Sexual & Reproductive Healthcare 13 (2017) 118–124

Contents lists available at ScienceDirect

Sexual & Reproductive Healthcare

journal homepage: www.srhcjournal.org

Unmet/met need for contraception and self-reported abortion in Ghana

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ARTICLE INFO

Article history:
Received 26 September 2016
Revised 24 January 2017
Accepted 3 February 2017

Keywords:
Unmet/met need
Contraception
Abortion
Prevalence
Ghana

ABSTRACT

Background: Unmet need for contraception in several sub-Saharan African countries, including Ghana, remains high, with implications for unintended pregnancies and unsafe abortion, associated maternal morbidity and mortality. In this paper, we analysed for any associations between unmet/met need for contraception and the prevalence of abortion.

Methods: The paper utilizes the 2014 Ghana Demographic Health Survey dataset. Applying descriptive statistics initially, and later, a binary logistic regression, we estimate two different models, taking into account, unmet/met need for contraception (Model 1) and a multivariable one comprising socioeconomic, spatial, cultural and demographic behaviour variables (Model 2) to test the associations between unmet/met need for contraception in Ghana.

Results: One-fourth (25%) of sampled women in 2014 had ever had an abortion. The bivariate results showed that women who reported "no unmet" considerably tended to report abortion more than the reference category – not married and no sex in the last 30 days. The elevated odds among respondents who indicated "no unmet need" persisted even after controlling for all the relevant confounders. Relatedly, unlike women with an unmet need for spacing, women who desired to limit childbearing had a slightly higher tendency to report an abortion.

Conclusion: The linkage between unmet need for contraception appears more complex, particularly when the connections are explored post-abortion. Thus, while an abortion episode is most likely due to unintended pregnancy, contraception may still not be used, after an abortion, probably because of failure, side effects or simply, a dislike for any method.

Introduction

Abortion, especially unsafe ones remain a threat to public health globally, particularly in countries where abortion is restricted to few circumstances [1]. Global estimates showed that 56.3 million abortions occurred annually between 2010 and 2014 and of these, 8.3 million occurred in Africa [2]. Half of all abortions are estimated to be unsafe and 97% of these occur in developing countries. The implications of these are: high maternal deaths and disability among women in the reproductive ages, high cost of care to patients (i.e. health care cost and loss of economic wages) and health systems [3,4].

Underlying the burden of abortion is mistimed or unplanned/unwanted pregnancies which is also exacerbated by low uptake of contraceptives or contraceptive failure among sexually active and fecund women [5]. It has been estimated that 82% of unintended pregnancies are due to unmet need for contraception, which is defined as a situation where women have desires to limit or space births but are using low-efficacy contraception or no method [6]. Unmet need for contraception is attributed to a host of factors including; perceived or real side-effects of contraceptive methods, low self-perception of risk of pregnancy, limited access to contraception, partner's anxieties and opposition to contraception, cultural and religious inhibitions against contraceptive use [7–9].

Closing the unmet need for contraception gap provides opportunities for reducing the burden of unintended pregnancies and associated abortions in developing countries where it is more likely to be unsafe and associated with deaths [10]. For instance, a Ghana Medical Association report showed that abortion contributed 15–30% of maternal deaths in Ghana [11] with higher rates occurring in rural areas [12].

Some evidence has emerged on the issue of contraceptive use and the occurrence of abortion and how in the absence of contraceptive use, some women are resorting to abortion as a fertility control mechanism [13–15]. These studies portend the impression

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http://dx.doi.org/10.1016/j.srhc.2017.02.002
1877-5756/

that increased use of contraceptives would eventually result in decreased abortion rates. However, an evidence adduced by Dueñas [16] contradicts this somehow long-held position. Aggregating a 10-year survey data from Spain, Dueñas [16] found that even though contraceptive use increased from 49.1% to 79.9%, abortion rates unfortunately increased from approximately 5.5% to 11.5% during the same period.

Other studies have proffered probable reasons that may account for increased contraceptive use yet unabated levels of abortion. Contraceptive failure or non-use are implicated primarily (e.g. [17]). For instance, relying on 20 DHS surveys across Africa and Asia, Bradley et al. [18] illustrated that more than half of all induced abortions in six of the countries studied were linked to contraceptive failure. Using evidence from three abortion clinics in China, Cheng et al. [19], observed about 52.2% contraceptive failure among young women undergoing repeat abortion. Previously, however, Senlet et al. [20] noted that increase in the number of abortions could be attributed to failure of traditional methods rather than modern methods. A recent qualitative study among educated urban Ghanaian women showed that there was heavy reliance on traditional methods (mainly withdrawal and calendar) and women resorted to induced abortion when unintended pregnancies occurred [21].

In Ghana, prior research (e.g. [22–25]) point to a seeming use of abortion as a form of contraception. While these studies have expanded our perspectives on contraceptive use and abortion, some of these relied on micro datasets to investigate the nexus between contraceptive use or non-use and abortion (see [24,25]). Even though the study by Blanc and Grey [23] utilized national-level data, they focused primarily on plausible explanations for fertility decline in Ghana, arguing that abortion is one of the drivers of fertility decline. These findings have been corroborated recently [21]. The existing studies also fail to account for how the different reasons for contraception use (e.g. spacing or limiting) account for occurrence of abortion. Building on this literature, this study investigates whether any relationships exist between the different genres of contraception needs and the occurrence of abortion in Ghana. The prevailing argument is that meeting the contraception needs of women in the reproductive stage can help reduce the burden of induced abortions of which a sizeable number are unsafe [26,27].

Research context

Over the last 4 decades, family planning has been one of the important priorities on Ghana's development agenda. It is considered a key pillar for sustainable population management and not surprisingly, it has found expression in key government development blueprints with the recent being the Ghana Shared Growth and Development Agenda II: 2014–2017. Dating back to 1994, when the 1969 Population Policy was revised, others such as the National Adolescent Health Policy (2000), the Reproductive Health Service Policy and Standard, the Reproductive Health Commodity Security Strategy (2011–2016), have been documented to guide implementation of programmes to improve population management. Specifically, the contraception programme of Ghana is intended to: (1) provide information, education, and counselling to individuals and couples, enabling them to decide freely and responsibly when to start childbearing and how to space the children they choose to have; (2) provide affordable contraceptive services and make available a full range of safe and effective methods; and (3) provide information on how to manage reproductive tract infections (RTIs) and sexually transmitted infections (STIs), including HIV and AIDS (GHS 2014). In spite of the far-reaching importance of well-implemented contraception interventions, progress has been tardy, primarily linked to funding gaps. Currently, contraceptive prevalence rate (CPR) is estimated at 22% with 23% use among all women. These statistics also vary substantially by individual characteristics such as age, wealth, education, urban–rural residence and region of women (Ghana Statistical Service et al., 2015).

On the other hand, polemics on abortion in Ghana are shrouded in secrecy although the legal environment for procuring and providing services are liberal. Ghana's 'moral' atmosphere for abortion partly contributes to some women seeking abortion services from clandestine providers that frequently leads to complications of different kinds [28]. As part of national efforts to moderate the negative outcomes associated with unsafe induced abortions, the 2003 National Reproductive Health and Standards Policy mandates health providers to grant women abortion as permitted by law. This was reinforced in the 2006 Prevention and Management of Unsafe Abortion: Comprehensive Abortion Care Services, Standards and Protocols. In 2008, approximately 16% of women, 15–49 years, compared to 25% in 2014, reported abortion of any kind, a 9-percentage point rise [29]. The possible reasons for these increases are not readily available but Ghanaian women are gradually becoming aware of the liberal legal regime of abortion in the country [28].

Definition of unmet need for contraception

Westoff [30], defined unmet need as the proportion of married women who at the time of a survey (a) wanted to avoid or postpone pregnancy, (b) are not using contraception and (c) are actually exposed to the risk of contraception. This definition is, however, considered limiting since it practically reduces the pool of eligible women for meaningful analysis. Since then, several revisions have been made [31–33] with a recent one by Bradley et al. [34], which was used for the 2014 GDHS. By Bradley et al. [34], women with unmet need are those currently married or sexually active and fecund who want to postpone their next birth for two or more years or who want to stop childbearing altogether but are not using a contraceptive method. From this definition, pregnant women are considered to have an unmet need for spacing or limiting if their pregnancy is mistimed or unwanted. Non-pregnant and fecund women who want the next child later or no more are considered either having a need for spacing or for limiting if they were not using a contraception at the time of the survey. On the other hand, women who had experienced spacing and limiting failure as well as those who desired a birth within two years were captured as having no unmet need. However, fecund women who want a child soon are not considered in the computation; same as amenorrheic women.

Data and methods

Data for this paper was extracted from the women's file of the 2014 GDHS. The GDHS offers basic demographic and health information to guide policy and programme across several developing countries globally. The 2014 GDHS was the sixth in the series of data collection that started in 1987/88. In Ghana, the exercise is under the auspices GSS and GHS with technical support from ICF Macro International.

The survey followed a multi-stage sampling procedure where 427 clusters were selected from an updated list of enumeration areas used for the 2010 National Population and Housing Census. Of the total clusters, a slight majority (216) was drawn from urban areas whereas the rest were from rural areas. In each cluster, 30 households were selected, which gave a total household sample of 12,831. In these households, women and men between ages