

POLICY IMPLICATIONS OF THE VARIATIONS IN GHANA'S FERTILITY TRANSITION

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Abstract

The results of three consecutive Demographic and Health Surveys (GDHS), carried out in 1986, 1993, 1998, show that Ghana's population has been experiencing a fertility transition. An analysis of the data, however, indicates that there are wide and increasing differentials in both the timing and trends in the process among geographic and socioeconomic subgroups of the population. Current Total Fertility Rate (TFR), for example, varies from around 3 to 7.

This paper examines the policy implications of the variations in the fertility transition. The transition is associated mainly with urbanization and education (particularly of mothers). The differentials are therefore explained by increasing economic inequalities among the socioeconomic subgroups of the population and the administrative regions. Policies that seek to remove the disparities in the fertility transition in the country must therefore address this underlying factor. While implementation of reproductive health/family planning programmes will have to be continued, even as the level of unmet need for contraception is still high in the population, socioeconomic development goals that seek to address such population problems must be a first priority and also be at the centre of population programmes in the country. Another policy approach will be the documentation of the details of the process at regional, district and other levels because the national averages obscure the peculiar patterns and trends presents at such levels. The quantitative data so far gathered on the various issues in reproduction in the country will also have to be supplemented by micro studies that adopt qualitative approaches to discover issues that are not captured by quantitative approaches.

Introduction

Three Demographic and Health Surveys (GDHS I, II and III) conducted in 1988, 1993 and 1998 respectively show that Ghana has achieved significant reduction in her fertility rate. Over a ten-year period, the Total Fertility Rate (TFR) dropped from 6.4 at the 1988 GDHS to 4.6 at the 1998 survey. This shows a two-child drop in the average number of children ever born alive to women in their reproductive period.

The results of the surveys however indicate significant differentials in the fertility change among geographical entities as well as socioeconomic subgroups of the population. The disparities are obscured by the national averages.

This paper discusses the patterns and trends in the variation of the fertility change and the associated factors. The main objective is to examine the emerging patterns and trends in this important demographic process in the population. Assessing how the observed variations are accounted for by disparities in socio-economic development and health indicators, the paper then shows how these pose challenges to Ghana's socio-economic development policy and the family planning/reproductive health policies and programmes that have been implemented in the country so far. It recommends equitable principles in development policy formulation and implementation to manage the challenges of the disparities observed. It also stresses that better understanding of the differentials in the fertility transition requires data on smaller geographical units and more socio-economic subgroups (apart from the educational and residential categories)

of the population as well as qualitative approaches to data collection on fertility and related demographic and related issues.

Data Sources

The main sources of data for the study are the GDHS of 1988, 1993 and 1998 and the report on the Ghana Fertility Survey (GFS) conducted in 1979/80. Data from the Ghana Living Standards Surveys (GLSS) of 1985, 1990, 1995 and 2000 have also been used. The reports of the various censuses conducted in 1960, 1970, 1984 and the 2000 (population and housing) provided some information for the study (Ghana Statistical Service 2000a).

The GFS is part of a worldwide fertility survey which was conducted in the 1970s. The GDHS is also part of an international effort coordinated by Macro International Inc. (U.S.A.) and funded by the USAID). It began in 1984 in some forty-six countries (The Allan Guttmacher Institute 1998, Ghana Statistical Service 1994: 2). In Ghana, the three surveys GDHS I, II, and III were carried out in 1988, 1993 and 1998 respectively.

The various GLSS are nation-wide surveys which collected data on a variety of socioeconomic issues – demographic characteristics of the population, education, health, employment and time use, migration, housing conditions, household agriculture and non-farm business (Ghana Statistical Service 2000b: v). The main purpose of these surveys was to provide needed information to policy makers and others to evaluate living standards and information on labour force systems in the country as well as enable monitoring and evaluation of the welfare of the population following the introduction of the Structural Adjustment Programmes with poverty reduction components.

Theoretical Perspectives

Evidence from research and historical records on fertility transitions shows that the process hardly occurred in uniform patterns over geographical entities or even within socioeconomic subgroups of a population. This is because the process itself is determined by several factors which may vary within any given population and also bring about the onset or precipitation of the process at widely varying levels of their presence (Bongaarts and Watkins 1996: 640).

The European experience is often cited in the literature. France was the forerunner and experienced fertility decline between 1780 and 1950 and was followed by the majority of the countries who had recorded fertility change in their populations during the second half of the Nineteenth Century. The few who were the stragglers experienced their transition at the beginning of the Twentieth Century (Livi Bacci 1992 cited by Agyei—Mensah 1997:15, Knodel and van de Walle 1986: 412). Differentials in fertility transition within the various countries have also been noted.

The earliest demographic explanation on fertility decline which is embodied in the Demographic Transition Theory is based on the European experience (Notestein 1953). According to the Demographic Transition Theory, fertility decline occurs in a population when socioeconomic changes (termed “modernization” in the theory) brings about new lifestyles which discourage large family size. The modernization process which occurs as a result of urbanization and industrialization comes with rising cost of raising children due mainly to the cost of their education and their declining economic value. These two forces considered the central forces driving fertility decline (Bongaarts and Watkins 1996) weaken the motivation for having large number of children. An associated increased child survival rate in the modernization process (due to improved living conditions and subsequent drop in mortality levels) also encourages adoption of fertility control measures to limit the size of the family. By implication, the Demographic Transition Theory provides explanation on how variations in socio-economic

development within any population can result in disparities in the patterns and trends in its fertility change (Bongaarts and Watkins 1996: 40-41).

Even though empirical evidence suggests that no society¹ has gone through significant socioeconomic transformation without experiencing some level of fertility decline, the role of socioeconomic development in accounting for the process has been challenged not only by new or recent findings on earlier transitions such as Europe's but even some recent ones.

In the European region, the forerunner, France experienced fertility transition when rural and agrarian conditions were characteristic of the population. In addition, infant mortality level was high in France when fertility level begun to fall, though drop in infant mortality is considered critical in fertility change. Britain, on the other hand, achieved high levels of socioeconomic development and technology before the onset of fertility transition in her population (Guinnane et al. 1994). Recently, Bangladesh has made some progress in fertility decline even though socioeconomic development in that country has not advanced much and there is "little apparent change in traditional values" (Mason 1997: 444). Bongaarts and Watkins (1996) in their study on contemporary fertility transitions have also found out that a number of developing countries apart from Bangladesh, have experienced the onset of fertility decline under low levels of socioeconomic development. They have also referred to Kirk's (1971) observation that the pace of development in the developing world as a whole has been substantially more rapid than that observed in Europe around the turn of the Twentieth Century. One major finding of Bongaart and Watkins (1996) and other works such as Cleland and Wilson's (1987) which also found similar relationship, is noted in the diffusionist explanation of fertility decline. The diffusionist approach states that family practices may be adopted apparently independently of social and economic circumstances.

Demographers have had to explain fertility transition as resulting from two contrasting underlining view points. The earlier adaptation explanation argues that fertility control reflects couple's response to changes in economic and social circumstances. The innovation hypothesis links fertility transition with behavioural change – a new behaviour whose origins may be new knowledge most likely about contraception. Such new knowledge may also result from changes in cultural conditions that makes family limitation practices "acceptable for the first time on moral grounds" (Guinnane et al. 1994: 1-2).

However, the diffusionist explanation and the narrow view that the spread of information on modern contraception from western countries to developing countries can bring about fertility change has been challenged by the wide gap between knowledge attitude and practice (KAP – gap) in many of these populations. In other words, the presence of the family planning programmes does not necessarily lead to the practice of family limitation.

The distinction between the diffusion of the information regarding fertility regulation and the diffusion of preferences regarding family size/limitation (Pollak and Watkins 1993) explains this paradox. While the presence of family planning facilities and services creates awareness about contraception, diffusion and subsequent adoption of preferences for family limitation innovation is what actually results in fertility change. This distinction is important but it must be accepted that the presence of the facilities and services do sometimes serve both purposes, and bring about increases in Contraceptive Prevalence Rate (CPR) and subsequent fall in fertility change. Recent fertility changes in Bangladesh and Kenya are associated with family planning programmes implemented in those countries (Piotrow et al 1997).

¹ The case of the Arab nations which continue to have relatively high levels of fertility despite significant socioeconomic transformations may be an exception. Adherence to socio-cultural and some religious practices account largely for this situation.

In Ghana, the recent fertility change is associated with socioeconomic factors. Thus the variations in Ghana's fertility transition are explained by differentials in socio-economic processes or fit the adaptation explanation. As we will see in the next section, disparities in development levels within geographical and socio-economic subgroups of the population underlie the variations in fertility transition among them. The implications of the variations in the fertility transition are challenges to the socio-economic policies that have been inequitable.

The Fertility Change – Patterns And Trends

Even though the earliest fertility decline in Ghana was observed at the 1979/80 GFS, it was the results of three consecutive surveys – GDHS I, II, III, conducted in 1988, 1993 and 1998 respectively which indicated that the population has begun to experience fertility transition. Thus from a high fertility level which was in excess of 6 in the 1980s, the onset of fertility transition was observed by the early 1990s and has since been sustained by further significant drop in the TFR.

National

Before the mid-1970s the TFR in Ghana was estimated to be between 7 and 8 (National Population Council 1994). The 1979/80 GFS results show that five years before the survey the TFR had declined to 6.5, that is by the mid-1970s. Thus the earliest decline in fertility levels in Ghana was observed at the 1979/8 GFS. See Table 1. The decline was however not sustained as revealed by the 1988 GDHS results, The TFR dropped insignificantly between the two surveys from a TFR of 6.5 at the 1979/80 GFS to 6.4 at the 1998 GDHS.

Table 1: Trends in Total Fertility Rate, 1979/80 to 1998

Year	TFR
1979/80	6.5
1988	6.4
1993	5.5
1998	4.6

Source: Ghana Statistical Service 1989 and 1999

The temporary decline in fertility level during the mid-70s was attributed to large scale emigration from the country especially of males due to intensified economic hardship in the country (Adjei-Mensah 1997). Their partners who were left behind therefore postponed their next child birth.

Fertility decline begun to be significant from early 1990s. Between the GDHS of 1988 and 1993 the TFR dropped by 14% from 6.4 to 5.5. A higher rate of decline, 16 %, was recorded between the 1993 and 1998 surveys, bringing the TFR to 4.6 in 1998. Table 1. Between the ten-year period from 1988 to 1998 the TFR dropped by 28% from 6.4 to 4.6 showing a two-child drop in the average number of children ever born alive to women in their reproductive ages. Thus from a pretransition fertility level which was in the excess of 6 in the 1980s, an onset of decline was observed in the early 1990s and is being sustained.

The national averages of the fertility changes have however obscured differentials in the transition among various geographical entities and socioeconomic subgroups of the population.

Regional Disparities

The most noticeable differences in fertility patterns and trends are between the northern and southern parts of the country. In the southern parts of the country fertility decline has been

experienced in all the regions. Generally, the rate of change is faster here than in the northern regions except in the case of the Upper East Region where significant fertility change was recorded between 1993 and 1998. See Figure 1. Differences are observable among the individual regions too. Refer to Table 2.

Table 2: Total Fertility Rate (TFR) by Region, 1988 – 1998

Region	Total Fertility Rate (TFR)			% Change in TFR		
	1988	1993	1998	1988-93	1993-98	1988-98
Western	6.1	5.5	4.7	-09.8	-14.5	-23.0
Central	6.6	5.6	4.7	-15.2	-14.3	-27.3
Greater-Accra	4.6	3.6	2.7	-21.7	-25.0	-41.3
Volta	6.6	5.4	4.4	-18.2	-18.5	-33.3
Eastern	5.7	5.1	4.4	-10.5	-13.7	-22.8
Ashanti	5.9	5.6	4.8	-05.1	-14.3	-18.6
Brong-Ahafo	6.9	5.5	5.4	-20.3	-01.8	-21.7
Northern	6.8	7.4	7.0	+8.8	-05.4	+02.9
Upper West	6.8	6.0	6.1	-11.8	-01.7	-10.3
Upper East	6.8	6.4	5.0	-05.9	-21.9	-26.5
All Region	6.4	5.5	4.6	-14.1	-16.4	-28.1

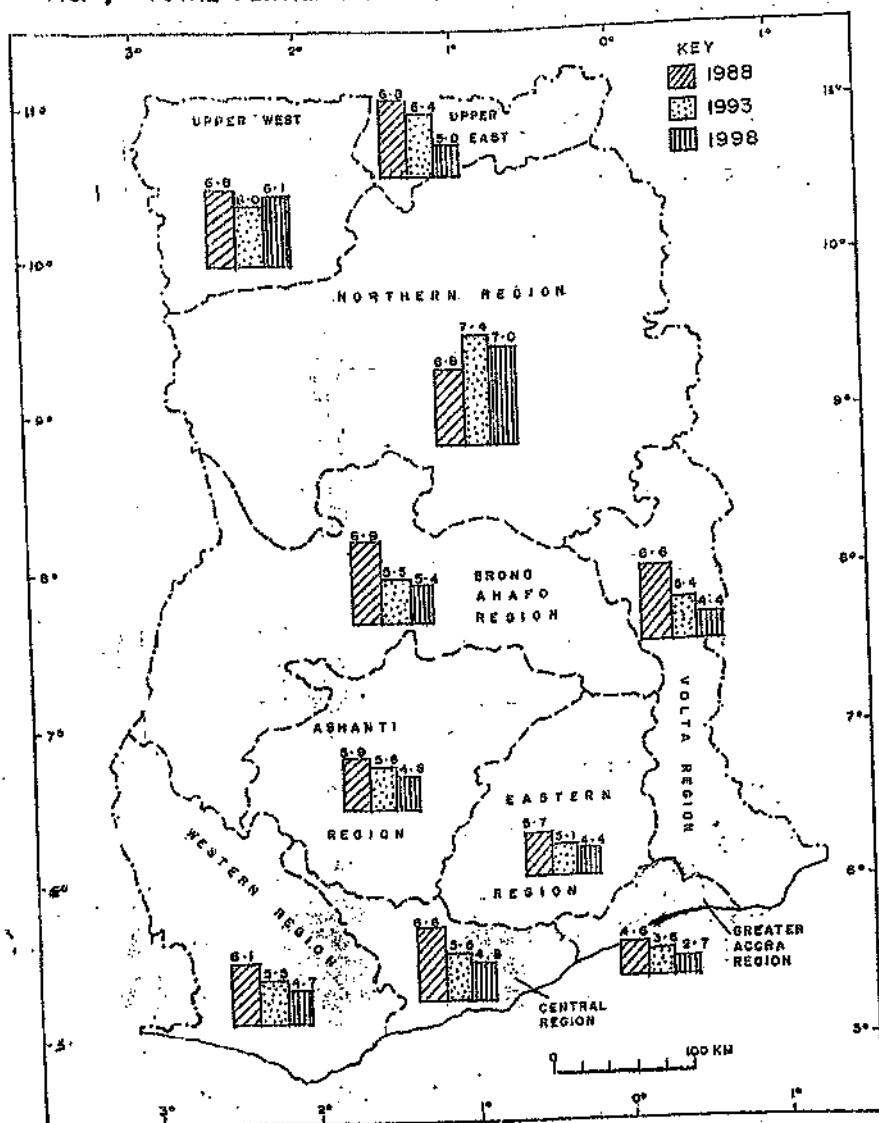
Source: Ghana Statistical Service 1989: 1993: 1998:

The Greater Accra Region has had the lowest TFR and the fastest rate of decline. During the ten-year period (from 1988 to 1998), its TFR dropped by 41%, from 4.6 to 2.7. All the other regions in the south, (except Ashanti), also recorded over 20% drop in their TFR during the same period. Another feature of the trend in fertility change among the regions in the south is the increased rate of change in fertility from the period 1988 to 1993 and 1993 to 1998. Two regions, the Central and Brong Ahafo are the exceptions in this regard.

In the northern regions on the other hand, both increase and decrease in TFR were recorded. The increase in TFR was observed in the Northern Region between 1988 and 1993, which was followed by an insignificant decline of 5% between the 1993 and 1998 surveys. The other two regions had decline both significant and negligible between the 1993 and 1998 surveys, 21.9%, is worth nothing. The exceptionally high rate of decline between 1993 and 1998 in the Upper East Region where socioeconomic conditions have not changed just as in the other northern regions is interesting. A study by (Appiah et al. 2001) observed that a temporary drop in birth rates was recorded in one of the districts in the Upper East Region, Kasena-Nankana. This was attributed to agricultural adversity or drought and famine. Other parts of the region might have had the same experience. It may however be important to investigate if the process has become permanent or not, and if it is not due to other factors.

Sudden decline in fertility has been observed in some developing countries too. Bongaarts and Watkins' (1996: 653) study on contemporary transitions observed that "the most striking feature of these transitions is the suddenness with which the fertility levels changed". They found out that in some populations (Chile, China, Colombia, Mauritius, Singapore, Thailand etc.) fertility declined by more than 30% per decade. The lower rate, 21.9% observed between 1993 and 1998 for Upper East may be another example and is worth investigating because of its uniqueness in that part of the region. Moreover, famine has been characteristic of the whole northern section of Ghana even in the past. We need to know why it is contributing to fertility change temporarily or may be permanently.

FIG. 1 TOTAL FERTILITY RATE (TFR) BY REGION 1988-1998



Source: Ghana Statistical Service 1989, 1994, 1999. RATE OF URBANIZATION: STATISTICAL SERVICE, 1987.

Another important feature of the patterns and trends among the regions is the increase in the range of TFR since the onset of the transition. In 1988, TFR ranged from 4.6 in the Greater-Accra Region, to 6.8 in the Northern Region. By 1998, the Greater Accra Region, still recording the lowest TFR had 2.7 while the highest was 7 in the Northern Region, which also had the highest rate. Considered in numerical terms as "long-term decline in the number of children from four or more per woman to two or fewer" (Mason 1997: 443), we can conclude that fertility transition in Ghana's population is a selective process among the geographical regions. Some regions cannot be said to have even experienced the onset of decline while others have had sustained and significant drop in their fertility levels.

The disparities in the regional trends are attributable to variations in the main factors associated with the fertility decline: urbanization, education (especially female education) and health status of the population measured in terms of mortality rates (particularly of infants and children). We defer discussion on this to another section to avoid repetition.

Variations in Fertility Change among Socioeconomic Sub-Groups of the Population

Disparities in fertility change exist among socioeconomic subgroups of the population too. Rural – urban differentials and variations by educational status (of mother) can be observed on Table 3.

Table 3: Total Fertility Rate By Background Characteristics

Background	1988	1993	1998
Residence			
Rural	6.6	6.4	5.4
Urban	5.1	4.0	3.0
Education			
No Education	6.7	6.7	5.8
Primary	6.1	6.1	4.9
Middle / JSS*	5.9	4.7	3.8
Secondary+	3.6	2.9	2.8
Total	6.4	5.5	4.6

* JSS: Junior Secondary School

Source: Ghana Statistical Service, 1994, 1999

While TFR dropped significantly (25%) in urban areas between the 1988 and 1993 there was negligible change (3%) in rural areas. The pace of fertility decline has since then remained higher in the urban population than in the rural. This has resulted in the increase in the difference between rural and urban fertility levels. See Table 3. Between 1988 and 1998, there was a two-child drop in the TFR of urban women compared with one among rural women. The difference in TFR between urban and rural areas which was less than one (6.6 and 5.1) in 1988 therefore increased to almost two (5.4 and 3.0) by 1998.

With regard to educational subgroups, the surveys show an inverse relationship between education and fertility as is normally so in many populations. The pace of fertility decline was higher among women with primary or higher levels of education than those with none. This may imply that the level of fertility among women with secondary or more education has reached a level. Women with Middle / JSS level of education experienced the fastest pace of decline over the ten-year period from 1988 to 1998, registering a two-child-drop in their TFR. This is even higher than the decline among women with secondary or more education. They had a little below one-child drop. Even though fertility levels are significantly lower at higher levels of education

(secondary and over) the data from the survey shows that there may be significant drop in fertility when Ghanaian women are educated just up to the Middle/JSS level.

Based on the patterns and trends in fertility among the socioeconomic subgroups and those of among the regions, we can agree with Agyei-Mensah and Aase (1998: 203) who studied the process at its early stages that "Ghana's fertility change is occurring in a socioeconomic and geographically distinct manner".

Policy Implications of the Patterns and Trends

There may be several policy implications of the patterns and trends in fertility decline in the country that have been observed thus far. We will however focus on (1) data needs, (2) socioeconomic development policy and (3) implementation of population and family planning/reproductive health programmes.

Data Needs

Our analysis indicates that the aggregate data or national averages obscure marked differences in the levels and trends of fertility decline among the regions and other subgroups of the population. We concluded that some regions cannot be said to have even experienced the onset of fertility decline yet while the process has so far been sustained in others.

Obviously, surveys or studies carried out at regional or within smaller geographical entities are needed to understand further the marked differences observed. Such studies can also aim at analysing intraregional disparities or differences among smaller or more socioeconomic subgroups of the population. The Ghana Statistical Service (who conducted all the surveys) can also consider disaggregating the data such that some aspects needed for planning and other uses at levels other than those so far available can be published.

The reports on the GDHS I, II, and III indicate that urbanization, education (of women) and improved health status (reduced infant and child mortality in particular) are the factors associated with Ghana's fertility transition. These are broad categorization of the determinants of the process. Urbanisation, for example, is a very broad terminology that comprises a number of social and economic characteristics. The degree to which these factors and their constituents influence fertility levels and trends can be determined when appropriate data is generated. Such analysis will then help policy makers to adopt informed policies to reinforce those factors that contribute significantly to the process within defined units or areas. Our analysis has shown that education to at least Middle/JSS level is required to influence fertility among Ghanaian women. Urbanization, education and health are interrelated and influence each other. The degree of influence may however vary within different socioeconomic and cultural contexts. Particular types of data will have to be generated for such observations to be made.

Finally, both quantitative and qualitative approaches to data collection and any type of study on the fertility transition will have to be encouraged. The study by Appiah et al. (2001) referred to in the previous section, suggests that we can discover more about the trends when we investigate the patterns observed to understand them by adopting micro study approaches too. We will thereby avoid making any generalizations or conclusions without any proofs. The qualitative studies will also capture those socio-cultural factors that may not be observed by quantitative research techniques.

Socioeconomic Development

The literature on Ghana's socioeconomic development has reiterated that urban bias and export-oriented policies of the country have resulted in regional inequalities in development in

the country. (See, for example, Songsore 2002; Deh 1986; Yankson 1985). The greatest evidence of this is the striking disparities in development between the southern and northern parts of the country; and rural-urban differences in access to basic needs such as drinking water, health and educational facilities and services. (Some deviations from the general patterns do exist within these broad regions though. They reflect in the patterns and trends in fertility observed as noted earlier).

Ghana's fertility transition which has been one of adaptation and associated with urbanization, education and improved health status of infants and children has consequently varied among the regions and socioeconomic subgroups of the population. The relationship between the factors associated with the process and the patterns and trends in fertility can be observed from Table 4. It shows that generally where smaller proportions of infants and children are dying, higher proportions of females aged 15 years and over have been to school, and the proportion living in urban areas are highest fertility decline is highest.

This general picture shows that the demographic process has been and in future will have to be influenced by socioeconomic policies. The revised 1994 Ghana Population Policy has stressed the need for population issues to be addressed in socioeconomic planning. This obligation for government to consider population issues in socio-economic planning is spelt out in Article 37, Clause 4 of the Fourth Republic Constitution of 1992 (National Population Council 1994). It demonstrates the expectation that population processes can be influenced by socio-economic policy.

Such policies required must include more equitable provision of health and educational facilities and services to the population. While the northern regions automatically may receive more attention than any other regions with respect to these and other social services the Western, Central and Brong-Ahafo regions need to be included in any health programmes aimed at reducing infant and child deaths. If data becomes available at district and other lower levels, peculiar conditions within some areas within some regions can receive more attention. Examples include northern parts of Volta and Western regions who problems of transportation and unattractiveness to teachers and health workers cannot be overlooked.

The implementation of the Free Compulsory Universal Basic Education (FCUBE) programme introduced since the early 1990s will also have to be considered as a very important component of population programmes that aim at reducing childbirth and mortality among infants and children. Table 4 shows that mothers with no education have 131 of their children under five years dying per 1000 live births compared with 91 among mothers with Middle /JSS level of education. Thus mother with no education on the average have 6 children compared with 4 among these with Middle /JSS education. The FCUBE programme can equally bring about decline in fertility as family planning/reproductive health programme.

Table 4: Socioeconomic Characteristics and Change in Fertility by Background

Background Characteristics	Infant Mortality Rate	Under-Five Mortality Rate	Females Aged Who Have Been to Urban 15years+ Ever School Rural		Proportion of Population Living in Urban Areas (%), 2000	Percentage change in TFR, 1988-1998	TFR 1998
			Urban	Rural			
Region							
Western	6.0	109.7	79.4	58.2	34.9	-23.0	4.7
Central	83.8	142.1	64.6	54.5	37.1	-27.3	4.8
Greater Accra	41.4	62.0	80.4	61.9	87.4	-41.3	2.7
Volta	53.8	98.0	70.4	55.0	26.6	-33.3	4.4
Eastern	50.2	89.0	74.6	62.3	34.7	-22.8	4.4
Ashanti	41.9	78.2	82.6	64.8	53.2	-18.6	4.8
Brong Ahafo	77.3	128.7	69.1	58.4	37.4	-21.7	5.4
Northern	70.1	171.3	20.1	23.0	27.0	+2.9	7.0
Upper West	70.6	155.6	56.2	23.8	17.5	-10.3	6.1
Upper East	81.5	155.3	50.0	12.3	15.1	-26.5	5.0
Residence							
Rural	67.5	122.0	N/A	N/A	N/A	-18.2	3.0
Urban	42.6	76.8	N/A	N/A	N/A	-41.2	5.4
Education (of Mother)							
No Education	66.1	130.8	N/A	N/A	N/A	-13.4	5.8
Primary	70.3	112.5	N/A		N/A	-19.7	4.9
Middle JSS	53.5	91.3	N/A	N/A	N/A	-35.6	3.8
Secondary+	36.8	59.8	N/A	N/A	N/A	-22.2	2.8
All	61.2	110.4	73.8	51.5	N/A	-28.1	4.6

Source: Ghana Statistical Service 1999: 85, 2000D:10. N/A: Not Applicable or Not Available

Another policy consideration that needs examination is the export-oriented production policies of government which has favoured some regions more than others. Those regions in the south which are endowed with resources and favourable climate for production of export commodities (cocoa, timber, minerals etc.) have made more progress in socioeconomic development than others in the north. Diversifying export commodities to include the products of other regions among the non-traditional export commodities will have to become not just an economic policy but one that can influence living conditions in hitherto deprived areas and indirectly affect fertility levels as well. Care must however be taken not to commercialize agriculture in any part of the country without some level of mechanization. This will ensure that child labour is not required on farms thereby adversely affecting education of children. The absence of some mechanization may encourage the keeping of large families to provide family labour for farm work.

Family Planning/Reproductive Health Programmes

A year after adopting a national population policy in 1969, Ghana launched a family planning programme with a main purpose of providing Ghanaians information about family limitation and modern contraceptives. The programme was relaunched in 1992 to raise the image of the service providers and in 2001 to introduce strategic communication approaches into the delivery of the service (Ministry of Health and John's Hopkins University 1992). Ghana has also adopted the reproductive health paradigm recommended by the 1994 International Conference on Population and Development (ICPD) held in Cairo (Hardee 1999).²

The major achievement of the family planning programme is the creation of awareness about contraception. Over 90% of both men and women know about some family planning method, according to the 1998 GDHS. The survey shows that only 22% of married women were currently using any family planning method (13% modern and 9% traditional) after almost three decades of family planning implementation in the population from 1970-1998.

The low contraceptive prevalence rate in the population suggests that the family planning programme has not contributed much to fertility decline in the country. The Ghana Statistical Service (1998: iii) has suggested that abortion is probably responsible for reduced births in the population and needs investigation.

The analysis in the previous section also demonstrates the crucial role that socioeconomic policy and development have played in determining the patterns and trends in fertility in the country. As the heydays of demographic targeting in family planning are over and ICPD recommendations are accepted by Ghana, policies that aimed at reducing the growth rate of the population must not just be shelved. Reduction in infant and child mortality rate, adoption of more equitable principles in socioeconomic development, successful implementation of educational policies such as the FCUBE, and the like which directly or indirectly influence reproductive behaviour will have to support the family planning programme in Ghana. The findings of the Ghana Living Standards Survey (GLSS4) of 1998/1999 stress the same issues. It shows a 12.2% reduction in poverty levels at the national level from the 1991/1992 levels and long-term progress in access to safe drinking water and higher rates of school enrolment. However, incidence of poverty has increased or declined marginally in the northern parts of the country and some other areas including rural communities. To remove inequalities in socioeconomic progress and reduce poverty in areas most afflicted are components of strategies that can influence fertility levels in those areas.

² The essential focus is on providing integrated reproductive health services / interventions within cultural, social and economic contexts, rather than the previously limited programs that focused on demographic targets and issues.

The socio-cultural context within which high fertility is prevailing in some parts of Ghana must be given the due attention. Caldwell and Caldwell (1987) have discussed this for sub-Saharan Africa and identify pronatalist and cultural practices in marriage and sexual practices that influence reproductive decision-making. The conference on which this paper and others in this volume have first been presented (see foreward) have stressed the need to investigate this area to understand better reproductive behaviour today. Such areas are rarely covered in surveys such as the GDHS. Qualitative approaches with indepth interviews capture such issues more easily. This need is again emphasized and hereby considered indispensable for the effective implementation of the family planning programme. We need to uncover people's values today and continuity of traditional one about childbirth under the rapidly transforming socio-cultural and economic contexts. Surveys and studies done by Oppong (1987) and Bleek (1987) provide methodologies that can be replicated for the micro studies that are needed on fertility now to inform the family planning programme.

Conclusion

Evidence from the three GDHS conducted in 1988, 1993 and 1998 shows that fertility transition has been sustained in some geographical areas and within some population sub-groups of the country. The aggregate data obscures the patterns and trends within smaller entities of the population. Data required to understand the process at such levels will help to adopt policies for distinct areas or subgroups of the population.

The analysis of the data further indicate that it is a process of adaptation to socioeconomic transformations that have taken place in the country over the past few decades. Since principles of equity have not been followed in the sharing of the benefits of socioeconomic progress disparities in the demographic process also have emerged. These are challenges to the socioeconomic policy of the country. It must now be seen as a tool that can be used to effect the patterns and trends of fertility observed. Socioeconomic policy must be regarded as an indispensable component of population programmes even as stated in the population policy and the 1992 constitution of Ghana.

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