

**THE SOCIAL IMPLICATIONS OF CONTRACEPTIVE USE FOR WOMEN
IN YILO KROBO DISTRICT**

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(10162920)



**THIS DISSERTATION IS SUBMITTED TO THE INSTITUTE OF
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DECLARATION

I, **VICTORIA ALHASSAN-BIBARAJIE** do hereby declare that except for references to works of other authors, which have been duly acknowledged, this dissertation **THE SOCIAL IMPLICATIONS OF CONTRACEPTIVE USE FOR WOMEN IN YILO KROBO DISTRICT**, is the result of my own research efforts and that, it has neither in whole nor in part been presented for any degree elsewhere.

.....
Victoria Alhassan-Bibrajie



.....
Date

This work has been submitted for examination with my approval as supervisor.

.....
Prof. Clement Ahiadeke

.....
Date

(Supervisor)

DEDICATION

I dedicate this work to God Almighty.



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I appreciate God for His divine provision and protection without which I could not have come this far.

My sincere gratitude also goes to my supervisor for all the lifelong lessons he thought me while we worked together.

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ABSTRACT

One of the world's problems in the 21st century has been high population growth which slackens economic growth and development of many developing countries. This is fueled by high fertility rates especially in the rural areas. The era between 1960 and now has seen unprecedented development in the area of birth control mechanisms but with very little decrease in human population particularly in sub-Saharan Africa. With the proliferation of modern contraceptives and Ghana's enunciation of a family planning policy in 1969, it is anticipated that family sizes will drop to the barest minimum (replacement level). Rural areas still have the highest fertility rates due to issues related to their work, accessibility, affordability of contraceptives and to a large extent, culture. This study adopted both qualitative and quantitative data collection methods. One hundred and fifty six (156) women between the ages of 15 and 49 were investigated for the quantitative aspect of the study and a focus group for the qualitative aspect. The role of women, place of children, contraceptive perceptions and fertility preferences as told by women formed the sinews of this research. It was found that both old and young women have extended knowledge of contraceptives. Also educational background was found to be quite influential on contraceptive use which increased with increased education. Place of work and whether or not respondent belongs to an association also influenced fertility. Average number of children desired was four.

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LIST OF ACRONYMS AND ABBREVIATIONS

DRCHR –	District Reproductive and Child Health Report
FGD –	Focus Group Discussion
GDHS –	Ghana Demographic and Health Survey
GHS –	Ghana Health Service
GSS –	Ghana Statistical Service
HIV/AIDS –	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IUD	Intrauterine Device
JHS –	Junior High School
NMIMR –	Noguchi Memorial Institute for Medical Research
NPC–	National Population Council
NPP –	National Population Policy
SHS –	Senior High School
TFR –	Total Fertility Rate
UNICEF–	United Nation Children Emergency Fund
WHO-	World Health Organization
YKD –	YiloKrobo District
YKDA –	YiloKrobo District Assembly
YKDWC –	YiloKrobo District Water Coverage

CHAPTER ONE

INTRODUCTION

1.1 Background

This study looks at the social implications of contraceptive use for women aged 15-49 years in the YiloKrobo District of Ghana. Women in this age group are the focus of this study because they are in their reproductive age. Also, according to the officer in charge of the YiloKrobo District Reproductive and Child Health, most of the births in the district are given by women aged 15-49 years. Even though the YiloKrobo district has recorded births by a number of women younger than 15 years and older than 49 years, these births were seen to be abnormal because the women involved were either too young or too old and usually experienced some form of complications during delivery. Apart from these reasons, the District Reproductive and Child Health reports suggest that most contraceptive users are within this age bracket of 15-49 years.

From the establishment of the YiloKrobo district in 1988 (YiloKrobo District Assembly (YKDA), 2012), contraception has been part of the district's slogan as a population control mechanism. Even though contraceptives have been in use in the district for all the years the district has existed, a lot of women and, especially, teenage girls interfered with their pregnancies. The reason for frequent termination of pregnancy was that they were unwanted. Besides, the women involved were ignorant about any safe precaution to prevent pregnancies. Most of these women attempted abortion which led to complications and sometimes death according to an informant at the YiloKrobo District Health Directorate.

Even though the people have reservations about modern contraception, acceptance rate has gone up as indicated by increased patronage over the years. For instance in 2010, total contraceptive use for all methods in the district was 7,026 and increased to 8,620 in 2011(District Reproductive and Child Health Reports (DRCHR), 2010, 2011). Injectable (Deprovera and Norigenon) was the most patronized method in 2010 and 2011 forming 57% (4004) and about 52% (4854) respectively of all the methods available. Other regularly used methods include the male condom which had 26% prevalence in 2010 and 30% in 2011. Other methods include the pill with about 15% and 12% prevalence in 2010 and 2011 respectively. Lactational amenorrhea, Intrauterine Device (IUD), gel and foam are among the least used methods constituting less than 3% in 2010 and 2011 (DRCHR 2010, 2011).

Contraceptive use in YiloKrobo can be said to be growing considering the statistics above. Moreover the district is making progress as far as reproductive health is concerned as it came close to achieving its 2011 target of 60% patronage of contraception by women in their reproductive years. Instead, fifty seven percent patronage was realized (DRCHR 2010, 2011).

According to an informant, an officer at the District Health Directorate, these have been achieved through family planning information dissemination, often through durbar on festive occasions, radio, community sensitizations and more recently, through stickers. Some of the programs the district has embarked on to promote contraceptive use include the Planned Parenthood Association of Ghana (PPAG) and Planned Parenthood Association of the Republic of Korea's (PPARK) collaboration which had an aspect of family planning. There is also the youth corner at the various health centers where the

special needs of teenagers are met with expertise to handle teen problems on reproductive health.

The service providers in YiloKrobo include Ghana Health Service, Non-governmental Organizations namely Chrismek Right Foundation and Larit Ideas. Private Maternity Homes and Planned Parenthood Association of Ghana (PPAG) also provide family planning services.

Unarguably, the problem of unwanted pregnancies interferes with the education of girls because they may drop out of school and sometimes lose their lives due to unsafe abortions. In view of this, health workers in the sector of public health in the district are devoted to clients in meeting their reproductive health needs in order to manage this precarious situation. To this effect, they counsel and help them to make informed decisions that will improve and sustain their reproductive health. Some of the successes of the district with family planning programs include a reduction in teenage pregnancy by 9% between 2010 and 2011 according to the DRCHR of 2010 and 2011.

These successes are however not without challenges most of which are either client based or service provider based. According to an officer at the District Health Directorate, the problem is with the supply of specific methods where users do not get the exact method they want to use. The Ghana Health Service is the major supplier of contraceptives but sometimes faces commodity shortage leading to choice shifting or total discontinuation due to the problems associated with method shifting for some clients.

Notwithstanding these problems, the future seems promising for the district with regard to family planning and reproductive health as health workers work within the framework of the National Policy on family planning which aims to reduce the Total Fertility Rate

(TFR) from 5.5 to 3.0 and a contraceptive prevalence rate of fifty percent for modern method by year 2020 (National Population Policy (NPP), 1994). According to the Ghana Demographic and Health Survey (GDHS) 2008 report, Ghana has already attained its 2010 target of a 4.0 fertility rate (Ghana Statistical Service (GSS), Ghana Health Service (GHS) & ICF Macro, 2009).

1.2 Problem Statement

The Eastern Region is the third most populous region having 10.7% of Ghana's population (GSS 2011) with YiloKrobo as one of its rural districts currently facing pressure on land due to high population density and continuous growth (YiloKrobo District Profile (YKDA) 2010; Kinder, 2012). Rural women suffer the most in events of high population growth (Todaro & Smith, 2009) due to their high fertility and low infrastructural development. More women (54.6%) than men are employed in the informal sector with most being farmers with irregular income while unemployment is a little high (51.8%) among women than men in YiloKrobo District (YKDA, 2012).

Also, a number of women in the district are saddled with single-handed childcare because the men do not want to marry them due to the high cost of marriage in the area (Okeyo, 1979; YKDA, 2010).

Ironically, rural women as compared to their urban counterparts are more likely to keep large families (Ghana Statistical Service, Noguchi Memorial Institute for Medical Research (NMIMR) & ORC Macro, 2004) even though household income reduces per head with more members (Todaro & Smith, 2009). This is because some rural women still believe in having many children even though they cannot afford to take care of their

educational, healthcare and even emotional needs. The GDHS 2003 report also makes it clear that 60% of people who have five plus children are usually agricultural workers (farmers) who are considered one of the poorest income groups in the country (GSS, 2008). Dependency ratio is therefore high (39.1% children and 8.5% aged of 60 years and above) (YKDA, 2010).

This research focused on contraception which helps curtail some of the problems related to fertility and over population with its social implications for rural women. In essence, the research generally sought to determine the social implications of contraception, particularly on family size for women in the YiloKrobo district.

1.3 General Objective

The research generally sought to investigate the social implications of contraceptive use among the women of YiloKrobo.

1.4 Specific Objectives

The specific objectives of the study were to find out:

- i. The determinants of contraceptive use and family size in YiloKrobo.
- ii. The desired number of children (family size) and the corresponding social implications of the number desired by women in the YiloKrobo District.
- iii. The involvement of women in decision making in YiloKrobo District.

1.5 Research Questions

- i. What are the determinants of contraceptive use and family size?

- ii. Does education influence women's decision on the number of children to have?
- iii. Do women in YiloKrobo have knowledge of contraceptives?
- iv. Do women in this area desire a large number (4+) of children and are there any social implications to that effect?
- v. Who pays for childcare and what is the place of children in this society?
- vi. Who takes decisions regarding family planning?

1.6 Relevance of the Study

As high population growth is perceived to be a global problem and not only national, Todaro and Smith (2009), suggest that these problems will trickle down to individuals of the world especially those in rural areas. Hence the social implications of contraceptives in this study will serve as a source of information to future researchers on which areas of research to give urgent attention apart from contributing to the larger ongoing discourse on contraceptive use.

Results of this study will also inform decision making in terms of population control mechanisms once determinants of contraceptive use and family size are established.

The study will also provide information on the people's perceptions on contraceptives and family size as well as the social implications of such perceptions for policy recommendation and adaptation.

1.7 Organization of the Study

The study has been organized into five chapters. Chapter one presents an introduction to the study comprising a background, problem statement, research questions, objectives, justification and limitation of the study.

This is followed by a literature review, a theoretical framework, an overview of concepts and a conceptual framework of the study in chapter two. The study's methodology is considered in chapter three. The fourth chapter presents the results and discussions of both the qualitative and quantitative analysis of the data drawing linkages between contraceptive use, respondents' background and the relationship these have with family size.

Chapter five concludes the report with a summary, conclusion and recommendation for policy making.

1.8 Limitation of the Study

The researcher had a number of limitations in the aspect of data collection. In this regard, administration of questionnaires could not be done systematically as intended because the district has no comprehensive list of all the households in a particular community.

The researcher could not measure continuity in contraceptive use because information gathered was on two different periods viz; current and future contraceptive use. Exacerbating this limitation is the fact that the YiloKrobo District Health Directorate also lacked this information in its DRCHRs.

CHAPTER TWO

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

2.1 Introduction

A little over half a century ago, women in Ghana did not have access to pills or any other modern contraception; they were totally not existent in the country because not much had been done in this aspect of public health (Kaunitz, 2008). Also the onset of contraceptive application to population control in Africa was late (Caldwell & Caldwell, 2002). Hence, the African region could be excused for doubling its population between 1982 and 2009 (BBC, 2009a). This is further projected to quadruple by 2050 as estimated by the United Nations in 1999 (Caldwell & Caldwell, 2002).

The mid twentieth century saw a lot of improvement in this area and consequently, modern contraception does not only exist but comes with different methods and different reliability period to suit individual specifications (Kaunitz, 2008). Owing to the African belief in child bearing and children (the need for families to increase their numbers for security and economic reasons), modern contraceptive use is minimal as some claim to be practicing the traditional methods (Caldwell & Caldwell, 1987; Adongo, Phillips, Kajihara, Fayorsey, Debpuur&Binka, 1997).

Some works suggest that nonuse of contraceptives is as a result of factors like non availability, accessibility and the fear of side effects rather than cultural resistance and acceptability which are no doubt serious limitations to the use of contraceptives (Bongaarts&Bruce 1995; Amirrtha& Reid, 2008; Williamson, Parkes, Wight, Pettycrew, & Hart, 2009). It can then be said that women everywhere have peculiar limitations in the use of contraceptives ranging from individual level, family and then to service provision

but these limitations will be relatively minimal in countries that have reached higher levels of socio – economic development (Caldwell & Caldwell, 2002a).

Caldwell and Caldwell (1987) continue their argument by maintaining that African marriage is a contract between two families hence the woman has no right to practice contraception when in-laws and ancestors desire more children. In effect a woman loses rights over her fertility once she marries. A similar view is made of the KasenaNankana people of the Upper East Region of Ghana where wives are perceived to be properties of their husbands (Adongo et al. 1997). According to the informant at the YiloKrobo District Assembly, wives are cherished among the Adangmes, to the extent that a man who takes another man's wife was put to death in the olden days.

Adongo et al. (1997) are of the view that increased access to contraceptive methods will cause fertility rates in Africa to decline since studies show that the women involved often wished to have fewer children but agree that there is more to it than accessibility.

2.2 The importance of birth control

The birth rate of developing countries is unprecedented in world history (Thirlwall 2006; Todaro& Smith 2009). Population analysts believe, to a large extent, that a country's population be it low or high has a significant role to play in its development (World Bank, 1975). The large population of countries like China and Nigeria is an economic advantage because of the access to large markets. This notwithstanding, according to the population-poverty cycle theory, "rapid population growth yields negative economic consequences and thus should be a real concern for developing countries" (Todaro& Smith, 2009. p. 299).

2.3 The Mixed Focus of Population Control and Reproductive Health

Just as the health of women is important, so is a reduced population growth. Both go hand in hand but an attempt to achieve a reduced population rate does not mean emphasizing on reproductive health. Scholars have suggested various interventions like social development and contraceptive use to control population. Should the focus be on the population that will be reduced or the health of women, the bearers of babies should be the focus?

Most countries adopted their family planning policies in order to control population. However there is a new wave of reproductive health that does not emphasize so much on the population control aspect but rather on the general health and wellbeing of the woman.

Ghana's population policy for example deals with everything pertaining to the country's population which includes strategies of limiting it. From an individualistic point of view family planning is first to help the individual to take decisions at the household level while from a communalistic point, it is to help "maintain a level of population growth which is consistent with national development objectives in order to improve the quality of life for the populace (NPC, 1994, p.1)". The two are not in pursuit of two distinct outcomes but ultimately, shifting the focus onto the individual brings up the idea of the health of women.

2.4 Reproductive health and the focus on women

Family planning policies often measure success with the reduction in fertility and population growth rates and increased contraceptive use. To Jain (2001), success by these

standards is partial without the individual success factor which he measures with the HARI (Helping Individuals Achieve their Reproductive Intentions) index.

Therefore as much as it is important to consider the objectives countries have for their family planning policies, it is prudent to zero in on the individual woman (Bhatia, Cleland, Bhagavan&Rao 1997) and her health most especially (Jain 2001).

The 1994 population and Development conference aimed at focusing family planning on reproductive health rather than population control. Reproductive health was defined by the World Health Organization as “a state of complete physical mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes”. It is rather population policy that must focus on reproductive health (World Bank 1975), slower population growth is beneficial but higher benefits of reproductive health are better.

Lane (1994) concedes to the World Health Organization definitions but adds male reproductive health and child survival. A more specific definition with a focus on women is one given by the Population Council’s Middle East Working group on Reproductive Health is: the ability of women to live through the reproductive years and beyond with reproductive choices, dignity and successful childbearing and to be free of gynecological disease and risk (Lane, 1994). Women should not be seen to be baby makers whose lives must be regulated; rather they should be seen as instruments of development whose health must be of utmost importance, because empowering them will help them to take decisions, especially relating to their fertility (World Bank 1975; Todaro& Smith 2009).

Some are also of the view that most of the contraceptive methods are fashioned in ways that work on the system of a woman rather than a man because it is the women who conceive. Apart from the male contraceptive methods, the support and approval from partners make a significant difference in population control as much as their women's reproductive health (Biddlecom&Fapohunda, 1998). However scholars like Thirlwall, (2006) and Todaro and Smith, (2009), believe that contraceptive use is not the only way to reducing fertility rate. They suggest socioeconomic development which will give women the opportunity to develop.

2.5 The History of Family Planning In Ghana

Family planning started in Ghana in the late 1960s (NPC 1994; Todaro& Smith 2009; Gyimah, 2011). Launched in 1969 precisely, it was revised in 1994 (NPC 1994; Gyimah 2011) as a response to the new issues of HIV/AIDs and other factors affecting the Ghanaian population.

Education and sensitization on population issues were to go on in order to reduce Total Fertility Rate (TFR) from 5.5 in 1994 to 3.0 in 2020. Meanwhile, population growth of 3% in the same year to 1.5% in 2020 is a major target. The GDHS 2008 report shows that Ghana has achieved its 2010 target of 4.0 fertility rate ahead of time, even though rural fertility is still high (4.9).

Some countries which have a family planning policy are not achieving their targets due to wobbling support from government and leadership (Caldwell & Caldwell 2002a). The cultural resistance and religious opposition of contraceptive use especially from the Catholic Church also limit contraceptive practice. These notwithstanding, more

commitment from governments will produce greater success. The Chinese experience could be said to be an extreme form of population control, but they could be excused on the grounds of the exceptionality of their population issue (Wei-xiong, 2012). Contraception in Ghana generally faces religious and ethnic opposition but that notwithstanding, Ghana still has one of the lowest fertility rates in the sub-region (GSS, GHS & ICF Macro, 2009).

Information on demographic changes with regard to women abound but are not enough unless they translate into policies that support women's reproductive health as well as the general wellbeing of the entire population (Quilodran, 1996).

The GDHS 2003 report "interprets findings within the context of reproduction, health and women's status and empowerment" (GSS, GHS & ORC Macro 2004, p. 23). Some background statistics used include age, marital status, education, residence and knowledge. Other variables are empowerment, earnings and decision making power. All these affect a person's decision to use contraceptives even as the decision may be further influenced by culture and religion (Ammirtha & Reid, 2008). In line with this, Quilodran (1996, p.6) points out that "to a large extent, patriarchal structures and religious prohibitions regulate the lives of women in many regions of the world [with distinctiveness]". This cultural effect is seen more among rural people as Quilodran (1996, p.12) puts it "lower socioeconomic groups tend to be more traditional and are most likely to resist contraception".

2.6 Some Social Implications of Contraceptive Use

Most poor families are large because the large numbers serve as assets for economic gains and insurance towards old age hardships and poverty (De Silva, 2006; Todaro & Smith, 2009). Also,

“ The respect for high fertility, the horror of barrenness and the belief that births are necessary to reincarnate one’s ancestors, central to most traditional African religions at first impeded the family planning message and caused governments to be uncertain about how successful a program promoting contraception would be” (Caldwell & Caldwell, 2002, p 77).

However the institutionalization of national family planning programs in most countries is consequential of the new fertility trends around the world (Mason, 1997).

Currently trends are changing as societies move from traditional agricultural where human labour is needed to maintain farms to industrial or modern societies. One of the emerging features in the modern family system is the changing attitude towards the value of children. A prequel to this change in attitude has been socio-economic development which influences the cost of children (Caldwell, Philips & Barkat-E-Khuda, 2002; De Silva, 2006). According to Caldwell and Caldwell (2002b), urbanization may be a stronger push to this transformation in Africa. It has therefore become necessary for couples to keep smaller families.

Contraceptive use has consequently become one of the reliable ways by which women limit progeny, free themselves from unwanted pregnancies and improve upon their reproductive health as well as the health of the family particularly in sub-Saharan Africa where most of the maternal deaths occur (Williamson et al., 2009).

Most women use contraceptives for diverse reasons sometimes apart from the obvious reasons of preventing pregnancy and spacing (BBC, 2009b; Rovner, 2011). Research

shows that some women use contraceptives to regularize their menstrual periods while others use it to reduce menstrual cramps and headaches related to menstruation (Rovner, 2011).

It is however worthy to note that irrespective of these new trends, opposition from some religious groups is still strong. Catholics for instance prohibit the use of the modern contraceptive methods because they give rise to wide spread promiscuity among others but accept the natural method of periodic abstinence (BBC, 2009c). Islam as a pro family religion on one hand may not accept contraceptives explicitly but on the conditions that the methods used do not cause early abortions or create permanent child-free marriage (BBC, 2009b).

These prohibitions however do not dissuade women who want to use contraceptives from practicing it (Rovner, 2011). Also, women who face cultural limitations but are persistent practice it in secrete often living with the trepidation of being caught by their partners and even ordinary community members (Bawah, Akweongo, Simmons & Philips, 1999).

Some of other social implications of contraceptive use are quite severe. Apparently, women are supposed to acquire permission from their husbands before they begin to use contraceptives but this permission, most women do not get this approval especially in the rural areas where men usually want larger families subsequently resulting in covert use of contraceptives by women. When a woman's covert contraceptive use is discovered, it gives rise to conflicts not only with her partner but with other family members (Bawah et al., 1999). Some of these conflicts according to Bawah et al. (1999) are violent, involving wife-beating while others may divorce their wives or take a new wife.

As much as contraceptives may create tensions among spouses regarding a woman's reproductive autonomy as a result of her use of modern contraceptives, they can also increase sexual satisfaction because they help to attain reproductive goals (Bawah et al., 1999). This is where partners know and understand the essence of contraception.

Usually when women use contraceptives successfully, they are able to achieve their reproductive goals of spacing and limiting progeny (Bawah et al., 1999; Caldwell & Caldwell, 2002b).

Contraceptive use is also associated with promiscuity which when materializes, brings dishonor to the spouse. Some women even tease their mates who use contraceptives (Bawah et al., 1999). Some profound social implications of contraceptive use have been stated by Frost and Lindberg (2012) as;

“In documenting the important role of family planning, research has emphasized the links between contraceptive use and later ages at marriage, smaller families, longer birth intervals and the ability of women and couples to plan when and how many children to bear. These outcomes in turn, linked to improvements in infants, child and maternal health as well as to improved social and economic roles for women” (Frost & Lindberg, 2012. p 3).

They further purported that family planning results in economic and health benefits for women. According to Kaunitz (2008), contraceptives reduce unintended pregnancies and abortions and facilitate family planning via spacing of births. Effective contraception to him; provides both health and social benefits to mothers and their children.

In line with the above, contraceptive practice according to Creanga, Gillespie, Karklins and Tsui (2011), is cost effective as women need not spend on problems that larger families could bring.

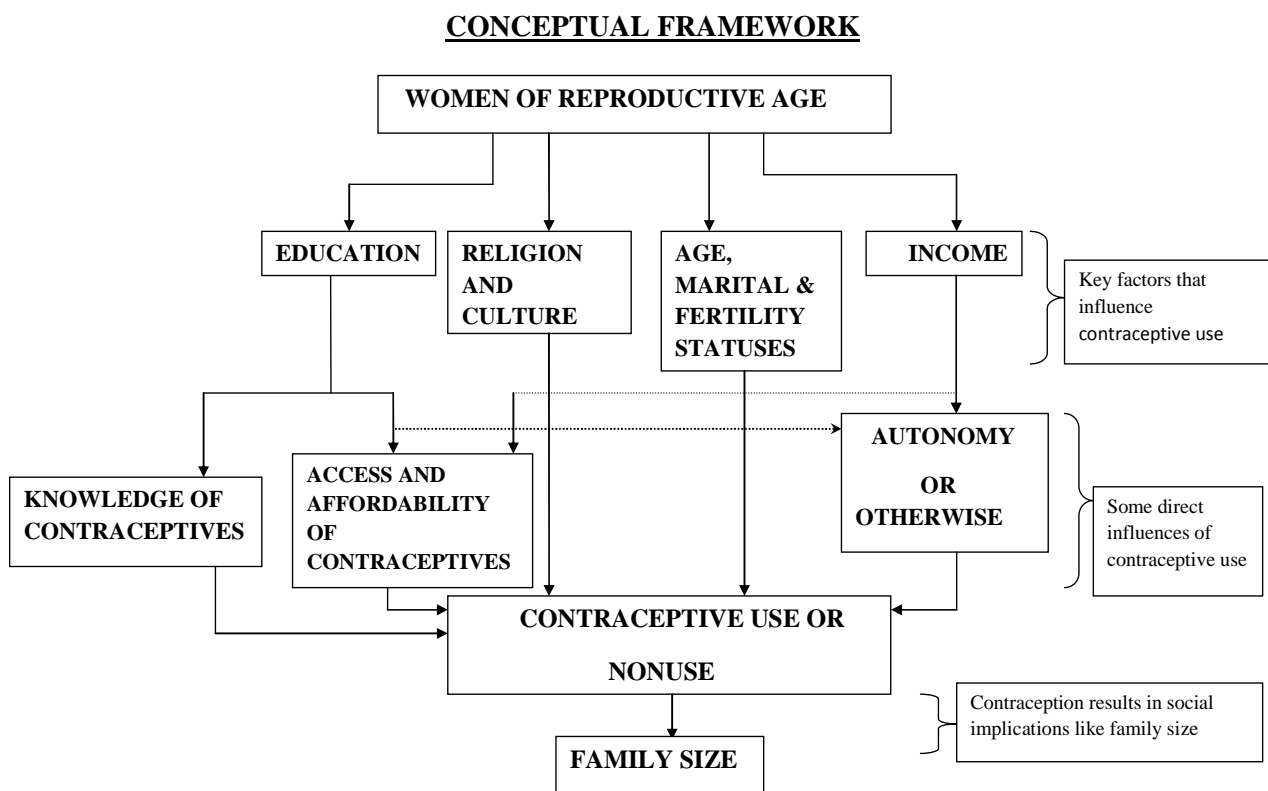
Another study by the University of Utah (2007) suggests that parents' survival decreases with increasing offspring. In the work of Bawah et al. it is suggested that contraceptive use give women some form of autonomy over their fertility and men detest this.

Families are better off when planned because of the many roles of women and limitedness of household resources per head (Todaro & Smith, 2009). Small family sizes will eventually reduce the country's population growth rate. Family planning helps to reduce maternal and child mortality and as an issue of social development, Beasley in the 1970s argued that family planning should be made an integral part of national agenda if countries want to reduce maternal and child mortality rates (Beasley, 1971). Singh, Darroch, Ashford and Vlassoff (2009) also believe family planning reduce maternal mortality while USAID/HAITI (2008) is also of the view that a small family size improves the quality of life in the home. Also, Hoan (1969), shares the opinion that birth control leads to improvement of life with regard to health and happiness of the community and the family in particular. The Muslim Women's League (1994) also shares this notion.

In a nutshell, contraceptive use generates many tangible consequences which are either positive or negative. Some of the positive implications include limiting procreation (small family size), longer child spacing, attainment of reproductive goals by couples and the creation of economic and health benefits for women. It also benefits the community in that, it reduces the risk of population explosion and gradually works towards population implosion. Teasing, beating, divorce and marital conflict constitute some negative implications. Apart from these, some women experience fertility related problems with

respect to their use of contraceptives but these are quite negligible. Ultimately, women who use contraceptives are able to limit their family size.

The effects and linkages of women’s various backgrounds as discussed above are summarized below in a conceptual framework. Social implication is therefore the sequel of a woman’s decision to use contraception, for example the size of her family.



(Source: Researcher, based on GSS, NMIMR & ORC Macro, 2004)

From the diagram, women in their reproductive age are influenced by their educational, religious and cultural backgrounds. Age, marital status and income levels help in their final decision to use contraceptives which eventually influences family size. Education further enhances knowledge, access and affordability of contraceptives as well as a

woman's autonomy over her reproductive choices. Religion and culture directly affect the contraception decision hence family size. Age and marital status also influence the decision directly. Income augments women's autonomy and hence affects access and affordability of contraceptives. These then affect the contraception decision which according to GSS, NMIMR and ORC Macro (2004), is "any method used to prevent or delay pregnancy". Contraception produces social implications, the major one of concern to this study being the size of the family defined by GSS, NMIMR and ORC Macro (2004) as the number of children women intend to have or has after completing her family.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This study used an approach that adopted a mixed methodology of both interpretivist and positivist approaches. The study has both qualitative and quantitative aspects thus the mixed methodology helped elucidate the fundamental findings of the study because both traditional methods have limitations. As Creswell (2009, p. 14) puts it “[researchers] recognizing that all methods have limitations, felt the biases inherent in any single method could neutralize or cancel the biases of other methods”. In line with Creswell’s suggestion, the study began with quantitative data to help generalize results to sampled population and then employed qualitative data sources like focus group discussion and in-depth interviews to collect detailed information from participants (Creswell, 2009).

The essence of a mixed method in this study cannot be overemphasized because as Mertens (2003) cited by Creswell (2009, p. 14), suggests “the methods can serve a larger transformative purpose to advocate for marginalized groups such as women [because of its expatriation attribute]”.

It also employed both primary and secondary data sources. Secondary data were acquired from the GDHS 2003 and 2008 Reports, YKDA (2010) and the DRCH Reports of 2010 and 2011. The study was conducted in the YiloKrobo District.

3.2 YiloKrobo District profile

YiloKrobo is one of the countrified districts in the Eastern Region of Ghana with its capital at Somanya. Its land resource is about 805 square kilometers, constituting about 4% of the Eastern Region.

According to the 2010 population and housing census, it has a population of 87,847 with an annual growth rate of close to 2.6% (YKDA, 2010). Females constitute about 51% in this current estimation. Also, children (0-14) form 39% of the population whereas the working group (15 – 59) account for 53% and the aged of 60 years and above form 8%. This signifies a high dependence ratio of close to 47%. This is because the 15 to 19 years group who are considered minors form about 10% of the population. Estimations from 2010 projections show that, about 32% of the people live in the capital, the only urban area in the district (YKDA 2010).

3.3 The Economy of the District

The district has good soil that does well with several food crops like plantain, cassava, palm and maize. Hence 58% of the people are employed in the agricultural sector alone. The remaining 42% are employed by other sectors like the small scale industries, services and trade. YiloKrobo has a forest reserve that is quite useful for the herbalists in the area as well as for the Mampong Scientific Research Center. It also has a limestone quarry which is an essential resource for cement making hence a major raw material for Ghana Cement factory (GHACEM). There are large deposits of clay in various parts of the district which are also extracted for industrial purposes. Farm lands are small, about 0.3 hectors and the main tools for farming are hoes and cutlasses. However a few of the

farmers are into large scale mango orchards where a little more sophisticated equipment are used (YKDA 2010).

3.4 The Fertility Profile of the District

Fertility is a sacred foundational concept among the YiloKrobo people. This is seen in some of their cultural practices like puberty rite which was initially done for girls between the ages of 15 – 18 but now at ages as low as four to usher the girls into womanhood and marriage which is another practice in which the sacredness of fertility is expressed. In marriage, Krobos expect that the woman would have as many children as possible to help on the farm and also to allow the good ancestors to be reincarnated (Caldwell & Caldwell 1987; Caldwell & Caldwell 2002a).

Currently, the district's population growth rate which could even be higher for the hinterlands is putting pressure on land (YKDA 2010).

3.5 The Culture of the People

The culture of the YiloKrobo people is similar to that of ManyaKrobo and Ada. They speak the Krobo language but because of trade and interactions with the other districts in the region, some can speak Twi as well. Their main food is fufu, kokonte and banku with palm nut or light soup.

The people celebrate the Kloyosikplemi festival in November and Kotoklo in May annually. They wear the African traditional cloth where women are forbidden to wear men's clothes and vice versa. Thus transvestism is a taboo in the area. Most of the people practice polygamy because they believe they must have as many children as possible and

also to have an alternative wife (or sex partner) when a wife is menstruating. Averagely, they contract marriage fairly early, by age 18-21 years even though not as early as in the olden days when girls were married immediately after their puberty rites were performed. They inherit patrilineally. It is their belief that women are the traditional housekeepers but a little education makes a difference in their output as mothers, wives and housekeepers. Children also have a special place in their traditions because more children have economic worth and also they bring respect to the bearers. Apart from this traditional belief, parents now believe that to secure the future of their children, they must have formal education according to one of the informants from the district assembly. For this special place of children, rites are performed for those born out of wedlock to be claimed by their fathers in a customary rite called 'Lapomi' (YKDA, 2010).

Education for young people forms an integral part of the Krobo society but unlike education, contraception is yet to become fully accepted as it is not existent in their culture. For them, it is normal for a barren woman to take medication to improve her fertility but unusual for a woman to do same to control her fertility. According to an informant, the only time a woman abstains from sex is when she is menstruating and voluntarily when she is in her menopause.

3.6 Survey Design

The research gave more weight to quantitative data than qualitative data. The qualitative aspect was to help give more meaning to the quantitative results. It involved an in-depth interview with three informants (the District Officer in-charge of National Commission

for Civic Education and Culture (NCCEC), the District Deputy Health Director and the Officer in-charge of Family Planning at the YiloKrobo District Health Directorate).

This aspect also involved a focus group discussion of twelve women from Adjikpo, one of the communities. The median age of the women was 29 years. The women involved in the focus group discussion were seven farmers, four traders and a nurse. Twelve women were chosen because the topic focused on women and the implications of their reproductive choices.

The focus group discussion was necessary because “it allows participants to share experience in a relatively unstructured way and enable both participants and researchers probe further for reasons why people hold certain views” and also “probing and arguments enable the researcher to settle on realistic accounts of situations” (Ofori&Dampson, 2011, p.51). In effect, focus groups help to fashion a meaning out of everyday life.

The quantitative aspect of the study involved a structured questionnaire administration. This was to help standardize both asking of questions and recording of answers (Ofori and Damson, 2011). One hundred and fifty-six (156) women between 15 and 49 years were involved from three rural communities in the YiloKrobo District. Age 15-49 was chosen because this is the reproductive age of women (GSS, NMIMR & ORC Macro, 2004).

3.7 Sampling Procedure

The sample population of women aged 15-49 years was selected using a multistage sampling procedure.

First, three of the seven (7) Area Councils (Somanya, Nkurakan, Boti, Oterkpolu, KloAgogo, Nsutapong and Obawale) in YiloKrobo were selected using a convenience sampling method based on proximity to the district capital, Somanya. At this stage, Somanya, Nkurakan and Boti were selected.

Second, one community each in these three area councils was randomly selected. All the communities under Somanya Area Council were put down on paper numbering 36. Subsequently, Adjikpo was randomly selected from the Somanya Area Council. The same was done for Nkurakan with forty-two (42) communities and Boti, fifty-two (52) communities (YKDA, 2009) where Wawase and Osoya were selected, respectively.

In 2010, Adjikpo in Somanya had a population of 1,868, Wawase in Nkurakan had 561 and Osoya in Boti had 348 (YKDA, 2010).

To further select houses where the sample would be drawn, the average number of persons in a house in the YiloKrobo district which is 9 (YKDA, 2010), was used to divide the population sizes of Adjikpo, Wawase and Osoya. It was found that approximately, there were 207 houses in Adjikpo, 62 in Wawase and 39 in Osoya.

With the help of the informant from the YKDA, Adjikpo was further divided into three equal clusters while Wawase was divided into two. Osoya was not divided due to its relatively small size. In all these divisions or community as it may apply, households were systematically selected based on the community's proportion of the sample frame.

With 3 clusters to select houses, the 207 houses in Adjikpo were also divided into three. That is in each Adjikpo cluster, there were approximately 69 houses. The same process was followed for Wawase. Eventually each Wawase cluster had 31 houses while the 39 houses of Osoya were maintained.

At this stage, households were systematically selected from every other house in all the clusters. In a situation where there was more than one household that had eligible women, (aged 15-49) in a selected house, the researcher randomly selected one household but was mindful of households with women aged 15-49 years where there was only one household with this category of women among other households. Also in cases where there was more than one eligible candidate in a selected household, one of the women was randomly selected.

In all, 35 women were selected from each Adjikpo cluster, 31 women in each of the Wawase clusters and in Osoya, 19 women were selected. Questionnaires were administered to the selected women but in selected houses where there were no eligible women to administer questionnaires to, the number of women was increased in the next house to make up for the short fall. The sampling procedure is summarized in Table 1.

Table 1: Sampling Procedure

Area Council	Selected Community	2010 Population	Approximated Houses	Percentage of Sample (%)	Community Divisions/ Clusters	Clustered Houses	Number of women	Total
Somanya	Adjikpo	1,868	207	67.3	Adjikpo (1)	69	35	105
					Adjikpo (2)	69	35	
					Adjikpo (3)	69	35	
Nkurakan	Wawase	561	62	20.3	Wawase (1)	31	16	32
					Wawase (2)	31	16	
Boti	Osoya	348	39	12.5	Osoya	39	19	19
Total		2,777	308	100	6	308	156	156

Table 1 shows the area councils that were selected for sampling as well as the randomly selected communities. Also the table shows the various divisions that were made in the

communities to aid data collection. It also shows information on the population sizes and number of households of the communities as well as the proportion of sample drawn.

3.8 Sample Size

In Somanya – Adjikpo, 105 women constituting 67.3% of the sample were interviewed through questionnaire administration. Also 32 (20.2%) women in Nkurakan-Wawase and 19 (12.2%) in Boti-Osoya were interviewed with the help of field assistants.

In all, 156 women of childbearing age (15-49 years) were investigated via structured questionnaires.

3.9 Structure of the Questionnaire

The questionnaire was structured into seven parts. The first was the background information which asked respondents for their age, educational level, religion, ethnicity, marital status, type and place of work, age at first intercourse, number of children ever born and the number of years spent in the district.

The second group of questions was on fertility preference. Respondents were asked whether they wanted to have more children, the number and the time they wanted to do that.

The third was on contraceptive use, knowledge, access, affordability and preference. Respondents' decision-making involvement in contraceptive use and household issues were investigated with questions in this sub-section.

Questions on social indulgence section were intended to probe the women on whether they find time to do other things apart from child-bearing and household chores. Data on

the value placed on children were collected through the questions on children's section while the last group of questions was on the facilities available to the respondents. This was meant to ascertain whether the people are living in rural communities and whether they have an economic value for children. It was also to bring the conversation to a relaxed closure.

3.10 Unit of Analysis

The Unit of Analysis was individual women in their reproductive years (15-49).

3.11 Theoretical framework

The researcher intends to explore the social implications of contraceptive use for women in the YiloKrobo District. For this reason, the researcher chose a mixed method approach which will reveal in-depth knowledge and also gather enough evidence to describe the situation. As Kusi (2012, p. 19) explains, "a qualitative approach like a survey compared to a case study tends to gather superficial information about a phenomenon and therefore cannot be employed to achieve in-depth adequately ...either a qualitative or mixed method will be more appropriate". In view of this, the qualitative or mixed method approaches enables a researcher to gather the views, feelings and experiences of the participants better for understanding.

The researcher also believes that social reality exists independent of the observer hence knowledge must be formed objectively by employing scientific method which have measuring qualities that can help make a set of laws for generalizations in human behaviour (Kusi, 2012).

3.12 Analytical framework

The research objectives include “the determinants of contraceptive use and family size in YiloKrobo”, “the desired number of children (family size) and the corresponding social implication of the number desired by women in YiloKrobo district”, “the decision making abilities of women and whose responsibility it is to pay for child care in the district”. These were achieved through descriptive statistical analysis and chi square test of association.

3.13 Variables

The dependent variable is family size which is acted upon by several independent variables identified in the study as age, marital status, affordability and accessibility of contraception, access to income, autonomy, religion, culture and contraception.

3.14 Explanation and operationalization of concepts

Women of reproductive age are usually aged 15-44years (WHO 2009) and 15-49 for demographic purposes (GSS, GHS & ORC Macro 2004). For the purposes of this study, reproductive age for women was defined 15-49years, because women younger than 14years or older than 49years barely reproduce hence may not consider using contraceptives.

Education was also defined as the highest level attained and measured as no education for those who had no formal education. The others included some primary, completed primary, Junior High School (JHS), Senior High School (SHS)and tertiary. It was presumed that educated women are likely to be more informed.

Age as another significant concept in this study was defined as respondent's age at last birthday measured in years put in range (15-19, 20-24 ...45-49). Age of women affects their fertility because fertility level falls as women advance in age (Sherbahn, 2013).

Respondents' marital status was relevant for issues of decision making with regard to this study. It was meant to ascertain whether respondents were in sexual relationships and whether those relationships were binding. Several questions in the questionnaire were used to elicit this relationship. Marital status was in this study defined as married, consensual union, single and widowed, divorced or separated. It was presumed that women in sexual relationships are more likely to be sexually active hence may consider the use of contraceptives to prevent unwanted pregnancies.

To ascertain whether respondents had some form of regular income, paid job, bank account 'susu' or access to micro-credit were used as proxies for having income. In this respect, having income was measured as paid job, bank account or 'susu' and access to micro loan. It was presumed that women who have income can afford contraceptives since the cheapest contraceptive cost Gh¢0.10p in the district.

Employment is what the respondent does for a living and was categorized into agriculture and non-agriculture related work or unemployed if respondent is not working.

Knowledge about contraceptives was elicited through a number of questions including whether respondent has heard of a contraceptive method and mentions it spontaneously. Another aspect of knowledge was formed by specific family planning messages respondents' were exposed to. Respondents' ability to identify a place where a

method can be acquired also formed a major part of contraceptive knowledge. Access augments contraceptive use. It was measured as getting preferred method when needed. Affordability increases contraceptive use to a large extent in that when they are too expensive, it dissuades its use. This was measured by respondent's ability to acquire a method when needed.

Religion as a subtle influencer of contraceptive use was measured by the various religious denominations of Christianity (Catholics for instance do not accept contraceptive use hence the categorization into the various denominations), Muslims and Traditionalists. Religion was thus measured as Catholic, Anglican, Methodist, Presbyterian, Charismatic or Pentecostal, Muslim and Traditionalist.

Autonomy was indicated by respondents' ability to take decisions that concern the family and themselves. This was elicited through a number of decisions respondents take solely by themselves or jointly with others. These decisions included contraceptive use, spending of respondent's income, respondent's health, making of large household purchases, making household purchases for daily needs, visits to family or relatives and what food should be cooked each day.

Contraceptive is the use of a method to prevent or delay pregnancy. It was measured by a respondent's current use of a contraceptive method. Family size is the number of children ever born to a couple hence it was measured as the number of children respondent has (for those who have completed their family) or hypothetically as the number of children respondent hopes to bear (for those who have no children yet) and the number of children respondent has plus the number she wishes to add. Desired family size is often smaller

than actual family size but these measurements often give an idea about the number of children women want at any point in time (GSS, GHS & ORC Macro 2004).

Social Implications are the various social consequences of respondents' decision to use contraceptives. These were obtained through questions under the social indulgence and children sections of the questionnaire as well as opinions from the focus group discussions. Table 2 provides a summary of the above.

Table 2 Operationalization of concepts

Concept	Operational Meaning	Expectation
Women of reproductive age	Women of reproductive age is defined as women aged 15-49 years.	These may be reproducing or have completed their family size.
Education	The highest level of education attained measured as: no education Some primary education primary JHS/Middle Secondary/SHS Tertiary	The higher the level of education the more likely a person will use contraceptives.
Age	Age at last birthday in years. Measured as 15-19, 20-24...45-49.	Younger women were expected to use contraceptives more than the older ones.
Marital Status (currently)	Married Consensual union Single Widowed/Divorced/Separated	Married women were more likely to use contraceptives than unmarried ones
Having income	Respondent has a paid job has bank account/ "susu" or access to microcredit	Women who have access to financial services were most likely to have some form of income hence can afford contraceptives with or without the help of their partners.
Employment	The kind of work respondent does. Agriculture related, Non agriculture related or Not applicable.	An employed woman is expected to have income which may augment her decision making abilities.
Knowledge/Information about contraceptives	Respondent has heard of a contraceptive method and mentions it spontaneously. Respondent also knows where to get a method.	Knowledge increases contraceptive use
Access	Respondent gets preferred method when needed.	It increases contraceptive use
Affordability	Respondent is able to acquire the	It increases contraceptive use

Concept	Operational Meaning	Expectation
	method needed.	
Religion	Catholic Anglican Methodist Presbyterian Charismatic/Pentecostal Other Christian Moslem Traditional/Spiritualist No religion	It depends on whether the religion accepts contraceptive use.
Autonomy	Indicated by a number of decisions respondent has final word or jointly decides with others.	The setting is rural and rural people are traditional in that they believe men should take all the decisions
Contraceptive use	Respondent uses a method used to prevent or delay pregnancy.	It is more likely to be low because the people desire more children culturally
Family Size	The number of children ever born or will be born to a couple	It is more likely to be high due to low use of contraceptives among rural people
Social Implications	The various consequences that develop due to a woman's use of contraceptives (example small family size, not more than 4 children)	Women with smaller family size are more likely to enjoy benefits like having more time for themselves and the children but may also face social problems like ridicules and violence

3.15 Univariate Analysis

In this sub section, the researcher analyzed individual variables of the study using Statistical Programme for Social Sciences (SPSS). Each variable was analyzed using univariate statistical tools like percentages and frequency distributions to summarize the data which were presented in the form of tables and graphs. This was to make comparison and communication easy (Booth, Colomb&Williams, 2008).

3.16 Bivariate Analysis

The researcher in this sub section analyzed two variables by constructing crosstabulation tables using SPSS. In addition, chi square tests were done and these were to disclose

relationships that may exist between them. Relationship between demographic features like age, level of education, and number of children ever born, type and place of work were established with other variables of the study.

3.17 Method of analysis

Objective one which was “to explore the determinants of contraceptive use and family size in YiloKrobo” was achieved through bivariate analysis using crosstabulation and chi square test constructed with several demographic features of the sample population in relation to the dependent variable of contraceptive use. The independent socio demographic and economic variables are age, education, religion and marital status. Others include place of work, knowledge of contraceptives, autonomy, association and access to electricity since contraceptive practice is influenced by access, literacy and availability of electricity (Caldwell & Caldwell 2002a). The chi square test was used to ascertain whether there were relationships among the dependent variable (contraceptive use) and the independent variables.

Objective two was to find out “the desired number of children (family size) and the corresponding social implications of the number desired by women in YiloKrobo District”. It was achieved through cross-tabulation and chi square test.

Objective three was to find out “the involvement of women in decision making in YiloKrobo”. This was achieved through frequency tables and chi square test using SPSS.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.1 Introduction

This chapter presents the results of the study using analytical tools such as cross tabulations and chi square test of association interlaced with discussions. Data were summarized into frequency tables and graphs to show relationships between some of the variables.

4.2 Univariate Analysis

This sub section presents data on individual variables used in the study. These include number of years in district, age, educational background, religion and ethnicity. Others include marital status, employment status, place of work, occupation and number of biological children. Also, data on contraceptive use, reproductive choices, knowledge of contraceptives, decision making abilities, income and various attitudes towards children and child labour are discussed at the latter part of this sub section. Some social engagements of respondents as well as household facilities available to them are discussed in the concluding part of the section.

Table 3: The background statistics of the sampled population

Characteristic	Frequency	Percentage
<i>Years in district</i>		
More than 5 years	141	90.4
Up to 5 years	15	9.6
Total	156	100
<i>Age (years)</i>		
15-19	12	7.7
20-24	35	22.4
25-29	45	28.9
30-34	34	21.8
35-39	7	4.5
40-44	10	6.4

45-49	13	8.3
Total	156	100
Ever attended school		
Yes	128	82.1
No	28	17.9
Total	156	100
Highest level of education		
No education	25	16.0
Some primary	22	14.1
Completed primary	34	21.8
JHS	22	14.1
SHS	27	17.3
Tertiary	26	16.7
Total	156	100
Religion		
Catholic	16	10.3
Anglican	8	5.1
Methodist	10	6.4
Presbyterian	13	8.3
Charismatic/Pentecostal	74	47.4
Moslem	18	11.5
Traditional/Spiritualist	17	10.9
Total	156	100
Ethnicity		
Akan	20	12.8
Ga / Dangme	86	55.1
Ewe	35	22.4
Mole Dagbani/ Guan/ Gruma/ Grussi/ Hausa	15	9.6
Total	156	100
Maritalstatus		
Married	84	53.8
Consensual union	30	19.2
Single	31	19.9
Widowed/ Divorced/ Separated	11	7.1
Total	156	100
EmploymentStatus		
Employed	151	96.8
Unemployed	5	3.2
Total	156	100
Placeofwork		
Home	124	79.5
Away from home	32	20.5
Total	156	100
Occupation		
Agric related worker	130	83.3
Non-agric worker	21	13.5
Unemployed	5	3.2
Total	156	100
Numberofchildren		
Zero (None)	7	4.5
One	23	14.7
Two	61	39.1
Three	27	17.3
Four	28	17.9
Five and more	10	6.4
Total	156	100

4.1.1 The socio-economic background characteristics of respondents

Table 3 shows data on the socio-economic characteristics of the respondents and it shows that majority of the respondents (90.4%) have lived in the district for 5 years or more while a few of them (9.6%) have lived in the district for less than 5 years. The data also show that 59% of the respondents are below age 30 while 41% were aged 30 years and above. In addition, more than 31.1% of respondents are in their youth. This is because those who are aged 15-24 constitute 31.1% hence could be said to be in their youth according to the World Health Organization's (WHO) definition of youth which is between 13-26 years. The modal age however is 25-29 years.

The results also show that 84% have ever attended school while close to 16% have not. Considering secondary and tertiary as higher education, 34% of the respondents have either secondary (17.3%) or tertiary education (16.7%). Also Table 3 further shows that while all the respondents are religious, a significant number of them (47.4%) are Charismatic or Pentecostal. Anglicans were in the minority with 5.1%. Those religious groups that do not accept contraceptive use are the Muslims, Catholics and the Traditionalists and these constitute about 32.7% of the sample.

Most of the ethnic groups in Ghana are found in the study area. Ga/Dangmes were in the majority (55.1%) obviously because they hail from the area. Ewes followed with 22.4%. Apart from the Akans who constituted 12%, the rest of the ethnic groups (Mole Dagbani, Guan, Grussi and Hausa) were minorities and therefore constituted 9.6% as shown in Table 3 above.

Further from Table 3 above, more than half of the respondents (53.8%) were married which is not surprising for a community that practices early marriage. Also, more than

half of the respondents were 30 years or more. Still from table 3, 19.2% were in consensual union, 19.9% singles while about 7% were either widowed, divorced or separated.

Employment status from Table 3 also shows that almost all the respondents (96.8%) were employed (they are engaged in some economic activity that generates income). Also, 79.5% of the women work from home because most of them are subsistent farmers whose farms are usually at the backyard or a short distance away from their houses.

In-depth interviews with informants revealed that unemployment is low because at least family lands were made available for farming whereas some women processed palm into palm oil, cassava into “gari” or sold the farm produce as they were harvested. However many of these were said to be seasonal employments. This situation invariably causes job switching according to the informant.

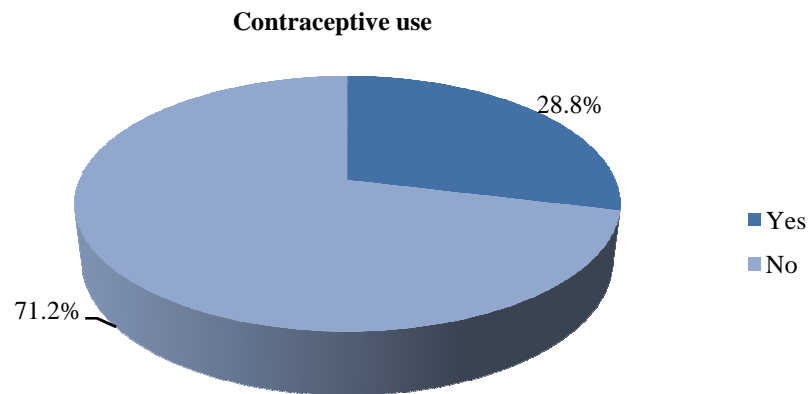
Agriculture workers constituted 83.3% of the respondents and 13.5% of them were engaged in non-agricultural economic activities. This is indicative of the fact that the area is mainly a farming community.

As a pro family community as well, results from Table 3 indicate that 85.5% of the respondents had one child at least but most (39.1%) had two children each.

4.1.2 Contraceptive practice among the respondents

The YiloKrobo District Profile (2010) states emphatically that the district has a high dependency ratio of 47% which worsens the poverty situation in the area. In view of this, it is anticipated that contraceptive use will be high but from Figure 1 below, only 28.8% of the respondents were using contraceptives.

Figure 1: Distribution of contraceptive practice among the women



From Figure 1 above, majority of the respondents (71.2%) did not use contraceptives. Only 28.8% said they used contraceptives and the reasons for low contraceptive prevalence have been discussed in the ensuing sub section.

Table 4: Contraceptive practice among the respondents

Characteristic	Frequency	Percentage
<i>Reasons for non-contraceptive use</i>		
Not married	9	5.8
Fertility related	47	30.1
Opposition to contraceptive use	14	9.0
Method related	8	5.1
Don't know	33	20.5
Not applicable	45	29.5
Total	156	100
<i>Future contraceptive use</i>		
Yes	57	36.5
No	99	63.5
Total	156	100
<i>Reasons for contraceptive use</i>		
Don't want any more children	19	12.2
Want to delay pregnancy or for spacing	8	5.1
Fertility control/ get pregnant when desired	9	5.8
Personal health	5	3.2
Enable respondent to give more attention to work	4	2.6
Not applicable (non-contraceptive users)	111	71.2
Total	156	100
<i>Association of promiscuity with contraceptive use</i>		
Yes	131	84.0
No	25	16.0
Total	156	100
<i>People who know respondent's use of contraceptives (Covet use)</i>		
Husband/Partner	6	3.8
Nobody	27	17.3
Some friends/relatives	12	7.7
Not applicable	111	71.2
Total	156	100
<i>Respondent's approval of contraceptives</i>		
Approve	16	10.3
Disapprove	42	26.9
Don't know	98	62.8
Total	156	100
<i>Partner's approval</i>		
Approve	7	4.5
Disapprove	61	39.1
Don't know	88	56.4
Total	156	100
<i>Affordability of contraceptives</i>		
Can pay for preferred method	35	22.4
Cannot pay for preferred method	10	6.4
Not applicable	111	71.2
Total	156	100
<i>Accessibility of contraceptives</i>		
Can get method when needed	22	14.1
Cannot get method when needed	23	14.7
Not applicable	111	71.2
Total	156	100

From Table 4, reasons given for low contraceptive use were varied. From the quantitative data reasons included fertility related issues with 30.1% preponderance. This however comprises interference with menstrual cycle, not having sex at all or infrequently, menopausal and breastfeeding. Of primary importance to this category are those who believe that contraceptive use delays pregnancy when a woman is ready to conceive. Another reason is opposition which may spring from the individual religious background or spouse. Opposition thus constitutes 9% of the reasons. About 5% gave reasons related to method unavailability, high cost or method incompatibility whereas 5.8% did not use contraceptives because they were not married. Contraceptive prevalence is low also because of the negative perceptions some women have about it. For instance the FGD found that contraception was all about pills and injections so to some women, “they were not sick to be taking drugs”. This was confirmed by the quantitative analyses which revealed that apart from the condom, the pill and Injectable are the most common contraceptive methods used among the women. Other women also associate promiscuity with it perceiving “you can sleep around and not even your husband will know”.

As the quantitative results have revealed, the qualitative data also presume an unmet need for contraceptive methods. From the FGD, women often listen to friends and end up using unfavorable methods which subsequently produce unsatisfactory results. Also, for some of the women, it makes them infertile and prolongs getting pregnant. In view of this, Jain (2001) suggests that a successful family planning program should meet these basic needs of women by solving peculiar individual method and fertility related problems. Also, the District Health Directorate in precognition of this real problem, charges extra GH¢ 0.50 on family planning services to enable it acquire more

commodities ahead of time in order to meet client's specific needs at every point in time. The DHD also educate women on what methods to use in order to avoid these problems associated with contraceptive use. Also, 20.5% did not indicate a specific reason why they do not use contraceptives.

In expectation that these obstacles will be removed in the future, respondents' views on future contraceptive use were solicited. Still from Table 4, only 36.5% of the respondents want to use contraceptives in the future, indicating that about 7.7% of respondents currently not using contraceptives may do so in the future.

Low contraceptive use could be attributed to the perception that contraceptive users are promiscuous. This is evident in the quantitative data where 84% of respondents associate contraceptive use with promiscuity as Table 4 indicates.

This notwithstanding, 12.2% of respondents use contraceptives because they do not want more children. Another 5.1% use it for birth spacing while 5.8% of respondents use it for fertility control or to get pregnant when desired. Other reasons for contraceptive use include personal health (3.2%) and to enable respondent to give more attention to work (2.6%).

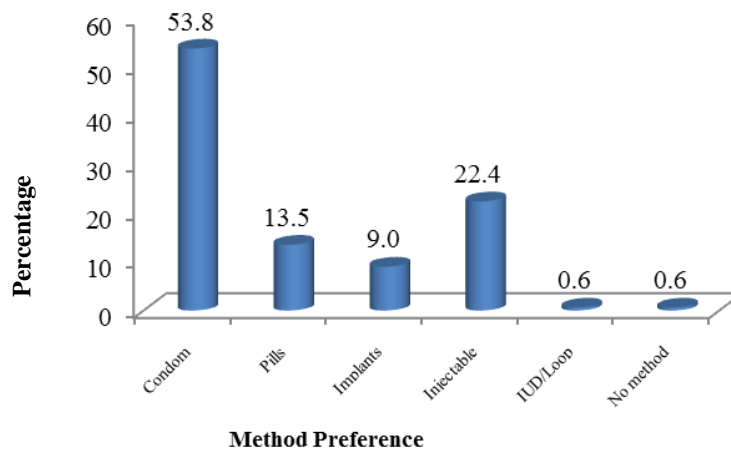
In most cases, respondents used contraceptives covertly because only 11.5% of them reported that either their partner, some friends or relatives know about their contraceptive practice (Table 4). The qualitative data on the other hand showed that most women were reserved about their contraceptive practice because of the misconceptions that come with it. This is further heightened by respondents' approval of contraceptive use. As revealed by the quantitative data, only 10.3% of respondents approve of contraceptive use, 26.9%

distinctly disapprove while majority (62.8%) doesn't know their position on contraceptive practice.

The story is not quite different with partners' approval as only 4.5% of respondents reported that their partners approve of contraceptive use. Thirty nine point one percent disapprove while 56.4% could not tell the position of their partners. Results from in-depth interviews and FGD however suggest that contraceptive practice is not supported by some traditional beliefs and practices such as "children are a blessing from God" and having many children to get ancestors to be reincarnated.

It is also evident from Table 4 that most contraceptive users (22.4%) could afford a preferred method while about half of users (14.1%) could access preferred methods when needed.

Figure 2: Distribution of method preference



Even though not all the respondents use contraceptives, knowledge, perceptions and individual experience from contraceptive use influence respondents' preferences of

contraceptive methods. In Figure 2 above, most of the women preferred condom arguably for its dual purpose as a contraceptive and as Sexually Transmitted Disease (STD) preventive mechanism. According to an informant, IUD and Loop are no longer available in the district. This may explain why only 0.6% of respondents prefer that method.

Injectable is the second highest contraceptive method preferred by respondents (22.4%) followed by pills (13.5%) and implants (9%) probably due to the high covert use of contraceptives among the respondents.

Table 5: Reproductive choices of respondents

Characteristic	Frequency	Percentage
<i>Age at first intercourse</i>		
Below age 15	4	2.6
15-19 years	119	76.3
20-24 years	29	18.6
Never had sex	4	2.6
Total	156	100
<i>Age at first birth (years)</i>		
15-19	84	53.8
20-24	58	37.2
25-29	6	3.8
Younger than 15	1	0.6
Not applicable	7	4.5
Total	156	100
<i>Number of children desired (Family size)</i>		
None	1	0.6
One	2	1.3
Two	19	12.2
Three	24	15.4
Four	85	54.5
Five and more	25	16.0
Total	156	100
<i>Actual family size</i>		
Same	34	21.8
Less than respondent wanted	111	71.2
More than respondent wanted	11	7
Total	156	100
<i>Reasons for exceeding number</i>		
Wanted a boy or a girl	7	4.5
In-laws wanted more children	1	0.6
Don't know, it just happened	2	1.3
Not applicable	146	93.6
Total	156	100

4.1.3 Respondents' reproductive choices

Both qualitative and quantitative results show that the respondents became sexually active fairly early in life as Table 5 shows, 2.6% of the women had their first sexual intercourse before age 15. A greater percentage (76.3%) had this encounter between ages 15-19 years and about 18.6% after age 19 years. Another 2.6% had never had sex. These figures are high as compared to the Eastern Regional average of 10.2% having first sexual intercourse between age 15-24 and the national average of (8.2%) having sexual intercourse between age 15 to 19 (GSS, GHS and ICF Macro, 2009).

Table 5 further shows that more than half (53.8%) of the respondents had their first child between age 15 and 19 years. Those who had their first child between age 20 and 24 years constitute 37.2% while 3.8% had their first child between ages 25-29 years. What may be considered an outlier is the 0.6% of the respondents who had their first child before age 15. These figures therefore presume that unless deliberate efforts are made, the women may have more than 20 years to have children up to about 10 if the birth intervals are assumed to be two years each.

Most of the respondents (70.5%) desire four or more children whereas 29.5% desire between one and three children. The qualitative results however suggest that women take pride in being able to bear more children. Some of the women in the FGD were of the view that four is the least a woman should have as a woman from the FGD reminisced, "four children are not many neither are they few, usually, by the fourth or fifth birth one would have gotten both sexes".

Apart from this maternal pride, the children may offer some support to parents. Since many of the respondents had not completed their family, results from Table 5 further

shows that 71.2% of respondents have less number of children than the respondents wanted and so have plans of having more children. Twenty one percent reported that they have completed their family while 7% had exceeded the number they initially wanted to have for various reasons.

The reasons for this “mistake” as respondents call it include ‘wanted a boy or a girl’ (4.5%), ‘in-laws wanted more children’ (0.65%) and ‘don’t know, it just happened’ (1.3%).

Table 6: Respondents’ knowledge of contraceptives and exposure to specific family planning messages

Characteristic	Frequency	Percentage
<i>Exposure to specific family planning messages</i>		
Life choices. Its your life , its your choice	149*	95.5
Make the choice that is best for you	142*	91.0
Contraceptives are safe and effective	142*	91.1
Obra ne warabo	150*	96.2
Emiredane a, wonsodane bi	151*	96.8
<i>Knowledge of a place to get a method</i>		
Yes	141	90.4
No	15	9.6
Total	156	100
<i>Place to get a method/Source of supply</i>		
Public health service	96	61.5
Pharmacy/ Chemist/ Drug store	24	15.4
Private health service	7	4.5
Friends, church or relatives	14	9.0
Knows no place	15	9.6
Total	156	100
<i>Source of knowledge</i>		
Radio	27	17.3
Television	3	1.9
Health worker	72	46.2
Community or social groups	32	20.5
Print media	22	14.1
Total	156	100

*Frequency is out of N= 156 (Total number of respondents).

4.1.4 Respondents' knowledge of contraceptive methods

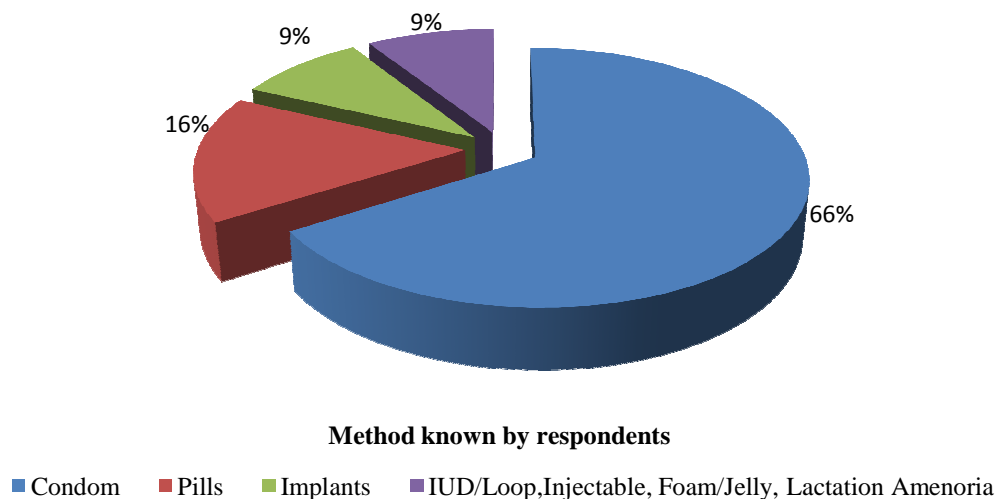
As revealed by the qualitative results presented earlier in this report, contraception is not accepted by most people in this community for traditional sacrosanct reasons. Table 6 summarizes data collected on respondents' knowledge about contraceptives and respondents' exposure to specific family planning messages. Table 6 indicates that more than 90% of respondents are exposed to all the family planning messages viz 'Life choices, it's your life it's your choice' (95.5%), 'make the choice that is best for you' (91%), and 'contraceptives are safe and effective' (91.1%). Others include 'Obra ne warabo meaning one's life depends on herself' (96.2%) and 'emiredane a, wonsodane bi meaning one should adopt new lifestyles based on the order of the day' (96.8%). Regardless of this level of knowledge and exposure, contraceptive use is low as the comparison in Figure 1 shows.

In addition to this, Table 6 further shows that 90.4% of the respondents have knowledge about a place to get a method whereas only 9.6% do not know an exact place to get a method. This is because superficially, some respondents claimed to know a place but could not mention a specific place where a method could be acquired. In this regard, 61.5% mentioned a public health service provider as a source of contraceptive method supply. Pharmacy, chemist or drug store is another well-known place with 15.4% prevalence. Others are private health service providers (4.5%) and friends and relatives (9%).

The contraceptive method known to respondents include Condom (both male and female) with 66% prevalence, Pills (16%), Implants (9%) and IUD/Loop, Injectable, Foam/Jelly and Lactation Amenoria collectively constitute 9%. Also 46.2% of them got their

information from health workers first before any other source. Other sources included radio (17.3%), television (1.9%), community or social group (20.5%) and print media (14.1%). The information on methods known is quite similar to respondents' method preference discussed earlier in this report and serves as stronger evidence that most respondents prefer the method they know about or are familiar with. Methods known by respondents are summarized in Figure 3.

Figure 3: Distribution of contraceptive methods known by respondents



The high level of knowledge expressed by respondents above is a confirmation of the GDHS report of 2008 as it stipulates that “knowledge of contraceptive methods among women age 15-49 in Ghana has increased substantially over the past two decades, although there has been little or no increase over the past five years” (GSS, GHS, and ICF Macro, 2009. p.82).

Table 7: Respondents ability to decide on some issues that affect them

Characteristic	Frequency	Percentage
<i>Decision to practice contraception</i>		
Entirely respondent's decision	40	25.6
Joint decision (respondent with partner)	5	3.2
Not applicable	111	71.2
Total	156	100
<i>Respondent's health</i>		
Respondent	99	63.5
Husband/Partner	27	17.3
Respondent and husband jointly	23	14.7
Someone else	7	4.5
Total	156	100
<i>Large household purchases</i>		
Respondent	78	50.0
Husband/Partner	16	10.3
Respondent and husband jointly	39	25.0
Someone else	15	9.6
Decision not made or not applicable	8	5.1
Total	156	100
<i>Purchases for daily needs</i>		
Respondent	84	53.8
Respondent and husband jointly	56	35.9
Someone else	10	6.4
Decision not made or not applicable	6	3.8
Total	156	100
<i>Visits to friends and relatives</i>		
Respondent	69	44.2
Husband/Partner	3	1.9
Respondent and husband jointly	68	43.6
Someone else	10	6.4
Decision not made or not applicable	6	3.8
Total	156	100
<i>Food to be cooked each day</i>		
Respondent	68	43.6
Husband/Partner	4	2.6
Respondent and husband jointly	68	43.6
Someone else	10	6.4
Decision not made or not applicable	6	3.8
Total	156	100

4.1.5 Participation in decision making among respondents as evidence of autonomy

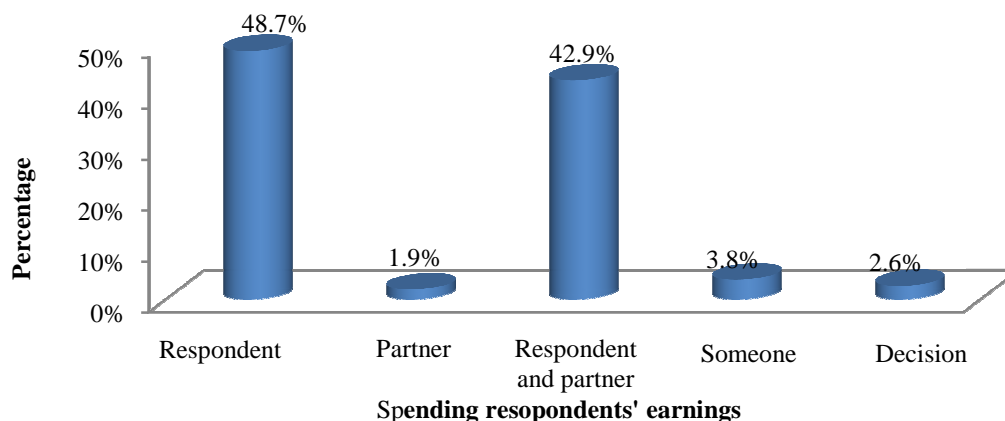
Earlier findings show that (71.2%) of the respondents are not contraceptive users while 28.8% are users. Out of the 28.8% who use contraceptives, 25.6% took that decision entirely by themselves while 3.2% took the decision jointly with their partners as shown

in Table 7. Still on Table 7, results suggest that 63.5% of the women take decisions concerning their health entirely by themselves, 14.7% took the decision jointly with their partners while in 17.3% of the cases, partners solely decide on respondents' health issues. Usually, parents or guardians took this decision for the younger respondents constituting 4.5%.

More than 75% of respondents were involved with decisions about large household purchases, purchases for daily needs, visits to relatives and friends and food to be cooked each day. They were involved either entirely by themselves or jointly with their partners. This is elaborated in Table 7.

Another instance where the autonomy of women could be examined is through spending of respondents' earnings. Quantitative results show that 48.7% of the respondents have final word on spending their own income while 42.9% decide with their partners on how respondents' income is to be spent. In all the cases, partners barely took decisions entirely by themselves whereas respondents were seen to be more involved in all the decisions. This signifies that the women are to some extent autonomous when it comes to taking decisions that concern certain aspects of their lives.

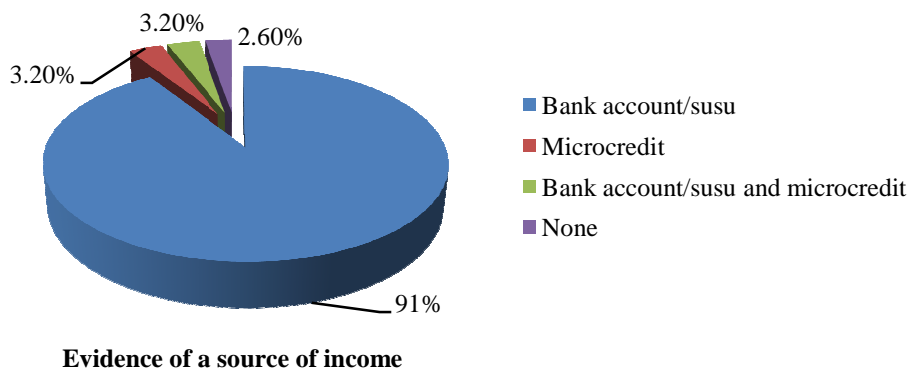
Figure 4: Decision on use of respondents' income



The quantitative results show that autonomy was high among individuals because a significant percentage (46.2%) was not in any legally binding relationship (not married) while the information gathered from the FGD suggest that most of the women are single or are single parents hence tend to take decisions by themselves. It further shows that a number of women are in polygamous marriages making it impossible to have their husbands around always to take part in daily decision making. Figure 4 shows the distribution of decisions on the use of respondents' income.

With regard to having income, 2.6% of respondents did not make this decision probably because they have no income or live with their parents or guardians who take the decision on their behalf.

Figure 5: Evidence of a source of income among respondents



Access to income allows respondents to purchase a contraceptive method of their choice but the choice also depends on respondents' income level. The study shows that almost all the women had some source of income. It indicates that 91% have bank accounts or

“susu” while 3.2% have microcredit. Those who had both also constituted 3.2% whereas 2.6% did not have any as illustrated in Figure 5.

Table 8: Some social implications of contraceptive practice

Characteristic	Frequency	Percentage
<i>Proportion of respondents' income spent on household expenditure</i>		
Almost none or none of income	6	3.8
Less than half of income	30	19.2
About half of income	38	24.4
More than half of income	82	52.6
Total	156	100
<i>Experienced ridicule for</i>		
Few children (1-3)	4	2.6
Many children (4+)	2	1.3
No such experience	150	96.2
Total	156	100
<i>Loss of opportunity</i>		
Further education	31	19.9
Employment opportunity	22	14.1
Further education and employment opportunities	18	11.5
No such experience	85	54.5
Total	156	100

4.1.6 Some social implications of respondents' reproductive choices

It is presumed that contraceptive use helps women to limit progeny hence the use or nonuse of contraceptives affects the size of the family. Also, the number of children a person has could influence her spending. As shown in Table 8, most of the respondents (52.6%) used more than half of their income on household expenses whereas only 3.8% spent almost none of their income on household expenditure.

Also, a good number of the women (96.2%) have never experienced any form of ridicule concerning the number of children they have. In like manner, 54.5% have not lost any opportunity to further education, get employment or expand their business. An ostensible reason suggested in the FGD for this occurrence is the cultural preferences and the momentary help mothers receive from other family members in taking care of children.

Rather it is as a result of lack of determination on the part of the women to pursue further education.

Table 9: Respondents' attitudes towards children

Characteristic	Frequency	Percentage
<i>Paying for child care practices</i>		
Mother only	46	29.5
Father only	6	3.9
Both parents	79	50.6
Both parents and extended family	1	0.6
Both parents, extended family and the entire village	24	15.4
Total	156	100
<i>Approval of children to work on the farm</i>		
Yes	72	46.2
No	40	25.6
Don't know	44	28.2
Total	156	100
<i>Extent to which children work on the farm</i>		
More times	72	46.2
Few times	40	25.6
Never	44	28.2
Total	156	100
<i>Extent of loses without the help of children</i>		
A lot of loses	20	12.8
Medium amount of loses	19	12.2
Little loses	54	34.6
No loses	9	5.8
Not applicable	54	34.6
Total	156	100
<i>Least level of education for children</i>		
JHS	3	1.9
SHS/Vocational/ Technical	30	19.2
Tertiary	123	78.8
Total	156	100

Further explanations are derived from Table 9 which shows that even though majority of the respondents (50.6%) believe that payment of child care should be the sole responsibility of both parents, a good number (49.4%) believe it should either be that of mothers only, fathers only, parents and extended family or the entire village.

Research has show that rural women are less likely to use contraceptives (Quilodran, 1996) resulting in their relatively high fertility rate. Also, due to the poor socio-economic

background of rural women, they are more likely to engage their children in revenue creation activities (Todaro & Smith, 2009). With this background, the researcher collected information on women's approval of children being allowed to work on the farm. The data suggest in Table 9 that 46.2% frankly approve that children should work on the farm. Also, 46.2% of the respondents allow their children to help them in an income generating activity mostly farming most of the time or few times (25.5%) as the details in Table 9 show. This is suggestive that children have an economic value as farming is the mainstay of the people. Also, 59.6% recounted that without the help of their children, they will incur some form of losses. This was obvious as some participants of the FDG could not stop praising their wards as in their view "the children are helpful, very good, unlike other children who would not help at home".

Other findings from the FGD suggest that sending children on errands or letting them help around the house or on the farm to augment meagre household income is a usual African practice hence the more the number of children the better (UNICEF Ghana, 2009).

The FGD further suggests that even though some people unconscionably engage children, no parent does this with the intension of using children to enrich themselves or foreclose the children's educational aspirations. As one of the focus group participants reported; "even some of the teachers have small farms where they engage the children to weed, sow and harvest sometimes during school hours so why can't we, their parents do the same?". This was however refuted by a number of women who think that practice is not good and therefore should not be encouraged. Regardless of all these, the women desire

that their children will have the highest education affordable, as such, 78.8% want their children to have tertiary education. These are illustrated in detail in Table 9.

Table 10: Activities respondents engage in apart from work and house chores

Characteristic	Frequency	Percentage
<i>Belong to an association</i>		
Social (Church or mosque)	102	65.4
Political (women's wing of a political party)	14	9.0
Economic (Microcredit group or lending scheme)	4	2.6
None	36	23.1
<i>Total</i>	<i>156</i>	<i>100</i>
<i>Time for relaxation or hobby</i>		
All the time (almost every day)	117	75.0
Few of the time (once in a week at least)	39	25.0
<i>Total</i>	<i>156</i>	<i>100</i>

Since most of the women were found to be religious, most of them (65.4%) were found to belong to social groups which were church or mosque based. Those who were quite politically active constituted 9% and belonged to the women's wing of a political party. Two point six percent however belonged to a village group lending scheme. Also, about 23.1% do not belong to any group. Majority (75%) had time to relax almost everyday. Table 10 gives the details.

Table11: Some household amenities available to respondents and material residential facility is made of

Characteristic	Frequency	Percentage
<i>Source of water</i>		
Well	31	19.9
Borehole	101	64.7
Pipe	21	13.5
Stream/Rain	3	1.9
Total	156	100
<i>Access to electricity</i>		
Yes	112	71.8
No	44	28.2
Total	156	100
<i>Source of cooking fuel</i>		
LPG	10	6.4
Kerosene	5	3.2
Firewood	17	10.9
Charcoal	124	79.5
Total	156	100
<i>Materials residential facilities are made of</i>		
Modern	27	17.3
Semi modern	109	69.9
Traditional	20	12.8
Total	156	100

4.1.7 The living conditions of the respondents

Research shows that rural people have less access to treated water than urban dwellers but rural dwellers have frequent access to water than their urban counterparts (Todaro & Smith 2009). This is reflected in the results in Table 11 which shows that many of the respondents (64.7%) had continuous access to water from a borehole. Another 13.5% depend on pipe born water for drinking. Majority of them (71.8%) also had access to electricity. The main source of cooking fuel identified was charcoal with 79.5% preponderance.

Also, most of the respondents (69.9%) lived in semi modern structures where roofs are either made of wood or old iron sheets and structure made of mud plastered with cement or made of wood. Such buildings mainly have floors that are rudimentary or made of

natural flooring materials such as sand or wood. Others however were found to be made of concrete. These details were intended to show living conditions of the respondents as people who live in a rural area.

4.3 Bivariate analysis

4.3.1 Some determinants of contraceptive use in YiloKrobo District

Women use contraceptives for diverse reasons. In order to ascertain the factors that propel the use of contraceptives among the women, the researcher collected data on the background characteristics of the respondents. These included age, level of education, religion, marital and employment status. They were also asked a series of questions including whether they are able to afford and access their preferred contraceptive method. They were also asked whether they belonged to an association or have time to rest. Information on place of work as well as respondents' proportion of income used on household expenditure was solicited. A chi square test of association and a cross tabulation were done with these variables with contraceptive use as the dependent variable using Pearson chi square in SPSS.

Table 12 presents the results of the cross tabulation and chi square tests which were to help ascertain whether age, level of education, religion, place of work, accessibility, affordability and marital status are related to contraceptive use. In order to perform the chi square test, some of the cases were collapsed to meet the minimum count for a chi square test, where for example, religion was regrouped into those religions that oppose contraceptive use (Category 1) identified in the study as Roman Catholic, Muslims and Traditionalists. The other group consisted of those who did not have a clear opposition to

contraceptive use (Category 2) also identified in the study as Charismatics, Methodist, Anglican and Presby. Education was likewise categorized into no education, low education (Primary and JSS) and high education (SHS and tertiary). Marital status subsequently became married and unmarried. Age was measured 15-24, 25-34 and 35-49 years.

Table 12: Contraceptive use in relation with education, religion, place of work and other determinants of contraceptives

Variable	Contraceptive use		N	Pearson Chi Square (significance)
	Yes	No		
Religion				0.789
Category 1 (Catholic, Islam and Traditional)	14	37	51	
Category 2 (Charismatic, Methodist, Presbyterian and Anglican)	31	74	105	
Total	45	111	156	
Education				0.013
No education	19	36	55	
Low education (Primary/JSS)	12	57	69	
High education (SSS/Tertiary)	14	18	32	
Total	45	111	156	
Place of work				0.00
Home	20	104	124	
Away from home	25	7	32	
Total	45	111	156	
Accessibility				0.00
Can get preferred method when needed	22	0	22	
Cannot get method when needed	23	0	23	
Not applicable	0	111	111	
Total	45	111	156	
Affordability				0.00
Can pay for preferred method	35	0	35	
Cannot pay for preferred method	10	0	10	
Not applicable	0	111	111	
Total	45	111	156	
Marital status				0.149
Married	30	60	90	
Unmarried	15	51	66	
Total	45	111	16	
Age				0.481
15-24	14	33	47	
25-34	25	54	79	
35-49	6	24	30	
Total	45	111	156	

Table 12 shows that 45 respondents used contraceptives. Among these, 31 belong to religious category 2 and the rest belonged to category 1. The data further suggests that more than half of respondents in each category did not use contraceptives. That is about two-thirds of category 2 (74) and category 1 (37) are not contraceptive users. The chi square test of 0.789 is higher than the predetermined alpha level of significance of 0.05 suggesting that contraceptive use and religion are independent of each other. It means therefore that religion does not influence contraceptive use of the respondents.

Education provides people with knowledge and skill that can lead to better quality of life. With such an orientation, the educational background of respondents were linked with their contraceptive practice in a cross tabulation and a chi square test. The result showed that most of the users (18) have either secondary or tertiary education and 12 have no education at all. Also there were some 15 respondents who use contraceptives and have low education. It can be observed that education had a positive relationship with contraceptive use thus as education increases, contraceptive use also increases. The chi square test of 0.013 indicates that education and contraceptive use are dependent on each other statistically. This means that education influences contraceptive use to some extent.

With respect to age and contraceptive use, it is evident from the table that most of the contraceptive users were aged 15-34 years. It shows for example that 14 respondents aged 15-24 years and 25 respondents aged 25-34 years used contraceptives. In effect, contraceptive prevalence is low among older respondents aged 35-49 years. The table further shows that non contraceptive use is also high among respondents aged 15-34 years. Thirty three women aged 15-24 years and 54 women aged 25-34 years do not use contraceptives. Older respondents have the lowest non contraceptive use with 24. When

the chi square test was done it revealed that age and contraceptive use were statistically different from each other. That is even though contraceptive use is highest among younger respondents age does not influence contraceptive practice because the chi square test of 0.481 is greater than the P value of 0.05.

Age is not a determinant of contraceptive use among the women because young and old women alike have misconceptions about contraceptives and are also influenced by the pro family culture of the area. This notwithstanding, younger women have prospects of high contraceptive use because most of the contraceptive users identified in the study were aged 15-34 as shown in Table 12.

The table further shows that variables like place of work, accessibility and affordability of contraceptive methods are statistically related to contraceptive practice. This is because they all have a chi square test significance lower than 0.05. For example, with place of work more than half of the contraceptive users (25) work from home while 20 work away from home. Among non-contraceptive users, 104 representing more than half worked away from home.

With regard to accessibility of contraceptives, about half (23) do not get their preferred method while the other half (22) get their preferred method when needed. These results point to the fact that sometimes there is commodity shortage in the district which causes users to switch methods. This however suggests that with increased accessibility, patronage of family planning methods may increase even though respondents may not get their preferred contraceptive methods. This will invariably lead to an upsurge in method switching.

Still from Table 12, marriage does not strongly influence contraceptive practice even though most of the contraceptive users (30) are married and only 15 users are unmarried. The pattern is the same for those who do not use contraceptives where 60 are married and 51 are not. To buttress this observation, the chi square test of 0.149 was used indicating that marriage and contraceptive practice are independent of each other. This could be attributed to the fact that in the sample population, most of the women irrespective of their marital status were non-contraceptive users.

4.3.2 Some social implications of family size

Research shows that women have a primary responsibility for childbearing and also spend a significant portion of income under their control on their children than fathers do (Todaro & Smith 2009). In view of this, the researcher collected information on family size and investigated how it may influence the amount of time available to respondents to do other activities such as relaxing or doing a hobby and being part of an association. Also, of primary importance in this sub section is the proportion of respondents' income spent on household expenditure.

Table 13: A cross tabulation of biological children with ‘association’, ‘relaxation’ and proportion of respondents’ income spent on household expenditure

Variable	Number of children		N	Pearson chi square
	0-3 children	4 and above		
Belong to an association				0.00
Social, political and Economic	105	15	120	
Does not belong to an association	13	23	36	
Total	118	38	156	
Relaxation				0.00
All the time (almost everyday)	101	16	117	
Few times (about once a week)	17	22	39	
Total	118	38	156	
Proportion of respondents’ income spent on household expenditure				0.00
None or at most half of income	68	6	74	
More than half of income	50	32	82	
Total	118	38	156	

Table 13 presents the results of a cross tabulation and chi square test of number of biological children by ‘association’, ‘relaxation’ and proportion of income spent on family expenses. The table shows that 118 women have between zero and three children while 38 have four or more children. It also shows that women who belong to an association (social, political and economic based) were more likely to have between zero and three children as compared to women who do not belong to an association. Also, most of the women (23) who have four or more children do not belong to an association. Furthermore, the chi square test of 0.00 presumes that number of biological children and ‘association’ are dependent on each other and suggestive that women who belong to an association may have fewer children. This may be attributed to the fact that women in associations may get to spend some more time outside home and in the case of economic associations get microloans to expand their businesses.

Still from Table 13, women who have between zero and three children are more likely to have time to relax or do a hobby every other day as compared to women who have four

or more children. The table further shows that 101 women with zero to three children invariably have time to relax whereas only 17 women could do same because they probably have four plus children. Also most of the women (22) who have four and more children only get to relax a few times. Furthermore, the chi square test of 0.00 show that there is a relationship between number of children and time to relax. That is even though basically rural people get some form of help in taking care of children the more children a respondent has the less time available to her for relaxation all things being equal.

With regard to income, 68 out of 118 women who have fewer children (0-3) spend none or at most half of their income on family expenditure while 32 out of 38 women who have 4 and above children spend more than half of their income on family expenses. This suggests that women with lesser number of children (0-3) spend less amount of income on family than women with more children. The table further shows that most of the women (82) are more likely to spend more than half of their income on family expenses as compared to 74 women who spend none or at most half of their income. This can partly be attributed to the meager incomes of rural women which can barely suffice household needs. Thus, most women tend to spend most of their income on household expenses. The results of the chi square test (0.00) suggest that income spent on household expenditure and number of children are statistically related. That is income spent on household expenditure is dependent on the number of children respondent has.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

Large family size is an effect of high fertility and one of the ways of curtailing it is family planning through modern contraceptive methods, which needs to be known, accepted and used. Knowledge of contraceptives over the years has been increasing but acceptance and practice are however lagging behind.

The study was done in YiloKrobo District and involved 156 respondents to whom questionnaires were administered for the collection of quantitative data. Qualitative data were also collected from three key informants and through an FGD of twelve participants moderated by the researcher.

The study was to find out the social implications of contraceptive use for women in the YiloKrobo district.

In order to achieve the specific set objectives of the study, the researcher analyzed factors that influence contraceptive use, which in turn, influence family size of women and its implications on their social lives.

The study identified age, educational attainment, marital status, income, autonomy, access to contraceptives and affordability as well as place of work and whether or not respondent belongs to an association as some influencers of contraceptive use which in turn influences family size.

Quantitative data were analyzed statistically using SPSS while the qualitative data were analyzed inferentially.

All the objectives of the study were met and elaborated in subsection 5.2 under key findings.

5.2 Key Findings

From the study, the researcher found out that:

Most respondents practice religions that do not prohibit contraceptive use hence acceptance and practice were expected to be high but the cultural inclination of the people towards large families was found to be the main prevailing factor against contraceptive use. However, there is prospect of high contraceptive prevalence among younger women, women who work away from home and those in associations because contraceptive prevalence was high among these groups as suggested by the bivariate analysis. For instance the chi square test of association between contraceptive use and women who work away from home and those who belong to an association appeared to be statistically significant. The exception here was age which was statistically insignificant. However, younger women were found to be most of the patronizers of contraceptives in the study.

Education influences contraceptive use to some extent as results of the bivariate analysis suggest because the more education a person has the more likely the person may use contraceptives. The pattern is a little different with family size where more educated people have four or more children which is explained by the pronatal cultural attitude of the people. This suggestive of the fact that most of the contraceptive users in this study use contraceptives for birth spacing rather than limiting progeny.

Place of work has proven to be very influential as most of the contraceptive users were found to have been working outside the home.

Family size is relatively not high (4 children) as the analyses revealed. From the study, women and children are important in the life of the community where the women are seen as the home makers. Also, apart from the joy and fulfillment children bring to parents, they also have a role of helping in ways possible to provide for their families. Albeit the family size of 4 identified in the study is lower than the rural family size of 4.7, it is higher than the urban family size of 3.9 (GSS, GHS and ICF Macro, 2009). In effect, family size is relatively not high as compared to the national averages. The study also found that all the contraceptive users have between 0-3 number of children. Also most of the women who have between 0-3 number of children use none or at most half of their income to support their families as suggested by the bivariate analyses.

Knowledge of modern contraceptives is high but practice is low and left to younger women. Even with that, most women use it for birth spacing other than limiting progeny. Though women have some economic value for children, average number of children desired is four and parents are the main benefactors not the extended family or the community as the people's communal lifestyle presumes. This therefore means that women get to spend more on their family and have relatively lesser time for themselves with regard to relaxation whenever they increase their progeny.

The women were found to be relatively independent since they can make decisions regarding their reproductive choices as well as some household decisions. However this does not affect contraceptive use much significantly and for that matter family size

because most of them were not contraceptive users albeit they could decide to use it in their own accord the same way as they took other decisions.

Contraceptives are effective in reducing family size but the low prevalence in the area makes it difficult to draw certain conclusions such as emphatically attributing low births among the respondents to contraceptive practice.

5.3 Conclusion

The study sought to investigate the social implications of contraceptive use for women in the YiloKrobo District. Contraceptive use is an effective mechanism for managing the district's population problem. Evidently, information on methods of contraception is available but rural fertility rate is still high because of certain entrenched cultural beliefs of fertility and marriage as well as some superstitions concerning the use of contraceptives.

A vast difference exists however between knowledge of contraceptives and contraceptive practice and where contraceptive knowledge and practice are absent, high fertility and its corresponding negative social implications for women can be tolerated. In areas like YiloKrobo district where knowledge of contraceptives is almost universal, a much stronger and focused programme is needed to get the women to accept and practice contraception. Thus a change of attitude towards contraceptives, large family size and contraceptive users are very crucial in an attempt to reduce rural fertility. It is also clear that prospects of contraceptive use is hindered by cultural factors which are difficult to change hence it is unable to affect family size as desired. Other methods or approaches could be explored through research and be considered to replace contraceptives or be

used with contraceptives to reduce family size to bring about positive social implications. The study for instance found that contraceptive users usually work outside home.

5.4 Implications of findings and recommendations

In consonance with some scholars who believe ‘contraceptives only’ are not effective and are slow in producing results, it is suggested that approaches like women’s empowerment through education, taking up paid jobs and leadership positions as well as working outside home will help women to control their fertility than working comfortably from home. It is presumed that when women are challenged in the areas mentioned above, they work hard at limiting their progeny in order to make time for their responsibilities outside home.

Most importantly, the abjuration of the cultural belief in high fertility especially in the YiloKrobo district through attitudinal change will help ease the situation as society builds incentives like free education to the tertiary level, government sponsored vacation, payment for not taking maternal leave, free apartments, clothing, food and regular health check-ups for small family sizes. Since culture is a strong influence on fertility, policy should continue to target the removal of misconceptions and unfounded fears about contraceptive use.

Based on the research findings, it is highly recommended that women in YiloKrobo should be encouraged to join associations, preferably, economic based (solidarity groups), where the skills of women mostly with little or no education could be

enhanced and put to use. In YiloKrobo for instance, the women could form food crop associations or food processing cooperatives to qualify them to access loans to increase their production and thereby increasing their earnings. This will reduce the stress put on children to help with household income generation. Thus the provision of more jobs outside home, better education for women and greater attention to cultural and human values, all of which will serve not only to enhance material wellbeing but also to generate greater individual and national self-esteem.

Another way of dealing with this is to reduce age at first birth while increasing the average age for marriage. Young people in the area should be encouraged to finish their education, have a source of regular income before they settle down to marry. On average a girl who goes through her education to the tertiary level will be about 22 years. Usually girls who go through apprenticeship finish their training rather early and the next step for them is marriage and making babies. It is suggested here that after training, such adroit young people should be set up in their area of expertise with goals and visions to pursue such that they could marry at a later age.

Girls who for a reason drop out of school to give birth should not be sent out of school but should be reinstated preferably in another school to enable them to finish their education rather than settling down early as family women. The work of Planned Parenthood Association of Ghana as a reproductive health advocate in the area will be appreciated in this regard.

The deliberate role of men and the broader society in the creation and utilization of educational and health facilities as well as job programmes by women are necessary to sustain any meaningful family planning programme. Above all, women in the area are encouraged to take responsibility of their own lives as support from the broader society will thrive on individual women's readiness for a change.

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APPENDICES

APPENDIX A SAMPLE QUESTIONNAIRE

Questionnaire No.....

This questionnaire is to help in a research on the social implication for contraceptive use on women in the YiloKrobo district. Whatever information given will be treated with absolute confidentiality. Anonymity is assured hence your name is not required. You are at liberty not to answer any question but I crave your indulgence to make the study successful as your contribution is of utmost importance.

Bio Data (1.0)

To start with, I would like to ask for your personal or background information.

1. How long have you stayed in this district?
 1. 5 years and more
 2. Less than five years
2. Did you celebrate your last birthday here?
 1. Yes
 2. No
3. When was your last birthday? (Month only)

1. January	7. July
2. February	8. August
3. March	9. September
4. April	10. October
5. May	11. November
6. June	12. December
4. How old were you then? (Put age in range if respondent finds it difficult to mention age, 15-19, 20-24, 25-29, etc).
5. Have you ever attended school? 1. Yes 2. Noif no, move to 7
6. What is the highest level of school you attended?
 1. No education
 2. Did not complete Primary
 3. Completed primary
 4. Completed JSS / Middle
 5. Completed Senior Secondary / Technical
 6. Tertiary
7. What is your religion?
 1. Catholic
 2. Anglican
 3. Methodist
 4. Presbyterian
 5. Charismatic/Pentecostal
 6. Other Christian
 7. Moslem
 8. Traditional/Spiritualist
 9. No religion

18. You said you have number of children, would you want to have another child or children?

1. Yes
2. No (skip 19)

19. How many?

1. One
2. Two
3. Three
4. Four
5. Five and above
6. Zero

Note

20. Add the number of children in 18 to the number of children in 19 to get the number of children respondent desires. _____ + _____ = _____.

Contraception

21. Do you use any method to delay or prevent pregnancy?

1. Yes (move to 27)
2. No (continue but skip 27)

22. Can you tell me why you are not using any contraception to delay or avoid pregnancy?

- | | |
|--------------------------------|--|
| 1. Not married | 5. Method related |
| 2. Fertility related reasons | i. Health concerns |
| i. Not having sex | ii. Fear of side effects |
| ii. Infrequent sex | iii. Lack of access / too far |
| iii. Menopausal / hysterectomy | iv. Costs too much |
| iv. Subfecund / Infecund | v. Inconvenient to use |
| v. Postpartum amenorreic | vi. Interferes with body's natural process |
| vi. Breast feeding | |
| vii. Fatalistic | 6. Don't know |
| 3. Opposition to use | 7. Other |
| specify..... | |
| a. Respondent opposed | |
| b. Husband opposed | |
| c. Others opposed | |
| d. Religious prohibition | |
| 4. Lack of knowledge | |
| a. Knows no method | |
| b. Knows no source | |

23. Do you think you would use any contraceptive method to delay or avoid pregnancy at any time in the future?

1. Yes
2. No
3. Don't know

(Skip 26 if respondent does not use contraceptives)

24. Can you tell me why you use contraceptives?
1. Don't want any more children.
 2. Want to delay pregnancy / for spacing
 3. Fertility control (get pregnant when respondent desires)
 4. Personal health
 5. Advised to
 6. Enable respondent to work
 7. Other, specify.....
25. Mention any contraceptive method you know. (Write the method respondent mentions spontaneously)
26. How did you get to know about it? (tick as many that are applicable)
1. Television
 2. Radio
 3. Print media
 4. Friends
 5. Health worker
 6. Community / social club meeting
27. Do you know where you can get that method to use?
1. Yes
 2. No
28. Can you tell me where?
1. Public health service
 - i. Government hospital / polyclinic
 - ii. Government health center
 - iii. Family planning clinic
 - iv. Mobile clinic
 - v. Fieldworker
 2. Private health service
 - i. Private hospital / clinic
 - ii. Private doctor
 - iii. Pharmacy / chemist / drug store
 - iv. Mobile clinic
 - v. Field worker
 - vi. FP / PPAG Clinic
 - vii. Maternity home
 3. Pharmacy, Chemist shop or drug store
 4. Church
 5. Friends / relatives
 6. Don't Know
29. Are you able to access preferred method?
1. Yes
 2. No
30. Are you able to afford method?
1. Yes
 2. No
31. Do you think women who use contraception can be promiscuous?
1. Yes
 2. No
- (for those who use contraception. You said you use contraception right? Refer to **Q 23**, if answer is **Yes**)
32. Who else apart from the one who administers the method to you **Knows** that you practice contraception?
1. Husband or partner
 2. Some friends
 3. Some relatives
 4. Nobody
33. Which method would you or do you prefer to use?

1. Condom
2. Pills
 - i. Micronor
 - ii. Lofem
 - iii. Orrette
3. Jadelle (**implants**)
4. IUD (loop)
5. Injectable
 - i. Depoprovera
 - ii. Norigynon
6. Foam / Jelly
7. Lactation amen
8. Periodic abstinence
9. Diaphragm
10. Withdrawal
11. Don't know

Family Planning

34. Have you heard of the following messages about family planning?

- | | | |
|--|--------|-------|
| a. Life choices. It's your life, it's your choice? | 1. Yes | 2. No |
| b. Make the choice that is best for you? | 1. Yes | 2. No |
| c. Contraceptives are safe and effective | 1. Yes | 2. No |
| d. Obra ne warabo | 1. Yes | 2. No |
| e. Emiredane a, wonsodane bi | 1. Yes | 2. No |
- (to be put in Krobo language)

(For users only)

35. Is using contraceptive entirely your decision, entirely your husbands or you both decided together.
1. Entirely respondent's
 2. Entirely husbands
 3. Joint decision
36. Would you say you approve or disapprove of a couple using a method to avoid getting pregnant?
1. Approve
 2. Disapprove
 3. Don't know
37. Would you say your husband or partner approves or disapproves of a couple using a contraceptive method to avoid pregnancy?
1. Approve
 2. Disapprove
 3. Don't know
38. Do you approve of women taking up paid jobs?
- a. Approve
 - b. Disapprove
 - c. Don't know
39. Who in your household usually has the final say on the following decisions?

Respondent = 1

Husband / partner = 2

Respondent and husband jointly = 3

Someone else = 4

Respondent and someone else jointly = 5

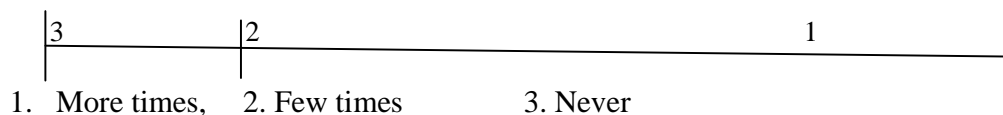
Decision not made / not applicable = 6

3. Less
 4. Don't know
46. For respondents with children. Is the number you have the exact number you always wanted?
1. Yes, same (move to 51)
 2. No, less than respondent wanted (move to 51)
 3. No, more than respondent wanted (continue from 50)
47. Why do you have more children than you wanted?
1. High child morbidity
 2. More children will take care of you better.
 3. Children will help with your present work
 4. maternal fulfillment (more children means fertility)
 5. A mixture of sexes
 6. Husband wants more
 7. In laws want more
 8. Don't know / just happened.
48. Have you had to face any social ridicule because you have no child, few children, many children or have had no such experience?
1. No child
 2. Few children (1 -3)
 3. Many children (4 and above)
 4. No such experience
49. Have you had to miss any opportunity of furthering your education or getting a paid job because of an unplanned pregnancy?
1. Missed furthering education
 2. Missed employment
 3. Both
 4. No such incidence

Children

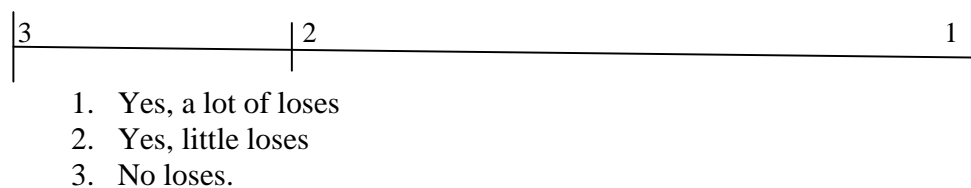
50. Should children be allowed to work on the farm to support the family?
1. Yes
 2. No
 3. Don't know
51. Do you allow your children to help with what you do for a living? More times, few times or never.

A continuum



52. Without their support, will your work suffer any loses?

A continuum



53. What is the least level of education you want your children to attain?

1. Primary
2. JHS
3. SHS/Vocational/technical
4. Tertiary

Social indulgence

A lot of women may not have time and or liberty to join associations and spend time outside home because of their being mothers or wives. I'd like to know about your situation.

57. Do you belong to any social, political or economic association?

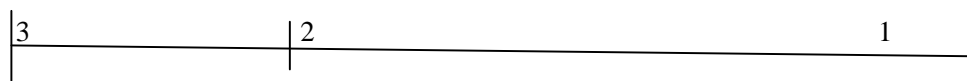
1. Social-Church/Mosque
2. Political-women's wing of a party
3. Economic-Microfinance group lending scheme
4. None

58. Do you find time to relax or do any hobby?

1. Yes
2. No

59. Are you able to attend functions whenever you are invited or required to be there without being restricted by family issues?

A continuum



- | | | |
|-------------------------|--|---------------------------------|
| 1. Yes all the time | | 3. No, rarely has time to relax |
| 2. Yes few of the times | | |

60. In your opinion should child care practices be the sole responsibility of the mother both parents, father, extended family, all the above.

- | | |
|-----------------|---------------------------------------|
| 1. Mother only | 4. Both parents and extended family |
| 2. Father only | 5. parents, extended family and state |
| 3. Both parents | |

Household amenities and conditions

61. Do you have electricity? 1. Yes 2. No

62. What is your major source of cooking fuel?

1. LP Gas
2. Kerosene
3. Fire wood
4. Charcoal
5. Other specify

63. What is your source of drinking water?

1. River
2. Well
3. Borehole
4. Rain
5. Stream
6. Pipe
7. 'Filtered water'

Observe

64. Is residential facility made of modern facilities, semi modern or local?

- | | | |
|-----------|----------------|----------|
| 1. Modern | 2. Semi modern | 3. Local |
|-----------|----------------|----------|

Roof -	(Tiles, iron sheets)	(wood, old iron sheets)	(thatch)
Structure -	(cement blocks/brick)	(mud plastered with cement wood)	(mud)
Floor-	(terrazzo/tiles)	(concrete, wood)	(sand, mud)

APPENDIX B**INTERVIEW GUIDE FOR FOCUS GROUP DISCUSSION**

1. How will you describe the people and culture of YiloKrobo?
2. What is the place (importance, role, limits) of women and children in the society?
3. What value does society place on early marriage?
4. Is there any traditional or cultural concept of contraception? (When a man and a woman marry, do they have to consider limiting progeny as something as normal as giving birth after marriage is normal?)
5. Are children associated with gods, ancestors, blessings or curses?
6. How many children do women generally desire and how are women with 5 plus children treated?
7. How women with no children (barren) are perceived and treated?
8. What do you understand by contraception
9. There are modern methods of controlling birth, what are some of them and where can we get them.
10. If partners (husbands) decide not to allow contraceptive use, what will you do?