunteer themselves for the study without being chosen randomly. The third type is snowball sampling and it deals with a population that has no known database, such as people involved with the use of illegal substances or people who are homeless. The fourth type is purposive sampling. This type of sampling involves the researcher using his/her judgment to select a sample considered to be most useful based on the purposes of the study. For this study, the purposive sampling method was used to select the ten elite persons interviewed.

3.3 Profile of the Study Population

Elites are considered to be small groups of people or citizens who have and often exercise disproportionate amounts of power in a nation-state concerning particular issues related to governance and administration in various spheres such as academia, business, governance, political parties, politics, tradition and religion. In relation to RH policies, elite persons are in charge of formulation and development of RH policies and are also the catalysts and conduits through which these policies are implemented for use by the population. Examples of elites concerned with the development and implementation of RH policies in Ghana include Government Ministers, Members of Parliament,

Directors in Departments and Ministries who initially formulate RH policies. Some elites come from Community and business institutions such as Traditional Councils and Trade Unions and Associations of Workers.

3.4 Case Study Area: Strengths and Weaknesses

According to Creswell (2014), some case studies generate theories, some are descriptive or analytical, and others show cross case or inter-site comparisons. This descriptive case study reports the results and findings of a qualitative study arising from the elicited views of ten elite people. For achieving the objective of the research study, the researcher describes the environment for the case study, provides the profile of population of interest, indicates the sampling technique and strategy used, the profiles of the interviewees, and their responses presented in a case-study analytic framework. This case study was conducted in the national capital of Ghana, in the Greater Accra Region, where those in charge of the formulation and implementation of Ghana's RH policies could be easily identified.

The strength of the case study was the choice of the national capital of Ghana, Accra where the key policy makers and State technocrats involved in RH policy formulation and implementation reside. This choice was to access policy makers, opinion leaders, traditional leaders, and technocrats involved with the development of RH policies. Accra is the administrative capital city of Ghana. It is located in the Greater Accra Region, the smallest of Ghana's 16 administrative regions, occupying a total land surface of 3,245 square kilometers. Greater Accra Region had the biggest population of Ghana's 16 regions with a population of about 5.5 million, constituting 17.7% of Ghana's population of 30.8 million in 2021 (Ghana Statistical Service, 2021). The region also accounts for 20.9% of Ghana's total household income, based on data from the seventh and latest round of the Ghana Living Standards Survey, conducted by the Ghana Statistical Service in 2016/2017. Therefore, the selection of interviewees from this region is significant for illustrating the role and views of elites who make and shape RH policies.

The central weakness of the study, related to the selection of the case study area within the Greater Accra Region, are two-fold. First, those persons in charge of the formulation and implementation of RH policies in the other 15 regions of the country were not included. While policy makers at the national level in the Greater Accra Region would be at the highest levels of policy formulation and decision making, policy implementation is done in all the 16 regions, 261 districts, and 180 traditional states (Paramountcies) of Ghana. As such, the skewness of the purposive sample to the Greater Accra Region is a weakness. The second weakness of the case study area is that the selected interviewees such as the Chief of a Traditional Area in Accra, a Member of Parliament, a Market Women Representative, and the two prominent leaders of a specific Muslim Community are limited to a small geographical area that could not be fully representative of Ghana even though the community leaders interviewed represented heterogeneous populations.

3.5 Methodology for the Case Study

Qualitative data are grouped into four basic types of information: observations, interviews, documents, and audio-visual and electronic materials. The researcher used the approach of open-ended interviews to elicit responses to selected questions dealing with the acceptance and use of birth control methods and their links to economic welfare in Ghana from selected elite individuals. The choice of the individuals was based on elites because of their extensive knowledge of the processes involved in the formulation, development and implementation of RH policies.

The researcher used purposive sampling strategy for this case study. Three issues are considered in this approach: first, decision of whom to select for interviewing; second, the specific strategy; and third, the size of the sample of individuals to interview. Purposive sampling strategy is appropriate because the size of elites with the detailed knowledge of RH formulation, development and formulation is very small. Further, purposive sampling is critical in allowing the researcher to interview only the elites with detailed knowledge about the formulation and implementation of RH policies with emphasis on the use of BC products and contraceptives.

4. Results and Discussion

4.1 Introduction and Description of the Ten Elite Persons

Ten persons were interviewed by the researcher. All interviewees had some experiences in the formulation and implementation of RH policies with emphasis on the acceptance and use of BC products and contraceptives. The selection process was narrowed to individuals who contributed by their positions, to the development and implementation of RH policies with emphasis on the acceptance and use of birth control products and contraceptives. For these reasons, each interviewee's view was examined under five major variables which the researcher identified as influencing the acceptance of RH policies. These five variables are demography, education, culture, quality of health systems and services, and awareness of RH policies related to BC products and contraceptives. The interviewees were:

A. Respondent 1 is a traditional ruler of an urban community in Accra, Ghana. As a traditional ruler, he has personal influence over people and events in this community and its close environs. Every major cultural activity in the area revolves around him.

B. Respondent 2 is a Member of Parliament. As a legislator in the Parliament of Ghana, he has political influence and his opinions are relevant in the formulation of RH legislative policies.

C. Respondent 3 is a senior officer at the Ministry of Health, Government of Ghana. He has a direct role as a health professional engaged in the continuous development and assessment of RH policies and implementation.

D. Respondent 4 is a Midwife and Nursing trainer and works at the Planned Parenthood Association of Ghana (PPAG). The main function of PPAG is to counsel women on birth control practices and provide them with the necessary birth control kits such as BC products and contraceptives.

E. Respondent 5 works at the National Population Council (NPC). The Council is directly under the Office of the President of the Republic of Ghana. NPC is the highest advisory body on population control and RH policies in Ghana. As a senior official of the NPC, she is involved with the formulation and implementation of population policies as directed by the Presidency. Her inputs are important to the content of RH legislative bills that would be passed by the Parliament of Ghana.

F. Respondent 6 is a key officer in the Market Women's Association of Greater Accra. She works in one of the largest market centers in Accra called "Makola Market" in Accra. Makola Market is a major market center in Accra. There is a wide range of goods and services sold at Makola Market. These include various forms of BC products and contraceptives. The population of traders and sellers of goods and services at Makola Market is about 10,000 and close to one million people patronize the market each week.

G. Respondent 7 works at the Family Health Division of the Ghana Health Service, the implementing arm of the Ministry of Health. Thus, she is directly involved in RH Programs at the regional, district and community levels.

H. Respondent 8 works at the Ministry of Gender, Children and Social Protection and is a senior officer in the Ministry.

I. Respondent 9 is an Imam and a Muslim Prayer Leader. He is considered to be a major Muslim Leader in Accra.

J. Respondent 10 is the head of a female Muslim organization in Accra. This organization is a community-based entity that caters to the needs of Muslim women in Amasaman and its environs and also interacts with other women-based Islamic organizations in Ghana.

4.2 Views of Elites on RH and Demography

Respondent 1 described the inhabitants of his community as a heterogeneous group of people coming from all the nine broad ethnic groups of Ghana. He indicated that many of the people were underemployed and were economically disadvantaged. According to him, the development of his community was not encouraging and was due to limited government involvement and the tendency of the private sector agents to exploit people through high charges.

The heterogeneous nature of the studied urban community was affirmed by Respondent 2. He suggested that the rapid influx of people from other parts of Ghana to settle in the area led to considerable loss of farmlands in the area for residents who were originally farmers. Poverty has increased due to the reduced opportunities for self-employment in farming and related activities. He stated that "Poverty is a household word among the people…". Increased poverty had resulted in lack of attention for RH policies and the acceptance and use of BC products and contraceptives.

In a summary, the salient features related to demography identified during the case study were a heterogeneous population from different ethnic and cultural backgrounds. The indigenes, the Gas, were increasingly getting poorer as a result of the loss of their farmlands to estate developers and the inadequate financial compensation offered by the private and government sectors for employing the young people.

4.3 Views of Elites on RH and Education

Respondent 1, speaking as a traditional ruler, in his words, "Education is the key to the acceptance of reproductive health policies and associated birth control methods and products in my traditional area and Ghana as a whole". He argued that the higher the formal educational level of a person, the more likely he/she would be better informed about RH policies. Further, when couples are educated, they planned their families, acquired adequate resources to look after the children.

He emphasized that more educational facilities and efforts (formal an informal) should be undertaken by the government through school programs, print media, radio and television shows, seminars and workshops, and fora and outreach programs through churches, mosques, market centers and traditional chieftaincy durbars to increase the acceptability of RH policies and the use of BC products and contraceptives. Respondent 1 further advocated for the improvement of the economic welfare of women as a route to allow them to make more independent decisions regarding their reproductive rights.

Respondent 2 indicated that inadequate funds limited the dissemination of government RH policies. This brought about lower levels of acceptability of RH policies and associated use of BC products and contraceptives. He suggested that education could increase the economic welfare of women and allow them to exercise their reproductive rights effectively.

Respondent 6, speaking as a mother and a woman retailer, suggested that to overcome the problem of low acceptability of BC products and contraceptives, parents should be encouraged to educate their children especially the girl child. This is because the girl-child education benefits the whole nation. She said both government and non-governmental organizations should re-introduce the "adult education system to compliment RH education. This re-introduction would allow adults to learn how to read and write for enlightenment on issues affecting their bodies, families and the national as a whole.

On the other hand, Respondent 4, a midwife suggested a specific aged-based target group of people for RH education and training. She argued that the reproductive age group of women, between the ages of 15 and 45 years should be the primary target of education and training programs within the State and non-State sectors. Once these women are properly trained on RH policies and BC products and contraceptives, she believed that there would be gains to society considerably. While the role of men was important in the creation of children, babies could only be produced by a specific group of women and these were in the target group of 15 to 45 years. Respondent 4 further indicated that sex education should begin from basic school and continued till university. She also said those who could not have access to formal education should be educated on RH policies by volunteers employed by the PPAG and other groups.

Another perspective of the role of education was provided by Respondent 9. He argued that from a Muslim point of view, "Muslims do not like formal education partly due to financial hardships imposed on families".

4.4 Views of Elites Related to RH and Culture

Respondent 1, speaking as a traditional authority on Ga culture indicated that the celebration of cultural practices such as naming of a child, puberty rites, marriage and funerals, influenced people to believe that having many children was useful and also encouraged them to have many sexual partners. These practices hindered the acceptability of BC products and contraceptives. On the other hand, Respondent 2 stated the people of the studied urban community, due to their cultural and religious beliefs, preferred large families. Most men thought that having large family size was prestigious and many men frowned on women who constantly used BC products and contraceptives.

Further, Respondent 2 indicated that sex was considered sacred in the community and religious leaders representing the three major faiths in Ghana – Traditional African religions, Christianity and Islam – were not willing to openly publicly discuss sex-related issues. This reluctance to talk publicly about sex-related issues was also confirmed by Respondent 6. She indicated that although there were many people in Ghana preaching the Word of God on a daily basis at public places, including market centers, it was difficult to find people who would talk about family planning practices and the use of BC products at public places. Such an activity would be considered sinful.

Respondent 7 indicated that the low acceptability of RH policies and BC products and contraceptives was largely due to misconceptions. The misconceptions about family planning reflected religious and cultural beliefs and adverse health implications from its use. These misconceptions primarily stemmed from lack of education, lack of funds to mount effective outreach programs to educate people and increase awareness of BC products and contraceptives. She stressed that although there were some fertility clinics and specialized family planning clinics, patronage was poor.

Respondent 9 said "culture of Ashazim is not generally practiced as Islam does not encourage open discussion of sex". Respondent 10 said "Muslim leaders and husbands do not encourage women to practice birth control because of misconceptions concerning a particular set of diseases".

4.5 Views of Elites on RH and the Quality of Health Systems and Health Services

Respondent 1 stated that "The area lacks social amenities and public utilities such as hospitals and potable drinking water. There was so much pressure on the only district hospital, such that the administration and hosting of family

planning and birth control methods and products were not a priority issue. A small facility existed at the outpatients' department of the district hospital but it lacked proper security and confidential outlook; hence, patronage was low as the facility was directly exposed to on-lookers and the general public.

Respondent 2 noted that the family health clinic established at Onyasanaa was not patronized because few people were aware of its existence. Further, the levels of fees for its use were high and many people could not afford those fees. He suggested that "more quality health centers, and family health clinics should be established in the Ga West District and that National Service Personnel could be employed to disseminate information about RH policies and use of BC products and contraceptives to the remotest villages".

Respondent 6 said that "though family planning clinics existed at major market centers in Accra to educate people about BC products and contraceptives, only a few women have shown interest in using these facilities". Respondent 3 noted that "the lack of availability and affordability of birth control methods hinder acceptability of these products". He argued that the provision of more family health centers and clinics and the expansion of the existing ones would positively influence the acceptability of RH policies and increase the use of BC products and contraceptives.

Respondent 4 responded to questions on availability and affordability of the birth control methods. She said availability of distribution centers, affordability of birth control products and the provision of information about the products are key factors necessary to generate interest from people to accept RH policies. Inadequate amounts of funds to recruit, train and pay skilled people to work in communities to educate people about the availability of BC products and contraceptives were a major obstacle in advancing acceptability of RH policies.

Regarding the poor performance of the Ghana Health Service (GHS) articulated by Respondent 4, the researcher organized a follow-up-interview at the Headquarters of the GHS in Accra and discussed the issue with Respondent 7. Respondent 7 indicated that "measures have been put in place at the regional levels to ensure acceptability". However, she was not able to elaborate on the exact measures that had been put in place by GHS to ensure acceptance of RH policies and BC products and contraceptives. Respondent 7 was also unaware of what precisely happened at the various district levels and communities.

4.6 Views of Elites Related to Awareness of RH and Family Planning Policies

Respondent 2 said that "involvement of non-governmental organizations to support reproductive health policy and use of birth control products are currently lacking and are no longer available because most foreign donors have withdrawn their financial assistance". He noted that government agencies had reduced their financial support of programs dealing with family planning. He emphasized the creation of awareness of the benefits of birth control methods. He said "when a community is educated on RH policies and birth control methods, they can influence friends and relatives". He also charged civil society organizations to undertake educational campaigns on family planning and the use of BC products and contraceptives.

Respondent 7 said that about two decades ago, serious attempts were made to aggressively tackle the increasing population growth. Radio and television advertisements were made in various Ghanaian languages. Public announcements were made using megaphones and the traditional "gong-gong" instrument at the various market places. This process continued until the advent of fertility herbal medicines. She indicated that after that "then came the free maternal service for the lower-income and less educated people in 2007. It was an opportunity to have more children, and thus, RH policy dissemination and birth control methods were no longer a priority".

Respondent 6 suggested that people needed to have incentives and regular information about the need to have small families because small families led to improved economic and health benefits. She said there was the need for volunteers at the market centers to carry out awareness on RH and the use of birth control methods. She expressed concerns that "life itself is making its own advertisement on the use of family planning; as life becomes harder, the acceptability of family planning and the use of BC products and contraceptives would increase".

In support of these views, Respondent 10 expressed her view that economic empowerment was important for Muslim women because they often did not have formal education to equip them with skills. She further said that "poverty is prevalent and extensive in Muslim communities".

Respondent 3 suggested that when the population was well informed through extensive interactions with stakeholders such as schools, media, chiefs, opinion leaders and other various community leaders and health providers, the acceptance of family planning and BC products would increase. Respondent 3 further stated that, "there should be a change in the attitude of people in Ghana in relation to RH policies and the use of birth control products for acceptability by the average Ghanaian". There was misinformation that the usage of BC products and

contraceptives could result in premature deaths of young women and continuous use by men would make them impotent.

Respondent 4 spoke about the general misconceptions attributed to the use of birth control products. She indicated that these included the following: (a) Serious health problems such as high blood pressure, diabetes, kidney problems, and cancers; (b) permanent sterility; and (c) increased likelihood of becoming overweight and obese with attendant serious health problems related to the heart. She noted that some of these misconceptions were exaggerated because of lack of awareness. She conceded that side effects from the use of BC methods and products existed. But she indicated that regular monitoring of the use of these products at family planning clinics could effectively control these side effects.

Respondent 7 supported the view of Respondent 4 that potential users of birth control methods should be made to understand the benefits from increased economic welfare and empowerment as a result of the use of BC products and contraceptives. She supported the position that "birth control product expenditures should be subsidized by the State. Private philanthropists could be encouraged to support RH programs through the adoption of villages for RH sponsorships".

Respondent 5 said that "the main factor that influences or hinders acceptance of RH policy and use of birth control methods is advocacy". She defined advocacy as forms of public education through the media, community engagement, and outreach programs through schools, market centers and durbars sponsored by Traditional Councils. She indicated that the National Population Council had met editors of radio, television and print media to encourage them to partner the Council to increase education and awareness on reproductive and sexual health including the use of BC products and contraceptives. The Council was planning to introduce a television series called "YOLO" to educate the youth on their reproductive health.

Respondent 5 further stated that the Council received funds from the Government of Ghana, international partners such as the United Nations Population Fund, World Health Organization (WHO), Palladium (UK), Communicate for Health USA, United States Agency for International Development, among others. Despite these multilateral sources of funds, she complained that the funding was inadequate to sustain the various RH programs.

Respondent 5 also complained about the problem of "duplication of efforts"; that occurs due to many stakeholders and institutions doing the same thing in very different ways thus confusing the populace. She suggested that each stakeholder should be advised to focus on particular areas of its strength and coordinate with others to improve overall performance.

Respondent 8 stated that major factors that affected or influenced acceptability of RH policies and the use of birth control products and contraceptives were: (1) education; (2) availability and affordability of birth control methods; and (3) funding of the programs on reproductive issues. She also indicated that several misconceptions affected the level of acceptability and these misconceptions concerned with the quality of health of women deteriorating with the use of birth control products and contraceptives. In her opinion, men had been totally ignored regarding reproductive health policies and the use of birth control products and contraceptives. She suggested that future RH programs of the State and community institutions and organizations should involve men.

The Muslim perspective was given by Respondents 9 and 10. Respondent 9 emphasized that the creation of awareness was the key to the acceptance of RH policies. Respondent 10 reiterated her acceptance of the view of Respondent 9 by saying in her words as follows: "when people are aware of it, they will accept it".

4.7 Views of Elites on National RH Policies and International Perspectives

Respondent 3 noted that the first step in of RH Policy formulation is to develop an RH National Health Policy: - with the motto "Ensuring healthy lives for all". The scope of the policy should recognize the wider operational definition of health as being "a state of complete physical, mental and social wellbeing of a person and not merely the absence of disease or infirmity". He indicated that the WHO further recognized people and their actions that impacted on the health of the population and not just those directly involved in the provision of healthcare services.

Respondent 5 stressed that the current national population policy derived its strength from Article 37 of the 1992 Fourth Republican Constitution of Ghana. She indicated that in March 1961, the Government of Ghana adopted the first National Population Policy with a framework document entitled "Population, Planning for National Progress and Prosperity". This policy was reviewed in 1994 to incorporate emerging issues. In 2017, another review was undertaken to address issues and previous implementation challenges. There are two main objectives of the policy: (1) To have the national population growth rate reduced to sustainable levels; and (2) To have increased contraceptive prevalence rate to ensure fertility decline.

Respondent 5 stated that future programs of the National Population Council would focus on providing information to young people on reproductive health, helping the youth understand their reproductive health rights and to help the youth to identify the support channels where they could access legal representation in cases of rape, sexual abuse and others. She further stated that the National Population Council would establish information centers in urban communities to create awareness of reproductive health issues. School clubs would be inaugurated to educate students on health issues of teenagers.

4.8 Discussion

4.8.1 Similarities of the Views of the Elites

The researcher identified several areas of similarities. The important role of awareness and information in influencing the acceptability of RH policies was the first point of agreement. Awareness was also fully endorsed by the two elite representatives of the Muslim Community – Respondents 9 and 10. The influence of the affordability of BC products and contraceptives and their use was also a common point of agreement. The relatively high level of poverty in the Ghanaian society meant that BC products and contraceptives should be affordable by the majority of the adult population. Further, the limited numbers of proper family planning clinics and specialist clinics in Ghana were a point of agreement by the elites. Almost all the elites suggested increase in the numbers of these clinics.

Given the conservative nature of Ghanaian society, the general difficulty related to the discussion of family planning and sexual matters was noted by most of the elites. Several elites indicated that this reluctance or difficulty in discussing sexual matters cut across the religious and cultural divides. Further, limited funding by the government in supporting outreach services was identified as a common item the elites agreed upon. The need to involve men in the implementation of RH policies dealing with BC products and contraceptives was generally agreed upon by the elites; however Respondent 9 expressed reservation for this role for men.

4.8.2 Contrasting Views of the Elites

The researcher also identified two main areas of disagreement among the elites. The first point of disagreement was the role that non-governmental organizations (NGO) play regarding awareness of availability of BC products and contraceptives. Elites who were bureaucrats working for the State or NGOs felt that NGOs had an important part to play in the formulation and implementation of RH policies. Other elites, especially the Muslim community leaders, did not see an important role for NGOs in the formulation and implementation of RH policies. Second, the international aspects of RH policies were discussed by the government bureaucrats with little participation by community leaders.

4.8.3 Implication of the Findings

The findings derived from the responses of the interviewees have several implications related to the acceptance of RH policies related to the use of BC products and contraceptives. From the discussions with the elites, the following factors were identified as hindering the acceptability of RH policies and use of BC methods and products. These included the exclusion of men from RH policy formulation and implementation, poverty in the community, especially among women, misconceptions about diseases resulting from the side effects from the use of BC products and contraceptives, inadequate awareness of these products and lack of incentives by State authorities.

Awareness of birth control methods and products was a point agreed upon by all the ten elite persons as necessary requirement for the wide acceptance and use of birth control products and contraceptives. An implication of this finding is that the relevant State institutions need to step their awareness and publicity campaigns to reach the wider population with regards to the availability of birth control products and contraceptives that could be used to ensure proper family planning in the country. Given the conservative and religious nature of the country's population, proper care is needed to ensure the successful implementation of awareness and publicity campaigns.

5. Conclusions and Recommendations

A major finding of the qualitative study involving the elites was the role of awareness and information in influencing the acceptability of RH policies. The influence of the affordability of BC products and contraceptives and their use was also a common point of agreement. The limited numbers of proper family planning clinics and specialist clinics in Ghana were seen to be a hindrance towards the acceptance of RH policies and the use of BC products and contraceptives. The elites agreed that the Ghanaian society was a conservative one and this presented a general difficulty concerning the discussion of family planning and sexual matters. There was some disagreement of the role of NGOs in creating awareness of availability of BC products and contraceptives in the community.

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