

PN-ACE-316

**Getting From
Awareness to Use
Lessons Learned from
SOMARC III about
Marketing VFTs in
Ghana**

**SOMARC III
Special Study 7**

**The Futures Group
International**

September 1998

**Getting From Awareness to Use Lessons Learned from SOMARC III about
Marketing VFTs in Ghana**

SOMARC III Special Study 7

Prepared by

Lori Bollinger

**Social Marketing for Change III Project
The Futures Group International
1050 17th St, N W, Suite 1000
Washington, D C 20036**

TABLE OF CONTENTS

Executive Summary	ii
Introduction	1
Background	1
Lessons Learned	9
Discussion	12
Bibliography	14

EXECUTIVE SUMMARY

Since 1987, vaginal foaming tablets (VFTs) have been sold in Ghana as part of its contraceptive social marketing program. Initially called the Ghana Contraceptives Supply Project (CSP), then the Ghana Family Planning and Health Project (FPHP), the current program is called the Ghana Population and AIDS Project (GHANAPA), and is in effect until the year 2000.

VFTs have enjoyed an extraordinary and unique success in Ghana. In 1988, one percent of married women in Ghana used VFTs as a contraceptive. Because of the low contraceptive prevalence rate (CPR) at this time, this figure means that VFTs accounted for 20 percent of all modern contraceptive use by married women. Since 1990, VFTs have accounted for an average of 22 percent of couple years of protection (CYPs) distributed by the Ghana Social Marketing Foundation (GSMF), the principal partner of the Social Marketing for Change (SOMARC) project in Ghana.

There are many advantages to VFTs: ease of use, no prescription necessary, freedom from systemic side effects, can be used intermittently, as needed, helps protect against sexually transmitted infections (STIs), possibly including HIV/AIDS, is female-controlled, and serves as a lubricant. In addition to these benefits, certain cultural characteristics of Ghana may increase the perceived benefits of VFTs. For example, VFTs can be used during lactation, which is a distinct advantage in Ghana given that breastfeeding is quite prevalent. Although the low efficacy of this method should be a major concern, the perceived benefits appear to outweigh this cost for users at this time.

The Kamal VFT, which is marketed by GSMF, is priced very competitively. The current price for a package of 12 tablets is 400 cedis, while the retail price for the major competitor, Neosampoon, is 1000 cedis for 20 tablets, on average. The Kamal VFT is also competitively priced in comparison with other contraceptive method choices.

Currently in Ghana, almost all VFTs sold by GSMF are sold through pharmacies and chemist shops, all of which are commercial outlets. Pharmacies are concentrated mainly in urban areas, and pharmacists are trained to dispense contraceptives and advise potential users. Chemist shops are important particularly in rural areas, where hospitals, clinics, pharmacies or family planning centers are not available. GSMF has been very successful in persuading consumers to utilize the commercial marketing outlets; between 1993 and 1995, the percentage of customers using commercial outlets to buy VFTs, condoms or pills rose from 50 percent to 72 percent of users.

A very small fraction of VFTs from GSMF are distributed by the Ghana Registered Midwives Association. Between 1990 and 1992, another innovative distribution outlet accounted for as much as 40 percent of VFT sales for GSMF—the market women program. Under this program, stalls in various market centers were staffed by women selling VFTs and condoms on a consignment basis.

GSMF has been extremely active in advertising VFTs, and is the only organization that advertises VFTs to any degree. Promotional interventions include advertising, public relations activities, point-of-sale materials, contests and coupons. Both urban and rural areas are covered, although more advertising takes place in urban areas.

In implementing the VFT program in Ghana, GSMF and SOMARC have learned several valuable lessons.

Lessons Learned

- ***In countries where modern contraceptive prevalence is low, VFTs may serve as a hook into modern contraceptive use.*** In a country where the modern contraceptive prevalence rate is very low, as in Ghana, a method such as the VFT can attract first-time users who are concerned about possible side effects of other, more effective methods.
- ***Broadening the method mix by allowing VFTs as a choice, along with continued support by the government, contributes to its success.*** Many governments are not interested in pursuing the VFT as one of the methods to be offered in the set of contraceptive choices, primarily due to its relatively high failure rate. One of the possible reasons for the success of VFTs in Ghana is simply that the government allowed and supported the tablet as a contraceptive method.
- ***The gap between awareness and use in Ghana does not appear to be due to price issues. Ghanaian consumers are willing to pay current prices for their contraceptives, including VFTs.*** The gap between knowledge and use of contraceptives in Ghana is well-documented. However, in none of the surveys was cost given as the reason for not using a contraceptive or for discontinuation of use.
- ***The advantages of VFTs may outweigh their main disadvantage (low efficacy) in countries with low modern contraceptive prevalence and high levels of distrust of modern methods.*** In addition to its general effect in increasing the number of contraceptive choices, it may be that it is important to offer VFTs in particular as one of the contraceptive choices. As discussed above, there are certain advantages to using VFTs in general, and in Ghana in particular. VFTs can be used during lactation (breastfeeding is widespread in Ghana) and can serve as an alternative family planning method for the many Ghanaian women who are concerned about negative side effects associated with hormonal methods.

I INTRODUCTION

Since 1987, vaginal foaming tablets (VFTs) have been sold in Ghana as part of its contraceptive social marketing (CSM) program. Initially called the Ghana Contraceptives Supply Project (CSP), then the Ghana Family Planning and Health Project (FPHP), the current program is called the Ghana Population and AIDS Project (GHANAPA), and is in effect until the year 2000. The purpose of GHANAPA is to lower fertility in Ghana through maternal/child health interventions and to increase awareness and prevention of HIV/AIDS. Currently, the Ghana Social Marketing Foundation (GSMF), established under the FPHP, is responsible for managing the CSM program under GHANAPA. Technical assistance is provided by the Social Marketing for Change (SOMARC) III project.

VFTs have enjoyed an extraordinary and unique success in Ghana. Worldwide, average use of VFTs in developing countries is usually much less than 1 percent of women in union.¹ In 1988, 1 percent of married women in Ghana used VFTs as a contraceptive. Because of the low contraceptive prevalence rate (CPR) at this time, this figure means that VFTs accounted for 20 percent of all modern contraceptive use by married women, in 1993, all vaginal methods accounted for 12 percent of married women's modern contraceptive use.² Since 1990, VFTs have accounted for an average of 22 percent of couple years of protection (CYPs) distributed by GSMF/SOMARC III.³ The other methods currently offered by GSMF are condoms, orals, IUDs and injectables. Why are VFTs so popular? Are there circumstances particular to Ghana that make that success unique? Can this success be replicated in other countries? These and other questions will be addressed in this paper.

II BACKGROUND

Contraception Culture

Ghana has a history of high fertility and low modern contraceptive prevalence. The Ghana Demographic and Health Surveys (GDHS) of 1988 and 1993 indicate that the total fertility rate (TFR) fell from 6.4 in 1988 to 5.5 in 1993, this is still well above replacement levels of fertility. Fertility rates are lower in urban areas and among more educated women, but most of the population is rural (66 percent) and education levels are

¹ Population Council, 1997

² Ghana Statistical Service and Macro International, 1989 and 1994. Note that in the 1993 GDHS, VFTs were no longer specified as a separate category, but were included in the "vaginal methods" category, in 1988, the comparable statistic was 25 percent use of all vaginal methods. Note also that these percentages are not CYPs, so are not strictly comparable to CYP statistics.

³ Stover and Heaton, 1997. There are only two other countries where SOMARC III currently offers VFTs as part of its method mix: Ecuador, where they account for a small percentage of CYPs, and Nepal, where they have a declining share of sales. An earlier SOMARC program in the Eastern Caribbean offered VFTs for four years, and then discontinued their distribution in 1992. Note that the SOMARC programs in Jamaica and the Philippines may begin offering VFTs at some point in the future.

quite low, with 35 percent of women having no education at all, contributing to high overall total fertility rates. Although awareness of at least one modern contraceptive is almost universal, at 90.7 percent of the respondents in 1993, modern contraceptive use is still quite low, at 10.1 percent of the respondents. This rate, however, is twice as high as in 1988, where only 5.0 percent of respondents were using modern contraceptives. Of those women who have never used contraceptives, fully 48.9 percent of them have no intention to ever use contraception. Of those women who have used contraceptives at least once, 26 percent never intend to use them again.⁴

This failure to move from awareness to consistent use reflects, to some extent, certain cultural biases that exist against the use of family planning in Ghana, and in Africa in general.⁵ The prevailing social context is one of high fertility, some attribute this to a religious belief that ancestors are reborn in the current generation. Thus, if fertility is limited, the ancestors are not allowed to live again. Note that, usually, the ancestors are the husband's ancestors, not the wife's ancestors, this is part of the reason that males appear to be so highly involved in family planning decisions in Africa. In fact, many women view their reproductive behavior as under the domain of their husbands and husbands' families. High fertility is actually viewed as a reward for highly moral and spiritual behavior. This traditional belief is part of the reason why spacing behavior is acceptable, yet stopping behavior, or sterilization, is not. Africa has had a long history of extensive breastfeeding and postpartum abstinence to facilitate birth spacing, yet this is combined with polygyny and immediate remarriage of widows to achieve high fertility. In fact, some argue that the cultural determinants of high fertility in Western Africa are so important that using an economic cost-benefit analysis framework is inappropriate. Others claim that economic incentives such as a predominantly agricultural society, where children are used for labor, can be considered important as well.

SOMARC

Government support for family planning in Ghana dates back to 1969, when the first family planning program was initiated. The current population policies address such issues as the empowerment of women, transmission of sexually transmitted infections (STIs) and HIV, child survival, and male involvement in these programs.⁶ One dimension of the government's family planning program is the CSM program. Private sector distribution of contraceptives is rare in Ghana, almost all contraceptives are distributed through the Ministry of Health (MOH), the Planned Parenthood Association of Ghana (PPAG) and GSMF, which implements the CSM. In 1995, GSMF was the largest distributor of VFTs, followed by the MOH and PPAG. These three entities accounted for all VFT sales.⁷

⁴ Population Council, 1995

⁵ For Africa references, see Caldwell and Caldwell, 1987a, Caldwell and Caldwell, 1987b, Mbacke, 1994, Sonko, 1994. For references specific to Ghana, see Ezeh, 1993, Oheneba-Sakyi et al., 1995, Ezeh, 1991, Kanna, 1993.

⁶ Okwabi, 1995

⁷ Research International and Family Health International, 1997

The initial CSM program began in 1987 with three products "Panther," a condom, "Norminest," a low-dose oral, and "Kamal," a VFT. This product line has expanded so that it currently includes three brands of condoms, the Depo-Provera injectable, the CuT380A IUD, the "Secure" brand of oral (also low-dose), and the "Kamal" VFT.

Since 1987, VFTs have been an integral part of Ghana's various CSM projects. The strategy behind including VFTs consisted of trying to appeal to the young consumer who did not have intercourse frequently, and so did not want to commit to other methods. Although the efficacy rate is low, the Ghanaian government agreed to their inclusion as part of the CSM program, and supported the advertising of the product. VFTs were cheap, easily accessible and had no side effects. They represented a viable alternative to condoms, which were not popular at that time. The product was marketed successfully to both females and males. A large secondary market of mature females also developed, partly as they were first-time users themselves, and partly as they suffered from pelvic inflammatory disease and other related problems, which VFTs can help address. Finally, GSMF established a brand image that appealed to both the young and the mature.⁸

Unit sales of VFTs have grown at double-digit rates since 1987, with the exception of 1994 and 1996 (see Table 1). During the first three years of the program, VFTs accounted for about 10 percent of total CYPs sold by the Ghana CSM. Beginning in 1990, the share of CYPs held by VFTs jumped to 19 percent, and then continued to grow until 1996. Since SOMARC III began in 1993, sales have been fairly static. This reflects a decline of 16 percent in 1996, since that time, the level of sales has recovered to approximately the same level as 1995, and accounts for about 19 percent of total CYPs sold by GSMF.

Table 1
GSMF Sales of VFTs in Ghana

Year	Sales	CYPs	% change	% of CYPs
1987	544,224	5,183		10
1988	614,498	5,852	13	9
1989	725,784	6,912	18	10
1990	1,602,200	15,259	121	19
1991	1,909,400	18,185	19	21
1992	2,190,392	20,861	15	24
1993	2,580,776	24,579	18	26
1994	2,439,000	23,229	(5)	22
1995	2,774,860	26,427	14	22
1996	2,334,250	22,231	(16)	16
1997	2,716,350	27,164	22	18

⁸ Levy, 1997

Note that the pattern of sales in terms of total VFT market share is somewhat different. A recent report contains sales figures for selected years for the total VFT market in Ghana (see Table 2). According to total sales figures provided by the U.S. Agency for International Development (USAID), the market share of Kamal tablets rose from 44 percent in 1988 to 71 percent in 1993. This share, however, dropped back to about 44 percent in 1995. Given the overall growth in Kamal sales between 1993 and 1995, this implies that the growth of the total VFT market in Ghana was quite high in 1994 and 1995.⁹

Table 2
Total VFT Sales and Kamal Market Share

Year	Total Sales	Kamal Sales	Kamal Market Share
1988	1,382,269	614,498	44.4 %
1993	3,645,314	2,580,776	70.8 %
1995	n/a	2,774,860	44.0 %*

*This Kamal market share percentage was supplied for 1995 in this report, although total sales were not provided.

Product

The VFT is a tablet containing spermicide that is inserted into the vagina about 10 minutes prior to intercourse. The spermicide then kills the sperm or prevents the sperm from moving to the egg. Estimates of failure rates range from 6 percent if used perfectly, to approximately 20 percent in actual use. Note that this failure rate is comparable to the failure rates of both periodic abstinence and withdrawal, other modern methods have failure rates ranging from less than 1 percent for perfect use, to between 1 and 3 percent in actual use.¹⁰

There are many advantages to the use of VFTs: ease of use, no prescription necessary, freedom from systemic side effects, can be used intermittently, as needed, helps protect against STIs, possibly including HIV/AIDS¹¹, is female-controlled, and serves as a lubricant. The disadvantages include possible irritation or feeling of heat to either woman or partner, possible messiness, may interrupt sex, due to the waiting period, and, most importantly, the lack of efficacy in preventing pregnancy.¹²

⁹ Research International and Family Health International, 1997

¹⁰ Hatcher et al, 1994; Stover et al, 1997. The other modern methods include orals, IUDs, injections, implants and sterilization.

¹¹ Recent evidence (Mackay 1998) suggests that VFTs may not be an anti-virulent.

¹² Hatcher et al, 1994; INTRAH, 1993; Hatcher et al, 1997

In addition to these benefits, certain cultural characteristics of Ghana may increase the perceived benefits of VFTs. VFTs can be used during lactation, in Ghana, this is a distinct advantage, as breastfeeding is quite popular and is of long duration. In 1993, 97 percent of children born during the previous three years had been breastfed, for an average of 22 months¹³. Since patterns of postpartum abstinence have changed significantly, where the average abstinence period has dropped to six months (except for one ethnic group, the Mole-Dagbani)¹⁴, it is important to supplement breastfeeding with some kind of modern contraceptive.

Another characteristic of the contraception culture in Ghana is that it is widely believed that there are significant negative side effects for other contraceptive methods, and for hormonals in particular. There is a belief that the amenorrhea associated with oral contraceptives is a precursor of sterility, an important concern for Ghanaians¹⁵. Some believe that condoms can break and remain inside the vagina, causing concern on the part of both males and females¹⁶. In fact, the negative perception of modern contraceptive methods is so strong that some have abortions rather than use contraceptives¹⁷. The VFT presents an easy-to-use choice with almost no side effects—valuable characteristics in Ghana.

Another advantage of VFTs in Ghana is that they are a female-dependent barrier method, as compared to condoms. A great deal of evidence exists that males have a decisive role in decision-making in Ghana about a variety of issues, family planning is just one of these many issues. Since VFTs are controlled by women, and experienced by women, this circumvents some objections men could make about contraceptives¹⁸.

VFTs are also easy to use, and require very little training and knowledge prior to use. This is important in a low-prevalence society such as Ghana, where actual experience with contraceptives and general knowledge about specific facts are low. As an example, in the 1993 GDHS, of those who had ever used rhythm, only 55 percent could actually identify their fertile period¹⁹. In order to use VFTs, information needs are minimal.

One final advantage of VFTs in Ghana is that the foil packaging utilized by VFTs holds up well in the tropical climate. Latex condoms degrade in the heat, and so their shelf life is limited, as is the length of time they can be used after purchase. Unless the turnover in sales is high enough, significant quality-control measures are needed in distribution outlets²⁰.

¹³ Tawiah, 1997, p. 143

¹⁴ Benefo et al., 1994

¹⁵ Adjei and Adansi, 1989, Banful, 1997, various focus group/trip reports

¹⁶ Various focus group/trip reports

¹⁷ Anonymous, 1994

¹⁸ Ezech, 1993, Doodoo, 1995, Salway, 1994

¹⁹ Anonymous, 1994

²⁰ Miller, 1993

In summary, VFTs present an easy-to-use contraceptive choice for Ghanaians, with few side effects, low information needs, minimal storage requirements and breastfeeding compatibility. Although the low efficacy of this method should be a major concern, the perceived benefits appear to outweigh this cost for users at this time. Here, the product offered satisfies the needs of this customer base of new contraceptive users.

Price

The Kamal VFT is priced very competitively (see Table 3). The current price for a package of 12 tablets is 400 cedis, while the retail price for the major competitor, Neosampoon, is 1,000 cedis for 20 tablets, on average. Thus, the average price for one Kamal tablet is 33.3 cedis, and 50 for one Neosampoon tablet. This translates into 3,500 cedis for one CYP for Kamal, using a conversion factor of 105 tablets per year. Note that, because of the difference in the size of the packages, although more packages of Kamal tablets are sold, the actual unit sales of Neosampoon tablets are higher, due to the greater number of tablets in the package. Together, these two brands account for over 95 percent of the total VFT market.²¹

Table 3
Comparison of Contraceptive Prices
(cedis)

	Price per Package (n)	Price per Unit	Price per CYP*
VFTs			
Kamal	400 (12)	33.3	3500
Neosampoon	1000 (20)	50	5250
Condoms			
lower-priced		20-25	2600
Protector (higher-priced)		45	4725
Orals			
MOH outlets	15/cycle		210
GSMF/PPAG	120-150/cycle		2100

* Conversion factors are 105 for VFTs and condoms, and 14 for orals.

The Kamal VFT is also competitively priced in comparison with other contraceptive method choices. The average price for a lower-priced condom, distributed either through

²¹ Research International and Family Health International, 1997

GSMF, commercial sources or PPAG, is between 20 and 25 cedis per condom. A representative price for a higher-priced condom, such as Protector, which is distributed by GSMF, is about 45 cedis per unit. Thus, one CYP using lower-priced condoms and an average use of 105 condoms per year²² results in a total cost of about 2,600 cedis per CYP. Prices of oral contraceptives vary substantially by source, commercial, GSMF and PPAG sources all cost between 120-150 cedis per cycle, while MOH outlets have an average price of 15 cedis per cycle. Using the higher-priced distribution outlets results in an average cost per CYP of 2,100 cedis to the consumer, while using the MOH outlet results in an average total cost of 210 cedis²³. Thus, the VFT compares favorably along the price dimension for a choice between the methods of VFTs, condoms and oral contraceptives.

Placement

Currently in Ghana, almost all VFTs sold by GSMF are sold through pharmacies and chemists' shops, all of which are commercial outlets. Pharmacies are concentrated mainly in urban areas, and pharmacists are trained to dispense contraceptives and advise potential users. Although chemists cannot legally sell the pill, some specially trained chemists are able to do so, along with other, over-the-counter products. Chemists' shops are important particularly in rural areas, where hospitals, clinics, pharmacies or family planning centers are not available²⁴. GSMF has been very successful in persuading consumers to utilize the commercial marketing outlets, between 1993 and 1995, the percentage of customers using commercial outlets to buy condoms, pills or VFTs rose from 50 percent to 72 percent of users²⁵.

A very small fraction of VFTs from GSMF are distributed by the Ghana Registered Midwives Association, the midwives, however, concentrate on distributing oral contraceptives and IUDs²⁶. Between 1990 and 1992, another innovative distribution outlet accounted for as much as 40 percent of VFT sales for GSMF—the market women program²⁷. In this program, stalls in various market centers were staffed by women selling VFTs and condoms on a consignment basis²⁸. Although this program was discontinued prior to the beginning of SOMARC III, some lessons will be drawn below resulting from the existence of this network. Some distribution through community-based distribution (CBD) outlets was attempted, but of the 17 organizations that began selling the VFTs, there are only three or four left in operation, mostly selling condoms.

²² Stover et al., 1997

²³ Recall that these are out-of-pocket expenses only, total cost to the consumer will include transportation time and waiting time, both of which are substantially higher at MOH clinics

²⁴ Banful, 1997

²⁵ The Futures Group International, 1995

²⁶ Banful, 1997, Population Reference Bureau, 1994, Turner, 1992

²⁷ Tipping, 1993

²⁸ Consignment sales are when goods are turned over to an agent for sale without the agent paying an initial amount for the goods. It is understood that payment to the distributor will occur after the sale of the product

The difficulty with both the market women and the CBD programs was that the product was sold on a consignment basis, and the money was not paid back to the wholesaler ²⁹ The majority of the VFT product is distributed now in pharmacies and chemical shops

Promotion

Promotional interventions include advertising, public relations activities, point-of-sale materials, contests and coupons GSMF has been extremely active in advertising VFTs The annual advertising budget for all products is approximately half of the overall budget, or about US\$490,000 for 1996 These expenditures are split evenly among brands, implying that condoms as a method receive more advertising expenditures, as there are three brands of condoms sold by GSMF, and only one brand each of orals, injectables, IUDs and VFTs GSMF is the only organization that advertises VFTs to any degree, both PPAG and MOH do very little, if any, advertising Advertisements are placed on television, radio, outdoor posters, billboards and point-of-sale materials Both urban and rural areas are covered, although more advertising takes place in urban areas ³⁰

Initial advertising campaigns in the late 1980s targeted young people as first-time users of contraceptives, and thus potential candidates for VFTs, viewed as a first step in contraceptive use Note that the Kamal VFT has always been referred to in advertisements as Kamal contraceptive foaming tablets ³¹ In late 1993, the packaging and advertisements were changed, with an even stronger focus on young people This campaign showed students in a university, and love between young people The campaign “raised a furor” in Ghanaian society, as it was interpreted as encouraging premarital sex, and people did not approve of this ³²

The advertisements were changed to reflect various lifestyle types The tag line for the VFT ads is, “Enjoy the Fullness of Life” The advertisements show young people in different settings, such as boating, diving and swimming VFTs are assumed to be used by the young, as they enter the contraceptive market, and as such the messages are targeted to them The radio spot that is used is very general, and simply mentions VFTs as a way to avoid unintended pregnancy

The VFT campaign is similar to the campaigns used currently for other methods, which also strive to portray certain lifestyles, and are linked through the GSMF name Other advertisements include a young couple shown on a candlelight boat cruise, and a married couple enjoying a wedding anniversary One important aspect of each of these “lifestyle-type” advertisements is that they are targeted at couples as a unit—although not

²⁹ Banful, 1997

³⁰ Banful, 1997

³¹ The name may have been changed in deference to societal concerns about modesty issues But, as one reader pointed out, even if there was not a problem in using the word “vaginal” in a sensitive society such as Ghana, if he had to promote VFTs, the first thing he would do is change the name so that potential consumers actually know what they are for, rather than where they go.

³² Banful, 1997, Levy, 1997

necessarily married couples. That is, men have been included in the advertisements. For example, in the ad for oral contraceptives, a man comes in to reassure his wife regarding the side effects of orals. This is also the pattern in the current injectables advertisement.

Although there was a dip in sales of the Kamal tablets in 1996, 1997 sales have returned to previous levels. The packaging for the product was changed in early 1997, this may have contributed to the sales recovery observed³³. The packaging prior to 1997 was a rather plain, black-and-white picture of a couple imposed on a green background, with the title, "Kamal Contraceptive Foaming Tablets" printed across the package. The new packaging was a full-color picture of red roses and baby's breath flowers, with the same title printed on the lower part of the package, yet with the tag line, "Enjoy the Fullness of Life" printed on the upper right-hand corner of the package in bright yellow. The second package is clearly more attractive and appealing.

Further promotional activities included training the market women sellers of VFTs and condoms between 1990 and 1992. Although this was an existing program for about two years prior to GSMF's involvement, GSMF then took over the monitoring and training portions of the project at the request of USAID/Ghana. This can be viewed as a form of field promotional activity.

III LESSONS LEARNED

1 In countries where modern contraceptive prevalence is low, VFTs may serve as a hook into modern contraceptive use

In a country where the modern contraceptive prevalence rate is very low, as in Ghana, a method such as the VFT can attract first-time users who are concerned about possible side effects of other, more effective methods. As discussed above, a great deal of evidence suggests that much mistrust is present in Ghanaian society regarding other contraceptive methods, particularly hormonals. In fact, the perceptions of negative side effects from hormonals are so deeply embedded in the society that they formed part of the initial advertising campaigns for Kamal tablets, and are in the training manuals for providers. The initial poster for Kamal tablets in 1987 reads, "When You Don't Need Pregnancy Prevention All The Time, Or Cannot Use 'THE PILL' Choose Kamal." The GSMF Training Manual contains many precautions against the use of oral contraceptives, and in the instructions for physicians singles out the pill as a contraceptive that could cause complications. At the same time this manual was produced, an entire poster was developed and distributed listing possible side effects of oral contraceptives³⁴.

Given these biases, and the biases against condoms discussed above, VFTs seem to present a contraceptive choice for Ghanaians that they feel comfortable with, particularly first-time users. Note that the current age distribution of VFT users is fairly uniform.

³³ Banful, 1997

³⁴ GSMF Training Manual, 1986. Early Kamal poster, 1987

across age groups, rather than being concentrated in the younger cohort, as one might expect for first-time users³⁵ This may reflect the fact that, because the modern contraceptive prevalence rate is so low in Ghana, first-time users are distributed across all age segments of the population It may also reflect the fact that innovators are also spread across age groups Initially, social marketing efforts were targeted at young people as first-time users The market women program, however, seemed to reach a different segment of the population, note how VFT sales jumped in 1990, the year the program began The new customers were probably older—out doing their marketing, and stopping by the market women’s stalls on the way Given the low modern contraceptive prevalence rate in Ghana, which in 1990 was about 7 percent, these older women were most likely first-time users as well The distribution of use across all age groups actually confirms the hypothesis that VFTs are a choice for first-time users, because of the low prevalence rate

As prevalence rates increase, the pattern of VFT use may change Evidence of this can be seen in two recent surveys performed by the Ghana FPHP, a baseline survey in 1993, and a tracking survey in 1995 In these surveys, although total modern contraceptive use had increased for orals, injectables, IUDs and sterilization, total VFT use had remained constant at about 2 percent of the population It appears that some of the first-time users had moved on to other, more effective methods, although some of the increase in more effective methods may come from first-time users, as well One hypothesis is that, once a modern contraceptive method has been experienced with few ramifications, the user may be encouraged to try another, more effective method Further research is needed to test this hypothesis, current data sets are not large or detailed enough to address this issue

In summary, as long as modern contraceptive prevalence rates remain low in Ghana, VFTs may be a viable contraceptive option for first-time users of all ages Particularly given the fears of side effects of other contraceptive methods, which may be present in other low-prevalence societies as well, VFTs may present initial users with a good method choice, because of the lack of side effects This speaks to both the “Trial” and the “Consistent Use” phases of the behavior-change model, the user becomes comfortable with trying contraceptives in the form of the VFT, due to its lack of side effects, and is encouraged to use it consistently In addition to this, she becomes interested in trying another, more effective method, if her experience is as favorable, then she may move on to be a consistent user of this method, as well

2 Broadening the method mix by allowing VFTs as a choice, along with continued support by the government, contributes to its success

Many governments are not interested in pursuing the VFT as one of the methods to be offered in the set of contraceptive choices, primarily due to its relatively high failure rate

³⁵ Ghana Statistical Service and Macro International Inc , 1994, Research International and Family Health International, 1997

One of the possible reasons for success of VFTs in Ghana is simply that the government allowed and supported the tablet as a contraceptive method³⁶

There are a few reasons why this support may have a strong effect in Ghana, and possibly other countries as well. First, programmatic effort is important. When the central authority recognizes the legitimacy and viability of a modern technology, the citizens are encouraged to try the new technique. Part of this encouragement is due to the efforts of a central government as guardian, that is, ensuring that certain standards are met prior to allowing the sale of various products, and for medicines in particular. Their endorsement in many countries provides a guarantee to consumers of a certain quality. The other part of this encouragement effect may be that, as discussed by Caldwell and others, the sponsorship of family planning by the government represents approval by an authority figure that is vital in encouraging contraceptive use³⁷. This is particularly important at the first stage of behavior change—"Awareness"—where sponsorship of the new behavior by various public agencies and figures can have an effect on the perceptions of potential users.

A second reason why government support may have contributed to the success of the VFT is that, simply by allowing it to be offered, the method mix was broadened. Research indicates that people use different contraceptives at different times for different reasons³⁸. One paper shows that, simply by increasing the number of contraceptive choices, prevalence rates in one area in India were 25 percentage points higher than in other areas—60 percent vs. 35 percent. Although some of the difference may be due to the fact that the area with the greater number of choices is urban, some of the effect is due to increased choice³⁹. Thus, part of the VFT's success may be because the government increased the number of contraceptive choices by allowing VFTs to be part of the method mix in Ghana.

3 The gap between awareness and use in Ghana does not appear to be due to price issues. Ghanaian consumers are willing to pay current prices for their contraceptives, including VFTs

Although clearly there is a gap between knowledge and use of contraceptives in Ghana, as discussed above, the gap does not appear to exist due to issues of affordability. The gap between awareness and use is well-documented in both DHS surveys, as well as both surveys performed through GSMF. A fifth survey, the Ghana Female Autonomy Micro Study (GFAMS), administered in 1992/93, observed the same gap⁴⁰.

Yet in none of the surveys was cost given as the reason for not using a contraceptive or for discontinuation of use. In the 1993 DHS, only 0.3 percent of married women gave

³⁶ Levy, 1997

³⁷ Caldwell, 1992, Sinding, 1991

³⁸ Cochrane and Guilkey, 1995

³⁹ Bhende et al., 1991

⁴⁰ Oheneba-Sakyi et al., 1995

cost as their reason for not using contraception⁴¹ In the 1992/93 GFAMS, less than 1 percent of men gave as their reason for discontinuation, "Costs too much," while no women gave this as their reason⁴²

Further evidence of the lack of concern about prices can be found in the 1993 and 1995 surveys sponsored by the Ghana FPHP The majority of women obtained pills, condoms or VFTs from retail outlets in 1993, while only 32 percent obtained supplies from either PPAG clinics or MOH clinics and hospitals Only two years later, the percentage of women using the public health clinics as a source of supply dropped in half, to only 16 percent, while most of these users seemed to switch to private retail sources Pharmacies and chemical shops alone account for 72 percent of total supplies of pills, condoms or VFTs

4 The advantages of VFTs may outweigh their main disadvantage (low efficacy) in countries with low modern contraceptive prevalence and high levels of distrust of modern methods

In addition to its general effect in increasing the number of contraceptive choices, it may be that it is important to offer VFTs in particular as one of the contraceptive choices As discussed in the background section on VFT as a product, there are certain advantages to using VFTs in general, and in Ghana in particular Of course, the main disadvantage is the lack of efficacy in actual use Advantages include foil packaging, which is important in a tropical climate such as Ghana, the ability to use the tablets while breastfeeding, again an important consideration in Ghana, where breastfeeding is almost universal for a substantial amount of time, impeding the spread of STIs, including HIV/AIDS, and the lack of side effects, which matters in Ghana because of the widespread concerns about negative side effects of hormonals

Because VFTs are used by females, simply making them available in this culture may be quite effective In a male-dominated society, where males are reluctant to use condoms and can choose to use another method such as VFTs, the tablets may become a viable alternative to condoms This effect may be relevant to other countries where males are heavily involved in the decision-making process about contraceptive use

IV DISCUSSION

Although contraceptive prevalence is increasing in Ghana, it is still far from the levels needed to reach replacement fertility Knowledge of modern contraceptives is nearly universal, yet moving from knowledge to use appears to be problematic Some of the underlying reasons behind this are cultural and religious beliefs regarding high fertility, perceptions about negative side effects of certain modern contraceptives, hormonals in

⁴¹ GSS and DHS, 1994, p 48

⁴² Oheneba-Sakyi, 1995, p 103

particular, and levels of certain economic factors, such as high child mortality and low female education rates

VFTs have enjoyed an enormous success in Ghana, relative to other countries. This paper has explored the possible reasons for this success, including effective first-time user choice, innovative distribution channels, mass media promotion, government support, and actual characteristics of VFTs, including the fact that it is a female-controlled method. While modern contraceptive prevalence rates remain relatively low in Ghana, VFTs will probably remain popular as a viable alternative for first-time users there.

Given the low efficacy of this method, however, promotion efforts should concentrate on encouraging a switch to more efficacious methods. An increased focus of mass media and other programmatic efforts on men may be an effective strategy to achieve this goal, as well as providing more training for providers. Ghana appears to be in the early stages of behavior change at this point in time, where mass media efforts are still of paramount importance. Yet as more of the population begins to move to the "trial" stage of behavior change, interpersonal communication approaches will become even more important than they are today.

BIBLIOGRAPHY

- Adjei, S and P G Adansi 1989 Biomedical issues in family planning in Africa In *Developments in Family Planning Policies and Programmes in Africa* University of Ghana, Legon, Ghana
- Anonymous 1994 Misperceptions about contraceptives keep abortion incidence high in Ghana *Progress in Human Reproduction Research* 29 3
- Banful, A 1997 Conversations with director of GSMF, October, 1997
- Benefo, K D and T P Schultz 1994 Fertility and Child Mortality in Cote d'Ivoire and Ghana LSMS Working Paper No 103 Washington DC The World Bank
- Benefo, K D , A O Tsui, and J D Johnson 1994 Ethnic differentials in child-spacing ideals and practices in Ghana *Journal of Biosocial Science* 26(3) 311-26
- Bhende, A A , M K Choe, J R Rele, J A Palmore 1991 Determinants of contraceptive method choice in an industrial city of India *Asia-Pacific Population Journal* 6(3) 41-66
- Caldwell, J C and P Caldwell 1987a The limitation of family size in Ibadan City, Nigeria An explanation of its comparative rarity derived from in-depth interviews In van de Walle, E , ed , *The Cultural Roots of African Fertility Regimes* Proceedings of the Ife Conference, Department of Demography and Social Statistics, Obafemi Awolowo University, Ile-Ife, Nigeria, and Population Studies Center, University of Pennsylvania
- Caldwell, J C and P Caldwell 1987b The cultural context of high fertility in sub-Saharan Africa *Population and Development Review* 13(3) 409-438
- Caldwell, J C , I O Orubuloye, and P Caldwell 1992 A new type of fertility transition in Africa *Population and Development Review* 18(2) 211-242
- Cochrane, S H and D K Guilkey 1995 The Effects of Fertility Intentions and Access to Services on Contraceptive Use in Tunisia *Economic Development and Cultural Change* 1995 779-804
- Dodoo, F N -A 1995 Contraceptive Behavior in Ghana A Two-Sex Model *International Journal of the Family* 25(1) 43-61
- Ezeh, A C 1991 "Gender differences in reproductive orientation in Ghana A new approach to understanding fertility and family planning issues in sub-Saharan Africa" *Demographic and Health Surveys World Conference Proceedings Vol 1* Columbia MD IRD/Macro International Pp 291-320
- Ezeh, A C 1993 "The Influence of Spouses Over Each Other's Contraceptive Attitudes in Ghana" *Studies in Family Planning* 24, 3 163-174
- Futures Group 1995 Results of 1995 Tracking Survey Ghana Family Planning and Health Project Futures Group Washington DC
- Ghana Statistical Survey 1994 A Situation Analysis of Family Planning Service Delivery Points in Ghana Ghana Statistical Service Accra
- Ghana Statistical Service and Macro International Inc 1988 Ghana Demographic and Health Survey

- Macro International Calverton, MD December 1989
- Ghana Statistical Service and Macro International Inc 1993 Ghana Demographic and Health Survey
Macro International Calverton, MD December 1994
- Hatcher, R A , J Trussell, F Stewart, G K Stewart, D Kowal, F Guest, W Cates Jr , and M S Policar
1994 Contraceptive Technology, 16th edition Irvington Publishers, Inc New York, NY
- Hatcher R A , W Rinehart, R Blackburn, and JS Geller 1997 The Essentials of Contraceptive
Technology Johns Hopkins School of Public Health Baltimore, MD
- INTRAH 1993 Guidelines for Clinical Procedures in Family Planning A Reference for Trainers, second
edition School of Medicine University of North Carolina, Chapel Hill
- Kannae, L A 1993 The masculine side of family planning male government employees' attitudes and
use of family planning methods in Ghana Doctoral dissertation, University of Akron, Ohio
- Levy, D 1997 Conversation with Don Levy, SOMARC Director, Futures Group Washington DC
- Mackay, B 1998 Personal communication
- Mbacke, C 1994 Family planning programs and fertility transition in Sub-Saharan Africa Population and
Development Review 20(1) 188-93
- Miller, Susan Katz 1993 'How to sell safer sex " New Scientist 27 February 1993 12-13
Condoms/AIDS in Africa
- Okwabi, A 1995 Ghana healthy beginnings West Africa (4064) 1362-63
- Oheneba-Sakyi, Y 1992 Determinants of Current Contraceptive Use Among Ghanaian Women at the
Highest Risk of Pregnancy Journal of Biosocial Science 24 463-475
- Oheneba-Sakyi, Y , K Awusabo-Asare, E Gbortsu, and A F Aryee 1995 Female Autonomy, Decision
Making and Demographic Behavior Among Couples in Ghana State University of New York Potsdam
Potsdam, NY and Regional Institute for Population Studies, University of Ghana Accra, Ghana
- Population Council 1995 Ghana 1993 Results from the Demographic and Health Survey Studies in
Family Planning 26(4) 245-249
- Population Council 1995b Gender inequalities and demographic behavior Population Briefs 1(1) 6
- Population Council 1997 Personal communication
- Population Reference Bureau 1994 Ghana The Registered Midwives Association Family Planning
Services Project Washington, DC PRB
- Research International and Family Health International 1997 Ghana Vaginal Foaming Tablet User
Dynamic Study FHI Research Triangle Park, North Carolina February 1997 ***
- Salway, S 1994 How Attitudes Toward Family Planning and Discussion Between Wives and Husbands
Affect Contraceptive Use in Ghana International Family Planning Perspectives 20(2) 44-47&74
- Sinding, S 1991 "The demographic transition in Kenya A portent for Africa?" Distinguished Lecture
Series on International Health, School of Public Health University of North Carolina, Chapel Hill

February 28

Sonko, S 1994 Fertility and culture in Sub-Saharan Africa a review International Social Science Journal 46(3) 397-411

Stover, J and L Heaton 1997 The Costs of Contraceptive Social Marketing Programs Implemented Through the SOMARC Project The Futures Group, International Draft

Stover, J, J T Bertrand, S Smith, N Rutenberg, and K Meyer-Ramirez 1997 Empirically Based Conversion Factors for Calculating Couple-Years of Protection Carolina Population Center University of North Carolina at Chapel Hill

Tawiah, E O 1997 Factors Affecting Contraceptive Use in Ghana Journal of Biosocial Science 29 141-149

Tipping, S 1993 Alternative Distribution Systems for Contraceptive Social Marketing Projects Special Study #2 Futures Group Washington DC August 1993

Turner, R 1992 Ghanaian midwives have new family planning role International Family Planning Perspectives 18(2) 71-2