

Comprehensive Reproductive Health in Ghana

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DAWN SEXUAL AND
REPRODUCTIVE HEALTH AND
RIGHTS PROGRAM



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Foreword

Abortion is a topical issue, which confronts many health workers, including doctors, nurses and also politicians, administrators and the general public. Not every physician involved with women's health care may choose to perform abortion but she/he should be fully aware of how to evaluate a patient with an unwanted pregnancy, how to assist her in the decision-making process and if she chooses not to continue her pregnancy, how to provide her with the appropriate care preoperatively and postoperatively to prevent unnecessary mortality.

Every day many young girls die from abortions performed by unqualified individuals in unsafe environment. The problem is compounded by the perceived misconception that abortion is illegal in Ghana.

This book "Abortion within Reproductive Health in Ghana" has made an extensive literature search on the various materials available in Ghana and the International scene and has come out with in-depth case studies about abortion as seen in the context of Reproductive Health. It has also documented the extent of the problem about the abortion law in Ghana, which should engage policy makers to reshape this law, and to help prevent unsafe abortion in the society.

The handbook also discussed the harmful effects of STI/HIV/AIDS and the various strategies and interventions adopted by the youth, non-governmental organizations (NGO), the private sector and the Ministry of Health to draw public awareness and to limit the spread of this disease.

This book is also unique in referencing relevant literatures from the sub-region, which should help health workers develop comprehensive approach to the management of old, and emerging diseases confronting women in the country.

Health policy makers, teachers, doctors, students and individuals seeking knowledge about Sexual and Reproductive Health of women should value "Abortion within Reproductive Health in Ghana". It should also be a companion for doctors in general and specialist practice in Women's Health in the sub-region.

This book will stimulate clinical questions about the potential harmful effects about abortion, what is known and what is not known, as well as new questions and studies. It is hoped that this knowledge will be integrated as part of the educational process in medical schools, postgraduate training and in the continuing education of physicians in practice.

The author has endeavoured to expand the insights into women's health and this should serve as a stimulus for continued questioning and changing policies regarding the health of women.

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Thanks also to the Prevention of Maternal Mortality Network (RPMM) and its directors who permitted me access to the information on abortion. Your work is indeed invaluable to highlight this national scandal and disaster, which must be stopped.

Thanks to the numerous unnamed health workers and individuals who collaborated in this research. This work is also a tribute to your continuing struggles to save the lives of Ghanaian women day in, day out.

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List of Abbreviations (in order of appearance)

DAWN	Development Alternatives with Women for a New era
TFR	Total Fertility Rate
GDHS	Ghana Demographic and Health Survey
HIV	Human Immunodeficiency Virus
SRH	Sexual and Reproductive Health
WHO	World Health Organization
MOH	Ministry of Health
BMC	Budget Management Centres
MTHS	Medium term health strategy
5YPOW	5-year programme of work
RH	Reproductive Health
RTI	Reproductive tract infection
STI	Sexually Transmitted Infections
PHC	Primary Health Care
NGO	Non Governmental Organisation
PMMN	Prevention of Maternal Mortality Network
GHS	Ghana Health Service
GDP	Gross Domestic Product
EMOC	Emergency Obstetric Care
TBA	Traditional Birth Attendant
UNFPA	United Nations Fund for Population Activities
CHPS	Community Health Prevention Services
ARH	Adolescent Reproductive Health
MVA	Manual Vacuum Aspiration
SHEP	School Health Education Programme
MDA	Ministries, Departments, Agencies
VCT	Voluntary Counselling and Testing
DRI	District Response Initiative
NACA	National Advisory Commission on AIDS
NACP	National AIDS Control Programme
STM	Short Term Methods
LAM	Lactation Amenorrhoea Method
LTM	Long Term Methods
IUD	Intra-Uterine Device

Introduction

This study forms part of a multi-country study on the issues of abortion within the broader scope of maternal mortality undertaken by Development Alternatives with Women for a New era (DAWN) collaborators in the area of Sexual and Reproductive Health and Rights. Country research findings form the basis for a global analysis of trends, achievements and obstacles regarding the linkages between Health Sector Reform, sexual and reproductive health policies at large, with a particular focus on measures and processes related to maternal mortality and abortion. The countries involved are:

In Africa:	Cameroon, Ghana, and Nigeria
In Asia:	Philippines
In the Caribbean:	Barbados, Jamaica, Suriname and Trinidad
In Latin America:	Argentina, Bolivia, Brazil, Mexico and Uruguay

Country specific analysis is always very relevant to identify differentials and common trends. This article publishes the country analysis for Ghana. This study was undertaken in 2 parts. The first part was of the situation of abortion in Ghana with a review of the available literature to date and a quantitative and qualitative study undertaken in 14 institutions and a regional Hospital in the Eastern Region of the country. The second part is a general review of some other aspects of reproductive health in Ghana that also have a bearing in general on abortion.

THE ABORTION PROBLEM IN GHANA

There is currently limited data available on abortion in Ghana. Some of the reasons for this paucity of data include poor record keeping generally, the reluctance of health staff in institutions to accurately document incidences of abortion often due to the stigmatization attached to the procedure, lack of categorization of complications related to pregnancy, a lack of a policy within institutions regarding abortion and a lack of knowledge of the laws on abortion by health professionals within the country. A number of procedures are also performed within the 'informal health sector' run by traditional practitioners,





and quack doctors from whom Ghanaian women seek abortion services and these will not admit to documenting their procedures.

The main aim of the study was to examine the current situation of abortion in Ghana in the context of reproductive health. In the process, various aspects relating to reproductive health in general were examined and have been highlighted.

DEMOGRAPHY OF GHANA

The 2000 population census of Ghana puts the population head count at eighteen million, nine hundred and twelve thousand and ninety seven (18,912,097). This is an increase of 53.8% over the 1984 census population and represents an intercensal growth rate of 2.7% per annum¹. Just over forty percent (41.3%) of the population is aged 15 years or less and just under half (47.3%) is aged 15-24 years, which is considered the group most at risk for unsafe abortion. The median age of the population has increased from 18.1 years in 1984 to 19.4 years in 2000. Females constitute 50.5% of the 2000 population. The 2003 Ghana Demographic and Health Survey (2003 GDHS)² show that the total fertility rate (TFR) has declined steadily from 6.4 in 1988 to 4.4 per woman in 2003. Unplanned pregnancies are common as 16% of births in Ghana are unwanted and 24 % are mistimed (wanted later). Unplanned pregnancies went from 42% in 1993 to 36% in 1998 and 40% in 2003. Unwanted births increased alarmingly from 9% in 1993 to 16% in 2003.

Usage of modern contraceptives increased from 5.2% in 1988 to 18.7% in 2003 but unmet needs for family planning even for married women is 34% with only 43% of demand for family planning being currently met. The needs of unmarried women and adolescents have not been measured.

The 2003 GDHS showed that the human immunodeficiency virus (HIV) prevalence among Ghanaian adults is 2%, for women aged 15-49 years it is nearly 3% with a female to male ration of 1.8:1 indicating the increased vulnerability of young women to HIV infection. Life expectancy at birth has increased from 57.7 years to 57.8 years between 2003 and 2004³.

TABLE 1 SUMMARY OF THE DEMOGRAPHY OF GHANA

Total Population	18,912,097
Female Population	50.5%
Annual Population Growth Rate	2.7%
% of Female Population 0-14 years	40.7%
% of Female Population above 65+ years	5.2%
% Female 15-49 years	47.3%
Adult Population 18+ years	52.6%
Female Population 18+years	53.4%
Adult Literacy Rate	53.3%
Female Literacy Rate	43.1%
Maternal Mortality per 100,000 Live Births	214
Infant Mortality per 1,000 LB Live Births	64
Average Life Expectancy	57.5 years

1 2000 Population and Housing Census Results - Summary Report of Final Results- Ghana Statistical Service. March 2002

Ghana Statistical Service (GSS), Noguchi Memorial Institute for Medical Research (NMIMR) and ORC Macro. 2004. Ghana Demographic and Health Survey 2003. Calverton, Maryland: GSS, NMIMR, and ORC Macro.

2 2004 Human Development Report

3 Fred Sai. Adam and Eve and the Serpent- pg 10-11

Part I: THE SITUATION OF ABORTION IN GHANA

THE GENERAL CONTEXT

INTRODUCTION


Internationally, in 2000, one hundred and eighty-nine (189) states at the United Nations adopted what has become known as the Millennium Development Goals (MDGs). Although not explicit on sexual and reproductive health (SRH), MDG 3 seeks to improving maternal health, reducing child mortality and combating HIV/AIDS in direct relation to health. Four other MDGs, namely, eradicating extreme poverty and hunger, achieving universal primary education, promoting gender equality and, empowering women, ensuring environmental sustainability have close relation to SRH.

These developments followed the much chalked successes women scored in putting their agendas on SRH on the front burner starting with the Safe Motherhood Initiative in 1985 which although a key start in the struggle for achievement of rights of women but did not recognize the problems attributable to unsafe abortion. This was followed by the International Conference on Population and Development Programme of Action in 1994 and the Beijing 4th World Conference on Women's Platform for Action in 1995. This MDG goal 3 talks about reducing by 75%, between 1990 and 2015, the maternal mortality ratio of which it is well known that 40% is caused by unsafe abortion.

Ghana is faced with the problem of very high maternal mortality much like other countries in sub-Saharan Africa. There is scarcity of accurate statistics on the maternal mortality and in particular the contribution made by abortion related deaths. The current data available on maternal mortality varies depending on the source and the method of data collection. There is also an apparent lack of information in abortion-related maternal mortality in Ghana.

In 1993, the Ghana Statistical Service conducted a community based study using the sisterhood method and documented a national maternity mortality ratio of 214/100,000 live births with a lifetime risk of dying from maternal





related causes of 1 in 71 pregnancies. The available figures for maternal mortality however ranged from 98/100,000 in urban areas in Southern Ghana to 870/100,000 in rural areas with a national average of 214/100,000 live births (GDHS 2003). There are also regional variations in the MMR: it is highest in the Upper East, Upper West and Northern regions.

One of the reasons for the wide variation in data is that maternal death is not a notifiable event. In addition, the cause of death is often ambiguous making it difficult after death to identify the precise cause of death.

PURPOSE OF THE STUDY

Ghana has a relatively liberal law on abortion, which permits a woman to obtain an abortion if she can get a physician to agree, among other things, that continuation of her pregnancy would cause harm to her mental and physical health. This is in addition to the other clauses allowing abortions in cases of rape, incest and foetal abnormalities.

It would appear that in Ghana, there is little education about these provisions. This study sought to document the extent of the ignorance of the law even among health professionals and health institutions in Ghana. It also sought to document the areas of abortion and post-abortion care available in the country.

OBJECTIVES:

The objectives of the study were:

- To perform a baseline literature search on abortion in order to document the extent of the problem in the country.
- To collect data on abortion related maternal morbidity and mortality from various health institutions in the country.
- To document available information on the implementation of the abortion laws in Ghana
- To perform quantitative and qualitative study of abortion services specifically in a health institution in Ghana
- To provide material for DAWN's comparative research book on 'The status of Reproductive Health in selected countries of the South'; this is currently in publication.

This publication focuses on the findings of the study both in terms of data and the policy trends identified, cross-cutting issues and areas requiring further analysis. The descriptions of context move from general information and data (political scenario, economics, demographic and social data, etc), to "specifics", Sexual and Reproductive Health and Rights (SRHR) policies and debates, maternal mortality initiatives, the "state of abortion" (laws, debates, crisis) and political actors at play.

METHODOLOGY

The research was carried out between 2000-2002 and it included the following:

- A baseline literature review of Ghanaian data on abortion;
- Secondary data was obtained from the international scene for comparison.
- Appropriate questionnaires were designed and administered on both institutional and individual basis to institutions working in SRHR in Ghana. The questionnaire also looked at abortion initiatives started or carried out by the institutions.
- University students who had been trained in appropriate interview techniques used questionnaires and other direct questions to interview individuals and clients seeking services at a hospital individually.
- An in-depth case study was undertaken of the Koforidua General Hospital, a Regional Institution that provides Reproductive Health Services.
- The results were then analysed and discussed.

USE OF FINDINGS

Conclusions were documented on the extent of the problem, which will be brought to the attention of policy makers.

In this process, some health professional groups have been engaged in beginning to address the practicalisation of the abortion law.

ABORTION LAWS AND POLICY IN GHANA

BACKGROUND

The definition of abortion in Ghana is: 'the termination of pregnancy before viability'. By medical definition viability is established at 28 weeks but with modern technologies this is changing. This national definition of abortion is in conformity with that of the World Health Organization (WHO).

In Ghana, 20% of births are by adolescents, with most occurring out of ignorance, as sexual and reproductive health education is inadequate or often even not available. Sexually transmitted infections are common among this age group. Single women, especially adolescents, are not targets of family planning (FP) clinics and most clinics cater for married women⁴.



⁴ Susannah Mayhew. "Sexual and reproductive health in Ghana and the role of donors".



Until 1985, abortion in Ghana was governed by the Criminal Code of 1960 (Act 29, sections 58-59 and 67). Under that Code anyone causing or attempting to cause an abortion, regardless of whether the woman was pregnant, could be fined and/or imprisoned for up to 10 years. A woman inducing her own abortion or undergoing an illegal abortion was subject to the same punishment. An abortion was legal, however, if carried out in good faith without negligence for the purpose of providing medical or surgical treatment for the pregnant woman⁵.

Ghana enacted a new abortion law in 1985 (Law No. 102 of 22 February, 1985). In general, under this law any person administering any poison or other noxious substance to a woman or using any instruments or other means with the intent to cause an abortion is guilty of an offence and is liable to imprisonment for a term not exceeding five years, regardless of whether the woman is pregnant or has given her consent. Any person inducing a woman to cause or consent to an abortion, assisting a woman to cause an abortion or attempting to cause an abortion may also be imprisoned for a term not exceeding five years. A person who supplies or procures any poison, drug or instrument or any other thing knowing that it will be used to perform an abortion is also subject to the same punishment.

A legal abortion must be performed by a registered medical practitioner with the consent of the pregnant woman. If the woman lacks the capacity to give her own consent, the consent of her next of kin or guardian is required. The abortion must be performed in a government hospital or a private hospital or clinic registered under the Private Hospitals and Maternity Homes Act of 1958 (No. 9) or in a place approved for that purpose by the law.

Although there are no official statistics on abortion in Ghana, some studies suggest that it is a common practice. For example, a 1987 study conducted at Accra and Tamale suggested that abortion was commonly used as a method of birth control. In 1984, a survey carried out at Accra among obstetric patients also found that 20 per cent of the women who had at least one previous hospital delivery had had at least one induced abortion.

LITERATURE REVIEW ON THE HEALTH ASPECTS OF ABORTION IN GHANA

In the 1960's Akinla and Adadevoh et al described abortion as a 'medico-social problem'. Ampofo D.A. further stated that 'the nature of abortion and the notoriety attached to the word makes its scientific study difficult. This statement has continued to hold true to date.

A study conducted in 3 towns from different regions in the country from December 1998 to March 1999 showed that out of over 750 youth aged 14-24 years, 52% were sexually active. Of the women, 35% of them had actually become pregnant and of these, 70% had terminated or attempted to terminate the pregnancy using unsafe methods or in an unsafe environment.

Data from the 1998 Ghana Youth Reproductive Health Survey showed that 11% of males and 16% of females aged between 12 years and 24 years who

⁵ Akinla, O & Adadevoh, B.K
J of Nigeria Med. Assoc.,
1969. 6, (3): 1-7

were sexually active also indicated some involvement in terminating a pregnancy. Agyei WKA *et al* in 2000 found that 47% of young unmarried women in the Greater Accra and Eastern Regions of the country who were sexually active had terminated a pregnancy at one time or the other⁶. Ahiadeke C also confirmed this finding in 2001 when he reported an abortion prevalence rate of 19 per 100 pregnancies for women in Southern Ghana aged less than 30 years^{*}. Addo NA however studying a population of student nurses in 1985 found abortion prevalence rate of 96.46 per 100 pregnancies with about 40% of these having had more than one abortion. Non-physician practitioners performed 17% of these⁷.

Hospital based studies have shown:

- Ampofo DA showed in 1970 that the majority of abortions seen in Korle-Bu Teaching hospital were incomplete and involved intrauterine instrumentation of some sort⁸.
- In other research, Ampofo showed that 37.8% of abortions seen were performed at the abortionist's clinic, 34.5% were performed in the woman's home and 26.7% were self-induced⁹.
- 22% of maternal deaths have been due to abortions in 1993 at the Konfo Anokye Teaching Hospital¹⁰.
- Abortion was found to be the cause of death in 30% of all autopsies done at Korle-Bu Teaching Hospital, which is the primary centre for all autopsies in the community in urban Accra¹¹.
- 58% of abortions presenting to KBTH over a period were performed outside legally designated health institutions¹².
- 9.8% of obstetric admissions in Nsawam District hospital in 2002 were due to induced/septic abortion (RPMM)

The literature review also provided some insights in to the possible reasons for women obtaining abortions and the sources of abortion provision I the country.

Reasons for procuring abortions included the need to delay childbearing thus effectively using it as a means of family planning, the wish of the young lady to continue her education as pregnancy invariably meant automatic expulsion from school, denial of paternity by the man, fear of sanctions imposed by the community and the stigma and shame associated with pre-marital child bearing in most communities.

A survey carried out by Ahiadeke from 1997-1998, showed 38% of women surveyed in Southern Ghana had obtained help from a pharmacist, 12% from a physician and 11% had self medicated¹³ (An assessment of the provision of comprehensive abortion care to the full extent of the law-. An MOH/GHS document)

In 2000 Agyei WKA in a survey of 120 women had shown that 20% has obtained their termination from a health institution¹⁴.

On the issue of the stigma associated with abortion, Gyang SR in 1974 refers to 'the reluctance of people to discuss their views on abortion openly¹⁵.

6 Akinla, O (1968) *Abortion in Africa, First International Conference of the Association for the Study of Abortion*

***** Ampofo D. A., 330 cases of abortion treated at Korle-Bu Hospital: The epidemiological and medical characteristics, GMJ 1970 :156-162

7 MOH/GHS. *An assessment of the provision of comprehensive abortion care to the full extent of the law (Workshop briefing papers).*

8 Addo NA. *Abortion-an exploratory study of induced abortion among students of the Korle Bu Nursed Training College; an attempt at a community based study, June 1985, Women in Ghana- An annotated bibliography, Ed. Ardayfio-Schandorf E. and Kwafo-Akoto 1990, 124-125*

9 Ampofo DA. 330 cases of abortion treated at Korle-Bu Hospital; the epidemiological and medical characteristics, GMJ, 1970; 9(3): 156-162.

10 Ampofo DA-The dynamics of induced abortion and the social implication for Ghana-GMJ 1970; 9(4): 295-302.

11 Deganus-Amorin KATH.

12 Akosa AB.,2000 (Personal communication)

13 Lassey AT, *Complications of induced abortions and their preventions in Ghana. East African Medical Journal,1995; 72(12):774-777*

14 *Changing attitude to fertility - Women in Ghana, An annotated bibliography, 1990 Ed. Ardayfio-Schandorf E. and Kwafo-Akoto K., pg 111*

15 Richard B Turkson. *Overview of the Legal situation regarding abortion in sub-Saharan Africa. African Journal of Fertility, Sexuality and Reproductive Health, 1996 (1): 5-7*



THE SITUATION OF ABORTION LAWS IN THE COMMONWEALTH

Abortion laws in most Commonwealth countries, as in most colonized countries have remained a legacy of colonial rule and for the most part, even after independence, these countries have continued to remain 'attached' to these outdated laws even in the face of modernization and recognition of integral human rights of women. The 'mother countries' have long since apologized for imposing those laws on their colonies and amended their own laws to reflect on changing human rights perspectives.

Ghana being a Commonwealth country is no exception to those Commonwealth countries that have maintained archaic laws. Cook and Dickens in a paper entitled "Abortion Laws in Commonwealth countries" suggests a classification for analysis of abortion laws as:

- a) Basic law, which prohibits abortion under any circumstance and was exemplified by the 1861 English Offences against the Person Act. This constitutes extreme restriction with no exceptions whatsoever.
- b) Developed law, which state a general prohibition against abortion but specifies certain circumstances under which an abortion may be lawful. Examples are the famous English case of R vs. Bourne (1938), which constitutes statutes of judicial decisions. Under this category, the exact scope of permissible abortions will vary from narrow to wide depending on the intention of the legislature in the particular country.
- c) Advanced law, which provides categorically that a woman can seek abortion lawfully when specified indications are satisfied. In Africa, South Africa exemplifies this type of law most clearly.

The laws of other countries within Sub-Saharan Africa fall into the category of either basic or developed law. R.B. Turkson¹⁶ exemplifies the above clearly by stating that the situation is similar for Anglophone and Francophone countries and that even though the original countries may have modified their laws several times, the provisions on abortion remain as restrictive in many of those countries. The case of R vs. Bourne, the necessity to recognize the need to preserve the health especially mental health as well as the woman's life has been underscored in several judicial decisions in

English speaking jurisdictions in sub-Saharan since then. In Ghana, before 1985, the law in existence was the PNDC Law 102, which stated that abortion was lawful only if it was carried out in good faith and without negligence "for the purposes of medical or surgical treatment of a pregnant woman"¹⁷ This law in Ghana remained silent on who was qualified to perform a lawful abortion as well as specifying the medical or surgical indications, which would justify a legal abortion.

The law of 1960 was not sufficiently clear on several issues. It did not, for example, clarify who was qualified to perform an abortion, whether the consent of the woman (or guardian) was required, what the gestation limits

¹⁶ *Criminal Code of Ghana, 1960, Act 29 sections 58,59 & 67*

¹⁷ *Fred Sai. An overview of unsafe abortion in Ghana- A Foreword. African Journal of Fertility, Sexuality and Reproductive Health. 1996, 1 : 2-3*

were or where a legal abortion could be performed. Moreover, it did not define what constituted medical or surgical treatment. Two studies conducted among physicians and lawyers in the early 1970s confirmed that the law was so vague that different persons had varying interpretations of it. The studies also found that the overwhelming majority of physicians supported the drafting of a clearer and more liberal abortion law in Ghana.

Prof. F.T Sai reminds us that the rationale for these archaic 19th century laws was to save women from quacks and unsafe and experimental surgery thus their continuing presence leading to more deaths in women is a ‘cruel irony’^{3,18}.

HISTORY OF POLICY ON ABORTION IN THE MINISTRY OF HEALTH

Abortion has been shown to be most unsafe when laws are restrictive as it then becomes clandestine and ‘hushed’ as well as exploitative due to high cost for ‘safe’ services

In 1985, doctors in Ghana spearheaded an amendment of the Criminal code on abortion. The Criminal Code (Amendment) Law 1985 was passed which made the following provisions:

1. Abortions remained illegal unless carried out in a Hospital or designated clinic by a registered medical practitioner or gynaecological specialist.
2. When the above provisions have been satisfied, abortion is permitted when continuing the pregnancy will pose serious risk to the life of the pregnant woman or injury to her physical or mental health. This last provision remains however inconclusive and vague and according to the doctors too vague and undefined in interpretation.
3. Abortion is also permitted where the pregnancy is the result of rape, defilement of a female idiot or incest or where there is substantial risk of a serious physical abnormality or disease in the foetus.
4. The law was however silent on whether socio-economic reasons constituted grounds for abortion or what the limits of gestational age for legal abortion were. This leaves considerable latitude for interpretation.

R B Turskon concludes his article by suggesting that reform in countries will have to be gradual as the ‘scope of permissible abortions’ is expanded and the ‘exceptions become the general rule and vice versa.’

The medical doctors in the country through the Ghana Medical Association (GMA) continued their advocacy for a change in the law on abortion.

- In 1994, a Ghana Medical Association communiqué stated that unsafe abortion was the single highest contributor of maternal mortality in Ghana
- In 1996- Post abortion care training for midwives in the use of MVA under local anaesthesia as treatment for incomplete abortion was spearheaded by Ipas International and taken up by the Ministry of Health.



Existing Legal Framework in Ghana

Ghana in spite of being signatory to many international instruments and “extensive” health reforms does not have a comprehensive law on reproductive health. The substantive law on SRH falls under the Criminal Code 1960 (Act 29) and its subsequent amendment in 1995 and consolidated in 2000.

This code makes provision for sex related offences, criminalizing rape, defilement, abduction, indecent assault, unnatural carnal knowledge, incest, compulsion to marry, carnal knowledge of female idiots, harmful widowhood rights and customary servitude.

Commission of abortion is made a crime subject to three exceptions.

The law in Ghana dealing with abortion is defined under Section 58 of the Consolidated Criminal Code Act 29 defines abortion as: - “The premature expulsion or removal of conception from the uterus or womb before the period of gestation is completed”.

The W.H.O defines unsafe abortion as: - “A procedure for terminating unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal facilities or both”. Interestingly, in the Ghana Criminal Code, the provision on abortion is lumped together with suicide although the latter received only one short paragraph.

ADVANCES IN THE LEGAL PROVISIONS ON ABORTION.

Prior to 1985, abortion was prohibited under ALL circumstances. In Ghana, the law provides that “ It shall not be an offence if the abortion or miscarriage is caused in any of the following circumstances by a registered gynaecologists specializing in gynaecology or any other registered medial practitioner in a government hospital or in a private hospital registered under Private Clinics and Maternity Homes Board. Since the amendment in 1985, it is now permitted legally under the following stated conditions:

1. Where pregnancy occurred as a result of rape or defilement
2. Where there is substantial risk of a physical abnormality or disease occurring in the unborn child.
3. Where continuing with the pregnancy would risk the mental or physical health or the life of the pregnant woman.

Among medical practitioners, knowledge of the law especially as currently stated is low and is often misunderstood by those who are supposed to implement it.

The provisions in the law even as it stands leave ample room for women to access abortion services; however abortion services are not easily accessible, as the health providers remain largely unaware of the provision in the law. Most of the women requiring these services live in rural areas where even if health facilities are available, the doctors mandated by law to provide these services are rarely found thus limiting their access to services.

The Ministry of Health has developed several Reproductive Health policies in Ghana. These include: -

1. The National Reproductive Health Service Policy and Standards revised in 2003 to include the specific provision of safe abortion within the law
2. The National Reproductive Health Service Protocol.
3. The Adolescent Reproductive Health Policy - October 2000.

The office of the National Adolescent Health and Development Programme was established in 1996 to complement the efforts of partner organisations involved in youth friendly service provision. Due to some socio-cultural constraints the Adolescent Reproductive Health Policy was not operationalised till October 2000. This policy provides guidelines for ASRH programming.

Other documents include some aspects of reproductive health policies. Interestingly, on closer inspection of these documents, prior to 2003, the relevant components of reproductive health addressed are antenatal and post-natal care, family planning, prevention and treatment of reproductive tract infection, infertility, management of cancers of the reproductive tract, menopause, harmful traditional practices, information and counselling on human sexuality, responsible sexual behaviour, responsible parenthood, post-conceptional care and sexual health.

Closer inspection of these documents shows non-harmonization of policies especially between ARH policy, HIV/AIDS policy and the Reproductive Health policies. For example the age defined by adolescents is 10-19 years, however the age mandated for coverage by family planning services is over 18 years. Thus no provisions are made for adolescents to receive contraceptive service.

Abortion issues are dealt with under prevention and management of unsafe abortion and post-abortion care. No specific mention is made of abortion in the safe motherhood indicators as the issue is “lumped” under ‘maternal mortality’ in general.

Some steps have been taken, it must be admitted, to address prevention of unsafe abortion. The aims of post-abortion care mentioned include:

- Creating public awareness of the dangers of unsafe abortion, prevention of unwanted pregnancies and education of clients on the complications of abortion.
- Equipping doctors/midwives with the requisite skills.
- Decentralizing MVA services to the district level.

Interestingly, the 2002 annual report of RCH unit is silent on any achievements in the area of Post-abortion care¹⁹.

Although analysis of maternal mortality acknowledges unsafe abortion as being the second major cause of maternal mortality in Ghana, the report in 2002 remains silent even on their key stated objectives and abortion services are not listed in any activity.



¹⁹ Draft Position paper in the Legal Status of abortion on Ghana – the African Women Lawyers Association (AWLA)

In the state of current knowledge and understanding of the law as well as the implementation and policies by the Ministry of Health, the law does not promote and encourage the right of choice of women in Ghana.

The current RH policies of the MOH do not specifically allow for recognition of the exceptions in the provision of access to abortions services in cases where it is permissible under the law. It also concentrates on unsafe abortions.

The Criminal Code of 1960 with amended in 1985, has a provision in Section 58, which criminalizes the woman seeking the abortion as well as the person providing it subject to the exceptions mentioned earlier. This provision is obviously against the International documents developed within the last 10 years.

In the implementation of this provision of the law however, research shows that women in Ghana have rarely been prosecuted at the Accra High Court. In 1999, 172 cases of illegal abortions were reported to the Police. In the years of 2000, 2001 and 2002, 256, 165 and 177 cases were reported respectively with only 3 convictions so far. No change of the law is envisaged at present.

CASE STUDIES IN GHANA

INTRODUCTION

Case studies were undertaken at different levels of Reproduction Health (RH) service provision in Ghana. Information was obtained from 5 centres: 2 Teaching Hospitals, 1 Regional Hospital and 2 District Hospitals.

14 questionnaires were also administered; 10 to Health and health-related institutions, 1 to a Women Lawyers' organization and 3 to Health-related NGO's. Countrywide information was also sourced from the Ghana Prevention of Maternal Mortality Network's library.

FINDINGS

6 health institutions, 2 NGO's and the women lawyer's organisation returned the questionnaire. This comprised 64.3% of questionnaires administered. The two NGOs denied having any abortion-related services although they did admit to providing post-abortion counselling and managing incomplete abortions using manual vacuum aspiration (MVA).

Of the health institutions that returned the questionnaires, the average numbers of unsafe abortions treated were 5, 11, 24, 36, 78, 55, and 412 a day. The age range of service seekers was 19-35 years though in one institution, the lowest age on record was 15 years. One institution had 3 cases between 12, 15 and 18 years and 10 cases over 35 years.

Two institutions recognized that there is a law in place but that there is a need to institute the necessary modalities to ensure its "enforcement"

including provision for the 3 exceptions stated.

A number of NGO's are involved in training health workers in post-abortion care.

The commonest post-abortion complications presented to the institutions surveyed include: -

A. Immediate complications:

- Bleeding
- Uterine perforation
- Sepsis
- Peritonitis
- Renal failure

B. Long term:

- Infertility
- Chronic pelvic pain

These could all cause prolonged maternal morbidity as well as mortality.

Most institutions did not distinguish between the different types of abortion in the general study although data provided from the Regional Prevention of Maternal Mortality (RPMM) did.

Women have the right to be free of disease as evidenced by prolonged illness or morbidity and not just the right to life. Although these results are not comprehensive and consistently available for all the years, they give a good indication of the general trend in the 3 areas and different kinds of institutions.

The following Tables show the comparative results from 3 other institutions: -

1. Nsawam Hospital

This is a District Hospital in the Eastern Region of the country. In this Hospital no figures were available specifically for abortion related deaths until 2002 both for complications and for maternal deaths (Table 2)

TABLE 2. CAUSES OF MATERNAL MORBIDITY AND MORTALITY IN: NSAWAM DISTRICT HOSPITAL

	1997	1998	1999	2000	2001	2002
INDICATORS						
No. Obstetric admissions	2159	2031	2195	2801	2188	2656
No. Obstetric complications	1112	965	1062	1464	1395	874
Total no. of maternal deaths	17	17	17	16	14	12
TYPE OF DIRECT COMPLICATIONS						
Total	1048	867	1013	1412	1339	328
Haemorrhage	795	645	790	1147	997	51
Ruptured uterus	0	0	0	0	0	5
Induced/septic abortion	0	0	0	0	0	38
Percentage of abortion related complications						13.1
MATERNAL DEATHS						
Total (direct causes)	14	11	14	13	13	5
Haemorrhage	8	3	2	3	1	1
Induced/septic abortion	0	0	0	0	0	0

2. Juaben Hospital

This is another District Hospital in the Eastern Region of the country. In this district hospital in 2001, 27.5% of complications seen in the obstetrics and gynaecological service were due to abortion (Table 3). No figures were recorded for maternal mortality in this hospital till 2002.

TABLE 3. CAUSES OF MATERNAL MORBIDITY AND MORTALITY IN: JUABEN DISTRICT HOSPITAL-EASTERN REGION

	1997	1998	1999	2000	2001	2002
INDICATORS						
No. Obstetric admissions	231	241	244	350	406	387
No. Obstetric complications	72	89	85	134	139	96
Total no. of maternal deaths	0	0	2	5	0	0
TYPE OF DIRECT COMPLICATIONS						
Total	72	89	83	129	139	96
Haemorrhage	25	26	21	17	38	
Ruptured uterus						
Induced/septic abortion	25	38	27	28	38	7
Percentage of abortion related complications				21.7	27.5	7.3
MATERNAL DEATHS						
Total (direct causes)						
Haemorrhage						1
Induced/septic abortion						1

3. Komfo Anokye Teaching Hospital

This is a tertiary referral centre in the Ashanti region, which is the second most populous region in the country. In 2001, 2 maternal deaths were attributable to abortion (Table 4).

TABLE 4. CAUSES OF OBSTETRIC MORBIDITY AND MORTALITY IN KOMFO ANOKYE TEACHING HOSPITAL-ASHANTI REGION

	1997	1998	1999	2000	2001	2002
INDICATORS						
No. Obstetric admissions	13246	13573	11980	14239	14170	18585
No. Obstetric complications	3825	3232	3318	3365	3460	7340
Total no. of maternal deaths	49	40	63	55	72	107
TYPE OF DIRECT COMPLICATIONS						
Total	3030	2546	2765	2740	2940	4435
Haemorrhage	366	382	462	500	508	433
Ruptured uterus	28	30	36	34	40	26
Induced/septic abortion	2077	1596	1648	1626	1736	2529
Percentage of abortion related complications				11.4	12.5	
MATERNAL DEATHS						
Total (direct causes)	35	32	47	41	53	51
Haemorrhage	9	7	10	7	9	12
Induced/septic abortion	4	6	4	4	11	9
Percentage of abortion related deaths			8.5	9.8	20.8	

Tables 2-4 are courtesy of RPMM office - RPMM process/output indicators on Emergency Obstetric care services.

Overall, the data in Tables 2-4 show that 9.8% of obstetric admissions in Nsawam District hospital in 2002 were due to induced/septic abortion (RPMM), 27.3% in 2001, 9.7% in 2002 in the Juaben District Hospital-Eastern Region (RPMM), 59% in 2001 and 57% in 2002 in KATH- Ashanti Region.

Maternal mortality due to septic/induced abortions in KATH for 2001 and 2002 are 22% and 17.6% respectively. (RPMM)

DETAILED CASE STUDY OF THE KOFORIDUA CENTRAL HOSPITAL

Further information was obtained from a detailed study of abortion services in general provisions for obstetrical and gynaecological services available at a Regional Hospital. The methodology adopted was qualitative with direct interviews of individual staff and patients/clients.

Findings:

1. Obstetric and Gynaecological Services

All the basic essential and advanced obstetric care services are available at the hospital, and this is made possible due to new equipment such as an ultrasound, vacuum extractor etc available at their new ultra modern maternity building which was opened barely a year before the study. All the services for gynaecology are also available.

2. Inventory of Health Staff at the facility

DESCRIPTION	NUMBER
O & G Doctors	2
Other Doctors	4
Nurse / Midwives	16
Midwives (straight training)	41
Staff Nurse (no midwifery training)	1
Community Health Education Workers (CHEW)	0
Auxiliary Nurses	20
Trained TBA's	0
Records Officers	0
Orderlies	20
Ward Assistant	1
TOTAL	105



DETAILS OF REPRODUCTIVE HEALTH INDICES

	Years				
	1998	1999	2000	2001	2002
Indicators					
No. of obstetric admissions (Admitted at labour ward)	5	1863	1926	2036	1957
No. of obstetric complications	652	634	645	609	604
Total No. of Maternal deaths	40	31	35	40	19
No. Brought In Dead	2	1	-	3	2
Maternal Death Analysis					
Direct Causes					
Haemorrhage	13	11	7	16	5
PIH Eclampsia	8	8	3	2	2
Complications of Abortion	4	1	8	3	3
Sepsis	3	3	3	1	1
Indirect Causes					
Hepatitis	2	1	-	-	-
Anaemia	3	-	5	4	2
HIV/AIDS	2	-	-	-	-
Sickle Cell	-	2	2	-	-
Meningitis	-	-	-	-	2
Other causes	5	5	7	14	6
Abortion cases	209	178	241	454	411
Post abortion care offered					
Total		93	217	340	276
Family planning		183	290	276	

It is evident that over 400 abortions cases report to the hospital per year but this is probably just the tip of the iceberg of total abortion cases within this region. 7.5% of maternal deaths were attributable to abortion related complications

3. Types of abortion services available

Both surgical and medical methods of abortion services are available.

The surgical method using the manual vacuum aspiration or dilatation and curettage is more commonly carried out at the hospital due to patients not seeking for abortion in the earlier months of pregnancy.

With the medical methods the drugs frequently used by doctors include Misoprostol, Cytotec (which was actually developed to treat Non Steroidal Anti-Inflammatory Drug related peptic ulcers), and Mifepristone also known as RU486. These drugs are safely used for abortion purposes during the early weeks of pregnancy (up to 12weeks) after which time serious complications could result.

The cost of having an abortion varies from doctor to doctor, since according to the doctors interviewed, there has not been a consensus yet that hospitals should officially provide abortion services.

4. Profile of women who seek abortion services at the Hospital

Both literates and illiterates at different ages, usually between 14 years and 45 years are seen daily at the hospital seeking an abortion. From close scrutiny more literates turn up at the earlier stages of pregnancy than illiterates. This could be explained by the high cost of getting a safe abortion from a health professional. On the other hand, illiterates, usually the poor ones, come with the most complications since they use dangerous and unsafe methods to abort. These attempts are also undertaken at a more advanced gestational age.

5. Methods used to abort unwanted pregnancies

These include inserting sticks into their vagina, drinking concoctions made of blue and grinded bottles, hair dye and using leaves from trees such as Mampong Bedu. These people sometimes buy drugs over the counter from unauthorized and fake druggists with some even taking as many as 20 tablets of chloroquine to attempt to abort the foetus.

6. Pre and Post abortion care for procedures carried out in the hospital

Before an abortion is carried out, a patient is taken through pre-abortion counselling whereby the doctor ascertains the reasons for wanting an abortion and the health risks involved if the abortion is performed.

After the abortion if there are any complications, the patient is treated and then taken through post abortion counselling when family planning services are offered.

The above services are not offered 'openly' but currently in a rather 'clandestine' manner due to lack of appreciation of the provisions of the law in Ghana by health personnel and the population generally.

More emphasis is placed on post abortion care services within the hospital once the patient comes in with vaginal bleeding from any cause.

Basic post abortion care services available at the hospital include:

- Emergency treatment for complications including the use of MVA for uterine evacuation
- Post abortion family planning counselling and services
- Linkages with other reproductive health services e.g. STI/RTI clinics

There is a 24-hour blood transfusion service with clinical screening for HIV/AIDS, available within the hospital, for patients who report with complications.

FINDINGS FROM OTHER INSTITUTIONS SURVEYED

Analysis of 4 health institutions shows them to admit only to offering post-abortion care services and use euphemisms such as "manual vacuuming" and "family planning" even where it is obvious abortion services are available.

2 institutions did not see the obvious morbidity and mortality as associated problems. Indeed, it was very difficult to identify actual mortality figures that were attributed to illegal abortions. The study would have to be extended to



the regional mortuaries for their data..

Only one institution admitted that their lowest age presenting for abortion service was 14 years.

It was also obvious that health personnel in these institutions were not aware of the provisions of the law in Ghana regarding abortion.

POSTSCRIPT TO STUDY

In July 2003, safe abortion services were included in a review of Reproductive Health policies

In August 2003, the Ghana Health Service set up a committee to draw up plans to reduce the high level of unsafe abortions in Ghana.

This was the state of affairs until 2003 where within the revised RH policy of the MOH, provision is made for safe abortion services within the law, and the MOH is actively working towards putting it into practice.

Part II- REPRODUCTIVE HEALTH IN GHANA- OTHER ISSUES

HEALTH SECTOR REFORMS AND THE EFFECT ON SEXUAL AND REPRODUCTIVE HEALTH

INTRODUCTION

A series of health sector reforms have been initiated over the last ten years in Ghana which comprises institutional development, major policy and strategy work and strengthening management functions, negotiations, planning and design over various time phases during this period. Specific initiatives were then launched such as the district health system initiative in 1991 and the restructuring of the Ministry of Health (MOH) in 1992. Country wide, in 1993, decentralisation of authority occurred with 110 District Assemblies becoming Budget Management Centres (BMC), controlling financial resources, planning authority and government initiatives such as provision of social services to their communities. The theory was that sector ministries would work with district assemblies to ensure that sector issues are addressed and adequately resourced. In practice, full decentralisation is yet to happen.

In 1993, as a result of in-depth reviews and wide consultations with all stakeholders in health, private, public and external, a Medium Term Health Strategy was initiated and developed by 1996 (MTHS), which formed part of the national development strategy called 'Vision 2020'. The MTHS was turned into the 5 Year Programme of Work (5-YPOW) by the MOH in collaboration with its partners. Both documents gave detail to the vision, national priorities and key strategies for the health sector. These priority services included reproductive health, childhood immunizations, and other disease specific interventions.

The Reproductive Health (RH) programme includes the following:

- Safe motherhood including antenatal, safe delivery and postnatal care
- Family planning





- Prevention and management of unsafe abortion and post abortion care
- Prevention and treatment of reproductive tract infection (RTI) including sexually transmitted infections (STI) and HIV/AIDS
- Prevention and treatment of infertility
- Prevention and management of cancers of the reproductive tract including breast, cervical, testicular and prostate
- Issues of the menopause
- Discouraging harmful traditional practices affecting the reproductive health of men and women which include female genital mutilation
- Information, education and counselling on human sexuality, responsible sexual behaviour, responsible parenthood, pre-conceptual care and sexual health targeting adolescents and the youth in particular.

The MOH in collaboration with its partners developed reproductive health service policy standards in 1997.

The objectives of the RH programme were several-fold:

- Reduction of maternal mortality from 214 per 100,000 live births in 1997 to 100 per 100,000 live births by 2001
- Increasing birth intervals to an average of 3 years by 2001
- Attainment of a contraceptive prevalence rate of 15% by 2000, 28% by 2010 and 50% by 2020.

These objectives were to be achieved using concepts of primary health care (PHC), outreach and community based activities, health education, promotion of appropriate technology and collaboration.

In actual fact, it would appear that the figures for maternal mortality are on the rise inspite of efforts from both the MOH and other NGOs for example, the Prevention of Maternal Mortality Network (PMMN).

The Ghana Government passed the Ghana Health Service Bill in 1999, which became operational in 2000. This distinguishes a Ghana Health Council separate from the Ministry of Health, which is under the Minister of Health, who is a cabinet Minister. The Ministry is responsible for policy whilst the GHS has oversight of service delivery and institutional care.

The Head of the GHS is the Director- General with several Directors under him. One of these Directors is the Director of the Family Care Division under whom is maternal care, family planning, childcare and reproductive health.

Her budget is only a fraction of the total budget for the MOH, which we were told recently under this current NPP government, had gone up to 13% of the recurrent expenditure. The budget of this directorate is mainly for development of policy and training, safe motherhood, Emergency Obstetric Care (EMOC), training of TBAs, provision of post abortion care services only until recently when the scope of RH was reviewed and broadened.

The division has been working closely with UNFPA, private midwives as well as private/ family practitioners

Achievements noted within the Health Services

- Geographical access has been increased to existing health facilities
- 3 new Regional hospitals have been built
- Additional district hospitals have been built and upgraded as have health centres
- A novel concept, the community based approach to health services and planning (CHPS) which relies on the placement of a community health nurse within a community, working with the community health committee to improve the health of the community.
- Integration of vertical programmes in service delivery
- Evidence of resource shift from the centre and tertiary institutions to the districts
- Clear improvements in the delivery of such public health services as childhood immunizations and vitamin A supplementation.
- In reproductive health:
 - Improvement in coverage of antenatal services suggesting a doubling of antenatal registrants*
 - An increase in supervised deliveries to 52% in 2000
 - An increase in postnatal coverage rates
 - The maternal mortality rates have remained stagnant or worsened
 - The uptake of short-term contraceptive methods has increased**

Challenges in reproductive health

- The main challenge is that RH has not been accepted widely as a priority area within the districts and the annual review of the health sector has not placed any emphasis on it.
- There is also no real effort to pursue and achieve national targets in areas such as maternal mortality in spite of the safe motherhood initiative.
- One of the clear challenges in this area is the lack of attention to human resource development aggravated by the considerable 'brain drain' affecting in particular the health sector with little comparable attention being paid to staffing in the new health facilities being built.

MOH (1996): Health Sector 5 Year Programme of Work, Ministry of Health, Ghana

MOH (1997): National Reproductive Health Services and Policy Standards, Ministry of Health, Ghana

*MOH (2000): Consolidating the Gains: Managing the Challenges, 1999 Health Sector Review

**MOH: Annual reports on the Reproductive and Child Health Unit of the Public Health Division, 1997-2000



OTHER REPRODUCTIVE HEALTH INFORMATION

ROLE OF IPAS IN GHANA

Ipas used to be an acronym, which stands for International Project Assistance Services. It is now no longer an acronym. Ipas is an international NGO founded in 1973, involved in improving reproductive health services globally to help eliminate the causes of unsafe abortion particularly in developing countries. At the request of partners, Ipas collaborates to address restrictive policies, improve inadequate health care and overcome socio-economic barriers, offering practical solutions, working from several perspectives such as research, training and technical assistance, policy analysis and advocacy, information dissemination and the manufacture and distribution of reproductive health technologies. All these are aimed at addressing factors affecting women's access to safe reproductive health choices especially to safe abortion.

The Ipas philosophy is that in being denied access to safe reproductive health choices, women are denied a fundamental human right. Ipas works at creating the environment in various countries, which will enable women more easily exercise and enjoy these rights.

Ipas introduced post abortion care services to Ghana in the late 1980's. The services were initially provided in the 2 main University Teaching Hospitals that is Komfo Anokye Teaching Hospital in Kumasi and Korle-Bu Teaching Hospital in Accra.

Ipas has conducted some regional training and has supported the Ministry of Health and the Ghana Health Services in training health professionals in safe motherhood clinical skills throughout the country, which include the use of the manual vacuum aspiration kit.

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

According to WHO, adolescents are people between the ages of 10 and 19 years with adolescence being the period of transition from childhood to adulthood.

Reproductive health is 'a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and its function and processes. Sexual health is 'the integration of the physical, emotional, intellectual and social aspects of a sexual being in ways that are positively enriching and that enhance personality, communication and love'. Adolescent Sexual and Reproductive Health refers to the physical and emotional well-being of adolescents and includes their ability to remain free from unwanted pregnancy, unsafe abortion, sexually

transmitted infections and all forms of sexual violence and coercion and able to make responsible choices.

Adolescent Health Services are services designed to improve accessibility to and quality of existing health services including reproductive health as well as make their use more acceptable to adolescents. These services are available in clinics, pharmacies, health centres and workplaces (schools and other community outreach points) all across the country.

The aim of Adolescent Health services in Ghana is: -

- To strengthen human resource capacity building at all levels of the health delivery system.
- To establish a comprehensive Information, Education and Communication (IEC) / Advocacy system that will facilitate the commitment of the communities and their leaders as well as other key stakeholders including health workers to the Adolescent Health programme.
- To strengthen the capacity of service delivery points to provide a well-defined service package for adolescents.
- To foster partnership with collaborators from the public and private health sectors through effective data collection, analysis and dissemination of adolescent health issues.
- To equip adolescents with adequate information of emerging health issues including sexuality and reproductive health for effective decision-making regarding their health.
- To equip parents/guardians with requisite knowledge and skills for promotion of effective parental guidance and support for adolescent health services.
- To strengthen the capacity of key players in the ADH programme to establish a sustainable operational research system.

(Source: Adolescent Reproductive Health policy)

Policy and Planning

Adolescent health has been identified as a priority programme area for the Ghana Health Service for the period 2002 to 2006.

Capacity Building.

Initially, eighty-one (81) resource persons were trained. 35 from the Eastern, 36 from Central and 10 from the Greater Accra regions. The Director of School Health Education Programme (SHEP) of the Ghana Education Service was also trained. Subsequently more persons were trained. So far, two hundred and seventy-three (273) resource persons have been trained to man these facilities.

The total breakdown is as follows:



Greater Accra Region	44
Ashanti Region	26
Eastern Region	35
Central Region	36
Brong Ahafo Region	38
Western Region	34
Upper West Region	24
Volta Region	35
Head, SHEP	1

A training package has been developed to help trainees and this package includes:

- Situation analysis on adolescent health status
- Counselling
- Adolescent development
- Early and unplanned pregnancy
- Safe Motherhood
- Family Planning
- STI/HIV/AIDS
- Abortion
- Harmful practices affecting adolescents
- Reproductive health disorders affecting adolescents
- Adolescent nutrition
- Substance abuse
- Mental health
- Immunization for adolescents

Service Delivery

Adolescents are entitled to a full range of health services including reproductive health. The GHS ADHD programme will promote abstinence as much as possible and will provide a full range of Reproductive Health services including contraceptives for sexually active adolescents. However this statement is contradictory as the legal age limit for administration of contraceptives to adolescents is 18years although age of consent is 16 years. This in effect means that at present, contraceptives cannot be legally administered to sexually active adolescents below that age.

Monitoring and Evaluation

A Monitoring visit was made specifically for adolescent-friendly health services to Ada Foah Health Centre, La Polyclinic, Teshie Community Health Centre and Ridge Hospital all in the Greater Accra Region. The four (4) institutions have all met the following criteria:

- Sensitised all categories of health workers
- Orientated frontline health workers

- Trained frontline health workers
- Trained peer educators
- Signboards signify availability of adolescent-friendly health services
- Ensured that counselling rooms are available

At Ridge Hospital, one of the peer educators was located at the Out Patient Department to receive young people and direct them appropriately. A record was kept of young people reporting each day at the hospital including information on their ages and school going status and a temporary library has been established in the hospital for young people.

At La Polyclinic, a special apartment designated Adolescent Health corner has been established.

At Teshie Community Initiated Clinic, in the Greater Accra Region there was a signboard indicating availability of adolescent-friendly health services. A notebook with records of the young people who came for special services was kept to date.

At Ada Foah Health Centre, there was a signboard indicating adolescent health services as one of the services offered on daily basis. A counselling room had been created in the new block attached to the centre.

One of the major challenges faced in all areas is that of inadequate funding.

Summary

Promoting adolescent health is crucial to the health sector reform programme currently going on. This is so because adolescents form 2.9% of the total population and so contribute to the socio-economic development of Ghana. Like other sub-groups, adolescent health services are influenced by two factors:

The pattern of disease or conditions (incidence or prevalence, probability of suffering severe disability or dying from it and its potential as emerging problem of socio-economic importance)

The available interventions, their effectiveness, cause and compatibility with other interventions as a package.

However, adolescents are eligible for the current package of health services, which is a combination of public health, clinical, and maternity service.

Public health services provide immunization and mass treatment for appropriate disease or conditions for which this is an effective intervention. Mass screening surveillance serves as a monitoring mechanism for determining the magnitude, trends and outbreak of diseases. Clinical services provide effective treatment for common disease problems as well as emergency care. Maternity services, which have both public health and clinical service components, address the causes of the unacceptably high maternal morbidity and mortality rates and also the high fertility rates.



YOUNG AND WISE PROGRAM

The Young and Wise is a comprehensive, brand driven, youth programme targeting young people aged 10-24. It is a collaborative initiative spear headed by the Planned Parenthood Association of Ghana (PPAG) and the Ghana Social Marketing Foundation (GSMF), designed to effect positive behaviour change among the youth in order to reduce HIV/AIDS, Sexually Transmitted Infections (STIs) and Teenage Pregnancy.

Young and Wise promotes a positive lifestyle for young people by several means. These include:

- Creating a supportive environment that will increase their access to Sexual and Reproductive Health (SRH) information and services.
- Encouraging young people to seek information regarding their sexuality and make decisions based on the information they have.
- Providing young people with information, service and skills, that empowers them to make an informed choice either to abstain, be faithful in their relationships, use a condom or seek treatment and services from a youth friendly facility.
- Promoting a youth “brand” that will be part of popular youth culture.
- Empowering parents to discuss sexuality and sexual issues with their children.

Young and Wise Strategies:

1. The print and electronic media are used to promote and create awareness of the Young and Wise brand and to provide accurate information on HIV/AIDS and other youth concerns. Multi media includes television and radio programmes and advertisements, distribution of various behaviour change communication materials, drama, music and other culturally acceptable channels of communication

2. Service Delivery-The Young and Wise provide a variety of SRH services that respond to HIV/AIDS epidemic. These include:

a) Life Planning Skills;

Equipping young people with critical life planning skills through participatory discussions and teaching sessions that cover adolescent sexual and reproductive health topical areas. Life planning sessions are organized for all young persons desiring to be part of Young and WISE.

b) Young and Wise Centres;

Youth friendly centres that provide SRH information and education, recreation as well as clinical services. Clinical services include Voluntary Counselling and Testing (VCT) for HIV, Family Planning, treatment and management of Sexually Transmitted Infections (STI's), treatment of minor ailment and general counselling. The centres are supported with community outreach activities.

c) Peer Education

Trained and equipped peer education and supported to reach out to their peers with the SRH information and counselling and to make referrals to service delivery points within their communities.

d) Telephone Help line and e-Counselling Services

A dedicated help line and e-counselling facility –“BE WISE: LETS TALK” that provides young people with anonymous professional and confidential counselling.

e) Competitions

Competitions (Quiz, Football etc) for both in and out of school young people organized to provide opportunities to provide their talent and to use their recreational time positively.

f) Franchising:

Franchising in the context of the Young and Wise is social franchising whereby a branded package is given to a group for social benefit. Young and Wise as the franchiser provides a package to interested groups and organisations and build their capacity to enable them to effectively promote the objective of reducing HIV/AIDS and STI's among young people. The organisation or group that agrees to be part of the franchise thus commits itself to provide some or all of the Young and Wise services.

These interventions are to provide adolescent friendly services in the country and are proving very popular with adolescents.

Virgins Clubs/Organizations

In recent years, many nations have joined in the fight against HIV/AIDS. Many methods have been employed in this fight, the most recent of them in Ghana being the formation of Virgins clubs.

Virgins clubs are clubs set up by individuals to teach the youth about HIV/AIDS and other sexually transmitted diseases by encouraging them to be and remain virgins until marriage.

Virgins clubs are organizations set up by individuals to deal with adolescent health problems especially concerning virgins. Virgins here are put into three categories, namely Primary Virginity, Secondary Virginity and Tertiary Virginity.

Primary virgins are young boys and girls who have never had sexual contact with anyone since birth. They constitute the core membership of this group. Secondary virgins are boys and girls who have had sex before but have now decided to abstain from sex. Tertiary virgins are made up of older people who are married and are being faithful to their partners and have decided to join the club to help in their work (mainly in the financial aspect).

The main aim of these clubs is to combat adolescent health problems particularly STI's through the teaching of abstinence. They believe the surest way of combating HIV/AIDS is by abstaining from sex.

One of the most influential of these organizations is the Dzreke Virgin





Ambassadors Foundation founded by Mr. Kofi Fonu in October 2001.

These organizations have set up clubs in various second-cycle schools and churches and have trained and provided these clubs with the requisite materials to do their work.

The main activity of these clubs is to teach the members about adolescent health and how to combat HIV/AIDS and other STIs. The Virgin Organizations use these clubs to carry their message across to the public especially the youth in the community.

Churches often invite these organizations to organize fora for their youth and help them set up branches of their clubs in their church. As at August 2003, the Dzreke Virgin Ambassadors Foundation alone had inaugurated 30 virgin clubs in various schools and churches with the numbers expected to rise to 50 by May 2004.

Other activities undertaken by this organization to educate the youth, is an annual Miss Virgin Beauty Contest for the ladies. It is similar to any other contest except that primary virginity is essential for qualification as a contestant. Doctors are brought in to examine contestants and make sure they are truly primary virgins, which is highly unethical.

Prizes are awarded to deserving winners. At the moment, it is only organized for ladies in the Greater Accra Region. Plans are underway to organize a national contest with contestants from all over the country and also to organize one for the gentlemen. The idea behind this contest is to encourage abstinence and make the young ladies proud of their virginity status.

The organization is associated with various groups and organizations, which aid them in their work. Some of these organizations are Actionaid, Forum of African Women's Educationalists (FAWE) and The Ghana Aids Commission.

The Virgins clubs have increased their activities allegedly based on recent research in Uganda, which showed that the rate of infection of HIV/AIDS had decreased gradually in Uganda due to the teaching of abstinence to their youth. Other studies have however disproved these claims strongly, stating that the drop in rates in Uganda was due to the increased use of condoms and the reduction of partners by individuals.

Primary funding for these Virgin Clubs has come from concerned individuals in Ghana and from their own fund-raising events but interestingly also from the Ghana AIDS Commission.

The role of the churches has been underplayed in the discourse around Virgin Clubs, but as these seem to be gaining grounds, the influence of the church is beginning to be felt more and more.

Questions must continue to be raised as to the questions of freedom of informed choice for the young people involved and the strong ethical questions on infringement of rights of these young people must also be raised,

THE HIV/AIDS POLICY

General Policy Environment

The prevailing favourable policy environment in the country inspired the development of this document. The 1992 Fourth Republican Constitution of Ghana enjoins Government to, among other things, ensure that the general population enjoys a good quality of life. The Ghana Vision 2020 document, which for the period of the research is the blueprint for the country's human and socio-economic development, also highlights the need for quality life and expansion of opportunities for all members of society under its human development component. It further goes on to stress the need to reduce the incidence of preventable disease like HIV/AIDS.

In addition, the National Population Policy (Revised Edition, 1994) emphasizes the harmful effects of STI/HIV/AIDS and calls for the initiation of appropriate measures to prevent and control the epidemic. There are other policies, which have made explicit or implicit references to HIV/AIDS management in Ghana. These include the National Youth Policy, which identifies the provision of services to people living with HIV/AIDS as a priority; a draft Adolescent Reproductive Health Policy that has as one of its objectives, the implementation of programmes aimed at reducing or eliminating STI/HIV/AIDS. Others are the Reproductive Health Standards and Protocols, the Labour Bill, the Work Place HIV/AIDS Policy, draft policies on Ageing and Gender as well as Affirmative Action Policy Guidelines to facilitate a process of ensuring gender equality and empowerment of women in all aspects of life.

Finally, there was a draft National HIV/AIDS and STI Policy document that has provided the impetus for the development of this strategic framework. There is therefore, a conducive policy environment from which the HIV/AIDS strategic framework has drawn lessons and inspirations. It is hoped that this prevailing atmosphere would be sustained so that the implementation of the strategic framework would proceed unhindered.

Goals and Objectives

The goal of the Strategic Framework is to prevent and mitigate the socio-economic impact of HIV/AIDS on individuals, communities and the nation.

The objectives are:

- To reduce new HIV infections among the 15-49 age-group and other vulnerable groups especially the youth, by 30 percent by the year 2005
- To improve service delivery and mitigate the impact of HIV/AIDS on individuals, the family and the communities by the year 2005.
- To reduce individual societal vulnerability and susceptibility to HIV/AIDS through the creation of an enabling environment for the



implementation of the national response.

- To establish a well-managed multi-sectoral and multi-disciplinary institutional framework for coordination and implementation of HIV/AIDS programmes in the country.

Intervention Areas.

To address the HIV/AIDS epidemic in Ghana, five key intervention areas have been proposed as components or main groups of strategies of the National Strategic Framework within which to develop a comprehensive response. Each area is supported by a set of broad strategies, which will serve as the basis to guide the development of action plans by all Ministries, Departments and Agencies (MDAs), Non-governmental Organizations (NGOs) and other private sector institutions.

Intervention 1: Prevention of New Transmission of HIV

- Promoting safer sex particularly among the most vulnerable groups in the country;
- Providing effective management of STIs;
- Minimising the risk of transmission through blood and blood product;
- Reducing mother –to-child transmission;
- Promoting Voluntary Counselling and Testing (VCT).

Intervention 2: Care and Support for People living with HIV/AIDS

- Providing cost-effective institutional care;
- Providing home-based care.

Intervention 3: Creating an Enabling Environment for National Response

- Creating a supportive legal, ethical and policy environment for HIV/AIDS programmes.

Intervention 4: Decentralised Implementation and Institutional Arrangements.

- Strengthening national programme coordination and implementation – Mainstreaming HIV/AIDS into Ministries, Departments and Agencies (MDAs);
- Strengthening Regional institutions to implement HIV/AIDS programmes;
- Scaling-up the District Response Initiative (DRI) and strengthening Districts to implement and manage HIV/AIDS responses;
- Community level implementation.

Intervention 5: Research, Monitoring and Evaluation

- Strengthening Research, Monitoring and Evaluation systems including surveillance.

Programme Targeting

The strategies outlined will specifically target vulnerable groups such as the youth, women, commercial sex workers and their male clients, mobile and migrant populations, uniformed service personnel and the general public.

Review of the National Response to HIV/AIDS in Ghana

HIV/AIDS in Ghana was first managed as a disease rather than a developmental issue. The national response has consequently been medically oriented and directed by the Ministry of Health (MOH). The earliest national response was the establishment of the National Advisory Commission on AIDS (NACA) in 1985 to advise government on HIV/AIDS issues. In 1987 the National AIDS Control Programme (NACP) was established as an arrangement within the Ministry of Health for both implementation and co-ordination of the programme. Since then, Short-Term Plans and Medium Term Plans 1 and 2 have been developed. In addition, a National HIV/AIDS and STI Policy has also been developed to guide the national response.

Many stakeholders including numerous NGOs have been trained and are implementing a number of programmes and projects in different areas in various parts of the country. The capacity of various NGOs to implement these programmes prior to training was generally weak. Overall co-ordination of HIV/AIDS programmes has so far been weak at all levels: national, regional and district.

The NACP substituted for the absence of a national multi-sectoral arrangement. It had become increasingly obvious that the complexity of the HIV/AIDS epidemic requires a developmental, holistic, coordinated and multi-sectoral approach to address the multi-faceted and multi-dimensional nature of the epidemic.

Funding for HIV/AIDS activities has been inadequate. Even when funding exists, procedures for accessing funds are very cumbersome. There are unanimous reports, of profound funding problems, particularly among NGOs irrespective of their size and proven track records.

Key interventions that have so far underpinned HIV/AIDS control have been:

- Safer Sex Promotion
- Preventive Clinical Interventions
- Continuum of Care for People Living With HIV/AIDS (PLWHA)
- Legal and Ethical Issues

The Ghana AIDS committee was established in 2000 and was initially based in the MOH. The Ghana AIDS Commission (GAC) was established in September 2000 but was initially largely dormant. The Secretariat found its feet in 2001 and has been responsible for the rapid changes and activities in the HIV/AIDS field to date.

The GAC is a multidisciplinary, multi-sectoral Commission chaired by the Vice-President of Ghana.

It has developed a strategic framework, which has identified key strategies aimed at reducing the spread of the HIV/AIDS epidemic.



THE FAMILY PLANNING PROGRAMME AND CONCLUSIONS

AS is the experience in many other countries, the family planning programme is limited to contraceptives only. The range of contraceptives available as indicated in our research is not 'the full range' envisioned in many international documents. The 'unmet need' for contraceptives is considerable and we outlined the range that is available. There is no mention of infertility either as an identified problem or within the solutions offered. Both female and male methods are however available.

Family Planning Methods.

The following family planning methods are offered at service delivery points:

1. Short Term Methods (STM)
 - Condoms (male and female)
 - Spermicides (VFTs)
 - Oral pills
 - Natural family planning methods
 - Combined monthly injectable – Norigynon
 - Lactational Amenorrhoea Method (LAM)
2. Reversible Long Term Methods LTM)
 - Intra-uterine Device (IUD)
 - Injectable – Depo Provera (3 monthly)
 - Implants – Norplant
3. Permanent Long Term Methods
 - Sterilisation of females – bilateral tubal ligation (during mini laparotomy or Caesarean Section)
 - Sterilisation of male (Vasectomy)

Capacity building

Training remains an important aspect of the programme. During the year, various trainings were carried out to build capacity of service providers, trainers and managers to increase access and improve quality of service.

Engender Health – Ghana, facilitated the following training

- Mini-laparotomy and Norplant insertion and removal under local anaesthesia.
- Norplant insertion and removal for nurses and midwives.

- Family planning counselling for nurse/midwives
- Infection prevention
- Satisfied client.
- Facilitative supervision.

CONCLUSIONS

Our study shows that although Ghana has come along way, we are still very far behind in identifying and addressing the core of reproductive health and rights. In the main, abortion continues to be a big obstacle to effective reduction of maternal mortality and will be an impediment to our achieving the desired Millennium development goals unless abortion is addressed head-on without the socio-cultural and religious barriers that are used to effectively stop or retard discussions.

The issues we have identified in this research are a high unplanned fertility rate with 16% unwanted, 24% mistimed (GDHS 2003), lack of access to a full range of Family Planning commodities (unmet need of 57%, (GDHS 2003), lack of access to quality care with the non use of services even where they are available due to socio-cultural, economic or religious reasons, legal restrictions with lack of clarity around the law on abortion in Ghana and a lack of knowledge of the law by both citizens and health practitioners. Generally, the definitions of Reproductive Health are still within a narrow confine.

In the words of Dr Mahmoud Fathalla, a former President of the International Federation of Obstetricians and Gynaecologists: *"...women are not dying because of diseases we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving"*





APPENDIXES

1. QUESTIONNAIRE FOR STUDY ON ABORTION IN GHANA

ABORTION RELATED MATERNAL MORTALITY IN GHANA

Institution:

Introduction

Abortion has been a cause of maternal death for many decades. It has been well established that, irrespective of whether an abortion is spontaneous or induced, what happens subsequently and the quality of care received, determines in outcome whether an abortion is safe or unsafe. In view of this, the above research seeks to find the quality of care offered at your institution and the state of your obstetrics & gynaecology unit.

Any information provided shall be treated with utmost confidentiality.

You are therefore urged to contribute freely to the success of this research.

Instructions

Please indicate the answer most appropriate to you.

1. Please indicate the basic essential obstetric care services available at the hospital

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.....
.....
.....
.....

2. Please list some of the equipments available for O & G care at the hospital

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.....
.....
.....
.....

3. What post abortion care is available at the hospital?

.....

.....
.....
.....
.....
.....

4. Inventory of Health Staff in Facility {Please indicate number}

a) O & G Doctors

.....

b) Other Doctors

.....

c) Nurses / Midwives

.....

d) Midwives

.....

e) CHEWs

.....

f) Auxiliary Nurses

.....

g) Trained TBAs

.....

h) Records Officers

.....

i) Others {Specify}

.....

.....

5. Please list the types of abortion services available in the health facility.

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.....
.....

6. What blood transfusion services are available?

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.....
.....
.....



7. Is there clinical screening for HIV / AIDS? {Tick right answer}
 Yes { } No { }

2. CASE HISTORIES

Indicators	Year				
	19...	19...	2000	2002	2003
No. of Obstetric admissions					
No. of Obstetric complications					
Total No. of Maternal Death					
Type of Direct Complication					
Total					
Haemorrhage					
Ruptured Uterus					
Induced / Septic Abortion					
.....					
.....					
Maternal Deaths recorded					
Total					
Haemorrhage					
Induced / Septic Abortion					
.....					
.....					
.....					
Post Abortion Care Offered					
Total					
Type {Indicate}					
.....					

You had only 2 NGOs returning the questionnaire so you should not comment. If you do then be specific with the numbers