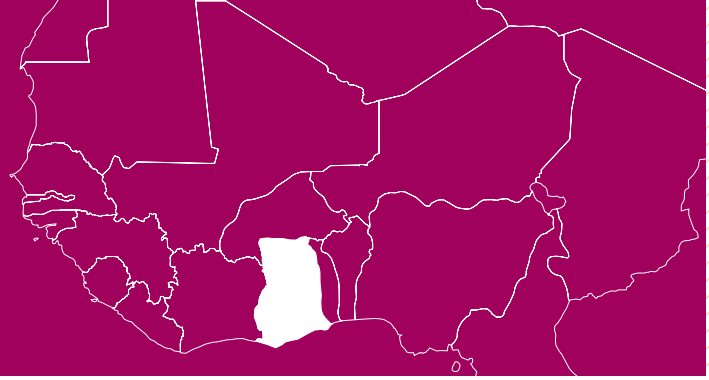
GHANA

PAC-FP COUNTRY BRIEF



Postabortion care (PAC) provides a comprehensive approach to preventing morbidity and mortality caused by abortion complications (PAC Consortium, 2014). As per the U.S. Agency for International Development (USAID) PAC model, a critical component of PAC is providing access to family planning (FP) counseling and services. Providing these services helps meet the reproductive intentions of women who most clearly demonstrate an unmet need for FP, reduces unintended pregnancies, and prevents repeat abortions, thus reducing maternal deaths (Curtis, Huber, and Moss-Knight, 2010). The information below highlights the Republic of Ghana's investment in providing PAC and FP services to women in need.

POLICIES, LEADERSHIP, AND GOVERNANCE

The Republic of Ghana's national policy on family planning (FP) and reproductive health (RH) is outlined in a number of documents, including the Health Sector Medium Term Development Plan 2014–2017 (2014) and the Reproductive Health Strategic Plan 2007–2011 (2007). The latter policy provides guidance related to the prevention and management of complications from abortion, the inclusion of FP counseling, and the provision of voluntary methods within postabortion care (PAC) and maternity services. The country's Prevention and Management of Unsafe Abortion: Comprehensive Abortion Care Services, Standards, and Protocols (2012) provides specific guidelines for PAC. This document aims to address service gaps and facilitate the provision of comprehensive abortion care to reduce maternal morbidity and mortality.

Legal Status on Abortion

The abortion law in Ghana, enacted in 1985, states that an abortion performed by a qualified medical practitioner is legal if the pregnancy is the result of rape or incest, if the abortion is performed to protect the woman's mental or physical health, or when it is a malformation of the fetus (Sedgh, 2010).

PAC TRAINING AND STANDARDS

In 2006, the Ghana Health Service and the Ministry of Health developed protocols for comprehensive abortion care, which includes PAC. Through the Reducing Maternal Mortality and Morbidity (R3M) program, the Ghanaian government and international partners trained providers in PAC, including the counseling and provision of voluntary contraceptives (Sedgh, 2010 and Ipas, 2014).

In 2009, the government updated the curriculum for midwifery training to include manual vacuum aspiration for PAC, a package of emergency treatment services for complications of spontaneous or unsafely induced abortion, postabortion FP counseling and services, and linkages to comprehensive RH services (Osei et al., 2005). PAC training for midwives lasts approximately five days (Ababio and Baird, 1998).

By 2012, through the R3M program, the government had trained 38 trainers, 320 midwives and physicians, and 637 health workers to provide long-acting reversible contraceptives (Population Council, 2015). Since 2015, approximately 2,100 auxiliary nurses completed FP training, which includes the provision of contraceptive implants. The provision of these

PAC·FP THE POSTABORTION CARE FAMILY PLANNING PROJECT
Expanding contraceptive methods and informed choice to PAC clients

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services align with the government's 2013 task-shifting policy, which has led to a significant increase in voluntary uptake of implants and other FP methods (FP 2020, 2016).

STRENGTHENING SERVICE DELIVERY

Ghana's decentralized health system helps ensure that contraceptives and PAC services are routinely available at all levels of the public and private health service delivery systems (Sedgh, 2010). In collaboration with Ipas and Marie Stopes International, the government has scaled up PAC from 2 to 8 out of the 10 regions since 2015 (FP 2020, 2016). Postpartum and PAC services are now available at all facilities with trained personnel.

BARRIERS TO PAC

Women in Ghana face multiple barriers to accessing PAC and FP services. Women who use FP face stigma from their communities; as a result, many women access FP services in secret, in the evenings or during market days—provided health staff and FP commodities are available and accessible at those times. Partner disapproval is another obstacle: in much of Ghana, large families represent wealth and men and women often have opposing views on desired family size.

Commodity and service costs, as well as fear of method side effects, further hinder demand for and uptake of FP. At the facility level, insufficient staffing for FP poses a particular challenge. Not only are dedicated FP staff unavailable in the public sector, lower-level facilities—where the need is highest—are often unable to provide FP services. Few practitioners are available to perform PAC and those who do are very expensive (Sedgh, 2010). For staff with the capacity to provide PAC and FP, lack of equipment and contraceptive supplies is frequently a challenge.

FINANCING MECHANISMS

Under the country's National Health Insurance Authority, PAC should be available at all levels of the health system (Rominsky, Morhe, and Lori, 2015). Further, the government recently amended the law to include FP as part of the package (FP 2020, 2016).

From a budgetary perspective, the Ghanaian government allocated $3 million for the procurement of FP commodities in the 2016–2017 financial year (FP 2020, 2016).

GHANA		Year	Source
Demographic/background indicators			
Country population	28,830,000	2017	World Bank[1]
Total fertility rate	4	2016	
Maternal mortality per 100,000 live births	319	2015	
Age at first birth	21.4	2014	Demographic and Health Survey, 2014
Newborn mortality per 1,000 live births	29		
Infant mortality per 1,000 live births	41		
Under-five child mortality per 1,000 live births	60		
Facility-based deliveries	73%		
Proportion of women who attended at least four antenatal visit during their last pregnancy	87%		
Proportion of women who received at least one postnatal visit after delivery	85.0%		
Abortion and FP-related indicators			
Abortions per 1,000 women	15	2007	Guttmacher Institute, 2013
Number of unintended pregnancies	848,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Proportion of maternal deaths caused by abortion complications	11%	2013	Guttmacher Institute, 2013
Number of unintended pregnancies averted due to use of modern contraceptive methods	594,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Number of unsafe abortions averted due to use of modern contraceptive methods	212,000		
Number of maternal deaths averted due to use of modern contraceptive methods	1,100		
All method contraceptive prevalence rate, all women of reproductive age (WRA)	23.0 %	2017–2018	Demographic and Health Survey, 2014
Modern method contraceptive prevalence rate, all WRA	22.1%		
Knowledge of FP, all WRA	99%	2010	
Contraceptive use by type		2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Long-acting and permanent methods			
Sterilization (female)	5.3%		
Sterilization (male)	0.0%		
Intrauterine device	2.2%		
Implant	30.7%		
Short-acting methods		2017–18	
Injection (intramuscular and subcutaneous)	28.5%		
Pill	17.4%		
Condom (male)	6.1%		
Condom (female)	0.0%		
Other modern methods (e.g., cycle beads, and lactational amenorrhea method)	9.7%		
Unmet need for FP[2] (2018)	30.0%	2014	Demographic and Health Survey, 2014
Unmet need for spacing	17.0%		
Unmet need for limiting	13.0%		
Percentage of all women who received FP information during their last visit with a health service provider	25.0%	2017–18	PMA2020, R6

[1] https://data.worldbank.org/indicator/SP.DYN.TFRT.IN

[2] Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior.

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