Fear, opposition, ambivalence, and abstinence: understanding unmet need in Ghana

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Abstract: Unmet need is a central concept in family planning research and a key indicator for programmatic interventions. Demographic and Health Surveys, the largest source of data on contraceptive patterns in developing countries, compute unmet need based on responses to 18 questions included throughout the interview. This study reports on the results from a novel mixed-methods follow-up study nested within the 2014 Ghana DHS. Women in 13 clusters who were identified as having an unmet need, along with a sub-sample of current users, were approached to be re-interviewed (RR=92%). Results show substantial underreporting of traditional method use. Among women who confirmed they were not using family planning, fear of side effects, personal or partner opposition, ambivalence about reproductive intentions, and abstinence emerged as key themes. In several cases, revised fertility intentions would have affected unmet need classification. Aversion to modern method use was generally more substantial than reported to DHS.

Note: For the full report, please see http://dhsprogram.com/publications/publication-QRS20-Qualitative-Research-Studies.cfm.

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Unmet need, a central concept in family planning research and a key indicator for programmatic interventions, is a composite measure based on apparent contradictions between women's reproductive intentions and non-use of family planning. It is intended to measure latent demand for family planning (Casterline and Sinding 2000); as such, it does not involve direct questions about women's own contraceptive preferences and proclivities.

Demographic and Health Surveys, the largest source of data on contraceptive patterns in developing countries, ask women questions about sexual activity, fertility preferences, fecundity, and contraceptive use to determine unmet need. Married or sexually active fecund women who are not using contraception but who wish to postpone the next birth for two or more years or stop childbearing altogether are the primary group classified as having unmet need. Additionally, women who are pregnant or postpartum amenorrheic with an unwanted or mistimed pregnancy are also considered to have an unmet need.[3] Ongoing measurement of unmet need is pivotal for programmatic and funding efforts and is enshrined in Millennium Development Goal 5.6.

DHS and other nationally-representative surveys such as MICS and PMA2020 use 18 separate questions to determine unmet need (Bradley 2012). Two key concerns with the concept of unmet need are that women themselves are not asked about the *strength* of their current or previous intentions regarding avoiding pregnancy; and women are not asked if they themselves *feel* that they want family planning. Additional concerns about the measurement of unmet need are the underreporting of natural methods in surveys (Rossier et al. 2014), the influence of male partners substantial instability in professed fertility intentions (Agadjanian 2005; Kodzi et al. 2010; Stash 1999; Tan and Tey 1994).

In 2008 Ghana recorded the highest level of unmet need for family planning among married women on the African continent, at 36 percent (GSS, GHS, and ICF Macro 2009). Yet modern contraceptive use among married women was higher than in 20 other African countries, at 17 percent. It is well known that unmet need is very sensitive to respondents' ability and willingness to articulate their preferences: the percent of women with an unmet need can increase even as demand for family planning is being satisfied simply due to an increased interest in reducing fertility during early stages of the demographic transition (Casterline, El-Zanaty, and El-Zeini 2003). It may be that high unmet need in Ghana in 2008 partly reflected women's growing proclivity to articulate a spacing or limiting intention despite some degree of reproductive ambivalence.

Open-ended, qualitative questions can provide substantial insight into ambivalence, perceptions, attitudes, and can be leveraged to help gauge effective demand-side interventions and to understand reasons for discontinuation and non-use. However, qualitative data is time-consuming to gather and is rarely generalizable at the regional or national level. This paper reports on an innovative follow-up qualitative study about unmet need that was funded by USAID and conducted among a subset of respondents to the Ghana 2014 DHS survey.

[3] Specifically, women are considered to have unmet need if they are any of the following: (1) At risk of becoming pregnant, not using contraception, and want no more children, or want children but do not want to become pregnant within the next two years, or are unsure if or when they want to become pregnant; (2) Pregnant with a mistimed or unwanted pregnancy; (3) Postpartum amenorrheic for up to two years following an unwanted or mistimed birth and not using contraception (Bradley et al. 2012).

Methods

At the end of the Ghana Demographic and Health Survey (GDHS), all female respondents age 15-49 were asked if they consent to be re-contacted for a follow-up study on family planning and childbearing. The qualitative study selected 13 selected clusters for follow-up fieldwork (5 in Northern Region, a very high-fertility region, 5 in Central Region, a moderate fertility region, and 3 in Greater Accra, the region with the lowest fertility). Figure 1 indicates the approximate placement of these clusters within Ghana.

With appropriate ethical clearance, after initial DHS data entry was complete, a program confidentially selected eligible follow-up respondents from these 13 clusters: married or sexually active women age 15-44 who had consented to be contacted for a follow-up interview and who either met the standard DHS definition of unmet need or were a randomly-selected modern contraceptive user ('control group').

Along with a guide from Ghana Statistical Service (GSS), field teams attempted to relocate the selected DHS respondents within three weeks of the original survey using household address, the name of the head of household, and the woman's relationship to head of household. Interviewers returned up to three times to complete the interview. Interviews were randomly audited to ensure that they were correctly completed.

The follow-up interviews were conducted using Android tablets to import respondent data and guide questions; audio recorders were used to capture women's full responses to each question. Because the DHS had already collected extensive background information about respondents' education, reproductive history, marital status, and knowledge of family planning, qualitative interviews were conducted in fewer than 30 minutes on average.

The survey questionnaire was designed to verify respondent's identity, re-ask a small number of actual DHS questions, and follow up with open-ended questions to learn more about women's responses. Respondents were re-asked some key pieces of identifying information and some of the components of unmet need. Additionally, they were asked qualitative questions about fertility desires, family planning use, attitudes toward family planning, role of partner and extended family in decision-making, and barriers to access.

Among women who do currently use family planning, the survey was designed to understand whether they are using their favorite method, how they feel about their method, and whether they intend to continue with their method. Among respondents with unmet need, the questionnaire was designed to understand which components of unmet need were most important (fecundity, fertility intentions, misreporting, difficulty accessing contraception, opposition to family planning, and ambivalence). Several questions asked about the attitudes and influence of the woman's partner. Closed-ended responses were entered onto Android tablets and open-ended responses were captured using audio recorders.

Figure 1. Map of Study regions and clusters in Ghana

Results

Out of 9,396 total female respondents age 15 to 44 in 427 GDHS clusters, 99.6% gave consent to a follow-up study. In the 13 selected study clusters, 142 women were eligible for follow-up. Of these, 135 women were successfully re-located and re-interviewed. At the end of the interview for four of these respondents it was determined that—despite matching on name and address—they could not be correctly verified.[4] Counting the unverified respondents as missed interviews, the response rate was 92.3%. The final analysis[5] includes 96 original DHS respondents interviewed on average 20 days after their DHS interview: 50 respondents with 'unmet need', per GDHS, and a reference group of 46 family planning users.

[4] For example, they claimed to have never given birth when the DHS respondent had or vice versa; their year of birth was at least 10 years apart from their DHS year of birth.

[5] Of the 131 validated respondents, two women were not de facto residents at the time of the DHS interview, so linkage to the final DHS dataset was not possible. Additional exclusions to the sample; see report for details.

All respondents to the follow-up survey accepted audio recording of their responses. This produced approximately 1,000 single-spaced pages of interview transcripts. Interview transcripts were input into ATLAS.ti qualitative analysis software and coded on 32 themes. Additionally, we cleaned and verified 65 variables from tablet data entry to compare to the GDHS.

Results

One major finding from the study is the level of discrepancy in two pieces of information that determine unmet need: fertility intentions and use of contraception. DHS respondents had underreported use of traditional methods, and believed themselves to be protected. Abstinence was sometimes an intentional method of preventing pregnancy but not recognized as such. Reproductive intentions were inherently ambivalent (joy versus cost, for example) and had frequently been revised during the follow-up period. Women were uncertain about having another child or about timing of next birth, many in part because they want to space or limit but their boyfriend or husband wants a/another baby very soon. Fertility intentions were also unstable among the reference group of family planning users, but less so than among the group of women originally identified as having unmet need.

Among women with unmet need who gave consistent information about family planning and reproductive intentions in DHS and the follow-up survey, the most frequent reason for non-use was fear of the side effects or health consequences of family planning. This is already widely known from DHS data; less well-known is what women mean when they refer to side effects. Respondents' main concern was the menstrual irregularity caused by hormonal methods. Of secondary concern was weight gain on injectables. Many respondents have had adverse reactions to hormonal methods of family planning, know someone who has, or have heard rumors about side effects. Other reasons for not using contraception were that women were opposed themselves or whose husbands oppose to using contraception, including fatalism and religious convictions. In follow-up interviews, we tended to find that women's opposition to modern methods was much more substantial and multifaceted than was apparent from GDHS data.

Discussion and conclusions

Accurately measuring the demand side of family planning has taken on increased importance in recent years due to MDG 5 and to new efforts to scale up family planning for millions of women by USAID and several donors as part of FP2020. There is a need to better understand the underlying factors behind observed variations in unmet need and to strengthen assessments of the demand for family planning. This study is designed to enhance our collective understanding of the meaning of unmet need as measured in large-scale surveys.

The study findings have two major implications. First, after adjusting for method underreporting and intentional abstinence, the category of women defined as having unmet need for any method appears to be substantially smaller than statistical estimates show. The high prevalence of unwanted pregnancies attest to an ongoing need for family planning in the developing world. But even if we focus only on women with an unmet need for modern methods, the group defined as having an unmet need appears to be unstable, even in the very short-term: women express ambivalence and changing preferences about timing of the next birth even within a week of their original interview. Second, the possibility of supply-side interventions to ameliorate unmet need appears to be limited: not only is the group of women having an unmet need unstable, but opposition to modern methods among non-users is frequently more substantial than what is

apparent from survey data. Women who are not using modern family planning because of cost or access are relatively rare, even in isolated, rural communities. Women frequently cite multiple reasons for non-use: side effects, partner opposition, personal opposition, and religious opposition. Enhancing method choice and ensuring safe access to family planning is critical, but not sufficient: additional demand generation and outreach activities appear to be a necessary prerequisite to access. Programs providing client-centered or couple-centered counseling about contraception that supports total method choice, including proper use of traditional methods and discussion about side effects from modern methods should be supported and expanded. In the long-term, expanding access to the non-hormonal IUD in Ghana would help meet the needs of users who are opposed to methods that affect their menstrual cycles and who want long-term protection. Additionally, clinical development of non-hormonal contraceptive methods that have fewer side effects could also be as an important strategy to address the unmet contraceptive needs of women and couples in developing countries.

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