



Ghana: Market Segmentation Analysis



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Abstract

A market segmentation analysis was conducted using secondary data from the 1998, 2003, and 2008 Demographic and Health Surveys to better understand the variation in trends in contraceptive use by income, place of residence, region, education, and age. The findings will help better segment the contraceptive market and to provide policymakers information to develop targeted strategies and policies to increase contraceptive use, improve public-private collaboration, and make resource allocation decisions.

Cover photo: A healthcare worker in Ghana provides contraceptives to a client.

USAID | DELIVER PROJECT

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Acronyms

ASFR	age-specific fertility rate
CPR	contraceptive prevalence rate
CS	contraceptive security
DHS	Demographic and Health Survey
EC	emergency contraception
EXP SM	EXP Social Marketing
FP	family planning
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
GSS	Ghana Statistical Service
ICC	Interagency Coordinating Committee
IUD	intrauterine device
LAPM	long-acting and permanent method
MOH	Ministry of Health
MSA	market segmentation analysis
MSI	Marie Stopes International
NGO	nongovernmental organization
PPAG	Planned Parenthood Association of Ghana
TFR	total fertility rate
WRA	women of reproductive age

Executive Summary

The Government of Ghana has long supported contraceptive security (CS) and ensuring the availability of family planning (FP) commodities. Ghana was one of the earliest countries to hold a national stakeholders meeting on CS, to establish a working group specifically on CS, and to draft and implement a CS strategy in 2004 (Ghana Ministry of Health Agencies and Partners 2004). An essential piece of the CS strategy (2004–2010) is to ensure that resources are used to meet the contraceptives needs of the population. The country conducted a market segmentation analysis (MSA) in 2005 as one of the activities of the CS strategy, recognizing the need to better understand how the market is currently segmented so that public sector resources for FP can be targeted toward the most poor. The information from the MSA would be used to help increase financial sustainability to move those who can afford to pay to the private sector, freeing up more resources for those most in need.

From 1998 to 2003, there was an increase in the contraceptive prevalence rate (CPR) from 22 percent to 26 percent, respectively, and a slight decrease in the total fertility rate (TFR) from 4.6 to 4.4 in the same time period. However, the latest Demographic and Health Surveys (DHS) in 2008 showed that total CPR actually decreased to 24 percent with a small decrease in TFR to 4.0. Modern CPR increased from 13 percent (1998) to 19 percent (2003) but decreased to 17 percent by 2008. Unmet need has increased from 33 percent in 1998 to 35 percent in 2008. There is a need to continue and intensify the efforts to reverse the decline in CPR and continue the decrease in TFR. The country is currently updating the 2004 CS strategy, which coincides with the recent release of the new DHS, allowing an update of the 2005 MSA. These initiatives will guide the approaches needed to strengthen CS.

Currently, the public sector is the source for 48 percent of the population, which has been slightly declining as the private sector as a provider has increased from 44 percent in 1998 to 46 percent in 2008. Some segmentation is already occurring in the contraceptive market. Women in the poorest quintiles rely on the public sector (62 percent) almost twice as much as those in the wealthiest quintiles (34 percent). However, the public sector is still a considerable source of contraceptives accessed by 51 percent and 34 percent, respectively, by the two wealthiest income groups. Close partnerships between the public-private sectors is needed to better segment the market.

An MSA can show CPR and unmet need trends by geographic areas, urban versus rural residence, age group, education, and income quintile. The analysis can illustrate demographic groups and geographic areas that need more targeted assistance. The MSA findings can help develop and refine strategies, information campaigns, and policies to best meet the needs of these population segments. It can guide discussions between the public and private sectors on findings ways to collaborate.

The MSA results come from a secondary analysis of the Ghana DHS data for 1998, 2003, and 2008. With the exception of the reasons for non-use among those with unmet need, the population examined in this analysis was restricted to married (i.e., currently in union) women of reproductive age, with a total of 2,878 respondents. The analysis examined the variation in trends of the contraceptive segments by fertility, CPR, unmet need, reasons for non-use, source, and future use.

A summary of the findings and recommendations from the analysis are provided in the following section.

CPR and Unmet Need

- Total CPR slightly decreased between 2003 and 2008, most notably in the 30 to 34 age group (from 30 percent to 23 percent) accompanied by an increase in unmet need (31 percent to 33 percent).
- The high demand among the 15- to 19-year-olds is not being satisfied; high unmet need in this group is preventing them from spacing their births.
- The Central region has the highest unmet need in the country, second highest TFR in the country, and the fourth lowest CPR.
- Those who are poorest and with no education also have the lowest CPR in the country. The need for spacing is not being met especially in the rural areas.
- Unmet need is the highest among the poorer and the middle income groups, and generally decreases as wealth increases.
- Wealthier, more educated, urban women are more reliant than others on traditional methods, and their CPR is higher overall.

Method Mix

- Injectables and pills are the most popular modern method across urban and rural areas.
- Implant use is slightly higher in rural areas than in urban ones; condoms are much more popular in the urban areas.
- There is a high correlation between condom use and those with a higher education.
- The wealthier users use a wider range of methods than those who are poorer.
- Use of injectables constitutes over 70 percent of the modern method mix for those without education and in the two poorest quintiles.
- More rural women rely on long-acting and permanent methods (LAPMs); however, the method mix for LAPMs is nearly the same across income quintiles.

Reasons for Non-use

- Not having sex and fear of side effects continue to be the top reasons for not using contraception, followed by opposition to FP and not being married.
- Opposition to FP is now more frequently mentioned as a reason for not using than in 2003 and is more frequently cited among poorer women.
- Lack of knowledge and knowing no source are much more common reasons for not using in the non-educated group, while for those with higher education, lack of access and knowing no source were not mentioned.

Source of Contraceptives

- There is growing reliance on the private sector (46 percent) for contraceptives, but the public sector still remains a source for 47 percent of users, more so in rural areas than in urban areas.
- The poorer and less educated groups rely on the public sector for their contraceptives more than those in the richer and more educated groups.
- Regions where the public sector is the main source of contraceptives tend to have lower CPR and often high unmet need, including the Central, Northern, Upper East, and Upper West regions.
- Injectables and implants are provided mainly by the public sector while pills and condoms, methods requiring more resupply, are provided mainly by the private sector.
- Pharmacies and other sources are accessed more frequently by the 15 to 19 year age group than any other age group.

Future Use

- There is a stronger preference for injectables and implants among those who intend to use in the future than for current users. There is also a future preference for implants among urban, rural, across all income groups, and across a majority of regions.
- As preference for modern methods increases, the preference for use of traditional methods decreases, indicating women would prefer to use a more effective modern method over traditional methods.

Summary of Recommendations

Policy and Advocacy

- When the “Road Map for Repositioning Family Planning in Ghana (2006–2010)” is reviewed, consider whether the strategies in the road map and the 2011-2016 National Reproductive Health Commodity Security (RHCS) Strategy can be merged to have one definitive guideline to raise the profile of FP in order to increase the resources needed to increase CPR and reduce unmet need. The strategies should be multipronged based on both demographic and behavioral issues, and barriers that are precluding women from using contraceptives.
- Specific strategies are also needed to address the high TFR and low CPR rates among the rural, poorest, and women who have not had any education.
- Continue to develop strategies that are specific for and will resonate most with the poorest, less educated, and rural populations using various media such as radio, community-based forums, and materials printed in region-specific dialects.
- Develop strategies to address the high unmet need and increase CPR among the youngest age group of 15- to 19-year-olds.

Client Demand and Utilization

- More education on the importance and benefits of FP to increase FP use is needed, particularly among poorer income groups and those without education, where opposition to FP and fear of side effects are the two most common barriers for not using FP.
- Extra resources, advocacy, and focused efforts are needed to increase knowledge, demand, and use of contraceptives in three particular regions: Upper West, Upper East, and Northern where CPR is the lowest and TFRs are among the highest in Ghana.
- Ensure there are adequate youth-friendly services, both in terms of location and trained providers, to meet the high demands for FP for younger age groups, including specific targeting to increase the use of condoms among 15- to 19-year-olds, where use of condoms is lowest, to promote its benefits as dual protection.
- Increase condom use in rural areas and among the poorer quintiles where this method is less frequently used than other methods.
- Design strategies to ensure that women, especially among the rural, more poor, and less educated, are aware of other methods and have access to these other methods.

Service Delivery

- More advocacy is needed to ensure women are aware of LAPMs as an additional contraceptive choice, as well as additional service providers to provide these methods.
- Upgrading the skills of service providers is needed to ensure their knowledge and skills are standardized and are current to ensure clients are able to choose, obtain, and use the contraceptives of their choice. Service providers also need to have the counseling skills and knowledge to properly counsel women on all contraceptive methods including counseling about side effects.
- More advocacy is needed to increase CPR by eliminating opposition toward FP and dispelling misconceptions on the possible side effects of modern contraceptives among the general population.

Private Sector

- Because the private sector plays a major role in providing resupply methods, strong partnerships should be maintained to work together to maximize and leverage public-private resources. Particular attention should be given to increasing contraceptive access in the Northern, Upper East, and Upper West regions.
- A study should be conducted to determine the barriers (for the younger age groups) in accessing FP services and contraceptives in the private and public sectors. Interventions should be developed to address the issues identified.
- Work with the private sector to increase access to LAPMs and to ensure messages regarding FP and services are harmonized and standardized with those of the public sector.

Background

Ghana is one of the first countries in sub-Saharan Africa to take steps toward strengthening commodity security by developing a CS to address the issues to ensure contraceptive availability. One key aspect of commodity security is adequate financing for the procurement of contraceptives. Government and donor financing must be used efficiently and effectively to maximize the resources that are available. Toward this effort, the Ministry of Health (MOH) developed a financial sustainability plan to work with and across sectors to identify different financing options to sustain financing for contraceptives. A market segmentation analysis (MSA) can provide data and guidance on the best way to segment the market, ensuring public sector resources are targeted to those who most need them. Another important utility of conducting an MSA is revealing where, both in terms of geography and demographics, additional attention, education, and raising of awareness is needed to increase the contraceptive prevalence rate (CPR) and address unmet need. This report updates the 2005 MSA report with the recently completed 2008 Demographic and Health Survey (DHS).

Contraceptive Security in Ghana

In recognition of the issues and challenges facing Ghana in attaining CS, a strategy covering the period of 2004 to 2010 was launched in 2004. The strategy's pillars are based on the MOH's five key strategic objectives: quality, efficiency, financing, partnerships, and monitoring and evaluation. The strategy addresses the need to improve the quality and availability of the services provided by health workers and ensure that commodities entering the country meet international standards. Efficiency covers the strengthening of the supply chain. It focuses on regular supervision and evaluation of health workers to ensure they are following standard logistics management practices for contraceptives, that logistics data is reported up the supply chain, upgrading of warehouse equipment and structures, as well as the prevention of leakage of commodities within and across borders, and increasing the number of vehicles for service delivery. Financing covers a range of topics including conducting an MSA and implementing its recommendations. The financing pillar also looks into price revision, piloting voucher schemes, brand rationalization, and advocacy to increase the financing of contraceptives by both the government and donors. Partnerships work to improve collaboration and synergy between the public and private sectors and within the government, and to strengthen community-based services to expand family planning (FP). Finally, the monitoring and evaluation activities are intended to ensure that the Interagency Coordinating Committee (ICC)/CS meets regularly and monitors the progress of the strategy.

The CS strategy sets out to complement and support the country's policy goals. In 1994, the 1969 National Population Policy was revised to incorporate emerging issues and recalibrate policy objectives and goals. Major goals of the new policy include reducing the total fertility rate (TFR) and increasing the CPR, specifically:

- Reduce TFR from 5.5 in 1993 to 5.0 by 2000, to 4.0 by 2010, and to 3.0 by 2020
- Increase CPR to 15 percent by 2000, to 28 percent by 2010, and to 50 percent by 2020.

With this policy, the government has committed to improving access and equity of access for health care services, and has introduced Community-based Health Planning and Services in selected communities to extend the reach of its services.

The country has already exceeded the goal of reducing TFR falling from 4.4 in 1998 to 4.0 in 2008. However, although the country made great strides in increasing modern CPR from 13 percent in 1998 to 19 percent in 2003, modern CPR fell to 17 percent in 2008 (Ghana Statistical Service (GSS) and Macro International Inc. (MI) 1999; GSS, Noguchi Memorial Institute for Medical Research, and ORC Macro 2004; GSS, Ghana Health Service, and ICF Macro 2009).

CS is guided by the ICC/CS, which was formed in 2002 as one of the first CS initiatives in the country. The ICC/CS, led by the GHS within the MOH, provides general oversight of CS in the country, mobilizes resources, coordinates among partners, and implements activities to strengthen CS. Each year, the government commits financing for contraceptives along with support from development partners. In 2009, the share of government financing of contraceptives was 22 percent of total financing spent for the public sector.

As one of the first countries to develop a CS strategy, Ghana will be updating its strategy within the year to reflect the current RHCS situation. The findings from this MSA report will be used to inform and develop the activities to strengthen RHCS in the country. An MSA can provide insight into the reasons for CPR trends and unmet need. The analysis can show CPR trends in terms of geographic areas (regions), place of residence (rural versus urban), age and wealth groups, and whether or not education is a factor in contraceptive use. These findings can reveal potential areas that can be addressed through refinement of national policies, strategies, and focused targeting of human and financial resources. Furthermore, the findings from an MSA can help shape the dialogue between the public and private sectors on working together to improve access and availability of FP services and contraceptives.

Methodology

In its broadest sense, an MSA refers to the process of using survey data and statistical analysis to divide the reproductive health market into subpopulations whose needs, characteristics, and practices result in distinct service delivery and/or commodity marketing strategies. Typically, segmentation analysis of the FP market examines both supply and demand and helps to identify and target groups with an unmet need for FP. It also provides important information to government planners interested in improving the efficiency and effectiveness of national resource allocations and improving equity.

When used as a policy tool, MSA pinpoints opportunities for public and private sector stakeholders to better coordinate their efforts. Given the different objectives and target populations of the public sector, nongovernmental organizations (NGOs), and the commercial sector, an underlying assumption in any market analysis is that it should be possible to identify their complementary roles in the provision of FP products and services. With the growing demand for FP in Ghana, it is important to understand that a well-segmented contraceptive market will not necessarily reduce the role of any particular subsector. Instead, it should enable more efficient and equitable targeting of resources and ultimately lead to improved collaboration among providers. In a resource-scarce environment, where such coordination is a necessity for achieving national program objectives, the insights into the contraceptive market that a segmentation analysis provides can be invaluable.

The findings in this report are the results from a secondary analysis of the Ghana DHS (GDHS) data for 1998, 2003, and 2008. With the exception of the reasons for non-use among those with unmet need, the population examined in this analysis was restricted to married (i.e., currently in union) women of reproductive age (WRA), with a total of 2,878 respondents. The outcome of the FP program (i.e., the indicators to assess the performance of Ghana's FP program) considered for this study are as follows:

- Modern method CPR
- Traditional method CPR
- Unmet need for FP
- Reasons for non-use among those with unmet need
- Method-mix among those currently using modern FP methods
- Source for modern methods.

The sampled population of WRA in union was segmented and analyzed along several different dimensions to understand the influence or relevance of each dimension within the context of FP use. These dimensions include the distribution of WRA in union by:

- Place of residence: rural versus urban
- Wealth quintile

- Age group
- Region
- Education.

Household wealth is measured using an index constructed from household assets and characteristics. The index is constructed by Macro International and included with all recent DHS data sets. The index is widely used to classify WRA according to their socioeconomic status. The major assumption for constructing the index is that the household assets and characteristics vary according to the socioeconomic status of the household. Data on household assets and characteristics are obtained from the head of the household using the household questionnaire. The household items considered are household's ownership of a fan, radio, television, telephone, bicycle, and car; household characteristics such as floor material, wall material, roofing material; type of drinking water source; type of toilet facilities used; and presence of electricity. The index assigns a score to each household according to its socioeconomic status. The household sample is then divided into five equal groups, or quintile, based on the index score. The first quintile represents the poorest household and the fifth quintile represents the richest. It is important to note that the asset index used in this analysis ranks households based on those assets described, not on monetary income, and tend to be slightly skewed toward urban areas.

Population and Provider Profile

Characteristics by Wealth Quintile

Table 1 shows the relationship of wealth to other important characteristics examined in this analysis, including residence, region, age, and education.

Nearly 60 percent of WRA in union live in rural areas. Within the urban and rural settings, the populations appear to be fairly homogeneous. That is to say, the urban populations across regions appear to have similar characteristics to each other, such as distribution of income and level of education attained, as do the rural populations across regions. When comparing residence settings, there appears to be a higher concentration of wealth in urban areas. Ninety percent of WRA in union in the wealthiest quintile live in urban areas, while 97 percent in the poorest quintile live in rural areas.

The regional distribution of wealth follows a trend similar to that of residence: there is a positive correlation between urban density and level of wealth. Greater Accra and Ashanti are the two wealthiest regions, with 46 percent and 22 percent, respectively, of WRA in union living in these regions. Greater Accra, in particular, is comprised of a significantly larger urban and wealthy population than any other region. Northern and Upper East are the two poorest regions, with 33 percent of the poorest WRA in union living in the Northern region and 20 percent in Upper East.

Examining the distribution of wealth across age groups reveals that wealth tends to increase with age for WRA in union through age 34, but then decreases for older age groups. Overall, WRA in union aged 15 to 24 are less likely to be wealthy than older age groups; only 9.5 percent of the richest quintile is aged 15 to 24 whereas all other age groups in this quintile are 10 percent or greater. Younger WRA in union are also four times more likely to be in the poorest quintile than the richest, with 4 percent in the poorest quintile and 1 percent in the richest. In the oldest age groups (ages 40 to 49), wealth is more equitably distributed; 21 percent to 25 percent of WRA in union are represented in all wealth quintiles. Only in the age group of 30 to 34 years is there a notable bias toward greater wealth for WRA in union, accounting for only 16 percent of the poorest quintile but 25 percent of the richest.

The table indicates that there is also a positive correlation between education and wealth. Nearly 30 percent of the WRA in union have no formal education, with the highest concentration of those with no education in the poorest quintile. In contrast, a full 48 percent have secondary education or higher, including more than 80 percent of the richest quintile. When compared to 2003 DHS data, the average education level attained in Ghana by WRA in union shows a positive trend. The 2008 data indicates 30 percent of WRA in union have no formal education, whereas in 2003, this group represented 38 percent. This trend is mirrored in the higher educated groups: 2008 figures show a full 48 percent with secondary education or higher, whereas in 2003 this group was only 42 percent of WRA in union.

Table 1. Percentage Distribution of WRA in Union by Education, Residence, Age, and Region, According to Wealth Quintiles

Characteristics	Poorest (n = 573)	Poorer (n = 577)	Middle (n = 525)	Richer (n = 600)	Richest (n = 601)	Total (n = 2,876)
Residence						
Urban	3	10	39	66	90	42
Rural	97	90	61	34	10	58
Region						
Western	4	13	9	11	10	9
Central	1	12	14	11	5	9
Greater Accra	0	3	4	18	46	15
Volta	11	13	16	8	3	10
Eastern	5	13	13	9	5	9
Ashanti	7	20	20	24	22	19
Brong Ahafo	12	10	11	11	3	9
Northern	33	10	10	4	3	12
Upper East	20	4	1	2	2	6
Upper West	7	3	2	1	0	3
Age						
15–19	4	5	3	2	1	3
20–24	14	16	15	19	9	14
25–29	21	22	20	22	22	21
30–34	16	16	19	19	25	19
35–39	20	16	19	17	19	18
40–44	13	14	13	11	15	13
45–49	13	11	12	10	10	11
Education						
No education	70	33	24	15	7	30
Primary	20	32	26	22	12	22
Secondary	11	35	49	60	67	45
Higher	0	0	1	3	14	4

Note:

Totals may not add to 100 percent due to rounding.

Source: GSS, GHS, and ICF Macro 2009.

Provider Characteristics

Sources for female sterilization were not reported in the 2008 DHS and are therefore not included in the following analysis.

According to 2008 data, there continues to be a shift toward the commercial sector (“private sector”) as a source for contraceptive use by WRA in union. Use of the commercial sector, which includes pharmacy and private facility/delivery, for provision of contraceptives increased from 44 percent in 1998 to 48 percent in 2003 and declined slightly to 46 percent in 2008. Although the shift has seen a recent reversal, the long-term trend continues toward commercial sources. The main suppliers of contraceptives in Ghana are the MOH/GHS public health facilities, followed by pharmacies (including chemists and drug stores), private clinic facilities and NGOs such as Planned Parenthood Association of Ghana (PPAG) and Marie Stopes International (MSI).

Figure I. Distribution of WRA in Union Using Modern Contraceptive Methods by Source (1998–2008)

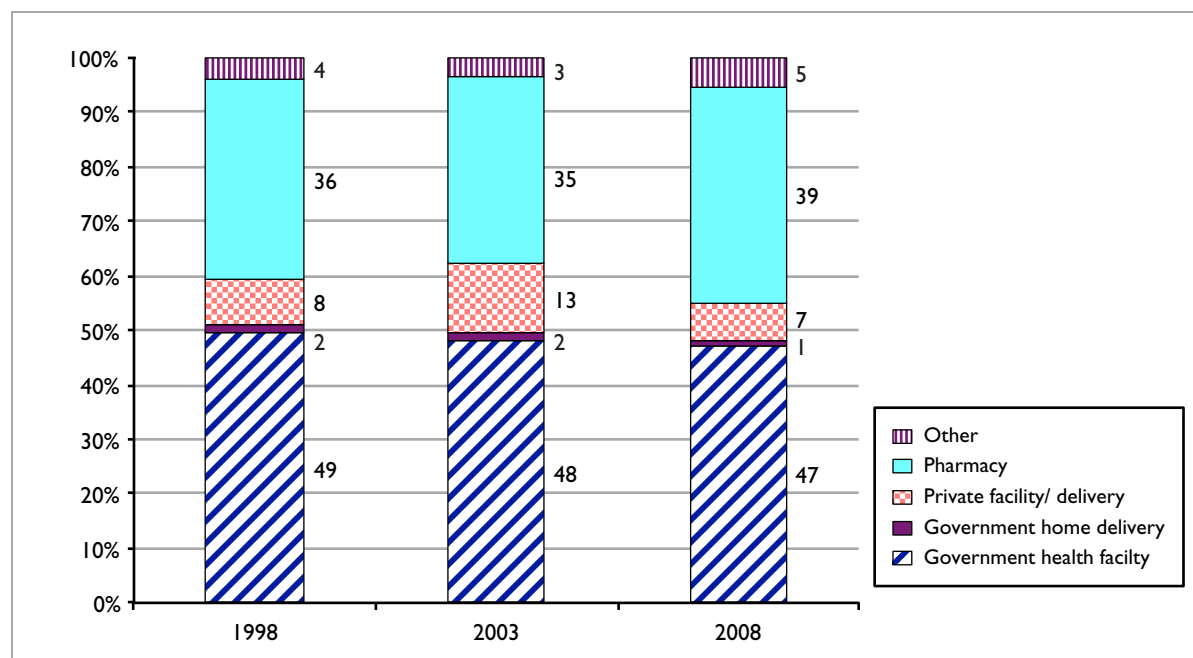


Table 2 illustrates the contraceptive methods provided by the public and social marketing sectors by different programs.

Table 2. Contraceptive Methods Provided According to Source Program (2008)

Method	MOH	PPAG	EXP Social Marketing	MSI
Orals	<ul style="list-style-type: none"> • Microgynon (combination pill) • Ovrette (progestin-only pill) • Micronor (progestin-only pill) • Pregnon (emergency contraceptive) • Lo-Femenal (combination pill - phasing out) 	<ul style="list-style-type: none"> • Microgynon (combination pill) 	<ul style="list-style-type: none"> • Duofem (combination pill) to switch in 2011 to Combination 3 	<ul style="list-style-type: none"> • Microgynon (combination pill) • Micronor (progestin-only pill)
Injectables	<ul style="list-style-type: none"> • Depo-Provera • Norigynon • Petogen (brand of Depo-Provera) 	<ul style="list-style-type: none"> • Depo-Provera • Norigynon 	<ul style="list-style-type: none"> • Depo-Provera 	<ul style="list-style-type: none"> • Depo-Provera • Norigynon
Condoms	<ul style="list-style-type: none"> • Generic male condoms • BeSafe male condoms • Female condom 	<ul style="list-style-type: none"> • Generic • Besafe • Female condom 	<ul style="list-style-type: none"> • Protector Plus 	<ul style="list-style-type: none"> • Generic • Female condom
Implants	<ul style="list-style-type: none"> • Jadelle 	<ul style="list-style-type: none"> • Jadelle 	<ul style="list-style-type: none"> • n/a 	<ul style="list-style-type: none"> • Jadelle
Intrauterine device (IUD)	<ul style="list-style-type: none"> • Copper T 	<ul style="list-style-type: none"> • Copper T 	<ul style="list-style-type: none"> • n/a 	<ul style="list-style-type: none"> • Copper T
Vaginal foaming tablets	<ul style="list-style-type: none"> • Neo Sampooon 	<ul style="list-style-type: none"> • n/a 	<ul style="list-style-type: none"> • n/a 	<ul style="list-style-type: none"> • Today

Public Sector

While reliance on the public sector has slightly declined between 1998 and 2008 according to the DHS, it remains the single largest source for FP in Ghana. MOH/GHS hospitals, health centers, and community-based clinics provide 47 percent of contraceptive supply. Although a range of FP methods are available through public facilities, more than 75 percent of contraceptives distributed by them are injectables, and a majority of users of injectables (87 percent) access this method through the public sector. Similarly, 84 percent of implant users obtain this method through the public sector. Only 14 percent of pill users and 4 percent of condom users are served through public facilities.

Social Marketing

EXP Social Marketing (EXP SM) is the main social marketing provider in Ghana. EXP SM markets three products: a male condom (Protector Plus), an oral pill (Duofem), and an injectable (Depo-Provera). EXP SM has plans to social market the Champion male condom to help meet the demand by providing an additional choice of a low-priced male condom in the market.

Commercial Suppliers

Private clinics primarily dispense injectables, followed by implants and other modern methods. Eleven percent of injectables users and 16 percent of implant users source them from private clinics. The commercial sector (primarily pharmacies) serves as the main source for male condoms (74 percent) and pills (81 percent).

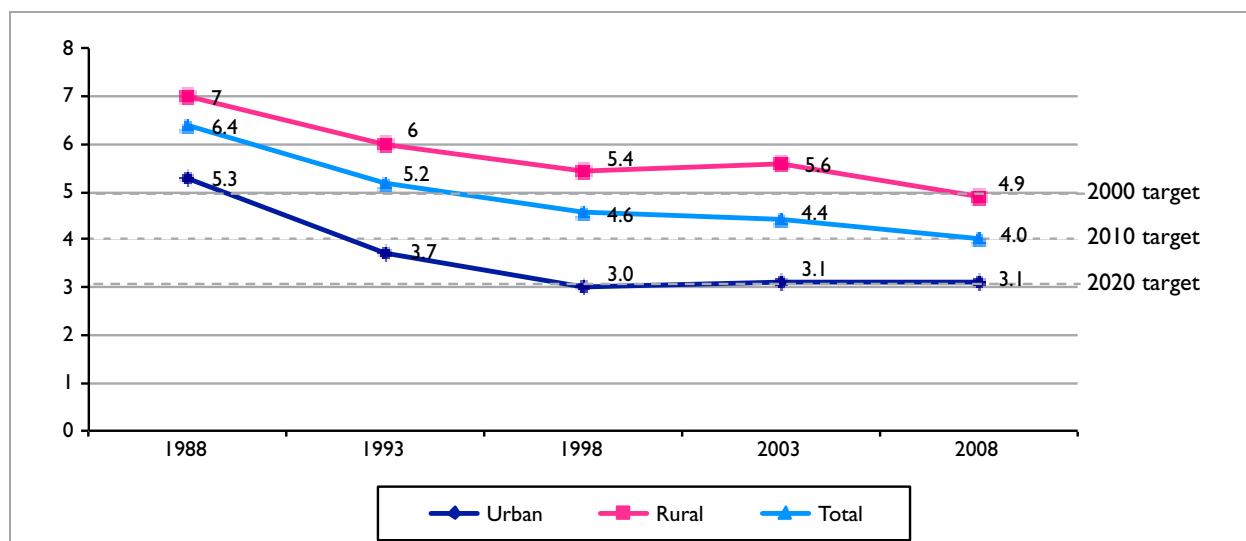
Trends in Fertility

Total Fertility Rate

One of the key objectives of Ghana’s National Population Policy is to reduce the TFR to 5.0 children per woman in 2000, 4.0 by 2010, and 3.0 by 2020 (National Population Council 1994).

As Figure 2 illustrates, Ghana saw notable decreases in TFR between 1988 (GSS and MI 1988; GSS and MI 1994) and 1998, dropping from 6.4 to 4.6, surpassing its 2000 target of 5.0. This trend, however, has slowed considerably since then, with 2003 showing a plateau in TFR at 4.4 and a slight increase, particularly in rural areas, from 5.4 (1998) to 5.6 (2003). TFR has shown only a slight decline by 2008 resulting in a TFR of 4.0.

Figure 2. TFR for WRA in Union Ages 15 to 49 (1988–2008)



In summary, the rate of decline doubled between 1998–2003 and 2003–2008 (Table 3).

Table 3. Decline of TFR from 1988 to 2008

Period	Rate of Decline in TFR
1988–1993	19%
1993–1998	12%
1998–2003	4%
2003–2008	9%

While the country has met its 2010 goal, recent volatility in the TFR and a slowing of the rate of decrease suggest that a focused effort will be required to continue to drive down the TFR and facilitate achieving the 2020 goal. A further analysis of the TFR along various dimensions of the

population reveals distinct trends according to residence, wealth, age, region and education level attained.

Residence

The data indicate that TFR in urban areas is lower than in rural areas. While urban areas remained unchanged from 2003 to 2008 (3.1), the TFR in the rural areas decreased from 5.6 to 4.9. This decline has caused the drop in the national rate (see Table 4).

Table 4. TFR for WRA by Residence (2003–2008)

Residence	TFR 2003	TFR 2008	Percent Change in TFR
Urban	3.1	3.1	-
Rural	5.6	4.9	-13%
National	4.4	4.0	-9%

Wealth

There is a strong negative correlation between wealth and TFR. The poorest quintile has the highest TFR (6.5) and the richest has the lowest at 2.3. From 2003 to 2008, the national TFR dropped almost 10 percent, from 4.4 to 4.0. During this period, only the poorer, middle, and richest quintiles saw any decrease in TFR. These quintiles saw downward movements of 17 percent to 18 percent since 2003. Of concern are the poorest and richer quintiles, which in fact showed a very slight increase since 2003.

Table 5. TFR for WRA in Union by Wealth Quintile (2003–2008)

Wealth Quintile	TFR 2003	TFR 2008	Change in TFR	Percent Change in TFR
Poorest	6.4	6.5	+0.1	+2%
Poorer	5.9	4.9	-1.0	-17%
Middle	4.9	4.0	-0.9	-18%
Richer	3.3	3.4	+0.1	+3%
Richest	2.8	2.3	-0.5	-18%
National	4.4	4.0	-0.4	-9%

Note:

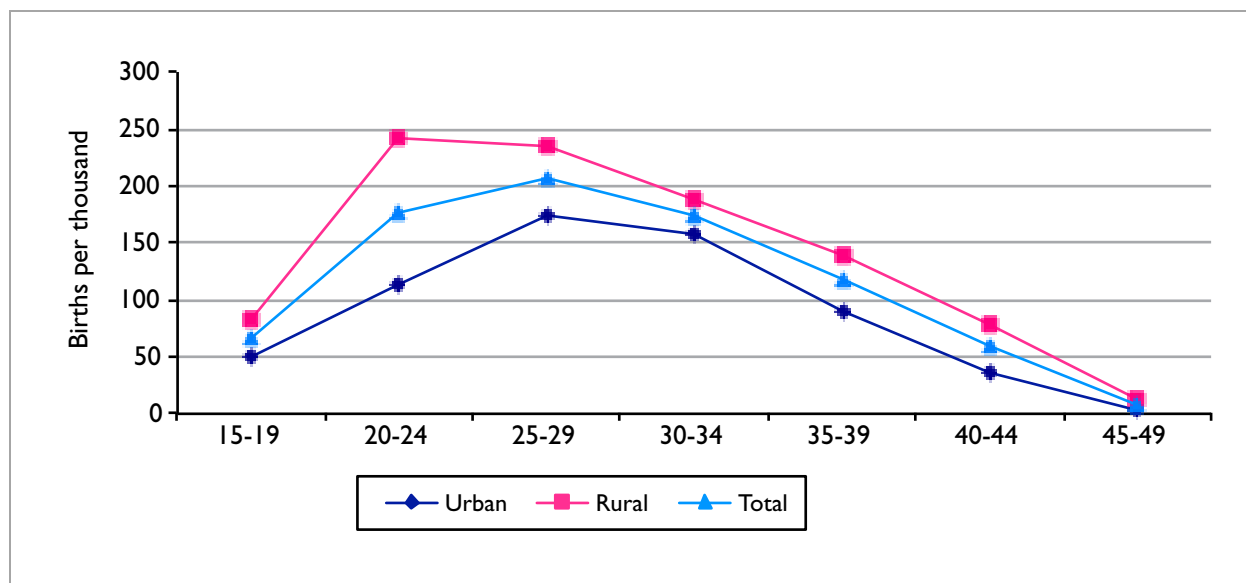
1998 total fertility rate by wealth quintile not available.

Age

As illustrated in Figure 3, the age-specific fertility rate (ASFR) for WRA in union varies considerably by age group. The fertility rate is highest for ages 20 to 34, with a steady decline that begins with the 30- to 34-year-old age group. The gap between urban and rural fertility rates is greatest in the 20- to 24-year-old age group, where the ASFR is 243 births per 1,000 in rural areas, more than double the

rate in urban areas, which is only 114 births per 1,000. Young, rural women consistently have the highest ASFR, while urban women have ASFRs lower than the national average of 4.0. Rural women also have more children peaking at a younger age (20 to 24 years). For urban women, ASFR is the highest between 25 to 34 years, indicating that urban women have children later than their counterparts in the rural areas.

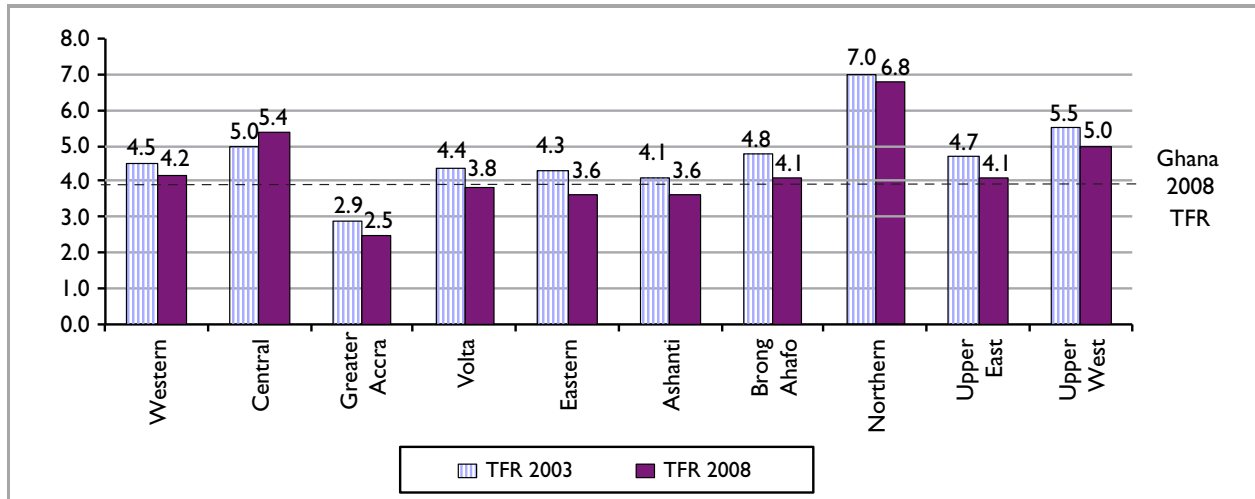
Figure 3. ASFR for WRA in Union (2008)



Region

Most regions hover around the national TFR; however, some important differences can be seen among regions, as shown in Figure 4. Greater Accra, an urban, populous, and wealthier region, has the lowest TFR. The highest TFR can be found in the Northern region, also a fairly populous region, though it is much more rural and is also one of the poorest regions. The Upper West and Central regions also have higher TFRs, being at least 1.0 above the national rate. Additionally, the TFRs in most regions decreased between 7 percent and 16 percent from 2003 to 2008, with the Eastern region having the greatest percentage decrease of 16 percent. TFR in the Central region, however, increased by 8 percent. Brong Ahafo and the Eastern region both had the greatest absolute decrease in TFR of 0.7 children per woman between 2003 and 2008.

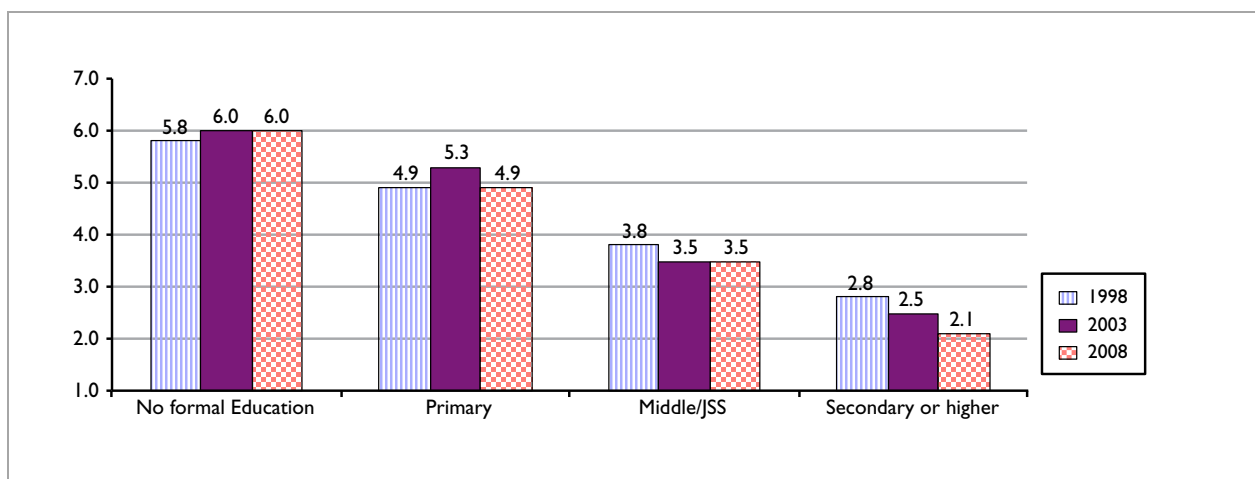
Figure 4. TFR for WRA in Union by Region (2003–2008)



Education

Education also plays an important role in reduction of the TFR. Similar to wealth characteristics, data indicate a strong negative correlation between education level and TFR. The highest TFR is found with the group with no formal education (6.0). A considerable decrease then is seen with each higher level of education attained. Those with primary education have a TFR of 4.9, but TFR drops to 3.5 for those with middle/junior secondary school education and further decreases to 2.1 for those with a secondary or higher education. An examination of these groups during the period of 1998 to 2008 reveals that those with no formal education and those with only primary education have not experienced any decrease in TFR. In fact, the non-educated group saw a slight increase in TFR over this period. Only those with middle education or secondary education or higher had any decrease in TFR.

Figure 5. TFR for WRA in Union by Education Level Attained (1988–2008)



Trends in Contraceptive Use/Method Mix

Contraceptive Prevalence

Another key goal of the National Population Policy in Ghana is to increase the modern CPR to 15 percent by 2000, to 28 percent by 2010, and to 50 percent by 2020. From 1998 to 2003, Ghana saw an increase in total CPR (including modern and traditional methods), reaching 26 percent. During the most recent period between 2003 and 2008, however, total CPR has decreased two points to 24 percent. Figure 6 shows current CPR for each region.

Figure 6. CPR in Each Region

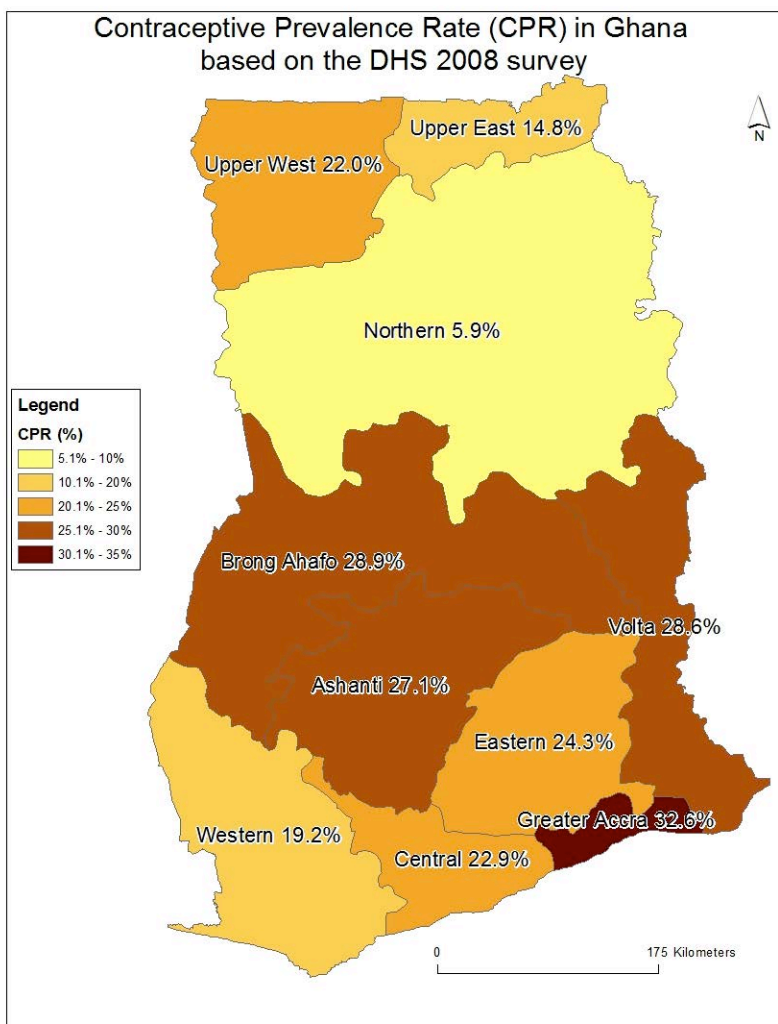


Figure 7 illustrates the changes in CPR during the period from 1998 to 2008 for total CPR by location for modern and traditional methods. The changes in total CPR during this period appear to be primarily driven by changes in use of modern methods and by use in urban areas. Use of modern methods increased from 13 percent to 19 percent between 1998 and 2003, and then decreased to 17 percent in 2008. Total CPR saw a rise and fall of comparable magnitude during the same period, while use of traditional methods remained flat. A similar pattern is seen with use in urban and rural areas, where urban use is correlated with the change in CPR while rural use remains flat. According to the 2008 GDHS date, use of modern contraceptives was 11 points lower than the 2010 target of 28 percent.

Figure 7. CPR According to Method and Location (1998–2008)

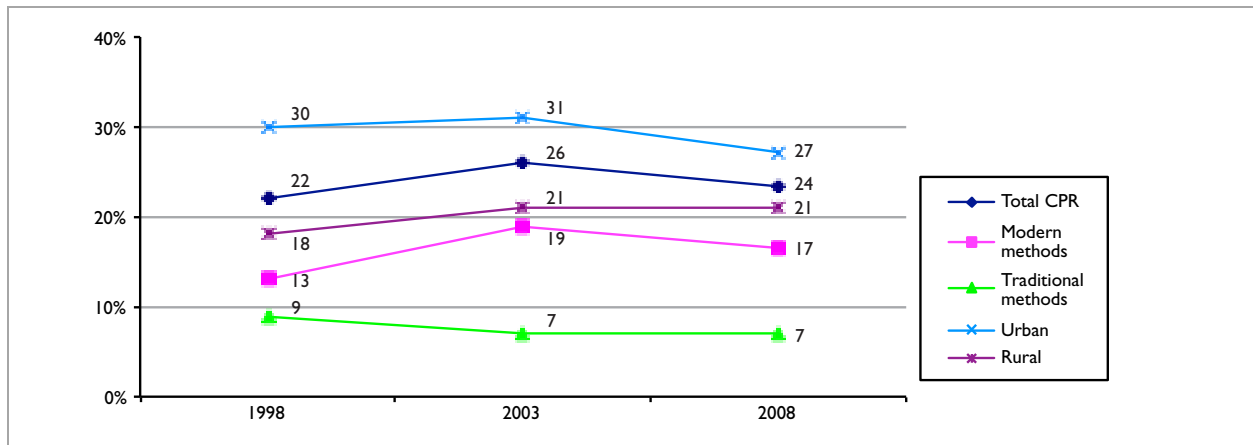
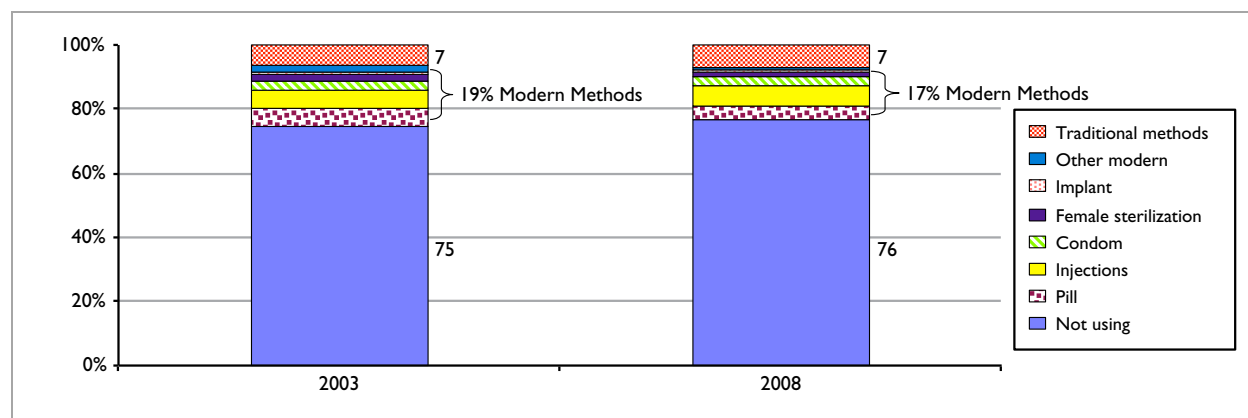


Figure 8 shows that the overwhelming majority of WRA in union are not using any form of contraceptive, and that there is a strong reliance on traditional methods. From 2003 to 2008, use of traditional methods remained unchanged at 7 percent, while use of modern methods shrank from 19 percent to 17 percent among all methods. Although use of most modern methods as a whole declined during this period, injectables saw an increase in usage, growing from 5.4 percent to 6.2 percent.

Figure 8. CPR for WRA in Union (2003–2008)

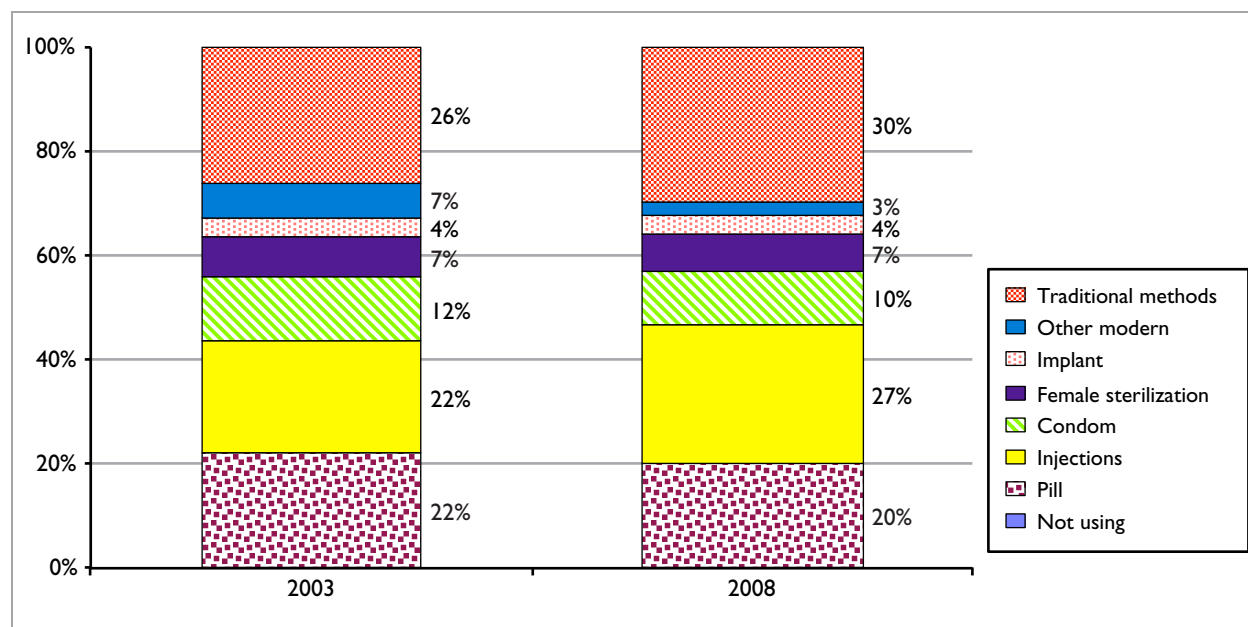


Method Mix

Figure 9 shows the contraceptive method mix. The currently available contraceptive methods in Ghana can be categorized into modern methods (injectables, pills, condoms, implants, and female sterilization), traditional methods, and other modern methods (intrauterine device [IUD], diaphragm, foam/jelly, and female condom).

Of the modern methods in use, injections (27 percent), pills (20 percent), and condoms (10 percent) remain the three most popular methods. These three methods combined represent 57 percent of current contraceptive method mix. Traditional method mix accounts for 30 percent in 2008, having increased from 26 percent in 2003.

Figure 9. Contraceptive Method Mix (2003 and 2008)



Residence

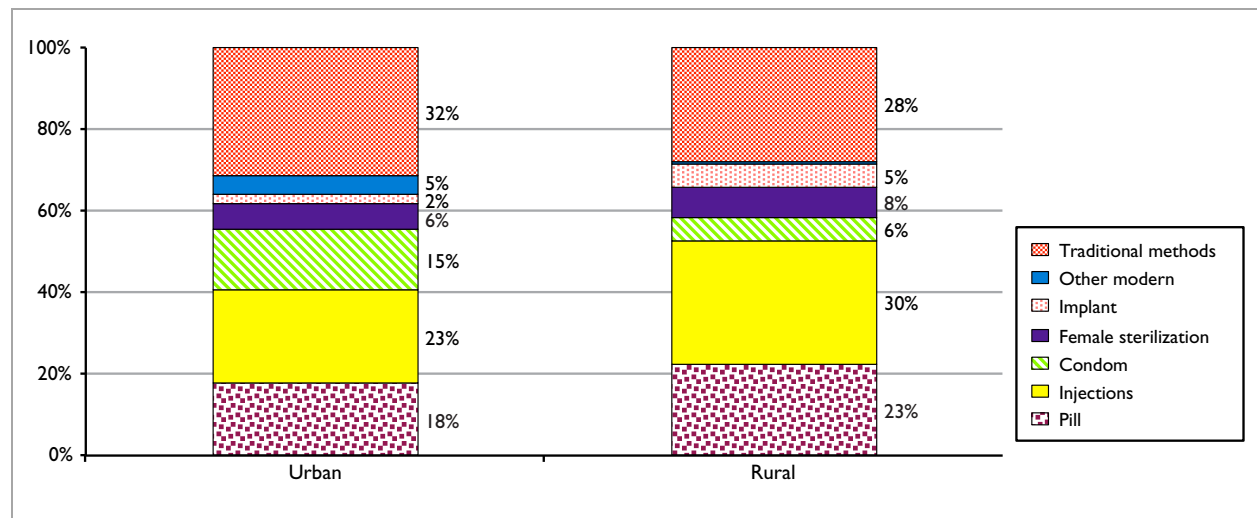
Usage of injectables (6 percent), pills (5 percent), and female sterilization (2 percent) are the same for WRA in union in both urban and rural areas. Most other methods have higher rates of usage in urban areas than rural, most notably condoms, which are used at a rate four times greater in urban areas than rural. Implants, however, is the only method showing the opposite usage trend. While usage of implants is very low compared to all other methods in general, its usage in rural areas is nearly double at 1.1 percent, whereas usage in urban areas is lower at 0.6 percent.

Table 6. Total CPR According to Location (2008)

Method	Urban	Rural
Pill	4.8	4.7
Injections	6.2	6.3
Condom	4.1	1.2
Female sterilization	1.6	1.6
Implant	0.6	1.1
Other modern methods	1.2	0.2
Traditional methods	8.6	5.8
Total CPR	27	21

When looking at the method mix by location, injectables and pills make up the largest proportion of method mix in both urban and rural areas. However, injectables are much more popular method among rural (30 percent) than urban (23 percent) women. The condom is used much more in the urban areas (15 percent) than in the rural (6 percent) areas, while the method mix for implants is higher in the rural (8 percent) than in the urban (2 percent) areas.

Figure 10. Method Mix by Location (2008)



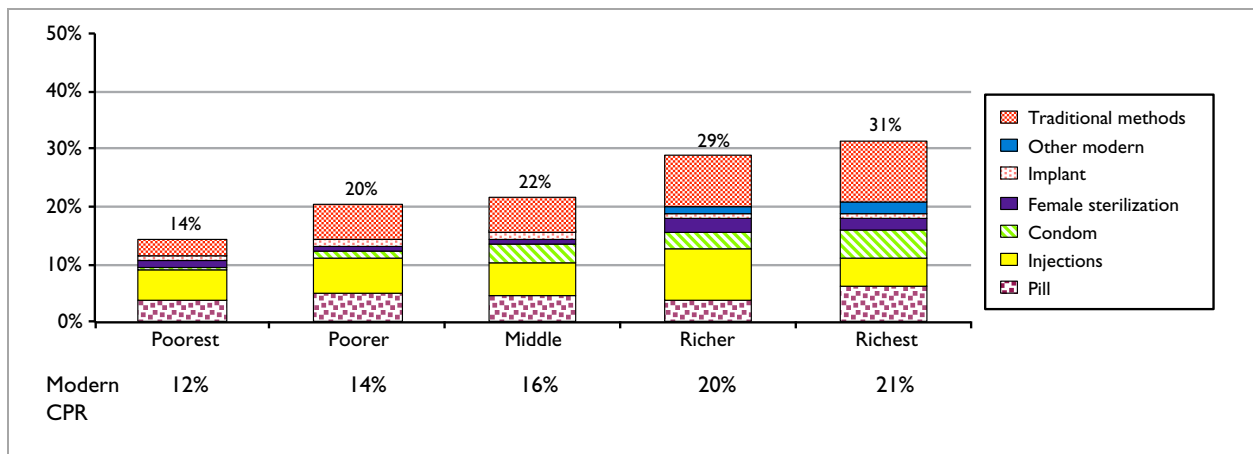
Wealth

Examining contraceptive usage across wealth quintiles reveals a strong positive correlation between total contraceptive prevalence and wealth. As Figure 11 illustrates, use of both modern and traditional methods increases with wealth. While contraceptive prevalence is relatively low for all WRA in union, CPR in the wealthiest quintile (31 percent), is more than double that of the poorest quintile (14 percent). In addition, greater use of a variety of methods increases with wealth.

For short-term methods, injections have the highest prevalence across income groups, with the exception of the wealthiest quintile, where use of pills is slightly higher. Interestingly, use of condoms increases considerably when moving from the poorest to the richest group. Condom usage in the poorest group is close to nil, while in the richest group it is 5 percent. This is consistent with the trend seen when comparing urban to rural settings: condom usage is higher in urban areas, which tend to be wealthier than rural areas.

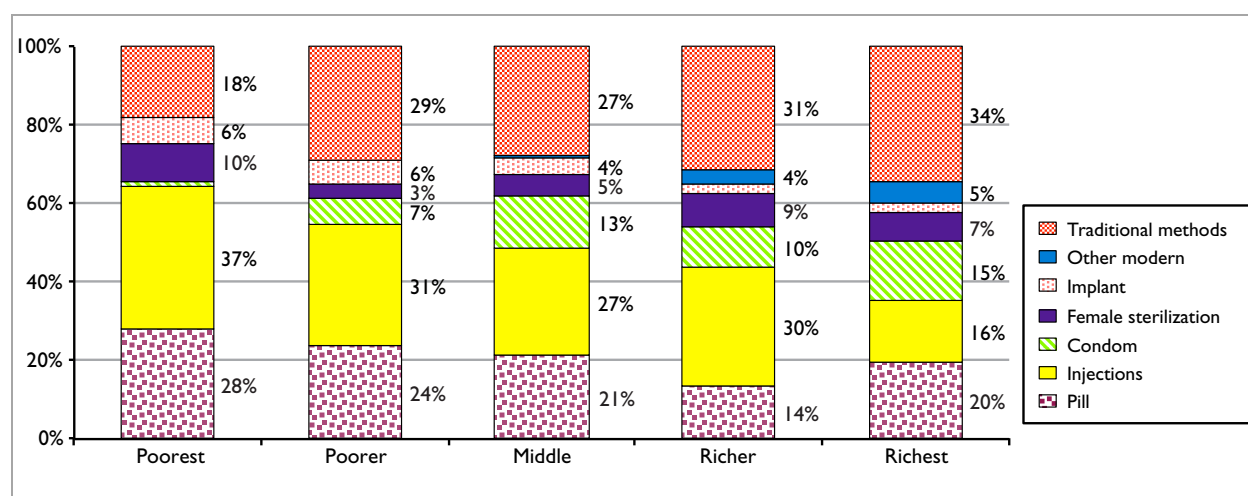
Long-acting methods (female sterilization and implants) are the least prevalent of all modern methods. Female sterilization tends to be more prevalent in top two wealthiest quintiles; however, in the poorest quintile, it is more common than condom use. Use of implants hovers around 1 percent for all wealth quintiles. Appendix A provides more detail on contraceptive prevalence by method.

Figure 11. Total CPR by Wealth Quintile (2008)



As Figure 12 illustrates, contraceptive users in the poorest quintile tend to rely more heavily on injections and pills, making up 65 percent of method mix. However, for women in the richest quintile, these two methods make up only 36 percent of method mix, and they use a variety of other modern methods to meet their contraceptive needs. Furthermore, in the richest quintile, injectables are less popular than in all other wealth quintiles. Condoms are 7 percent to 15 percent of method mix for all quintiles except the poorest where they are only 1 percent. Interestingly, implants become less popular as wealth increases.

Figure 12. Method Mix by Wealth Quintile (2008)



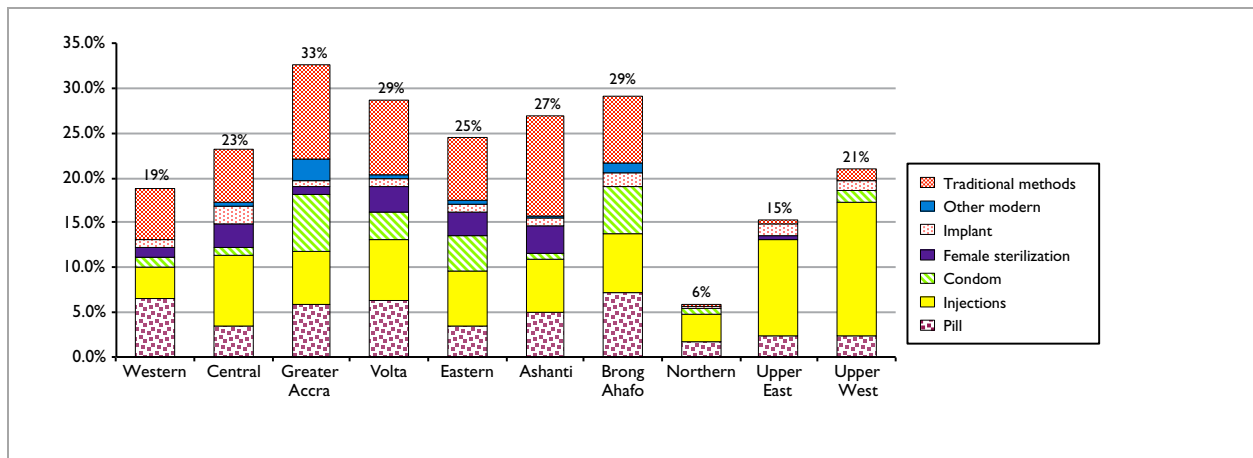
Region

Differences in contraceptive usage can also be seen by region. Greater Accra, Volta, Eastern, Ashanti, and Brong Ahafo regions have the highest CPR. The Northern region has the lowest contraceptive prevalence of all regions, with only 6 percent of WRA in union using contraception. Of those that are using, the large majority are using modern methods, with less than 0.5 percent using traditional methods. The Northern region is one of the poorest but also one of the largest and most populous regions, with nearly 12 percent of WRA in union from the sampled population in this region. This region appears underserved for contraception when compared to other regions with similar demographics. For example, the adjacent Upper East and Upper West regions have a similar wealth profile to the Northern region; however, they have much higher contraceptive prevalence. In fact, these two regions have the largest percentage of injection users, with Upper East at 11 percent and Upper West at 15 percent being the highest in the country. In all other regions except the Western, injectables are the most frequently used form of modern contraception.

Condom use is higher in Greater Accra, Brong Ahafo, Volta, and Eastern than in all other regions, where prevalence is 1 percent or less. Similarly, pill usage is higher in Greater Accra, Volta, Brong Ahafo, and Western than in all other regions. Pill usage is lowest, around 2 percent, in the Northern, Upper East, and Upper West regions.

Long-acting methods are more prevalent in some regions than others. Female sterilization is highest in Central, Volta, Eastern, and Ashanti. In fact, in Central and Ashanti, this method is used more frequently than condoms. In Brong Ahafo, Northern, and Upper West, however, this method is not used at all. Implants are the least prevalent form of modern contraception, but are used in all regions. Only in the Central region does prevalence of implants exceed 2 percent.

Figure 13. CPR by Region (2008)



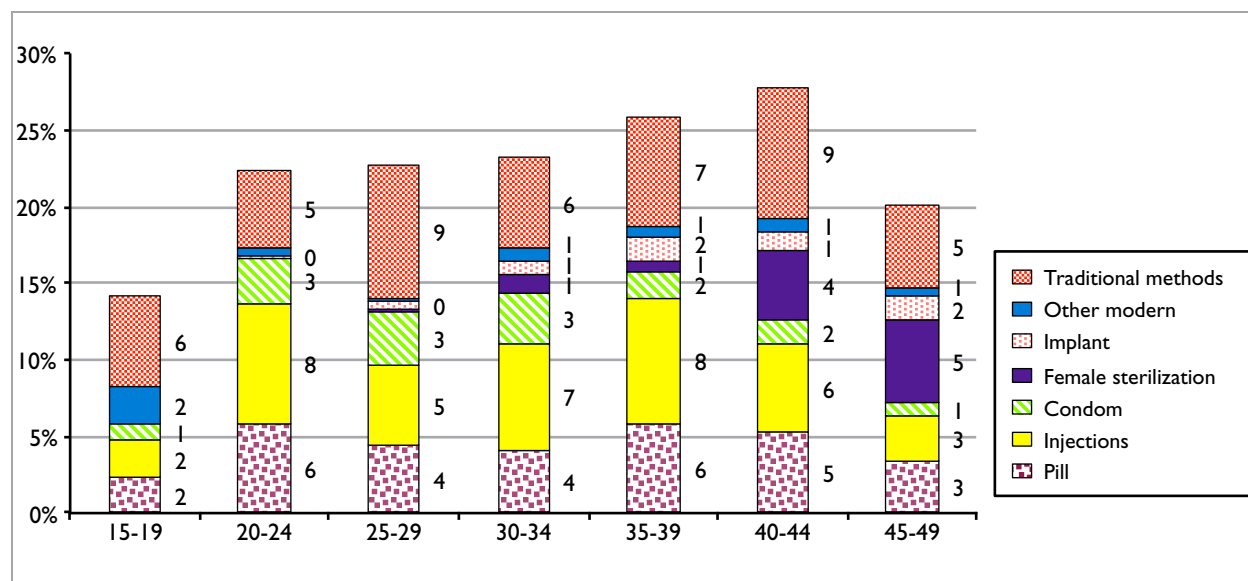
Age

This section looks at use within age groups of WRA in union. The most preferred method for 15- to 19-year-olds is the pill, followed by injectables, foam/jelly, and male condoms. The 20 to 44 age groups prefer injectables, then the pill, and then condom.

Looking at methods across all age groups, injectables and pills are used more frequently by the 35 to 39 and 20 to 24 age groups. Condoms are used most by the 20 to 34 age groups, but this decreases for those 35 and older.

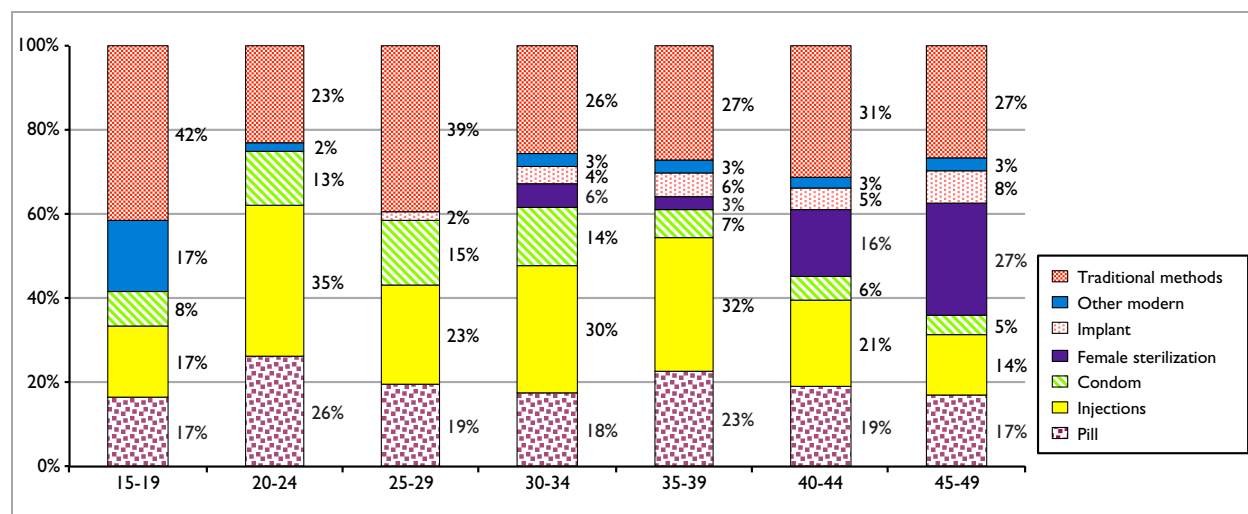
Preference for long-term methods increases with age groups. Implant usage by WRA in union ages 15 to 24 is close to nil; usage increases in older age groups. Similarly, preference for female sterilization increases with age groups, in particular with age groups of 40 years and above. In addition, overall contraceptive prevalence drops sharply in the oldest age group, 45 to 49 years. There also appears to be a strong reliance on traditional methods across all age groups.

Figure 14. CPR by Age Group (2008)



The method mix for the youngest age group shows that other modern methods (which includes IUDs, diaphragm, foam/jelly, and female condom) are used just as frequently as injectables and pills. Traditional methods are commonly used in the 25 to 29 age group. Injections and pills are a significant part of the methods mix for those in the 20 to 44 age groups. Condoms do not make up more than 15 percent in any age group. For those over 40 years, female sterilization and traditional methods become more prominent choices of contraception. Implants contribute to the method mix more for those 30 years and older.

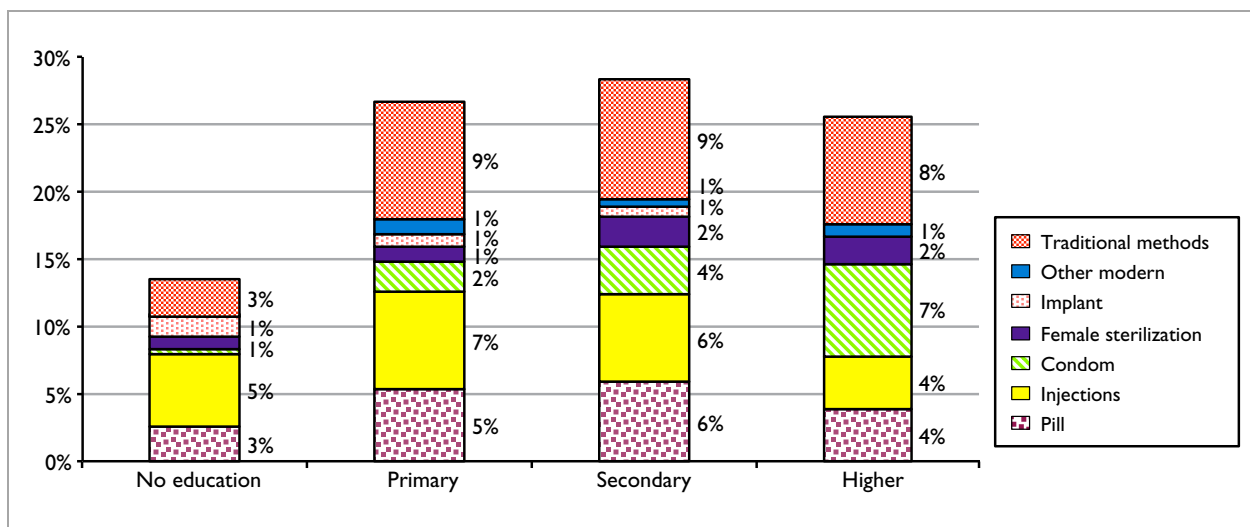
Figure 15. Method Mix by Age Group (2008)



Education

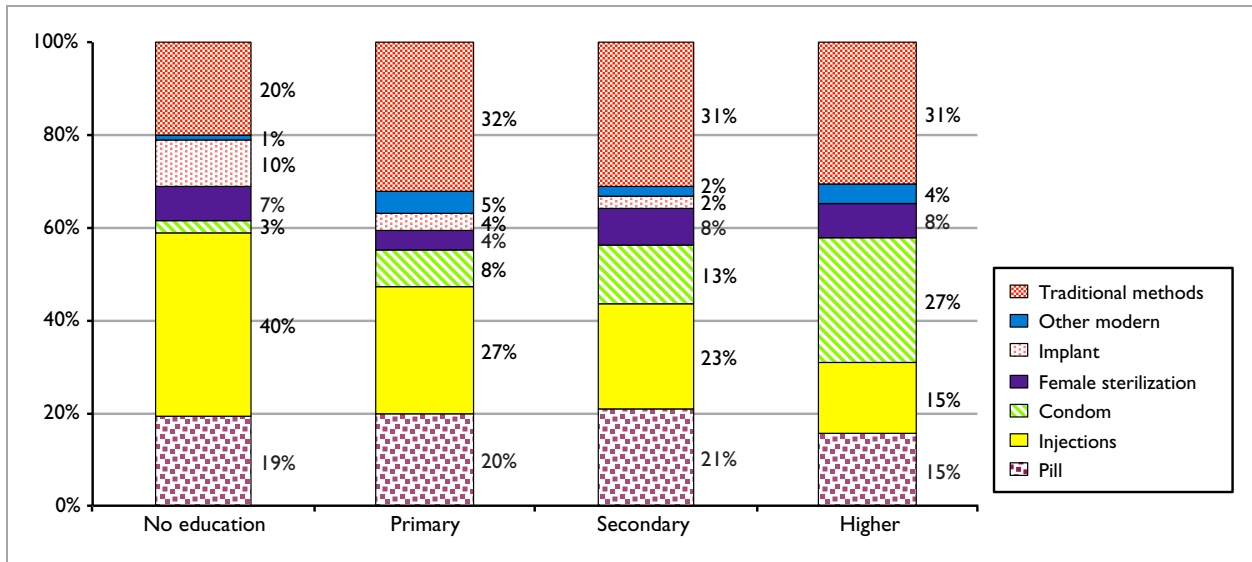
CPR also varies with attainment of education. WRA in union with some form of formal education are twice as likely to be using contraception as those with no formal education. Contraceptive prevalence for those with primary education or higher is between 25 percent and 28 percent, while those with no formal education is only 13 percent. It is interesting to note that use of traditional methods by the non-educated group is only 3 percent, while for all other groups it is 8 percent to 9 percent. Of the modern methods in use, injections are the most common, followed by pills. Use of implants, while small for all groups, is greatest in the non-educated group (1.4 percent) and decreases as education level increases (primary: 0.9 percent; secondary: 0.7 percent; higher: 0 percent). Condom use, however, increases with education level, starting at almost no use for those with no education and increasing to 7 percent for those with higher education. This may be an indicator of increased awareness not only of contraception, but of transmission of infections and disease.

Figure 16. CPR by Education Level (2008)



Examining the method mix shows that injectables make up 40 percent of the method mix for those without education, but reliance on this method decreases as education increases. Conversely, condoms are only 3 percent of the method mix for those without any education, but are 27 percent of the method mix for those with the most education. Pills range from 15 percent to 21 percent of the method mix among all age groups. Implants and female sterilization together are 17 percent of the method mix in the no education category, but long-term methods (female sterilization) decrease by half (8 percent) for those with higher education. Traditional methods play a much larger role among those with a primary education or higher, making up over one-third or a majority of the method mix.

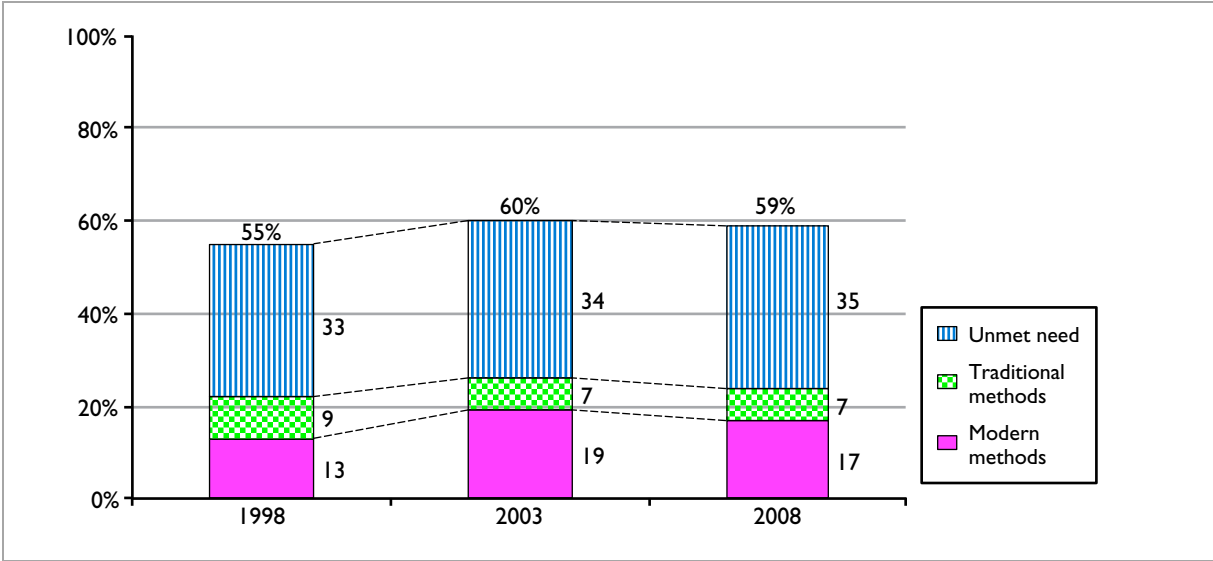
Figure 17. Method Mix by Education Level (2008)



Trends in Unmet Need and Total Demand

Total demand for contraception (if current unmet need were met plus CPR) has increased from 55 percent to 59 percent during the period 1998 to 2008. This has primarily been driven by an increase in the usage of modern methods, which has grown from 13 percent in 1998 to 17 percent in 2008. Similarly, CPR, including traditional methods, has increased from 22 percent in 1998 to 24 percent in 2008. However, of concern is that the modern CPR rate has declined from 19 percent to 17 percent from 2003 to 2008. It is worth noting that CPR peaked at 26 percent in 2003 and then was followed by a slight decline to 24 percent by 2008, primarily driven by a slight decrease in the usage of modern methods. Furthermore, and more importantly, unmet need has continued to increase over the observed time period from 33 percent to 35 percent. It is also notable to mention that in 2008, over 40 percent of WRA in union stated that contraception is not needed. As the percentage of those using modern methods increased, the percentage of those stating contraceptives are not needed decreased, and vice versa. This may indicate that unmet need is actually understated, particularly given that it continues to grow independently of changes to CPR.

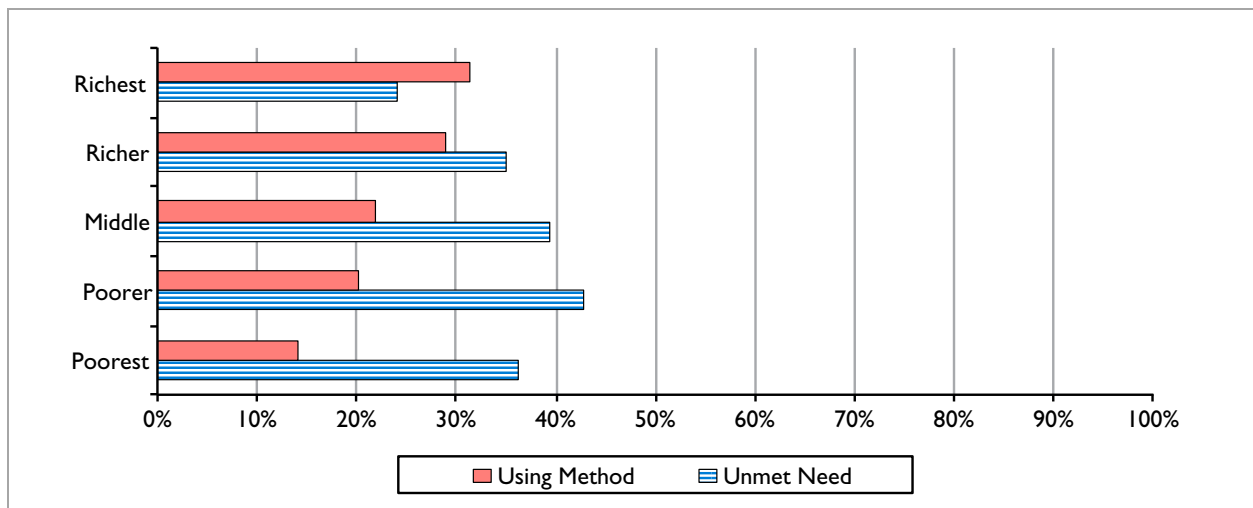
Figure 18. CPR and Unmet Need (1998–2008)



Wealth

From 2003 to 2008, CPR decreased or remained flat for all quintiles except the poorest quintile. Subsequently, this most likely was a factor in the increase in unmet need. Variances in 2008 CPR and unmet need among wealth quintiles are further illustrated in Figure 19. As shown, WRA in union in the three lowest quintiles have greater unmet need than those in the wealthier quintiles. Unmet need for the poorest and poorer quintiles are 36 percent and 43 percent, respectively, while in the richest quintile it is 24 percent. In addition, CPR tends to increase as income increases. CPR for the poorest quintile is only 14 percent, while it is more than double for the richest quintile at 31 percent. As noted earlier, wealthier women rely on a broader range of contraceptive methods, whereas use by economically disadvantaged women is concentrated on only a few. Sixty-five percent of contraceptive users in the poorest quintile rely on injections and pills as their primary methods; only 36 percent of users in the richest quintile rely on these two methods. For the poorest women, it could be an indication of what is available or being counseled to them at health facilities. Wealthier contraceptive users are meeting their contraceptive needs with a variety of methods and likely have greater access to private facilities as a means to better meet their FP needs.

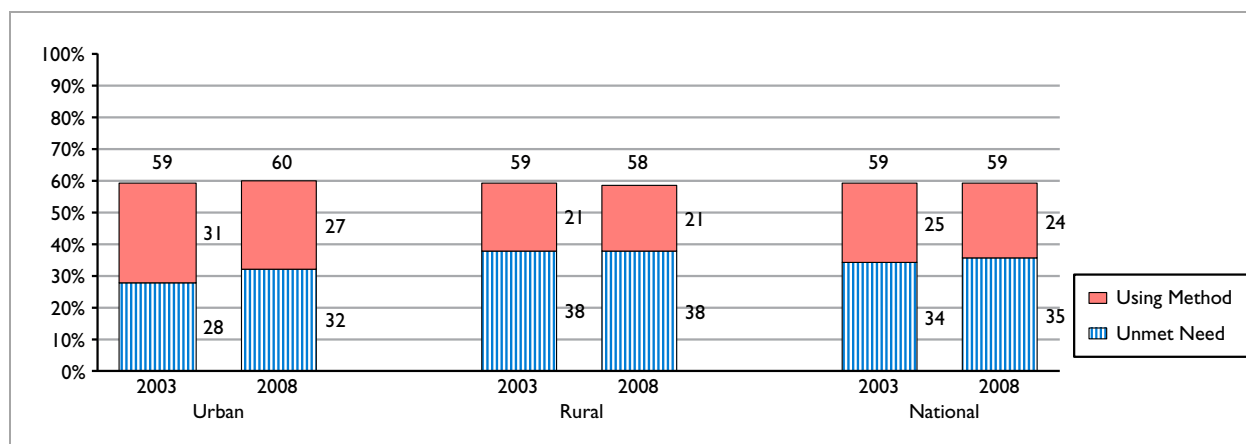
Figure 19. CPR and Unmet Need by Wealth Quintile (2008)



Residence

CPR in the rural areas has plateaued at 21 percent and has decreased from 31 percent to 27 percent in the urban areas. In conjunction, WRA in union in urban areas have seen an increase in unmet need from 28 percent to 32 percent during this period, while those in rural areas have had a constant higher unmet need (38 percent) than the urban areas. Total demand for contraceptives has remained fairly constant, at approximately 59 percent nationally from the period of 2003 to 2008, with only slight variances in urban and rural areas (less than 1 percent difference each).

Figure 20. CPR and Unmet Need by Residence (2003–2008)



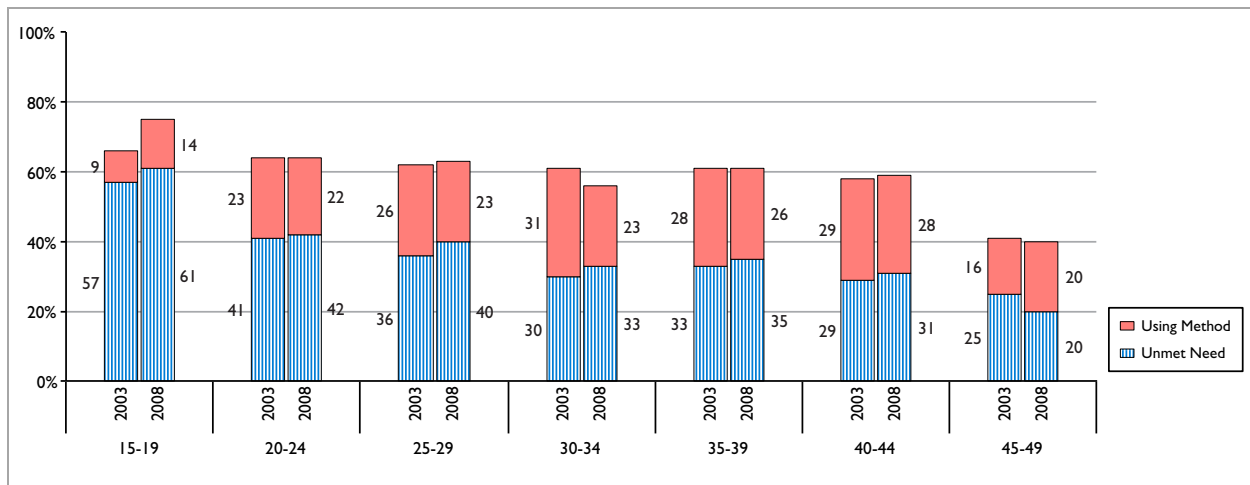
Age

The most notable decrease in CPR occurred in the 30 to 34 age group, where CPR decreased from 30 percent to 23 percent. However, more importantly, CPR decreased in four of the age groups, specifically the 20 to 44 age groups.

All age groups, with the exception of the oldest age group (45 to 49 years), also saw an increase in unmet need during this period. The greatest increase of unmet need from 2003 to 2008 occurred in the 15 to 19 and 25 to 29 age group, increasing from 57 percent to 61 percent and from 36 percent to 40 percent, respectively. The 25 to 29 age group also had a fairly large decrease in CPR from 26 percent to 23 percent. All age groups have unmet need that is greater than or equal to the percentage currently using any form of contraception, and as noted previously, unmet need increased in 2008 compared with 2003 for all groups aside from the oldest group, where it declined by 20 percent.

In terms of total demand, the most notable changes took place in the youngest age group. Total demand for contraceptives in the 15 to 19 age group increased from 66 percent to 75 percent between 2003 and 2008. This was driven by an increase in usage from 9 percent to 14 percent, as well as an increase in unmet need from 57 percent to 61 percent by 2008. This makes them the most underserved group for contraceptives compared to all age groups. Their unmet need is 50 percent greater than any other age group, and three times that of the 45 to 49 age group (20 percent). The increase in both CPR and unmet need in the 15- to 19-year-old age group could indicate that the increased awareness and use of CPR is also creating a higher demand for contraceptives that is not being met.

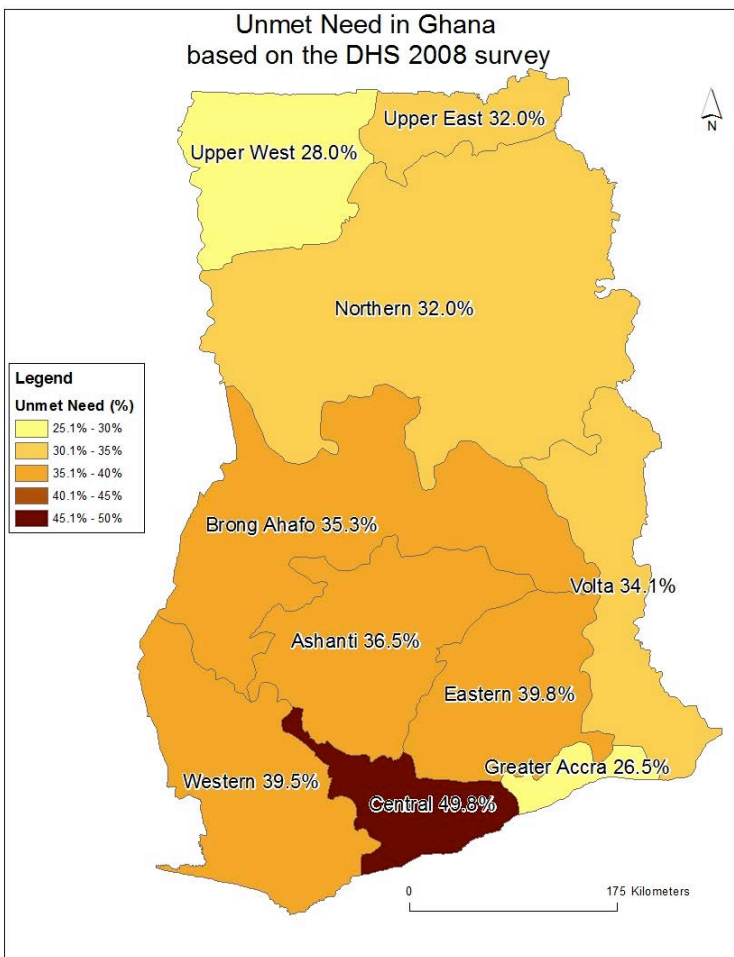
Figure 21. CPR and Unmet Need by Age Group (2003–2008)



Region

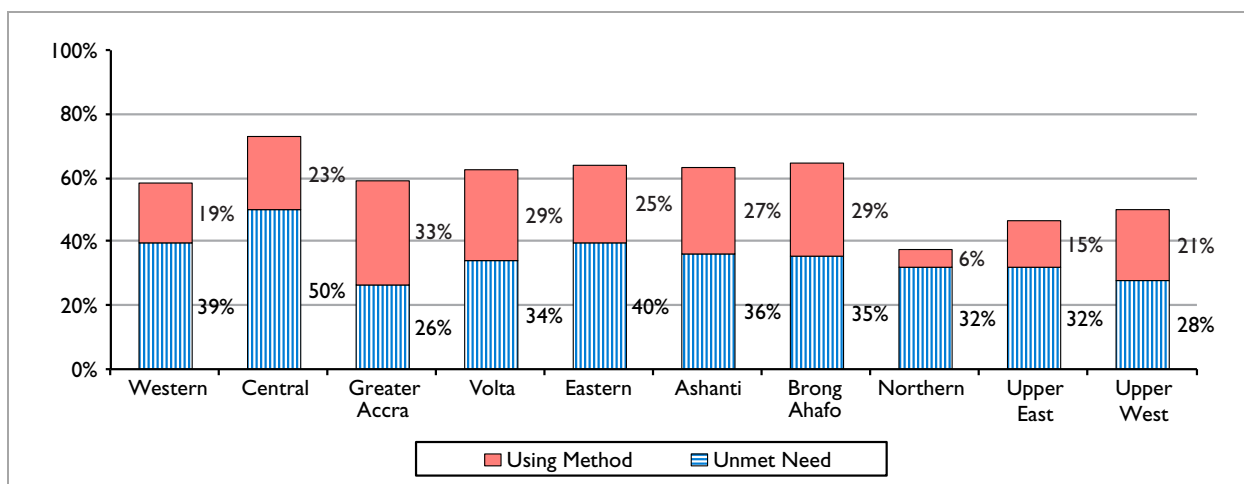
Across all regions, Greater Accra, the most densely populated and wealthiest region, has the highest CPR at 33 percent, and the lowest percentage of unmet need at 26 percent (see Figure 22). This is consistent with earlier findings related to residence and wealth. In contrast, the Northern region has the lowest CPR (6 percent) but one of the lowest unmet need (32 percent) in the country, while the Central region actually has the greatest unmet need in Ghana (50 percent). Interestingly, the Central region also has the lowest rate of those noting a method is not needed (27 percent), indicating there is a strong demand for contraceptives that is not being met.

Figure 22. Unmet Need by Region



Other regions in the north of the country share a different set of characteristics. Similar to the Northern region, the Upper East and Upper West regions have a combination of low CPR and low unmet need. As noted previously, the Northern region is a large and poor region, and has the lowest CPR of all regions. The adjacent Upper East and Upper West regions are less densely populated but have higher rates of contraceptive usage than the Northern region; however, overall CPR is still low at 15 percent and 22 percent, respectively. The percent of those not needing a method in Northern, Upper East, and Upper West are some of the highest in the country at 62 percent, 53 percent, and 50 percent, respectively. Correspondingly, they also have the lowest unmet need: Northern at 32 percent, Upper East at 32 percent, and Upper West at 28 percent. The combination of characteristics in these adjacent regions may indicate a lack of awareness of FP contributing to lower demand or a lack of access to contraception contributing to low CPR.

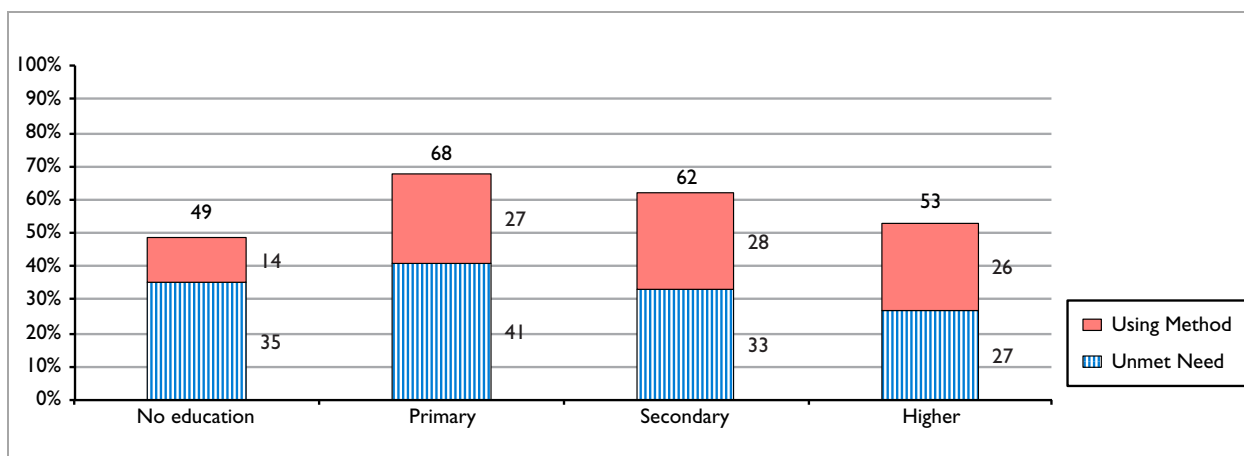
Figure 23. CPR and Unmet Need by Region (2008)



Education

Total demand and unmet need vary by level of education attained by WRA in union. The group with no formal education shows the lowest demand for contraception overall (49 percent) and the lowest percentage of users of contraception (14 percent). However, unmet need for this group is equal to the average for all WRA in union (35 percent). The large percentage not using contraception in this group (51 percent) may indicate a lack of knowledge of or access to contraceptives. That said, when moving from the group with no formal education to the group with primary education, there is a large increase in CPR from 14 percent to 27 percent and a higher unmet need of 41 percent. For groups with a primary level of education or above, unmet need then declines as the education level increases. For the educated groups, CPR does not differ greatly, with a range of 26 percent to 28 percent. The lower unmet need among those with secondary or higher education could indicate they are aware of where to sources and are able to better access contraceptives.

Figure 24. CPR and Unmet Need by Level of Education Attained (2008)



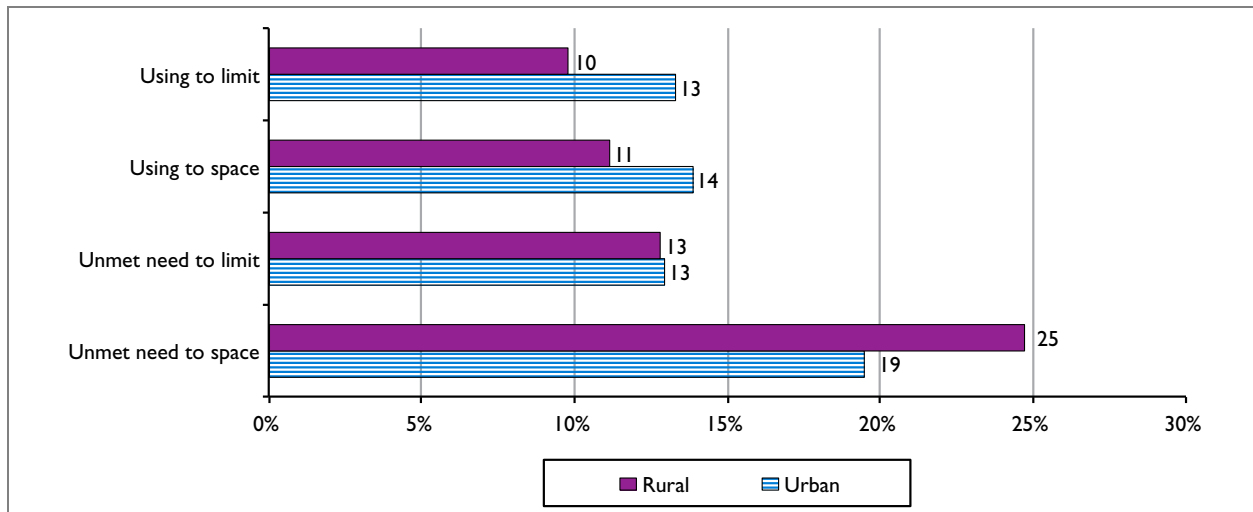
Use for Spacing and Limiting

As noted earlier, WRA in union in rural areas have the greatest unmet need for contraception, while those in urban areas have a lower but growing unmet need. Dissecting the 2008 figures according to motivation for use shows that unmet need is greatest for those using contraceptives for spacing and provides some insight on the needs of the underserved segments, as shown in Figure 25.

Unmet need is greatest for WRA in union who desire to space, with a greater unmet need in rural areas (25 percent) than in urban areas (19 percent). The greater requirement for spacing rather than limiting in rural areas underscores the higher TFR in rural areas. Unmet need to limit does not differ greatly between rural and urban users, but is still notable at 13 percent. The percentage currently using for limiting or spacing is greater in urban areas than in rural areas, as would be expected from the higher usage rates in urban areas noted previously.

The desire to space is apparent given the much higher unmet need for spacing in both urban and rural areas and the slightly higher CPR for spacing in both areas.

Figure 25. CPR and Unmet Need for Limiting and Spacing by Residence (2008)

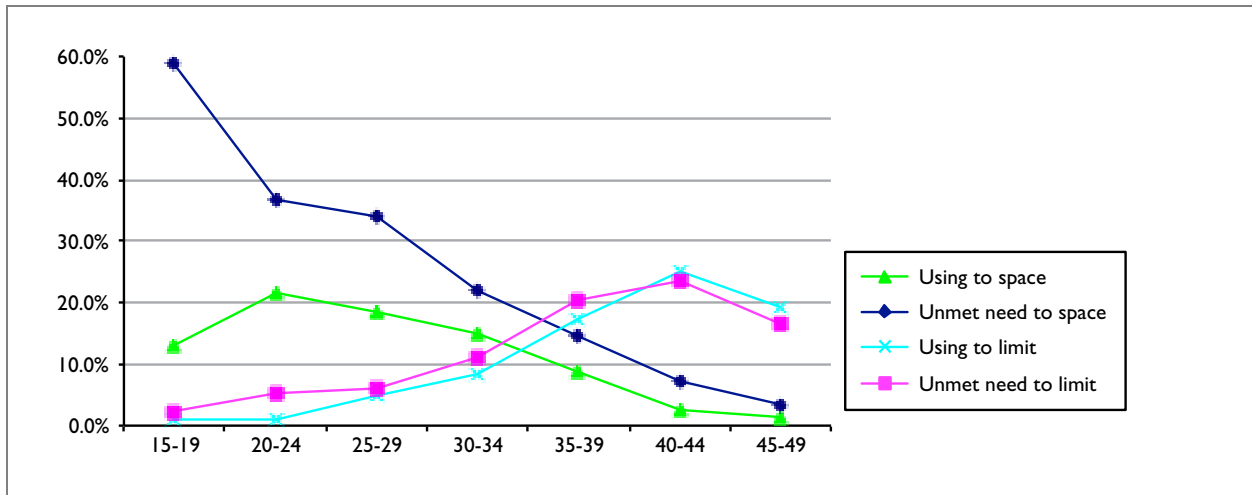


Examining this data according to age group highlights opposing trends between spacing and limiting, as illustrated in Figure 26. For spacing, younger age groups have by far the greatest unmet need but also the greatest CPR. As the age group increases, unmet need and CPR for spacing decrease, and the gap between the two narrows. CPR for spacing by the youngest age group, 15 to 19 years, is only 13 percent and unmet need is more than four times higher at 59 percent; for the oldest age group, 45 to 49 years, CPR for spacing is only 1 percent and unmet need only 3 percent.

The opposite trend is true for total demand and unmet need for limiting. For the youngest age group, CPR for limiting is 1 percent and unmet need only 2 percent. However, usage for limiting by the oldest age group is 19 percent and unmet need is 17 percent.

Overall, the younger age groups (15 to 34 years) have greater demand and unmet need for contraception in general and for spacing in particular. The 15 to 19 age group is the most underserved group for contraceptives used for spacing.

Figure 26. CPR and Unmet Need for Limiting and Spacing by Age Group (2008)



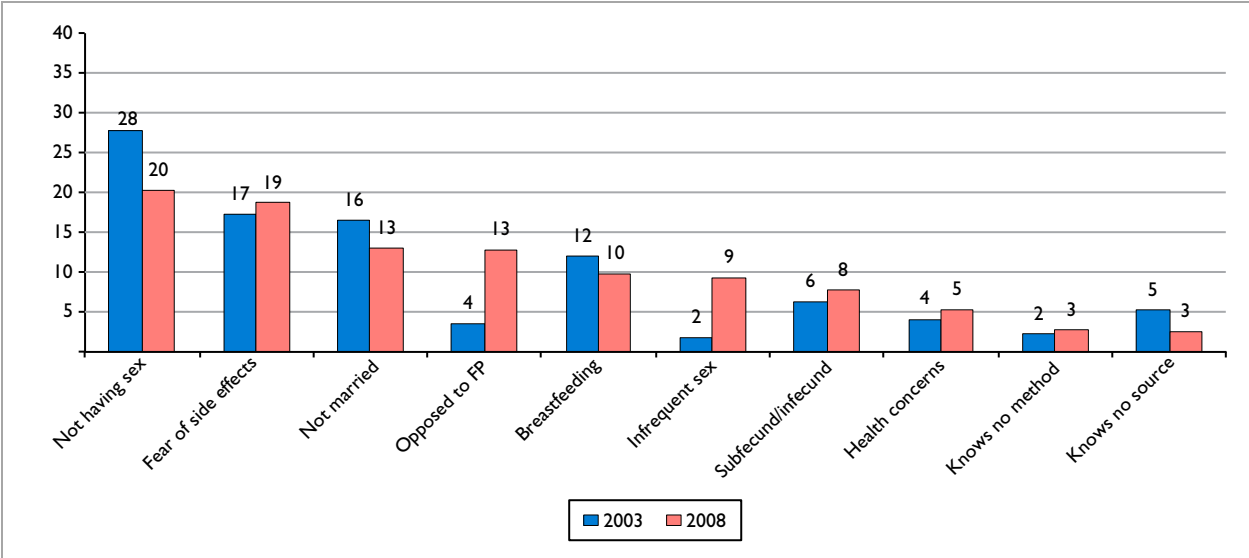
Reasons for Non-use

Unmet need for as well as non-use of contraception in Ghana has increased in the period from 2003 to 2008. This section explores possible explanations for non-use of FP by all WRA in Ghana, rather than just WRA in union. It should be noted that as women were able to provide more than one answer, the following data represents only the most frequently cited reasons and does not total to 100 percent.

As shown in Figure 27, the main reasons for non-use by WRA according to the 2008 DHS are 1) not having sex (20 percent), 2) fear of side effects (19 percent), 3) opposition to FP (includes respondent opposition, husband opposition, other opposition or religious reasons) (13 percent), 4) not married (13 percent), 5) breastfeeding (10 percent), and 6) infrequent sex (9 percent). Similarly, not having sex (28 percent) and fear of side effects (17 percent) were the most frequently stated reason for not using contraception according to the 2003 GDHS, followed by 3) not married (16 percent), 4) breastfeeding (12 percent), 5) subfecund/infecund (6 percent), and 6) knows no source (5 percent). However, there was a large increase in the number of women between 2003 and 2008 who noted opposition to FP as a reason for non-use, jumping from 4 percent to 13 percent. It is worth noting that cost as a barrier decreased from 4.9 percent (2003) to 2.4 percent (2008) and did not feature as one of the main reasons for non-use.

The strong increase in the percentage of respondents noting opposition to FP and the continued increase of side effects as a reason against using FP points to misperceptions or a lack of knowledge about FP that will need to be effectively addressed in the public health context. Furthermore, the increase in the number of women noting opposition to FP also suggests that more raising of awareness and education on FP is needed.

Figure 27. Reasons for Not Using FP (2003 and 2008)



Wealth

While there are variances around reasons for non-use according to wealth quintile, the differences tend to be subtle. However, a few differences stand out, in particular with regard to knowledge and source of FP. Fear of side effects, the most commonly cited reason for non-use after not having sex, is the primary reason for non-use cited by the top four wealth quintiles, whereas the poorest quintile cites opposition to FP as the main reason for non-use. Lack of knowledge and not knowing a source are highest in the two poorest quintiles, while being almost non-existent in the wealthier quintiles. Opposition to FP is also strongest in the poorer quintiles but exists for all quintiles. The data also indicate that there is a greater percentage of unmarried women in wealthier quintiles than in poorer quintiles.

Table 7. Reasons for Not Using FP by Wealth Quintile (2008)

Characteristics	Not having sex (%)	Not married (%)	Breast feeding (%)	Infecund/subfecund (%)	Infrequent sex (%)	Health concerns (%)	Fear of side effects (%)	Opposed to FP (%)	Lack of knowledge (%)	Knows no source (%)
Wealth quintile										
Poorest	20.5	6.4	13.1	5.6	8.8	4.8	14.7	16.3	6.1	7.5
Poorer	17.3	10.1	9.3	8.8	12.0	5.3	21.5	13.6	2.7	3.7
Middle	21.6	17.0	9.5	8.0	10.0	9.2	19.8	10.8	1.5	1.5
Richer	22.4	14.4	9.7	6.3	10.5	9.4	18.9	11.5	1.8	0.3
Richest	19.1	17.7	7.4	10.4	13.7	6.7	18.1	11.7	0.7	0.0

Residence

An analysis according to residence reveals similar trends as the wealth quintiles, as is expected based on earlier linkages between these two characteristics. Lack of knowledge and no source are cited three to four times more frequently as a reason for non-use by those in rural areas than by those in urban areas. Opposition to FP is higher in rural areas. Being unmarried was stated twice as often in urban areas than rural areas.

Table 8. Reasons for Not Using FP by Residence (2008)

Characteristics	Not having sex (%)	Not married (%)	Breast feeding (%)	Infecund/subfecund (%)	Infrequent sex (%)	Health concerns (%)	Fear of side effects (%)	Opposed to FP (%)	Lack of knowledge (%)	Knows no source (%)
Urban	21.2	17.8	8.3	7.2	11.7	7.4	19.2	11.9	1.4	0.5
Rural	19.5	9.2	11.1	8.2	10.3	6.9	18.3	13.6	3.5	4.5

Age

Analysis by age group reflects the overall trends for reasons for non-use. Fear of side effects is the most frequent reason for non-use in the 20 to 44 year age groups, other than not having sex and not being married. The youngest age group has a large percentage of women not married and not having sex, and the oldest age group has a large number of women who are infecund/subfecund. The group with the highest ASFR (20 to 29 years) cites breastfeeding as the most frequent reason for non-use after fear of side effects. Opposition to FP was the second most frequently cited reason for those in the 30 to 34 age group and was cited as the third most frequent reason for non-use by the 40 to 49 age groups.

Table 9. Reasons for Not Using by Age Category (2008)

Characteristics	Not having sex (%)	Not married (%)	Breast feeding (%)	Infecund/subfecund (%)	Infrequent sex (%)	Health concerns (%)	Fear of side effects (%)	Opposed to FP (%)	Lack of knowledge (%)	Knows no source (%)
15–19	36.1	47.1	2.8	0.0	8.3	1.4	12.2	3.1	1.4	2.8
20–24	22.2	16.8	16.2	0.7	13.8	3.7	16.8	13.5	4.4	2.7
25–29	13.3	4.2	17.2	1.9	13.6	9.4	22.4	14.6	2.9	2.9
30–34	17.4	1.4	16.4	2.7	9.1	8.7	21.0	19.1	3.6	3.2
35–39	14.3	2.5	11.5	4.5	12.7	11.5	22.6	12.3	1.6	3.7
40–44	20.3	3.3	3.3	11.3	10.8	10.4	24.4	14.2	3.3	1.9
45–49	15.9	8.0	0.0	36.7	7.2	7.2	12.7	15.5	1.2	2.0

Region

By region, there is great variation in reasons for non-use. The most common reason is the fear of side effects (outside of not having sex, infrequent sex, and not married), which varies by region and is not correlated to urban density or population. It is cited as the most common reason in the Brong Ahafo, Volta, Western, Central, and Eastern regions. In addition, opposition to FP and breastfeeding were cited more frequently than fear of side effects in the Northern and Upper East regions. Furthermore, opposition to FP is highest in the Upper East, Volta, and Northern regions. In the Volta and Western regions, health concerns were cited more frequently than in any other region. Lack of knowledge is cited across regions, even in the urban, wealthy region of Greater Accra. Not surprisingly, the reasons “lack of knowledge” and “knows no source” are common in regions with the lowest CPR: Upper West, Upper East, and Northern. Additionally, the Northern region had the highest percentage of respondents citing lack of knowledge and knowing no source as their reasons for non-use.

Table 10. Reasons for Not Using FP by Region (2008)

Characteristics	Not having sex (%)	Not married (%)	Breast feeding (%)	Infecund/subfecund (%)	Infrequent sex (%)	Health concerns (%)	Fear of side effects (%)	Opposed to FP (%)	Lack of knowledge (%)	Knows no source (%)
Western	11.1	21.4	9.0	2.6	8.1	13.7	26.4	5.6	1.7	1.3
Central	23.7	14.8	11.4	8.5	6.8	4.5	18.1	11.3	2.8	0.6
Greater Accra	25.9	12.1	12.1	11.1	13.0	5.6	12.5	11.6	1.4	0.0
Volta	18.0	3.8	11.2	12.4	10.6	18.1	28.6	22.5	0.6	3.8
Eastern	19.4	9.4	6.1	13.3	17.9	6.7	19.4	10.6	1.7	1.1
Ashanti	19.2	16.8	8.1	7.5	15.0	5.1	16.2	10.2	2.7	2.4
Brong Ahafo	18.7	14.1	2.2	11.2	5.2	6.7	31.9	11.2	0.7	3.7
Northern	22.9	11.0	8.3	2.3	8.7	3.7	11.9	16.4	7.8	10.5
Upper East	23.5	3.4	22.0	3.4	7.6	1.7	7.6	27.1	3.4	0.8
Upper West	30.6	14.3	16.3	6.1	10.2	2.0	14.3	8.2	4.1	2.0

Education

Analysis of non-use by education level also reveals some interesting findings. Recall that CPR increases considerably when moving from the non-educated group to the group with primary education. Data in Table 11 indicate that fear of side effects and opposition to FP also tend to decrease with more education. Increased knowledge of FP also appears to be linked with less fear of side effects. Health concerns were cited less frequently by the higher education group than the other groups. Furthermore, lack of knowledge and knowing no source are much more common reasons for non-use in the non-educated group; for those with higher education, lack of knowledge and knowing no source were not mentioned at all.

Table 11. Main Reasons for Not Using FP by Education Level (2008)

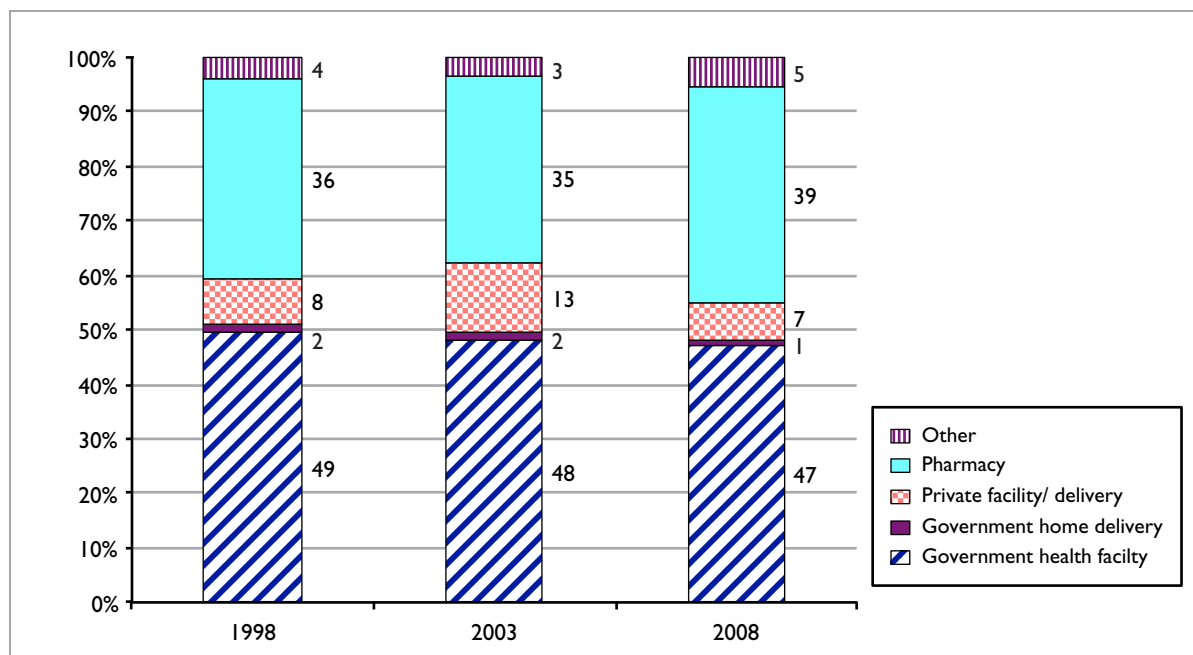
Characteristics	Not having sex (%)	Not married (%)	Breast feeding (%)	Infecund/subfecund (%)	Infrequent sex (%)	Health concerns (%)	Fear of side effects (%)	Opposed to FP (%)	Lack of knowledge (%)	Knows no source (%)
No education	17.6	3.3	12.8	8.8	6.7	5.7	17.4	17.4	5.7	6.9
Primary	17.9	10.5	7.9	6.9	10.5	8.5	23.8	12.3	1.8	1.3
Secondary	22.6	19.7	8.6	7.5	13.7	7.6	17.6	10.4	1.3	0.9
Higher	25.0	16.7	14.6	6.3	10.4	4.3	10.4	12.5	0.0	0.0

Sources of Contraceptive Supplies

It should be noted that sources for female sterilization were not reported in the 2008 DHS and are therefore not included in the analysis that follows.

Data collected over the period of 1998 to 2008 reveals a continuing shift toward the commercial sector as a source for modern contraceptive use by WRA in union. Use of the commercial sector (“private sector”), which includes pharmacy and private facility/delivery, for provision of contraceptives increased from 44 percent in 1998 to 48 percent in 2003 and declined slightly to 46 percent in 2008. Although the trend has recently reversed slightly, the long-term trend continues toward commercial sources. Use of government health facilities and home delivery during the same period has seen a gradual decline, from 51 percent in 1998 to 48 percent in 2008.

Figure 28. Distribution of Current Modern Contraceptive Users by Source (1998–2008)

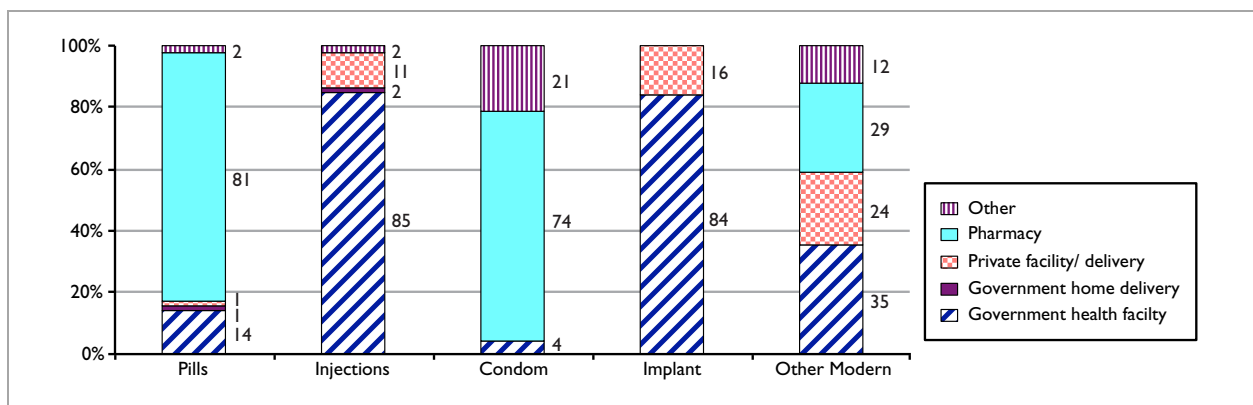


Methods/Brands

Recall that for modern methods, the most frequently used forms of contraception are injections, pills, and condoms, and that these three methods combined represent over 80 percent of the modern contraceptive method mix.

Figure 29 illustrates that longer-term methods, injections (85 percent) and implants (84 percent), are provided primarily by the public sector, with private facilities as a secondary source. This is likely due to the need or requirement of a trained and/or licensed health care provider to administer these methods. However, given that the prevalence rate of injections is fairly equal across wealth quintiles, one would expect that more users, in particular wealthier users, would access private sector sources for their supply of injectables. The relatively small presence of the private sector for injections may indicate that this channel is cost prohibitive for many users, as the cost through private sector clinics (99 pesewas) is approximately twice that available through public clinics (50 pesewas). Short-term methods, such as pills (81 percent) and condoms (74 percent), on the other hand, are primarily provided by the private sector, specifically pharmacies. Government facilities and other facilities are secondary sources for these methods.

Figure 29. Modern Contraceptive Source According to Method (2008)

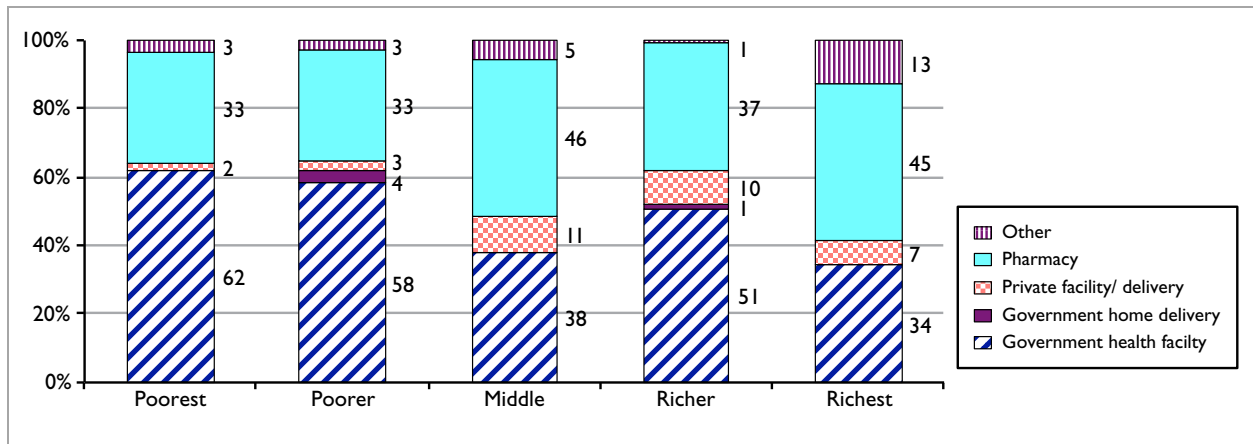


Wealth

Figure 30 shows that the poorer quintiles are accessing modern contraceptives primarily through public sources. In fact, reliance of the poorest quintile on the public sector (62 percent) is nearly twice that of the wealthiest quintile (34 percent). In contrast, the wealthier quintiles tend to rely more heavily on the private sector (primarily pharmacies) as well as “other” sources, accounting for 47 percent of the richer group and 52 percent of the richest. Private facilities are accessed at least twice as frequently by the wealthier quintiles (at least 7 percent) than by the poorer quintiles (at most 3 percent).

Although public sector usage by wealthier quintiles is lower than that by the poorer quintiles, it is still an essential source of contraceptives for these groups, with the two wealthiest groups relying on the public sector for 52 percent and 34 percent, respectively, for their contraceptive supply.

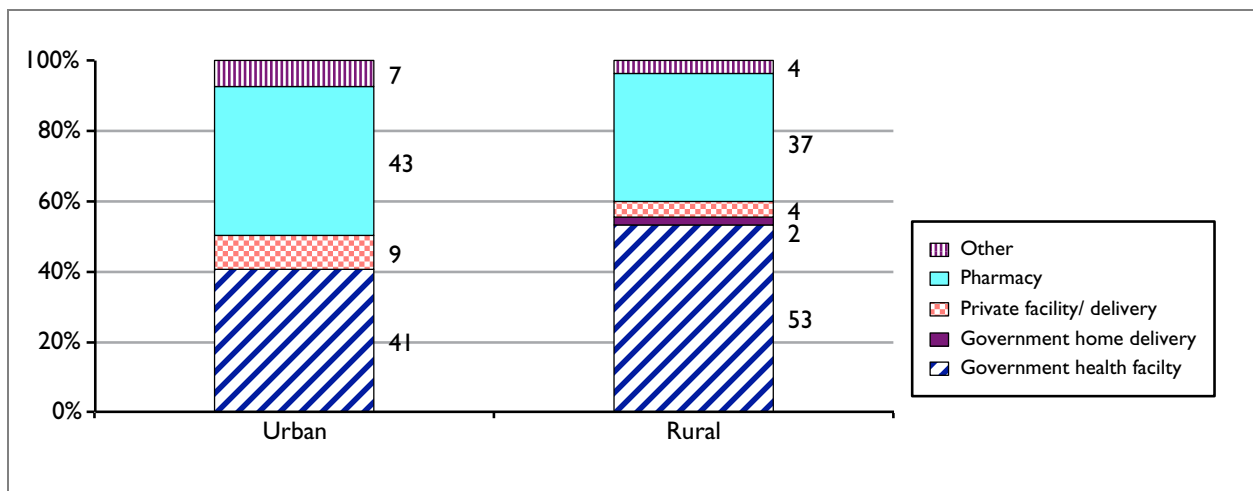
Figure 30. Modern Contraceptive Source According to Wealth Quintile (2008)



Residence

Residential variations of source align with findings from analysis of the wealth quintile. Sources of modern contraception for those living in rural areas are similar to sources for the poorer quintiles, and sources for those living in urban areas is similar to sources for those in the wealthier quintiles. Fifty-five percent of contraceptive users in rural areas rely on public facilities as their source as compared to only 41 percent in urban areas.

Figure 31. Modern Contraceptive Source According to Residence (2008)



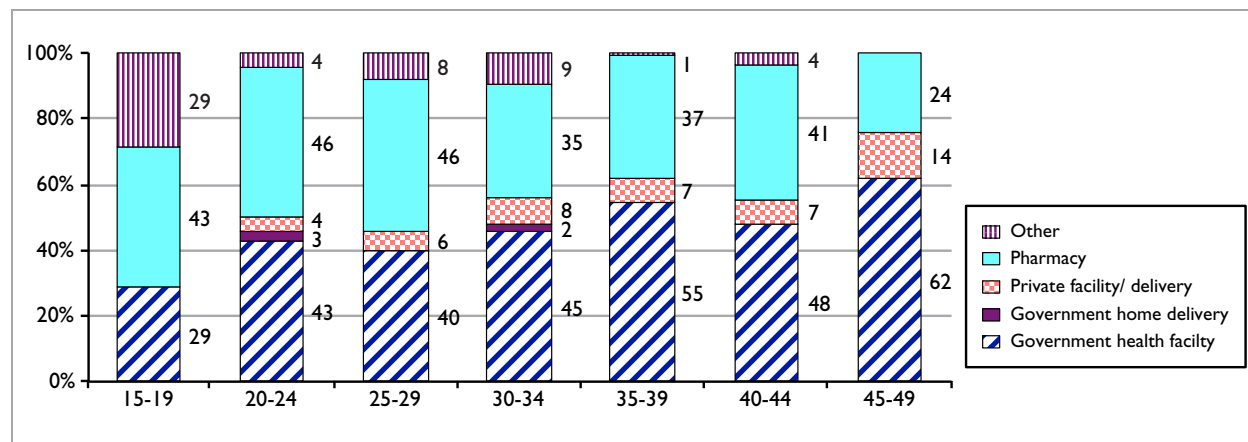
Age

Age also appears to be a determinant of source of modern contraceptives. Although there are some variations within the age groups, a general trend can be seen for each source. Public sector sources are accessed the least by the youngest age groups. Access tends to increase with higher age groups, and reliance on the public sector by the oldest age group is double that of the youngest. Similarly,

usage of private facilities by the youngest age group is nil while usage by the highest age group is 14 percent. In contrast, use of pharmacies by the younger age groups tends to be greater than usage by the older age groups, as does obtaining contraception through other sources. Furthermore, the 15- to 19-year-olds are obtaining 29 percent of their contraceptives from other sources, which can include friends, relatives, and shops. This is perhaps an indication that younger people are not able to obtain contraceptives in the public sector for reasons ranging from health provider bias toward providing youth contraceptives or not having enough youth-friendly points to access services and commodities.

This supports earlier findings that indicate women in older age groups tend toward use of longer-term methods, which are mainly sourced through the public sector, while younger age groups tend toward short-term methods. However, it may also indicate that government-supported programs for some longer-term methods do not adequately target nor reach younger age groups. Recall that while unmet need is high for all age groups, the 15 to 19 age group is the most underserved group. Their contraceptive needs are being supplemented by social marketing and other programs, which when combined still fall short of meeting their total need.

Figure 32. Modern Contraceptive Source According to Age Group (2008)



Region

Government facilities are the largest source of modern contraceptives in regions that tend to be mostly rural and poor, in particular, the Upper West, Upper East, Central, and Northern regions. Interestingly, three of these regions (Upper West, Upper East, and Northern), where the public sector is the largest source of contraceptives, also have by far the highest prevalence of injections use. In addition, there is also little to no presence of “other” sources in these regions, which may provide insight to the limited presence of other forms of contraceptives, especially long-term methods that are frequently accessed through this channel. Prevalence of female sterilization is, in fact, nil in Northern and Upper West, and only 0.6 percent in Upper East. Implant usage is less than 1.2 percent in all of the three regions.

In all other regions, the source of supply is more diversified, and CPR is driven by greater use of a variety of methods rather than concentrated in the use of injectables. In Greater Accra, Volta, Eastern, Ashanti, and Brong Ahafo, the public sector provides between 32 percent and 49 percent of contraceptives, and CPR is between 25 percent and 33 percent. The Western region is the only

exception, where the public sector provides only 31 percent of contraceptives but the CPR is only 19 percent.

The higher CPR among these regions may point to a higher awareness of FP methods in general, due to a greater variety and choice of sources and, therefore, exposure to a variety of methods. Alternatively, this may be an indicator of inadequate supply, where women who cannot obtain their preferred modern method through the public sector and cannot access the private sector rely on traditional methods.

Figure 33. Modern Contraceptive Source According to Region (2008)

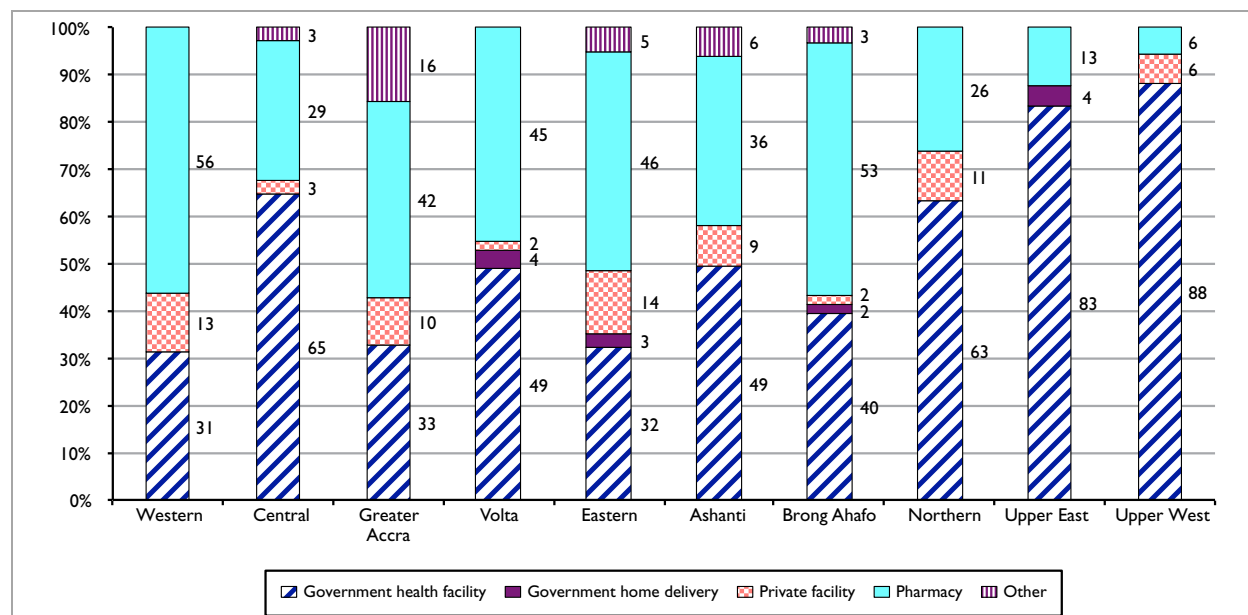


Table 12. Modern Contraceptive Source According to Region (2008)

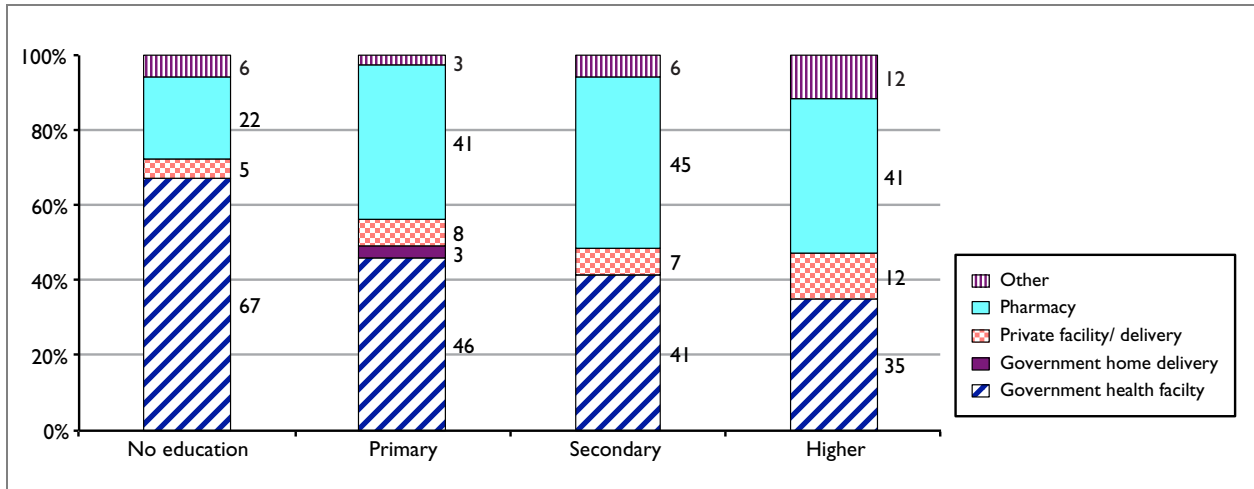
Region	Western (%)	Central (%)	Greater Accra (%)	Volta (%)	Eastern (%)	Ashanti (%)	Brong Ahafo (%)	Northern (%)	Upper East (%)	Upper West (%)
Government health facility	31	65	33	49	32	49	40	63	83	88
Government home delivery	0	0	0	4	3	0	2	0	4	0
Private facility	13	3	10	2	14	9	2	11	0	6
Pharmacy	56	29	42	45	46	36	53	26	13	6
Other	0	3	16	0	5	6	3	0	0	0

Education

Also similar to the analysis of the wealth quintile, the public sector as a source of modern contraceptives is greatest for those with no formal education and decreases in favor of service from private facilities, pharmacies, and other sources as education level increases. Those with no formal education obtain 67 percent of their contraceptives from public sources and only 27 percent from

private facilities and pharmacies, while those with higher education use public sources as little as 35 percent and private facilities and pharmacies as much as 53 percent. As noted previously, as wealth increases with education, those with higher education are able to access private sources with higher out of pocket costs.

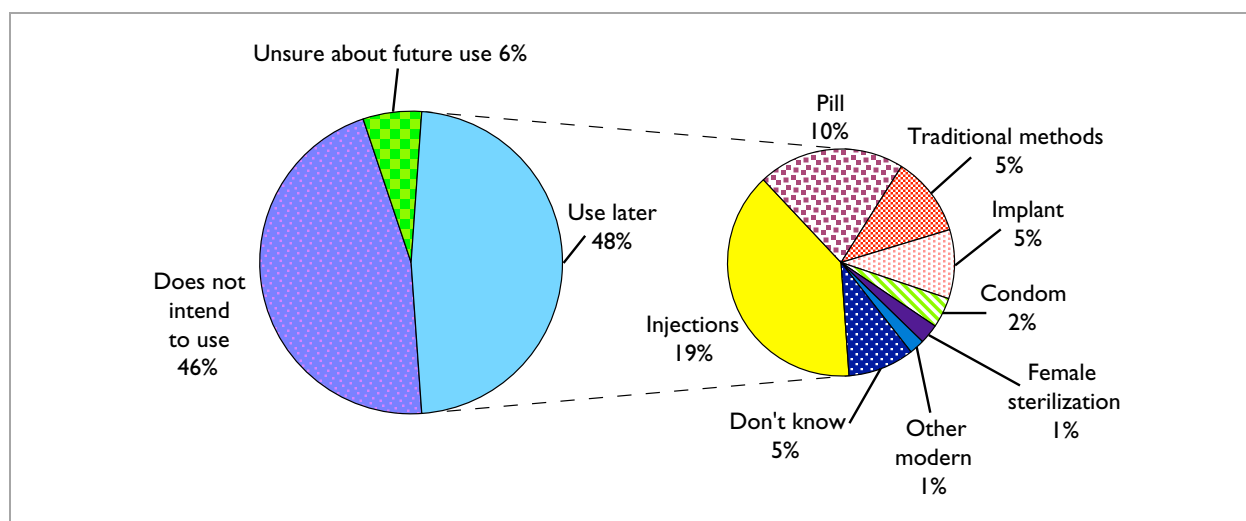
Figure 34. Modern Contraceptive Source According to Education Level (2008)



Future Use/Intention to Use Contraception

According to the 2008 GDHS, 48 percent of WRA in union who are currently not using some form of contraception intend to do so in the future. Of the methods identified, preferred methods tend toward longer-term methods, with injections being named as the most preferred method at 19 percent, followed by pills at 10 percent, implants at 5 percent, and condoms at 2 percent. Five percent of future users indicated that they did not know which method they would use. An additional 5 percent indicated they would use a traditional method of birth control. Also interesting to note is the large percentage of WRA in union (46 percent) who state that they do not intend to use contraceptives in the future.

Figure 35. WRA in Union Preferred Method of Contraception for Future Use (2008)



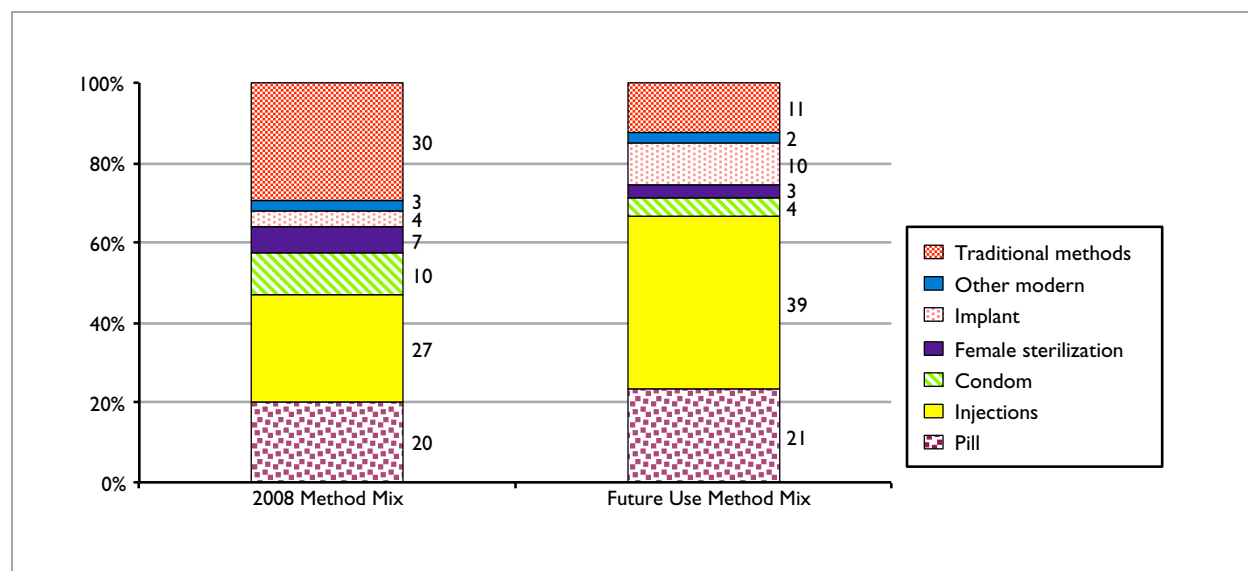
Analyses presented previously in this document have shown that location, age, and education are some of the characteristics with considerable impact on CPR. The demographic profile of WRA in union not currently using contraceptives and who intend to use in future was compared to the demographic profile for the entire sample population of WRA in union. The only notable variance between the profiles of the two groups is that WRA in union (the entire sample population) is more heavily weighted with older women (24 percent are age 40 and above) while the group of future users is more heavily weighted with younger women. The future users group is comprised of 11 percent above age 40 and 50 percent of age 29 and below. The urban/rural ratios are similar at approximately 40 percent urban and 60 percent rural. The percentage of educational attainment is also similar at approximately 30 percent with no formal education, 22 percent with primary education, 45 percent with secondary education, and 4 percent with higher education. The similarity

of these three characteristics enables some comparisons to be made and hypotheses to be formulated with regard to contraceptive preference.

Assuming that the preferences of future users are similar to the preferences of current users, comparing future use preferences to current use may highlight where there is a gap in supply and demand and may be indicative of which methods are preferred by those with current unmet need.

The percentage of current pill users is similar to that of future users, 20 percent and 21 percent, respectively. For injectables, however, there is a considerable difference between current users and future users. Although injectables have the highest usage of modern methods according to 2008 data (27 percent), there appears to be a much larger percentage who would like to use this method in the future (39 percent). Similarly, future use of implants is much higher (10 percent) than current use (4 percent). Conversely, use of condoms and female sterilization are less preferred by future users than current users. Some of this may be due to the higher concentration of older women in the current users group, who it has been shown have a higher preference for female sterilization than younger women. The lesser preference for condoms may indicate women prefer methods that require less resupply and those over which they have more control. Lastly, the percentage of women who rely on traditional methods is nearly three times higher with current users (31 percent) than with future users (11 percent). This may indicate that many women are relying on traditional methods in the absence of modern methods for FP. Figure 36 illustrates these points.

Figure 36. Current Contraceptive Method Mix and Future Use Method Mix for WRA in Union (2008)

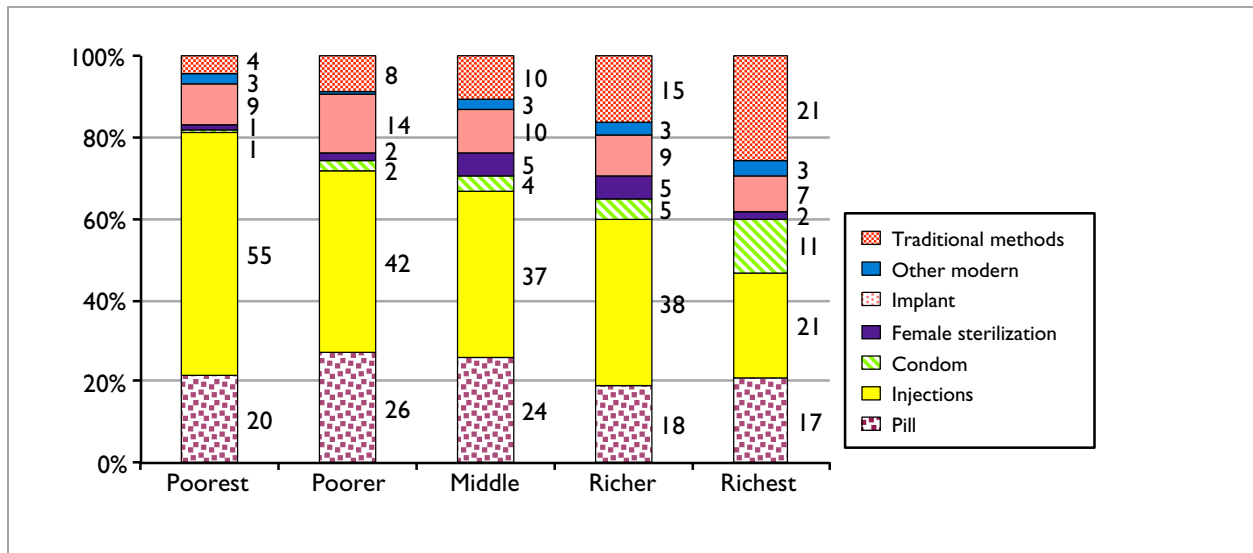


Wealth

As noted previously, injections and pills are more popular among women in the poorer wealth quintiles than in the wealthier quintiles. As Figure 37 illustrates, this trend is also true for those who intend to use contraception in the future. In fact, the preference for injections as a future method is much higher across all wealth quintiles than current use. Current use of injections ranges from 16 percent in the richest quintile to 37 percent in the poorest, while future use is estimated from 21

percent in the richest quintile and 55 percent in the poorest. A similar trend is seen with implants, where current use of implants ranges from 2 percent to 6 percent but increases to 7 percent to 14 percent as a preferred future method. Women in the poorer quintile have the highest preference for future use of implants (14 percent). The figure also illustrates that all women, regardless of wealth quintile, have a higher preference of using a modern contraceptive than relying on traditional methods when compared to current use.

Figure 37. WRA in Union Intention to Use Contraceptives in Future by Wealth Quintile (2008)

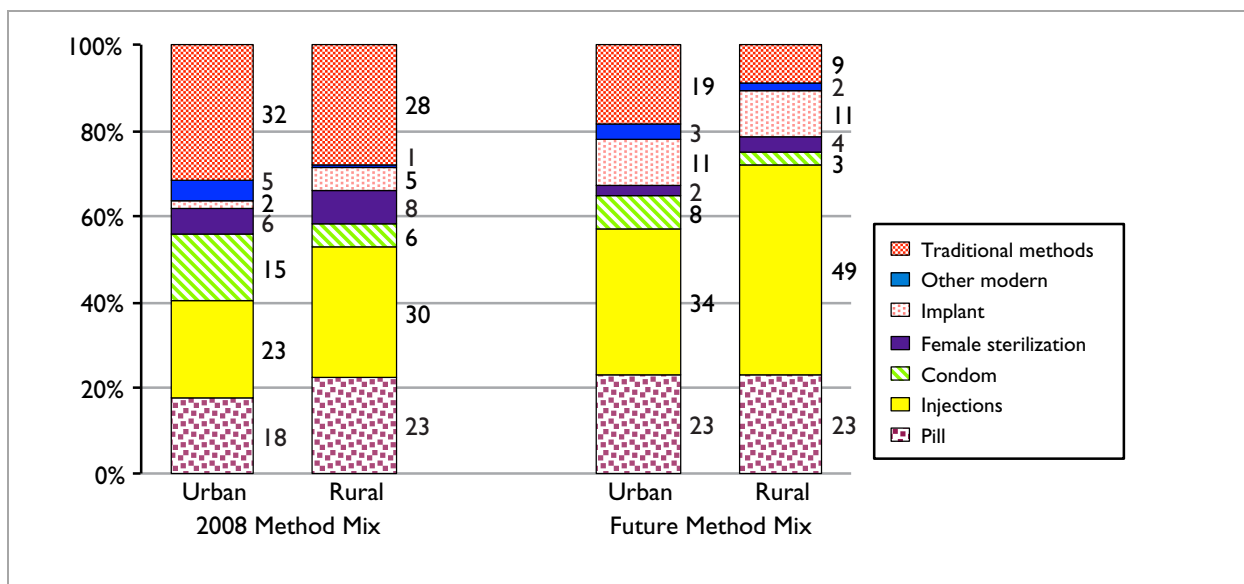


Residence

Preference for future use of injections is higher among rural women (49 percent) than urban women (34 percent), while condoms and traditional methods would be used twice as much by those in the urban areas than in rural areas. Future use of condoms is estimated at 8 percent for urban women and only 3 percent for rural users, and traditional methods at 19 percent for urban women and only 9 percent for rural users. Preference for implants is equal across areas, at 11 percent for both urban and rural women.

Comparing current and future method mix shows that women would prefer to use traditional methods much less than they do currently, particularly in the rural areas (Figure 38). There is a preference to use injections (49 percent) and pills (23 percent) over condoms (3 percent). This ranking of preference is similar for those in the urban areas. Future preference for traditional methods, although showing a reduction in percentage versus current use, is still higher in the urban areas (19 percent) than in rural areas (9 percent).

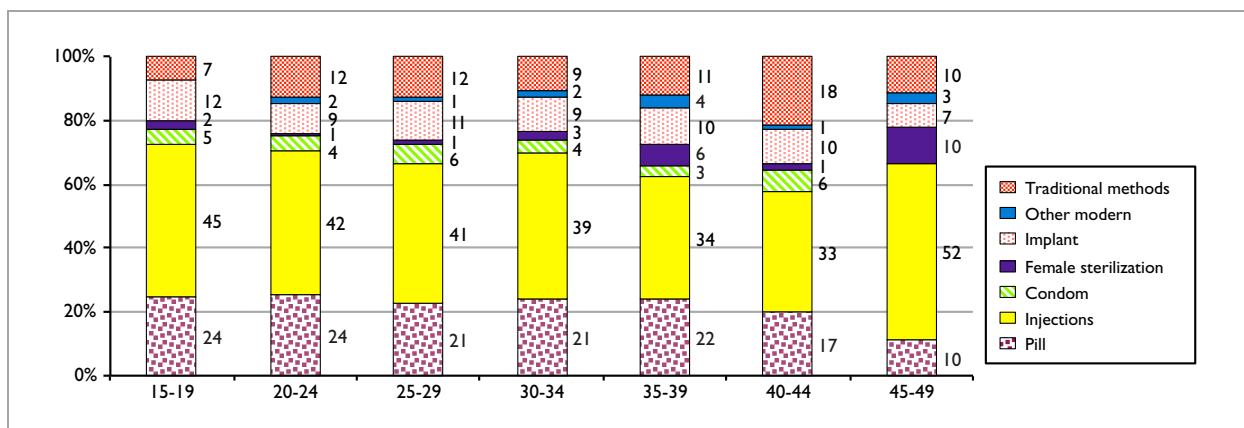
Figure 38. Current Contraceptive Method Mix and Future Use Method Mix by Residence for WRA in Union (2008)



Age

Women of all ages who intend to use contraceptives in the future also prefer injectables and pills. Preference for these two methods tends to decrease as age increases. The oldest age group (40 to 49), however, is the exception, having the highest preference for injections at 52 percent. Implants also are a prominent choice across age groups. This is a notable departure from earlier findings that indicated much lower implant use, particularly for the younger age groups. Similar to earlier findings, however, female sterilization is more preferred among the oldest group. Findings for future use reflect the same pattern of preference for a modern method over traditional methods.

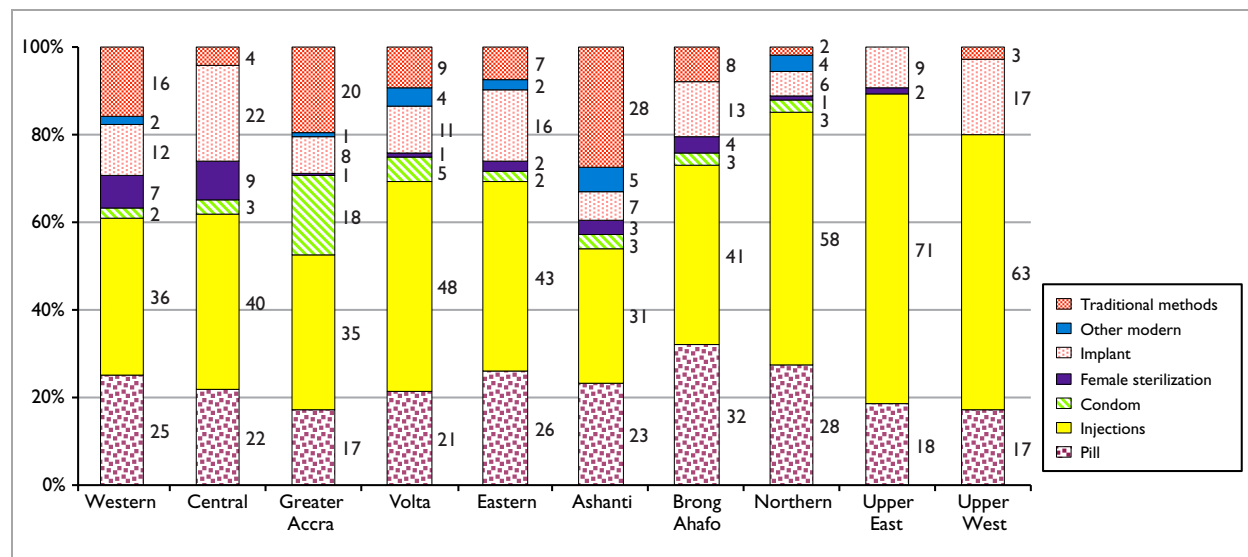
Figure 39. WRA in Union Intention to Use Contraceptives in Future by Age Group (2008)



Region

Similar to the current CPR, injections are the most preferred method for women in the Northern, Upper East, and Upper West regions. Preference for future use of implants is greater than current use in all regions and is more than double in all regions except in Northern and Upper East. Preference for condoms, however, decreases in all regions except Greater Accra, where current use (19 percent) and future use (18 percent) are similar.

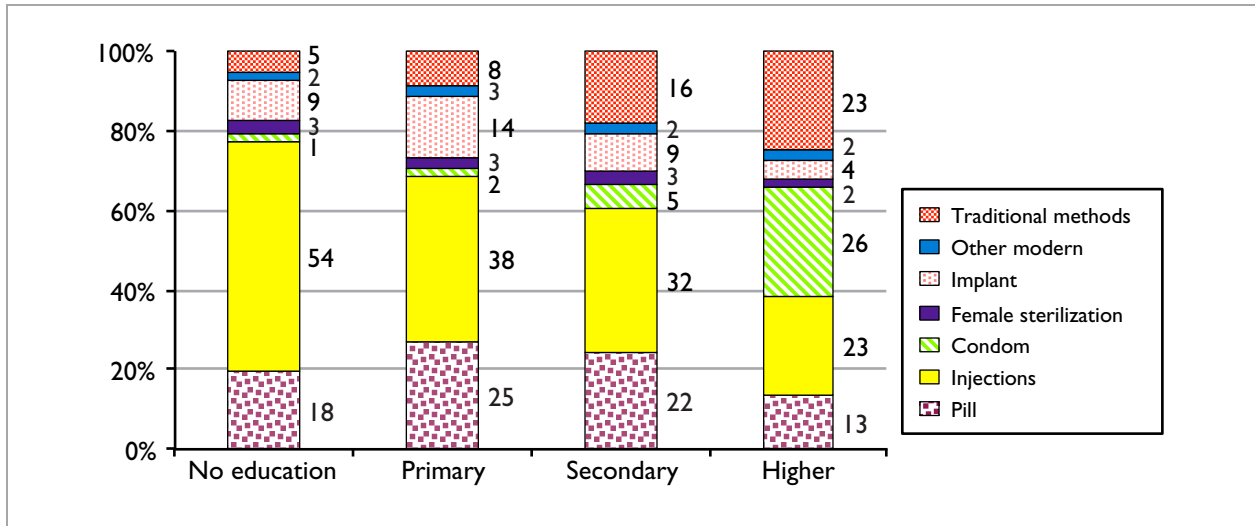
Figure 40. Method Mix of WRA in Union Intention to Use Contraceptives in Future by Region (2008)



Education

As education increases, preference for implants and injections decreases. Conversely, preference for condoms and traditional methods increases for those who have more education. Preference for pills increases considerably when moving from the non-educated group (18 percent) to the group with primary education (25 percent), then declines steadily as more education is attained.

Figure 41. WRA in Union Intention to Use Contraceptives in Future by Education Level (2008)



Summary of Findings and Conclusions

Contraceptive Prevalence Rate and Unmet Need

- Total CPR slightly decreased between 2003 and 2008. With the exception of the youngest and oldest age groups, CPR declined and unmet need increased. Of most concern was the steep decrease in contraceptive use among 30- to 34-year-olds, falling from 30 percent to 23 percent while unmet need in the same age group increased from 31 percent to 33 percent.
- There is high demand among the 15- to 19-year-olds that is not being satisfied. Although their CPR increased by 55 percent, it is still the lowest in the country at 14 percent among all age groups. This age group has the greatest unmet need in the country at 61 percent. Their high unmet need is preventing them from spacing their births.
- The Central region has the highest unmet need in the country, second highest TFR in the country, and the fourth lowest CPR.
- The Northern and Upper West regions have high TFR, correspondingly low CPR (6 percent and 21 percent, respectively), and low demand.
- Those who are poorest and with no education also have the lowest CPR in the country while CPR nearly doubles with wealth and education.
- The need for spacing is not being met, especially in the rural areas. The unmet need for spacing (25 percent) is nearly twice as high as the unmet need for limiting (13 percent) in the rural areas. The unmet need to space in general is much greater in both the rural and urban areas.
- Unmet need is the highest among the poorer and the middle income groups, and generally decreases as wealth increases.
- Implant use is slightly higher in rural areas than in urban ones. The wealthier, more educated, urban women are more reliant than others on traditional methods, and their CPR is higher overall.
- Condoms are much more popular in the urban areas.

Method Mix

- Injectables and pills are the most popular modern method across urban and rural areas, in almost all age groups, income quintile, and education with the exception of those with the most education where condoms are more popular.
- Condoms are used by more urban, wealthier women, in the 20 to 34 age range. There is a high correlation between condom use and those with a higher education where it is 27 percent of the

method mix. Preference for condoms is low in Northern, Upper West, Central, and Ashanti regions.

- The wealthier users use a wider range of methods than those who are poorer, perhaps indicating that with more wealth there is more choice and access to methods and sources of contraceptives.
- Those without education and in the two poorest quintiles rely heavily on injectables. This method constitutes over 70 percent of the modern method mix in both of these categories.
- More rural women rely on long-acting and permanent methods (LAPMs), making up 13 percent of method mix versus 8 percent for urban women. However, the method mix for LAPMs is nearly the same across income quintiles ranging from 16 percent for the poorest to 9 percent for the middle income to 10 percent for the richest quintile.
- Those who are 40 and older have a greater inclination toward using LAPMs.
- The three regions with the lowest method mix for LAPMs are Upper West (6 percent), Greater Accra (5 percent), and Northern (5 percent).

Reasons for Non-use

- Not having sex (20 percent) and fear of side effects (29 percent) continue to be the top reasons for not using contraception, followed by opposition to FP (15 percent) and not being married (13 percent). Opposition to FP (15 percent) is now more frequently mentioned as a reason for not using than in 2003 (9 percent) and is more frequently cited among poorer women.
- Fear of side effects and opposition to FP are frequently mentioned as reasons for not using contraception across all wealth quintiles, urban and rural areas, those with primary or no education, and for those between the ages of 30 to 34 and 40 to 49.
- Fear of side effects and opposition to FP are the top two reasons for not using contraceptives for those who have no education and for those who are in the poorest wealth quintiles (after not having sex).
- The regions that had the highest percentage of women citing fear of side effects as a reason for non use were Volta, Western, Brong Ahafo, and Eastern. Furthermore, Volta and Western had a much higher percentage of women who noted health concerns as a reason for not using than in other regions.
- Lack of knowledge (6 percent) and knowing no source (7 percent) are much more common reasons for not using in the non-educated group, while for those with higher education, lack of access and knowing no source were not mentioned.
- The Northern region has the highest TFR (7 percent), the lowest CPR (6 percent), and the greatest percentage saying a method is not needed (62 percent). The Northern region also had the highest percentage (10.5%percent) responding that not knowing of a source was a reason for not using contraceptives.

Source of Contraceptives

- There is growing reliance on the private sector (46 percent) for contraceptives, but the public sector still remains a source for 47 percent of users. Those in rural areas (55 percent) rely on the public sector more than those in urban areas (41 percent).
- Injectables and implants are provided mainly by the public sector while pills and condoms, methods that require more resupply, are provided mainly by the private sector.
- The two poorest quintiles rely nearly twice as much on the public sector for their contraceptives than those in the richest quintile. Those without education also rely on the public sector almost two times more than those with higher education.
- Pharmacies (43 percent) and other sources (29 percent) are accessed more frequently by the 15 to 19 age group more than any other age group; the public sector is accessed by this age group the least.
- The private sector provides over half of the modern contraceptives for the Brong Ahafo, Greater Accra, Eastern, and Western regions.
- The public sector is the source for 65 percent of contraceptives in the Central region. Their modern CPR is 17 percent and unmet need is 50 percent (the highest in the country), indicating this region may need to work more closely with the private sector to help supplement the services of the public sector to meet the high demand.
- The Northern, Upper East, and Upper West regions rely on the public sector for the majority of their contraceptives (between 63 percent and 88 percent). These regions also have the lowest CPR in the country, possibly indicating that public sector facilities are not accessible in those regions or that there are very few private sector facilities offering FP.
- In addition to having the lowest CPR (6 percent) and highest fertility rate (6.8), 43 percent of Northern region's population are in the two poorest wealth quintiles, and lack of access was cited more frequently as a reason for not using more than in any other regions. This region requires additional resources and attention to further reduce TFR and increase contraceptive use.

Future Use

- Preference for injectables increase from 27 percent to 39 percent of methods for potential future users.
- There is strong preference for implants among those who intend to use in the future. Current method mix is 4 percent for implants. Among those who intend to use in the future is 10 percent. There is also a preference for implants among urban, rural, across all income groups, and across a majority of regions.
- With more preference for modern methods, the use of traditional methods decreases, indicating women would prefer to use a more effective modern method over traditional methods.
- Women also prefer pills, injectables, and implants over condoms.

Recommendations for Improving Equity and Contraceptive Security

Policy and Advocacy

- When the “Road Map for Repositioning Family Planning in Ghana (2006–2010)” is reviewed, consider whether the strategies in the road map and the National Reproductive Health Commodity Security Strategy can be merged to have one definitive guideline to raise the profile of FP in order to increase the resources needed to increase CPR and reduce unmet need. The strategies should be multipronged based on both demographic and behavioral issues, and barriers that are precluding women from using contraceptives.
- Specific strategies are also needed to address the high TFR and low CPR rates among the rural, poorest, and women who have not had any education.
- Continue to develop strategies that are specific for and will resonate most with the poorest, less educated, and rural populations using various media such as radio, community-based forums, and materials printed in region-specific dialects.
- Develop strategies to address the high unmet need and increase CPR among the youngest age group of 15 to 19 years.

Client Demand and Utilization

- Opposition to FP and fear of side effects are the two most common barriers for not using FP among the poorer income groups and those without education. This segment of the population needs more education on the importance and benefits of FP to increase FP use.
- Upper West, Upper East, and Northern have the lowest CPR among the regions in Ghana. The Northern region also has the highest TFR in the country, while Upper East and Upper West have TFR that is among the five highest in the country. Extra resources, advocacy, and focused efforts are needed to increase knowledge, demand, and use of contraceptives in these three particular regions.
- Because condoms use is the lowest the 15- to 19-year-olds, specific targeting is needed to increase the use of condoms among this age group and to promote its benefits as dual protection.
- Ensure there are adequate youth-friendly services both in terms of location and trained providers to meet the high demands for FP for this age group.

- Increase condom use in rural areas and among the poorer quintiles where this method is less frequently used than other methods.
- Design strategies to ensure that women, especially among the rural, more poor, and less educated, are aware of other methods and have access to these other methods.
- Use of reversible LAPMs (IUDs and implants) across all age groups is very low. LAPMs may have higher upfront costs, but they are very effective and have the added benefits of reducing the burden on the health worker because of the fewer revisits required associated with LAPMs. It also reduces travel costs and the frequency of need for the client to take time off from work/other activities to travel to the health facility.

Service Delivery

- Not only is more advocacy needed to ensure women are aware of LAPMs as an additional contraceptive choice, but additional service providers are needed to provide these methods.
- Upgrading the skills of service providers is also needed to ensure their knowledge and skills are standardized and are current to ensure clients are able to choose, obtain, and use the contraceptives of their choice.
- More advocacy is needed to increase CPR by eliminating opposition toward FP and dispelling misconceptions on the possible side effects of modern contraceptives among the general population.
- Service providers also need to have the counseling skills and knowledge to properly counsel women on all contraceptive methods including counseling about side effects.

Private Sector

- Because the private sector plays a major role in providing resupply methods, strong partnerships should be maintained to work together to maximize and leverage public-private resources. Create strategies, activities, and harmonized messages to work and better target resources with the private sector (commercial and NGOs) to expand access to FP services and to increase service delivery points, especially in the rural and the more hard to reach areas. The private sector will continue to be an important partner in meeting the increasing demands of 15- to 19-year-olds.
- Determine how the public and private sectors can work together to increase access to contraceptives throughout the county but with particular attention to the Northern, Upper East, and Upper West regions.
- A study should be conducted to determine the barriers (for the younger age groups) in accessing FP services and contraceptives at the private and public sectors. Interventions should be developed to address the issues identified.
- Work with the private sector to increase access to LAPMs and to ensure messages regarding FP and services are harmonized and standardized with those of the public sector.

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Appendix A

Table AI. Method Mix and CPR by Background Characteristics

	Pill	Injections	Condom	Female sterilization	Implants	Other modern	Traditional methods	Not using	Total CPR	Modern CPR
Residence										
Urban	5%	6%	4%	2%	1%	1%	9%	73%	27%	19%
Rural	5%	6%	1%	2%	1%	0%	6%	79%	21%	15%
Region										
Ashanti	5%	6%	1%	3%	1%	0%	11%	73%	27%	16%
Brong Ahafo	7%	7%	5%	0%	1%	1%	7%	71%	29%	22%
Central	4%	8%	1%	3%	2%	0%	6%	77%	23%	17%
Eastern	4%	6%	4%	3%	1%	0%	7%	75%	25%	17%
Greater Accra	6%	6%	6%	1%	1%	2%	10%	67%	33%	22%
Northern	2%	3%	1%	0%	0%	0%	0%	94%	6%	6%
Upper East	2%	11%	0%	1%	1%	0%	1%	85%	15%	15%
Upper West	2%	15%	1%	0%	1%	0%	1%	79%	21%	20%
Volta	6%	7%	3%	3%	1%	0%	8%	71%	29%	20%
Western	7%	3%	1%	1%	1%	0%	6%	81%	19%	13%
Age										
15-19	2%	2%	1%	0%	0%	2%	6%	86%	14%	8%
20-24	6%	8%	3%	0%	0%	0%	5%	78%	22%	17%
25-29	4%	5%	3%	0%	0%	0%	9%	77%	23%	14%
30-34	4%	7%	3%	1%	1%	1%	6%	77%	23%	17%
35-39	6%	8%	2%	1%	2%	1%	7%	74%	26%	19%
40-44	5%	6%	2%	4%	1%	1%	9%	72%	28%	19%
45-49	3%	3%	1%	5%	2%	1%	5%	80%	20%	15%
Wealth Quintile										
Poorest	4%	5%	0%	1%	1%	0%	3%	86%	14%	12%
Poorer	5%	6%	1%	1%	1%	0%	6%	80%	20%	14%
Middle	5%	6%	3%	1%	1%	0%	6%	78%	22%	16%
Richer	4%	9%	3%	3%	1%	1%	9%	71%	29%	20%
Richest	6%	5%	5%	2%	1%	2%	11%	69%	31%	21%
Education										
No education	3%	5%	0%	1%	1%	0%	3%	87%	13%	11%
Primary	5%	7%	2%	1%	1%	1%	9%	73%	27%	18%
Secondary	6%	6%	4%	2%	1%	1%	9%	72%	28%	19%
Higher	4%	4%	7%	2%	0%	1%	8%	75%	25%	18%
Sample Size	136	180	70	46	27	17	200	2200	676	476

Note:

Totals may not add to 100 percent due to rounding

Table A2. Unmet Need for Spacing and Limiting by Background Characteristics

	Unmet need to space	Unmet need to limit	Using to space	Using to limit	Not using	Unmet need	CPR	Total demand
Residence								
Urban	19%	13%	14%	13%	40%	32%	27%	60%
Rural	25%	13%	11%	10%	42%	38%	21%	58%
Region								
Ashanti	23%	14%	16%	11%	36%	36%	27%	64%
Brong Ahafo	25%	10%	20%	9%	36%	35%	29%	64%
Central	34%	16%	11%	13%	27%	50%	23%	73%
Eastern	23%	17%	10%	14%	36%	40%	24%	64%
Greater Accra	13%	14%	13%	20%	41%	27%	32%	59%
Northern	25%	7%	5%	1%	62%	32%	6%	38%
Upper East	23%	10%	7%	7%	53%	32%	14%	47%
Upper West	20%	9%	16%	6%	50%	28%	22%	50%
Volta	21%	13%	16%	13%	37%	34%	29%	63%
Western	22%	17%	8%	10%	42%	39%	19%	58%
Age								
15–19	59%	2%	13%	1%	25%	61%	14%	75%
20–24	37%	5%	21%	1%	35%	42%	22%	65%
25–29	34%	6%	18%	5%	37%	40%	23%	63%
30–34	22%	11%	15%	8%	43%	33%	23%	57%
35–39	14%	21%	9%	17%	39%	35%	26%	61%
40–44	7%	23%	3%	25%	41%	31%	28%	59%
45–49	3%	17%	1%	19%	60%	20%	20%	40%
Wealth Quintile								
Poorest	26%	11%	7%	7%	49%	36%	14%	51%
Poorer	26%	16%	12%	8%	37%	43%	20%	63%
Middle	25%	14%	12%	10%	39%	39%	22%	61%
Richer	21%	14%	15%	14%	36%	35%	29%	64%
Richest	15%	10%	14%	17%	44%	24%	31%	56%
Education								
No education	22%	13%	6%	8%	51%	35%	13%	49%
Primary	25%	16%	16%	11%	32%	41%	27%	68%
Secondary	22%	12%	15%	14%	38%	33%	28%	62%
Higher	17%	9%	15%	12%	48%	26%	26%	52%
Sample size	646	370	353	323	1181	1016	676	1692

Note:

Totals may not add to 100 percent due to rounding

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