

Awareness and Practices of Family Planning in the Wa Municipality

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Abstract

The decisions of individuals to adopt family planning are affected by a number of factors. But the choice of family planning practice can affect fertility rates and population growth with its attendant problems. Family planning is a voluntary prevention of pregnancy and it entails the interruption of a chain of events that leads to conception. This study examines the awareness and practice of family planning. In all 100 respondents were sampled through stratified sampling procedure. Simple random sampling is then used to select the 100 respondents'. The binary logit model is used to examine the socioeconomic and demographic variables influencing the adoption of family planning. Given that knowledge and level of awareness of family planning is high. However, the practice of family planning remains low.

Keywords: Family Planning, Human Immunodeficiency Virus, World Health Organisation, Non-Governmental Organisations, Community.

INTRODUCTION

1.1 Background/Introduction

The continued growth of world's population has become an urgent global problem. Most of these growths are occurring in developing countries where fertility rates are very high (Bandura et al., 2002). Ghana like most sub-Saharan African countries is characterized by high fertility and rapid population growth. Family planning is defined as a program to regulate the number and spacing of children in a family and the practice of contraception or other methods of birth control (Houghton Mifflin Company (2004). Every year approximately eighty million people are being added to the world's population. As the twenty-first century began, world population was estimated to be almost 6.1 billion people (Todaro, 2006). According to the UN projections; the world's population will reach 9.2 billion by the year 2015 before reaching a maximum of 11 billion by 2020. Increases of such magnitude are unprecedented. Almost all of this net population increases – 97% according to the United Nation is in developing countries including Africa (Todaro, 2006). According to Cassen(2002) , the potential negative consequences of population growth for economic development can be divided into seven categories; its impact on economic growth, poverty and inequality, education, food, health, the environment, and international migration (as cited in Todaro, 2006). Fertility and future projected population growth rates are much higher in sub-Saharan Africa than in any other region of the world and the decline in birth rates, which was already modest, has slowed even further over the past decades. The trend of population growth rate in developing countries appear to have peaked at an annual rate of 2.35% around 1970s compare to annual growth rate of only 0.1 % of the population of developed nations (Todaro, 1994). The biggest single change in the history of family planning in Africa came at 1994 Cairo international conference on population development at which a landmark census was achieved that formally broadened the concept and scope of reproductive health. The aim of this conference was to enlighten African leaders about the worrying trend of population growth rates brought about by the high fertility rate in African countries (Global Health Council, 2002). In Ghana, the Cairo conference lead directly to a revised population policy, one that included HIV/AIDS and adolescent sexuality in a nation where more than half of the population falls under the youth category. This implies that, Ghana like other sub-Saharan African countries has one of the highest fertility rates hence the adoption of the charter of the Cairo conference on family planning policy in Africa (ibid). By 2008, the total fertility was down to four children per woman, placing Ghana two years ahead of schedule. However, the upper west region was still behind target. In 2008, a woman in the Upper West region was expected to have five children on the average, however, recent report indicate that very little has changed since 2008 when the last Ghana Demographic and Health Survey was done (GSS,2010).

1.2 Problem Statement

In 2008 total fertility rate in Ghana stood at 4.0 percent. This means a Ghanaian woman who is at the beginning of her child bearing years will give birth to 4.0 children by the end of her productive period if fertility levels remains constant at the level observed 3 years before 2008 (GDHS, 2000). With this result Ghana has one of the highest fertility rates in sub-Saharan Africa, 14th after Gabon in 2008. If this continues unabated the population of Ghana will have doubled in 23 years preventing any gain in national development efforts (Berhane et al., 1999).

According to(USAID, 2002) many studies and surveys have heightened a persistent gap between knowledge (greater than 95%) and the practice of modern family planning (19%) in the upper west region of Ghana. These failures have contributed to the rapid population growth and its negative consequences such as poverty and inequality, environmental degradation, food insecurity, low quality of health and poor standard of living on the people of upper west region and for that matter Wa municipality. Therefore, this study focuses on awareness and practices of family planning in Wa Municipality.

1.3 Research Questions

The major question: What are the factors affecting the awareness and practices of family planning in the Wa municipality?

The specific questions are:

What are the socio-economic and demographic variables that determine family planning practices in Wa Municipality?

What is the level of awareness and knowledge of family planning?

1.4 Objectives of the Study

1.4.1 General Objective

To analyse the level of awareness and determinants of family planning practices in Wa Municipality.

1.4.2 Specific Objectives

To examine the socio-economic and demographic variables that determine family planning practices in Wa Municipality.

To examine the level of awareness and knowledge of family planning practice in Wa Municipality

1.4.3 Methodology

1.4.4 Research Design

This study is a cross sectional study due to the fact that, time will not affect the data to be collected.

1.4.5 Sample Size and Sampling Procedure

1.4.7 Sample Size

The sample size for the study was determined by the formulae;

$$n = \frac{N}{1+N(\epsilon)^2}$$
 Where;

n =sample size, N = total population, ϵ = margin of error.

Assuming a margin of error of 10% and a total adult population of 409,412 in Wa municipality, the formula above gave a sample size of 100 respondents which was used for the study.

1.4.8 Sample Unit

The sample units for this research comprised of married couples.

1.4.9 Sampling Technique

Respondents were selected using probability sampling technique specifically, the stratified sampling technique. The basis of stratification was marital status.

1.5 Data Analysis and Presentation

Qualitative and quantitative data were collected and analysed. Data was inputted into statistical package for social scientists (SPSS). The estimates were then analysed. The result of the analysis of the quantitative data was presented using tables (frequency tables), charts (pie chart) and Binary logit model while the qualitative data was analysed and presented in written discussion.

1.5.1 Technique of Data Analysis

To examine the socio-economic and demographic variables that determines family planning practices in Wa Municipality. For this objective Binary logit model was used. This was because the dependent variable (adoption of family planning) is binary or dichotomous.

Model Specification

Empirical specification of the model variables are presented as follows;

$$L = Ln\left(\frac{P_i}{1 - P_i}\right) = \beta_0 + \beta_1 C_1 + \beta_2 I_1 + \beta_3 H_0 + \beta_4 M_0 + \beta_5 R_1 + \beta_6 W_p + \epsilon$$

Where: L = Adoption of family planning (assigning 1 if one practices family planning and 0 if otherwise).

β_0 = the intercept.

C_1 = Number of living children (to be measured by the number of children one has).

I_0 =Income (in Ghana cedis)

H_0 = Household Size

M_0 =Exposure to media (the source of information available to one).

R_1 = Religion (religious denomination).

W_p= Wife's or husband's education (measured by the level of schooling).

e = random element.

To test whether there is a significant relationship between family planning adoption (Dependent variable) and the predictors (Education, Children, Income, Household size and Religion) a hypothesis was formulated.

H₀: Socioeconomic and demographic variables do not influence family planning adoption.

H₁: Socioeconomic and demographic variable have a significance influence on family planning adoption

1.5.2 Justification, Measurement and Expected signs of the variables

The variable "**L**"= "Adoption" is the dependent variable. It was measured as a dummy variable, assigning one (1) if one adopts or practices family planning and zero (0) if otherwise. On 'a priori', it is expected that an increase or decrease in the predictors would have a positive or negative influence on the dependent variable (L).

C₁= the number of children. This variable is measured by taking the number of children a respondent has. It is expected that the number of children will have a negative relationship with the regressand. This is because the more one wants more children, family planning adoption is lessened.

I₀=Income. Income is measured by taking the annual earning of respondents. It is expected that income would be positively related to the practice of family planning in terms of cost involved.

M₀=Exposure to media. Here the various sources of information with regards to family planning are taking. It is expected that the more exposed one is with regards to information about family planning, the better on can adopt. Hence a positive influence on adoption.

H₀= Household Size. This refers to the number of people who eat from the same pot. The size is recorded. The sign on 'a priori' is expected to be negative.

R₁= Religion. The religion of respondents is expected to influence adoption. However, a prior sign is uncertain since certain religion frown upon family planning practice whiles others encourage it. Catholic Church disapproves the use of modern contraceptives and this has been a major reason for non-use of modern contraceptives among the predominantly Catholics of the south-eastern Nigeria (Oye-Adineran et al., 2006).

W_p= Education. This variable is measured by the number of years of schooling. It is expected to be positively related to family planning practices. There is a significant association between the number of family planning methods known and woman or husband education (Beekle and McCabe, 2006).

To examine the level of awareness and knowledge of family planning practices. For this objective, the study used descriptive statistics to yield the estimate for discussion.

2.0 LITERATURE REVIEW

2.1 Introduction

These deals with the review of relevant literature to the research topic: awareness and practices of family planning in the context of married couples. The review of literature is discuss under four main sections which are; Determinants of family planning, definition of key terms and concepts, overview of contraceptive usage and levels of awareness and knowledge of contraceptives . The sections have been captioned to deal with the general and specific objectives of the study.

2.2 Determinants of family planning practices

Although, contraceptive usage has increased in recent years, consistent reliance on effective form of contraception remains low. Reasons for inconsistent use are not easily characterized as there are as diverse as they are as complex (Davies, 2006). Although continuous correct use of contraceptives all periods of risk can greatly reduce the likelihood of unintended pregnancy, women have difficulty adhering to such a regimen over a long period. Women attitude towards pregnancy prevention, service providers, experience with contraceptive methods, socioeconomic and sexual partner's characteristics are some factors that affects the use of contraceptives (Frost, 2004).

Major factors influenced the choice of contraceptives for users and these were convenience and effectiveness, so where users are offered a range of commodities, effectiveness and convenience of usage will likely increase (Oye-Adeniran et al.,2006).

Using the 1990 National Family Fertility Size, Sahelysus (1995) studied determinants of contraceptive use and practices among married women in Urban Ethiopia. His findings showed that the number of surviving children and ideal family size are the most important determinants of family planning practices in urban Ethiopia.

The effect of number of living sons in the use of contraception shows a highly significant result after controlling the other predictors. The probability of using contraception among women with two living children and those having two sons is substantially higher (70 per cent) than who do not have any son (36 per cent). Higher number

of sons leads to higher probability of using contraception. It has also been observed in earlier studies that couples with fewer sons are more likely to continue to have children and less likely to use contraceptive (*ibid*).

2.3 Review of key terms and concepts

2.3.1 Family planning

Family planning implies the ability of individuals and couples to participate and attain their desired number of children and the spacing and timing of their birth. Family planning is a programme to regulate the number and spacing of children through the practice of contraception or other methods of birth control (Houghton et al., 2004). Family planning through contraception tries to achieve two objectives; firstly, to have only the desired number of children and secondly, to have these children by proper spacing of pregnancy (Babral, Malik SL, 2004). From the above, family planning can be defined as the practice of reducing family size by birth spacing.

2.3.2 Awareness

It is a situation of having knowledge about the existence of something in this case family planning.

2.3.3 Practice

Practice can be defined as doing something repeatedly in order to improve performance.

Usage 2.4 Overview of contraceptive

The infant mortality rate in Ghana stood at 50 deaths per 1000 live births. This implies that one in every three births die before age five in Ghana (GDHS, 2008). A variety of contraceptives are available which are generally extremely safe compared with the risk associated with pregnancy and childbirth. Not all methods are suitable for everyone. Expanding the number of family planning options available to women is a critical part of increasing contraception coverage, decreasing unintended pregnancies and reducing maternal morbidity around the globe (Baveja et al., 2000).

Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity in all matters relating to the reproductive processes, functions and systems at all stages of life (WHO, 1946).

2.5 Contraceptive methods.

The common contraceptive methods such as condom, oral contraceptives, implants, intrauterine device (IUD), dermal patch and vaginal rings will be discussed.

2.5.1 Condoms

The male condom is the most common used form of the barrier methods, which create a physical barrier to block sperm from reaching ovum and, reduce the risk of sexually transmitted infection (STIs). Male condoms may be made of latex, polyurethane or treated animal tissue (Scott and Glassier, 2006).

2.5.2 Oral contraceptives

The introduction of oral hormonal contraceptives in the early 1960s was the significant turning point of contraception and, since then the combined oral contraceptive pill has been used by approximately 200million women worldwide. Oral contraceptives act mainly by inhibiting ovulation. Progestagen-only pills (mini pills) act mainly by altering cervical mucus to reduce sperm penetration and the endometrium to reduce implantation. (Scott and Glassier, 2006).

2.5.3 Implantable contraception

Sub-dermal contraceptives implants deliver a continued low dose of progestagen from polymer capsules or rods. Norplant contraceptive contains levonorgestrel in six implantable rods to be removed in five years. Implanon contains two rods of 4cm in length with total dose of 150mg levonorgestrel for three-to-five-year duration. A newer single implant system contains etonogestrel for three-year duration. A levonorgestrel prevents sperm transport through the female genital tract and etonogestrel causes an ovulation (Scott and Glassier).

2.5.4 Intra-uterine devices (IUD)

The intra-uterine devices (IUCD) are placed within the uterine cavity; they may contain materials such as copper as in copper T or hormone as in the fourth hormone-releasing devices which were introduced in 1976. The hormone-releasing IUD solves the menorrhagia problem which is associated with previous IUD'S. Levornogestrel acts on the endometrium to cause atrophy and it also alters the characteristics of the cervical mucus (Scott and Glassier, 2006).

2.5.5 Other contraceptive methods

Other methods of contraception are withdrawal, lactation amenorrhea, rhythm method and other natural family planning methods, diaphragms and cervical caps, Emergency contraceptive, Dual protection, patch and ring and many more.

2.6 Awareness and knowledge of contraception.

Family planning education programs should reach out to both men and women and provide accurate information on the risk of pregnancy, the benefit of birth spacing, and safety and possible side effects of contraception, and encourage positive attitudes towards family planning (WHO, 2008). Lack of awareness and poor knowledge of contraception has been found to be common among women seeking for abortion. And that it is necessary to

ensure correct and appropriate information to women about contraceptives. The main sources of information about contraceptives are friends, radio and nurses (Oye-Adeniran et al., 2006) where clients of family planning services have prior counseling about choosing method and help to counter side effects of such choosing methods. The level of awareness of contraceptives has been found to be high in some communities in Nigeria, but good knowledge of different contraceptive methods is very low (Onyuzurike and Ozuchukwu (2001). Therefore the need for women to receive information about contraception and promote women right to control their reproductive health, generate awareness and discard myths about contraceptives (Shoveller et al., 2007).

According to Bongaarts (2002), the knowledge, attitude, and practice surveys revealed no complete correspondence between knowledge and attitude and between attitude and practice of family planning methods in Pakistan. Fawcett (2002), has also reported that respondents in a family planning survey in Morocco usually exhibit considerable knowledge and attitude change overtime but do not always exhibit corresponding changes in contraceptive practice.

Study on awareness of contraception in Ghana by Aryeeet al., (2010).They reported that in a survey of 332 women in the Ga east used for the study, knowledge of family planning was universal (98%) although knowledge of more than three methods was 56% (Aryeeet al., 2010).

2.7 Methodological Issues

Beekle and McCabe (2006), used the social cognitive theory for social change as a theoretical framework because it helps to understand and explain how social and cultural norms, values, peoples believes, behaviors, gender roles and social networks influence people's choice about family planning (Bandura, 2001, 2002). According to Bandura, one of the most important composition of social cognitive theory is efficacy believe. It plays an important role in adopting a change and regulates human function through cognitive, motivational, effective, and decision making processes. Among the mechanism of self-influence for change, none is more central or pervasive than believes in one's efficacy to exercise control over one's functioning and events that affects one's life. This core believes is the foundation of human motivation and accomplishment. Unless people believe that they can produce effects by their actions, they have little incentive to act or to preserve in the face of difficulties. Whatever other factors serve as guide and motivators, they are rooted in the core belief that one has the power to effect changes by one's actions (*ibid*).

However, in many spheres of life, people do not leave their lives independently. They depend on those who have power and resources and they act according to the desires of the powerful (Bandura, 2002; Hogan et al., 1999; Nagase et al., 2003).

3.0 DATA PRESENTATION AND ANALYSIS

3.1 Introduction

Data analysis was done under the following headings; background of respondents, socioeconomic and demographic variables determining family planning practice, level of awareness and knowledge of family planning practices.

3.2 Background of Respondents

These include sex, age, marital status, religion, educational status as well as income of respondents. In addition most of the respondents are married with a few of them being divorced/ separated and widowed. The married made up a large percentage of 90 whiles 7% and 3% represented divorced/separated and widowed respectively. Generally, majority of respondents interviewed had attained basic level of schooling. Results from the study indicate that about 32%of the respondents had attained basic level of schooling, 35% attained secondary level of schooling whiles 21%attained tertiary level of schooling. The study also showed that 36% of respondents had annual income below GH₵ 2000, 16% of the respondents had annual income of between GH₵ 2001 and GH₵3000, 22% had annual income of between GH₵3001 and GH₵4000, whiles 26% had GH₵4001 and above. Furthermore, about 2% of respondents do not have any child, 38% of them had between 1 and 3 children, whiles 60% of them had 4 and above children. Data on the background characteristics are presented in Table 4.1.

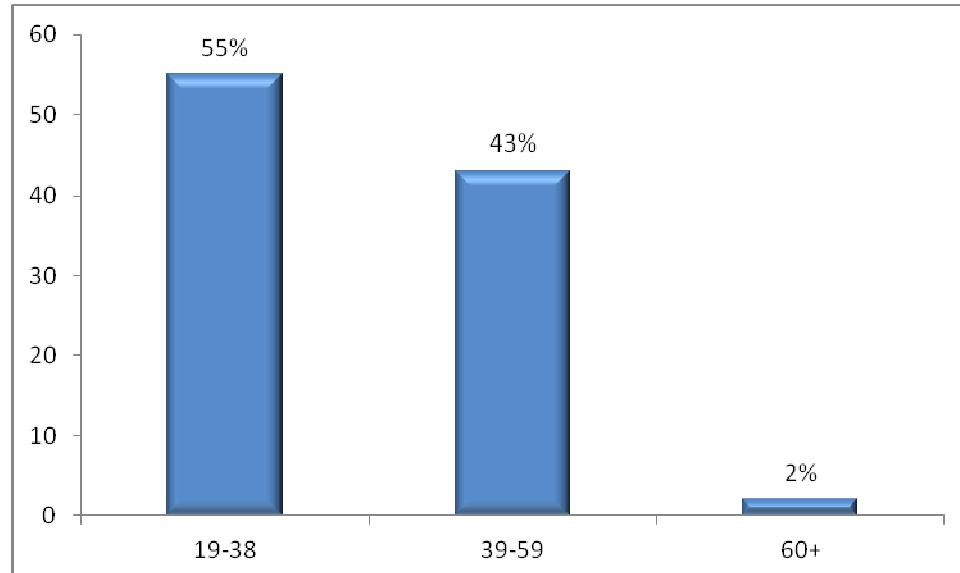
Figure 1.0 : Background of Respondents

Variable	Frequency (N =100)	Percentage (%)
Sex of Respondents		
Male	55	55
Female	45	45
Marital Status of respondents		
Married	90	90
Divorced/Separated	7	7
Widowed	3	3
Educational Status of Respondents		
No Schooling	12	12
Primary	21	21
JHS/Middle	11	11
SHS	35	35
Tertiary	21	21
Annual Income of Respondents		
Below 2000	36	36
2001-3000	16	16
3001-4000	22	22
4001 and Above	26	26
Number of Children of Respondents		
None	2	2
1-3	38	38
4 and Above	60	60

Source: Field Survey, 2013

3.3 Age Distribution of Respondents

Figure 1.1 Respondents' Age distribution

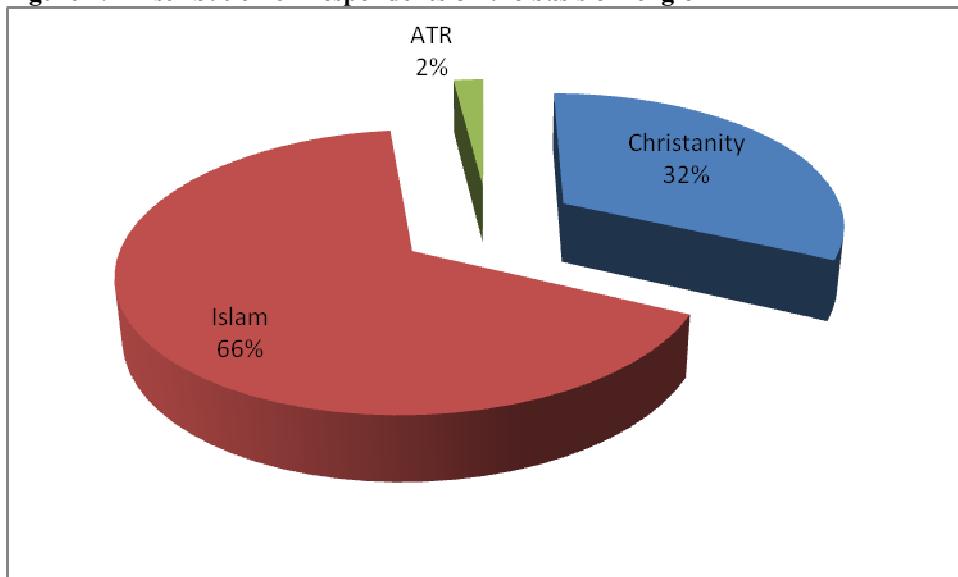


The age distribution of respondents interviewed during the study is presented in figure 4 above, with majority of respondents falling within the 19 and 38 age range representing 55% whilst 43% of the respondents are within the age range of 39 and 59 and the rest 2% of respondents are above age 60. Since majority of the respondents are married, it implies that a number of the married in the study area could be youthful.

4.1.3 Religion of Respondents

Out of the 100 respondents interviewed, 32, 66, and 2 said they practice Christianity, Islam and African Traditional religion respectively making up 32%, 66%, and 2% of the sample in that order. With majority of respondents being Muslims, it implies that the effects of religion on family planning practises could be affected negatively since the issue of contraceptive practice is debatable among majority of Muslims.

Figure 1.2 Distribution of Respondents on the basis of religion



Source: Field Survey, 2013

3.4 Socioeconomic and Demographic variables Determining Family Planning Practices

To test whether there is a significant relationship between family planning adoption (dependent variable) and the predictors (education, number of children, income, household size and religion) a hypothesis was formulated under the analytical technique.

To determine the relationship between the dependent and the independent variables binary logistic regression analyses was used to analyse the probability of one adopting family planning subject to a number of factors. The merit of using binary logistic regression over other qualitative choice models is the fact that it is not numerically complicated because it is based on the logistic distribution (Gujarati and Porter, 2009) and also the response variable is dichotomous. The output of the binary logistic regression model from STATA is presented in the table 4.2.

Figure 1.3: Estimates of logit model

Variable	Coefficients		Marginal Effects	
	Coef.	Std. Err.	dy/dx	Std. Err.
Education	3.404***		0.897	0.137***
Religion	-0.436		1.274	-0.018
Children	-2.708**		1.135	-0.109***
Household Size	0.488		0.290	0.020
Income	1.227**		0.595	0.049**
Information	0.295		0.528	0.012
Constant	-8.731		5.128	0.021

Model diagnostics				
Log Likelihood	-13.712	LR Chi ²	103.26	Prob. > Chi ² 0.0000
Pseudo R ²	0.79	Correct classification		95.0 %

***and ** indicates significant at the 0.01, 0.05 and 0.05 levels respectively

Source: Field Survey, 2013

As a prelude to the discussion of the results, the model diagnostics are log likelihood, pseudo R² and log likelihood ratio (LR) Chi². From the diagnostic test in table 4.2, it is clear that the goodness of fit of the model is good enough given the log likelihood which is an omnibus test of the overall significance of the model is -13.711 as against the constant only log likelihood of -65.342. Again the pseudo R² value of 0.790 indicates that about 79% of variations in the dependent variable (adoption) can be explained by the predictors. Also, the log likelihood ratio (LR) Chi² value of 103.26 is significant at the 0.01 level as indicated by the p-value of 0.000. These suggest that the variables included in the model together predict significantly variations in the decision to adopt family planning. In addition, the model has correctly classified 95% of cases in the model.

Religion, household size and information source do not significantly explain respondents' decision to adopt family planning in the study area. However, educational attainment, number of children and income are significant at the 0.01, 0.05 and 0.05 levels respectively. This suggests that they have significant influence on respondents' choice of family planning adoption.

All the predictors that have significant influence on respondents' choice of family planning adoption have signs as expected. However, even though not significant, religion, household size and information source were expected to have uncertain, negative and positive signs respectively.

The number of years of completed schooling by a respondent positively affects a particular respondent's decision on family planning adoption. Indeed, the marginal effects show for every additional year of schooling attained by a respondent, respondents are 0.137 more likely to adopt family planning and this was found to be significant at the 0.01 level controlling for other predictors. This finding corroborates findings in the literature. For example, a research conducted by Harihar (2007), in India, showed that educational level of couple makes a significant difference in the use of contraception in all the categories of children. As the educational level increases, they become more likely to plan their family size through deliberate use of birth control methods. They are more informed of contraceptive methods and are able to participate in the decision-making process of their lives and that of their families. The social cognitive theory used by Beekle and McCabe (2006), in Ethiopia also confirms this finding. They found out that the lack of formal education for couples limits their ability to make informed and independent choice about family planning and indeed many other aspects of their lives.

Again, the more one wants more children the less likely it is that one adopts family planning. Controlling for other predictors in the model, the marginal effects value of -0.109 suggests that, for every additional child one has, family planning adoption is lessened by 0.109 and this is significant at the 0.05 level. This finding has been confirmed by Harihar(2006), in a research conducted on the determinants of family planning in India. The study found that the higher the number of children the higher the probability of using contraceptives. They further observed that couples with fewer children are more likely to continue to have children and less likely to use contraceptive. Indeed this variable is found to be significant after controlling for other predictors in the current study.

Income has a positive influence on the choice of adoption of family planning. The model estimate of marginal effect of 0.049 in this study indicates that as respondents annual income increases, the probability that they will choose to adopt family planning increases. This implies that controlling for other predictors in the model, when respondents annual income increases by GHC 1, family planning adoption increases by 0.049.

The results here are in line with a research conducted by Beekle and McCabe

(2006), in Ethiopia on the awareness and determinants of family planning. In that study, knowledge and current practices of modern contraceptive methods were analyzed together with the socio-economic and demographic characteristics of the respondents to determine if there were significant associations between these variables. The study found that there is a significant association between the number of family planning methods known, women's education, and monthly family income, while age and religion were not found to have any significant association with the number of family planning methods known by respondents.

From the above, there is enough evidence to suggest that the coefficients are not equal to zero in the population from which these data were drawn. Hence, we reject the null hypothesis and conclude that there are indeed socioeconomic and demographic variables that influence family planning adoption.

3.5 Level of Awareness and Knowledge about Family Planning

Here the study sought to deal with issues such as the level of awareness of family planning, the methods of contraceptives respondents know about family planning and sources of information about family planning. To find out the level of awareness of family planning among respondents. With reference to table 4.3, 88 respondents representing 88% stated they were aware of family planning and 12 respondent representing 12% answered in the negative.

Table 1.4: Respondents Awareness of Family Planning

Awareness of family planning	Frequency	Percentage (%)
Aware	88	88
Not Aware	12	12
Total	100	100

Source: Field Survey, 2013

3.6 Knowledge of Family Planning

Apart from the respondents' awareness of family planning, the study sought to further find out respondents' knowledge about family planning. This was done by asking respondents to in their own opinion define family planning. The results as presented in table 4.4 depicts that respondents have entirely diverse opinions when it comes to their knowledge about what family planning is? While majority of them (89%) know what family planning is even though in different ways, 11% of the respondents do not know what family planning is.

Figure 1.5: Respondents Knowledge about Family Planning

What is Family Planning	Frequency	Percentage (%)
Spacing Children	37	37
Preventing Pregnancy	13	13
Few Children	18	18
Use of Contraceptives	21	21
Don't Know	11	11
Total	100	100

Source: Field Survey, 2013

According to Bongaarts (2002) the knowledge, attitude, and practice surveys revealed no complete correspondence between knowledge and attitude and between attitude and practise of family planning methods. Fawcett (2002) has also reported that respondents in a family planning survey usually exhibit considerable knowledge and attitude change overtime but do not always exhibit corresponding changes in contraceptive practice.

The findings by Bongaarts (2002) and Fawcett (2002) have in a way been confirmed by the result of this study presented in Tables 4.3 and 4.4. However, in this study there have been considerably high levels of awareness, knowledge and family planning practices where only about 36% of the respondents out of 100 saying they do not practice family planning for various reasons.

3.7 Methods of Contraceptives

In order to further access respondents' level of awareness and knowledge of family planning, respondents were asked to list the number of contraceptive they know. Among the methods listed are condoms, emergency pills, oral contraceptives, patch, injectable, IUCD, natural method etc. Table 4.5 gives the breakdown of the number and percentages.

figure 1.6: Methods of Contraceptives Respondents know

Number of methods	Frequency	Percentage (%)
1-2	53	53
3-5	45	45
6-8	1	1
9+	1	1
Total	100	100

Source: Field Survey, 2013

From Table 4.5 it can be seen that out of 100 respondents, 98% of them know up to 5 different methods of contraception. Awareness of contraception was also conducted by Aryee et al.,(2010) .They reported that in a survey of 332 women in the Ga East District used for the study, knowledge of family planning was universal (98%) although knowledge of more than three methods was 56% (*ibid*).

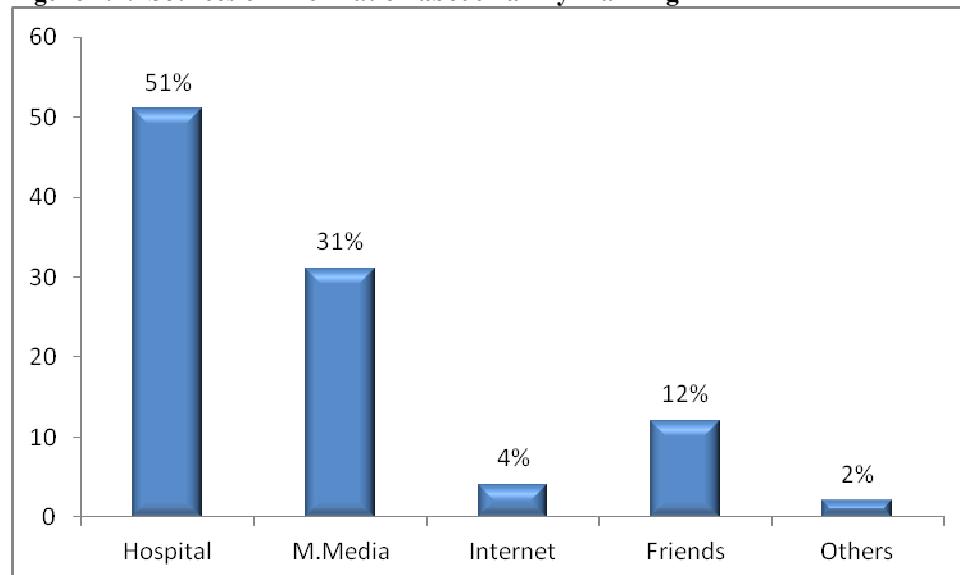
In this research, knowledge of up to 5 methods of contraception has increased probably as a result of increased availability of information about the different methods of contraception.

3.8 Sources of Information about Family Planning

Respondents were asked to indicate the sources of information about family planning. Figure 6 presents sources of information available to respondents about family planning.

The figure indicates the various sources of information about family planning available to respondents are the hospital (51%), mass media (31%), internet (4%), friends (12%) and other sources (2%). This implies that most of the challenges faced by respondents in the use of family planning can be overcome with a myriad of information available to respondents.

Figure 1.7: Sources of Information about Family Planning



Source: Field Survey, 2013

The main sources of information about contraceptives are friends, radio and nurses (Oye-Adeniran et al.,2006) where clients of family planning services have prior counseling about choosing method and help to counter side effects of such choosing methods.

4.0 SUMMARY, CONCLUSIONS AND RECOMMENDATION

4.1 Introduction

The summary summarizes key findings of the study. With a sample size of 100 respondents, the study seeks to examine the socioeconomic and demographic variables influencing family planning practices in Wa Municipality. Semi-structured questionnaire was the main data collection tool used for the study.

4.2 Summary

The study revealed that, education, number of children as well as annual income of respondents are significant determinants of respondents choice of family planning adoption. Religion, household size and information source are not significant factors in explaining the behaviour of respondents' choice of family planning adoption. The study also showed that 88% of respondents are generally aware of family planning even though family planning practices remains low. Also, knowledge of family planning was universal. Almost all respondents had idea about what family planning entails.

Again, the study showed that knowledge of contraceptive methods was high. At least 98% of respondents have knowledge of between 1 and 5 methods even though those with knowledge on 5 methods were low (2%).

The results of the study have important policy implications. For example, the results of the study are important if the Ghana National Population Policy(GNPP) 1994 is to achieve its objective of achieving minimum birth spacing through family planning practice of atleast two(2) years for all births by the year 2020. Awareness and knowledge of family planning are considerably high but practise remains low. According to UN projections, almost all of the net increases in populations are in developing countries including Africa. This could eradicate any significant gains in national development of these countries. An answer to these population growths requires family planning practices to be increased.

4.3 Conclusion

The study sought to examine the socioeconomic and demographic variables influencing the practice of family planning. Education, number of children and income were found to be significant determinants of individuals' choice of family planning adoption in the study area.

The study also revealed that the level of awareness and knowledge of family planning are high although practise remains considerably low.

4.4 Recommendations

Based on the findings of this study, it is recommended that;

The health directorate in collaboration with the family planning unit should roll out more programmes such as organising workshops and seminars to educate married couple on the benefits of family planning practices. This will bridge the gap between awareness and knowledge and practices of family planning.

Community-based family planning clinics need to be expanded and strengthened in the Municipality so as to disseminate information and provide counselling on family planning practices and contraceptive usage. This will help married couple choose appropriate methods so as to reduce the fear of side effects associated with contraceptive usage.

Government and other stakeholders in the health service delivery should help subsidise the price of effective but costly contraceptive methods so that couples can patronise the most effective and efficient methods rather than relying on low cost and ineffective methods.

Government should intensify measures aimed at improving living standards and quality of life of families through fertility control policies to reduce large family sizes and in effect decrease population growth. These measures may include education and campaigns on awareness and practices of family planning.

Family planning services should be incorporated in all public and private hospitals and clinics within the Municipality with the view of increasing access to and supply of contraceptives. This will help reduce if not eliminate the accessibility constraint.

Chiefs, opinion leaders and the community as a whole should be made part of the awareness and practice campaign. This will help reduce the negative perceptions society have about people who practice family planning.

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