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THE INCIDENCE OF SELF INDUCED ABORTION IN GHANA: WHAT ARE THE FACTS?

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Abstract

In Ghana, despite the growing number of studies, induced abortion remains a relatively unknown aspect of the national demographics. Interest in abortion research is, however, reemerging, partly as a result of political changes and partly due to evidence of the contribution of induced abortion to the high level of maternal mortality. A recent prospective study in Southern Ghana indicates that abortion rates in Ghana could range between 22 and 28 abortions per 1,000 women of reproductive age. Most of the abortion patients studied were young, some married and others unmarried. Results of logistic regression models suggest that those who work outside their homes, the self-employed, urban dwellers, single persons, women who have had a previous abortion, women with levels of education beyond Middle/JSS and Christians rather than Muslims are the ones likely to have an abortion. Because official statistics on illegal abortion do not exist and the numbers of such procedures must be estimated, the data presented here are the best available estimate; but they are not definitive.

Introduction

Unsafe abortion, defined as the termination of an unwanted pregnancy by a person lacking the necessary skill, in an environment lacking the minimal medical standard or both (WHO 1993) is an important global health problem, particularly in developing countries. In Ghana, despite the growing number of studies, induced abortion remains a relatively unknown aspect of the national demographics. Interest in abortion research is, however, reemerging, partly as a result of political changes and partly due to evidence of the contribution of induced abortion to the high level of maternal mortality.

Any study of abortion activity is also confounded by a host of issues, including the national law on abortion, societal mores, religious and political beliefs, the availability of family planning methods and the accuracy of abortion reporting. Although the 1980s have seen a gradual liberalization of abortion legislation in Ghana (Ghana Criminal Code 1985; Cook and Dickens 1981), the country continues to ban abortion on request. Clearly in settings where access to abortion is restricted, many women resort to unsafe practices to end an unwanted pregnancy, and in many cases they suffer complications, which sometimes lead to hospitalization or death.

Within the field of public health, abortion is traditionally investigated through two types of data: hospital-based data obtained from health care information systems, and survey data from population-based studies. Each approach suffers from substantial underreporting and errors in measurement (Coeytaux et al., 1989).

Reliable measures of the incidence of induced abortion are scanty and hard to come by. Of the 23 published studies conducted on abortion in Ghana between 1972 and 2001, only two employed population-based data; the remaining 21 were hospital-based studies, 19 of which relied mainly on data from the Korle Bu Teaching Hospital. However, induced abortion studies based on hospital data alone can hide much vital information needed for maternal health planning. Even when abortions performed in a hospital are within the legal framework, few medical personnel

record such events in the hospital logbooks. In an environment where induced abortion is restricted, women hospitalized for complications resulting from an induced abortion are likely to be counted as women hospitalized for complications resulting from spontaneous abortions. Thus, poor record-keeping, the unwillingness of hospital staff to accurately classify the type of abortion and perhaps the lack of hospital policies regarding accurate classification of abortion make hospital data inadequate for estimating nationwide incidence of induced abortion.

On the other hand, researchers attempting to study abortion through community-based surveys or ethnographic interviews typically discover that women are reluctant to talk about abortion and are likely to underreport their recourse to it. Despite the seeming de facto systems of abortion on request, clandestine abortions, performed by curettage or with the use of herbal and other non-patent abortifacients, remain common and perhaps are the main causes of maternal morbidity and mortality.

How Rampant is Induced Abortion in Ghana?

To minimize some of the problems associated with hospital data, the Maternal Health Survey Project conducted a community based study in eight districts involving four regions over the period 1997/98 (Ahiadeke 2001). A total of 18,301 women aged 15-49 years were identified in the eight study communities. The final screening procedures identified 1,689 women for follow-up studies. Of the 1,689 women in the study, 1,187 carried their pregnancies to term, nine died (one as a result of complications related to a self-induced abortion), 317 terminated their pregnancies during the study period, 21 miscarried and 15 had stillbirths (Table 1). Of the remaining 140 women, 97 (nearly 6% of pregnant women) were lost to follow-up and 43 (about 3%) were dropped from the study because they refused to cooperate later in the study.

According to the unadjusted data from the Maternal Health Survey Project, the abortion ratios were 19 abortions per 100 pregnancies and 27 abortions per 100 live births; the abortion rate was 28 induced abortions per 1,000 women of reproductive age.

According to data compiled from medical records at the Korle Bu Teaching Hospital, 55,779 and 52,131 women aged 15-49 visited the hospital in 1997 and 1998 respectively, as both inpatients and outpatients. Of these women, 12,137 gave birth in 1997 and 11,412 did so in 1998. The number of women treated for abortion-related complications was 1,775 in 1997 and 1,649 in 1998. These data produce abortion ratios for 1997 and 1998 of 15 and 14 abortions per 100 live births respectively, and abortion rates of 32 abortions per 1,000 women of reproductive age for both years. These figures are comparable to the World Health Organization's estimate of 31 abortions per 1,000 Ghanaian women aged 15–49 years for 1997 and 1998 (WHO 1994). Because the study sample includes just two enumeration areas each in four out of the 10 regions of Ghana and because the study team was unable to ascertain the pregnancy outcomes for 140 women (8% of the sample), the rates and ratios in Table 1 are likely to be lower than actual rates.

Table 1

Numbers of women, of pregnancies and of pregnancy outcomes, and abortion ratios and rates, by source of abortion data, Ghana, 1997 - 1998

Measure	Maternal Health	Korle-Bu Hospital	
	1997-1998	1997	1998
No. of women	18,301	55,779	52,131
No. of pregnancies	1,689	na	na
Abortions	317	7,775	1,649
Terms births	1,187	12,137	11,412
No. dead 42 days postpartum	9	na	na
Miscarriages	21	na	na
Stillbirths	15	na	na
Lost to follow-up	97	na	na
Refused to cooperate	43	na	na
Abortion ratio:			
Per 100 births	27	15	14
Per 100 pregnancies	19	na	na
Abortion rate per 1,000 women	22-28	35	32

Risk Categories

The majority (60%) of women who had an abortion were younger than 30 (Table 2). More than a third had not given birth before, while one-quarter had two children. Less than one-fifth of women who had an abortion had one child. Together these figures suggest that women are using abortion to delay childbirth. This however does not mean that abortion is being used in place of family planning. Almost half of the women (45%) had obtained their abortions before the seventh week of gestation, and 90% had done so before the tenth week. There were very few early second-trimester abortions (at 13–16 weeks), perhaps because of the cost and the risk involved. These figures are quite comparable to post abortion cases for the period 2000/2001 in which data from Korle Bu show that out of a total of 2,119 cases, 77.8% had an abortion before 12 weeks of gestation, 21.0% had it 13-16 weeks of gestation and only 1.2% of the cases were more than 16 weeks of gestation.

Only 12% of the women said they had obtained an abortion from a physician. Even if one considers that 20% of the women who obtained an abortion from a nurse or midwife, who may have been trained to perform abortions, that would still mean only one-third of women obtained an abortion from within the health care system. The remaining women (68%) said they obtained an abortion from a pharmacist (30%), through self-medication (11%), from a "quack doctor" (16%) or by some other means (3%).

Characteristics of Women Who Seek Abortion

Sixty-four percent of women who obtained an abortion during the study period claimed they were married (Table 3). A smaller proportion (54%) were married when they had obtained their previous abortion. It appears that the sampling procedure over- sampled married women, possibly because unmarried women pretended to be married to avoid stigmatization, a situation that the

sampling procedure carefully tried to avoid. In addition those in consensual unions named "permanent" partners (17%), which perhaps swelled the proportion who were in a union to the 64% observed above.

While this figure may represent an overestimation, the fact still remains that married women induce abortions. In the 2000/2001 post abortion care data, the proportion married who went for post abortion care was 51.0%, although this included both spontaneous and self-induced cases. Studies elsewhere in sub-Saharan Africa put the proportion of married women reporting for induced abortion at 30.0%. In essence, women cohabiting and single women are more likely to induce abortion than married women.

Table 2
Percentage distribution of women who had an abortion, by selected characteristics

Characteristic	N	%
Age at abortion		
15-19	14	4.5
20-24	81	25.5
25-29	96	30.4
30-34	76	23.9
35-39	39	12.3
40-44	8	2.4
45-49	3	1.0
Parity		
0		
1	115	36.3
2	58	18.3
3	78	24.6
4	33	10.4
5	16	5.0
≥6	9	2.9
	8	2.5
Gestation (in weeks)		
5		
6	31	9.8
7	111	34.9
8	49	15.4
9	56	20.5
≥10	30	9.4
	31	10.0
Type of provider		
Pharmacist	121	38.2
Nurse/midwife	64	20.2
Physician	39	12.3
Self-medication	34	10.7
Quack doctor	51	16.1
Other (paramedical)	8	2.5
Total	317	100.0

Table 3 further shows that 56.0% of the women going for induced abortion live in urban areas and 44.0% have a rural background. A larger proportion said they were Catholics or Protestants (81.0%) than said they were Muslim (16.0%) or practiced traditional religion (3.0%). Twenty-seven percent of women who obtained abortion had no education, 40.0% had received primary education, 17.0% had received a higher education and 15.0% had received Islamic education.

We further examined whether abortion patients differed from women of reproductive age in general. We did this by comparing the social and demographic characteristics of the women who aborted and women from the 1998 Demographic and Health Survey. Overall, the mean age of abortion patients from the Maternal Health Project was 27.8 years, and 28.3 years for the post abortion care data compared to 29.5 years for the general population. The differences in age are not statistically significant, which suggests that abortion is quite common among the general population of childbearing women.

Note that in principle, abortion rates are typically highest among women aged 20-24 years and lowest among those younger than 20 and those in their 40s (Bankole et al., 1999). This pattern simply confirms that women in their early 20s are the most likely to be sexually active, the most fecund and the most likely to become pregnant. However, although abortion rates are lowest among women at the very beginning (< 20 years) and at the end (> 34 years) of their reproductive careers, when these women become pregnant, they are much more likely than those aged 20-34 to have an abortion.

In terms of work, the majority of women who aborted (65.0%) worked outside their homes, and almost half of them were self-employed. Results of logistic regression models suggest that those who work outside their homes, the self-employed, urban dwellers, single persons, women who have had a previous abortion, women with levels of education beyond Middle/JSS and Christians rather than Muslims are the ones likely to have an abortion.

Reasons Why Women Go For an Abortion

Women provided three main reasons for obtaining their current abortion: fifty-seven percent were not sure that they wanted a child now, 26.0% cited financial constraints and 17.0% said that the pregnancy was unplanned. Interestingly, 42.0% of women cited the last of these as the reason for their previous abortion, significantly more than the proportion who cited it for the abortion that they had during the study period ($p < 0.001$). There is no evidence that women chose to have an abortion based on the sex of their last child.

In a wider study covering 27 countries worldwide to determine reasons why women go in for induced abortion, Bankole et al., (1998) found that 35.5% of the reasons were due to poverty (Table 4). This is followed by problems associated with contraception because the women involved do not want any more children. Other major reasons include youthfulness (too young to take responsibility) and problems associated with job or education disruption. Surprisingly, maternal/fetal health problems (9.8%) and victims of rape or incest (5.9%) constitute the least of the reasons why women go in for abortion. Ironically, the restrictive laws worldwide are made to protect a handful of women while the large majority is left unprotected by the law.

Table 3

Distribution of most recent and previous abortions by social and demographic characteristics

Characteristic	Most recent abortion		Previous abortion	
	%	N	%	N
Status of preceding child (N=202)				
Alive	62.5	126	68.0	137
Dead	37.5	76	32.0	65
Sex of last child (N=202)				
Boy	54.8	111	50.8	103
Girl	45.2	91	49.2	99
Reasons for abortion				
Unsure to bear child	56.9	180	33.8	107
Financial reasons	26.0	82	23.9	76
Accidental pregnancy	17.4	55	42.3	136
Education				
None	26.9	85	28.4	90
Primary	40.4	128	41.5	132
Higher	17.4	55	16.2	51
Islamic	15.3	49	13.9	44
Marital status				
Single	36.3	115	45.9	146
Married	63.7	202	54.1	171
Religion				
Catholic	21.1	67	21.8	69
Protestant	60.0	190	59.3	188
Muslim	16.1	51	16.1	51
Traditional	2.8	9	2.8	9
Place of work				
Home	34.8	110	24.9	79
Outside home	65.2	207	75.1	238
Type of work				
Employee	25.6	81	20.7	66
Self-employed	47.8	152	47.0	149
Family worker	26.6	84	32.3	102
Settings				
Urban	55.6	176	52.7	167
Rural	44.4	141	47.3	150
Total	100.0	317	100.0	317

Since the decision to abort a pregnancy is usually made in utmost secrecy, women probably choose as an emergency contact the person they trust most. Not surprisingly, the partner

(husband, boyfriend) was the contact person for 43% of the sample overall. This also means, however, that one in four of women in union did not have enough confidence in their partner to designate him as their contact person. Eleven percent of women, mostly young and single, gave their mother as their contact person and 10% gave their sister. For 7% of women, most of them young, their father was the contact and for 9% it was their fiancé. Among more distant kin, female and male relatives were similarly trusted (9% and 6%, respectively). Outside the family circle, women's trust was clearly vested in female friends and coworkers (3%). Finally, 10% of women, more than two-thirds of whom were not married, did not provide any contact name.

Table 4
Distribution of reasons why women go in for induced abortions

Reasons	Proportions
Want to postpone childbearing	21.4
Last child is too young	
Wants to delay having another child	
Wants no more children	25.8
Experienced contraceptive failure	
Already have as many children as wanted	
Does not want any children	
Having a child will disrupt job/education	22.0
Feels should establish career before having a child	
Will affect schooling	
Having a child now will change my life in a way I do not want	
Cannot afford a child; poor	35.5
Cannot afford a child now	
Not ready for responsibility	
Relationship problems	19.4
Has problem with partner	
Partner does not want child	
Does not want to be single mother	
Cannot identify father; I am in casual relationship	
Believe I should marry before having a child	
Too young; parents (others) object to pregnancy	22.7
I am too young to have a child	
Parents do not want me to have a child now	
I do not want parents (others) to know about the pregnancy	
Maternal/fetal health	9.8
Health reasons	
Possibility of fetal defect	
Other	5.9
Victim of rape or incest	

Source: Bankole et al., 1998

Factors Giving Rise to High Prevalence of Abortion

The question as to whether induced abortion is used as a means of fertility regulation is a researchable question. Some participants in the debate on abortion feel that if abortion is legalized and made easier to obtain, it could discourage contraceptive use or come to replace contraception as a means of spacing births and regulating family size. This proposition is difficult to test, because it is hard to find countries in which the trend in abortion can be tracked over a similar period as trends in contraceptive and family size. However, data from those countries that have some strands of these information indicate that abortion will not replace contraceptive use as a means of regulating family size. Such data also suggest that abortion should decline as contraceptive use rises.

Estimates of unmet need and current use of contraception (contraceptive prevalence) are needed to investigate part of this daunting question. DHS data show that Ghana is one of the countries that have experienced the greatest declines in unmet need for birth spacing with a decline from 35 to 23 percent in 10 years. The overwhelming evidence for most of sub-Saharan Africa suggests that most married women use contraceptives for spacing rather than for limiting births. In earlier studies of such trends that also included estimates of unmet need (for limiting births) from the 1980s with a few survey data, sharp increases in unmet need were observed in comparison to other regions of the world. The observation then was that "unmet need is a moving target rising in the early stages of the fertility transition as interest in family limitation grows and declines in the later stages when family planning is adopted" (Westoff and Bankole 2000). However, even though the proportion of women with an unmet need for family planning is diminishing, the continuing population increase can significantly offset the relative decline. Unlike other developing regions of the world, interest in the family in sub-Saharan Africa is focused on spacing rather than limiting births. For example, the 1998 DHS data for Ghana shows that the total demand for current use of contraception is 22.0% made up of 12.3% spacing and 9.7% for limiting births. The total demand for family planning is 45.0% including 27.3% for spacing and 21.5% for limiting altogether giving the total demand satisfied for currently married women to be 48.8%.

Recent declines in fertility in Ghana suggest that couples are increasingly exerting controls over their reproductive lives. The TFR has declined dramatically from 6.4 children per woman in 1955 (GSS and IRD 1989) to 5.5 children per woman in 1993 (GSS and MI 1994) and to 4.6 children in 1998. Accompanying this decline in fertility is also a modest rise in the population of couples using contraceptives. Since the 1980s, the current use of family planning methods has increased from 13% in 1988 (GSS and IRD 1989) to 20% in 1993 (GSS and MI 1994). The use of modern contraceptive methods doubled from 5% in 1988 to 10% in 1993 and increased to 13% in 1998.

Fertility Preference and Birth Spacing

Despite this trend, however, the incidence of unintended pregnancy remains high (various studies have shown that almost as many unintended as intended pregnancies occur each year (without counting miscarriages). Mainly the number of children desired by a couple affects the level of unintended pregnancy. In societies where large families are desired, the potential unintended pregnancy rate tends to be low (Bongaarts 1997). However, as societies move through the fertility transition, the desired number of children declines along with the number of years required for bearing intended children.

Examination of women's actual lengths of birth intervals and of preferred lengths of birth interval shows a clear pattern. Women in Ghana prefer much longer birth intervals than they actually experience. The Ghana DHS-111 (1993) interviewed 2,358 married women and 5,130 actual birth intervals (AB1) and 2,976 preferred birth intervals (PB1) were analyzed. These statistics show that the median length of actual birth interval was 38.9 months (3.2 years) compared to 51.6 months (or 4.3 years) if preferences prevailed. These figures suggest that in Ghana birth occurs among married couples more than one year (4.3-3.2 = 1.1) sooner than women would prefer. As a consequence, the potential effects of spacing preferences on the level of fertility, as well as on the prevalence of short birth intervals (less than 24 months) and child malnutrition, are also greatest. An explanation based on the observed sharp decline in fertility experienced by Ghana recently is offered for this pattern.

An examination of the co-variables of the preferred birth interval lengths also suggests that in general, women who know, approve of, discuss and use family planning prefer longer intervals than women who do not. The educational attainment of husbands matters more than that of female respondents in determining spacing preferences.

Summary and Conclusion

Various measures of abortion provide somewhat different perspectives of the incidence and impact of abortion. The number of women having abortion tells us how many women seek the procedure. The rates indicate how big a factor abortion is in the reproductive lives of women and its role in preventing unplanned pregnancies. Estimates of safe and unsafe abortion suggest the possible impact of abortion on women's overall reproductive health. Because official statistics on illegal abortion do not exist and the numbers of such procedures must be estimated, the data presented here are the best available estimate; but they are not definitive.

Given the current estimated abortion rate of between 28 to 32 abortions annually per 1,000 women of reproductive age, over the course of a woman's reproductive years, about 900 abortions will occur per 1,000 women. These are quite high and thus constitute a reproductive health risk deserving of official attention.

In terms of the effects of legalization, the evidence suggests that legal status makes little difference to overall abortion levels. Levels are very high in Eastern Europe and low in Western Europe yet abortion is broadly legal in both regions. Levels are far lower in Western Europe than in Latin America, where abortion is highly restricted. What is needed is public policy that is congruent with behavior. What we have now is private sexual behavior that is far freer than publicly advocated sexual beliefs and fundamentalist religious views would suggest.

In Ghana, although the law prohibits induced abortion except when a woman's life is endangered by her pregnancy, abortion on request is de facto available in both public and private health facilities, and legal charges are rarely filed against abortion providers or women obtaining abortion. Paradoxically, the changes in the 1985 abortion laws helped to intensify the discrepancy between the de jure and the de facto status of abortion in Ghana. Legal and ethical proscriptions that stood in the way of this process have become easily negotiable, and both medical personnel and hospital administrators have come to regard abortion services as a source of significant revenue.

The criminal prosecution of a woman or doctor for having or performing an abortion is not easy to pursue. Restrictive abortion laws are difficult to enforce because in the absence of a

complaint, police and judicial authorities do not easily learn of violations. Even if they do, they often have difficulty locating witnesses who are willing to testify. Sometimes, the general public and even law enforcement agencies are not likely to favor punishing a woman who has already undergone the ordeal of a clandestine abortion.

In the case of the law itself, the ambiguity in the language of an abortion law sometimes can work in favor of the woman. For example, not all laws prohibiting abortion after a particular point in gestation specify how to determine the length of gestation. It can be calculated from the first day of a woman's last menstrual period or from the estimated day of conception, which is about two weeks later.

It is true that restrictive abortion laws contribute to high levels of obstetric deaths, particularly of teenage girls. However, those who advocate a more liberal abortion law in Ghana must also answer the question: Who pays for abortion on request during the first trimester of pregnancy? Is it pay as you request? (Cash and carry).

References

Ahiadeke C., 2001. Incidence of induced abortion in Southern Ghana. *International Family Planning Perspectives* 27.2: 96-101; 108.

Bankole A., S. Singh and T. Haas, 1999. Characteristics of women who obtain induced abortion: a worldwide review. *International Family Planning Perspectives* 25.2: 68-77.

Bankole A., S. Singh and T. Haas, 1998. Reasons why women have induced abortions: Evidence from 27 countries. *International Family Planning Perspectives* 24.3: 117-127.

Bongaarts, J., 1997. Trends in unwanted childbearing in the developing world. *Studies in Family Planning* 28.4: 267-277.

Coeytaux F.M., A. Leonard and E. Royston, 1989. *Methodological Issues in Abortion Research.* Proceedings of a seminar held by the Population Council in Collaboration with IPAS and WHO, Dec. 12-13, 1989. New York: Population Council.

Cook R.J. and B.M. Dickens, 1981. Abortion laws in African Commonwealth countries. *Journal of African Law* 25.2: 60-79.

Ghana Criminal Code (29), 1960. 5558-59, amendment February 22, 1985.

Ghana Statistical Service (GSS) and Institute for Resource Developments Macro System Inc (IRD). 1989. *Ghana Demographic and Health Survey 1985.* Columbia, Maryland: GSS and IRD.

Ghana Statistical Service (GSS) and Macro International Inc. (MI), 1999. *Ghana Demographic and Health Survey 1998.* Calverton, Maryland: GSS and MI.

—, 1994. *Ghana Demographic and Health Survey 1993.* Calverton, Maryland: GSS and MI.

Westoff, C.F. and A. Bankole, 2000. Trends in the demand for family limitation in developing countries. *International Family Planning Perspectives* 26.2: 56-62.

World Health Organization (WHO), 1993. Prevention and Management of Unsafe Abortion. Report of a Technical Working Group. Geneva: WHO.

—, 1994. *Abortion: Tabulation of Available Data on the Frequency and Mortality of Unsafe Abortion.* 2nd ed. Geneva: WHO.