



IMPLICATIONS OF FAMILY PLANNING ON CHILD LABOR: A GHANAIAN CASE STUDY

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Abstract

Researchers conducted twenty-two interviews in Ghana in collaboration with a Ghanaian NGO, Patriots Ghana. Interviewers recruited local elite interviewees through snowball sampling. Interviewers asked questions regarding perceived access to contraception and household decision-making on childhood education. All interviews were semi-structured and were conducted in summer 2017 with translators provided by the host NGO. Researchers transcribed interviews from recordings and crosschecked against handwritten notes before developing a coding matrix to run descriptive statistical analysis. Analyses suggest that 75% of respondents believe contraception is highly accessible in Senya-Beraku, Ghana. However, 82% went on to say that community perceptions of contraception are mixed or negative. Further, 81% of respondents identify a relationship between increased family size and the prevalence of child labor. In conclusion, this research delineates the necessity of further education on both family planning and child labor in Central Region, Ghana.

Introduction

“Every family wishes the child attends school, but that’s a lot of money,” explained one Ghanaian community leader during an interview in the Ghanaian fishing village of Senya-Beraku. The interviewee went on to explain that a lack of adequate finances in Ghana means the difference between a child working and attending school. Unfortunately, such “work” is in actuality child labor. Aligning with International Labor Organization (ILO) standards, the Ghanaian Children’s Act prohibits exploitative labor [LS1] (Section 87), defining exploitative as depriving the child of health, education or development. Further, it sets minimum age requirements for work: thirteen for light work, defined as work that is not likely to be harmful to health/development and that does not affect a child’s ability to attend school or capacity to benefit from schoolwork (Section 90); fifteen for employment (section 89); and eighteen for hazardous employment (hazardous work being work that poses dangers to the health, safety, or morals of a child).¹ Despite these legal actions, 30%

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of children in Ghana, and 27% of children aged twelve to fourteen, work illegally, with 14% engaged in hazardous work.²

To address the poverty that drives child labor, both the Ghanaian government and NGO programs promote family planning to reduce family size and ameliorate strain on households’ limited financial resources.

The Ghana Shared Growth and Development Agenda for 2014-2017 includes improving the country’s family planning infrastructure and increasing access to affordable contraception and educational resources on childbearing and birth-spacing.³ While family planning has grown in popularity in urban areas, such as Accra and Kumasi, it remains a developing concept in rural areas.⁴ This project seeks to understand the relationship between poverty, family size, and child labor, by exploring how local stakeholders in a midsized fishing village in Central Region, Ghana, understand the role of family planning in reducing poverty and child labor within their community.

Theoretical Approach

The ILO considers children to be engaged in child labor if “they are doing hazardous work, they are less than 12 years and engaged in economic activity, or they are aged 12 to 14 years and are engaged in economic activities that are not defined as light work.”⁵ This paper adopts this definition in accordance

with the ILO, the Hazardous Child Labor Activity Framework for Ghana (HAF) and the National Plan of Action (NPA) for the Elimination of the Worst Forms of Child Labor.⁶ Across the country in 2013, 76.8% of working children were employed in the skilled agriculture/fishery sectors, and 14.9% in sales.⁷ However, in rural coastal areas, 65.8% worked in agriculture/fishing industries and 15.9% in sales, and in Central Region, 83.2% were employed in agriculture/fishery and 10.2% in sales.⁸ On average, children started work at age nine both overall and in Central Region.⁹ This not only poses threats to children's health, but can also prevent them from going to school. As such, 9.2% of rural Ghanaian children have never attended school, despite the Ghanaian constitutional mandate of free, universal, compulsory basic education.¹⁰

Often, children work because their families cannot afford the additional costs associated with formal education [LS3]. Ghana Statistical Service reports that 14.8% of children aged 5–17 not in school said they were not enrolled because their families could not afford it; in rural coastal areas, 29.9% cited the same reason. Further, indirect costs associated with education—transportation, uniforms, etc.—or the opportunity cost of losing the child's potential income are used as justifications for a parent's decision to send his child to work instead of school.¹¹ While locals argue that working children offset their cost to the household and receive skills-training for careers, children who work are less likely to go to school, earn less as working adults, and are later more likely to make their children work.¹²

Within Central Region, the Awutu-Senya District where this research was located has the second-highest rate of poverty, with a poverty incidence rate of 33.6%.¹³ Larger family size increases the probability that a child will work, and correlates with increased hours that a child will work [LS4].¹⁴ The cooccurrence between family poverty and child labor is illustrated by children being more likely to work in households that lack basic infrastructure, such as running water, because household chores require more labor.¹⁵

Although both the Ghanaian government and NGOs promote family planning, Ghana maintains a 30% rate of unmet need for family planning, and increasing [LS6] attitudinal resistance towards contraception use.¹⁶ Community knowledge supersedes formal health outreach, and many women fear the rumored side effects of birth control, such as infertility or permanently irregular menstruation.¹⁷ Further, local religions regard family size as a blessing of virility and health, providing children to care for their parents in old age.¹⁸ This belief transcends religion into a social ideology where families expect children to care for their aging parents; by having more children, parents have a higher chance of being cared for as they age.¹⁹

Patterns of child labor, unmet need, and poverty are also gendered and affect women's health and economic status. Girls are more likely to be pulled out of school as family size increases, and they often work domestic labor at earlier ages than boys. Women have a greater disadvantage at breaking cyclical poverty when they are pulled out of school earlier and lack access to family planning resources, as higher education rates are correlated with lower family size and increased use of contraception.²⁰ In 2014, the Ghana Health Service recorded that in Central Region, 21% of women aged 15-19 have begun childbearing, compared to the national average of 14%.²¹ Women in rural areas, with no education, or from the poorest households, experience childbearing earlier than other women of the same age group.²² Often, women have children because of pressure from their husbands' extended families and because they fear that their husbands will have children with other women if they are refused.²³

Methodological Approach

This project utilizes formal interviews, informal testimony, and community observations along with existing literature on child labor. Researchers conducted interviews in the medium-sized fishing village of Senya-Beraku, with a population of approximately 19,000, located in Central Region, Ghana. The researchers collaborated with a small Ghanaian NGO called Patriots Ghana whose mission is to promote civic participation through community service and economic empowerment. Through a mixture of snowball sampling and their connections in the community, NGO staff assisted researchers in recruiting local elites from a variety of occupational and educational backgrounds in the fishing village. Examples of interviewees included local government officials, religious leaders, and clinicians. The twenty-two interviews were semi-structured, and all but one was recorded.

Of the twenty-two interviewees, sixteen were male, twelve were married, twelve were educated at the university level, and thirteen were under forty years old. The occupational breakdown of interviewees was: seven NGO workers (32%), six religious leaders (28%), five assemblypeople (23%), two community leaders (9%), and two healthcare professionals (9%). Researchers designed the interviews after an extensive review of literature regarding both child labor and family planning in Ghana in collaboration with community partners and adjusted them after interviews with a sample group from the host NGO. In these interviews, researchers asked questions regarding perceived access to contraception and how families account for limited financial circumstances

in household decision-making. The interviewers assessed views surrounding local prevalence and conceptions of child labor. All interviews were conducted in-person during summer 2017.

After interview completion, researchers used recordings to transcribe interviews and checked the transcriptions against handwritten notes taken during the interviews. They then developed a coding matrix by which they qualitatively coded the interviews. Although the sample size is limited, the research team examined response frequencies and descriptive statistics. Further, they compared interview responses from NGO staff based in a large neighboring town with interviews of local elites in Senya-Beraku.

Limitations

As foreign researchers, language barriers impeded direct communication with research participants. Despite using local translators, participants were at times hesitant to disclose the challenges their communities faced and would often try to use English to accommodate the researchers, despite not having sufficient fluency to fully answer the interview questions. This barrier was partially mitigated by the presence of translators to assist with interpretation of idioms and vernacular challenges, even for interviews conducted primarily in English. For example, one community leader answered a question about ideal family size by saying that 100 children would be the maximum acceptable size. The translator got the same response after multiple attempts at clarification. This response was removed from descriptive statistical analysis because of its status as an extreme outlier.

Similarly, the snowball sampling strategy was employed by a field assistant for Patriots Ghana, an NGO known to promote reproductive health rights and advocate against child labor. While the perception of this NGO may have influenced the recruited participants, we believe this limitation was curtailed because of the community status of the field assistant: he was a fixture in the community before he began working with Patriots Ghana, so participants knew him as a community member more than as an NGO employee.

Demographically, this project was limited by the gender imbalance of community stakeholders. While the majority of healthcare workers in the sample were women, religious and political leaders in the community were overwhelmingly men. This imbalance biases

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the responses in favor of a masculine perspective, especially for questions about reproductive health. Further, existing data on the fishing village was limited, as the only major health and demographic survey was conducted by the Ghanaian government in 2014. Additionally, researchers found response rates to be much lower when asking about contraception and family planning than when asking about family size and child labor. This could be because of the stigma associated with contraception, particularly given the researchers' aforementioned outsider and perceived elite status.

Findings

Family Size

Researchers began interviews by inquiring about the current size of the interviewee's family and the ideal size of a family in the village. The mean number of children for interview respondents was 2.7 children. However, after removing the ten unmarried respondents—only one of whom had children—the mean for the remaining twelve respondents was 4.4 children. The mean ideal number of children for married respondents was only 3.6 children (as compared to mean ideal number of children for unmarried respondents at 3 children). This suggests that project respondents chose to have more children than they said is ideal for a family living in the research village. This could result from some interviewees, specifically those from the host NGO, not living in the research village, as customs and social norms differ substantially between villages or regions, or from the elevated social status of local elite interviewees.

Further, NGO workers had a mean of .14 children as compared to a mean of 3.9 children in their village counterparts. This is likely accounted for when marital status is considered; only one of seven NGO workers was married as compared to eleven of fifteen community members. However, it is interesting that NGO workers, regardless of marital status, held a mean ideal family size at 2.8 children while community members viewed mean ideal family size to be 3.6 children, in comparison to the actual average of 5.2 children per woman at the end of her childbearing years.²⁴ A statement from a religious leader suggests that social pressures encourage respondents to have more children than they ideally would, as people tell families with only two or three children that their children will be “lonely.”

One reason for large Ghanaian family sizes is elder care. Aging parents expect their children to act as caretakers, reinforcing the idea that large families have a higher chance of children being successful enough to care for their

elderly parents.²⁵ This perception was reflected in community observations as well as in formal interviews. As explained by one interviewee, “When you’re old, children will take care of you.”

Further, interviewees and extant literature support the idea that patriarchal power dynamics contribute to large family sizes in Ghana. In practice, women keep having children with their husbands to prevent their husbands from having children with other women.²⁶ A religious leader interviewee exemplified such attitudes through a story he told about a man in his congregation. When the man’s wife only gave birth to one child in five years, the woman was classified as “barren” by his extended family, and the man was encouraged to have children with another woman.

While it may be expected that this power dynamic would contribute to short birth intervals, this does not necessarily seem to be the case. Interviewee responses reflected a mean ideal birth interval of 2.7 years for a family in this village. The relatively small standard deviation of .96 years and variance of .93 years are reflected in the fact that 86% of respondents thought that two or three year intervals were best. Responses were fairly consistent between nonprofit workers’ mean response of 2.6 years and community members’ mean response of 3.0 years.

Given that 76% of respondents mentioned finances as a factor that families should take into consideration before deciding to have another child, it seems paradoxical that family size in this research village is so large when financial resources are so limited. Other factors to consider cited by interviewees included emotional considerations (mentioned by 29%), religious considerations (mentioned by 33%), medical considerations (mentioned by 33%), and educational considerations (mentioned by 29%).

Interviewees reinforced the importance of finances in family decision making when asked about which factors contribute to families choosing if children should go to school or work. Interviewees explained that extenuating circumstances like crippling poverty force parents to make strategic decisions to employ one child so that his siblings can eat or go to school. As such, 85% of respondents cited finances as a factor to consider in this decision. Financial considerations stood far above the rest, as other considerations like child age (15% of respondents), child choice (15%), and child gender (10%) were less representative than expected in our sample.

The prevalence of young children working in Central Region, Ghana, exemplifies the effect of these factors. Interviewees identified the mean age of children beginning work in the village as 8.1 years (SD = 3.6). The most

common types of work done by children in the village outside the home, as reported by respondents, includes selling goods (mentioned by 82% of interviewees), fishing (73%), agricultural work (23%), and fetching water (9%).

Family planning

When asked about the definition of family planning, 55% of respondents spoke about birth spacing (also referred to as birth intervals). Further, 55% referenced a family's ideal number of children as being a part of family planning. 30% spoke of family planning as a mindset, whereas 20% viewed it as a mechanism. Without being directly asked, 56% of interviewees mentioned the importance of partner communication in family planning.

When asked how community members in this fishing village learn about family planning, interviewees spoke of hospitals (referenced by 50%), education by community nurses (43%), advertising (29%), talks in schools (29%), and word of mouth (7%). While religious leaders interviewed spoke of educating their congregations on issues of family planning, no interviewees mentioned this as a source of community knowledge. Further, general community perception suggests that family planning is rarely addressed in religious settings. This

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suggests that such education, if present, is highly ineffective.

Data suggest that 75% of respondents believe contraception is highly accessible in the research village. However, 82% went on to say that community perceptions of contraception are mixed or negative.

As such, general community perception was that while contraception may be technically available, it is rarely utilized in marriage. Interviewees cited religious reasons, fear of side effects, perceptions of contraception causing unfaithfulness in marriage, or fear of promiscuity as contributing factors to this stigma. Specifically, when asked about the actual availability of contraception within the village, 64% of respondents mentioned a contraception stigma, 18% mentioned cost, and 27% mentioned lack of knowledge of contraception. It is worth noting that most interviewees who mentioned stigma and lack of knowledge spoke of these factors as barriers to availability, whereas the low cost of contraception was often mentioned by the interviewees who view contraception as accessible.

According to our interviewees, perception and utilization of family planning varies widely between generations. One interviewee explained that older

couples prevent pregnancy through utilization of the rhythm method and abstinence, while younger couples, being more promiscuous, use methods such as chemical birth control and condoms. Another interviewee, a religious leader, spoke of the effect of the contraception stigma on his behavior: as a member of the clergy, he was afraid that purchasing contraception would invalidate his moral standing. Further, this shame is exemplified in our comparatively low response rate to questions regarding contraception. Only 10 of our 22 interviewees responded to our question about reasons for a positive or negative community view of contraception. Of these, 90% identified perceived side effects of contraception as a barrier to utilization. Interviewees spoke of women believing community myths surrounding birth control and fearing irregular menstrual cycles stemming from birth control. One nonprofit interviewee suggested that collectivist culture promotes groupthink by discouraging women to focus on the individuality of health choices. For example, if one woman has negative side effects with birth control, she will tell everyone she knows to avoid it.

Further, both male and female respondents (30%) referenced fear of infidelity as a reason for negative perceptions of birth control. Three interviewees—a nonprofit staff member, a community leader, and a clinician—explained that men believe that their wives will be unfaithful if they are taking long-term birth control. They went on to explain that some women fear that if they refuse sexual advances from their husbands, their husbands will seek women elsewhere.

Men are not only unwilling to allow women to use contraception, but they are also unwilling to use it themselves. Although it did not surface during any of our formal interviews, a Twi phrase often circulated when speaking of condoms roughly translates to, “Why eat the toffee with the wrapper?” Further, one interviewee explained the general Ghanaian male view of contraception:

“Why should I use a condom to protect myself? I’ll use the natural way to protect myself. Because when I’m using a condom to have sexual intercourse with my partner, the way I feel it, it is different from if I do not use a condom to have sexual intercourse with my partner.”

The “natural way” refers to the withdraw (“pull out”) method of contraception. Utilization of this method is particularly dangerous in low-income areas such as Senya, where the financial consequences of unexpected pregnancy can be devastating for already-struggling families.

Child Labor

Perceptions regarding what is considered child labor varied significantly among respondents. When asked about aspects of child labor, respondents pointed to perceived harm to the child (62% of respondents). Further, they referenced child age (57%), child health (29%), and profit gained from work (29%). Many respondents expressed a multifaceted view of what constitutes child labor by referencing more than one contributing factor.

Beyond the definition of child labor, interviewees identified influences that contribute to child labor. Examples of contributing factors include local customs (62% of respondents), religion (29%), peer pressure (24%), and the value of child labor in large families (5%). The value in large families specifically references the aforementioned idea of elder care. Further, 29% of interviewees identified no external community influences on child labor. An example of this is an influential community leader who does not acknowledge the existence of child labor in Senya-Beraku.

Additionally, 81% of respondents identified a relationship between family size and prevalence of child labor. When asked to elaborate on this relationship, 78% referenced financial reasons, 61% emphasized number of children, and 30% made generalized value statements about the types of people who send their children into child labor.

Conclusions/Significance

Community Solutions

Government and NGO public health programs have reduced the shame around family planning by emphasizing the role of child welfare and poverty and the role of birth spacing as parts of the responsible decision-making process for couples. While people can more comfortably discuss the role of family planning, contraception is still associated with promiscuity and is not considered appropriate for genial conversation. Because families do not take advantage of family planning resources, family sizes continue to exceed families' economic capacities, forcing families to turn to child labor to offset the financial strain of having many children. As long as families lack financial resources to provide for their children, child labor will continue. However, the emphasis on economic solutions may be in part because of the overrepresentation of male interviewees. One of the female NGO workers offered solutions that focused on women's empowerment and increasing their economic independence, ideas that were not present in responses for more general economic improvements.

This project demonstrates the necessity of further education on both family planning and child labor in the Central Region of Ghana, as well as the importance of increasing scholarly attention to the community perspective on poverty. Of respondents in the current work, 87% referenced education as a potential community solution. Further, 31.3% of respondents referenced economic solutions, and 11.8% of respondents mentioned vocational training. Patriots Ghana has expressed interest in using this research to seek additional funding for programming regarding family planning education from the Ghanaian Ministry of Social Services.

Such education must reach all sectors of the community to maximize its effectiveness. Family planning education is often ineffective because it primarily (or exclusively) reaches women, which is particularly harmful in patriarchal societies in which men hold disproportional power.²⁷ Further, education must reach community leaders. The relationship between religious beliefs and family planning demonstrate the potential impact of educating religious leaders.

A nonprofit interviewee exemplified the impact of such education by speaking of a recent experience with a community member. He explained that the village man refused to use any form of family planning despite pleadings from his wife and peers, but changed his perspective after the staff member encouraged him to think of the future he wanted for his children. Specifically, he chose to use family planning after realizing that he would not be able to afford schooling for his children unless he limited his family size. Peer-to-peer educational methods such as this are emerging, promising practices in the field of family planning education.

Formal education also has a role in this issue. Educated societies promote more accountable and educated governments, have lower rates of poverty, and encourage economic advancement. The education-fertility-reduction hypothesis explains that the more educated parents are, the fewer children they are likely to have.²⁸ Explaining the importance of schooling to village families has the potential to change behavior.

Further, poor infrastructure necessitates vocational training and economic empowerment to enact meaningful change. A nonprofit interviewee summed this up when asked about solutions: “You need to help them have jobs.”

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Economic diversification is particularly important to facilitate financial stability in villages like Senya-Beraku, where the economy is primarily dependent on only one industry (e.g., fishing). This could be accomplished through programs such as microloans to female entrepreneurs, a solution suggested by the same nonprofit interviewee.

Future research

Future research on this topic could be conducted as a survey with a larger sample size in order to establish statistical correlations between community demographics and perception of family planning and child labor. Further, future research should consider a wider variety of community members instead of limiting itself to community elites, and should consider demographic factors such as gender during the recruitment phase. Future studies should also inquire about interviewees' religious affiliations in order to allow for statistical comparisons of attitudes toward family planning and child labor between religious traditions. Additionally, future research should continue to focus on Central Region, Ghana to increase local capacity for family planning and prevention of child labor.

Endnotes

¹ Ghana Statistical Service, *Ghana Living Standards Survey Round 6 (GLSS 6): Child Labor Report* (2013): ix, http://www.statsghana.gov.gh/docfiles/glss6/GLSS6_Child%20Labour%20Report.pdf.

² Ibid.

³ Ibid., 79.

⁴ ICF Macro, *Trends in Demographic, Family Planning, and Health Indicators in Ghana, 1960-2008: Trend Analysis of Demographic and Health Surveys Data* (2010): 15, <https://dhsprogram.com/pubs/pdf/TR6/TR6.pdf>.

⁵ "Child Labor," *International Labor Organization* (December 8, 2017): <http://libguides.ilo.org/child-labour-en>.

⁶ Ghana Statistical Service, *Child Labor*, 1.

⁷ Ibid., 37.

⁸ Ibid.

⁹ Ibid., 35.

¹⁰ Ibid., 14.

¹¹ Sudharshan Canagarajah and Helena Skyt Nielsen, "Child Labor in Africa: A Comparative Study," *The Annals of the American Academy of Political and Social Science* 575 (2001): 71-91, *JSTOR*, <http://www.jstor.org/>

stable/1049181.

- ¹² Indrajit Thakurata and Errol D’Souza, “Child Labour and Human Capital in Developing Countries—A multi-period stochastic model,” *Economic Modeling* (2007): EBSCO, 10.1016/j.econmod.2017.09.006.
- ¹³ Ghana Statistical Service, *Ghana Poverty Mapping Report*, ix, <http://www.statsghana.gov.gh/docfiles/publications/POVERTY%20MAP%20FOR%20GHANA-05102015.pdf>.
- ¹⁴ Ellen Webbink, Jeroen Smits, and Eelke de Jong, “Hidden Child Labour: Determinants of Housework and Family Work of Children in 13 Developing Countries,” *World Development* 40.3 (2012): 639.
- ¹⁵ Ibid., 632-633.
- ¹⁶ Sarah Staveteig, *Understanding Unmet Need in Ghana: Results from a Follow-up Study to the 2014 Ghana Demographic and Health Survey*, USAID (2016): <https://www.dhsprogram.com/pubs/pdf/QRS20/QRS20.pdf>.
- ¹⁷ Stephen Obeng Gyimah, et al., “Religion, Contraception, and Method Choice of Married Women in Ghana,” *Journal of Religion and Health* 51, no. 4 (2012): 1371, JSTOR, www.jstor.org/stable/23352790.
- ¹⁸ Ibid., 1361.
- ¹⁹ Joseph Kofi Teye, “Economic Value of Children and Fertility Preferences in a Fishing Community in Ghana.” *GeoJournal* 78, no. 4 (2013): 701, JSTOR, www.jstor.org/stable/42002540.
- ²⁰ Abiba Longwe & Jeroen Smits, “The Impact of Family Planning on Primary School Enrolment in Sub-national Areas within 25 African Countries,” *African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive* 17.2 (2013): 26, JSTOR, <http://www.jstor.org/stable/23485918>.
- ²¹ Ghana Statistical Service, *Child Labor*, 13.
- ²² Ghana Statistical Service, *Demographic and Health Survey 2014*, (2015): 86, <https://dhsprogram.com/pubs/pdf/FR307/FR307.pdf>.
- ²³ Teye, 703-4.
- ²⁴ Ghana Statistical Service, *Demographic and Health Survey 2014*.
- ²⁵ Teye, 701.
- ²⁶ Ibid., 703-4.
- ²⁷ Ibid., 707.
- ²⁸ Ibid., 698.