



THE CONSEQUENCES OF ABORTION RESTRICTIONS FOR ADOLESCENTS' HEALTHCARE IN GHANA: THE INFLUENCE OF GHANA'S ABORTION LAW ON ACCESS TO SAFE ABORTION SERVICES

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Abstract

Unsafe abortion accounts for 22,500 to 44,000 maternal deaths worldwide. It is the second leading cause of maternal mortality among adolescent girls (aged 10 – 19 years) worldwide. In Ghana, abortion is more common among adolescents than among other women of reproductive age. Annually, Ghana spends about GH¢37.8 million (US\$8.5 million) out of pocket on unsafe abortions, which suggests an increased risk of catastrophic expenditure and poverty for many. Moreover, 11%-30% of maternal deaths in Ghana are due to unsafe abortions and adolescents contribute about 35% of those deaths. Although laws cannot alter adolescents' need for abortion, restrictive ones are associated with increased unsafe abortions and risk of abortion-related maternal mortality. This qualitative study explored the influence of Ghana's abortion law on adolescents' access to safe abortion services using literature review. The search terms "Ghana abortion law" and "adolescent access to induced abortion in Ghana" were used to retrieve relevant articles from PubMed and the Lancet. The study found that although safe abortion is legal in Ghana, it is not available on request which, is a barrier for adolescents. This study concludes that Ghana's abortion law is restrictive, outdated and does not facilitate adolescents' access to safe abortion services. The study recommends that the Ghana Health Service and the Ministry of Health advocate for the liberalisation of the law to ensure abortion is legally available on request for adolescents.

Keywords: Abortion, Law, Adolescents, Ghana, Health

Introduction

Abortion is the termination of pregnancy before foetal viability. It may be spontaneous or induced; the latter is often implied, as is the case in this study when the word "abortion" is used (Tindanbila, Agyei, Amooba, Apiribu, & Kugbey, 2014). Unmet need for contraception, contraceptive failures, unprotected sex, coerced sex, and ambivalence towards contraception often lead to unintended and unwanted pregnancies which, often lead to induced abortion. About 2.9 million induced abortions among older adolescents (15-19 years) are due to unintended pregnancies (Guttmacher, 2016a). Adolescents (defined as persons aged 10-19) often seek abortion because the pregnancy interrupts their education or work, due to financial or relationship difficulties, or the need to space childbirth (Guttmacher, 2016b). According to the World Health Organization (WHO), adolescents in developing countries who

need abortion services often face socio-economic and legal obstacles (WHO, 2012). Unmarried adolescents face stigma whether they seek an abortion or choose to continue with a pregnancy (Singh, Remez, Sedgh, Kwok, & Onda, 2018). In countries with 'de facto' availability of safe abortion care (SAC), 'de jure' barriers including financial obstacles and stigma often limit adolescents' access (Sedgh, Singh & Ashford, 2012; WHO, 2012). For example, safe abortion is legally available and accessible on demand in Cuba, however, adolescents are burdened with the responsibility of obtaining prior parental authorisation (Rowlands, 2013). Safe abortion mortality risk in adolescence is lower than that of carrying a pregnancy to full-term or receiving a penicillin injection (WHO, 2011). However, worldwide, between 22,500 and 44,000 women die annually due to unsafe abortions

(Guttmacher, 2016c). Obstetric complications form the second leading cause of mortality among older adolescent girls globally (WHO, 2014). Governments of developing countries spend about US\$232 million treating unsafe abortion complications, which could more than double to US\$562 if all those who need post-abortion care services have access (Singh, Darroch, & Ashford, 2014). Abortion-related disease burden can be reduced by liberalised abortion laws and universal access to safe abortion services for all women (WHO, 2010; 2012). Globally, countries that restrict or prohibit abortion under all circumstances have about the same General Abortion Rate (GAR) as those that permit abortions on request. This means that neither restrictive nor liberal abortion laws can influence adolescents' need or demand for abortion (Guttmacher, 2016c; WHO, 2012). Ghana is a signatory to several international treaties and conventions such as the Maputo protocol, that guarantee safe abortion for adolescents, but, the country's abortion law does not seem to meet these obligations (Aniteye & Mayhew, 2013; WHO, 2017).

In Ghana, most induced abortions are either unreported or misclassified, which results in under-reporting (Ghana Statistical Service [GSS], Ghana Health Service [GHS] and Macro International, 2009; Guttmacher, 2013). As the available data represent the tip of the iceberg, the magnitude of the problem is not likely to be appreciated by policy-makers. According to the 2014 Ghana Demographic and Health Survey (GDHS), 44% of women and 27% of men had their first sexual intercourse by age 18. The GDHS suggests that about a quarter of adolescent boys (15-19 years) and over 40% of girls are sexually active. The GDHS also found that although 96.5% of adolescents have knowledge of contraception, less than a tenth (6.3%) of them use any modern contraceptive (GSS, 2015). Majority of adolescents in Ghana have an unmet need for contraception which, suggests that some of the resulting unintended and unwanted pregnancies would end in abortions (GSS, 2015). In 2013, the Ghana Health Service (GHS) recorded 13,716 safe induced abortions (GHS, 2014). Moreover, about 90% of women in Ghana have heard of abortion and nearly 2 in 10 have had an abortion (GSS et al.,

2009). Approximately, 39% of all pregnancies in Ghana belong to young people (10-24 years), of which 32% are adolescents (GHS, 2015). Ghana's adolescent abortion rate is 17 abortions per 1000 girls aged 10-19 years which, is higher than the GAR of 15 abortions per 1000 women aged 15-49 years (GSS et al., 2009). These facts suggest that abortion is more common among adolescents than the rest of the women of reproductive age.

Data on Unsafe Abortion among Adolescents in Ghana

Data on unsafe abortion among adolescents in Ghana is scarce, however, the 2017 Ghana Maternal Health Survey (GMHS), revealed that adolescents are more likely to have induced abortions (19% of pregnancies) than the rest of women of reproductive age (GSS, ICF & GHS, 2018). About 45% of induced abortions in Ghana are unsafe (Guttmacher, 2013). Between 11%-30% of maternal deaths in Ghana are due to unsafe abortions and adolescents contribute 35% of those deaths (GSS et al., 2009; Guttmacher, 2013). Ghanaians spend about US\$8.5 million (GH¢37.8 million) out of pocket on unsafe abortion, which suggests an increased risk of catastrophic expenditure and poverty for many (Schieber, Cashin, Saleh, & Lavado, 2012). Consequently, this study sought to explore the influence of Ghana's abortion law or Provisional National Defence Council Law 102 (PNDCL 102) on adolescents' access to safe abortion services.

Methodology

This qualitative study reviewed both published grey and scientific literature. On 20th October 2017, a literature search was carried out in PubMed and the Lancet using the search terms "Ghana abortion law" and "adolescent access to induced abortion in Ghana". The results were filtered by date to eliminate articles published earlier than 2007 and then by access to remove articles without full access. The references of relevant articles were also reviewed. The search retrieved 32 articles, but, 10 articles were included in the study because they contained data on either the law or abortion among adolescents in Ghana. Grey literature was retrieved from sources such as GHS, Ministry of Health

(MoH), Guttmacher, Ghana Statistical Service and WHO.

Results and Discussion

Ghana's Abortion Law

Before 1985, the Criminal Code of 1960 permitted abortion, if, it was part of any medical treatment of the woman (Schwandt, et al., 2013). In 1985, the Code was repealed by PNDCL 102. Section 58 of the law states thus (Republic of Ghana, 1999, pp.37-38): “(1) Subject to the provisions of subsection (2) of this section –

(a) any woman who with intent to cause abortion or miscarriage administers to herself or consents to be administered to her any poison, drug or other noxious thing or uses any instrument or other means whatsoever; or

(b) any person who –

(i) administers to a woman any poison, drug or other noxious thing or uses any instrument or any other means whatsoever with the intent to cause abortion or miscarriage, whether or not that the woman is pregnant or has given her consent;

(ii) induces a woman to cause or consent to causing abortion or miscarriage;

(iii) aids and abets a woman to cause abortion or miscarriage;

(iv) attempts to cause abortion or miscarriage; or

(v) supplies or procures any poison, drug, instrument or other thing knowing that it is intended to be used or employed to cause abortion or miscarriage, shall be guilty of an offence and liable on conviction to imprisonment for a term not exceeding five years.

(2) It is not an offence under subsection (1) of this section if an abortion or a miscarriage is caused in any of the following circumstances by a registered medical practitioner specialising in gynaecology or any other registered medical practitioner in a Government hospital or in a private hospital or clinic registered under the Private Hospitals and Maternity Homes Act, 1958 (No. 9) or in a place approved for

the purpose by legislative instrument made by the Secretary:

(a) where the pregnancy is the result of rape, defilement of a female idiot or incest and the abortion or miscarriage is requested for by the victim or her next of kin or the person in loco parentis, if she lacks the capacity to make such a request;

(b) where the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health and such woman consents to it or if she lacks the capacity to give such consent it is given on her behalf by her next of kin or the person in loco parentis; or

(c) where there is substantial risk that if the child were born, it may suffer from, or later develop, a serious physical abnormality or disease.”

The Legal Grounds for Adolescents Access to Safe Abortion in Ghana

PNDCL 102 permits abortion to save the woman's life or to preserve the woman's physical or mental health. Abortion is also permitted on grounds of rape, incest or foetal impairment (Republic of Ghana, 1999). In figure 1 below, Ghana's abortion law is juxtaposed with other countries. Assuming a scale of 1 to 6 levels of abortion laws, with each succeeding level inclusive of the preceding level, Ghana's abortion law can be placed in level 4, which is neither liberal nor restrictive. At level 1 abortion is either permitted only to save the woman's life or prohibit abortion under every circumstance such as in Chile, Malta and Nicaragua. Level 2 laws permit abortion to save mother's life or preserve health such as in Algeria and Burundi. Level 3 laws include rape/incest to the previous levels. Level 4 laws include foetal impairment as is the case in Ghana and Benin. Level 5 laws, as in Zambia, include broader socio-economic grounds such as the woman's resources, age, marital status or parity. Finally, South Africa, Angola, Cape Verde and Angola are among countries that have legalised abortion on request – level 6 laws. That means adolescents in those countries can have access to legal abortion on demand. Levels closer to 1 represent more restrictive laws whereas those closer to 6 portray more liberal laws. Compared to Cape Verde, Angola and South Africa where abortion is available on request, Ghana's abortion law is restrictive.

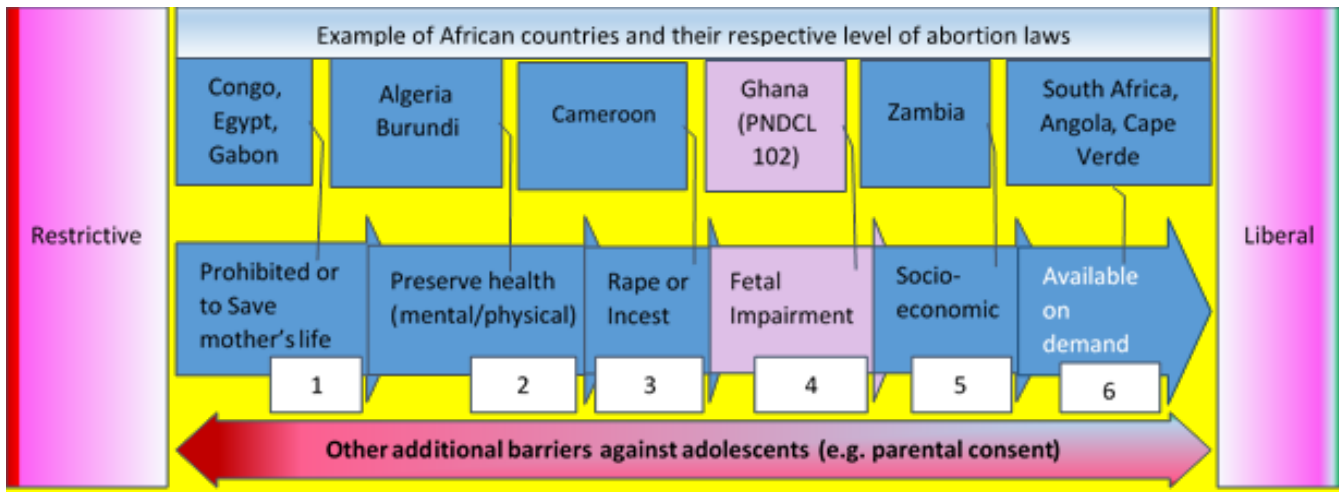


Figure 1. Ghana's abortion law in the international context,
Source: Guttmacher (2016d) and WHO (2017).

On the other hand, PNDCL 102 can be described as liberal when compared with countries like Congo, Rwanda, and Eritrea where adolescents cannot obtain an abortion due to foetal impairment (Guttmacher, 2015; 2016d; WHO, 2017).

Restrictive laws force adolescents to use clandestine unsafe abortions, which often lead to complications, death or litigations (Guttmacher, 2016a; 2016c). For example, in Rwanda, where reporting abortions to law enforcement are mandatory, nearly a third of prisoners are abortion incarcerations (Kane, 2015). Generally, countries that restrict/criminalise abortion tend to have increased unsafe abortion-related maternal mortality compared to those with liberal laws (WHO, 2012). For example, in 1996, South Africa legalised abortion on request (Sedgh et al., 2012). From that time to 2008, the abortion case fatality rate fell from 32.69 to less than one (0.59) maternal death per 1000 abortions. Empirical evidence attributed 91% of the reduction of abortion to the liberal law (Benson, Andersen, & Samandari, 2011; Sedgh et al., 2012). This suggests Ghana's abortion law in its current form is not liberal enough to achieve optimum reduction of unsafe abortion-related maternal mortality. The 2007 GMHS findings suggest that nearly all the reasons why adolescents seek abortion may not fall within the legal conditions (GSS et al., 2009). Another study found that most adolescents in Ghana seek abortion due to socio-economic reasons (Aniteye & Mayhew, 2011). These facts show a mismatch between the law and the practical abortion needs of adolescents. It is vital

to resolve this as part of the efforts to achieve sustainable development goal (SDG) 3.1 target of reducing maternal mortality to 70 per 100,000 live births by 2030 (WHO, 2016). The facts presented in this study suggest that the removal of legal obstacles that hinder adolescents' access to safe abortion care is perhaps the most financially inexpensive yet, effective intervention that can help Ghana meet the sustainable development goal 3.1 target.

Performing Institutions and Personnel for Legal Abortions

The law specifies that gynaecologists or medical doctors can perform abortions in a registered hospital, clinic or an approved place. However, such specialists and facilities are not available in most parts of Ghana, especially in rural areas. Moreover, due to increased technology sterile environment is no longer necessary except for outmoded invasive abortion procedures such as Dilation and Curettage (D&C). Medical Abortion (MA), for instance, can be carried out anywhere. Moreover, the WHO (2012) states that MA is acceptable to most users, safe, effective, inexpensive and feasible to implement in every environment. This signifies that adolescents who cannot or do not visit a health facility can conveniently access safe abortion from trained personnel irrespective of their location. Studies suggest that adolescents in Ghana are already safely conducting abortions at home (Rominski, 2015). These facts show that the need for an approved place for abortion is outdated and an obstacle for

adolescents seeking SAC. Furthermore, growing evidence points to the fact that some abortions can be safely conducted by mid-level staff such as nurses and midwives. For example, one systematic review found no statistically significant increase in the risk of failure for MA and Manual Vacuum Aspiration (MVA) administered by midlevel staff compared to doctors (Barnard, Kim, Park, & Ngo, 2015). The evidence is enough for Ghana's law to widen the list of persons who can perform abortions to include midlevel staff.

Third-Party Authorisation

One common contradiction within abortion laws is the requirement for adolescents to obtain parental consent (Guttmacher, 2015). In Cuba for instance, despite the availability of abortion on request, adolescents below 18 years need parental consent to access SAC. Such a requirement is a barrier to access for adolescents who want to keep their reproductive health behaviours secret from their parents. Ghana's abortion law does not require parental or spousal authorisation. It allows the person in loco parentis to request an abortion for an adolescent only if she is incapacitated.

Gestational Age Limitations

Perhaps one of the most liberal parts of Ghana's abortion law is the absence of gestational limits to accessing abortion. The law defines abortion or miscarriage "as the premature expulsion of or removal of conception from the uterus or womb before the period of gestation is completed" (Republic of Ghana, 1999). Tindanbilla et al. (2014) suggest that the period before completion of gestation indicates a perceived period prior to foetal viability. However, Norman, Kweku and Binka (2015) interpret the period before completion of gestation to mean any time before delivery. Other literature suggest that the latter interpretation is more appropriate because the period of foetal viability is part of an ongoing gestation, which ends when it is either aborted or the child is delivered (American College of Obstetricians and Gynecologists, 2013). Gestational age limitations for abortion is likely to negatively affect adolescents more than any other age group because adolescents are less likely to identify pregnancy or decide to terminate it early

(Guttmacher, 2016b). In Ghana, abortion is paid out of pocket, which makes adolescents less likely to afford the service fee upfront. Additionally, some adolescents try to hide the pregnancy from people while they attempt to self-induce abortions before reporting at health facilities thus, causing delays (Rominski, 2015). That means suggestions by Norman et al. (2015) for gestational limitations could be counterproductive and hinder adolescents' access to safe abortion. It is also unlikely that the absence of gestational limits would necessarily lead to increased late-term abortions. Nonetheless, educating adolescents to seek safe abortion early in pregnancy is necessary. Abortions conducted in the first trimester tend to be financially inexpensive, less likely to result in complications and politically less controversial compared to late-term abortions (Guttmacher, 2016b; WHO, 2012).

Conscientious Objection

PNDCL 102 does not have provision for conscientious objection. According to Awoonor-Williams et al. (2018), more than a third of trained providers and over half (57.6%) of the Christian Health Association of Ghana (CHAG) facilities in northern Ghana are conscientious objectors. Moreover, some health workers either discourage adolescents or prevent abortions from being carried out in their facilities (Aniteye & Mayhew, 2011; Payne et al., 2013). Adolescents who find the courage to approach conscientious objectors may be given inaccurate information or scolded for seeking safe abortion services. For example, one service provider was quoted as saying;

"you tell them during counselling that, look here you have committed a crime already. If you go ahead and do this thing [abortion] you are using one sin to cover another sin" (Aniteye and Mayhew, 2013, p.8).

This kind of advice creates the impression that the adolescent is seeking to commit a crime and a sin, thus forming a barrier to utilising SAC.

Policy Implications

Although the law spells out specific conditions for accessing abortion it does not indicate who determines that the conditions are met. Limiting

abortion access to specific cases does not resonate with the WHO recommendation that legal regimes ensure universal access to SAC (WHO, 2010). Further, client-doctor relationship in Ghana is largely paternalistic, which means that care providers ultimately determine whether adolescents can receive a legal abortion. The WHO (2012) recommends service providers use their knowledge to ensure that access to safe abortion is implemented to the fullest extent of the law. However, most service providers are not well-informed on the abortion law or policies (Voetagbe, et al., 2010). This creates room for fear, speculations, myths and misinterpretations of the law. Misperception means that cases of physical or sexual abuse of adolescents in the process of receiving an abortion are likely to go unreported. Although permitting abortion on broad socio-economic grounds is a good starting point for Ghana, the legislative changes that can make a significant impact on adolescents are those that make abortion available on request. The removal of all legal barriers could encourage more service providers to join the market, which could drive down prices through competition. The apparent lack of political will to implement such reforms seems to be changing as some legislators are now publicly calling for the law's amendment (Ibrahim, 2017). Advocacy groups such as Ipas, Pathfinder, Marie Stopes International, Ghana and the Willows Foundation may recruit such legislators as "champions" to help push the needed reforms.

Regarding personnel who can perform abortions, the MoH/GHS already allow task-shifting of abortion from the specialists to trained midwives. However, unlike community health nurses – the largest category of human resource for health in Ghana – who are found in almost every community, midwives tend to be concentrated in urban areas. A policy that widens the permitted personnel to include community health nurses could increase the availability, affordability and accessibility of SAC for adolescents. This will be more effective if the GHS use mobile platforms to educate adolescents on safe abortion. Furthermore, due to the restrictions on the places for abortion a few government, private and non-governmental organisation facilities such as Marie Stopes International (Ghana) and the Planned Parenthood Association of Ghana provide SAC for

adolescents. But, most of these facilities appear to be concentrated in urban areas which, means rural adolescents will have difficulty getting access to SAC. Ghana has legalised the use of Mifepristone (Mediprist) and Misoprostol (Cytotec) for MA (Kuffour, Esantsi, Tapsoba, Quansah-Asare, & Askew, 2011; MoH, 2010). A policy that removes place/facility restrictions could lead to increased availability of SAC for adolescents as homes and pharmacies can be used for MA. Since MA is relatively more affordable compared to other methods of abortion, adolescents can procure medicines from trained personnel and perform abortions at any convenient place. This could help bring down the cost of abortion and reduce the apparent inequity in access to abortion. However, such a policy must be accompanied by proper training and supervision of providers and mass education to ensure that adolescents are well-informed about MA.

Moreover, the Ghana Comprehensive Abortion Care Services Standards and Protocols encourage adolescents to seek parental consent although they must not be denied abortion if they are unable to obtain it (MoH/GHS, 2012). This policy should be maintained because it reduces adolescents' vulnerability to delays and denial of SAC by parents, thus, reducing their risk of falling victim to quacks and unsafe abortions. Although adolescents need counselling prior to an abortion, the final decision should always come from them or at the very least be in their best interest.

Additionally, regarding gestational age limitation, the current policy elaborates that abortion refers to the termination of pregnancy prior to foetal viability (defined as any time before 28 weeks of gestation). The policy also adds that second-trimester abortion is one done from 13 through 28 completed weeks of pregnancy (MoH/GHS, 2012). It, however, does not indicate any specific gestational limits for safe abortion, which would have constituted a barrier for adolescents who are unable to act within such time.

On the subject of conscientious objection, the current abortion policy mandates conscientious objectors to counsel adolescents in need of abortions and refer them to appropriate personnel/facilities where they can access help (MoH/GHS, 2012). This is in line with international norms as indicated in Article 141,

Section V of the Economic Community of West African States (ECOWAS) Harmonised Code of Ethics and Practice (ECOWAS, 2013). The current policy will ensure continuity of care for adolescents in need of abortion without upsetting conscientious objectors.

Finally, it is worth noting that legalisation of abortion, although necessary, does not guarantee adolescents access or utilisation of safe abortion services. Interventions to remove financial cost/barriers and improve the availability of adolescent-friendly quality services should also be considered as part of the policy reform. The WHO states that refusing to remove financial barriers to safe abortion or not adding safe abortion services to national health insurance constitutes an inequity and a violation of their rights (WHO, 2015).

Conclusion

Although Ghana's abortion law is relatively liberal – permits abortion to save a woman's life, to preserve a woman's health, on grounds of rape, incest or foetal viability – it does not meet the needs of adolescents. The exclusion of broad socio-economic reasons for abortion and the law's failure to make abortion available on request constitute legal barriers for adolescents in need of SAC. Additionally, due to improved technology and the established safety of MA which can be performed by midlevel staff in almost every environment, the law's definition of persons and places where abortion can be obtained is outdated and does not facilitate adolescents' access to safe abortion. Additionally, abortion in Ghana is paid out of pocket which constitutes a barrier to adolescents' access to safe abortion and puts most families at risk of catastrophic expenditure and poverty. Providers inadequate knowledge of the law, conscientious objection and bias further limit adolescents' access to safe abortion. This means that despite the available policy guidelines, adolescents still lack access to safe legal abortion due to inadequate implementation.

Recommendations

The study recommends that the GHS and MoH advocate for the legalisation of abortion on request using scientific evidence to inform such changes.

The legal reforms should include scrapping the limitation on places where abortion can be performed and adding community health nurses to the permitted performing personnel. This can be achieved by recruiting like-minded legislators as 'champions' and collaborating with like-minded organisations to advocate for the changes.

Moreover, the study recommends that the GHS regularly train service providers on value-clarification, the abortion law and policies to build their capacity to provide value-free abortion services to adolescents. As part of the capacity building training, copies of the law and the policies can be put on the GHS website to ensure workers have access to them.

Finally, the study recommends that the GHS and the MOE advocate for the addition of safe abortion care to the NHIS minimum package. This will remove the financial barriers and ensure equity in access to safe abortion among adolescents.

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