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STATEMENT

BY

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AT THE

COMMISSION ON POPULATION AND DEVELOPMENT
FORTY –FOURTH SESSION

GENERAL DEBATE ON NATIONAL EXPERIENCES IN POPULATION MATTERS: FERTILITY REPRODUCTIVE HEALTH AND DEVELOPMENT

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Mr. Chairman, please accept the compliments of the Ghana delegation on your election as chair of this forty-fourth Session of the Commission on Population and Development. My delegation is confident that under your able leadership, this meeting will attain a successful outcome.

Mr. Chairman, the interrelationships between population, fertility, reproductive health and development has clear policy priorities that stress the need for harmonizing population and economic growth rates. As a result, the 1994 Revised National Population Policy emphasized the need for development to center on the people especially the integration of population variables into development planning. It also dwelt on the need to reduce fertility in order for population growth to compliment national development efforts.

Generally, improvement in fertility over the years has been encouraging, although various socio-cultural practices and beliefs tend to support and sustain high rates of fertility. Ghana's Total Fertility Rate (TFR) declined from 5.5 children per woman in 1993 to 4.0 in 2008; two years before the target year of 2010 and is projected to reach 3.0 in 2020. According to the 2008 Ghana Demographic and Health Survey (2008 GDHS), trends in age-specific fertility also revealed a decline in fertility as the median age at first birth has also improved over the years. The current median age at first birth for women aged 25-49 is 20.7 in Ghana.

Adolescent childbearing which could result in infant, child and maternal mortality also remains high. The GDHS (2008) indicates a teenage child bearing rate of 13.3%. This, however, is not universal across space as certain areas in the country record higher rates than others.

Although the country is on track regarding its targets for fertility, indicators for contraceptive prevalence do not paint the same picture. The current family planning acceptor rate reduced from 33.8% in 2008 to 31.1% in 2009 (2009, Service Statistics, Ghana Health Service) and preference for shorter term methods continues to remain high compared to other modern methods. The use of contraceptives in Ghana for any family planning method is 24%, while that of any modern method is 17%, a reduction from 19% in 2003 for modern methods (2008 GDHS).

As a result of high unmet need (35%) for family planning combined with Ghana's attainment of middle income status, repositioning family planning in national development planning is valid. The current medium term policy framework i.e., The Ghana Shared Growth and Development Agenda (2010-2013), emphasizes the urgency required over the immediate short-term for family planning to be addressed as a priority for national development employing a multi sectoral approach. Policy objectives target increasing political commitment for family planning in reproductive health service delivery and promoting acceptance of family planning as healthy lifestyle behavior especially in 15-24 year olds.

In addition, Ghana has developed a Reproductive Health Commodity Security Strategy which elaborates on ways to make reproductive health commodities and more especially, family planning commodities affordable, available and accessible to everyone who needs them. Other measures include the training of a wider cadre of providers in family planning service delivery and proper integration of family planning into other reproductive health services.

Mr. Chairman, since the introduction of the National Health Insurance Scheme (NHIS) in 2003, coverage of the population has increased steadily to 54%. Though contraceptives are included in the Essential Drugs List (EDL), the NHIS benefit package does not provide contraceptives and services to the clients. To address this, a multi stakeholder group of advocates is lobbying government to get the free maternal health policy to include family planning commodities and are

advocating for the National Health Insurance Scheme's (NHIS) benefit package to cover surgical methods of family planning as an initial step.

Mr. Chairman, maternal mortality continues to be a challenge to the country. In 2008, maternal mortality was declared a national disaster and a consultative meeting identified increased coverage of family planning, basic and emergency obstetric and newborn care, prevention and management of unsafe abortion and adolescent health and development as priority interventions. Furthermore research into socio cultural determinants and provision of maternal health services in the Community-Based Health Planning and Services (CHPS) strategy were identified as necessary for progress toward the attainment of MDG5 if the target is to be attained.

The Maternal Health Study (2007) also identified abortion as the second highest contributor to maternal death (15%), the highest being hemorrhage (24%). In addition, 16.0 per cent of adolescent pregnancies also result in abortions. To address these concerns, the Reproductive Health Policy and Standards was reviewed in 2003 to include the provision of abortion care services to the extent permitted by law in Ghana. This package of Comprehensive Abortion Care includes provision of family planning for primary prevention, counseling as well as post abortion care and post abortion family planning and linkage to community Information Education and Communication (IE&C) on dangers of unsafe abortion. We note that abortion is not a family planning method in Ghana.

In 2010 Ghana developed an MDG Acceleration Framework (MAF) with the assistance of UNDP and also undertook an assessment of Emergency Obstetric and Newborn Care (EMONC) situation in our facilities. We believe that with the findings of this assessment and the priority interventions identified, we can better chart our course towards the attainment of MDG5.

Mr. Chairman, despite these checkered results, Ghana is convinced that with continued political will, adequate funding, and integrated package of services, we will record better progress in our reproductive health indicators. Mr. Chairman, We cannot conclude without expressing our appreciation to the UN and its agencies as well as our development partners whose continued partnership and support are key elements in our reproductive health agenda.

Thank you for your interest and attention.