PIT-FALLS IN FERTILITY CONTROL IN GHANA

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ABSTRACT

The population growth in Ghana has been a matter of great concern. Resources are inadequate to cater for the growing population. The demographic variable that chiefly accounts for the growth is fertility.

The research examines the factors that inhibit the regulation of fertility in Ghana. Two districts, Kumasi Metropolis representing urban areas in the country, and Kwabre-Sekyere representing rural areas, were the selected areas for study. Literature on the theme in other areas of Ghana was reviewed to buttress the findings.

The sources of data were books on fertility, surveys on fertility, and population and vital statistics report of the United Nations. Personal interview was the main research instrument, supplemented by a few questionnaire schedules. A total sample size of 168 females was used, apart from a sample of 416 by other researchers. The selection was made through stratification. Data were analysed with the statistical techniques of percentages, proportions and classifications.

The study revealed that, the greatest hindrances to fertility regulation in Ghana are illiteracy and traditionalism. There is the need for pragmatic steps by the governmental and non-governmental organisations to reverse the trend, else, the population problem will continue to haunt efforts at socio-economic development.

KEY WORDS: *fertility rate; demographic; family planning; matrilineage; polygynous.*

INTRODUCTION

The problem of high fertility rate in the developing world which is still wallowing in the quagmire of economic stagnation calls for solutions which are hard to come by. Measured against resource-supply, the rate of which trudges behind the growth of this vital demographic phenomenon, the probability of the survival of such developing and underdeveloped societies is left to staggering hope. In Ghana, with an annual growth rate now estimated at 3.17% (United Nations, 1991: 113) (1) and with 42.2% of the female population constituted by women in the reproductive age group of 15 - 44 (Statistical Service, 1987: 1) (2) a great potential for future growth, the need for family planning strategies assumes a gigantic prominence.

The population growth problem could be viewed from the broader perspective of its relationship with resources needed to maintain the population, maintenance of environmental quality, effect on maternal and child health, and negative repercussions on socio-economic development. Following the high fertility rate are the negative consequences of high infant and maternal mortality rates, with their adverse effects on socio-economic development.

The net effect of the upward trend in populations growth is thus to reduce the quality of life and reverse the wheel of national progress, thereby setting in motion a vicious cycle of poverty in the long run. The Gross National Product (GNP) per capita, for instance, was three hundred and ninety-eight dollars ($398) in 1989 (The World Bank, 1992: 10) (3) which falls within the poverty level. Resources must therefore be made available to execute a programme of fertility decline. Though such an action might affect the development of certain sectors in the short-run, in the long-run, the results would be seen to be worth the expenditure committed to it.

The paper examines the causes and implications of high fertility rate in Ghana, and suggests solutions to this unsavoury demographic phenomenon which has served as a serious obstacle to the development of developing and underdeveloped economies. The Kumasi metropolis and Kwabre-Sekyere district were

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used as case studies from which projections were made. Work by researchers in other ethnic and social groups, as well as data from the 1988 Ghana Demographic and Health Survey (GDHS) (4) and GDHS 1993 were also used to buttress the Ashanti regional experience thus, putting the theme in a national perspective.

CAUSES OF HIGH FERTILITY

The fertility rate in Ghana has not shown a significant downward trend. In 1981, the crude birth rate was 48.3 per thousand population (Agyei et al 1984: 62)[1] (5). The United Nations estimate for 1990 was 44.4 per thousand population (United Nations, 1991: 114) (6). The Total Fertility Rate for 1988 was 6.4 (Ghana Statistical Service, 1988: 19)(7). These high rates are against the background of policies initiated to regulate fertility.

Following recommendations contained in the Ghana Population Policy of 1969 (Government of Ghana, 1969) (8) the Ghana National Family Planning Programme was established to institute measures to stem the tide of increasing fertility. Other institutions like the Ministry of Health, religious organisations, and Planned Parenthood Association of Ghana, have been educating the public on the need to reduce the growing birth rate, and to sell family planning devices.[2] Foreign organisations like the United Nations Fund for Population Activities (UNFPA) and International Planned Parenthood Federation have been giving technical and material assistance to reverse the fertility situation, yet, there has not been a significant change in the trend.

The causes of increased fertility, are among others, the pro-natalist mentality of the wider segment of the population, mass illiteracy especially of the rural dwellers, the demise of certain essential cultural values, the concentration of family planning services in the urban centres to the disadvantage of the rural areas, improvement in medical services, poverty, lack of political will of government to implement fully the recommendations in the population policy of 1969 on fertility regulations,[3] public fears and distaste for certain family planning methods, and religious bias and fanaticism.

The Ghanaian is by nature pro-natalist. Among the Asantes who constitute a greater proportion of the tribal populations of the country, a large family size is a source of prestige, and a public ceremony is organised to honour a woman after having her tenth child (Fortes, 1950)[4] (9). This is partly because the Ashanti society is matrilineal, where, according to Sarpong (1977: 7) (10), the survival of the matrilineage depends upon the fertility of its females. On the other hand, "childlessness is felt by both men and women as the greatest of all personal tragedies and humiliation, and a barren woman is looked upon with contempt, and enjoys at best, the malicious sympathy of the public" (Gaisie, 1976: 52)[5] (11).

The high illiteracy rate has imposed a great strain on fertility regulation. With fertility showing an inverse relationship with educational status (Gaisie & Nabila, 1978) (12) / (Anker & Knowles, 1982: 31, 32) (13), the high illiteracy rate of 43.5% of persons of school-going age (Ghana Statistical Service, 1987: 41) (14) jeopardises the prospects of a successful family planning programme.

Thirdly, the gradual eradication of certain cultural practices like puberty rites, with the introduction of western culture, is partly responsible for the phenomenal teenage pregnancies, leading to an upward trend in fertility.[6] In the Akan traditional system, it was an anathema for a girl to indulge in pre-initiation sex, and a taboo to become pregnant when the puberty rites had not been performed (Sarpong, op cit: 47, 48) (15). So strict were the laws on female sexual behaviour that a girl who got pregnant before puberty rites were performed on her, was banished with her illegal male partner from her motherland. Among some tribes in Northern Ghana, a girl who failed to prove her virginity on the matrimonial bed stood the risk of being divorced.[7] Thus, a girl should ensure that she refrained from pre-marital sex which now has increased the frequency of births among teenagers.

Fourthly, there are poor family planning programmes in the rural areas. There is the concentration of such programmes involving sex education and sale of family planning devices in the urban centres, and very little of such programmes in the rural areas. In Ghana, there are 413 fixed delivery points which provide Maternal and Child Health and Family Planning Services; and out of 330 that offer family planning services, more than 50% are in the urban areas (Ministry of Health, 1991)[8] [16].

In the Ashanti Region, there are 60 Family Planning clinics that effectively distribute the devices. Out of the number, 35 are in the urban and peri-urban areas that constitute about 33% of the total population (Ministry of Health, Kumasi, 1990[17] Ghana Statistical Service, 1987: 56)[9] [18]. Consequently, fertility in the rural areas is still high.

Fifthly, there has been a significant improvement in medical service which has had positive effects on female reproductive performance. Many females are

more fecund than they used to be before the introduction of scientific technology. Gynaecological examinations are able to detect complications that affect fecundity, and cases of successful medical and surgical treatment to make one reproductive are not uncommon. Moreover, with improvement in medical services, the rate of natural abortions has reduced, thus, increasing the birth rate.

Furthermore, the predominance of poverty in the rural areas, and among certain groups in the urban, which is also a function of educational status, is primarily responsible for the upward trend of fertility rates. Fertility rates are high in poverty-stricken countries (Bogue, D.J., 1969: 21) [19]. Such countries tend to have illiteracy rates which serve as a barrier to the knowledge, attitude and practice (KAP) of family planning methods. It is among such groups that tradition, also a barrier to the acceptance of diffused innovation, is prevalent.

Besides, there is the inability of the lower status group to purchase family planning devices which are cheap for the average earner. A household head considers the purchase of family planning devices as of secondary importance, considering his meagre income, as compared with the feeding of his wife and children. It is an unfortunate paradox that, poverty should be a stumbling-block to a measure which should help to eradicate it.

There is also the problem of limited political will by governments to implement fully the recommendations contained in the Population Policy of 1969 on fertility regulation. It was recommended among others that, a woman enjoy maternity-leave with pay for only three births during her entire working life (Government of Ghana, 1969: 21[20]. Such a measure would encourage the use of family planning devices, thus, regulate fertility.

Moreover, sections of the public express fears about certain family planning methods, and also, not an insignificant number that is practising some of the devices complain of lack of sexual satisfaction with some of the methods, thus, they begin to lose interest in the whole exercise. Generally, there is the fear that methods like sterilization by vasectomy, the diaphragm, Intra-Uterine Devices (IUDs) and cervical cap are associated with serious infections that can shorten life. On the other hand, some users of creams, jellies and foaming tablets complain of lack of complete sexual satisfaction, since the devices over-lubricate the passage. Others complain that the condom makes the sex act unnatural.

Finally, there is the more serious problem of religious fanaticism among various religious groups, notably, some Christian groups like the Catholics. The view is held that God, who is the provider and sustainer of life, commanded Adam and Eve during creation to bring forth to populate the earth [21]. It is held by such adherents that, practising family planning reveals lack of faith in God to cater for one's offspring.

ATTEMPTS AT FERTILITY CONTROL

Several steps have been taken by both governmental and non-governmental organisations to control the high birth rate, but these measures have not resulted in significant decrease in fertility rates. The Ghana Government has been very instrumental at international fora on population issues. On Human Rights Day in 1967, Ghana became the first sub-Saharan African nation to sign the World Leaders' Declaration on population growth (Government of Ghana, 1969) [22]. In the realisation of the objective of the Government to control population growth, the National Liberation Council (NLC) Government in March, 1969, upon further recommendations of the Ghana Manpower Board, officially published a population policy entitled "Population Planning for National Progress and Prosperity" (Nabila, 1986: 35) [23]. The main objectives of the policy, were to control population growth through family planning devices and education, the encouragement of the employment of women in productive occupations, and control of internal migration.

Steps were taken to implement the policy without delay. As a first step, in May, 1970, the Ghana National Family Planning Programme (GNFPP) was formally launched with the sole objective of reducing the high rate of population growth which was around 3 per cent (Nabila, ibid:36) [24].

Operating simultaneously with the GNFPP are private organisations like Planned Parenthood Association of Ghana (PPAG), the Committee on Christian Marriage and Family Life (CMFL), the Christian Council of Ghana, and the Ghana Social Marketing Programme. These private agencies contribute more meaningfully than government organisations. The Ghana Ministry of Health contributes only 44% of the overall Couple Years of Protection (CYP). More than 50% of CYPs is provided by private agencies (Ministry of Health, Ghana, 1993: 15)[25].

The GNFPP is faced with problems like finance, personnel and transport. Nevertheless, through its activities and those of the private organisations, awareness of the danger of large family sizes that national population growth poses to development, has been created. Knowledge of contraceptive methods has

improved. In 1979, whereas the percentage of all currently married women with no education who had knowledge of any method of contraception was 55.8% (Ghana Fertility Survey (GFS), 1979)[26], in 1988, the figure rose to 63.7% (Ghana Demographic and Health Survey (GDHS), 1988)[27].

Women organisations like the National Council on Women and Development (NCWD) and the 31st December Women's Movement (DWM) are contributing towards reducing fertility rate among women through public education, seminars and equipping the illiterate women especially in the rural areas with some vocation. The NCWD was established by the Government of Ghana in 1975 with the aim of identifying problems facing women, and to formulate and execute policies to improve the status of women (Nukunya, 1992: 218-219) [28]. It was hoped that if the welfare of women was improved through vocational training and gainful employment, fertility rates would reduce.

The DWM on the other hand, was formed in 1982 as a functionary of the 31st December, 1981 revolution launched by some military officers who seized power in a bloody coup. The DWM has created the awareness that women have some potentials in them to develop. It has established small-scale industries in the rural areas where majority of illiterate women are, to train them to acquire certain basic skills in rural vocations. It is hoped that, if women are gainfully employed, the entanglements of home life will be reduced, and that, their interest in family planning would be stimulated.

Finally, the Government of Ghana on May, 1992, authorised the establishment of the National Population Council (NPC) which was inaugurated on November 25, 1992. The NPC shall generally offer advice on, and interprete Government policy concerning population, and its related matters, and make suggestions on areas to be addressed in a comprehensive population and development programme (Ministry of Information, Ghana, November, 1992[29].

Private medical practitioners have also been exploring possibilities for herbal devices to control fertility. A model is Dr. Noamesi's 'navel contraceptive' which has been proved to be effective.

The measures by the Government and private agencies notwithstanding, the fertility rate is quite high. The Total Fertility Rate (TFR) was 6.4 in 1988 (Ghana Statistical Service, 1989)[30]. The Crude Birth Rate (CBR) which was 44.4 per 1,000 females (Agyei et al., 1984: 62)[31], is now estimated at the same rate of 44.4 per 1,000 females (U.N., 1991: 114)[32]. These statistics indicate that very little had been achieved with regard to fertility control by 1988. The 1993 GDHS), however, indicates a TFR of 5.5 [33]. The decrease is encouraging but not significant, compared with the rate in the advanced countries.

RESULTS FROM THE ASHANTI SURVEY

The results of the survey vindicate the hypotheses some of which have been tested and validated by earlier researchers. On the issue of the predominance of pro-natalist tendencies, it was discovered that, the desire for many births is still strong. Out of a sample size of 168 women in the reproductive age group each of whom had at least a child, drawn through stratification from the two districts, 76, representing 45.2% of the respondents, expressed the need and desire to have more children.

There were variations between the rural-urban and the literate-illiterate, and also within each of these categories. In Kwabre-Sekyere, out of a total sample of 66 women, 34, representing 51.5% desired more children while in the Kumasi Metropolis, out of a total sample of 102 women, 42 representing 41.1% were interested in having more children. Out of a sample size of 42 literates drawn from the Kumasi metropolis, 12 respondents, representing 28.5% desired to have more children. Of the 12 literates who desired to have more children, 10 had attained an educational level below the General Certificate of Education, Ordinary Level, and the other two, post-secondary teachers. No graduate preferred a family size of above 2. Out of the 60 illiterates interviewed in Kumasi, 30, representing 50.0%, preferred to have more children.

The Kwabre-Sekyere (Agona-Ashanti) District showed a variation with the Kumasi urban. Out of the 26 literates interviewed, 12, representing 18.81% of the sample size for the district and 46.1% of the literate, desired having more children, whilst of the 40 illiterates, 22, representing 55% wished to have large family sizes. The statistics are represented in Table 1.

TABLE 1: RESPONDENTS' PREFERENCE FOR HIGH FERTILITY IN THE KWABRE-SEKYERE DISTRICT AND KUMASI METROPOLIS

LITERACY STATUS	KWABRE-SEKYERE		KUMASI	
	Desire for more chn.	%	Desire for more chn.	%
Literate	12/26	46.1	12/42	28.5
Illiterate	22/40	55.0	30/60	50.0
Total	34/66	51.5	42/102	41.1

SOURCE: Author's Personal Construct from Field Survey, July, 1988

N.B: Numerators are the number of respondents showing preference for high fertility, and denominators, sample in each group.

It is apparent from the statistics that, the desire and potential to have more children is great. The disparity between the rural and urban areas is due primarily to the fact that literacy rate is relatively higher in the urban areas, and that the illiterates from the rural areas are influenced by the relatively low fertility tendencies in the city. The high cost of living in the city too puts pressure on the rural migrants to adopt family planning methods. The proportion of rural migrants in this category is not very significant though it is also clear from the statistics that, the illiterates in the rural areas did not differ significantly in performance from those in the urban.

The average family size was also high, with variations between rural-urban and social groups.[11] Forty-one female patients from Komfo Anokye Teaching Hospital in Kumasi, and twelve from both Asamang SDA Hospital and Wiamoase Salvation Army Clinic were randomly selected for inverview on their fertility behaviour. The average family size for the respondents (Patients at the ante-natal and neo-natal wards) in Komfo Anokye Teaching Hospital, 36 of whom resided in the city, was 4.8, while that of Asamang SDA Hospital and Wiamoase Salvation Army Clinic, all of whom were resident in the rural area, was 5.8. This showed some improvement over the national figures for the 1970s in the rural areas, which were established by a post-enumeration survey by Gaisie and Nabila (1974: 13)[34] as 6.5 for the rural areas and 4.7 for the urban. This decline is explained by the falling illiteracy rate as well as improvements in family planning services. The total fertility rate which was 6.7 was thus quite high (Table 1). This deviates markedly from the 1993 national rate of 5,5 [35]. This would be explained by the fact that most of the respondents in the Kumasi metropolis were of low-level education, and had also migrated from the rural areas, thus had traits of rural fertility behaviour. Moreover, with good medical facilities, they had improved in fecundity.

TABLE 2: TOTAL FERTILITY RATE FOR KUMASI METROPOLIS AND KWABRE-SEKYERE DISTRICT IN 1988

AGE GROUP OF WOMEN	NUMBER OF WOMEN	BIRTHS TO THAT AGE GROUP	FERTILITY RATE
16 - 20	32	6	0.187
21-25	36	10	0.277
26-30	24	8	0.333
31-35	32	6	0.187
36-40	26	4	0.153
41-45	18	4	0.222

SUM —— 1.359
SUM X 5 — 6.7

SOURCE: Author's Personal Construct based on Field Data, June, 1988.

Besides, attitudes to family planning programmes generally showed a negative trend, and differed from rural areas, and among social groups. These facts are illustrated in Table 3.

TABLE 3: ATTITUDE TO FAMILY PLAN ING PRACTICES IN THE KWABRE-SEKYERE DISTRICT AND THE KUMASI METROPO LIS.

LITERACY STATUS	KNOWLEDGE Kwabre-Sekyere %	KNOWLEDGE Kumasi %	ACCEPTANCE Kwabre-Sekyere %	ACCEPTANCE Kumasi %	PRACTICE Kwabre-Sekyere %	PRACTICE Kumasi %
Literates	20/26(76.9)	36/42(85.7)	18/26(53.8)	32/42(76.1)	12/26(46.1)	20/42(47.6
Illiterates	14/40(35.5)	26/60(43.3)	10/40(25.0)	24/60(40.0)	6/40(15.0)	18/60(30.0)
Total	34/66(51.5)	62/102(60.7)	24/66(36.3)	56/102(54.9)	18/66(27.3)	38/102(37.3)

SOURCE: Author's Personal Construct from Field Survey, July, 1988. Numerators are the number of respondents and the denominators the sample in each group.

As borne out by the statistics, knowledge of family planning methods is higher among the literates than the illiterates in both Kwabre-Sekyere and Kumasi, and generally lower among the illiterates in both areas. It is however, higher in Kumasi than Kwabre-Sekyere, even among the literate, in view of wide publicity of the programmes in the urban centres than the rural. Acceptance rate however declines with variations between the literate and illiterate. The proportion practising is however quite low, especially among the illiterate, compared with the proportion accepting to practise the use of the devices.

The proportion among the illiterate practising family planning methods, though encouraging, is not significant at a time that population growth rate outpaces the rate at which resources are being produced. In the rural areas, the population density is much lower, but a little better in the Kumasi metropolis where the high cost of living and the desire for better living standards have influenced the residents, most of whom are migrants from the rural areas, to make use of the family planning devices.

On the issue of having children, the results show that pro-natalist tendencies are still high. The cultural influence is not insignificant even among literates. This is illustrated in Table 4.

TABLE 4: RESPONSES OF RESPONDENTS ON REASONS FOR HAVING LARGE FAMILY SIZES

TYPE OF RESPONDENTS	REASONS FOR LARGE FAMILY SIZES					
	Prestige	%	Security	%	Perpetuation of Matrilineage/ family	%
Literates	5	6.6	11	14.5	8	10.5
Illiterates	19	25.0	13	17.1	20	26.3
Total	24	31.6	24	31.6	28	36.8

SOURCE: Author's Construct from Survey Data, July, 1988. % is the proportion of the sample desiring large family sizes.

Large family sizes for prestige and the perpetuation of families lie at the core of the cultural institutions of the people. The survey showed that, there is an inverse relationship between fertility and income. The poor normally have large family sizes. This is illustrated in Table 5.

TABLE 5: INCOME AND FERTILITY BEHAVIOUR

INCOME GROUP	FAMILY SIZES 1 - 3	%	4 & 5	%	6 & 7	%
Below minimum wage	21	12.5	49	29.2	34	20.2
Above minimum wage	22	13.1	36	21.4	6	3.6
Total	43	25.6	85	50.6	40	23.8

SOURCE: Author's Construct from Survey Data, July, 1988

Income status was found to have a relationship with the patronage of family planning devices. Those in the lower income group tended to patronise the devices less than those in better financial circumstances. Table 6 vindicates this fact.

TABLE 6: INCOME AND PATRONAGE OF FAMILY PLANNING DEVICES

INCOME GROUP	PURCHASE OF DEVICES					
	Not at all	%	Seldomly	%	Regularly	%
Below minimum wage	91	54.1	10	6.0	3	1.8
Above minimum wage	21	12.5	28	16.7	15	8.9
Total	112	66.6	38	2.7	18	10.7

SOURCE: Author's Construct from Survey Data, July, 1988.

The causes of the growth which highlight the problems are so embracing that, there is the need for pragmatic methods which cut across socio-cultural, ethnic and religious barriers to achieve the desired results.

RESULTS OF OTHER SURVEYS

Surveys in other areas carried out by other researchers go to confirm the Ashanti situation. New phenomena on fertility behaviour not covered by the field survey are evident in such works.

Among the traditional societies in Ghana, fertility rate is quite high. They are generally pro-natalist. Honour to a couple having more children did not apply to the Asantes alone. In the Nyongbato ceremony of the Gas which is a patrilineal society, the husband honoured his wife for having a tenth child (Nukunya, ibid.)[36]. Bleek (1987: 149)[37] discovered that, among the Kwahus, an ethnic group in the Eastern Region of Ghana, child-bearing was so vital to marriage that, credence is least accorded fertility regulation. Indeed, among the Kwahus, to stop or to limit fertility while married seems contradictory and absurd.

One significant factor which cuts across all ethnic groups in fertility behaviour is the type of marriage union, whether monogamous or polygynous. Studies have shown that, couples in polygynous unions prefer higher fertility than those in monogamous unions. This finding by Bleek (Ibid, p.296) is illustrated in Table 7.

TABLE 7: FERTILITY PREFERENCE AMONG MONOGAMOUS AND POLYGAMOUS UNIONS AT AGAWE EWE (PERCENTAGES IN PARENTHESIS)

MARRIAGE UNION	DESIRED NO. OF CHILDREN		Total
	Less than 5	5 and more	
Monogamous Union	60 (38%)	96 (26%)	56
Polygamous Union	5 (15%)	28 (85%)	33
Total	65 (34%)	124 (66%)	189

SOURCE: Based on, Bleek 1980, p.296[38].

The table clearly reveals that, there is a higher preference for higher fertility among polygynous unions. Greenstreet (1987: 7)[39] in a study on the Ghanaian Woman discovered that, women in polygynous unions tended to feel more secure when they had many children. Incidentally, polygynous unions are predominant in Ghana. Males on the other hand would like to prove their sexual potency to their wives (Greenstreet, Ibid.) [40]

Research has also shown that, education generally shows an inverse relationship with fertility. This is succinctly shown by Mawutor (1992: 66)[41] drawing a GDHS 1988 data. The percentage distribution of currently married women currently using any method of contraception by education is indicated in Table 8.

TABLE 8: PERCENTAGE DISTRIBUTION OF CURRENTLY MARRIED WOMEN CURRENTLY USING ANY METHOD OF CONTRACEPTION BY EDUCATION

EDUCATIONAL STATUS	NO.	NOT USING	CURRENTLY USING
No Education	1,467	91.5	8.5
Primary	1,511	84.8	15.2
Secondary	156	73.1	26.9
Higher	22	59.1	40.9
Total	1,356	87.1	12.9

SOURCE: Mawutor, 1992, Computer Tapes, GDHS 1988.

The table shows a significant difference between the highly educated and the illiterate in the use of family planning methods, and indeed, in fertility rates. Whereas 40.9% of currently married women with higher education were currently using any method of contraception, 8.5% of illiterates were women of no formal education who are primarily pro-natalists. In Ghana, there is a high illiteracy rate.

Moreover, it has been established that in Ghana, urban dwellers and those who have had some urban experience exhibit smaller family sizes than those who have predominantly lived in the rural areas. This factor is substantiated by Bleek (Ibid, p. 159)[42] in his studies at Awere, a rural settlement in the Eastern Region of Ghana. His findings are illustrated in Table 9.

TABLE 9: URBAN EXPERIENCE AND IDEAL FAMILY SIZES IN COMBINED MALE AND FEMALE SAMPLES AT AWERE

(PERCENTAGES IN BRACKETS)

URBAN EXPERIENCE	DESIRED NUMBER OF CHILDREN		
	Less than 5	5 or more	Total
Having Lived in Accra, Tema, Kumasi, and Tokoradi	61 (144)	77 (56)	138 (100)
Other	25 (28)	64 (72)	89(100)
Total	86 (38)	141 (62)	227 (100)

SOURCE: Bleek, Op. cit., p.159.

The result is explained by the fact that, there is an elitist city culture which tends to inspire the ambition and aspiration of all classes for better living standards which cannot be realised by high fertility. Illiteracy rate tends to be lower in the urban areas, and education on family planning and sale of contraceptive devices concentrated in the urban areas. With a predominant rural population, positive demographic innovation is thus remote.

Finally, income and employment status have impact on fertility behaviour of Ghanaian women. Generally, poor rural women who indulged in strenuous work tended to have more children. These include pito brewers, farmers and traders (Obeng Afriyie, 1985: 27)[43].

On the impact of employment status, Gaisie and Nabila (1978:24)[44] discovered a dichotomy in fertility rates between the employer and employee. They found out that, in Ghana the employee exhibited lower family size than the self-employed. For both rural and urban areas, the completed fertility for self-employed with and without employee were 6.6 and 7.1 respectively, whilst that of the employee was 4.7. Moreover, whereas the average number of children born alive by women aged 15 and above was 1.20 for University and Higher Education Teachers and Research fellows, that of farmers was 5.47.

It is clear from the foregoing that, research in other areas apart from the Ashanti Region confirms the survey results in the Ashanti Region with respect to relationships between education, place of residence, income and employment status, and fertility behaviour.

CONCLUSIONS

The survey reveals succinctly the fertility situation of the country as reflected in that of the region and in research by others in other areas, and the bottlenecks that have impeded the progress of regulatory measures.

The pro-natalist nature of the population which is built in the culture is clearly exemplified. The size of a family is a source of prestige, especially in the rural communities where tradition is hegemonic. This is confirmed by a public ceremony to honour the couple for having their tenth child. This practice is however limited to the typical rural communities.

Variations in family size exist between the rural and urban communities. In the urban communities where illiteracy rate is relatively lower, family sizes are smaller. On the other hand, family sizes are still high in the rural areas where tradition and ignorance are dominant.

The survey also shows that, educational status is an important determinant of family size. The highly educated tends to have a smaller family size. The difference between the lowly educated and illiterate is however not significant. In some situations, there is no difference. The significant difference in family size between the highly educated and illiterate is due to the awareness of the latter of the health and developmental implication of high fertility.

Moreover, the study has brought into sharp focus the relationship between education and attitude to family planning. The educated have greater knowledge

of family planning devices and tend to accept and practise their use than the illiterate. They are also instruments for innovative diffusion, with regard to the knowledge, attitude to, and practice of family planning methods.

Besides, family planning programmes are concentrated in the urban areas than the rural areas which need them most, in view of the dominance of illiteracy and tradition which are negative factors in fertility regulation.

RECOMMENDATIONS

The solutions to the problem of increased fertility, which is turning out to be a demographic spectre, should be of national concern. The burden should not be left to the government alone. It is such a critical issue, since it is a determinant, in no small measure, of the national survival and prosperity, at a time that natural resources are declining at an alarming rate.

First and foremost, there is the need to integrate family planning into the national development programme. Family planning should not be seen as a separate entity divorced from the national development programme, since natural increase is the primary factor of the population growth problem which negates every development effort. Educational institutions must include sex education in their curricula, while health personnel should educate the public on the methods of family planning. Agricultural extension officers, who are in close touch with rural pronatalist farmers, could use the opportunity to educate them on the demographic and socio-economic implications of large family sizes.

Secondly, public education must be intensified, especially in the rural areas, not only on the socio-economic implications of rapid population growth, but the bio-demographic effects of increased fertility. The effects of increased fertility on maternal and child health must be stressed, since that can scare and discourage mothers who constitute a significant factor in fertility regulation. Public education should not exclude the men whose decision can change the trend of increased fertility.

Hitherto, the onus of the problem seems to rest on the women, but, considering the primary role of men in the family structure, if they are convinced of the negative implications of the fertility problem it will reflect in the attitude of their wives. What a change will occur in the fertility trend if most males, with minimum family sizes, would embrace the method of vasectomy which is one of the most efficacious.

There is no gainsaying the fact that, public fears serve as a barrier to the acceptance and practice of family planning methods. Such fears are aggravated by the unfavourable report by users about the side effects of certain methods. Some of such users take to self-medication, not having been examined by qualified personnel before prescriptions are made. The experiences of such users scare those still in the valley of decision on the acceptance and use of the devices. The public education should emphasise the need for prospective users to receive medical advice on the appropriate method that suits the individual's biological and physiological constitution. The Ministry of Health and the Pharmacy Board should ensure that only drugs prescribed by qualified personnel are sold to the prospective users.

The problems of ignorance and poverty rear their heads deep into the fertility aspect of the population dilemma. Even though the devices, most of which are donated free by international organisations, are sold at low prices, it is strongly recommended that they are supplied free as done in Kenya (Mugo, G., 1973:6)[45]. A family head in the lower income group considers spending a portion of his income to purchase family planning devices which are cheap, as of secondary importance, when weighed against the need to feed the family. The government should therefore absorb the full cost of the devices, to ensure the success of the programme. The ultimate result will be to reduce population growth, improve the quality of the labour force, thus, increase productivity.

On the issue of ignorance and illiteracy, the mass education and informal education programme introduced by the government will help reduce the illiteracy rate in the foreseeable future. This will ensure a wider reading public, and wide acceptance of innovations in this all-important demographic dilemma.

There is yet the need to broaden the base of the use of the injectable forms of contraceptives which have high success rates. In Kenya, where women with families of five or more are being encouraged to embrace, the result has been remarkable (Mugo, G., 1973: 15)[46]. Added to these are other effective forms like tubectomy, tubal ligation and male vasectomy, public fears of which can be allayed through effective public education and successful administration of such devices by qualified personnel.

Furthermore, the problem of scarcity of personnel needs to be addressed with all seriousness. Since doctors have heavier commitments in view of the high doctor-population ratio, registered nurses should be

trained to administer the devices, especially, those not requiring surgery. The training of such personnel would not be as expensive as training more doctors which will put a greater strain on the resuscitating economy. Graduate nurses who have a good background in the biological sciences can be of great use in this exercise.[12]

The spatial distribution of family planning clinics which are skewed towards the urban centres, is a barricading factor in the success of the programme in the rural centres. With limited financial resources, it shall not be possible to spread the clinics over the scattered rural settlements. Field personnel of the Ministry of Health could take advantage of periodic market days to educate the rural folk, and sell the devices. The family planning clinics in the district capitals, especially the rural districts, must be well-equipped to serve the rural population who need the services most.

The other means of solving the problems of the use of family planning methods in the rural areas, is the development of "herbal" contraceptives, which would be more acceptable to them because of the dominance of traditional medicine in their socio-cultural roots. Doctor F.K. Noamesi of Noamesi Laboratory Limited at Hohoe in the Volta Region of Ghana has been a pioneer in this field. He has developed herbal medicine called "navel contraceptive," said to be very effective for family planning. It is reported that, 130 women between the ages of 18 and 51 have been using the navel contraceptive successfully (Sam Clegg (Ed.), 1992:1)[47].

Finally, the government must adopt policies to induce families which accept and practise the methods, thus having smaller family sizes, and discourage increased fertility by introducing anti-maternity leave measures. These measures will go a long way to alter the 'status quo ante' of increased fertility, hence, reducing the rate of population growth and its concomitant socio-economic and demographic problems.

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NOTES

1. The fertility rate of 48.3 per 1,000 was the average based on a post-enumeration survey. In the rural areas and depressed urban quarters like the slums, the average could be as high as 60.

2. The religious organisations operate a good number of health institutions which they use as centres of disseminating family planning information, and to sell the devices. These institutions derive their drug-supply from the government. They can also import drugs especially through their headquarters, mostly in Europe or United States.

3. In view of the seriousness of the population growth problem, the government of Ghana in 1968/69 formulated a population policy for the country. One of the major features was fertility regulation which would be contingent on the education and employment of women.

4. During the ceremony, the local community including the chief and his elders assemble. Folk music is played to entertain the people. A sheep known in Asante language as 'badudwan' is presented to the husband as a gift for the demographic feat.

5. Among the Akans of which the Asantes are a part, and among several other tribes in Ghana, children constitute the parents' security in life. Members of a household based upon the matrilineage are supposed to support one another. Therefore, a woman who goes through life, childless, shall be in perpetual misery.

6. With increasing influence of Western culture with its Christian ethics, most of the traditional cultural practices like puberty rites have lost taste with the people, especially in the urban areas. Now, an educated mother finds it a moral and social disgrace to make her daughter go through the traditional puberty rites.

7. On the other hand, especially among the Akans, it was fashionable that a son-in-law present a

gift in cash or kind to the parents of a girl who was found a virgin, as a reward for their good parental care and guidance.

8. Out of the number, over 80% distribute the devices. The number excludes government hospitals, all sited in the urban centres, that have periodic clinic days, to give family planning education. There are certain private health institutions (mostly in the urban areas) that deliver family planning services.

9. Data on family planning devices in Ashanti Region were derived from the family planning officer, Ministry of Health, Kumasi.

10. In the rural areas, parents find it odd for sex education to be taught in schools. There is often the fear that it will rather encourage than discourage immorality, since their children will be introduced to safety devices.

11. The rural-urban difference is determined more by educational status. The literate in both areas show smaller family sizes than the illiterate. The place of residence however, modifies the fertility behaviour. Women of the same educational level in rural and urban areas are likely to show different fertility patterns. Those in the rural areas tend to have larger family sizes than those in the urban.

12. The University of Ghana awards a degree in Nursing. An Advanced Level Certificate in the basic sciences is the requisite requirement for admission into the B.Sc. Nursing Course. Such calibre of Nurses have been known to be of a very high quality and, with some further training, can perform medical functions of a higher order.