St. Luke's International University Repository

Review of Unsafe/Induced Abortions in Ghana

メタデータ	言語: English 出版者: 公開日: 2008-03-11 キーワード (Ja): キーワード (En): Ghana, Maternal mortality, unsafe abortion, health promotion materials 作成者: Rosemary, Opare Henaku, 森, 明子, 堀内, 成子 メールアドレス: 所属:
URL	http://hdl.handle.net/10285/1300

This work is licensed under a Creative Commons Attribution-NonCommercial-ShareAlike 3.0 International License.

報 告

REVIEW OF UNSAFE/INDUCED ABORTIONS IN GHANA

— Development of Reproductive Health Awareness Materials to Promote Adolescents Health —

Rosemary Opare HENAKU, RN-Diploma[1] Shigeko HORIUCHI, NM, PhD[2] Akiko MORI, NM, PhD[2]

〔Abstract〕

PURPOSE

Review one of the causes of maternal mortality issues in Ghana; unsafe abortion, with the aim of proposing some measures for its prevention. Maternal mortality ratio has not made remarkable improvement due to high rates of unsafe abortion among women in the fertility age group of 15-44, with two-thirds occurring among women ages 15-30. This problem has received little attention from the Health Ministry of Ghana. Studies revealed that Japan, a developed South East Asian country, has extensive experience in implementing a comprehensive abortion policy and therefore deems it possible to share ideas from that perspective.

METHOD

Compilation of existing abortion statistics, review of Japan's clinical information, review of extant research literature and discussion with health promotional agencies provided data for this study. Some clinical information was based on both experts' opinions in Ghana and my work experience in Ghana.

FINDINGS

Problems identified were strong social and cultural factors, the resulting legal and health policies and subsequent lack of adequate reproductive health knowledge among women. They were identified to be the major causes of unplanned pregnancies leading to unsafe/induced abortions. These factors require intervention from health professionals, social groups and government policy makers.

CONCLUSION

The evidence suggested that health service providers should intensify awareness about the use of contraception, highlight the dangers of induced/unsafe and repetitive abortions, through health education. The findings clearly show that high rates of unprotected sex would be a threat to achieving the proposed Millennium development goals.

〔Key words〕 **Ghana, maternal mortality, unsafe abortion, health promotion materials**

INTRODUCTION

The UN Millennium Development Goal to improve maternal health with the target of reducing by three quarters (3/4) the maternal mortality ratio is an expression of the international concern and commitment towards reducing maternal deaths (Despite difficulty in collecting data and prevailing underreporting and misclassification, data collected by World Health Organization (WHO) indicated that, 99% of maternal deaths occur in developing countries while only 1% occurs in industrialized nations (Adams, Darko & Accorsi, 2004).

1) Research Student from District Hospital, Begoro, Ghana/St. Luke's College of Nursing, Maternal Infant Nursing and Midwifery
2) St. Luke's College of Nursing, Maternal Infant Nursing and Midwifery

2006年11月20日 受理

Ghana records about 540 deaths per 100,000 live births among women between the ages of 15-44 (United Nations population Fund, 2005). These deaths are mostly due to six major causes: (i) postpartum haemorrhage, (ii) sepsis, (iii) eclampsia, (iv) uterine rupture due to obstructed labour, (v) cerebral malaria and (vi) complications from unsafe abortion.

WHO has documented that 44% of women who die of complications arising from unsafe abortion are in Africa, rating its prevalent death rate at 100 per 100,000 persons. The number of deaths due to unsafe abortion in West Africa was similarly rated as 90 per 100,000 live births while South-east Asia records only 40 per 100,000 live births (Ghosh, 2001; Lithur, 2004). Unsafe abortions are the second leading cause of maternal deaths in Ghana.

Although accurate statistics regarding the number of abortions are difficult to obtain, because medical personal fail to document the abortion or the abortion was performed by a non-medical person (Obed & Wilson, 1999), the information that is available, points to the seriousness of the unsafe abortion situation. For example between 1990 and 1994, the Korle-Bu Teaching Hospital in Accra Ghana, managed a total of 79 cases of perforated uterus due to termination of pregnancy presumably by a non-qualified person and this represents an incidence of 3.6% induced/unsafe abortions among women between the ages of 21-28 years. "The specific case mortality associated with this calamity was 227.8 per 1000" (Obed & Wilson, 1999). During 2001-2003, in the Upper East Region of Ghana, the Wa Memorial Hospital recorded 24 (29.1%) maternal deaths with unsafe abortion being the leading cause (Baiden et al (2006). The age of women who died ranged from 18 to 38 years with median of 26.5 years.

According to a recent report, (one of the few available) the Eastern region of Ghana recorded 3,867 attempted abortion cases in the year 2005 (Ghana Health Service, 2006) [8]. For this region more detailed statistics are available. The 1ST Quarter 2005 abortion cases in the Eastern Region of Ghana are in Table 1 below. The statistics indicate the number of women who attempted abortions by themselves and later visited the hospital with complications. It includes the number of women who were treated and discharged, those who were referred to specialist hospitals for further treatment, number of those who were counseled and accepted family planning methods and the number of deaths. A total number of 813 unsafe abortion cases were recorded between January and March 2005, out of which 563 (69%) were treated and discharged, 31 (3.8%) were referred to specialist for further treatment, and 10 (1.2%) died. Only 209 (25.7%) accepted the use of various available barrier methods after counseling and the number of woman accepting family planning various widely among the districts indicating that factors are present that can support women's decision to accept family planning. The 74.3% of women not accepting family planning after an unintended or unwanted pregnancy constitute a highly vulnerable group who may find themselves in the same situation at a later time.

Unfortunately, countrywide contraceptive acceptance rate decreased from 24.3% in 2004 to 23.0% in 2005 (Ghana Health Service, 2005). These statistics portray how abortion is becoming a threat to adolescents in Ghana and must be addressed.

By comparison, in Japan statistics indicated that 319,831 induced abortions were recorded in 2003 rating its prevalence rate as 11.2 per 1,000 women. Interestingly there was no report of incidences of unsafe abortion (Japan Organization for International Cooperation in Family Planning, 2005; Ministry of Health & Labor Workforce, 2006-9-10). The trend of abortion cases between these two countries representing both West Africa (Ghana) and South East Asia (Japan) varies and needs to be considered. Japan has been recording a downward trend of abortions while Ghana's situation is on the ascendancy. Therefore some lessons need to be shared and adopted to resolve Ghana's Reproductive health problems taking policies, economy and culture into consideration.

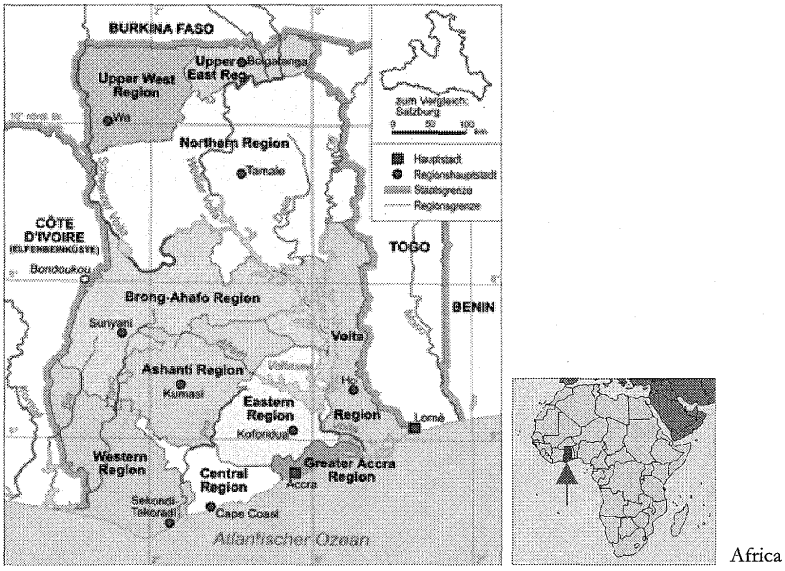
PURPOSE

It was the purpose of this project to analyze the factors that contribute to induced abortions. From the analyses we developed an educational plan for youth aimed at reducing unwanted pregnancies that lead to unsafe abortion among women.

DEMOGRAHIC CHARACTERISTICS

Ghana lies on the Gulf of Guinea, on West coast of Africa. The distance across the country from north to south is 672 km and from east to west is 536 km (Central Intelligence agency, 2006) (see **Figure 1**). It is a developing sub-Saharan country, with half of its population roughly living on two dollars a day. It occupies an area of 238,550 km^2 about the same size as Hokkaido, and is divided politically into 10 regions (see **Figure 1**). The current total population is 22,409,572. It is a multicultural country with multiple languages with English as the official language. Christianity (63%) is the dominated religion followed by Islam (16%) and other indigenous beliefs (21%) (See **Table 1**).

Table 2 below shows the statistics of both Ghana and Japan. Japan's statistics are representative of a technological developed country and provided as a benchmark for understanding and to clearly demonstrate the severity of Ghana's Reproductive health issue. From that perspective Japan's statistics, are presented. Japan's population, gross domestic product (GDP), life expectancy and literacy rates are higher than Ghana's Maternal mortality rates were significant lower, as Japan records about 10 maternal deaths per 100,000 live births compared to Ghana's 540 per



1. Ashanti
2. Brong Ahafo
3. Central
4. Eastern
5. Greater Accra
6. Northern
7. Upper East
8. Upper West
9. Volta
10. Western

Africa

Figure 1. Ghana map with its 10 political regions:

Table 1. 1ST Quarter 2005 abortion cases in Eastern Region of Ghana

Districts	Total No. of abortions	No. treated and discharged	No. Referred	No. who accepted family planning	No. of Deaths
A	160	118	0	42	0
B	133	81	0	52	0
C	127	63	1	63	0
D	99	77	3	19	0
E	59	55	0	0	4
F	47	27	9	10	1
G	45	42	1	0	2
H	44	28	1	15	0
I	21	20	0	0	1
J	19	8	8	2	1
K	19	17	1	0	1
L	15	11	0	4	0
M	8	2	4	2	0
N	8	8	0	0	0
O	6	6	0	0	0
P	3	0	3	0	0
Total	**813**	**563**	**31**	**209**	**10**

Note: Each district assigned an alpha designation;(Ghana Health Service 2006).

100,000.

Comparing Ghana and Japan's Reproductive Health Status

For an intervention strategy to be effective the various differences such as cultural, social, economical, and religious beliefs need to be considered by caregivers to improve maternal health. **Table 3** displays the contrasts in reproductive problems between Ghana and Japan and highlights the areas where Japan's health policy has promoted reproductive health for women.

FINDINGS

After reviewing the reproductive health statistics, discussions with maternal health care experts, and the research in the area of reproductive health, we identified five areas of concern: lack of adequate knowledge, legal framework for abortion, lack of communication, poor accessibility, and social-cultural problems.

Lack of adequate knowledge: Although, Ghana Health Service is doing much to promote maternal health education on contraception, few people have accepted it in totality. There are many misconceptions on the use of contraception. Some of the concerns, expressed to me, by health care experts in Ghana were; inability to conceive again, deformation of subsequent pregnancy after contraceptive use, and IUD causing vaginal infections or fibroids.

Education on women empowerment has still not been successful; men are considered as heads of family and therefore lack of negotiation skills exist between partners. This makes it difficult for women to persuade their male

Table 2. Vital statistics for Ghana and Japan

	GHANA 2005/2006	JAPAN 2006
Population	22,409,572	127,463,611
Percentage of Population by age (%)		
Population by age 0-14	38.8%	14.2%
Population by age 15-65	57.7%	65.7%
Population by age 65	3.5%	20%
Area of Country (km^2)	238,540km^2	377,835km^2
Population by density (km^2)	88.2km^2	337km^2
Population growth rate (%)	2.07%	0.02%
Official Language	English	Japanese
Other written languages	Ga, Ewe, Twi, Dagbani, Fante	
Gross Domestic Product (GDP per capita)	2,500 Dollars	31,600 Dollars
Birth Rate	30.52 per 1,000 population	9.37 per 1,000 population
Total Fertility Rate	3.99 children/woman	1.4 children/woman
Maternal Mortality Rate	540 deaths per 100,000 live births	10 deaths per 100,000 live births
Mean Life Expectancy Rate	Men: 58.07/Female 59.69 Total: 58.87 years	Men 77.96/Female 84.7 Total: 81.25 years
Diffusion Rate Plumbing (%)	79%	100%
Literacy Rate	74.8%	99%
Religion	Christians 63%; Muslims 16%; Indigenous beliefs 21	Shinto/Buddhist 84%; Others16% (including Christians 0.7%)

Note: (Central Intelligence Agency, 2006)

Table 3. Comparisons between Ghana and Japan's Reproductive Issues:

GHANA	JAPAN
1. High rates of abortions with upward trend	1. High rates of abortions with downward trend
2. Abortion is legal and highly restrictive	2. Abortion is legal and minimally restrictive.
3. High rates of crude practices	3. All cases are induced in hospitals
4. Health insurance, abortion excluded	4. Health insurance; abortion for health reasons partially covered.
5. Poor access to health care facilities	5. Easy access to health care facilities
6. Discussing human sexuality openly is a problem.	6. Human sexuality is discussed quietly and openly.
7. Contraceptive acceptance rate was 24.3% in 2004	7. Contraceptive acceptance rate was 52% in 2004

partners to protect themselves to prevent unplanned pregnancy (Moos, 2003). In addition many women seek for permission from their partners before using a family planning method. Rosa Bustamante-Forest and Co recommended that men should be involved in reproductive health awareness as it will give them vivid understanding of the issue (Bustamante-Forest & Giarrotano, 2004).

Legal framework of abortion: Restrictive legislation could be linked with a high incidence of unsafe abortion. The outcome of complications from unsafe abortion will depend not only on the availability and quality of post-abortion services, but also the women's willingness to seek hospital care on time. Unfortunately, the abortion policy in Ghana is restrictive. The law, revised in 1985, stipulates that a legal abortion is one performed by gynecological specialist or other registered practitioner in a government or registered private hospital or clinic for a pregnancy that is the result of rape or incest or the female is mentally deficient. If continuation of the pregnancy will endanger the mother's life (mentally or physically) or if carried to term the child would suffer from a serious physical abnormality or disease, then abortion is also legal (Ahiadeke, 2001).

This law does not encourage the health care provider to deliver formal abortion services to patients who might be in need in cases of unwanted or unplanned pregnancy. The situation becomes worse when women are induced by unqualified practitioners or themselves and then develop complications. They feel reluctant to seek official medical care and usually report late with severe damage often leading to death.

Lack of communication: Parents find it inappropriate and also don't have the courage to discuss sex openly with their adolescent children. The youth only get access to sex education from their peers, a bit from the minor mass media such as brochures, magazines, films and counseling units of churches or clinics when they are preparing for marriage. This does not encourage them to make an informed choice.

Poor accessibility: The needs of our youth are neglected with respect to reproductive health; therefore almost all family planning services apart from condoms are only available in clinics and hospital facilities. Youth friendly services are inaccessible especially in our rural communities. This makes it uncomfortable for youth to patronize the service. People in the rural communities have to travel for long distances to access a health facility, which is both time-consuming and expensive because of high transportation and service costs. Due to these and unknown reasons, the family planning acceptance rate, after a steady five-year increase, showed a declined from 24.3% in 2004 to 23.0% in 2005, far below their goal of 30% (Ghana Health Service, 2005).

Social/Cultural problems: Studies have showed that religious, cultural and traditional beliefs play contributory role in people seeking for health care (Taylor, 1992). Also societal norms dictate that unmarried women should not have sex and certainly should not become pregnant. It is highly unacceptable. Adolescents are indirectly excluded from contraceptive services. Cultural and religious disapproval of pregnancy termination persist, hence unhygienic, clandestine induced abortions occur. Abortion is generally considered to be an unethical or shameful act in Ghana and therefore difficult for a woman to express her opinion when she is not ready to carry the pregnancy to term. Women who have performed abortions may be shunned in their communities and are given anti-abortion derogatory names. (Lithur, 2004).

Nana Oye Lithur a legal practitioner in Ghana explained that women could access formal abortion services within the confines of the law if provision of legal abortion services were culturally acceptable within the Ghanaian community (Lithur, 2004). She stated three strategies that would help to de-stigmatize abortion, "(i) liberal interpretation of the three exceptions of the law on abortion (ii) expanding awareness of its health benefits, and (iii) improve and increase access to legal abortion services within formal health facilities" (abstract). Based on the five areas of concern, we construct a diagram that suggests the sequence of events leading to an unsafe abortion (see **Figure 2**).

PLANNED AND PROPOSED PROGRAMS

Considering the lack of communication and misunderstanding that surrounds family planning and reproductive health, providing adolescents with a comprehensive and acceptable educational approach requires a model that is sensitive to their needs. Pillars of reproductive health awareness by M. Marshall, V. Jennings and J. Cachan (1997) is one such approach. Marshall and colleagues explained their concept based on the following four pillars: Body/self

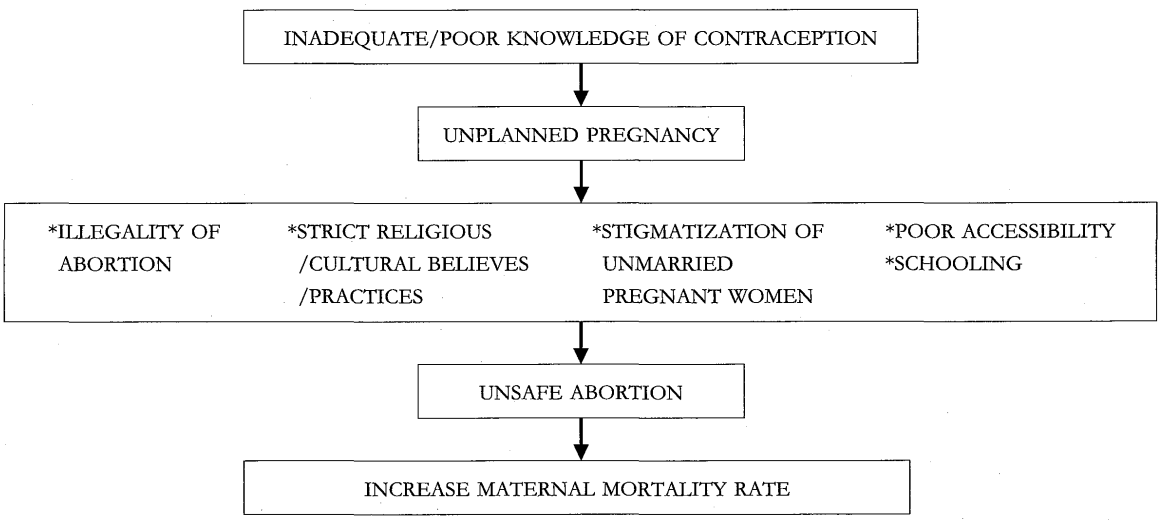


Figure 2. Some Factors Contributing To Unsafe/Induced Abortion

awareness explained how we learn to care for and respect our bodies, and how we view sexuality. To have body/self awareness means that one continues to express maturation of the body, fertility awareness, signs and symptoms of disease and avoidance of high-risk behaviors. Gender awareness requires looking at ourselves through the filter of our own culture. Integration of sexuality was explained that an individual should establish one's own safe and healthy sexual norms, understand the norms of our society and work to eliminate behavior that is unsafe.. Interpersonal communication was introduced as the ability to speak openly and deeply with parents, children, partners and peers. We need to be able to communicate without embarrassment to health providers, negotiate sexual behavior with partners teaching children with respect and correct information (see Figure 3).

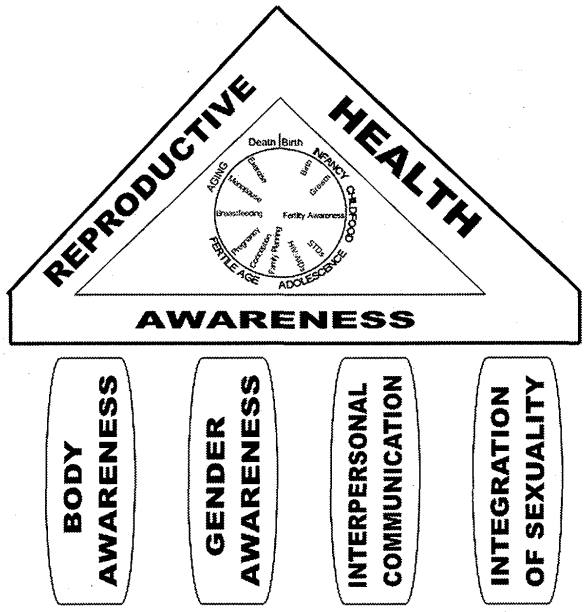


Figure 3. Pillars of reproductive health awareness (Marshall, Jennings & Cachan, 1997)

We assessed this as an effective model of a comprehensive educational tool. However, the model is sensitive and must be adopted considering social, environmental, cultural and religious beliefs. It is not every religion or community that will accept reproductive health education for teenagers. Many are concerned that adolescents may become more promiscuous when introduced to such education; therefore the module will be used with caution.

Health awareness materials to promote adolescents health

The target for the educational program will be adolescents between ages of 16-22. A comprehensive education plan involving religious groups, traditional authorities and other social clubs will be organized. Role-play with charts and songs concerning reproductive health will be introduced to achieve our aim. It is estimated that, about 45% of Christians gather every Sunday, while about 12% of Muslims also go to the mosque to pray on Fridays. This will be a good venue for our priests to spend a few minutes at each gathering to sensitize worshipers on the dangers of induced abortions. This will help solve most of the problems as such leaders' expressions have strong impact.

There are already established peer groups of adolescents in churches and clubs. They would be sensitized to our programs at their own convenient places and times. Eventually some adolescents' volunteers would be trained to teach others about reproductive health and its problems. It is believed that peer-to-peer education will be more comfortable and effective for the youth. However some adults would be monitoring their activities.

In our clinical set ups we would want to create a suitable time and friendly services to the youth. Communities

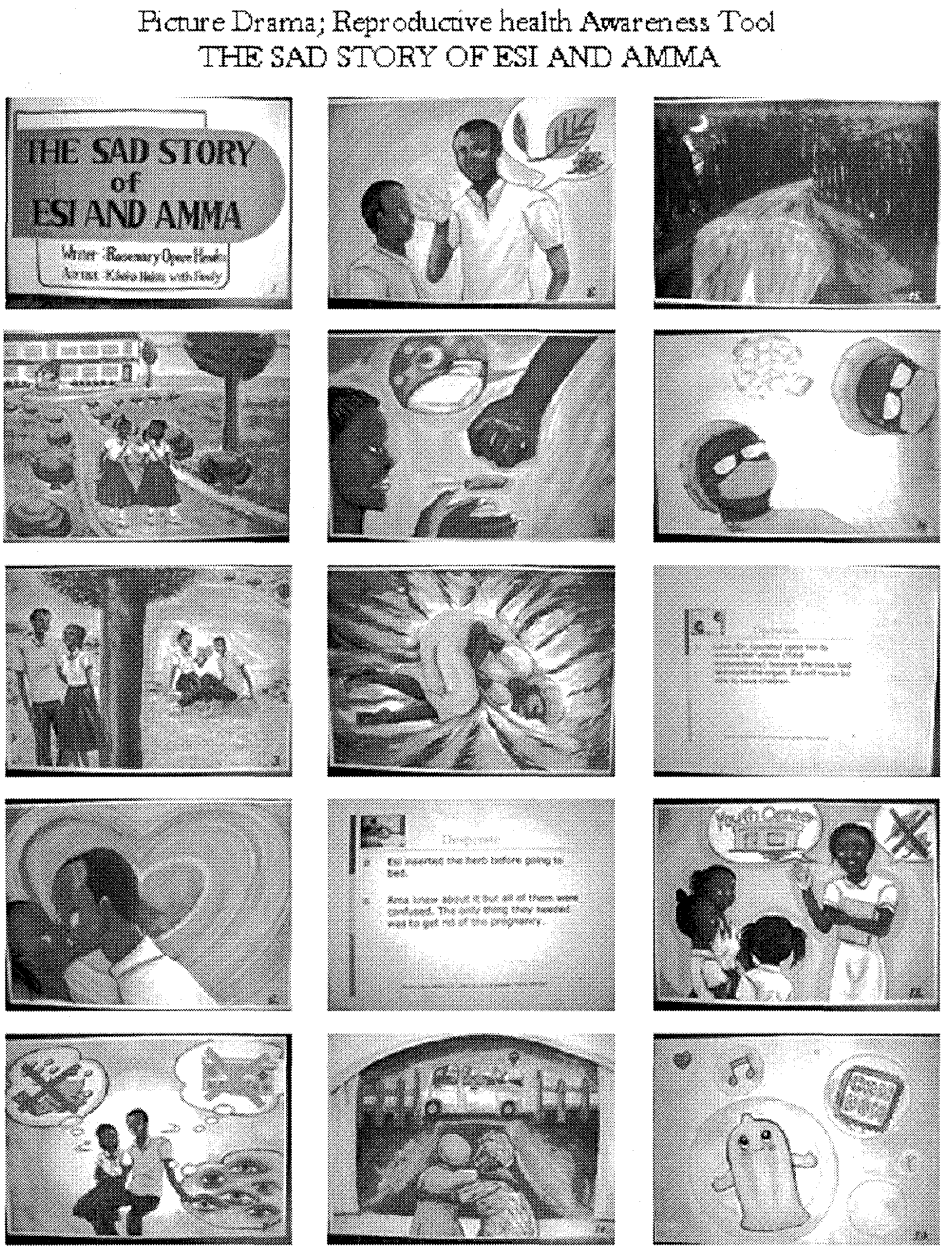


Figure 4. Picture drama of 15 or 20 pictures including two script messages on back side of picture.

would be visited on the occasions of activities like hairdressers or dressmakers meetings to educate them. Simple and comprehensive videos, dramas, songs and Marshall et al's (1997) Pillars Of Reproductive Health Awareness would be included in the program.

It has been proposed that health officials and other stakeholders be reminded about the need to increase the availability of condoms countrywide. Interventions for high-risk groups should be promoted. Media coverage and other educational programs will also be in need to achieve our aim.

TEACHING MATERIALS

Rosemary Henaku, author, and Kihoko Nakai, artist, created a picture drama that depicts adolescents who engaged in sexual activity leading to unwanted pregnancy with unpleasant consequence has been produced that includes 20 pieces of sturdy drama material measuring 30cm by 42cm. The front part of the material contains the artwork while the back has the written story. The drama has also been recorded on a CD, which makes it easier to carry. The script is easily understood and could be used in the hard to reach areas where electricity is inaccessible. In **Figure 4** is the

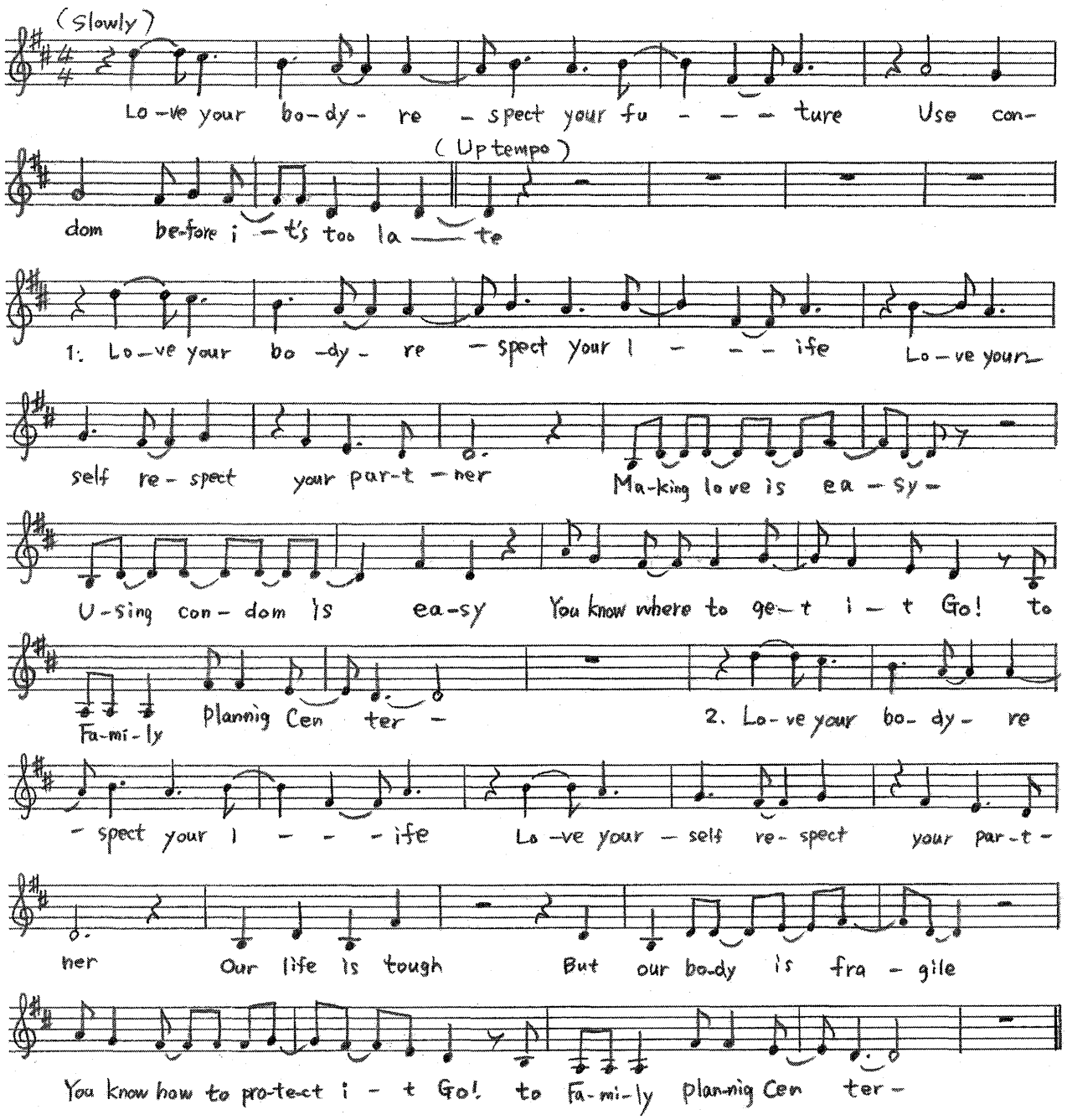


Figure 5. The music score "Love your Body, Love your Life"

picture drama with 15 of the 20 pictures and two show the written story on the back pages.

This drama was introduced at three conferences in Japan of both adolescents and health officials: 11th Conference of St. Luke's Society for Nursing Research - September, 2006; 21st Annual Meeting of Japan Association for International Health - October 2006; and St. Luke's College of Nursing undergraduate class of human sexuality - November 2006. From all the conferences it received positive responses and comments that the drama will be useful in Ghana.

A health promotional song titled 'Love your Body' has also been produced that we think will be of immense help to the program. The lyric writer was Ms. Rosemary Henaku and was composed by Ms. Hisagae Takako. The following words were used to get our message across: love your body, development of negotiation skills, using and insisting on condoms, respect of partner's opinion and honest communication among partners. (See **Fig. 5** for the song lyrics details.)

EVALUATION

The programs should be ongoing to achieve its purpose. In view of this, quarterly evaluation will be conducted, to assess its impact, through questionnaires, interviews and observations of behavioral change. Adolescents should be able to demonstrate and verbalize the impact of the education on their lives.

CONCLUSION

Health service providers should intensify awareness about the use of contraception, highlighting the dangers of induced/unsafe abortions, through health education. Effective use of the various materials will give the nation a more positive result. Provision of youth friendly services in our clinics and youth centers will contribute to the reduction of the incidence of unsafe abortions.

[ACKNOWLEDGEMENT]:

I acknowledge Bishop William's Memorial Fund; Rikkyo University Tokyo for the sponsorship, the Board members of the fund and St. Luke's College of Nursing, Tokyo for the opportunity to undergo this research in their University. Support from Faculty members of Midwifery of St. Luke's is greatly appreciated. I also acknowledge my employers, Ghana Health Service for the permission and Anglican Diocese of Koforidua Ghana, for the opportunity. My thanks also go to Ms. Junko Muramatsu who introduced me to the composer of the song. I would like to thank Sarah E. Porter RN MPH PhD from Oregon Health Sciences University (retired), for her editorial assistance.

REFERENCES

1) Adams, I., Darko, D. & Accorsi, S. (2004). Reducing avoidable deaths. *Institutional Maternal Mortality Bulletin of Health Information,* 1(1).

2) Ahiadeke, C. (2001). Incidence of induced abortion in Southern Ghana. *International Family Planning Perspectives* 27(2), 96-101 & 108, Retrieved November 9, 2006, from http://www.guttmacher.org/pubs/journals/2709601.html

3) Baiden, F., Amponsa-Achiano, K., Oduro, A. R., Mensah, T. A., Baiden, R., & Hodgson, A. (2006). Unmet need for essential obstetric services in a rural district in northern Ghana: complications of unsafe abortions remain a major cause of mortality. *Journal of the Royal Institute of Public Health,* 120(5), 2006, 421-6.

4) Bustamante-Forest, R. & Giarratano, G. (2004). Changing men's involvement in reproductive health and family planning, *Nursing Clinics of North America* 39, 301-318.

5) Central Intelligence Agency. (2006). *World Fact Book.* Retrieved September 10, 2006, from http://www.cia.gov/cia/publications/Factbook/goes/gh.html

6) Clarke, E. (2004). The experience of starting a poison control centre in Africa-The Ghana experience. *Toxicology,* 198, 267-272.

7) Ghana Health Service. (2005). *Annual Report,* Retrieved September 9, 2006, from http://www.ghanahealthservice.org

8) Ghana Health Service. (2006). *Annual Report.* Ghana: Regional Health Administration, Eastern region.

9) Japan Organization for International Cooperation in Family Planning (2005). *Population and Reproductive Health -World and Japan.* Retrieved September 9, 2006, from http://www.joicfp.or.jp

10) Lithur, N. O. (2004). Destigmatising abortion: Expanding community awareness of abortion as a reproductive health issue in Ghana, *African Journal of Reproductive Health,* 8(1), 70-4.

11) Marshall, M., Jennings, V., & Cachan, J. (1997). Reproductive health awareness: An integrated approach to obtain a high quality of health, *Advances in Contraception,* 13, 313-318.

12) Ministry of Health and Labor Workforce. (2006) *Maternal Statistics in Japan* Retrieved September 10, 2006 from, http://www.mhlw.go.jp/toukei/saikin/hw/eisei/03/kekka4.html

13) Moos, M. (2003). Unintended Pregnancies: A call for nursing action. *Maternal Child* Obed, S. A., Wilson, J. B. (1999) Uterine perforation from induced abortion at Korle-Bu Teaching Hospital, Accra, Ghana: A five-year review. *West African Journal of Medicine,* 18 (4), 286-9.

14) Taylor, J. E. (1992). Life-saving skills training for Midwives: Report on Ghanaian experience. *International Journal of Gynecology Obstetrics,* 38, Suppl., 41-3.

15) United Nations Population Fund. (2005). *Country Profiles for Population and Reproductive Health: Policy Developments and Indicators 2005.* Retrieved September 9, 2006, from http://www.unfpa.org/publications/index.cfm

16) United Nations. (2006). *The Millennium Development Goals Report.* Retrieved September 10, 2006, from http://www.un.org/millenniumgoals

17) World Health Organization. (2004). *Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2000* (4th ed.). Geneva: WHO.