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# How are educated women in Ghana regulating fertility without high levels of modern contraceptive use?

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# EVIDENCE SUMMARY

# STEP UP

STRENGTHENING EVIDENCE FOR PROGRAMMING ON UNINTENDED PREGNANCY

JUNE 2018

# How are educated women in Ghana regulating fertility without high levels of modern contraceptive use?


## SUMMARY

While Ghana has made striking gains in enabling its women to use family planning to reduce family size —the total fertility rate shifted from 7.0 to 4.2 children per woman from the 1970s to the 2010s — reported modern contraceptive prevalence is lower than expected for this relatively low level of fertility. A full picture of the reasons underpinning this decline in fertility is only now beginning to emerge. This evidence summary aggregates research from the Strengthening Evidence for Programming on Unintended Pregnancy (STEP UP) Research Programme Consortium along with other related evidence to explore this question of how educated women in Ghana are able to control their fertility.


STEP UP generates policy-relevant research to promote an evidence-based approach for improving access to family planning and safe abortion.

We work in Bangladesh, northern India, Ghana, Kenya, and Senegal.


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## FINDINGS AT A GLANCE

- Ghana has achieved its current level of fertility despite reported low levels of use of highly effective contraceptive methods.
- Women are commonly practising "periodic contraception" and make use of "counting days" (using a calendar and the date of one's last menstrual period to estimate "unsafe" days, or those on which the risk of conception is high) and practising contraception such as withdrawal, condoms and emergency contraceptive pills.
- Use of fertility awareness methods is common but under-reported in the Demographic and Health Survey.
- Desire to keep normal menses and concerns about protecting fertility mean some individuals avoid the most effective methods like hormonal methods and IUDs.
- Women wishing to use the most effective methods may be asked not to do so by their partners or family members who fear they will affect fertility, so the women may use these methods—particularly injectables—in secret.

## KEY RECOMMENDATIONS

- Family planning programmes must focus efforts on ensuring family planning providers explain effects and side effects of contraceptives to women and their families so that they get the best information and needed support. The question of disruption of menses and return to fertility associated with using different contraceptive methods should be a key part of any family planning counselling/messaging.
- Effective use of coital and traditional methods should be more centrally integrated into family planning programmes. Providers should commit adequate time to help both men and women understand the menstrual cycle, particularly those who opt to use traditional methods, to explain use and effectiveness (or lack of effectiveness).
- Providers should consider suggesting that stable couples use a more effective contraceptive regimen (such as condoms, with emergency contraception in case of failure or non-use) during periods when they prefer to avoid prolonged use of hormonal contraceptives, and provide safe abortion and post-abortion care permissible under the law.

## INTRODUCTION

### Fertility decline and modern contraceptive use in Ghana

Ghana is in the vanguard of fertility decline and family planning in West Africa, having achieved lower national fertility and significant improvement in health of women and children compared with neighbouring countries. This trend of fertility decline is similar to that seen in Kenya, which has been at the forefront of family planning programmes in East Africa.

A study from the STEP UP Research Programme Consortium assessed similarities and differences in trends in fertility, contraceptive use, and family planning programmes in the two countries[1]. Total fertility rates (TFR)[i] declined from 7.0 to 4.2 in Ghana and from 8.1 to 3.9 in Kenya between the 1970s and the early 2010s. Ghana and Kenya were the first two African countries that developed policies to address population growth in the 1960s and have had strong family planning programmes.

However, Ghana has achieved the same level of fertility with only half the contraceptive prevalence (CPR)[ii] of Kenya (Figure 1). While prevalence of all contraceptive methods increased by almost 30% in Kenya between the late 1980s and the early 2010s, Ghana observed only a 14% increase in the same period, reaching a CPR of 27%—yet saw the same levels of fertility decline.

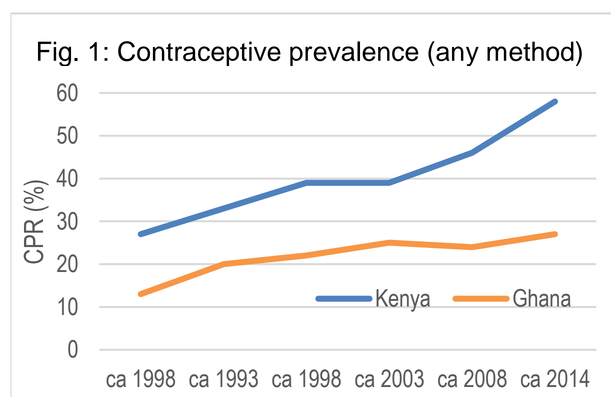
[i] Average number of children that would be born alive to a woman during her life time if she were to live to the end of reproductive life and give birth to children according to a current schedule of age-specific fertility rates.

[ii] Percentage of women of reproductive age who are currently using, or whose sexual partner is currently using, any method of contraception.

## EVIDENCE

### Lower modern contraceptive prevalence among rich, urban and educated women

In Ghana, some unusual patterns in contraceptive prevalence have been observed. The 2014 Ghana DHS reported that currently married women aged 15–49 in the top wealth quintile had a lower modern contraceptive prevalence (mCPR) than less affluent women (20% vs. 21–25%), and that urban women had a lower prevalence than rural women (20% vs. 25%).[2] This is the opposite of what is generally seen in countries worldwide. It was also unusual that the mCPR was higher among women with a primary education only compared with more educated women (27% vs. 24%), while the TFRs were 4.6 and 2.6, respectively. Moreover, despite the fact that mCPR in Greater Accra was the second lowest in the whole country (19%), the level of fertility was the lowest (TFR 2.8).




Data source: Demographic and Health Surveys

## Normalised use of fertility awareness approach

DHS data do not fully explain the paradox of low fertility among rich, educated urban women, and STEP UP is among the research projects seeking to understand this. Two STEP UP studies did reveal underreporting of traditional method use in DHS. The first was an analysis of the 2008 DHS data, which showed higher use of traditional methods among educated urban women, and found that women who wanted to wait for two years or more or who wanted to stop childbearing were more likely to report not having had sex in the last 4 weeks.[3] This finding suggests that couples may deliberately control timing or frequency of sex according to their fertility desires and that the DHS may not adequately account for abstinence as a method of fertility control, something also indicated by a separate qualitative study.[4]

## "Counting days"

The second STEP UP study was a qualitative enquiry among educated women in Accra examining their fertility regulation strategies.[5] Many women mentioned "counting days." By this they meant that they used the date of their last menstrual period to estimate which would be "unsafe" days in their cycle—those on which they perceived their risk of conception was high—and then acting to reduce the risk of pregnancy on those days. Counting days was almost universally used at one time or another, and participants described it as a taken-for-granted part of a woman's life. Surveys in Accra and Ouagadougou which specifically asked about use of calendar methods recorded far higher reported use of traditional methods than the DHS.[6,7]

Opinions about exactly which days were safe differed among women, as did counting techniques. Some women considered the fertile period to last "four to five days" or "from day 10 to day 16"; all focused on the middle of the cycle, although there was little precise agreement.

## "Periodic contraception"

Whereas the rhythm method usually refers to avoiding sexual intercourse during periods in which the risk of pregnancy is perceived to be high, counting days does not often involve abstinence. Rather, women said that they used other methods to avoid pregnancy on unsafe days. These practices are, therefore, better characterised as "periodic contraception" than as the rhythm method.

*Interviewer: "Okay, alright, apart from this period where you used…tried the condom and the spermicides, have you ever tried any [other] methods [to prevent pregnancy]?"*

*Respondent: "No, no those are the only two methods I have tried… he is gotten to know about my cycle"… "and so he knows when I am safe, and when am not safe." … "And so that is what he usually uses. Any time that we want to have sex, it's around the times that I am safe."*

*(Exchange from a qualitative study in Accra showing how 'counting days' is a taken-for-granted method)*

## Multiple methods

The STEP UP study documented the ways in which multiple methods are used within and across menstrual cycles, forming what we have called contraceptive 'mosaics'. A typical way of using multiple methods for periodic contraception reported by women involved counting days combined with withdrawal and/or condoms on unsafe days plus emergency contraceptive pills (ECPs) when they felt they needed them. The combination used in each cycle might vary. In some cycles, she might use all three in combination: for example, counting days and then taking ECPs if she had intercourse on an unsafe day and her partner did not withdraw in time. In other cycles, she might use only two (e.g., counting days and withdrawal). This extends previous qualitative work showing how couples may switch method types depending on the stage of their relationship.[8]

Women in the STEP UP study expressed few concerns about the side effects of ECPs. Some did say they worried about overuse, although what constituted "overuse" or the perceived harms associated with it were not defined. Women seemed to consider ECPs to be different than other hormonal methods, for which side effects were frequently mentioned. In particular, the younger focus group participants emphasised their own and their friends' use of ECPs, and talked about it

in a way that suggested it was normalised in their peer groups, and perhaps more widely as well, as shown in the focus group for 25–39-year-olds. This extends work from a previous study that had shown how ECPs are used both for "emergencies" and as a routine postcoital method in this setting.[9]

Several women recounted their personal and friends' experiences of terminating pregnancies. Among the study participants, most reported self-induced abortions using Cytotec (misoprostol). Another method reported was use of herbal medication. However, some attempts were not successful, and the women had to go to the hospital for the termination to be completed.

## DISCUSSION

### Why do women not use highly effective methods?

The commonly mentioned reasons for non-use of highly effective contraceptive methods have changed over time. According to women's own reporting in DHS, lack of access was the major reason for non-use in 1988 (26%) but only 5.2% reported the same reason in 2014. The most commonly reported reason in the 2014 DHS for non-use is side effects/health concerns and infrequent/no sex.[3]

The qualitative STEP UP study showed how being confident about one's ability to become pregnant, and evidence of 'normal menses' can help women comply with family and societal expectations of womanhood while also allowing them to delay childbearing in order to meet their own education and career goals.[10] In this context, it is clear that "periodic contraception" with withdrawal and condoms (often ECPs), far from being an irrational choice, is a way for women to navigate these complex and sometimes contradictory social pressures.

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## CONCLUSION

The STEP UP studies found that educated women in Ghana are achieving their fertility goals by limited use of highly effective contraceptive methods. Their fertility regulation strategies involve contraceptive method mosaics that have not been captured by the DHS.

Family planning programmes must focus efforts on ensuring that providers explain effects and side effects of contraceptives to women and their families so that they get the best information and support possible. The question of disruption of menses and return to fertility associated with using different contraceptive methods should be a key component of family planning counselling/messaging so that women and their families know what to expect.

Effective use of coital and traditional methods should be more centrally integrated into family planning programmes. It is important for providers to explain use and effectiveness (or lack of effectiveness) of traditional methods if clients choose those methods to ensure they are using them in the best way possible. Current reliance on less effective methods means unwanted pregnancies are likely to occur in fairly high numbers. Provision of safe abortion and post-abortion care including post abortion family planning is important to protect women's sexual and reproductive health in Ghana.

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