How Reproductive Health Laws Help to Explain the Gap Between Contraceptive Use and Fertility Decline: The Curious Case of Ghana

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In explaining the fertility decline that most countries around the world have experienced, social scientists either attributed it to preferences for children (Pritchett 1994) or access to contraception (Bongaarts, Maudin and Phillips 1990) or the relative weight that each contributes to the fertility decline.

For there to be even a debate about the relative role of preferences compared to access to modern contraception, modern contraception needs to first be legally available. Moreover, examination of the reproductive health laws provides a potentially exogenous change to reproductive health services that affect fertility. Data relying on self reported contraceptive use and incidence of abortion may not fully reflect the uptake of services following legalization as respondents are reluctant to reveal such private information, and a revealed response through an exogenous shock may be more informative.

In this paper we aim to outline the role of reproductive health law changes on fertility outcomes. In determining the exact role of the reproductive health law changes, we explore in detail how the legal changes came about and what the practical implications were as a result of the legal change. In exploring the social and political environment prior to the change in the law we seek to understand who and what were the driving forces behind the change: changing demands from women who required greater command over the timing and number of children they had; pressures from international organizations encouraging the likes of Ghana to keep pace with legal change in other countries; or the dominant role of individuals in the judicial system. These and others remain possibilities as the driving force behind reproductive health laws changes.

In many a context, a change in the law is ineffectual as it results in no change in practice. Liberalization in abortion laws without a change in the number of illegal abortions or without change in the availability of safe legal abortion carries with it a certain redundancy. But not total redundancy as it may be that the change in the law had an indirect effect on reproductive health by invoking attitudinal change amongst decision

makers and leaders who then become more open to other reproductive health needs. Moreover the change in the law may change the public's awareness of reproductive health issues in general.

Considering the chain of events from legal change to fertility outcome, one would expect that the obvious channel is that a reproductive health method (abortion or pill for example) becomes legal, incidence of use of this method increases, thus increasing the number of averted births, and reducing fertility. But self reporting of use reproductive health method (getting an abortion, regularly taking the pill, regularly using condoms, having and IUD fitted, being sterilized) carries with it the obvious problem of under-reporting due to the fact that practicing birth control, and the choice of method, remains stigmatized in many countries.

Through examination of the legal change we bi-pass the issue of self reporting of use of a reproductive health method. We can directly observe the change in the law and the fertility outcome. The channel by which this occurs could be through improved access and use of services, or simply ideation. The latter is less likely as simply thinking about reproductive health matters more deeply as a results of the informed debate the surrounded the legal change, may not effectively reduce fertility.

Changes in Reproductive Health Laws

Between 1960 and 2008 Ghana has experienced two major reforms in their reproductive health laws. Prior to 1985 laws associated with abortion, pill, condom, IUD and sterilization were relatively strict. Abortion was not legally available for any reason, not even in the case when the pregnancy was life threatening to the mother. The pill was available for contraceptive purposes but a prescription was required and had to be purchased in a pharmacy. There was no subsidy on the pill, and advertising was strictly prohibited. Condoms were available for contraceptive purposes, but there was no subsidy to consumers and advertising was strictly prohibited. IUD was available, but had to be installed by a physician (and not by a nurse or other trained health care provider). There were no laws associated with sterilization.

In 1985 abortion was legalized and became available for five of the seven (United Nations) standardized reasons: the save the life of the mother, the physical health of the mother, mental health of the mother, fetal impairment, or rape. Abortion was not available on the grounds of economic hardship or on request. In the same year, Sterilization became legal. There have been no further changes to the abortion or sterilization laws since these changes in 1985.

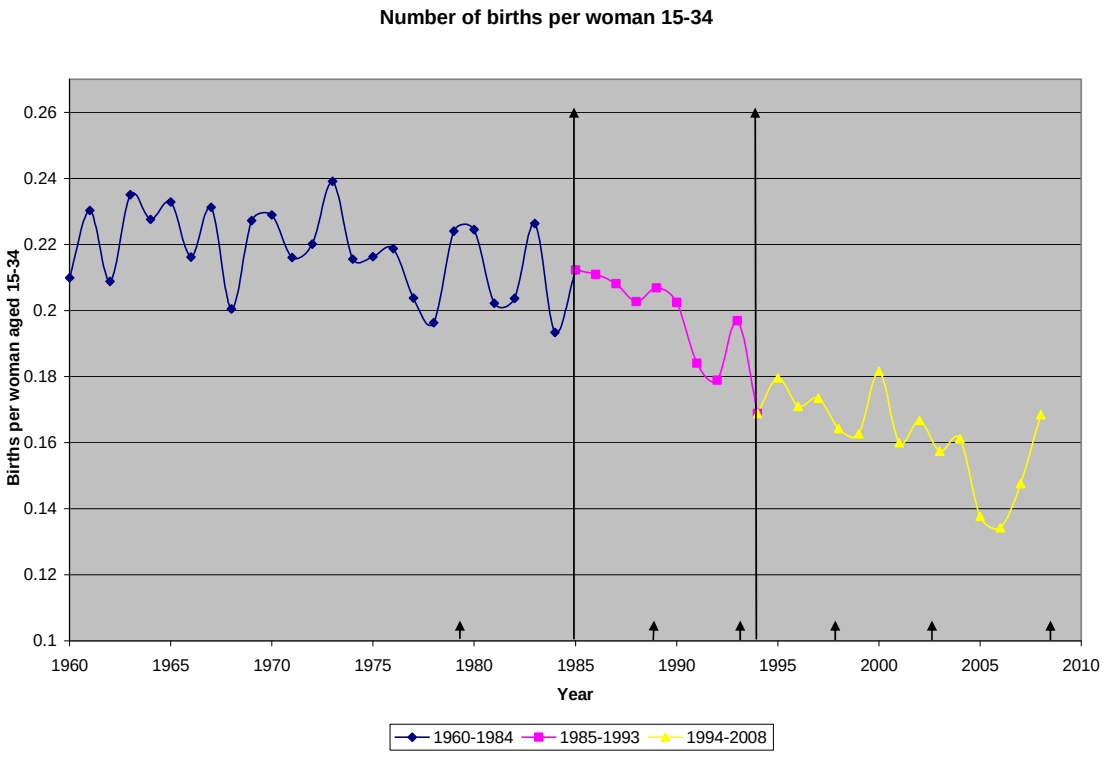
In 1994 the National Population Policy was released, and this had legal implications for the pill and condom – both could now be legally advertised with restrictions. The policy included changes that permitted "the provision of information to allow couples to space or limit their reproduction;" and "sex and family planning education". See Appendix 1 for details. Since 1994 there have been no further changes to the reproductive health laws in Ghana.

Empirical Motivation: Law Change and Fertility Decline

In an empirical context, we examine the effect of changes in the reproductive health laws on fertility outcomes using data from the World Fertility Survey (1979) and Demographic and Health Survey (1988, 1993, 1998, 2003, 2008) we reconstruct the Ghanaian birth rate by year. The birth rate is defined as the number of children born in a given year relative to the number of women who are between the ages of 15 and 44 in that same year.

There is much variation in the birth rate from year to year, but if we consider the trends over the 1960-2008 period we gain a much more informative picture of fertility outcomes over the 48 year period. In Table 1, it appears that the birth rate had a relatively constant average just above 0.2 children per woman age 15-44. Then from 1985 onwards, the birth rate began to decline. The timing of this decline coincides with liberalizations of reproductive health laws in Ghana.

Table 1: Births per woman age 15-34 in Ghana between 1960 and 2008.



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The WFS and DHS have detailed information regarding fertility, demographic and health data. Within the sample there are 30,625 respondents who are women between the ages of 15 and 49. There are six surveys, but it is not a panel. The survey is randomized at the cluster level and the clusters change each survey round. From survey to survey we compare national or regional averages conditional on characteristics of the respondent. In addition to a detailed fertility history, the WFS and DHS contain detailed information regarding urban-rural living, education, household size, and contraceptive use. In Table 2 we summarize the fraction of women currently using modern contraception by type.

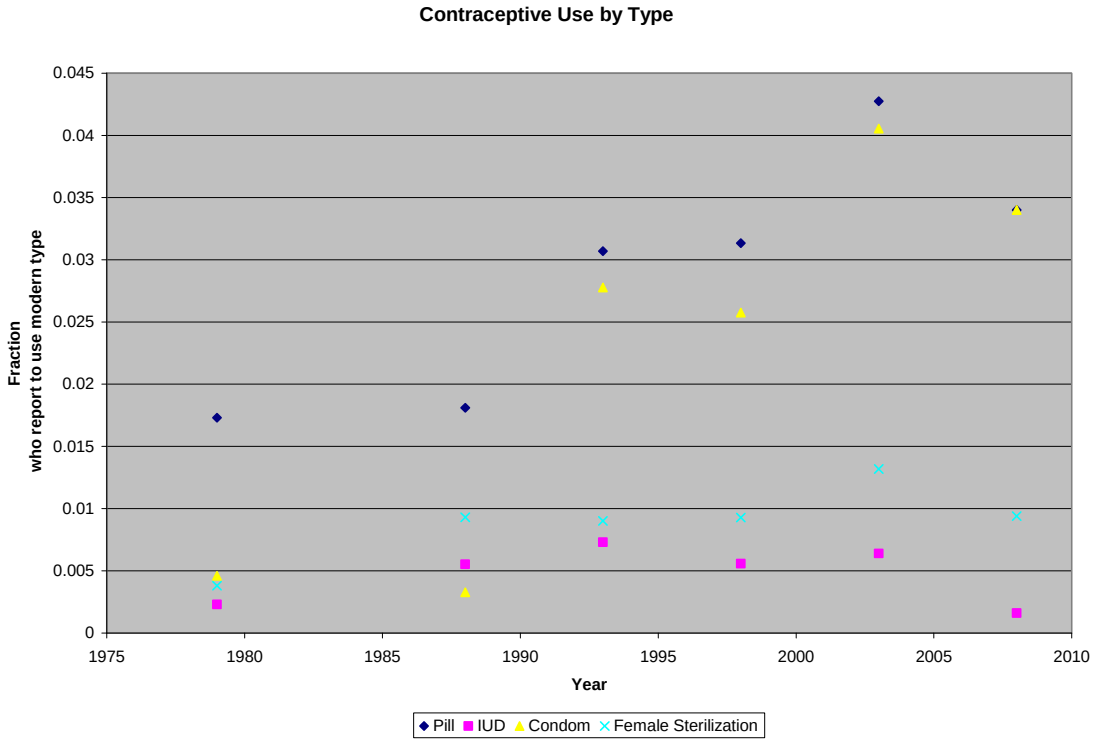
In Table 2, we can see that use-rates of pill and condom increase between the 1988 survey and the 1993 survey. Thus the large climb in pill and condom use preceded the change in the pill and condom advertising laws that occurred in 1994. A pervasive truth of these data are that use rates are very low – less than 5 percent of the respondents report to use a form of modern contraception in 2008.

What is striking is the strong association between the timing of the legal changes and fertility outcomes in Table 1, and the weak association between the legal changes and contraceptive use in Table 2. This leads us to think that either woman are reluctant to reveal their choice of contraception and there is under-reporting of contraceptive use.

An alternative explanation is that changes in reproductive health laws do cause changes in fertility outcomes, but it is not through the obvious channel of contraceptive use. Is it that the legalization of reproductive health methods brings with it a broader awareness of reproductive health issues and not simply boosting use-rates of modern contraception? Is it that legalization of abortion or the liberalization of advertising laws delivered to the

public a message of the importance of reproductive health. Birth spacing, timing, and event come onto the agenda for women whereas such issues were previously ignored. Is it that awareness of reproductive health issues is enough to influence fertility, and although a more subtle connection it may be that it has greater impact.

Table 2: Contraceptive Use in DHS Survey Year -- Ghana



Stakeholders: Domestic Politics, the Church, International Organizations, International Conventions

Figure 1 is quite telling. The birth rate appears to start its decline coinciding with the introduction of abortion laws in 1985 and strongly declining immediately following the change in advertising laws in 1994. Yet in Figure 2 we do not observe a corresponding change in contraceptive use and low levels of use persist across the time period.

So, are the changes in abortion laws and contraceptive laws and subsequent decline in fertility a representation of a causal relationship or just mere coincidence?

To answer this question we explore in detail the political and social environment surrounding the legal change. First we investigate the domestic political environment to understand who the key players were in driving the legal change. Was the legal change in response to growing pressure from lobby groups demanding better access to reproductive

health methods to meet the evolving needs of women and their desire to control family size to pursue education and employment? Or was the change in the law independent of social pressure, and driven by an individual within the judicial system?

In addition to exploring the internal environment, we also consider the international context in which the law changed. The role of international organizations in either shaping the law, or once the law is introduced aiding with implementation.

Thirdly, we explore the role of international conventions in shaping domestic legal change. The United Nations International Conference on Population and Development was influential in shaping domestic law and policy of participating countries.

Domestic Political Environment Surrounding Reproductive Health Laws Changes

(Still to write this section with respect to the 1985 abortion law change).

With respect to the legal change in 1994 in Ghana reproductive health arena we consider the domestic political environment in the lead up to this change.

After many years of provisional leadership under military rule, 1992 marked a watershed year in Ghana's political history with the drafting of a new constitution and the introduction of multiparty elections. The Fourth Republic was inaugurated on January 7, 1993 with the swearing-in of Flt. Lt. Rawlings as President and his running mate, Mr.K.N. Arkaah as Vice President. The newly elected Parliament was opened on the same day and elected, Mr. Justice D.F. Annan as Speaker.

The new constitution was based on a participatory analysis organized by the National Commission for Democracy through regional forums to gather insight from the people about the type of government they wanted. The draft constitution, like many in the region, integrates specific human rights clauses from international human rights covenants including article 27, which protects women's rights, according special care is to mothers during a reasonable period before and after childbirth, during which time working mothers are entitled to paid leave) and article 26, which prohibits all customary practices that dehumanize or a injurious to a person's physical or mental well-being are prohibited.

It was this political opening in 1992, followed by the first multiparty elections in 1993 since independence that generated a window of opportunity for the reform of reproductive health laws. Though abortion laws were liberalized in 1985, regulation of advertising for contraceptives and condoms had remained strictly enforced. In 1994, a change in these advertising laws, was part of the legislative reform in SRH that occurred in keeping with the newly adopted constitution.

In the health sector, this change in government concomitant with international trends in sexual and reproductive health, ushered in an era of reform in the health sector reform.

Just two years after endorsing the 1994 ICPD Programme of Action, Ghana's government drafted a comprehensive Reproductive Health Policy and Standards document, finalizing it in 2003. Adolescent reproductive health, central to the Cairo declaration, received separate attention in a policy drafted in 1996 that outlines a broad multi-sector approach to adolescents, including links among the Ministry of Education, Youth and Sports and the Ministry of Health. This is not yet fully implemented, and its commitment is weak on addressing adolescent sexuality and the need for dedicated reproductive health services, including access to contraceptives (Mayhew, case study).

In total, three different national bodies produced at least seven separate policy documents on sexual and reproductive health after 1994. While the attention was positive overall, it has confused providers on which guidelines to apply and where accountability and responsibility should lie. There is also confusion over the roles of the Ministry of Health (which is expected to handle policy development and monitoring) and of the Ghana Health Service, created in 1996 (which is supposed to take care of implementation, day-to-day management and staffing) (Mayhew, case study).

In the parliamentary elections held on December 29,1992, the Progressive Alliance made up of the National Democratic Congress, the National Convention Party and the Egle Party won 198 seats out of a total of 200, within the Alliance the NDC won 189 seats, the NCP had 8, the Egle Party 2, and Independents 2. Four parties - the NPP, PNC, NIP and PHP - boycotted the parliamentary elections, dissatisfied with the pro posed election strategy.

The Role of the Church

While Ghana chaired the Population Conference in Cairo (September 1994) and was a key member of the Committee that drafted the program of action that knit together the objectives of population and development, it has however been slow in the uptake of family planning and safe motherhood programs. The puzzle therefore is that in spite of a considerable reserve of political will in the 1990's, there have been important challenges to the advance of contraception and more broadly, sexual and reproductive health programs in Ghana.

While the use of contraception in bringing about fertility transitions is accepted widely, in an unproblematized way – this work will trace a more nuanced background to the acceptance of fertility control measures based on the intersection of institutional and ideational factors. It will explore the challenges or limitations to state authority and policy making, by the influence of the Church and its influence over both medical and political institutions directly and more indirectly, over reproductive choices and behavior in society. Based on Bongaart's (1978,1983) classification of 'proximate' reproductive determinants as being governed by direct and indirect effects, this part of the paper will focus on the indirect effects of ideology, identity and institutional change by focusing upon the historical influence of the Church in Ghana over the politics of defining family roles in legislation, in setting political agenda relating to marriage laws, fertility and child maintenance laws etc.

This study will therefore map the international alliances and networks of the Church in Ghana, its relationship historically with issues of privacy and ethics as and when raised over contraception priorities, both at a domestic level and in international population conferences (in alliance with the Holy See); as well as the Church and its interaction with other religious communities, such as the Muslims with separate family law entitlements. State authority and its challenges in a key policy arena will therefore be explored to understand the role of the Church as a key political influence over the reform and implementation of contraception policies.

International Organizations

It is important to place changes in family planning services in the context of a country's family planning program strategy. In Ghana, government support of family planning programs began in 1969, though the more recent program initiatives include the Contraceptive Social Marketing (CSM) project (1987- 1990), the Ghana Family Planning and Health Program (FPHP) (1990-1996), and the Ghana Population and AIDS Project (GHANAPA) (1996-2000). The initial focus of these projects was to increase demand and utilization of modern contraceptive methods for family planning by means of social marketing.

Ghana's Population Policy in 1969 was one of the first on the African continent. However, on the 20th anniversary of the policy in 1989, an assessment documented the lack of progress in increasing contraceptive use, in part because of the lack of grassroots involvement in its development and the lack of a strategic plan for implementation. The policy was revised in 1994 to focus on these strategies, and the 1990s saw increased progress in improving family planning in Ghana. With a total fertility rate (TFR) of 4.4 and modern method contraceptive prevalence (CPR) of 18.7%, the country has been said to be well on the way to meeting the goals set out in the National Population Policy of 1994: to reduce the TFR to 5.0 by 2000, 4.0 by 2010, and 3.0 by 2020, and to increase modern CPR to 15% by 2000, 28% by 2010, and 50% by 2020.

The Ghana Family Planning and Health Program (FPHP) is a bilateral agreement between the Government of Ghana and the United States Agency for International Development (USAID). The six-year, US$30 million project agreement was signed in April 1991. The project components included intensive educational efforts, training, and advertising; delivery of contraceptives and other health-related services and products focusing on social marketing of condoms, oral contraceptives, and vaginal foaming tablets; improved logistics systems; support to the clinical laboratory system; and monitoring via management information systems and HIV surveillance.

The program was originally designed as an MCH/FP activity; however, it became apparent late in the design process that USAID could at the same help strengthen the physical infrastructure and human resources needed to support Ghana's expanding HIV/AIDS control program. This effort built on prior USAID support channeled through the World Health Organization (WHO) to support the nascent Ghana National AIDS

Control Program (NACP) and from 1988 through 1992, US$1.3 million was provided through AIDSTECH and AIDSCOM.

To consolidate gains made through the support of FPHP, USAID/Ghana designed and implemented a bilateral program with the government called the Ghana Population and AIDS Project (GHANAPA). GHANAPA was a US$45 effort to increase contraceptive prevalence to 20 percent, bring long-term method usage up to 40 percent, and increase awareness and practice of HIV/AIDS risk reduction behavior by increasing the use of condoms and improving knowledge of HIV infection prevention.

The discontinuation of these programs may have contributed to the very recent rise in fertility, but also raises concerns about potential drop off of reproductive health support that may still be needed within Ghana.

Summary

From our analysis we observed in the data that fertility rates decline dramatically following the liberalization of abortion law in Ghana and then later when there was a liberalization of contraceptive laws. The usual pathway: liberalization of reproductive health law; increase in abortion and contraceptive use; and decline in fertility was not evident in the data – reports of abortion and contraceptive use did not match the stimulus (legal change) and outcome (fertility decline).

This led our analysis to consider two core options. The first that there was under-reporting of abortion and contraceptive use; the second, that the change of abortion and reproductive health laws invoked the concept of ideation and greater awareness of reproductive health had an effect on fertility without changing contraceptive use.

In considering these two options, we then explored the political environment in which these legal changes came to pass. Through this we analyzed whether the legal change was purely exogenous, or driven by heightened demand by women voters. Thus drawing into the direction of information flows – government to the people or visa versa? If the information flowed from the government to the people, then it may be that the government brought increased awareness of reproductive health. If it came from the people, then the awareness was already there.

Under-reporting of contraceptive use may be expected in a highly religion state, as Ghana is, and there is stigma attached to controlling one's fertility. Understanding the role of the church in helping or hindering family planning guides us to understand how deeply reproductive health methods are stigmatized and thus the degree to which under-reporting of use is likely.

In a developing country context, as in the case of Ghana, access to contraception is often limited due to inefficient health systems or high pricing. International aid agencies, such as USAID, have played an instrumental role in developing Ghana's reproductive health agenda. They navigate through the maze of domestic politics and religious values and

practices to provide reproductive health services. We analyze the role of USAID to gain a sense of the types of services and the coverage of these services to the broader population.

Through this analysis we aim to uncover whether the legal change was exogenous event – that is independent of demands from women. We then aim to understand the mechanism by which the legal change led to a change in fertility.

References

To be added