A Decade of Unmet Need for Contraception in Ghana:

Programmatic and Policy Implications

Pav Govindasamy and Emmanuel Boadi

Macro International Inc.
Calverton, Maryland USA

National Population Council Secretariat
Accra, Ghana

August 2000

This report presents findings from one of two further analysis projects undertaken as part of the follow-up to the Ghana Demographic and Health Surveys (GDHS). Macro International Inc. coordinated the project and provided technical assistance. Funding was provided by the U.S. Agency for International Development (USAID) through its mission in Ghana.

The GDHS further analysis project is part of the MEASURE *DHS+* programme designed to collect, analyse, and disseminate data on fertility, family planning, and maternal and child health. Additional information about the MEASURE *DHS+* programme may be obtained by writing to MEASURE *DHS+*, Macro International Inc., 11785 Beltsville Drive, Calverton, MD 20705 (Telephone 301-572-0200; Fax 301-572-0999).

Acknowledgements:

The authors thank Charles F. Westoff for his review of this paper, Ann Blanc for comments on an earlier draft, Noureddine Abderrahim for data processing help, and Arlinda Zhuzhuni for research and bibliographic assistance.

Recommended citation:

Govindasamy, Pav, and Emmanuel Boadi. 2000. *A decade of unmet need for contraception in Ghana: Programmatic and policy implications.* Calverton, Maryland: Macro International Inc. and National Population Council Secretariat [Ghana].

1 Introduction

Unmet need arises from a discrepancy between women's stated fertility preferences and their contraceptive behaviour. The existence of unmet need was first documented in developing countries in the late sixties after the collection of data on women's knowledge, attitudes and practices (KAP) of contraception, and their reproductive intentions (Westoff and Pebley, 1981). When unmet need was first defined, women who stated that they wanted to stop bearing children but were not using contraception were simply identified as having an unmet need for contraception. During the past three decades, however, this measure has become increasingly sophisticated.

Unmet need is a powerful concept for designing family planning programmes and has important implications for future population growth. The magnitude of unmet need and information on the characteristics of the unmet need population provide a more comprehensive measure of the expanded future demand for contraception (Ross, 1994). Unmet need also allows the estimation of the impact on fertility if this additional demand is met (Sinding et al., 1994).

Today, more than 100 million married women throughout the developing world are estimated to have an unmet need for contraception (Robey et al., 1996; Bhushan, 1997). Robey et al. (1996) estimate that the level of unmet need is highest in sub-Saharan Africa, ranging from 15 percent in Zimbabwe to 32 percent in Rwanda. Their findings show that in most of these countries, more married women have unmet need than use contraceptives.

This study focuses on unmet need in Ghana over a decade, using information gathered in the Ghana Demographic and Health Surveys (GDHS) conducted in 1988, 1993, and 1998. Although use of contraception increased noticeably between 1988 and 1993 (from 13 percent to 20 percent), use of family planning increased by only 2 percentage points between 1993 and 1998 (Table 1 and Figure 1). Total unmet need also changed little between 1988 and 1998, with one in three women expressing a need for contraception. However, during this decade, there was a shift from a need for spacing toward a need for limiting. The unmet need for limiting increased in the first half of the decade (from 8 percent to 12 percent) and remained unchanged in the second half, whereas the unmet need for spacing did not change much in the first half of the decade but declined by 14 percent in the second half. Nevertheless, the potential demand for spacing far exceeds the demand for limiting—by two and a half times in 1988 and one and a half times in 1993 and in 1998. The total demand for family planning increased by nearly 29 percent between 1988 and 1993 but declined by 3 percent between 1993 and 1998. During the same period, the demand satisfied increased by 22 percent in the first five-year period, but by only 12 percent in the second. Even more striking is the fact that programmes in 1988 were not meeting the contraceptive needs of 7 in 10 women, and ten years later, they were still not meeting the needs of 6 in 10 women. While the statistical relationship between unmet need, levels of abortion, and contraceptive prevalence is unclear, the fact that nearly one in four Ghanaian women age 15-19 has experienced early pregnancy losses may indicate that young women are resorting to other means of controlling unwanted pregnancies (GSS and MI, 1999).

This analysis focuses on a decade of change in Ghanaian women's need for family planning and addresses several questions:

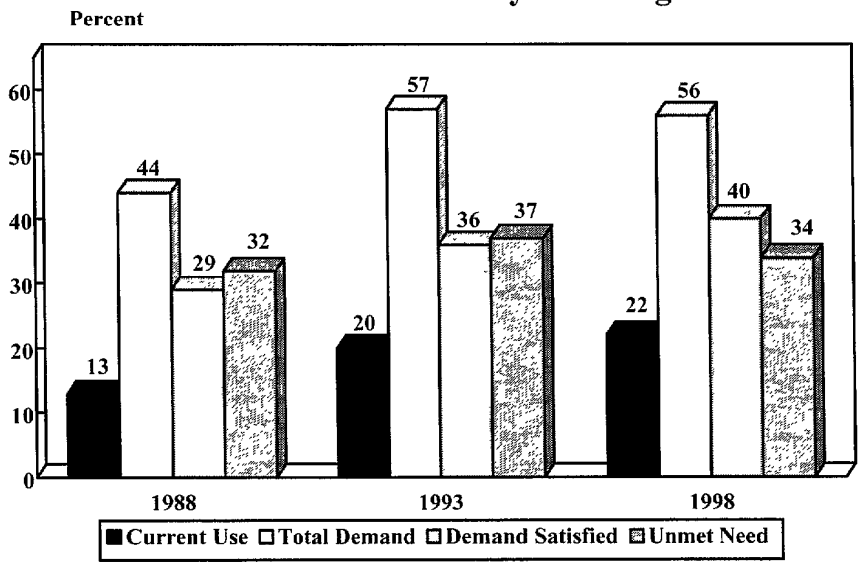
- How much of this need is real and not an artefact of definitional differences in the measurement of unmet need over the decade?
- Who are these women and how are they distinct from women who do not have a need for family planning?
- Why do women have an unmet need for contraception and why are programmes not meeting the needs of most of these women?
- How can programmes better address women's contraceptive needs?

Table 1 Demand for family planning, 1988-1998

	1988[a]	1993[b]	1998[c]
Unmet need			
Spacing	24.0	25.2	21.7
Limiting	7.5	11.5	11.8
Total	31.6	36.8	33.5
Current use			
Spacing	8.0	10.5	12.3
Limiting	4.9	9.7	9.7
Total	12.9	20.3	22.0
Demand for contraception			
Spacing	32.0	35.8	34.0
Limiting	12.4	21.3	21.5
Total	44.4	57.1	55.5
Percentage of demand satisfied			
Spacing	25.0	29.3	36.2
Limiting	39.5	45.5	45.1
Total	29.0	35.5	39.6

[a] Recalculated using the 1998 GDHS definition, subject to some data limitations;
[b] Recalculated using the 1998 GDHS definition
[c] GSS and MI, 1999: Table 6.5 revised.

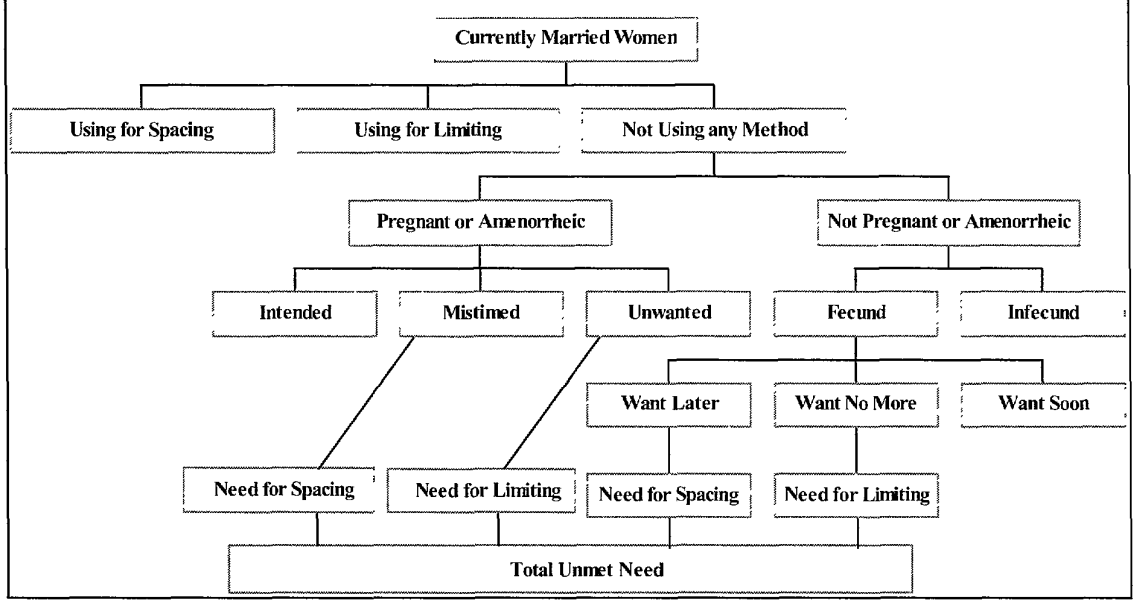
Figure 1 Percentage of Currently Married Women with Demand for Family Planning



2 Defining Unmet Need

A diagrammatic representation of the derivation of unmet need as it is widely understood is presented in Figure 2. Of interest are women who are currently not using contraception. These women are divided into those who are pregnant or amenorrhoeic and those who are neither. This latter group is further divided into fecund and infecund women. Infecund women are assumed to have no need for contraception. Fecund non-users, whether pregnant, amenorrhoeic, or neither, are then separated by their reproductive intentions as follows: having no unmet need if they have or recently had an intended pregnancy or want to have a birth in less than two years; having a need for spacing if they wanted to wait at least two years for the current or recent pregnancy or the next birth; and having a need for limiting if they did not want the current pregnancy or do not want another birth.

Figure 2
Unmet Need for Contraceptives



Definitional differences in identifying the group of women at each level of categorisation have resulted in a myriad of estimates for the same country. In order to evaluate the contraceptive need in Ghana, the extent to which trends in unmet need are an artefact of these definitional differences must be established. Thus, this analysis begins by looking at the way the concept of unmet need has evolved over the decade and how this evolution has affected its estimation. In 1988, women who were currently married or in union, who expressed a desire to space or limit the number of children that they have, but were not using a method of contraception, were deemed to have an unmet need for contraception. According to this broad definition of unmet need, the 1988 GDHS estimated that 66 percent of Ghanaian women were in need of family planning, with 18 percent having a need for limiting and 48 percent having a need for spacing (GSS and IRD, 1989).

In a subsequent study, Westoff and Ochoa (1991) refined the measurement of unmet need. They included in their estimate of unmet need for spacing, pregnant or amenorrhoeic women whose pregnancy was mistimed and fecund non-users who wanted to postpone their next birth for at least two years. Women

with an unmet need for limiting included those with an unwanted pregnancy (or those amenorrhoeic after an unwanted birth) and fecund non-users who wanted no more births. Excluded from the definition of fecund were women who had been in union for at least five years, had never used a method of contraception, and had not had a birth. Also excluded were non-pregnant women who had not menstruated in the previous 12 weeks. According to this estimate, the unmet need for contraception in Ghana in 1988 was recalculated at 35 percent, with 26 percent of women having an unmet need for spacing and 9 percent having an unmet need for limiting. Minor changes and corrections were incorporated in another article by Westoff and Moreno (1991) that puts the unmet need for Ghanaian women in 1988 at 34 percent.

In 1993, after the second GDHS, the estimate of unmet need was further restricted by excluding women who had not menstruated for 6 months or more (up from 12 weeks or more in 1988) from the fecund category. All else remained the same as in the 1991 estimate by Westoff and Moreno (1991). Using this definition, the unmet need in 1993 was estimated at 39 percent, with 26 percent having an unmet need for spacing and 13 percent having an unmet need for limiting (GSS and MI, 1994).

In a subsequent comparative report, Westoff and Bankole (1995) introduced further refinements. The definition of infecundity was expanded to include women who reported that they were not using contraception because they were unable to get pregnant or had reached menopause. For currently pregnant women to be counted as having an unmet need for limiting, they had to report a pregnancy as never wanted *and* they had to want no more children in the future. The authors believed that this change was necessary to determine the family planning status of currently pregnant women, because of ambiguity in the way the question was worded. They noted that there was a significant number of women, especially in sub-Saharan Africa, who reported the pregnancy as not wanted, but who stated that they wanted another child soon or later. The cutoff point for the last menstrual period remained at 6 or more months. According to this definition, the unmet need for Ghana in 1993 was estimated at 33 percent, with 24 percent having a need for spacing and 9 percent having a need for limiting.

This definition was restricted even further in 1998. Women were defined as infecund if they were in a union for at least five years, had not had a birth, and had never used a method of contraception or if they declared themselves infecund or menopausal. This restriction may tend to overestimate infecundity slightly (and thus underestimate unmet need) because it assumes continuous exposure for women who have been married more than once. Using this definition, the unmet need in Ghana from data collected in the 1998 GDHS was estimated at 34 percent, with 22 percent having an unmet need for spacing and 12 percent having an unmet need for limiting.

A similar comparison using the 1988 data and taking into consideration some data restrictions[1] resulted in an estimate of unmet need of 32 percent, with 24 percent of women having a need for spacing and 8 percent having a need for limiting. As expected, a more stringent definition of infecundity excluded more women from the unmet need group and lowered the percentage of women with unmet need in 1988 than was estimated by Westoff and Moreno (1991). Incorporating this change into the 1993 data yields an estimate of unmet need of 37 percent, with 25 percent having a need for spacing and 12 percent having a need for limiting. This level of unmet need represents a slight increase from the Westoff and Bankole (1995) estimate because it excludes more women from the estimate of infecundity.

Nevertheless, it is reasonable to conclude from this exercise that there was little real change in the unmet need for contraception between 1988 and 1998. However, one in three women in Ghana continues to have an unmet need, and this statistic by itself has important programmatic implications. Who are these women, and why have programmes not encouraged more women to use contraception?

---

[1]In 1988, pregnant women were not asked about the preferred timing of that pregnancy. Unmet need was therefore estimated from the timing of the last pregnancy for all women, whether currently pregnant or amenorrhoeic or fecund non-users who were neither pregnant nor amenorrhoeic. In 1993 and 1998, unmet need for pregnant women was based on the intended timing of the current pregnancy, while unmet need for amenorrhoeic women and fecund non-users who were neither pregnant nor amenorrhoeic was based on the intended timing of the last pregnancy.

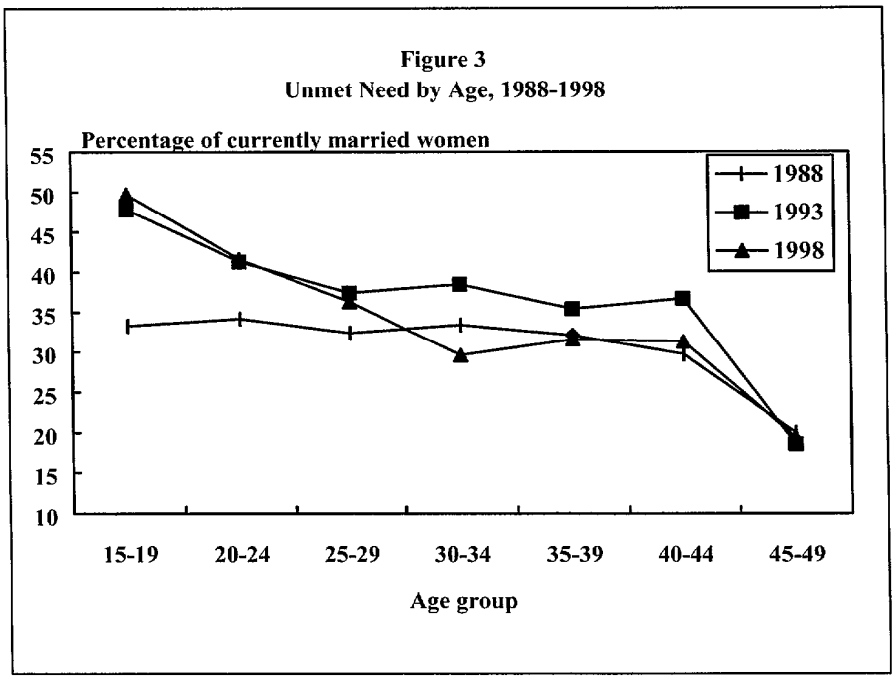
3 Characteristics of Women with Unmet Need

Table 2 shows a breakdown of women with unmet need in 1988, 1993, and 1998 by important background characteristics. In general, the unmet need for spacing declines with age, while the unmet need for limiting increases up to age 44 and then declines. Unmet need is highest among young women age 15-19, with one in two women having a need for family planning, an increase from one in three in 1988, mostly as a result of an increased need for spacing (Figure 3). There was only a small increase (two percentage points) in unmet need among these women between 1993 and 1998. Unmet need is lowest among women age 45-49, the oldest age group included in the surveys. One in five women in this age group has an unmet need for contraception, and this proportion has not changed over the decade.

Table 2 Percentage of currently married women with unmet need for family planning, by background characteristics, 1988-1998

	1988			1993			1998		
Background characteristic	Unmet need for spacing	Unmet need for limiting	Total unmet need	Unmet need for spacing	Unmet need for limiting	Total unmet need	Unmet need for spacing	Unmet need for limiting	Total unmet need
Age									
15-19	33.3	0.0	33.3	46.6	1.2	47.8	47.3	2.4	49.7
20-24	33.4	0.8	34.2	37.6	3.6	41.3	39.3	2.3	41.6
25-29	29.1	3.3	32.4	31.9	5.6	37.4	30.6	5.8	36.3
30-34	26.0	7.4	33.4	24.7	13.8	38.5	17.3	12.3	29.6
35-39	18.8	13.3	32.1	18.3	17.1	35.4	14.1	17.6	31.6
40-44	11.0	18.7	29.7	11.5	25.2	36.7	6.5	24.8	31.3
45-49	4.6	15.4	20.0	3.2	15.4	18.6	1.5	17.8	19.4
Residence									
Urban	21.2	9.2	30.4	20.9	12.8	33.7	16.9	11.5	28.4
Rural	25.3	6.8	32.1	27.3	11.1	38.3	23.9	11.9	35.8
Region									
Western	25.4	5.4	30.8	24.4	9.2	33.6	25.4	12.9	38.3
Central	22.2	6.4	28.6	31.2	11.6	42.9	20.4	16.8	37.2
Greater Accra	18.9	10.3	29.2	17.1	11.2	28.4	17.4	10.6	28.1
Volta	27.0	10.3	37.3	23.5	17.8	41.3	22.4	17.3	39.7
Eastern	24.4	9.6	34.0	25.0	12.9	37.9	21.3	11.4	32.8
Ashanti	25.0	9.8	34.8	29.3	16.3	45.6	20.0	11.6	31.6
Brong Ahafo	28.2	5.5	33.7	29.6	11.1	40.7	25.1	11.3	36.4
Northern	20.4[a]	1.9[a]	22.3[a]	23.7	5.6	29.3	26.6	5.0	31.7
Upper West	U	U	U	21.3	7.4	28.7	22.9	5.6	28.6
Upper East	U	U	U	23.3	4.7	28.0	21.9	6.0	27.9
Education									
No education	21.1	7.9	29.0	25.1	11.6	36.7	22.5	11.7	34.1
Primary	24.2	9.2	33.4	26.6	13.6	40.1	24.4	14.2	38.6
Middle/JSS	28.3	6.2	34.5	27.7	11.6	39.4	22.1	11.3	33.5
Secondary+	18.1	8.3	26.4	11.7	6.7	18.3	10.4	8.8	19.2
Parity									
No children	5.2	0.0	5.2	15.5	0.0	15.5	16.3	0.3	16.5
1-2 children	29.5	0.8	30.4	31.0	3.8	34.8	32.3	3.0	35.3
3-4 children	29.7	3.6	33.3	29.4	9.5	38.9	20.5	11.6	32.1
5+ children	19.1	16.9	36.0	17.9	23.1	41.0	12.7	24.7	37.5
Months since last birth									
No children	5.2	0.0	5.2	15.5	0.0	15.5	16.3	0.3	16.5
0-15 months	32.8	5.2	38.0	33.7	8.6	42.4	34.0	11.5	45.5
16+ months	21.4	9.6	31.0	22.5	14.0	36.5	17.9	13.3	31.2
Intention to use Family planning									
Within 12 months	37.3	20.5	57.8	47.4	24.1	71.5	42.4	23.4	65.8
Sometime in the future	34.9	6.8	41.7	29.2	10.1	39.2	28.9	8.3	37.3
Do not intend to use	16.9	4.1	21.0	13.2	6.2	19.5	10.9	8.1	19.1
Total	24.0	7.5	31.6	25.2	11.5	36.8	21.7	11.8	33.5
Number			3,156			3,204			3,131

[a]In 1988, the Northern, Upper West, and Upper East regions were treated as a single region for the estimation of all indicators.
U = Unknown (not available)



In the past 10 years, while the unmet need in rural areas increased by 12 percent, unmet need in urban areas declined by 7 percent. This discrepancy has contributed to a widening of the gap in unmet need between rural and urban women. In 1988, there was little difference in unmet need between rural and urban women. In 1993, however, unmet need among rural women was 14 percent greater than among urban women, and in 1998, the rural-urban gap nearly doubled to 26 percent. Much of this difference is due to the increasing gap in unmet need for spacing between rural and urban women, which increased from 19 percent in 1988 to 31 percent in 1993 and 41 percent in 1998. On the other hand, the gap in unmet need for limiting between urban and rural women has narrowed. It was two percentage points higher among urban women than among rural women in 1988 and 1993 but has since evened out.

Over the decade, unmet need for contraception increased in the Western, Central, Brong Ahafo, Northern, Upper West, and Upper East regions, decreased in the Eastern and Ashanti regions, and changed little in the Greater Accra and Volta regions. The Central region changed the most over the decade—increasing 30 percent between 1988 and 1998. Surprisingly, the Ashanti region exhibited a 31 percent increase between 1988 and 1993 and a 31 percent decline between 1993 and 1998. In 1998, unmet need was highest in the Volta region and lowest in the Greater Accra and Upper East regions.

In general, women with a primary education have twice the unmet need of women with at least a secondary education, with little difference in unmet need among those with less than a secondary education. In the past 10 years, unmet need increased 18 percent among women with no education and 16 percent among women with a primary education. However, unmet need declined 27 percent among women with at least a secondary education, with little change among women with a middle/JSS education. The increase in unmet need among women with little or no education was primarily due to an increase in the need for limiting.

Unmet need increases with the number of children women have. For example, in 1998, it ranged from 17 percent among women with no children to 38 percent among women with five or more children. As parity increases, the need for spacing declines and the need for limiting rises. Between 1988 and 1998, there was a threefold increase in total unmet need, primarily because of a demand for spacing among women with no children. There was little change in total demand among women with one or more children.

However, over the same period, unmet need for spacing dropped markedly among women with three or more children, and unmet need for limiting rose dramatically among the same group.

Unmet need is markedly higher among women whose last birth was 0-15 months before the survey than it is among women whose last birth was at least 16 months ago. Although unmet need among the former group has increased steadily over the past 10 years, unmet need among the latter group increased between 1988 and 1993 but dropped back to its 1988 level between 1993 and 1998, resulting in little overall increase over the 10-year period. The increase in unmet need among women whose last birth was 0-15 months before the survey was primarily due to an increase in unmet need for limiting. The trend was less clear among women whose last birth was at least 16 months ago, with little change in the unmet need for spacing in the first half of the decade but a substantial increase (46 percent) in the unmet need for limiting over the same period. However, in the second half of the decade, there was a 20 percent decline in the unmet need for spacing among these women and no change in the unmet need for limiting.

Women differ by their intention to use contraception in the future. There was a substantial increase in unmet need among women who intended to use family planning within 12 months of the survey, from 58 percent in 1988 to 72 percent in 1993 and 66 percent in 1998. However, over the decade, total unmet need changed little among women who stated that they intended to use contraception sometime in the future and among women who said that they did not intend to use contraception in the future. Nevertheless, unmet need for spacing declined among these women, while unmet need for limiting increased. Total unmet need is three times higher among women who intend to use contraception within 12 months and two times higher among women who intend to use contraception later in the future than among women who do not intend to use contraception at all.

In summary, unmet need is greatest among women who have the least access to contraception. Ghana is no exception, with young women age 15-19, rural women, and women with less then a secondary education showing the most need. Unmet need has increased markedly over the decade among younger women age 15-24, but has not changed much for older women. The gap in unmet need between rural and urban women has widened, with rural women exhibiting a greater need for family planning than urban women. Regional differences have also emerged. Unmet need has increased noticeably among women living in the Western and Central regions, with little change among women living in the other regions. In the first half of the decade, unmet need increased dramatically among women living in the Ashanti region, but subsequently declined in the second half of the decade. Unmet need has fallen substantially among the most highly educated women in Ghana, with little change for other women. Over the ten years, women with no children have increasingly expressed a wish to postpone the birth of their first child but are not using contraception. Unmet need for spacing has also risen among women who have had a birth in the 0-15 months before the survey. Over the same period, more women who intended to use contraception within 12 months of the survey intended to use it for spacing rather than for limiting. There was also a shift away from a need to space to a need to limit among women who intended to use contraception sometime in the future and among those who did not intend to use it at all.

4 Reasons for Unmet Need

The three GDHS surveys sought to explain why women who have an unmet need for family planning do not use contraception. However, over the decade, the questions about reasons for non-use took several forms and addressed different subgroups of women. In order to understand whether women's reasons for non-use have changed over time, it is necessary to examine how these questions differed and to compare similar subgroups of women. Although their responses may be limited in coverage and scope, these questions offer valuable insight for designing programmes and identifying and targeting subgroups of women for successful implementation. Tracing the changing profile of women with unmet need by reasons for non-use also reveals the success of programmes in addressing women's concerns about contraceptive use.

Most studies of unmet need treat women as a single group when analysing their reasons for non-use (Bhushan, 1997; Robey et al., 1996). This analysis differentiates the reasons for non-use among three groups of currently married women with unmet need: women who were not using a method of family planning at the time of the survey, but who intended to use one in the future; women who were not using a method at the time of the survey, and who did not intend to use one in the future; and women who had stopped using a method, either temporarily or permanently. Reasons for non-use will be analysed separately for ever-users and never-users. It is important to recognise this distinction because a successful intervention programme has to differentially address women's contraceptive needs. Women who were not currently using a contraceptive method may have different programme needs from women who do not intend to use in the future. Women who discontinue use of a method may also have different concerns from women who have never used a method. The first step toward a better understanding of the reasons for non-use is therefore to isolate and analyse these groups of women separately.

Reasons for non-use can be organised into four categories—fertility-related reasons, method-related reasons, opposition to use, and lack of knowledge. Fertility-related reasons, which are not easily addressed by family planning programmes, refer to non-use due to not having sex or having infrequent sex, being menopausal or having had a hysterectomy, being subfecund or infecund, being postpartum amenorrhoeic or breastfeeding, and wanting more children. Method-related reasons, which are more amenable to programmatic interventions, encompass health concerns, fear of side effects, lack of access, high cost of contraceptives, inconvenience of using a method, and a belief that the method interferes with the body's natural processes. Women cite opposition to use by themselves, by their husbands or partners, or by others and religious opposition as reasons for non-use. Lack of knowledge includes not knowing a method of family planning or not knowing a source for a method.

Reasons for Not Using a Contraceptive Method

This analysis begins by looking at the reasons for non-use among women who were not using a method of contraception at the time of the survey but who intended to use one in the future (Table 3). In the 1988 GDHS, never-users and ever-users who were not using a method at the time of the survey and who stated that they would be 'unhappy' or 'that it would not matter' if they became pregnant in the 'next few weeks' were asked for the main reason they were not currently using a method of contraception to avoid pregnancy (GSS and IRD, 1989). In 1998, however, this question was asked of all current non-users, without filtering out women who stated that they would be 'unhappy' or 'that it would not matter' if they became pregnant in the 'next few weeks' (GSS and MI, 1999). In order to make the two groups comparable, women who stated that they would be 'happy' if they became pregnant in the next few weeks were excluded from the 1998 data. A subgroup of current non-users also stated that they did not intend to use a method in the future. These women were excluded from the table to gain a better understanding of why women were temporarily not using contraception. Reasons for non-use in the future are discussed in the next section. In 1993, women were not asked about their reasons for not using at the time of the survey. The discussion in this section is therefore restricted to 1988 and 1998.

A sizeable percentage of women were not using a method of contraception because of fertility-related reasons. Women believed that they were not at risk of becoming pregnant either because they were not sexually active or because they perceived themselves to be infertile (menopausal or subfecund/infecund). Together these women accounted for nearly one in five women not using contraception at the time of the 1998 survey, a substantial increase from 1988. Non-use because of infrequent sex increased noticeably over the decade and ever-users were much more likely to cite this as a reason for non-use than were never-users. Non-use due to postpartum amenorrhoea or breastfeeding is also important, with 8 percent and 12 percent of women citing this reason for non-use at the time of the survey in 1988 and 1998, respectively. The lack of motivation for fertility control is also a result of women, irrespective of use status, wanting more children (10 percent in 1998). This information was not categorised separately in 1988, most likely because the question about reasons for non-use filtered out

Table 3 Percentage of currently married women with unmet need who were not using a method of contraception at the time of the survey but who intended to use one in the future, by reasons for not currently using contraception, 1988 and 1998

Reason for not currently using contraception	1988			1998		
	Unmet need for spacing	Unmet need for limiting	Total unmet need	Unmet need for spacing	Unmet need for limiting	Total unmet need
NEVER-USERS						
Fertility-related reason	8.2	7.1	7.9	9.1	1.4	6.7
Infrequent sex[1]	0.9	0.0	0.7	2.4	5.3	3.3
Menopausal/subfecund	13.6	4.8	11.2	4.7	2.6	4.0
Postpartum/breastfeeding	U	U	U	10.6	7.8	9.7
Wants more children[2]						
Method-related reason	7.3	7.1	7.2	2.5	4.1	3.0
Health concerns	U	U	U	13.3	22.2	16.1
Fear of side effects[2]	4.5	4.8	4.6	0.9	1.3	1.0
Lack of access/availability	1.8	4.8	2.6	1.5	3.4	2.1
Costs too much	2.7	0.0	2.0	1.3	5.5	3.1
Inconvenient to use[3]						
Opposition to use	3.6	0.0	2.6	10.6	6.1	9.2
Respondent opposed	0.0	2.4	0 7	5.2	4.7	5.0
Husband opposed	0.0	0.0	0.0	0.4	0.0	0.2
Others opposed	0.0	0.0	0.0	5.0	8.2	6.0
Religious opposition	41.8	54.8	45.4	21.1	18.6	20.3
Lack of knowledge[4]	0.0	4.8	1.3	4.2	2.1	3.5
Other	9.1	9.5	9.2	6.7	6.6	6.7
Don't know	100.0	100.0	100.0	100.0	100.0	100.0
Total	110	42	152	189	87	276
Number						
EVER-USERS						
Fertility-related reason						
Infrequent sex[1]	13.2	13.4	13.3	26.5	23.3	25.3
Menopausal/subfecund	0.0	0.0	0.0	1.6	0.0	1.0
Postpartum/breastfeeding	7.9	1.5	4.9	25.1	12.5	20.1
Wants more children[2]	U	U	U	14.9	3.5	10 3
Method-related reason						
Health concerns	15.8	22.4	18.9	2.3	16.1	7.7
Fear of side effects[2]	U	U	U	14.9	16.6	15.5
Lack of access/availability	3.9	4.5	4.2	0.0	0.0	0.0
Costs too much	1.3	1.5	1.4	1.7	3.1	2.3
Inconvenient to use[3]	3.9	3.0	3.5	3.9	6.8	5.1
Opposition to use						
Respondent opposed	1.3	1.5	1.4	3.2	1.0	2.3
Husband opposed	7.9	9 0	8.4	2.9	9.2	5.4
Others opposed	1.3	1.5	1.4	0.0	1.2	0.5
Religious opposition	1.3	0.0	0.7	0.0	0.0	0.0
Lack of knowledge[4]	14.5	10.4	12.6	0.0	1.1	0.4
Other	5.3	19.4	11.8	1.5	3.3	2.2
Don't know	7.9	11.9	9.8	1.6	2.3	1.9
Total percent	100.0	100.0	100.0	100.0	100.0	100.0
Number	76	67	143	155	102	257
TOTAL						
Fertility-related reason						
Infrequent sex[1]	10.2	11.0	10.5	17.0	13.3	15.7
Menopausal/subfecund	0.5	0.0	0.3	2.1	2.4	2.1
Postpartum/breastfeeding	11.3	2.8	8.1	13.9	8.0	11.8
Wants more children[2]	U	U	U	12.5	5.5	10.0
Method-related reason						
Health concerns	10.8	16.5	12.9	2.4	10.6	5.3
Fear of side effects[2]	U	U	U	14.0	19.1	15.8
Lack of access/availability	4.3	4.6	4.4	0.5	0.6	0.5
Costs too much	1.6	2.8	2.0	1.6	3.2	2.2
Inconvenient to use[3]	3.2	1.8	2.7	2.8	6.2	4.0
Opposition to use						
Respondent opposed	2.7	0.9	2.0	7.2	3.3	5.9
Husband opposed	3.2	6.4	4.4	4.2	7.2	5.2
Others opposed	0.5	0.9	0.7	0.2	0.7	0.4
Religious opposition	0.5	0.0	0.3	2.7	3.8	3.1
Lack of knowledge[4]	30.6	27.5	29.5	11.7	9.1	10.8
Other	2.2	13.8	6.4	3.0	2.7	2.9
Don't know	8.6	11.0	9.5	4.4	4.3	4.3
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number	186	109	295	344	189	533

Note: Total for 1988 includes 2 women for whom a response was missing; totals may not add up to 100.0 due to rounding.
[1] In 1998 this includes 'not having sex'
[2] In 1988 these two categories were not present
[3] In 1998 this includes 'interferes with body'
[4] In 1998 this refers to 'knows no method' and 'knows no source'.
U = Unknown (not available).

women who stated that they would be 'happy' if they became pregnant in the next few weeks, women who were presumably more likely to state that they were not currently using a method because they wanted more children. In 1998, the question about reasons for non-use was asked of all women and it is therefore reasonable to assume that women who were not currently using because they wanted more children were included. However, although the data for 1998 are restricted to women who stated that they would be 'unhappy' or 'that it would not matter' if they became pregnant in the next few weeks, a sizeable percentage stated that they wanted more children. Presumably they did not want children immediately but wanted them in the future or were unsure about the timing of their next birth. It is likely that this response was coded under 'other' in 1988. However, because of data limitations, this category could not be isolated and tabulated separately.

Non-use for method-related reasons is primarily due to health concerns and the fear of side effects. In 1988, 13 percent of women cited health concerns as a reason for non-use. Fear of side effects was not categorised separately in 1988. In 1998, these two reasons together accounted for non-use among one in five women. In fact, fear of side effects was the most frequently cited reason for non-use at the time of the survey in 1998 (16 percent). It was more likely to be mentioned by women with an unmet need for limiting than for spacing. Lack of access, cost of contraception, and inconvenience of use of methods are relatively unimportant, and over the decade, there was a small decrease in the percentage of women citing these reasons for non-use. Method-related reasons for non-use varied little between never-users and ever-users.

Fifteen percent of women cited opposition to use as a reason for non-use in 1998, with never-users more than twice as likely to state this reason as ever-users. Over the decade, there has been a notable increase in the percentage of women citing this reason for non-use, with both the respondent and her husband equally opposed to use in 1998 (around 5 percent). Religious opposition among non-users also became more important between 1988 and 1998. Opposition to use varies little between women who have an unmet need for spacing or limiting.

A substantial percentage of women with unmet need who were not using at the time of the survey cited lack of knowledge as a reason for non-use. Not surprisingly, the percentage is markedly higher among never-users than ever-users. Although the percentage of women who were not currently using because they did not know a method or a source for a method fell substantially between 1988 and 1998, nearly one in ten women with unmet need continued to cite this reason at the end of the decade. This lack of knowledge is a handicap among women in general, with little difference between women who express a need to space or a need to limit.

Reasons for Not Intending To Use a Contraceptive Method in the Future

The second group of women with unmet need is those who were not using a contraceptive method at the time of the interview and did not intend to use one in the future. This group includes both ever-users and never-users. In 1988 and 1993, the question about reasons for non-use in the future was asked only of women who stated that they did not intend to use contraceptives in the future. However, in 1998, women whose response was 'don't know' were also asked about their reasons for not intending to use contraception in the future. For reasons of comparability, this group of women was excluded from this analysis. Table 4 gives a breakdown of women with unmet need by reasons for not intending to use a method of family planning in the future.

Two questions come to mind when analysing the reasons for non-use among women who do not intend to use a method of contraception in the future: How do reasons for not intending to use in the future compare with reasons for not currently using a method? Have reasons for not intending to use in the future changed over the decade?

Table 4 Percentage of currently married women with unmet need by reasons for not intending to use in the future, 1988, 1993, and 1998

Reason for not intending to use contraception in the future	1988[a]			1993			1998		
	Unmet need for spacing	Unmet need for limiting	Total unmet need	Unmet need for spacing	Unmet need for limiting	Total unmet need	Unmet need for spacing	Unmet need for limiting	Total unmet need
NEVER-USERS									
Fertility-related reason									
Infrequent sex[1]	U	U	U	2.1	5.3	2.9	2.5	5.6	3.5
Menopausal/subfecund	U	U	U	8.0	15.8	9.8	1.4	2.1	1.6
Wants more children	59.9	18.6	54.4	31.9	5 3	25.7	13.0	1.6	9.3
Method-related reason									
Health concerns	5.8	9.3	6.3	3.2	5.3	3.7	3 7	3.1	3.5
Fear of side effects	U	U	U	9.0	12.3	9.8	23.1	38.5	28.1
Lack of access/availability	U	U	U	0.5	1.8	0.8	0.0	0.0	0.0
Costs too much	U	U	U	0.5	0.0	0.4	1.4	2.4	1.7
Inconvenient to use[2]	U	U	U	1.1	1.8	1.2	1.8	3.2	2.2
Opposition to use									
Respondent opposed	U	U	U	4.8	5.3	4.9	24.1	15.4	21.3
Husband opposed	4.0	7.0	4.4	0.5	1.8	0.8	4.1	5.0	4.4
Others opposed	U	U	U	1.1	0.0	0.8	0.7	0.0	0.5
Religious opposition	7.6	16.3	8.8	3.7	0.0	2.9	5.6	10.5	7.2
Lack of knowledge[3]	U	U	U	22.3	33.3	24.9	11.2	9.4	10.6
Other[4]	6.5	20.9	8.4	4.8	10.6	6.1	0.7	0.0	0.5
Don't know	16.2	27 9	17.8	6.4	1.8	5.3	5.8	3.3	5.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number	277	43	320	188	57	245	156	74	230
EVER-USERS									
Fertility-related reason									
Infrequent sex[1]	U	U	U	2.6	18.0	11.4	0.0	9.4	6.1
Menopausal/subfecund	U	U	U	10.5	32.0	22.7	0.0	20.3	13.2
Wants more children	39.2	8.6	26.7	13.2	2.0	6.8	4.7	1.7	2.8
Method-related reason									
Health concerns	31.4	28.6	30.2	7.9	4.0	5.7	18.1	16.2	16.8
Fear of side effects	U	U	U	36.8	16.0	25.0	37.7	22.7	27.9
Lack of access/availability	U	U	U	0.0	0.0	0.0	0.0	0.0	0.0
Costs too much	U	U	U	0.0	0.0	0.0	3.1	0.0	1.1
Inconvenient to use[2]	U	U	U	10.5	2.0	5.7	9.4	14.5	12.7
Opposition to use									
Respondent opposed	U	U	U	0.0	2.0	1.1	7.1	3.3	4.6
Husband opposed	11.8	5.7	9.3	7.9	0.0	3.4	9.2	3.1	5.2
Others opposed	U	U	U	0.0	0.0	0.0	0.0	0.0	0.0
Religious opposition	0.0	0.0	0.0	5.3	8.0	6.8	10.8	4.8	6.9
Lack of knowledge[3]	U	U	U	5.3	4.0	4.5	0.0	0.0	0.0
Other[4]	5.9	31.4	16.3	0.0	8.0	4.5	0.0	3.2	2.1
Don't know	7.8	11.4	9.3	0.0	4.0	2.3	0.0	0.9	0.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number	51	35	86	38	50	88	39	72	111
TOTAL									
Fertility-related reason									
Infrequent sex[1]	U	U	U	2.2	11.2	5.1	2.0	7.5	4.4
Menopausal/subfecund	U	U	U	8.4	23.4	13.2	1.1	11.0	5.4
Wants more children	56.7	14.1	48.5	28.8	3.7	20.7	11.3	1 7	7.2
Method-related reason									
Health concerns	9.8	17.9	11.3	4.0	4.7	4.2	6.6	9.5	7.8
Fear of side effects	U	U	U	13.7	14.0	13.8	26.0	30.7	28.0
Lack of access/availability	U	U	U	0.4	0.9	0.6	0.0	0.0	0.0
Costs too much	U	U	U	0.4	0.0	0.3	1.7	1.2	1.5
Inconvenient to use[2]	U	U	U	2.7	1.9	2.4	3.3	8.7	5.6
Opposition to use									
Respondent opposed	U	U	U	4.0	3.7	3.9	20.7	9.4	15.9
Husband opposed	5.2	6.4	5.4	1.8	0.9	1.5	5.1	4.1	4.7
Others opposed	U	U	U	0.9	0.0	0.6	0.6	0.0	0.3
Religious opposition	6.4	9.0	6.9	4.0	3.7	3.9	6.6	7.7	7.1
Lack of knowledge[3]	U	U	U	19.5	19.6	19.5	9.0	4.7	7.1
Other[4]	6.4	25.6	10.1	3.9	9.3	5.7	0.6	1.6	1.0
Don't know	14.9	20.5	16.0	5.3	2.8	4.5	4.7	2.1	3.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number	328	78	406	226	107	333	194	146	340

Note. Total for 1988 includes 7 women for whom a response was missing and the total for 1998 includes 1 woman for whom a response was missing; totals may not add up to 100.0 due to rounding.
[a] In 1988 reasons for non-use in the future were categorised into only six categories
[1] In 1998 this includes 'not having sex'
[2] In 1998 this includes 'interferes with body'
[3] In 1998 this refers to 'knows no method' and 'knows no source'
[4] In 1993 this includes 'fatalistic'
U = Unknown (not available)

Women were more ambiguous about the reasons for not wanting to use a method of family planning in the future than they were about not wanting to use currently. Surprisingly, these women were identified as having an unmet need for contraception because they were not using a method but stated that they would like to space their births or limit their number of children. Yet when asked why they do not intend to use in the future, they stated that they wanted more children—a somewhat contradictory response. Respondents may not have understood that the intent of the question was to elicit a reason for not wanting to use a method in the future *after* they have already had their desired number of children. Such a response could also reflect the women's uncertainty about the timing of their next birth. Women may also think that contraception is a means of limiting births but not of spacing them. This misconception was especially obvious in 1988 when more than one in two women stated that they did not intend to use in the future because they wanted more children. Even though the percentage who want more children declined by more than half between 1988 and 1993, and even more during the second half of the decade, the lack of clarity continued to exist, especially among women who expressed an unmet need for spacing. In 1988, 16 percent of women stated that they did not know why they did not intend to use a method in the future. However, this dropped to 5 percent in 1993 and 4 percent in 1998. In general, women with an unmet need for spacing were much more likely to be ambiguous about not intending to use in the future than women with an unmet need for limiting, as are never-users compared with ever-users. The sharp decline over the years may be due to interviewers' probing women who stated that they wanted more children and clarification that the question is trying to elicit a reason for non-use in the future after the respondent has satisfied her childbearing desires. Among the other fertility-related reasons, infrequent sex is not as important a reason for non-use in the future as it is for current non-use. In both cases, non-use due to perceived infertility is minimal.

As with women who were not currently using family planning, fear of side effects and health concerns continued to be important method-related reasons for women who did not intend to use contraception in the future. In 1988, the only method-related reason listed in the questionnaire was health concerns, and most likely, this response included fear of side effects. There has been a sharp increase in non-use due to these two reasons over the decade. In 1998, they accounted for more than one in three women who did not intend to use contraception in the future, twice as many as in 1993, and three times as many as in 1988. In fact, in 1998, fear of side effects and health concerns were the most important reasons for not intending to use in the future. Nearly one in two women who had used a method before cited health concerns and fear of side effects as reasons for not wanting to use in the future. Nevertheless, one in three women who had never used a method also cited these reasons for not wanting to use in the future. In 1988, women with an unmet need to limit were more likely than women with an unmet need to space to cite these reasons for non-use in the future, but over the years, this difference has narrowed.

Over the decade, opposition to the use of family planning, especially opposition from respondents, has emerged as an important reason for non-use. However, this reason appears to be more important for women who do not intend to use in the future than for women who are not currently using. For example, in 1998, three times as many women who did not intend to use in the future cited this reason as women who were not currently using. Not surprisingly, respondents' opposition to family planning was noticeably higher among never-users than ever-users. Furthermore, women with an unmet need for spacing rather than limiting, and husbands, were more likely to oppose family planning.

The percentage of women who cited lack of knowledge as a reason for non-use differs little between those who were not using currently and those who do not intend to use in the future. Never-users were much more likely to state this reason for non-use than ever-users.

Reasons for Discontinuing Use of a Contraceptive Method

Analysing women who have discontinued use of a contraceptive method is somewhat more complicated than analysing other women who are not using a method. For programmatic purposes, it is important to know why women stopped using specific contraceptive methods, and whether they discontinued use for method-specific reasons. Tables 5 and 6 summarise for the 1988 GDHS and the 1993 GDHS the reasons for non-use among women who had discontinued use. In 1988, ever-users who were not currently using a method of contraception were asked why they had stopped 'using a method' without reference to a specific method. Information was also not available on the last method used. In 1993, the question about reason for discontinuation was specific and referred to the last method used.

In 1988, one in four women had stopped using because of health concerns (Table 5). Thirteen percent of women had stopped using because they wanted a child. Women who had stopped using because of health concerns were more likely to have an unmet need for limiting, whereas women who had stopped using because they wanted a child were more likely to have an unmet need for spacing. One in ten women had stopped using because of their partner's disapproval, and another one in five had stopped using for other reasons not individually classified. Although most women who had stopped using a method of contraception (62 percent) intended to use a method sometime in the future (data not shown), a sizeable percentage who had used a method before did not intend to do so in the future. Two in five women who had stopped using because they wanted a child, because the method was inconvenient, or because their partner disapproved, and one in three women who had stopped using because of health concerns, did not intend to use a method in the future.

Table 5 Percentage of currently married women with unmet need who stopped using a contraceptive method, by reason for stopping, 1988

	Unmet need		
Reason for stopping use	Spacing	Limiting	Total
Fertility-related reason			
Menopausal	1.6	4.9	3.1
Wanted a child	33.1	12.7	12.7
Method-related reason			
Health concerns	15.7	34.3	24.0
Not effective	3.1	5.9	4.4
Difficult to get	2.4	2.0	2.2
Cost too much	0.8	0.0	0.4
Inconvenient to use	7.9	2.0	5.2
Opposition to use			
Partner disapproves	10.2	11.8	10.9
Other	18.1	22.5	20.1
Don't know	4.7	3.9	4.4
Total	100.0	100.0	100.0
Number	127	102	229

Note: Total includes 3 women for whom information on reason for stopping use is missing.

In 1993, the majority of users of the pill and injectables had discontinued use for method-related reasons (Table 6). Fear of side effects was the most important reason for discontinuing use of the pill (41 percent) and injectables (52 percent). About one in four women using periodic abstinence and withdrawal and one in five women using vaginal methods had discontinued use because they believed these methods to be ineffective. The majority of condom users and women using periodic abstinence and withdrawal had discontinued use because of fertility-related reasons. A sizeable proportion of women had stopped using a method because they wanted a child: 19 percent of women using the pill and condom, 23 percent using vaginal methods, 34 percent using periodic abstinence, and 28 percent using withdrawal. One in three condom users and one in six women using periodic abstinence had stopped using because of infrequent sex. Opposition to use from their husbands was relatively more important among women who used vaginal methods (16 percent). As in 1988, the majority of women who had discontinued use of a method in 1993 intended to use in the future. Only one in five women who had discontinued use did not intend to use a contraceptive method in the future (data not shown).

Table 6 Percentage of currently married women with unmet need who stopped using a specific contraceptive method, by reason for stopping, 1993

	Last method used					
Reason for stopping use	Pill	Injectables	Diaphragm/ foam/jelly	Condom	Periodic abstinence	Withdrawal
Fertility-related reason						
Infrequent sex	7.0	3.4	9.1	30.8	16.5	11.1
Wanted a child	19.3	6.9	22.7	19.2	34.2	27.8
Method-related reason						
Health concerns	8.8	10.3	2.3	0.0	1.3	0.0
Side effects	41.2	51.7	11.4	0.0	0.0	1.9
Not effective	5.3	13.8	18.2	0.0	27.8	24.1
Inconvenient to use	1.8	0.0	4.5	7.7	2.5	5.6
Opposition to use						
Partner disapproves	3.5	3.4	15.9	7.7	3.8	5.6
Lack of knowledge	0.9	6.9	4.5	0.0	5.1	0.0
Other	7.9	3.4	4.5	15.4	5.1	13.0
Don't know	4.4	0.0	6.8	19.2	3.8	11.1
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number	114	29	44	26	79	54

Note: Not shown above are 24 women who used other methods including 5 women who used the IUD, 89 women who were currently pregnant (and the question about reason for discontinuation was not asked), and 5 women for whom information on reasons for discontinuing a method was missing.

5 Programmatic Implications and Policy Issues

The foregoing analysis clearly demonstrates that the reasons for unmet need differ among different groups of women. Programmes designed to provide family planning services should therefore be more specific and target-oriented in their approach to addressing women's demand for family planning. Table 7 summarises the most important reasons for non-use by women's background characteristics. The most important reasons for not using a contraceptive method at the time of the survey among women who intended to use in the future are fertility-related. The perceived low risk of conception associated with infrequent sex is most commonly cited by women age 15-19, urban women, women with at least a middle school education, and women with less than three children. The perceived low fecundity associated with breastfeeding and postpartum amenorrhoea, most often mentioned by women less than 30 years old, rural women, women with at least a middle school education and women

with three or fewer children, is an important reason for ever-users to not currently be using a method. Programmes have much to offer young women who have unprotected sex. Information, education, and counselling services on contraceptive use, reproductive health and sexually transmitted diseases should be provided to young adults in schools and youth clubs.

In more recent years, ambivalence about future childbearing is less of an issue among women who do not intend to use in the future, than among women who were not currently using a method. This fertility-related reason was also more important among women with an unmet need for spacing than among women with an unmet need for limiting. These women need to be better informed about the benefits of a small, well-spaced family; the choices available to them; and, most important, the types of contraceptive methods available. Moreover, these women need to be informed that contraception performs the dual role of facilitating birth spacing and birth limiting.

Table 7 Percentage of currently married women with unmet need, by main reasons for not using contraception and background characteristics, 1998

	Main reason for not using a method at the time of the survey						Main reason for not intending to use a method in the future		
Background characteristic	Infre-quent sex[1]	Postpartum /breast-feeding	Want more children	Fear of side effects	Lack of knowledge[2]	Number of women	Fear of side effects	Respon-dent opposed	Number of women
Age									
15-19	36.3	15.8	0.0	3.3	17.0	36	*	*	16
20-29	13.9	14.8	14.1	13.3	11.0	251	33.9	16.4	130
30+	14.4	8.1	7.3	20.3	9.6	246	25.2	13.8	193
Residence									
Urban	25.5	8.4	8.0	19.0	2.2	141	35.2	13.8	88
Rural	12.1	13.0	10.7	14.7	13.8	393	25.5	16.6	252
Education									
No education	10.3	7.1	12.8	10.5	21.7	185	23.2	15.9	145
Primary	16.5	9.0	9.5	18.8	6.9	123	30.3	18.6	68
Middle/JSS+	19.6	17.2	8.0	18.6	3.9	226	32.3	14.5	127
Parity									
0-2	24.0	15.3	11.1	13.6	10.4	210	27.1	17.9	117
3+	10.2	9.5	9.3	17.2	10.9	323	28.5	14.8	223
Total	15.7	11.8	10.0	15.8	10.7	533	28.0	15.9	340

[1] Includes 'not having sex'
[2] Includes 'knows no method' and 'knows no source'
* Suppressed because based on less than 25 cases

Method-related reasons for non-use appear to be significantly higher among women who do not intend to use in the future than among women who do intend to use in the future. Fertility-related reasons are also important for these women but less so. Fear of side effects is the single most important method-related reason for non-use. Over the decade, fear of side effects has emerged as a significant reason for non-use among both women who are not currently using a method but intend to use one in the future and women who are not currently using and do not intend to use a method in the future. The prevalence of fear of side effects is consistently high among all groups of women irrespective of use status. Surprisingly, urban and educated women are more likely to cite this reason for non-use than rural and less-educated women, as are women age 30 years and older. Health concerns and fear of side effects affect contraceptive use in two ways. First, they may discourage users from continuing to use a method. Users may also quit because they do not have suitable alternatives, adequate counselling, or follow-up services. Second, non-users may be

discouraged from starting to use a method because they fear the side effects, whether real or perceived (Bhushan, 1997). Both of these are clearly evidenced in Ghana among users of the pill and injectables and among never-users. The dramatic rise in the percentage of Ghanaian women who were not using contraception because of health concerns and fear of side effects over the past decade points to the importance of addressing this issue. Of particular concern is that more users than non-users cited this reason for non-use. This finding could indicate a serious lack of pre-adoption counselling and effective follow-up for users of contraceptive methods. In fact, according to the 1998 GDHS, more than one in three women did not have a consultation before first use of the pill, and one in two did not have a consultation at last use of the pill. Family planning providers should be trained to provide high-quality services and to monitor the health of new clients. Besides addressing health concerns associated with a specific method, family planning programmes should also make available alternative methods aimed at meeting women's specific health needs, while providing pertinent information to dispel unfounded fears associated with contraceptive methods. The mass media could be used more effectively to dispel rumours associated with the use of specific methods and to provide educational information pertaining to the availability of and accessibility to alternative methods within the community.

Opposition to family planning, especially on the part of respondents, is another reason given for non-use in the future. In Ghana, women are more likely to cite their own personal opposition to family planning as the most important reason for not using a contraceptive method as opposed to the opposition of others. Respondent opposition to family planning has increased significantly in the past ten years. In general, the percentage of women who oppose contraceptive use is about equal irrespective of their background characteristics. Not surprisingly, women who do not intend to use contraception because they oppose its use are also less likely to approve of it (Table 8). For example, they are less likely to approve of couples using a method to avoid getting pregnant and are less accepting of information on family planning being provided on the radio and or television. Moreover, although the husband's disapproval does not emerge as an important influencing factor in and of itself, husbands play a crucial role in promoting family planning use in terms of wives' perception of their husband's attitude toward contraceptive use. Women who do not intend to use contraception in the future because they are opposed to it are also less likely to think that their husband approves of family planning and less likely to have discussed family planning with him. Services and communication strategies in Ghana should strive to involve women in more open dialogues to discuss why they disapprove of the use of contraception. Furthermore, communication programmes should also focus on informing and educating men about reproductive health, encourage male involvement in family planning decision making, and support greater spousal communication.

Table 8 Percentage of currently married women with unmet need who do not intend to use a contraceptive method in the future because they are opposed to the use of contraception, percentage of currently married women with unmet need, and percentage of currently married women who are using contraception, by selected approval indicators, 1998

Approval indicator	Currently married women with unmet need who do not intend to use a method in the future, because they are opposed to the use of contraception	Currently married women with unmet need	Currently married women who are using contraception
Approve of couples using a contraceptive method to avoid getting pregnant	12.7	76.7	94.8
Acceptable for information on family planning to be provided on the radio and/or television	32.6	84.2	97.3
Thinks husband/partner approves of family planning	14.9	49.2	68.1
Has discussed family planning with husband/partner once, twice, or more often	20.3	49.4	67.1
Number of women	54	1131	873

Lack of knowledge is the only reason for non-use that has declined in importance over the years. Nevertheless, lack of knowledge continues to be an important reason for non-use in Ghana among women age 15-19, rural women, and women with no education. Service availability studies in Ghana point to provider bias in disseminating family planning information to young, rural, and uneducated women (GSS, 1997). Family planning programmes have to include the contraceptive and health needs of adolescents in their list of priorities. Providers have to be educated to address the concerns of all women regardless of their socioeconomic and education status and to improve the quality of services offered to young, rural, and uneducated women. New strategies should be employed to more fully integrate community-based distribution (CBD) agents, paramedical personnel, traditional birth attendants, women's groups, and other organised social and voluntary organisations into the mainstream of family planning and reproductive health activities.

6 Conclusion

The level of unmet need for family planning has changed little in the past ten years in Ghana, with one in three currently married women expressing a need for contraception. Although the proportion of demand satisfied has increased, use remains low, with family planning programmes still not satisfying the demand for contraception of three in five women. Need is particularly high among adolescents with almost one in two having unmet need. Health concerns and fear of side effects of methods are paramount reasons for non-use among many women. At the same time, women themselves are increasingly opposed to the use of contraception. An increasing number of young women believe that they face little risk of conception due to infrequent sex.

These findings have pertinent implications for policy makers and family planning programme administrators in Ghana. Family planning service providers should improve the provision of counselling both before and after a method has been adopted. Counselling should be accompanied by follow-up services to monitor discomfort and side effects that may arise. The media should be constantly engaged in dispelling misconceptions and misinformation about specific methods. Expansion of contraceptive choices should be considered an important strategy to meet women's unmet need. Greater emphasis should be placed on improving and expanding information, education, and counselling services to young women, rural women, and women with little or no education. Communication strategies should also reach out to more men to inform and educate them about the alternatives to a large family and encourage spousal communication on reproductive matters.

References

Bhushan, I. 1997. *Understanding unmet need.* Working Paper Number 4. Baltimore, Maryland: Johns Hopkins School of Public Health Center for Communication Programs.

Ghana Statistical Service (GSS). 1997. *Second Round Situation Analysis Study of Family Planning Service Delivery Points in Ghana.* Accra, Ghana: Ghana Statistical Service.

Ghana Statistical Service (GSS) and Institute for Resource Development/Macro Systems (IRD). 1989. *Ghana Demographic and Health Survey 1988.* Columbia, Maryland: GSS and IRD.

Ghana Statistical Service (GSS) and Macro International Inc. (MI). 1994. *Ghana Demographic and Health Survey 1993.* Calverton, Maryland: GSS and MI.

Ghana Statistical Service (GSS) and Macro International Inc. (MI). 1999. *Ghana Demographic and Health Survey 1998.* Calverton, Maryland: GSS and MI.

Robey, B., J. Ross, and I. Bhushan. 1996. Meeting unmet need: New strategies. *Population Reports* Series J, No. 43. Baltimore, Maryland: Johns Hopkins School of Public Health, Population Information Program.

Ross, J. 1994. Program implementation of the unmet need approach. Presented at the 1994 Annual Meeting of the Population Association of America, Miami, Florida.

Sinding, S., J. Ross, and A. Rosenfield. 1994. Seeking common ground: Unmet need and demographic goals. *International Family Planning Perspectives* 20(1): 23-27.

Westoff, C. and A. Bankole. 1995. *Unmet need: 1990-1994.* DHS Comparative Studies, No. 16. Calverton, Maryland: Macro International Inc.

Westoff, C. and L. Moreno. 1991. The demand for family planning: Estimates for developing countries, In *The role of family planning programmes as a fertility determinant*, ed. J. Ross and J. Phillips. New York, New York: Oxford University Press.

Westoff, C. and L. Ochoa. 1991. *Unmet need and the demand for family planning.* DHS Comparative Studies, No. 5. Columbia, Maryland: Institute for Resource Development.

Westoff, C. and A. Pebley. 1981. Alternative measures of unmet need for family planning in developing countries. *International Family Planning Perspectives* 7(4): 126-136.