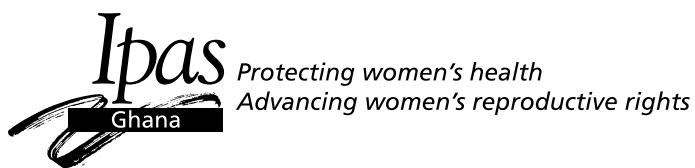


An assessment of the readiness to offer contraceptives and comprehensive abortion care in the Greater Accra, Eastern and Ashanti regions of Ghana

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Ipas works globally to increase women's ability to exercise their sexual and reproductive rights and to reduce abortion-related deaths and injuries. We seek to expand the availability, quality and sustainability of abortion and related reproductive health services, as well as to improve the enabling environment. Ipas believes that no woman should have to risk her life or health because she lacks safe reproductive health choices.

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List of tables

- Table 1:** Intended versus achieved quota sampling
- Table 2:** Characteristics of the survey instruments
- Table 3:** Proportion of facilities with postabortion care (PAC) log books by region (n=84)
- Table 4:** Distribution of facilities by district and region (n=90)
- Table 5:** Census of facilities by type (n=90)
- Table 6:** Geographical distribution of survey respondents (n=645)
- Table 7:** Sociodemographic characteristics of survey respondents (n=645)
- Table 8:** Knowledge of Ghanaian legal indications for termination of pregnancy (n=631)
- Table 9:** Regional differences in knowledge of the law (n=645)
- Table 10:** Staff training in contraception by cadre (n=3003)
- Table 11:** Eligible staff currently providing and willing to offer contraception
- Table 12:** The availability of PAC and legal abortion by type of facility (n=90)
- Table 13:** Facilities offering PAC by level and district (n=22)
- Table 14:** Facilities providing safe-abortion care (SAC) services
- Table 15:** Facilities offering treatment of incomplete abortion (e.g., PAC) by district and evacuation method (n=22)
- Table 16:** Facilities offering legal abortion by district and evacuation method (n=12)
- Table 17:** Estimated average monthly postabortion and legal abortion-care caseloads
- Table 18a:** National estimates of facilities that offer PAC by region
- Table 18b:** National estimates of PAC caseloads
- Table 19:** Number of public hospitals lacking furniture by region (n=16)
- Table 20:** Number of public polyclinics, maternity homes, health centres and Reproductive Child Health Clinics (RCH) lacking furniture by region (n=74)
- Table 21:** Number of public hospitals lacking infection-prevention (IP) supplies by region (n =16)
- Table 22:** Number of public polyclinics, maternity homes, health centres and Reproductive Child Health Clinics (RCH) lacking infection-prevention (IP) supplies in by region (n=74)
- Table 23:** Public hospitals lacking medical equipment by region (n=16)
- Table 24:** Public polyclinics, maternity homes, health centres and Reproductive Child Health Clinics (RCH) lacking medical equipment (n=74)
- Table 25:** Number of public hospitals lacking the recommended stocks of uterine-evacuation equipment by region (n=16)
- Table 26:** Number of public primary-level facilities lacking the recommended stocks of uterine evacuation equipment by region (n=74)
- Table 27:** Perceptions of the advantages of manual vacuum aspiration (MVA) versus sharp curettage (n=18)
- Table 28:** Distribution of staff eligible to provide uterine evacuation by district
- Table 29:** Training in PAC by cadre (n=3,003)
- Table 30:** Provision of specific reproductive health services and demand for training and support (n=513)
- Table 31:** Staff previous provision of services (n=513)
- Table 32:** Respondents' assessment of the frequency with which their faith influences their behaviour in the workplace (n=645)
- Table 33:** Motivational factors that encourage health workers to participate in provision of SAC as permitted by law (n=393)
- Table 34:** Comparison of motivations between those willing and those unwilling to offer MVA up to 12 weeks (n=393)
- Table 35:** Concerns that might preclude health-worker participation in SAC as permitted by law (n=406)
- Table 36:** Comparison of hesitations between those willing and those unwilling to offer MVA up to 12 weeks (N=393)
- Table 37:** Fees for uterine evacuation by technique and service (n=5)



List of figures

- Figure 1:** Facility possession of specific policy documents (n=90)
Figure 2: Availability of temporary and permanent contraception (n=90)
Figure 3: Health-worker attitudes toward providing contraceptive services (n=430)
Figure 4: Public hospitals offering induced abortion by indications (n=16)
Figure 5: Distribution of public facilities providing postabortion care (PAC) or legal termination by indication and by region (n=90)
Figure 6: Hospital-management attitudes toward implementations of specific services (n=65)
Figure 7: Health-worker attitudes toward implementation of specific services (n=513)
Figure 8: Support for establishment of legal-abortion services by region (n=578)
Figure 9: Health-worker preferences regarding the location of personal comprehensive abortion care (CAC) practice
Figure 10: Attitudes among management and health workers toward the provision of early safe abortion by midlevel cadres
Figure 11: Health-worker attitudes toward personal performance of specific services (n=430)
Figure 12: Health-worker and management beliefs about the link between mental health and unwanted pregnancy (n=563)
Figure 13: Health-worker and management concerns regarding potential for false rape claims by pregnant women requesting legal abortion by region (n=563)
Figure 14: Health-worker attitudes toward the charging of fees for provision of safe abortion care (SAC) in the first trimester in accordance with the law (n=513)
Figure 15: Current versus recommended charges for legal abortion by region

List of acronyms

CAC	comprehensive abortion care
CBD	community-based distributors
CHN	community-health nurses
CHO	community-health officers
D&C	dilatation and curettage
DFID	United Kingdom Department for International Development
EVA	electrical vacuum aspiration
FP	family planning
GHS	Ghana Health Service
GRMA	Ghana Registered Midwives Association
HLD	high-level disinfection
IP	infection prevention
IRB	Institutional Review Board
LTPM	long-term and permanent methods of contraception
MOH	Ministry of Health
MR	menstrual regulation
MVA	manual vacuum aspiration
PAC	postabortion care
QI	quality improvement
R3M	Reducing Maternal Mortality and Morbidity programme
SAC	Safe-abortion care
SIDA	Swedish International Development Cooperation Agency
SPMDP	Society for Private Medical and Dental Practitioners
TBAs	traditional birth attendants



Table of contents

Executive summary	6
Key findings.....	7
Recommendations	8
Introduction	9
Study objectives.....	10
Long-term and permanent methods of contraception (LTPM).....	10
Maternal morbidity and mortality from unsafe abortion	11
The scope of abortion behaviour.....	12
Abortion legislation and policy.....	12
Current models of service delivery.....	13
Human-resource opportunities and challenges	13
Study methods	15
Recruitment strategy.....	15
Data analysis.....	17
Facility characteristics	17
Respondent characteristics.....	18
Results	20
Reproductive health policy access.....	20
Legal and policy knowledge	21
Contraceptive services: Access and attitudes	22
Postabortion care (PAC) and legal abortion services.....	25
Use of appropriate technologies.....	28
Caseloads reported	29
Quality of care	30
Equipment and logistics	31
Manual vacuum aspiration (MVA) perceptions and acquisition.....	35
Attitudes toward implementation of aspects of comprehensive abortion care (CAC)	36
Location preferences.....	38
Staffing preferences.....	40
Training in postabortion care (PAC) and CAC services	41
Interest in training and service provision.....	42
Role of faith and trust in service delivery	44
Motivations to offer safe abortion care (SAC) as permitted by law.....	49
Concerns regarding participation in SAC as permitted by law.....	49
Cost of CAC	50
Financial burden for families	53
Staff priority strategies for reducing abortion-related maternal mortality	53
Community outreach and referral	53
Study limitations	54
Recommendations	54
Conclusions	55
References	56
Appendix: Ghana abortion law	60



Executive summary

Ghana has embarked upon one of Africa's most comprehensive approaches to tackling the heavy burden of maternal mortality due to unsafe abortion. The government and its partners are addressing both the root causes of unsafe abortion and its consequences. The Ghana Health Service (GHS) has adopted a multi-sectoral, multi-dimensional approach to reducing the incidence of unplanned pregnancies and unsafe abortions. Since reducing maternal mortality through the expanded provision of long-term and permanent methods of contraception (LTPM) and comprehensive abortion care (CAC) is an innovative strategy, the GHS chose to explore the issue carefully.

Under the leadership of the Ministry of Health (MOH)/GHS, a programme named Reducing Maternal Mortality and Morbidity (R3M) was initiated in September 2006 with a consortium of six agencies consisting of EngenderHealth, Ipas, Marie Stopes International, ORC Macro International, Population Council and Willows Foundation. The R3M provides the commitment and financial and technical resources that enable the government to significantly expand women's access to modern contraception and CAC to reduce unwanted fertility and the severe complications and deaths caused by unsafe abortion.

To anticipate the challenges associated with such an innovative programme and to assure that the programme matches the current needs of the public sector, this baseline-readiness study was conducted. The GHS/Ipas team sought to quickly provide a comprehensive description of the readiness of 90 public-health institutions to offer expanded services to women. For the purposes of this study, "readiness" refers to the infrastructural capacity as well as the staff and administrative willingness to offer comprehensive reproductive health services in accordance with the law.

The objectives of the study were to:

1. Describe the public-health facilities' infrastructural and staff capacity to offer LTPM and CAC;
2. Identify facilities that are best positioned to and most interested in offering LTPM and CAC services;
3. Establish a benchmark for measuring the impact of future capacity-building efforts.

To gather input from all stakeholders, especially those health workers who would be directly involved, the GHS and Ipas designed an attitudinal survey to explore the full spectrum of knowledge and beliefs. Historically, stigma and lack of legal clarity at the facility level have presented challenges to providing specific reproductive health services.^{1,2,3,4}

This study reveals that most public-sector facilities in 10 districts of Ghana's three most populous regions are motivated to offer LTPM and certain aspects of CAC. Moreover, health workers have moderate and reasoned approaches toward long-term contraception and CAC. They favour a practical and comprehensive approach to maternal mortality reduction. Ghana's health workers have a wide range of views on how to implement the abortion law, but many are awaiting further information before deciding what services they are willing to provide.

¹ Hord, Charlotte E. 1997. The safe motherhood initiative and abortion care: Compatible or not? *Initiatives in Reproductive Health Policy*, 2(2):1-3.

² Lithur, Nana Oye. 2004. Destigmatizing abortion: Expanding community awareness of abortion as a reproductive health issue in Ghana. *African Journal of Reproductive Health*, 8(1):70-4.

³ Lassey, Anyetei T. 1995. Complications of induced abortions and their preventions in Ghana. *East African Medical Journal*, 72(12):774-7.

⁴ Morhee, R.A.S. and E.S.K. Morhee. 2006. Overview of the law and availability of abortion services in Ghana. *Ghana Medical Journal*, 40(3).



Key findings

- Fewer than one in five (16.7%) public-health care facilities in the 10 districts offer long-term methods of contraception.
- One quarter (24.4%) of public facilities report offering postabortion care (PAC),⁵ treating an average caseload of 26 cases per month.
- When caseload estimates are extrapolated to the nation, they yield a rough morbidity burden of approximately 105,720 women treated for incomplete abortion annually in Ghana's public and private sectors.
- The total direct cost burden on families for treating incomplete abortion is estimated to be as high as US\$8,460,137 annually.
- Fewer than one in seven (13.3%) public facilities reported offering legal abortion services. The facilities report serving an average combined caseload of only six women per month. This figure is likely to be underreported.
- Half of public hospitals surveyed (50%) have two or more functional manual vacuum aspirators (MVA) for uterine evacuation, and only 8.1% of primary-care facilities have one or more functional aspirators. Medical equipment and infection prevention (IP) commodity gaps affect up to three-quarters of the sites in the census.
- Less than one in five health workers were aware of all the legal indications for termination in Ghana. One-third of health-facility managers (32%) and health workers (33%) are aware that the legal indications for abortion include mental health, and 65% were cognizant of the legal indication for termination in cases of rape or incest.
- Health workers generally (63.6%) favour a comprehensive approach to reducing morbidity and mortality from unsafe abortion with a major focus on prevention of unwanted pregnancy. The majority of clinicians (87.5%) are comfortable offering temporary contraceptives, and 68% would be comfortable providing permanent methods if given training and support.
- The majority (59-76%) of health-facility managers and roughly one-half (34-56%) of health workers in each region are "generally" or "strongly" supportive of having early legal-abortion care at their facilities.
- Given adequate training and support, Ghanaian clinicians reported comfort with rendering menstrual regulation (MR) (81.4%) and nonjudgmental counseling (77.8%) for women with delayed menses. Less than one-half (42.8%) would feel comfortable offering MVA up to 12 weeks, safe abortion for adolescents with consent (42%), or misoprostol up to nine weeks (32.4%). Almost one-quarter of clinicians (23.4%) were undecided about their future scope of practice.
- The catchment area's pool of potential CAC providers who have been previously trained in PAC is 32.5%. There is a large unmet demand for training in permanent contraceptive methods (68%), PAC (81.4%), and MR (81.4%).

⁵ Postabortion care refers to a package of curative, preventative and psychosocial interventions designed to treat incomplete abortion, prevent future unwanted pregnancy and serve as an entry point for a full range of sexual and reproductive health services.



- Despite national standards that authorize them to provide care, midwives' and medical assistants' role in early legal abortion provision was contentious, with 55% of health workers and 62% of management opposed to their involvement. A considerable proportion (10-18%) is undecided on their role.
- Main motivators of clinicians to offer comprehensive reproductive health services were: the desire to reduce maternal death and disability (75.6%), desire to restore women's physical and emotional health after forced sex, rape or incest (65.4%), desire to render comprehensive patient care (59.8%) and belief in women's right to make their own moral choices (49.6%).
- Main hesitations in offering CAC were: perceived religious conflict (50.2%), uncertainty of the legality of abortion (47.8%), protocol doubts (37.9%) and perceived lack of administrative support (33.3%).
- Although 62.7% of health-care workers reported that unwanted pregnancy could cause psychological distress, more than one-half (52.2%) reported a concern that pregnant women would assert false mental-health claims to access safe abortion. Similarly, a majority (71.6%) feared that pregnant women would falsely claim to be raped in order to qualify for a legal termination.

Recommendations

1. It is vital to engage all stakeholders in the dissemination and enforcement of Ghana's national reproductive health policies and protocols to improve access to life-saving emergency care as well as preventive care, including legal abortion. This includes the dissemination of the abortion law; LTPM and 2006 CAC Standards and Guidelines; and related policies on sexual and gender-based violence to service providers, managers and facility leadership.
2. The R3M partners should cooperate intensely to integrate CAC and LTPM as part of the unified plan to reduce maternal mortality and morbidity because health workers perceive the two services as part of a broader initiative.
3. It is critical for the R3M to work with the medical associations, the Ghana Registered Nurses and Midwives Council and other midlevel provider associations to educate and change attitudes regarding the role of midlevel providers in comprehensive reproductive health services.
4. A referral strategy is needed for the public-health centres that lack the staffing and infrastructure to offer LTPM and CAC in the immediate term.
5. The study highlights the need for effective values clarification and education to help health workers understand the root causes and relationships between unwanted pregnancy, abortion, sexual violence, mental health, and maternal morbidity and mortality.
6. An equipment sustainability plan is needed to address gaps and shortages in essential equipment and commodities for LTPM and CAC in the public sector, including MVA.
7. Clinical training in PAC, MR, nonjudgmental counseling and long-acting or permanent contraception and early legal abortion may need to precede training in second-trimester legal services, due to the greater acceptance of these skills and services.



8. The language of the R3M programme should be sensitive and reflective of health workers' preferences for "menstrual regulation" and other nonstigmatizing terms for uterine evacuation.
9. An outreach strategy is essential to educate women, policymakers, and the general public (including adolescents) on pregnancy and unsafe-abortion prevention and to increase awareness of services.
10. Government authorities must register and include misoprostol and mifepristone on the essential drugs list to increase women's access to important technologies for the prevention of maternal morbidity and mortality.
11. The GHS should strengthen services at the primary levels (health centres and maternity homes) through capacity building, equipment provision and training.
12. The GHS should support supervisors and managers to ensure compliance with the GHS Code of Ethics, GHS Patients Rights, GHS Code of Conduct, CAC Standards and Guidelines, and conscientious-objection policies.
13. The GHS should support physicians and midwives in offering services despite societal stigma and hesitations regarding legal LTPM and CAC services and provision by midlevel cadres in particular.
14. The GHS should support research on CAC costs and ability to pay; this research is needed to inform the development of a uniform-pricing policy for services.
15. Community-based research on care-seeking behaviour for abortion services and how best to address societal-attitudinal barriers to CAC and FP services is needed.
16. Public/private sector collaboration should be promoted by actively strengthening collaboration with bodies such as the Ghana Registered Midwives Association (GRMA) and the Society for Private Medical and Dental Practitioners (SPMDP).
17. Given the underreporting of existing services, it is vital to develop and support simple management-information systems for CAC and contraception to assure documentation and quality of services.
18. Incorporating LTPM and CAC into existing quality-improvement programmes (QI) is important to guarantee quality and coherence with GHS standards of care.

Introduction

Under the leadership of the Ministry of Health (MOH)/Ghana Health Service (GHS), a programme named Reducing Maternal Mortality and Morbidity (R3M) programme was initiated in September 2006 with a consortium of six agencies: EngenderHealth, Ipas, Marie Stopes International, ORC Macro International, Population Council and Willows Foundation. The R3M initiative provides the commitment and financial and technical resources that will enable the government to significantly expand women's access to modern family planning (FP) and comprehensive abortion care (CAC) to reduce unwanted fertility and the severe complications and deaths caused by unsafe abortion.



To anticipate the challenges associated with such an innovative programme and to assure that the programme matches the current needs of the public sector, this baseline-readiness study was conducted by the GHS in cooperation with Ipas. The GHS/Ipas team sought to quickly provide a comprehensive description of the readiness of 90 public health-care institutions to offer expanded services to women. For the purposes of this study, “readiness” refers to the *infrastructural capacity*, as well as the *staff and administrative willingness* to offer comprehensive reproductive health services in accordance with the law.

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The objectives of the study were to:

1. Describe the public-health facilities’ infrastructural and staff capacity to offer LTPM and CAC;
2. Identify facilities that are best positioned to and most interested in offering LTPM and CAC services;
3. Establish a benchmark for measuring the impact of future capacity-building efforts.

To gather input from all stakeholders, especially those health workers who would be directly involved, the GHS and Ipas designed an attitudinal survey to explore the full spectrum of knowledge and beliefs about LTPM; postabortion care (PAC); and CAC laws, policies and service-delivery models. Historically, stigma and lack of clarity at the facility level about what the law permits have presented challenges to providing these specific reproductive health services.^{6,7,8,9}

Long-term and permanent methods of contraception (LTPM)

The unmet need for contraception is estimated at 34% in Ghana.¹⁰ However the Greater Accra, Ashanti and Eastern Regions are among the nation’s best in terms of contraceptive coverage at 26%, 21% and 21%, respectively. Effective long-term contraceptive methods are underutilized in Ghana.¹¹ Since 2003, there has been a decline in the use of IUD in relation to other contraceptive methods.¹² A shortage of trained providers, fears of prolonged side effects and dissatisfaction with IUD design have contributed to reduced use of long-term methods.¹³

⁶ Hord, Charlotte E. 1997. The safe motherhood initiative and abortion care: Compatible or not? *Initiatives in Reproductive Health Policy*, 2(2):1-3.

⁷ Lithur, Nana Oye. 2004. Destigmatizing abortion: Expanding community awareness of abortion as a reproductive health issue in Ghana. *African Journal of Reproductive Health*, 8(1):70-4.

⁸ Lassey, Anyetei T. 1995. Complications of induced abortions and their preventions in Ghana. *East African Medical Journal*, 72(12):774-7.

⁹ Morhee, R.A.S. and E.S.K. Morhee. 2006. Overview of the law and availability of abortion services in Ghana. *Ghana Medical Journal*, 40(3).

¹⁰ Ghana Statistical Service, Noguchi Memorial Institute for Medical Research and ORC Macro. 2004. Ghana demographic and health survey 2003. Calverton, Maryland, Ghana Statistical Service, Noguchi Memorial Institute for Medical Research and ORC Macro.

¹¹ Ghana Statistical Service, Noguchi Memorial Institute for Medical Research and ORC Macro. 2004. Ghana demographic and health survey 2003. Calverton, Maryland, Ghana Statistical Service, Noguchi Memorial Institute for Medical Research and ORC Macro.

¹² Ghana Health Service. 2004. Reproductive and child health annual report. Accra, Ghana, Ghana Health Service

¹³ Osei, Ivy, Harriet Birungi, Gifty Addico, Ian Askew and John O. Gyapong. 2005. What happened to the IUD in Ghana? *African Journal of Reproductive Health*, 9(2):76-91.



On a national scale, Ghana is striking for its steady decline in total fertility despite very modest expansion in contraceptive uptake. Researchers posit that there is either widespread recourse to abortion or widespread abstinence.¹⁴ Evidence for the former explanation is found in the GHS National Strategic Assessment and other recent community-based research that reveal a high prevalence of induced abortion, both safe and unsafe.^{15,16,17}

Maternal morbidity and mortality from unsafe abortion

The human costs of unsafe abortion are dramatically apparent in Ghana. While most causes of maternal mortality have declined since 1987, abortion-related complications and deaths have risen in some parts of the country from 13.1% to 26.5% in 2000, making it the leading cause of maternal death.¹⁸ In 1994, before government intervention, unsafe abortion provision in Berekum district led to a temporary spike in maternal mortality of 790 deaths per 100,000 live births.¹⁹

Death and disability from uterine perforation and sepsis are well-documented.^{20,21} In fact, one of the major catalysts for the inauguration of poison-control centres in Ghana was the need to respond to the high number of chemical overdoses by Ghanaian adolescents attempting to end unwanted pregnancies.²²

The financial costs of unsafe abortions are also staggering. Ghanaian families can spend up to 11% of their annual earnings addressing acute maternal morbidity.²³

¹⁴ Blanc, Anne and Steve Gray. 2000. *Greater than expected fertility decline in Ghana: An examination of the evidence*. Calverton, Maryland, Macro International.

¹⁵ Henry, Rebecca and Clara Fayorsey. 2002. *Coping with pregnancy: Experience of adolescents in Ga Machi*, Accra. Calverton, Maryland, ORC Macro.

¹⁶ Geelhoed, Diederike W., Lucia E. Visser, Kofi Asare, Jules H. Schagen van Leeuwen and Jos van Roosmalen. 2003. Trends in maternal mortality: A 13-year hospital-based study in rural Ghana. *European Journal of Obstetrics, Gynaecology and Reproductive Biology*, 107(2):135-9.

¹⁷ Ghana Ministry of Health. 2005. *A strategic assessment of comprehensive abortion care in Ghana*. Accra, Ghana, Ghana Health Service and Ipas.

¹⁸ Geelhoed, Diederike W., Lucia E. Visser, Kofi Asare, Jules H. Schagen van Leeuwen and Jos van Roosmalen. 2003. Trends in maternal mortality: A 13-year hospital-based study in rural Ghana. *European Journal of Obstetrics, Gynaecology and Reproductive Biology*, 107(2):135-9.

¹⁹ Geelhoed, Diederike W., Lucia E. Visser, Kofi Asare, Jules H. Schagen van Leeuwen and Jos van Roosmalen. 2003. Trends in maternal mortality: A 13-year hospital-based study in rural Ghana. *European Journal of Obstetrics, Gynaecology and Reproductive Biology*, 107(2):135-9.

²⁰ Obed, Samuel A. and John B. Wilson. 1999. Uterine perforation from induced abortion at Korle-Bu Teaching Hospital, Accra, Ghana: A five year review. *West African Journal of Medicine*, 18(4):286-9.

²¹ Lassey, Anyetei T. 1995. Complications of induced abortions and their preventions in Ghana. *East African Medical Journal*, 72(12):774-7.

²² Clarke, Edith E. 2004. The experience of starting a poison control centre in Africa — The Ghana experience. *Toxicology*, 198(103):267-72.

²³ Borghi, Josephine, Kara Hanson, Charles Adjei Acquah, Gatien Ekanmian, Veronique Filippi, Carine Ronsmans, Ruari Brugha, Edmund Browne and Eusebe Alihonou. 2003. Costs of near-miss obstetrical complications for women and their families in Benin and Ghana. *Health Policy and Planning*, 18:383-90.



The scope of abortion behaviour

In urban Accra, 47% of women report having terminated one or more pregnancies.²⁴ Abortion is common among all religious, ethnic and socioeconomic groups in Ghana.²⁵ Fifty percent of women receiving maternity care at Korle-Bu hospital report a previous history of abortion.²⁶

Unsafe abortion is particularly common among Ghanaian adolescents. In Accra, young women between the ages of 18 to 24 are six times more likely to report having an induced abortion than adult women.²⁷ Experts find that up to 70% of Ghanaian urban adolescents 12 to 24 years of age self-report previous abortions.^{28,29} The National Adolescent Reproductive Health Policy aims to reduce abortion among adolescents by 50% by 2010. The GHS has a special focus on improving adolescent health by preventing early, coerced and/or unprotected sex and treating its consequences.³⁰ Among Ghanaian women and adolescents, 18% of first sexual encounters are forced. A recent survey found that one in five Ghanaian women has been raped; however, less than 1% formally report the crime.³¹

Abortion legislation and policy

Unlike the laws of many African countries, Ghanaian law is in harmony with Ghana's Road Map to Maternal Mortality Reduction and largely compatible with its international commitments. The law facilitates a broad range of legal indications as well as restrictions.^{32,33,34} The current abortion law, dating from 1985, permits abortion services to be performed in a registered health facility by a medical practitioner for cases of incest or rape, when necessary to preserve the physical and mental health of the woman, or where there is risk of foetal abnormality. The MOH and the GHS revised the national reproductive health policy in 2003 to incorporate the provision of PAC and included an objective to clarify the provision of CAC as permitted by law.³⁵ The 2006 GHS standards and guidelines provide direction for interpreting the law and are largely consistent with the World Health Organization's guidelines and standards of best practice.³⁶

²⁴ Oliveras, Elizabeth. 2006. *Abortion in the fertility transition in Accra, Ghana*. Unpublished.

²⁵ Oliveras, Elizabeth. 2006. *Abortion in the fertility transition in Accra, Ghana*. Unpublished.

²⁶ Klufio, Cecil A., Anyetei T. Lassey and B.D. Annan. 2002. Socio-demographic and reproductive characteristics of mothers delivered at the Korle-Bu Teaching Hospital, Ghana. *East African Medical Journal*, 79(4):176-80.

²⁷ Oliveras, Elizabeth. 2006. *Abortion in the fertility transition in Accra, Ghana*. Unpublished.

²⁸ Glover, Evam Kofi, Angela Bannerman, Brian Wells Pence, Heidi Jones, Robert Miller, Eugene Weiss and Joana Nerquaye-Tetteh. 2003. Sexual health experiences of adolescents in three Ghanaian towns. *International Family Planning Perspectives*, 29(1):32-40.

²⁹ Agyei, William K. A., Richard B. Biritwum, Gladys A. Ashitey and Robert B. Hill. 2000. Sexual behaviour and contraception among unmarried adolescents and young adults in Greater Accra and Eastern regions of Ghana. *Journal of Biosocial Science*, 32(4):485-512.

³⁰ Ghana National Population Council. 2000. Adolescent reproductive health policy. Accra, Ghana, Ghana National Population Council.

³¹ Coker-Appiah, Dorcas and Kathy Cusack, eds. 1999. Breaking the silence and challenging the myths of violence against women and children in Ghana: Report of a national study on violence. Ghana, Gender Studies & Human Rights Documentation Centre.

³² Turkson, Richard. 1996. The role of law in population and development. *National Population News Bulletin*, 1(3) 6-7.

³³ Morhee, R.A.S. and E.S.K. Morhee. 2006. Overview of the law and availability of abortion services in Ghana. *Ghana Medical Journal*, 40(3).

³⁴ United Nations Department of Economic and Social Affairs, Population Division. "Ghana: Abortion policy," in *Abortion policies: A global review*. Vol. 2, Gabon to Norway. New York, N.Y.: United Nations, 2001.

³⁵ Taylor, Joseph, Ann Starrs and Traci Baird. 1997. Postabortion care and safe motherhood in Ghana. *Initiatives in Reproductive Health Policy*, 2(2):3.

³⁶ World Health Organization. 2003. *Safe abortion: Technical and policy guidance for health systems*. Geneva, WHO.



Current models of service delivery

PAC has been offered in Ghana since 1994. Eighteen percent of maternal health-care providers report having received in-service training in manual vacuum aspiration (MVA).³⁷ With almost one in five providers already exposed to some clinical training in uterine evacuation, there is widespread familiarity with this life-saving technique. The Eastern Region played a leadership role in developing the PAC model in Ghana and linking PAC and FP.^{38,39} Ghanaian women treated for unsafe abortions often require a comprehensive reproductive health approach, since as many as 64% of PAC patients are also experiencing reproductive-tract infections.⁴⁰

Although investments in PAC have been significant, the national coverage of PAC has declined in recent years. In a recent nationwide survey, only 21% of eligible facilities and 11% of public sector facilities offered PAC services.⁴¹

The availability of legal terminations has also been limited in the public sector. Public facilities are rendering services informally and do not consistently document the care provided.^{42,43,44} Women are referred to other sites, usually in the private sector. Effective postabortion contraceptive counseling, method provision and quality assurance have been challenging in this framework.⁴⁵ Plans to improve and integrate the provision and supervision of preventive sexual and reproductive health services are being implemented.

Human resource opportunities and challenges

Reducing maternal mortality requires the full participation of all clinical staff, especially mid-level providers. The GHS policies permit midwives and medical assistants with midwifery training to provide both PAC and CAC. The role of midlevels is important because there are currently shortages of Ghanaian obstetricians and medical officers.⁴⁶ According to GHS figures, only 70 to 80 of 110 registered obstetrician-gynecologists are reported to be practicing, while there are up to 2,415 practicing midwives in the country.⁴⁷

³⁷ Ghana Statistical Service, Health Research Unit of the Ministry of Health and ORC Macro. 2003. Ghana Service Provision Assessment 2002. Calverton, Maryland, ORC Macro.

³⁸ Billings, Debbie, Victor Ankrah, Traci L. Baird, Joseph Taylor, Kathlyn P.P. Ababio and Stephen Ntow. 1999. Midwives and comprehensive postabortion care in Ghana. In Huntington, D. and N. Piet-Pelon, eds. *Postabortion care: Lessons from operations research*. New York, Population Council.

³⁹ Fullerton, Judith, Alfredo Fort and Kulmindar Johal. 2003. A case/comparison study in the eastern region of Ghana on the effects of incorporating selected reproductive health services on family planning services. *Midwifery*, 19(1):17-26.

⁴⁰ Lassey, Anyetei T., Richard M.K. Adanu, Mercy Jemima Newman and J.A. Opintah. 2004. Potential pathogens in the lower genital tract at manual vacuum aspiration for incomplete abortion in Korle-Bu Teaching Hospital, Ghana. *East African Medical Journal*, 81(8):398-401.

⁴¹ Ghana Health Services and ORC Macro. 2003. Ghana service provision assessment. Accra, Ghana, Ghana Health Service.

⁴² Henry, Rebecca and Clara Fayorsey. 2002. Coping with pregnancy: Experience of adolescents in Ga Machi, Accra. Calverton, Maryland, ORC Macro.

⁴³ Lassey, Anyetei T. 1995. Complications of induced abortions and their preventions in Ghana. *East African Medical Journal*, 72(12):774-7.

⁴⁴ Ghana Ministry of Health. 2005. A strategic assessment of comprehensive abortion care in Ghana. Accra, Ghana, Ghana Health Service and Ipas.

⁴⁵ Henry, Rebecca and Clara Fayorsey. 2002. Coping with pregnancy: Experience of adolescents in Ga Machi, Accra. Calverton, Maryland, ORC Macro.

⁴⁶ Prosser, Michelle, Emily Sonneveldt, Margaret Hamilton, Elaine Menotti and Penney Davis. 2006. POLICY Project. The emerging midwifery crisis in Ghana: Mapping of midwives and service availability highlights gaps in maternal care. Washington, DC, POLICY Project.

⁴⁷ GHS Annual Report 2005 Facts & Figures. Accra, Ghana, Ghana Health Service.



Midwives are dispersed more widely in rural areas. Midlevel providers struggle to serve when their scope of practice is considered low status, legally ambiguous or overtly contested. They also are more likely to work in outdated facilities, experience equipment shortages, have few support networks, and experience limited opportunities for continuing education.⁴⁸ An aging midwife population, urban migration, a heavy workload and facility-imposed restrictions are resulting in loss of midwives to the public sector in what has been termed the “emerging midwifery crisis” in Ghana.⁴⁹ The GHS is committed to task-shifting policies to rationalize the use of these highly skilled professionals for the most appropriate clinical roles.⁵⁰ Research has demonstrated that with adequate training and clinical hands-on practice, midlevel providers can offer uterine evacuation with MVA as skillfully as medical doctors.⁵¹

In 2003, only 37% of professional midwives who had been trained in PAC/MVA during the previous five years were rendering PAC services.⁵² The actual expansion of responsibility for PAC and CAC to midwives and medical assistants with midwifery skills may be impeded by professional turf protection, lack of awareness of GHS policy or fear of “abuse” of uterine-evacuation skills by midlevels.⁵³ In 2003 and 2006, prominent obstetrician-gynecologists and policymakers spearheaded policies to promote PAC and CAC services by midwives and medical assistants with midwifery training. Yet many midwives are not aware that their scope of practice includes performing uterine evacuation.⁵⁴ In facilities which have copies of these reproductive health policies, midwives are more likely to use their PAC training, suggesting the value of policy education and dissemination.⁵⁵

⁴⁸ Prosser, Michelle, Emily Sonneveldt, Margaret Hamilton, Elaine Menotti and Penney Davis. 2006. POLICY Project. The emerging midwifery crisis in Ghana: Mapping of midwives and service availability highlights gaps in maternal care. Washington, DC, POLICY Project.

⁴⁹ Prosser, Michelle, Emily Sonneveldt, Margaret Hamilton, Elaine Menotti and Penney Davis. 2006. POLICY Project. The emerging midwifery crisis in Ghana: Mapping of midwives and service availability highlights gaps in maternal care. Washington, DC, POLICY Project.

⁵⁰ Ghana Health Service. Strategic Interventions 2006-2010, Strategic Objective #1. Accra, Ghana, Ghana Health Service.

⁵¹ Warriner, Ina K., Olav Meirik, Margaret Hoffman, Chelsea Morrioni, Jane Harries, Nguyen T. My Huong, Nguyen D. Vy and Armando H. Seuc. 2006. Rates of complication in first-trimester manual vacuum aspiration abortion done by doctors and mid-level providers in South Africa and Vietnam: a randomized controlled equivalence trial. *Lancet*, 368:1965-1972.

⁵² Clark, Kathryn Andersen, Ellen M.H. Mitchell and Patrick Kuma Aboayge. 2007. *Return on investment for postabortion care training among midwives in Ghana*. Unpublished.

⁵³ Billings, Debbie, Victor Ankrah, Traci L. Baird, Joseph Taylor, Kathlyn P.P. Ababio and Stephen Ntow. 1999. Midwives and comprehensive postabortion care in Ghana. In Huntington, D. and N. Piet-Pelon, eds. *Postabortion care: Lessons from operations research*. New York, Population Council.

⁵⁴ Prosser, Michelle, Emily Sonneveldt, Margaret Hamilton, Elaine Menotti and Penney Davis. 2006. POLICY Project. The emerging midwifery crisis in Ghana: Mapping of midwives and service availability highlights gaps in maternal care. Washington, DC, POLICY Project.

⁵⁵ Andersen Clark, Kathryn, Ellen M.H. Mitchell and Patrick Kuma Aboayge. 2007. *Return on investment for postabortion care training among midwives in Ghana*. Unpublished.