Research Review NS 19.1 (2003) 57-66

ABORTION: THE CASE OF CHENARD WARD, KORLE BU FROM 2000 TO 2001

Richard W.N. Yeboah and Monica C. Kom

Abstract

This paper examines the number of abortion cases attended to in the Chenard Ward of the Korle Bu Teaching Hospital, Accra during the years 2000 and 2001. A total of 1,935 abortion cases were handled in the year 2000 and 1,838 in 2001. Though there was a 5% decrease in the number of cases in 2001, there was an increase in 'incomplete abortions', which happened to be the most frequent, 78% and 83% in 2000 and 2001 respectively. The majority of the abortions were found among women in the age bracket 21-30: 58% in 2000 and 55% in 2001. There were also 63 (3.3%) and 42 (2.3%) abortions in 2000 and 2001 respectively between the ages of 41 and 50 years. These figures call for the intensification of the campaign for safer sex practices, family planning and the teaching that there is good care for those that call to the hospital early enough.

Introduction

Abortion of any kind is of importance to government all over the world because of the complications that are dangerous to the lives of women. Between 10 and 15 percent of all pregnancies terminate as spontaneous abortion, and about 10 – 60% are terminated by an induction either legally or illegally. About 80% occurs in the first trimester that is within the first to the third months of pregnancy. This can lead to hazards such as pain, ill health, infertility as well as other long-term complications (Taylor and Ablordey 1993). In fact WHO (1994) estimates that half a million women die each year from complications of pregnancy and childbirth and 28% of this has been associated with unsafe abortion.

WHO (1997) reports that an estimated 53 million pregnancies are terminated by induced abortion each year in the world. One third of these abortions are performed in unsafe conditions resulting in some 50,000 – 100,000 deaths each year. Many more women have complications, which may have long-term consequences for their health. Glenn (1996) indicates that about 50 million self-induced abortions occur per year worldwide and half of these occur outside the health care system. These figures are alarming, the more so as most of these occur in developing countries.

Since most of the self-induced abortions are performed outside the health care system, the risks are higher for the women. In order to reduce the risks and loss of lives, there are still struggles as to whether abortion should be legalised or not though it is illegal in Ghana now (see PNDCL 102; 1985). The argument may stem from the fact that many abortions take place outside the hospitals and in some cases lead to complications and death. According to Sai (1996) the laws against abortion are mainly old laws, and it is worth recalling that part of the rationale for most 19th century abortion laws was to save women from quacks and unsafe and experimental surgery. To make a firm argument on this issue it is necessary to know the details of what has been happening.

Many women over the years have used induced abortion as a means of birth control, that is, to terminate unwanted pregnancies whilst others have it done for medical reasons. A few pregnancies are terminated spontaneously. Whatever the cause of abortion, it still has adverse effects on the individual and the nation at large.

Induced abortion in particular is a significant public health problem, especially in developing countries such as Ghana where it is often illegal (International Fertility Research Programme 1981). Because of its illegality, most women seek to terminate their pregnancies by unqualified personnel under unhygienic conditions and environments with the use of dangerous agents of abortion. The consequences of this are usually acute complications such as bleeding and infection or permanent damages to the reproductive system or even death of the individual. In addition, abortion of all types, causes financial and time loss to the individual and the family. A sizeable number of physicians, nurses and other health workers spend considerable time caring for women with complications from abortions. This results in the straining of the already limited medical and economic resources of the nation. There is also a loss of productivity since most of these women are among the working populace.

For about three decades now, modern contraceptives have been in use in Ghana. These modern contraceptives and safer sex practices are advertised daily to help prevent unwanted pregnancies as well as sexually transmitted diseases. It is expected that the rate of induced abortions per year would decrease, but they seem to be occurring in high numbers each year. It is against this background that this study sought to examine the situation in the Chenard Ward of the Korle Bu Teaching Hospital and to come out with policy recommendations.

The objectives of the study are to find out the number of abortion cases attended to in the Chenard Ward in the years 2000 and 2001, and investigate the various types of abortions attended to during this period and the age groups of the patients. It also seeks to find out why the pregnancies were terminated and determine the social effect of these abortions and make policy recommendations to address the problem of abortion.

The Study

Secondary data were extracted from the records of the Chenard Ward at the Korle Bu Teaching Hospital. All cases reported were recorded there. Some nurses were interviewed to find out the reasons given by the patients for abortion.

Chenard Ward is a gynaecological emergency ward under the Department of Obstetrics and Gynaecology of the Korle Bu Teaching Hospital (KTH). It has a bed capacity of 50. The ward is well endowed with various categories of experienced health workers. All gynaecological emergencies such as ectopic gestation and all forms of abortions are admitted to the ward. The total number of admissions per month stands at an average of one hundred and thirty-five. Out of this number seventy, ie. 51% are abortion related. Incomplete abortion cases, the most common abortion, form 71% of the abortion patients who are admitted to the ward.

During the year 2000 the number of abortion cases handled by the Chenard Ward was 1,935. In 2001, the number reduced by 5% to 1,838 (Table 1). This gives an average of 161 and 153 abortions per month in 2000 and 2001 respectively or not less than 3 abortions daily. These were only those that were reported in Korle Bu alone, not considering that there were abortions reported to other hospitals and those that were illegally done are never recorded. The data shows only 38 abortions recorded in April 2000, far below the average. This is because there was a strike by health workers and services were not available and admissions fell. Very high numbers were recorded for November and December of both years. It is assumed that most women get pregnant around July to September when the weather is very cold. In November/ December, when the pregnancies are about two to three months old, the unwanted ones are terminated.

Table 1
Total Number of Abortions per month in 2000 and 2001

Months	**2000**	**2001**
January	208	171
February	157	142
March	173	143
April	38	174
May	141	132
June	117	108
July	137	122
August	142	127
September	175	169
October	159	154
November	295	201
December	203	195
Total	**1,935**	**1,838**

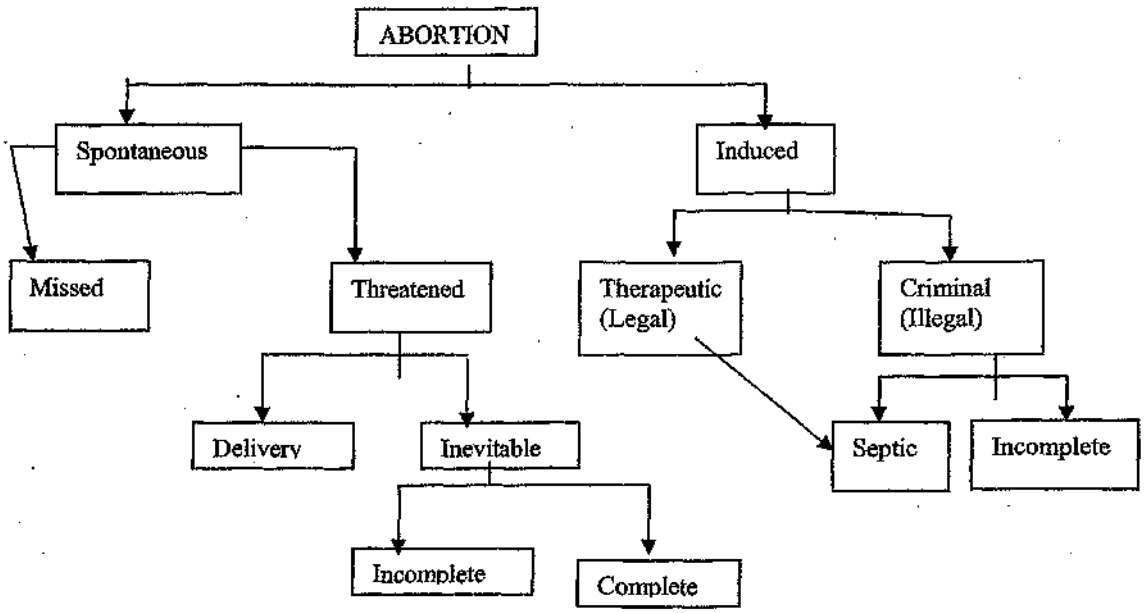
Source: Derived from Chenard Ward, Korle Bu, 2002

All forms of abortion fall under two main categories: spontaneous (miscarriages) and induced as shown in Figure 1. Induced abortion is the voluntary termination of pregnancy by oneself or someone else. It could be either therapeutic or criminal.

In Korle Bu Teaching Hospital, abortions are classified into five types. All five types of abortion cases were reported and handled in Chenard Ward during the years 2000 and 2001. These include incomplete abortion, inevitable abortion, septic abortion, threatened abortion and missed abortion.

Bennett and Brown (1999) show the types of abortions as in figure 1.

Figure 1
Types of Abortion



Source: Bennett and Brown (1999)

Tables 2 and 3 show the various types of abortions attended to and their numbers by the hospital per month in 2000 and 2001. In both years, the Incomplete Abortions were the dominant types. In 2000, 78% of the abortions were of the Incomplete type. This increased to 83% in 2001. Though there was a reduction in the total number of abortions in 2001 by 5%, there was rather an increase in the Incomplete Abortion. This shows that this type of abortion is very common and if there should be any intervention, the focus should be on the reduction of this type of abortion. According to the nurses interviewed, most of the Incomplete abortions attended to were the induced (criminal or illegal) type. The patients come after they have attempted the abortion and it is incomplete.

Inevitable Abortion follows after incomplete abortion forming 10.5% of abortion cases in 2000 and 7.8% in 2001. It is usually due to threatened abortion. Threatened and missed abortions together were 7.9% in 2000 and 6.2% in 2001. These types of abortions have minimal complications.

Septic abortion, on the other hand, results from complications of induced abortion mostly of the criminal type due to the use of contaminated instruments under unhygienic conditions. It was the least recorded in 2000 (3.5%) and in 2001 (2.6%).

From these figures, it could be deduced that reported cases of induced abortion were high despite family planning education that has been introduced in the country since 1970.

Table 2
Number of Abortions in 2000 by Types

Months	Incomplete	Inevitable	Septic	Threatened	Missed	Total
January	164	13	7	13	11	208
February	124	17	5	3	8	157
March	112	34	10	5	12	173
April	23	10	3	2	0	38
May	100	15	7	14	5	141
June	91	13	2	7	4	117
July	105	20	4	2	6	137
August	100	21	6	7	8	142
September	146	13	9	3	4	175
October	137	5	8	4	5	159
November	266	16	1	5	7	295
December	152	29	5	10	7	203
Total	**1,510**	**206**	**67**	**75**	**77**	**1,935**
Percentage	**78**	**10.6**	**3.5**	**3.9**	**4.0**	**100**

Source: Derived from Chenard Ward, Korle Bu, 2002

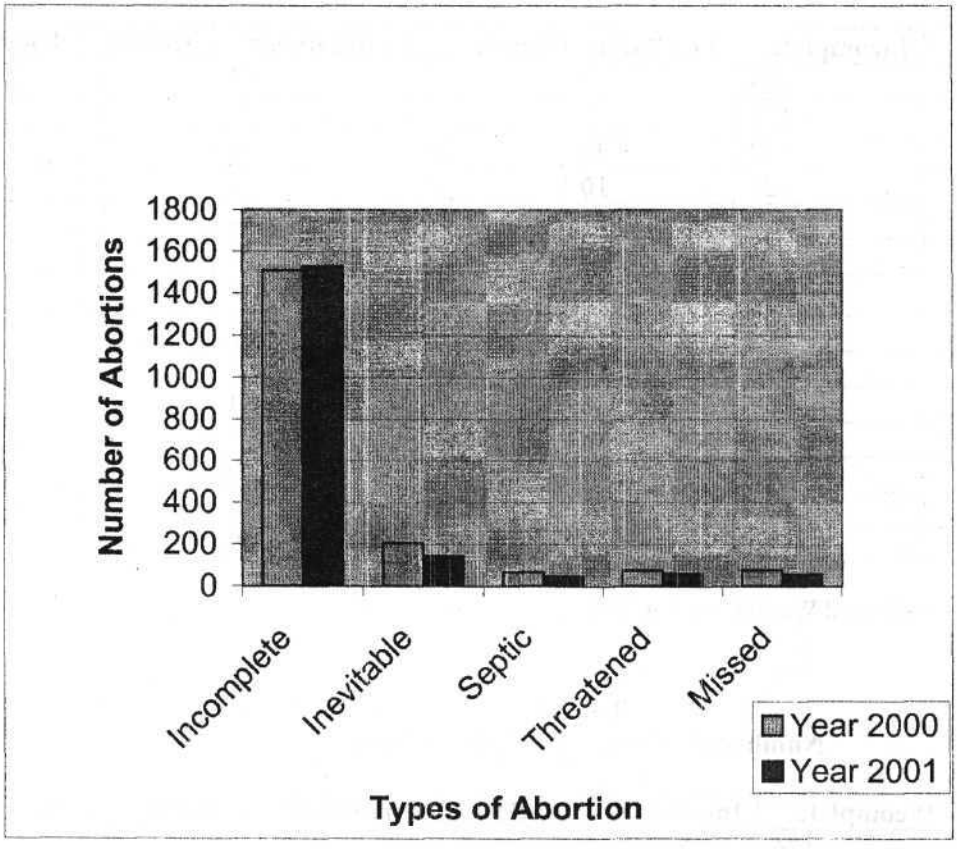
Table 3
Number of Abortions in 2001 by Types

Months	Incomplete	Inevitable	Septic	Threatened	Missed	Total
January	126	26	5	7	7	171
February	102	19	6	8	7	142
March	118	8	1	9	7	143
April	145	13	4	8	4	174
May	112	5	4	4	7	132
June	92	9	-	5	2	108
July	107	7	3	1	4	122
August	110	9	-	4	4	127
September	148	10	4	4	3	169
October	131	13	5	2	3	154
November	174	12	9	3	3	201
December	167	13	7	4	4	195
Total	**1,532**	**144**	**48**	**59**	**55**	**1,838**
Percentage	**83.4**	**7.8**	**2.6**	**3.2**	**3.0**	**100**

Source: Derived from Chenard Ward, Korle Bu, 2002

Figure 2 compares the total number of each type of abortion during the two years. In both years, Incomplete Abortion was the highest and it was higher in 2001 than 2000.

Figure 2
Types of Abortion Recorded in Chenard Ward, 2000 and 2001



Source: Derived from Chenard Ward, Korle Bu, 2002

Age of patients attended to for abortion

Table 4 shows that the majority of the cases treated were between ages 21 and 30. These ages constitute 57.8% of the cases in 2000 and 55.4% in 2001. Over 95% of the cases fell between 16 and 40 years and most of these were of the incomplete type of abortion. Almost all of the cases recorded above 40 years aso fell under the incomplete type.

There were few instances of abortions in the extremes. There was a case in 2000 when the patient was above 50 years and it was of the Incomplete Abortion type. There were ten cases of girls under fifteen, five in each year.

Abortions occur to women of all ages but the most proportion of the cases examined fall in the active reproductive ages. The number of abortions recorded for women above 40 were few, and decreased in 2001. There is the need to prevent unwanted pregnancies among all age groups but especially for those above 40 years who do not want any more children.

It is surprising that few teenage pregnancies were aborted during the years under consideration though there has been wide-spread fear of increasing teen-age pregnancy in the country of late. It could be that most teen-age pregnancies aborted do not usually end up at health institutions such as the Chenard Ward.

Table 4
Number of Abortions By Age Group

Age Group	2000		2001	
	Number	Percentage	Number	Percentage
16 – 20	259	13.4	264	14.4
21 – 30	1,118	57.8	1,019	55.4
31 – 40	492	25.4	513	27.9
41 – 50	66	3.4	42	2.3
Total	**1,935**	**100**	**1,838**	**100**

Source: Derived from Chenard Ward, Korle Bu, 2002

Reasons given for abortion

The study could not follow up the patients to find out why they had terminated their pregnancies. The nurses reported the reasons given by the patients for the abortions. These confirmed the findings of Kom (1999) in an earlier study when she followed up patients in the Chenard Ward in Korle Bu Teaching Hospital. They also agree with the findings of Akinrinola, Susheeba and Haas (1998). The reasons given were:

i) Unmarried: some of the patients said they did not have husbands and were not sure they could care for the child when born
ii) To space births: some patients who were married and living with their husbands resorted to abortion when they had unplanned pregnancies, usually when their last child was not old enough, according to their judgement.
iii) Still in school: some patients were students who were still in school and could not combine the pregnancy with studies. In some of these cases, they had aborted the pregnancy without the knowledge of their parents.
iv) Financial problems: this cuts across most of the patients. They claim they do not have money to take care of the pregnancy to maturity, much less to cater for a child.
v) No responsible man: the women realise that their partners are irresponsible and will not be able to take care of them during pregnancy nor when the child is born. In some cases the men refuse responsibility for the pregnancy or run away to hide in a place unknown to the woman.
vi) Deteriorating health: these abortions are often spontaneous or advised by a medical officer. They are not normally unwanted pregnancies but they cannot be carried to maturity.

The major reasons recorded were i, iii, iv and v. These were unmarried, still in school, financial problems and no responsible man.

Unsafe abortion is illegal (see PNDCL 102 1985) in Ghana hence offenders are supposed to be prosecuted. According to the nurses, however, none of the patients was brought before any law court.

Social Implications and Effects

Abortion may reduce the fertility rate of a nation. It also creates psychological and social problems such as those related to infertility. In Ghana, infertility in any marriage is of serious concern to both the couple and the extended families. In some cases the extended families create many problems for the couple which may lead to divorce. This is because children are considered as custodians of the family lineage.

Secondly, almost all religions frown on abortion, such that individuals who undergo abortion suffer the guilt of committing an unpardonable offence. The traditional believers resort to means of pacifying the gods, which becomes another cost to them. In some communities most mishaps like droughts are attributed to offences against the gods, including abortions. Christians likewise consult with their pastors to confess and ask for cleansing through prayer, thus adding to the duties of the pastors and spiritual leaders.

Thirdly, the patient undergoes psychological torture due to guilt. It becomes more serious when the patient suffers permanent damage to her reproductive system.

In the past, until a girl underwent puberty rites she could not be sexually active nor be married, hence, abortion among teenagers and the immature was not common. In recent times, puberty rites are seldom performed, yet the girls are given sex education early enough. Many believe that giving girls sex education at early ages makes them promiscuous. Many young girls get pregnant before they are ready for motherhood. They seek abortion for fear of parents who frown at such behaviour or in order to continue their education.

In the same vein, it is not an accepted norm for married couples to engage in abortion. Abortion among couples is considered an abomination to the gods and ancestors and calls for cleansing. The cleansing process is so difficult that it creates a lot of psychological problems that the victim hardly overcomes.

Abortion does not permit the children to be born. These children could have been the best human resources the nation could depend on but they never entered the world. Ghana therefore lost 3,773 children in 2000 and 2001 at Korle Bu alone. There is also the fact that this could be a way of reducing the fertility rate.

A nation's human resource is an asset for productivity. Women who have abortions of any type are in the active and productive age group. Abortions take them out of work. Each abortion, without complications, takes the woman out of work for between 3 and 14 days. The number of days off work increases with complications. In the case of Chenard Ward in 2000 and 2001, Ghana lost between 3 and 14 working days times 3,773 people. In addition, the psychological effect on the patient can make her less productive for some time. The duration of loss of productivity depends on the attributes of the individual.

Emergency treatment of abortion complications consumes a significant portion of scarce hospital resources in many developing countries (Brasier et al. 1998). In recent years, there has been constant news of brain drain among workers in the medical field. This has brought about increases in the medical personnel-patient ratios. The few medical staff spend much time attending to abortion patients instead of taking care of patients suffering from other diseases.

The average cost of a normal abortion, without complications, is two hundred thousand cedis (¢200,000). The individual bears the cost of treatment. Complications that lead to anaemia, infections and even permanent infertility could occur, which increases the cost to the patient.

Conclusion

Abortion, especially unsafe abortion, has been a problem in Ghana and needs attention. The number of recorded abortions in Korle Bu Teaching Hospital alone is considerable. The number of abortions performed outside the health system and in private health systems is estimated to be far larger than that reported to the health system. It shows that the situation is very serious.

The increase in the Incomplete Abortion type is of concern. This type of abortion is very important and if there should be any intervention, the focus should be on this type of abortion.

The study shows that abortions cut across all ages and occur especially among women in the active reproductive ages. Though the numbers of abortions recorded for women above 40 years were few, and decreased in 2001, there is the need to prevent unwanted pregnancies during those ages since these could be more complicated.

Recommendations

The health institutions are doing well in the midst of the constraints facing them, The education and campaigns going on in the country are having some positive effect. We however recommend that:

1. Family planning education and promotion of the use of contraceptives should be continued and intensified.
2. Family life education should be encouraged to alert young women to the dangers of abortion.
3. None of the patients who conducted an illegal abortion was prosecuted. This makes the law on illegality of unsafe abortion ineffective. Until abortion is legalised, patients who terminate their pregnancies without medical advice or care should be made to face the law (see PNDCL 102 1985). In addition, those who perform the abortions for them should also be made to face the law. The law on abortion should be either revised or enforced.

References

Ajayi, Victoria, 1990. *A Textbook of Midwifery* 4th Edition. London: Macmillan Publications.

Akinrinola, Bankole, Sing Susbeeba and Taylor Haas, 1998. Reasons why women have induced abortion. *International Family Planning Perspectives* 24.3.

Bennett, V.R. and L.K. Brown, 1999. *Myles Textbook for Midwives.* 13th Edition. London: Churchill Livingstone

Brazier, Ellen, Rahna Rizzuto and Merrill Wolf, 1998. *Prevention and Management of Unsafe Abortion: a Guide for Action.* New York: Family Care International

Glenn, P.S., 1996. Nurse-Midwives Attitude Toward Abortion Performance and Related Procedures. *Journal of Nursing-Midwifery* 41.1.

International Fertility Research Programme, 1981. Traditional Abortion Practices; a Clinical Term Paper. USA

Kom, Monica C., 1996. Factors contributing to unsafe abortion among patients of Chenard Ward at Korle Bu Teaching Hospital. Unpublished BSc Long Essay in the Department of Nursing, University of Ghana.

Mosaase, B. and P. Tiebere, 1996. Abortion in Africa. *African Journal of Fertility, Sexuality and Reproductive Health* 1.1. Nairobi.

Population Council, 1991. Critical Issues in Reproductive Health and Population. The Population Council.

PNDC, 1985. PNDCL 102, Criminal Code (Amendment law, 1985). Printed In *Ghana Medical Journal* 21.1 (1987).

Sai, Fred, 1996. An overview of unsafe abortion in Africa. *African Journal of Fertility Sexuality and Reproductive Health.* 1.1.

Taylor, J. and M. Ablordey, 1993. The dimension of abortion in Ghana: the case study of Kwahu South District. International Planned Parenthood Federation Ghana.

WHO Division of Family Health, 1993. A tabulation of available data on the frequency and maturity of unsafe abortion. Maternal Health and Unsafe Motherhood Programme. Geneva: WHO.

WHO,1997. Technical Report Series, World Health Organisation 1997 871, I – VII.