Bixby Summer Internship Sirina Keesara

My study included 110 qualitative interviews from women in the north of Ghana, Northern Region (TFR 7.0), and the south of Ghana, Greater Accra Region (TFR 2.9). In the South I interviewed women around the urbanized area of Accra by focusing on both market-women and women in the community of Adenta. I also completed a two-week rotation in a Family Planning Unit in one of the Reproductive Health Centers and conducted interviews with nurses and patients. In the North I interviewed women in the rural village of Nakpanduri.

The difference between the contraceptive use and knowledge of side effects in the northern and southern areas in which I worked were notable. In the Greater Accra Region (high urbanization and relatively low fertility), I encountered a prominent fear of side effects. The fear is especially prominent in younger women who have not had children. In the village of Nakpanduri women feared of side effects substantially lower than women in the South of Ghana; almost every married woman of child bearing age uses after she had her first baby. Furthermore, they did not know any other women who experienced substantially problems preventing them from using family planning. In contrast to the main village in Nakpanduri, a sub-village less than a mile away from the family planning clinic, the contraceptive use was much lower and fear of infertility was high. This small change in access to family planning, a mile walk to the family planning center, changed the perception and use of contraceptives drastically. The women I interviewed in this sub-village did not cite any specific reason for not using family planning, but agreed that they felt that it would compromise their fertility after a long period of use. Furthermore, husband's fertility preferences mattered more to Northern women than to Southern women. Most Southern Ghanaian women in this study said that they would be willing to

use contraceptives secretly if they wanted to prevent giving birth because they did not worry that their husbands would get upset if they did not have more children. However, because polygamy is an accepted tradition in the North, many Northern women in this study feared that their husbands would marry an additional wife if they were not fertile or ready to give birth. Overall, Northern women wanted slightly more children than their Southern counterparts.

Access and use of abortion may play another large role in the difference of fertility in the North and South of Ghana. In the North, none of the women whom I interviewed admitted to having an abortion or knowing anybody who had an abortion. In the South many women in this study admitted to having abortions themselves as well as to knowing friends who had abortions. Notably, women in my previous study, which was conducted in a hospital setting, were more willing to talk about their abortions than women in the current study. This could mean that the best place to study abortion behavior would be in a hospital or clinical setting. Because Southern women have access to abortions, they may have been able to achieve a lower fertility in the last few decades with minimal increase in use of contraceptives.

The fear of side effects is more exaggerated in the South of Ghana. These women have much more communication about contraception and access to wider variety women with different experiences. Their fear of side effects comes from stories related by their friends and relatives who experienced health that they associated with use of contraceptives. Women in Nakpanduri did not know anybody who had problems using contraceptives and did not fear that they were bad for the health. The one hesitation that ran across the country was the fear that using contraceptives compromised fertility. This caused women to delay contraceptive use until after they gave birth. Furthermore, these women would not recommend contraceptives to women who did not have children. Many

women said that they did not believe that contraceptives were bad for the health, but also said that they did not use contraception before they had children. When probed further, and specifically asked the question "Would you have used family planning if you knew it would not cause problems giving birth?," most women said that they would have.

The women throughout Ghana who have the least access to contraception are the adolescent girls. They are most greatly affected by the fear of side effects, as they do not want to risk their future fertility by using the contraceptives. Furthermore, the only place for education about contraception for young girls is in school. If girls do not have money to pay for their formal education they do not have access to education about contraception. This exaggerates misconceptions and fears about contraceptives because they do not have an initial source of accurate information. In the North, young girls know and understand contraceptives less than girls in the South. This could be due to cultural difference; less freedom to talk about sexual behavior and contraceptives, or due to less access to education about contraceptives; fewer girls go to school in the North. The girls I interviewed were also afraid of maltreatment from nurses in family planning clinics. They did not believe that they have a right or reason to go these clinics and believed that family planning is best suited for older married women. This could be due to family planning advertisements they saw that they said featured married wealthy women. Furthermore, my work in the family planning clinic demonstrated that fears of maltreatment in the clinics are not unfounded as there is some discrimination against girls between the ages of 15-19 using contraceptives. Therefore, adolescent girls who are sexually active have the greatest unmet need due to fear of side effects and exclusion from the contraceptive market.

Considering my evidence, contraception is the key factor to enhancing and expanding women's options and control over their lives. Understanding contraception

and having non-discriminatory access to contraception allows women to choose when they want a baby and increases their ability to control the course of their lives. Because giving birth to many children is highly valued in Ghanaian society, many young women will say that they want around 3 to 4 children, but also say that they are satisfied with having 2 children, and would not seek more children if their two children survived. Even if a young woman says that she wants 3 or 4 children, if she had enough money to support another child or more schooling, she would generally pursue schooling or career enhancement. Furthermore, the women in this study say that they want to space their children about 2 to 4 years apart. Therefore, if a woman has full access to contraception early in her reproductive career, she can prevent childbirth and pursue her education and career. By the time that she done with schooling and feels ready to have a child she has delayed her pregnancy to a time that it is unlikely that she would be biologically able to have 4 children spaced 2 to 4 years apart. I believe that access to contraception at first sexual activity is critical factor in fertility decline and plays a huge role in actual fertility behavior. Contraceptive use and fertility outcome may change drastically a result of a new understanding and access to contraception, but stated fertility preferences may not necessarily change as much. Therefore, knowledge that contraception exists may create an achievable desired family size between 3 and 4, actual use of contraception may drop TFR to between 2 and 3, and other options for women's career may drop TFR to below replacement level.

For future studies I recommend that it would be especially helpful to focus on the younger cohort to understand their fertility preferences and use of contraceptives. Contraceptive use at first sexual activity may be a good indicator of those who are not afraid that their use will cause detrimental side effects or fertility compromise.

Exploration of barriers to contraceptives for adolescent girls could throw light on fertility trends in countries that are experiencing stalls in fertility decline.