

**G**loria is 22 years old and lives in a traditional village in eastern Ghana where abortion and contraception are not only difficult to access, but widely disapproved of. She has had two abortions but won't tell her parents because she fears she will be thrown out of the family home. Gloria knew continuing with her pregnancy meant the end of her education, so she enlisted the help of a friend and attempted an abortion using a mixture of a local plants and stones, which she ground into a paste and inserted into her uterus. When that didn't work, Gloria tried a branch. After a second self-induced abortion — using a ground-up, broken bottle, sea water and detergent — she said, "I bled and bled and bled for more than five days." Gloria now lives with constant pain and won't see a doctor. The stigma is so great that Gloria will not approach her own mother, who is a midwife (Goldsmith 2007).

### Background

Although African nations have some of the world's most restrictive abortion laws, Ghana's abortion law is one of the continent's most progressive. Since the 1985 reform of the criminal code, Ghanaian law permits abortion if the pregnancy is the result of rape or incest, threatens the woman's physical or mental health, or if there is substantial risk of fetal abnormality.

However, despite liberalization of the law, women's access to abortion services is extremely limited. Unsafe abortion con-

tinues to be a leading cause of maternal mortality in Ghana. Safe abortion was not integrated into the national reproductive health policy until 2003, despite postabortion care (PAC) being an accepted, routine service for women who had attempted unsafe abortions — and unsafe abortion continues to threaten the lives of women and girls who have unintended pregnancies.

Ghana has one of the highest maternal mortality rates in the western Africa — 560 deaths per 100,000 live births — and a Ghanaian woman has a one in 45 chance of dying from a pregnancy-related cause during her lifetime (WHO 2007). According to a study conducted at the Korle-Bu and the Komfo Anokye teaching hospitals, 22 to 30 percent of maternal deaths in Ghana are attributable to complications from unsafe abortion — significantly more than the World Health Organization's (WHO) global estimate of 13 percent (Lithur 2004).

Unsafe abortion is prevalent among women of all ages in Ghana, where only 14 percent of married women of reproductive age use modern methods of contraception (PRB 2007). Adolescents and young women, often unable to access or afford reproductive health services, are particularly vulnerable to suffering injuries or dying from botched abortions they self-induce or procure from an unskilled provider.

Today, Ghana faces the challenge of implementing the existing abortion law to the fullest extent possible to preserve women's health and lives. Founded in 2006 and based in Accra, Ipas Ghana is a key voice in a national coalition of government stakeholders and nonprofit organizations united to reduce maternal deaths and injuries. As part of its role in the Reducing Maternal Morbidity and Mortality (R3M) consortium, Ipas Ghana advocates for women's access to a full range of reproductive health services, including family planning and safe abortion.

Statistic	Data
National population	23,000,000
Total fertility rate for women aged 15–49	4.4
Maternal mortality ratio (deaths per 100,000 live births)	560
Percent age of married women married aged 15–49 using modern contraception	14

## Key accomplishments

- In 2006, in collaboration with Ipas Ghana, the Ghana Health Service released safe abortion standards and protocols. Those guidelines outline the principles of comprehensive abortion care, which include nonbiased counseling and provision of postabortion contraceptives to reduce future unintended pregnancies. With the standards and guidelines in place, Ghana will define the mental health conditions that could qualify a woman for an abortion; create referral mechanisms to help women receive high-quality care in a timely manner; establish rules on the use of medical abortion, which can be cost-effective in low-resource settings; and is awaiting approval to authorize midwives to perform first-trimester procedures, thus expanding the base of abortion providers. Midwives are currently permitted to provide services within the first nine weeks of pregnancy.
- Ipas has trained service providers in 57 facilities in the Eastern, Ashanti and the Greater Accra regions. Together with Jhpiego, a Johns Hopkins University international nonprofit health organization, Ipas has started training tutors in comprehensive abortion care (CAC) instruction in all midwifery schools in the country.
- To better determine a strategy to improve comprehensive abortion care for women, Ipas and the Ghana Health Service conducted a baseline survey in 2007 for health workers and management in seven districts in the three selected regions. The results showed that only one in five health workers were aware of all the circumstances in which abortion is permitted. While an overwhelming majority — 80 percent — of hospital managers approve of safe abortion care, many other clinicians were found to be less comfortable using manual vacuum aspiration (MVA) in the first trimester of pregnancy or providing safe abortion for adolescents.

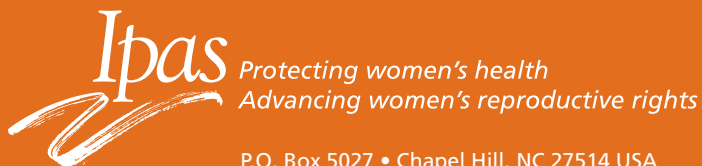
## What Ipas's work means for women

Ipas Ghana's work has resulted in services for more than 2,000 women, as well as important improvements in service quality, including a substantial increase in the proportion of women presenting for procedures early in pregnancy; an increase in the use of manual vacuum aspiration (MVA), which ensures women seeking services experience fewer abortion-related complications; and an increase in the number of clients who leave facilities with a contraceptive method.

Ipas has organized several workshops for women in leadership positions and traditional female leaders, or “queen mothers,” to reduce stigma and increase awareness of Ghana's abortion law and service availability in health facilities. These women are instrumental in creating dialogue around unsafe abortion and ensuring members of their communities — especially youth — receive accurate information about sexual and reproductive health.

## Works cited

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