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Editor: Friday Okonofua

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CONTENTS

Editorial
Defining a New Pathway for Family Planning in Africa after 2014 9-14
Friday Okonofua

Commentary and Articles
Does Access to Antiretroviral Drugs Lead to an Increase in High-risk Sexual Behaviour? 15-16
Zaake D.E. Coninck

Sarah D. Rominski and Jody R. Lori

A Comparative Analysis of Fertility Differentials in Ghana and Nigeria 36-47
Olatoregun Oluwaseun, Fagbamigbe Adeniyi Francis, Akinyemi Joshua Odunayo, Yusuf Oyindamola Bidemi and Bamgboye Elijah Afolabi

Determinants of Preference of Source of Injectable Contraceptives among Rural Women in Uganda: A Case of Depo-Provera 48-56
Olivia Nakayiza, Robert Wamala and Betty Kwagala

Defining Motivational Intensity of Need for Family Planning 57-66
Bernice Kuang, John Ross and Elizabeth Leahy Madsen

Fertility Desires and Intentions among HIV-positive Women during the Post-natal Period in Uganda 67-77
Sarah A. Gutin, Fatuma Namusoke, Starley B. Shade and Florence Mirembe

Obstetric Danger Signs and Factors Affecting Health Seeking Behavior among the Kassena-Nankani of Northern Ghana: A Qualitative Study 78-86
Aboriyo Raymond Akawire

Effects of Improved Access to Transportation on Emergency Obstetric Care Outcomes in Uganda 87-94
Stephen Mucunguzi, Henry Wamani, Peter Lochoro and Thorkild Tylleskar

Rural Origin and Exposure Drives Ghanaian Midwives’ Reported Future Practice 95-100
Jody R. Lori, Laura Livingston, Megan Eagle, Sarah Rominski, Emmanuel Nakua and Peter Ageyi-Baffour
Maternal Health Practices, Beliefs and Traditions in Southeast Madagascar
Jessica L. Morris, Samm Short, Laura Robson and Mamy Soafaly Andriatsihosena

Current Evidence Supporting Obstetric Fistula Prevention Strategies in Sub-Saharan Africa: A Systematic Review of the Literature
Aduragbemi O. Banke-Thomas, Oluwasola E. Wilton-Waddell, Salam F. Kouraogo and Judith E. Mueller

Understanding Maternal Deaths from the Family’s Perspective: Verbal Autopsies in Rural Tanzania
Gail C. Webber and Bwire Chirangi

Risk Factors for Transactional Sex among Young Females in Post-conflict Liberia
Chinelo C. Okigboa, Donna R. McCarraher, Mario Chen and Allison Pack

Attitude of Gatekeepers towards Adolescent Sexual and Reproductive Health in Ghana
Akwasi Kumi-Kyereme, Kofi Awusabo-Asare and Eugene Kojuor Maafu Darteh

Human Papilloma Virus Vaccine: Determinants of Acceptability by Mothers for Adolescents in Nigeria
M.C. Ezeanochie and B.N. Olagbuji

Unconsummated Marriage in Sub-Saharan Africa: Case Reports
V. M. Lema

Information for Authors

Subscription Information and Advert Rate

ABOUT AJRH

African Journal of Reproductive Health (AJRH) is published by the Women’s Health and Action Research Centre (WHARC). It is a multidisciplinary and international journal that publishes original research, comprehensive review articles, short reports and commentaries on reproductive health in Africa. The journal strives to provide a forum for African authors, as well as others working in Africa, to share findings on all aspects of reproductive health, and to disseminate innovative, relevant and useful information on reproductive health throughout the continent.

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The Women’s Health and Action Research Centre (WHARC) is a registered non-profit organization, committed to the promotion of women’s reproductive health in sub-Saharan Africa. Founded in 1995, the centre’s primary mission is to conduct multidisciplinary and collaborative research, advocacy and training on issues relating to the reproductive health of women. The centre pursues its work principally through multidisciplinary groups of national and international medical and social science researchers and advocates in reproductive health.

WHARC receives core funding and support from the Ford Foundation and technical cooperation and mentorship from International Perspectives on Sexual and Reproductive Health and Studies in Family Planning. Principal funding for the journal comes from the Consortium on Unsafe Abortion in Africa. The goal of the centre is to improve the knowledge of women’s reproductive health in Nigeria and other parts of Africa through collaborative research, advocacy, workshops and seminars and through its series of publications – the African journal of Reproductive Health, the Women’s Health Forum and occasional working papers.

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SOMMAIRE

Editoriaux
Définir une nouvelle voie pour la planification familiale en Afrique après 2014  
*Friday Okonofua*

Commentaire et Articles
Est-ce que l'accès aux médicaments antirétroviraux conduit à une augmentation des comportements sexuels à haut risque?  
*Zaake De Coninck*

Soins de l’avortement au Ghana: Un examen critique de la documentation  
*Sarah D. Rominski et Jody R. Lori*

Analyse comparative des différences de fécondité au Ghana et au Nigeria  
*Olatoregun Oluwaseun, Fagbamigbe Adeniyi Francis, Akinyemi Joshua Odunayo, Yusuf Oyindamola Bidemi et Bangboye Elie Afolabi*

Déterminants de la préférence de la source des contraceptifs injectables chez les femmes rurales en Ouganda: Un Cas de Depo-Provera  
*Olivia Nakayiza, Robert Wamala et Betty Kwagala*

Définir l'intensité de la motivation du besoin de la planification familiale  
*Bernice Kuang, John Ross et Elizabeth Leahy Madsen*

Désirs et intentions de la fécondité chez les femmes séropositives au cours de la période post-natale en Ouganda  
*Sarah A. Guti, Fatuma Namusoke, Starley B. Shade et Florence Mirembe*

Signes de danger Obstétrical et les facteurs qui affectent le comportement menant à la bonne santé chez les Kassena-Nankani du nord du Ghana: Etude qualitative  
*Aboriyo Raymond Akawire*

Effets de l’amélioration de l’accès au transport sur les résultats de soins obstétricaux d’urgence en Ouganda  
*Stephen Mucunguzi, Henry Wamani, Peter Lochoro et Thorkild Tylleskar*
<table>
<thead>
<tr>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Origine rurale et les pulsions d'être exposé : la pratique de l'avenir signalé de la sage-femme ghanéenne</td>
<td>95-100</td>
</tr>
<tr>
<td>Jody R. Lori, Laura Livingston, Megan Aigle, Sarah Rominski, Emmanuel Nakua et Peter Ageyi-Baffour</td>
<td></td>
</tr>
<tr>
<td>Pratiques de santé maternelle, croyances et traditions du Sud-est Madagascar</td>
<td>101-117</td>
</tr>
<tr>
<td>Jessica L. Morris, Samm Short, Laura Robson et Mamy Soafaly Andriatsihosena</td>
<td></td>
</tr>
<tr>
<td>Evidence actuelle qui soutient les stratégies de la prévention de la fistule obstétricale en Afrique subsaharienne : Un Compte rendu systématique de la documentation</td>
<td>118-127</td>
</tr>
<tr>
<td>Aduragbemi O. Banke-Thomas, Oluwasola E. Wilton-Waddell, Salam F. Kouraogo et Judith E. Mueller</td>
<td></td>
</tr>
<tr>
<td>Comprendre les décès maternels du point de vue de la famille: Les Autopsies verbales en Tanzanie rurale</td>
<td>128-132</td>
</tr>
<tr>
<td>Gail C. Webber et Bwire Chirangi</td>
<td></td>
</tr>
<tr>
<td>Facteurs de risque pour le rapport sexuel transactionnel chez les jeunes femmes au Libéria de l'après-conflit</td>
<td>133-141</td>
</tr>
<tr>
<td>Chinelo C. Okigboa, Donna R. McCarraher, Mario Chen et Allison Pack</td>
<td></td>
</tr>
<tr>
<td>Attitude des portiers envers la santé sexuelle et de la reproduction chez les adolescents au Ghana</td>
<td>142-153</td>
</tr>
<tr>
<td>Akwasi Kumi-Kyereme, Kofi Awusabo-Asare et Eugene Kofuor Maafo Darteh</td>
<td></td>
</tr>
<tr>
<td>Le Vaccin contre le virus du papillome humain: Les Détaillements de l'acceptabilité par les mères pour les adolescentes au Nigeria</td>
<td>154-158</td>
</tr>
<tr>
<td>M.C. Ezeanochie et B.N. Olagbuiji</td>
<td></td>
</tr>
<tr>
<td>Mariage non consommé en Afrique subsaharienne: Compte rendus des cas</td>
<td>159-165</td>
</tr>
<tr>
<td>V. M. Lema</td>
<td></td>
</tr>
<tr>
<td>Information Pour Les Auteurs</td>
<td>166-171</td>
</tr>
<tr>
<td>Subscription Information et frais d'annonce</td>
<td>172-173</td>
</tr>
</tbody>
</table>
APROPOS AJRH

La Revue Africaine de santé de la Reproduction (RASR) est publiée par le Women’s Health and Action Research Centre (WHARC). C’est une revue à la fois pluridisciplinaire et internationale qui publie des articles de recherche originaux, des articles de revue détaillés, de brefs rapports et des commentaires sur la santé de la reproduction en Afrique. La Revue s’efforce de fournir un forum aussi bien à des auteurs africains qu’a des professionnels qui travaillent en Afrique, afin qu’ils puissent partager leurs découvertes dans tous les aspects de la santé de reproduction et diffuser à travers le continent, des informations innovatrices, pertinentes et utiles dans ce domaine de santé de la reproduction.


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Le WHARC est une organization non gouvernementale à but non-lucratif s’engage dans la promotion de santé de la reproduction chez la femme en Afrique sub-saharienne. Fondé en 1995, le Centre a pour objectif principal de mener des recherches pluridisciplinaires et en collaboration, de promouvoir et de former des cadres en matières relatives à la santé de la reproduction chez la femme. Le Centre travaille surtout à travers des groupes multidisciplinaires de chercheurs aussi bien nationaux qu’internationaux en sciences médicales et en sciences économiques dans le domaine de santé de la reproduction.

Le WHARC reçoit une aide financière principale de la Fondation Ford et bénéficie de la coopération technique de l’International Perspectives on Sexual and Reproductive Health et de Studies in Family Planning. Le financement principal pour la revue vient de la part du Consortium on Unsafe Abortion in Africa. L’objectif du Centre est d’améliorer la connaissance en matière de santé de la reproduction chez la femme au Nigeria et dans d’autres régions d’Afrique à travers la recherche en collaboration, le paydoyer, des ateliers et des séminaires à travers des séries de publication - La Revue africaine de santé de la reproduction, Le Women’s Health Forum et des rapports des recherches de circonstance.
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_African Journal of Reproductive Health September 2014; 18(3): 8_
EDITORIAL

Defining a New Pathway for Family Planning in Africa After 2014

Friday Okonofua

Editor, African Journal of Reproductive Health

The International Conference on Population and Development (ICPD) was a landmark event that shifted emphasis from concerns with population growth to commitment to reproductive equity, rights and social justice in the implementation of all components of reproductive health. It placed women at the centre stage of development, creating a justifiable foundation for women to access safe and affordable modern contraceptives. ICPD positioned family planning as a fundamental human right of all sexually active couples, with the expectation that the new approach will galvanise efforts and lead to an improved use and acceptance of family planning by those who need them.

Since ICPD, the evidence has shown that indeed, contraceptive prevalence rates (CPR) increased worldwide between 1990 and 2013, with a parallel decrease in unmet need for family planning. The most changes in these parameters occurred in the 1990s, with a slower increase in CPR and decrease in unmet need occurring between 2003 and 2012. However, although increases in contraceptive prevalence also occurred in African countries during the period, the increases were less as compared to other regions. Both in Central and West Africa, CPR has remained low with little change occurring in unmet need which has remained at around 20% between 1990 and 2010. This slow progress in CPR and unmet need in Africa has led some to suggest that the principles of ICPD have not worked in the region. With the increasing emphasis on family planning both from the recognition of the possible impact of climate change on resource limitation (with Africa most likely to bear the greatest brunt), and projections made on the increasing number of women that would require family planning after 2014 (mostly in the African region), there is a call for new approaches to address gaps in family planning provision and access in Africa. Indeed, the commitment shown by world leaders at the London Summit in 2013 to provide family planning to an additional 120 million women and girls points to this need for galvanized and quicker action.

Many factors account for the slow progress in family planning indicators in the African continent over the past two decades. These include the poor uptake of the principles of ICPD with many African women still suffering the effects of social exclusion, marginalization and discrimination; the donor driven nature of family planning with many African governments still poorly committed to the principles and practice of family planning principles; limited efforts to address quality of care of available services with clinics still lacking trained staff, a constellation of commodities and youth-friendly approaches; the lack of integration of family planning to high prevalent reproductive health problems such as HIV/AIDS prevention and care; and limited attention paid to addressing the background factors that drive low utilization of family planning in Africa such as ignorance, illiteracy, poverty and harmful cultural beliefs and practices.

Four articles in this edition of the African Journal of Reproductive Health provide evidence of efforts being made in various parts of the region to understand the context of family planning provision in Africa needed to identify new approaches for improving key indicators of development. The paper by Olatoregun and his colleagues compare fertility differences between Ghana and Nigeria and conclude that preferences for high fertility are still dominant in both countries, while the paper by Kuang explains how couples in Uganda are being motivated to accept family planning methods using self-motivational and rights-based techniques. Although injectable contraceptives belong to the WHO group of second tier methods in terms of method...
effectiveness, they are often the most preferred methods by African women. The paper by Nakayiza and her colleagues\textsuperscript{8} from Uganda describes how the source of an injectable contraceptive influences the use of the method by rural women. It points to the need to integrate local needs and considerations in the design and implementation of family planning programs in Africa if increased uptake of these methods is to be achieved. Despite the high prevalence of HIV/AIDS in Africa, there have been little systemic efforts to understand the family need of affected populations and to design programs to address their needs. The paper by Sarah Gutin and her colleagues\textsuperscript{9} from Uganda is presently one of the few available empirical data that investigates fertility desires of HIV-positive women in the postpartum period.

However, these papers are not only a good exposition of the nature of the problem but they point only to a limited direction. There is a need to identify systemic approaches for improving contraceptive availability and use in the African continent after 2014. The 17-points Sustainable Development Agenda being proposed for world development after 2014\textsuperscript{10} appear to be a good start with many issues being included that will address the background social and economic factors that influence poor use of family planning in Africa. However, what will be most important and crucial is the political commitment of national governments both to implement the solutions embodied in the sustainable development agenda, and also to owe the process of change in terms of increased family planning provision. Most African governments have shown poor commitment to family planning services over the past two decades in part due to their internal conflict and beliefs about family planning, and also because of their limited prioritization of health and social development issues. The three countries that demonstrated powerful political commitment to development and family planning over the past years – Ethiopia, Rwanda and Malawi – have also witnessed the fastest growth in CPR and declines in unmet need, which testify to the importance of political commitment and leadership in promoting social development in the African continent. Additional factors that would need to be addressed to boost family planning provision and access in Africa include: increased indigenous funding of family planning (rather than reliance on donor funding), increased public education and advocacy with use of notable champions and partnership building, community provision of services (including the use of task-shifting), health systems strengthening, promoting the inclusion of youth and men in family planning, and the integration of family planning services to other reproductive health services such as HIV/AIDS.

In conclusion, family planning is an important consideration in efforts to foster development, reduce maternal mortality and promote the well-being and social development of women and youth in Africa. The 1990-2013 period witnessed a slow growth of family planning indicators in Africa, but the 2014 period and beyond offers a new window of opportunity to galvanise efforts to accelerate the trend. The Sustainable Development Agenda being proposed for world development after 2014 is a good entry point, but political commitment is critically needed both to implement the agenda and also to prioritise the implementation of family planning and social development programs in Africa. While not downsizing the importance of other areas of development, it is predictable that family planning would be the centre-piece of growth and development planning in the African region in the coming years.

Conflict of Interest
None

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Empowerment and Social Determinants 30th September – October 2, 2013. Mexico City.


Définir une nouvelle voie pour la planification familiale en Afrique après 2014

Friday Okonofua

La Conférence Internationale sur la Population et le Développement (CIPD) a été un événement historique qui a modifié l'accent mis sur la croissance de la population comme préoccupations pour le mettre sur l'engagement à l'équité en matière de la reproduction, les droits et la justice sociale dans la mise en Œuvre de toutes les composantes de santé de la reproduction. Il a placé les femmes au centre de la scène du développement, en créant une fondation justifiable pour les femmes d'avoir accès à des contraceptifs modernes sûrs et abordables. La CIPD a positionné la planification familiale comme un droit humain fondamental de tous les couples sexuellement actifs, tout en espérant que la nouvelle approche poussera les efforts et conduira à une utilisation et une acceptation de la planification familiale améliorée par les femmes qui en ont besoin.

Depuis la CIPD, l'évidence a montré que, de fait, les taux de prévalence de la contraception (TPC) ont augmenté dans le monde entier entre 1990 et 2013, avec une diminution parallèle des besoins non satisfaits en planification familiale1,2. La plupart des modifications de ces paramètres se sont produites dans les années 1990, avec une augmentation moins rapide de taux de prévalence de la contraception (TPC) et une diminution des besoins non satisfaits qui s'est produite entre 2003 et 2012. Cependant, bien que les augmentations de la prévalence de la contraception aient également eu lieu dans les pays africains au cours de la période, les hausses ont été moins importantes par rapport à d'autres régions. Le TPC est resté faible en Afrique Centrale et Occidentale, avec peu de changements qui se produisent à l'égard des besoins non satisfaits qui sont restés autour de 20% entre 1990 et 2010. La lenteur du progrès en TPC et les besoins non satisfaits en Afrique a conduit certaines personnes à penser que les principes de la CIPD n'ont pas marché dans la région. Avec l'importance croissante accordée à la planification familiale à la fois à partir de la reconnaissance de l'impact possible du changement climatique sur la limitation des ressources (avec l'Afrique étant la plus susceptible de porter le plus grand poids)3 et les projections faites sur le nombre croissant des femmes qui auront besoin de la planification familiale après 2014 (surtout dans la région de l'Afrique)4, il y a un appel à de nouvelles approches pour combler les lacunes dans la prestation de la planification familiale et l'accès en Afrique. En effet, l'engagement pris par les dirigeants du monde vers une action accéléré pour assurer la prestation de la planification familiale pour 120 millions de femmes et de filles de plus au cours du Sommet de Londres en 2013 témoigne de cette nécessité d'une action galvanisée et accélérée.

De nombreux facteurs expliquent la lenteur du progrès dans les indices de la planification familiale dans le continent africain au cours des deux dernières décennies. Il s'agit notamment de la faible adoption des principes de la CIPD étant donné que beaucoup de femmes africaines souffrent encore des effets de l'exclusion sociale, de la marginalisation et de la discrimination; la nature de la planification familiale qui s'appuie sur des bailleurs de fonds fait que de nombreux gouvernements africains s’engagent peu aux principes et à la pratique de la planification familiale; des efforts limités pour répondre à la qualité des soins des services disponibles vu les cliniques qui manquent encore de personnel qualifié, une constellation de produits et des approches favorables aux jeunes; le manque d'intégration de la planification familiale à des problèmes de reproduction élevés qui prévalent en matière de santé tels que la prévention et les soins du VIH / SIDA; et peu d'attention accordée à la...
lutte contre les facteurs de fond qui animent la faible utilisation de la planification familiale en Afrique tels que l'ignorance, l'analphabétisme, la pauvreté et les croyances et les pratiques culturelles néfastes.

Quatre articles de ce numéro de la Revue africaine de santé de la reproduction fournissent la preuve des efforts réalisés dans diverses parties de la région afin de comprendre le contexte de la prestation de la planification familiale en Afrique qui sont nécessaires pour identifier de nouvelles approches pour améliorer les indices clés du développement. L'article de Olatoregun et ses collègues fait une comparaison des différences de fécondité entre le Ghana et le Nigeria et conclut que les préférences pour une fécondité élevée sont encore dominantes dans les deux pays, tandis que l'article par Kuang explique comment des couples en Ouganda sont motivés à utiliser la planification familiale en se servant des techniques fondées sur l'auto-motivation et les droits. Bien que les contraceptifs injectables appartiennent au groupe des méthodes de deuxième niveau selon l'OMS en termes de l'efficacité des méthodes, ils constituent souvent les méthodes les plus préférées par les femmes africaines. L'article de Nakayiza et ses collègues de l'Ouganda décrit comment la source d'un contraceptif injectable influe l'utilisation de la méthode par les femmes rurales. Il souligne la nécessité d'intégrer les besoins et les considérations locaux dans la conception et la mise en œuvre des programmes de la planification familiale en Afrique. Malgré la forte prévalence du VIH / SIDA en Afrique, il y a eu peu d'efforts systémiques pour comprendre la nécessité de la famille des populations touchées et à concevoir des programmes pour répondre à leurs besoins. L'article de Sarah Gutin et ses collègues de l'Ouganda est actuellement l'un des rares données empiriques disponibles qui étudie les désirs de la fécondité des femmes séropositives dans la période post-partum.

Cependant, ces articles sont une bonne exposition de la nature du problème, mais ils n’indiquent qu’une direction limitée. Il est nécessaire d’identifier des approches systémiques pour améliorer la disponibilité et l'utilisation des contraceptifs dans le continent africain après 2014.

En conclusion, la planification familiale est un facteur important dans les efforts visant à favoriser le développement, à réduire la mortalité maternelle constitué des 17 points qui est proposé pour le développement du monde après 2014 semble être un bon point de départ étant donné qu’il comprend beaucoup de questions qui s’occuperont du fond social et les facteurs sociaux et économiques qui influent sur une mauvaise utilisation de la planification familiale en Afrique. Cependant, ce qui sera le plus important et crucial, c’est l’engagement politique des gouvernements nationaux à mettre en œuvre les solutions contenues dans le programme de développement durable, et aussi de devoir le processus de changement en termes de fourniture accrue de la planification familiale. La plupart des gouvernements africains ont montré leur faible engagement aux services de la planification familiale au cours des deux dernières décennies, en partie en raison de leur conflit interne et les croyances au sujet de la planification familiale et aussi à cause de leur ordre de priorité limitée des questions de santé et de développement social. Les trois pays qui ont démontré un engagement politique puissant au développement et à la planification familiale au cours des dernières années - l’Éthiopie, le Rwanda et le Malawi - ont également connu la croissance la plus rapide du TPC et un déclin des besoins non satisfaits, qui témoignent de l'importance de l'engagement politique et le leadership dans la promotion du développement social sur le continent africain. D'autres facteurs dont l’on devraient s’occuper pour augmenter ses prestations de la planification familiale et de l’accès en Afrique comprennent: un financement accru indigène de la planification familiale (plutôt que de dépendre du financement des bailleurs de fonds), l'augmentation de la sensibilisation du public et la sensibilisation à l'utilisation des champions notables et l'établissement des partenariats, l’assurance des services par la communauté (y compris l'utilisation de la délégation des tâches), le renforcement des systèmes de santé, la promotion de l'inclusion des jeunes et des hommes dans la planification familiale, et l'intégration des services de planification familiale à d'autres services de santé de la reproduction tels que le VIH / sida.

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et à promouvoir le bien-être et le développement social des femmes et des jeunes en Afrique. La période 1990-2013 a connu une croissance lente des indices de la planification familiale en Afrique, mais la période 2014 et au-delà offre une nouvelle possibilité de pousser les efforts pour accélérer la tendance. Le programme de développement durable proposé pour le développement du monde après 2014 est un bon point d'entrée, mais l'engagement politique est indispensable à la fois pour mettre en œuvre l'ordre du jour et aussi de privilégier la mise en œuvre des programmes de la planification familiale et du développement social en Afrique. Alors qu'on ne diminue pas l'importance des autres domaines du développement, il est prévisible que la planification familiale serait la pièce maîtresse de la croissance et de la planification du développement dans la région de l'Afrique dans les années qui viennent.

Conflit d'intérêts
Aucun

Références
COMMENTARY

Does Access to Antiretroviral Drugs Lead to an Increase in High-Risk Sexual Behaviour?

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Keywords: Antiretroviral, ARV, HIV, sexual behaviour, sub-Saharan Africa.

Over the last few years the fight against the HIV epidemic appears to be yielding increasingly positive results: the number of people surviving and living with HIV has been on the rise and, overall, the numbers of new infections have been on a steady path of decline. This progress is largely attributed to the increased accessibility to antiretroviral therapy (ART). Not only does ART improve the length and quality of life, the drugs are an important tool in suppressing HIV viral loads, thus reducing a) opportunistic infections such as Tuberculosis; b) transmission of HIV from a mother to her child; and c) transmission of HIV via sexual contact. These reasons have led to the emergence of a ‘treatment as prevention’ approach to tackling the epidemic, which urges for a scale-up in ART distribution worldwide. Initiatives such as that of the U.S. PEPFAR (President’s Emergency Plan for AIDS Relief), have advanced this strategy by making antiretroviral drugs exponentially accessible in low-income public health systems.

However, at this point the impact of the large-scale distribution of antiretroviral drugs needs to be critically examined – the positives have been outlined above so let us take a look at another potential facet altogether. First let us agree that the large-scale influx of ART is changing the perception of HIV: from a disease inevitably incurring suffering and death to a less feared and pronounced chronic disease. With this in mind we should thus venture to ask ourselves: could this lowered anxiety associated with HIV and AIDS lead to an increase in population-wide high-risk sexual behaviour (either because HIV transmission appears to be less likely - since HIV carriers are no longer as visibly distinguishable as they once would have been - or because HIV is no longer perceived to be the death sentence it once was)?

There has been very little research on the potential impact of large-scale ART distribution on the sexual behaviour of a general population (comprising of both HIV infected and uninfected people). During the 1990’s, some high-income countries reported an increase in high-risk sexual behaviour amongst men who have sex with men when antiretroviral drugs were made extensively accessible in their public health systems1,2,3. Although inconclusive, more recent studies exploring heterosexual behaviour amongst non-ART users (that consist of both HIV infected and uninfected people) in low-income settings suggest that access to ART may have led to an increase in risky behaviour4,5,6. Nevertheless, perhaps because ART availability in these settings is relatively recent, the scarcity of available research documenting the potential association between ART access and sexual disinhibition is striking. One retrospective study on a clinical cohort established between 2002 and 2009 in rural South-western Uganda suggests that the availability of HIV treatment may have led to an increase in risky behaviour7. However, this finding was inconsistent across the chosen behavioural indicators.

The importance of investigating the relationship between ART and population-wide sexual behaviour cannot be underestimated: ART access is going to be scaled up globally8 over the foreseeable future and an increase in high-risk

sexual conduct due to the false feeling of safety that ART may provide (either because HIV transmission appears to be less likely - since HIV carriers are no longer as visibly distinguishable as they once would have been - or because HIV is no longer perceived to be the death sentence it once was) would radically impact on the epidemiology of the HIV epidemic. But just to be clear: the increased distribution of ART should NOT be scaled down - its benefits are invaluable and making these drugs universally available is the only correct thing to do. However, if research conducted on this topic indicates that it may lead to an increase in high-risk sexual behaviour, then health education and a message of ‘prevention’ – which worked effectively in some settings over the past couple of decades - needs to be modernized and brought back to the fore to co-exist hand in hand with increased access to ART.

The Lancet highlights that HIV prevention is not simple but successful campaigns include goals that must include “knowledge, stigma reduction, access to services, delay of onset of first intercourse, decrease in number of partners, increases in condom sales or use, and decreases in sharing of contaminated injection equipment”9. Indeed, education and effective behavioural change programmes have been attributed to reduced rates of HIV infection in – amongst others – Uganda, Senegal, Brazil, Côte d’Ivoire, Kenya, Malawi, Tanzania, Zimbabwe, Botswana, Burkina Faso, Namibia, Swaziland, Burundi, Haiti, and Rwanda9. For instance, one combinatorial preventive program that was adopted across some countries to prevent the sexual transmission of HIV during the early stages of the epidemic was one that promoted three specific behavioural changes (Abstinence, Being faithful, and Condom use) – the ABC program10. Uganda’s case in point is important to highlight in light of the fact that, in the 1990’s, a combination of strategies focusing on abstinence, faithfulness, as well as the widespread distribution of condoms was promoted by the government and resulted in a fall in the annual number of HIV incidence and a drop in HIV prevalence rate from 15% in 1991 to 5% in 200111.

The success of such education programs should not be forgotten but rather should evolve to include the advent and accessibility of ART in order to ensure we continue to advance assuredly in our combat against the HIV epidemic.

References
Abortion Care in Ghana: A Critical Review of the Literature

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Abstract

The Government of Ghana has taken important steps to mitigate the impact of unsafe abortion. However, the expected decline in maternal deaths is yet to be realized. This literature review aims to present findings from empirical research directly related to abortion provision in Ghana and identify gaps for future research. A total of four (4) databases were searched with the keywords “Ghana and abortion” and hand review of reference lists was conducted. All abstracts were reviewed. The final include sample was 39 articles. Abortion-related complications represent a large component of admissions to gynecological wards in Ghana as well as a large contributor to maternal mortality. Almost half of the included studies were hospital-based, mainly chart reviews. This review has identified gaps in the literature including: interviewing women who have sought unsafe abortions and with healthcare providers who may act as gatekeepers to women wishing to access safe abortion services. (Afr J Reprod Health 2014; 18[3]: 17-35)

Keywords: Abortion, Ghana, Review

Résumé

Le gouvernement du Ghana a pris des mesures importantes pour atténuer l'impact de l'avortement à risque. Cependant, la baisse attendue de la mortalité maternelle est encore à réaliser. Cette revue de la documentation a pour but de présenter les résultats de recherches empiriques directement liés à la prestation de l'avortement au Ghana et d'identifier les lacunes de la recherche future. Un total de quatre (4) bases de données ont été recherchées avec les mots clés "Ghana et l'avortement" et la révision à main des listes de référence a été menée. Tous les résumés ont été examinés. Le dernier échantillon comprenait 39 articles. Les complications liées à l'avortement représentent une composante importante des admissions en services de gynécologie dans les hôpitaux au Ghana ainsi que d'un grand contributeur à la mortalité maternelle. Presque la moitié des études incluses ont été en milieu hospitalier, principalement l'examen des dossiers. Ce compte rendu a identifié des lacunes dans la documentation, y compris: interviewer les femmes qui ont recherché des avortements à risque et avec les fournisseurs de soins de santé qui peuvent agir comme gardiens de femmes qui souhaitent avoir accès aux services d'avortement sans risque. (Afr J Reprod Health 2014; 18[3]: 17-35)

Mots-clés: avortement, Ghana, Revue

Introduction

Maternal mortality is a large and un-abating problem, mainly occurring in the developing world. According to the World Health Organization (WHO), the United Nations Children’s Fund (UNICEF), UNFPA and the World Bank, 287,000 women die each year worldwide from pregnancy-related causes1. Sub-Saharan Africa has the highest maternal mortality ratio in the world of 500 per 100,000 births. WHO estimates 47,000 of these deaths per year are attributable to unsafe abortion, making abortion a leading cause of maternal mortality2. Not all unsafe abortions result in death, disability or complications. The morbidity and mortality associated with unsafe abortion depend on the method used, the skill of the provider, the cleanliness of the instruments and environment, the stage of the woman’s pregnancy and the woman’s overall health3. It is estimated that 5 million women per year from the developing world are hospitalized for complications resulting from unsafe abortions, resulting in long and short-term health problems4. The health consequences and burdens resulting from unsafe abortion disproportionately affect women in Africa5.

Unsafe abortion is defined by WHO as a procedure for terminating an unintended pregnancy carried out either by persons lacking the
necessary skills or in an environment that does not conform to minimum medical standards, or both\textsuperscript{6}. Approximately 21.2 million unsafe abortions occur each year in developing regions of the world\textsuperscript{1-7}. Over 99\% of all abortion-related deaths occur in developing countries. In sub-Saharan Africa, one in 150 women will die from complications of this procedure\textsuperscript{6}.

Although only 24\% of abortions worldwide are performed in sub-Saharan Africa, almost half of deaths related to this procedure occur in the region\textsuperscript{4,8}. In many countries in sub-Saharan Africa women’s access to safe abortion and post-abortion care for complications is hampered by restrictive laws, socio-cultural barriers, and inadequate resources to provide safe abortion\textsuperscript{4,9-12}.

The UN Millennium Development Goal (MDG) number 5 aims to reduce by three quarters the number of maternal deaths in the developing world. Without tackling the problems of unsafe abortion MDG 5 will not be reached\textsuperscript{13,14}.

**Ghana**

Ghana, a country in West Africa, has a population of approximately 24 million people. The average per capita income is approximately $1810\textsuperscript{15}, placing Ghana in the middle income bracket. Ghana has a similar pattern of health as other countries in the region, characterized by a persistent burden of infectious disease among poor and rural populations, and growing non-communicable illness among the urban middle class. Following generalized progress in child vaccination rates through the 1980s and 1990s, and corresponding declines in infant and child mortality (from 120/1000 in 1965 to 66/1000 in 1990), progress has stalled maternal and under 5 indicators in rural areas in the past decade. The national under-five mortality rate remains at 78 deaths/1,000 live births\textsuperscript{16}. Maternal death is currently estimated at 350 per 100,000 live births\textsuperscript{17}. In Ghana, abortion complications are a large contributor to maternal morbidity and mortality. According to the Ghana Medical Association, abortion is the leading cause of maternal mortality, accounting for 15-30\% of maternal deaths\textsuperscript{18,19}. Further, for every woman who dies from an unsafe abortion, it is estimated that 15 suffer short and long-term morbidities\textsuperscript{20}.

Compared to other countries in the region, the laws governing abortion in Ghana are relatively liberal. Safe abortion, performed by a qualified healthcare provider, has been part of the Reproductive Health Strategy since 2003\textsuperscript{19,21}. When performed by well-trained providers in a clean environment, abortion is one of the safest medical procedures with complications estimated at 1 in 100,000\textsuperscript{5}.

Currently in Ghana, abortion is a criminal offense regulated by Act 29, section 58 of the Criminal code of 1960, amended by PNDCL 102 of 1985\textsuperscript{22}. However, section 2 of this law states abortion may be performed by a registered medical practitioner when; the pregnancy is the result of rape or incest, to protect the mental or physical health of the mother, or when there is a malformation of the fetus. The government of Ghana has taken steps to mitigate the negative effects of unsafe abortion by developing a comprehensive reproductive health strategy that specifically addresses maternal morbidity and mortality associated with unsafe abortion\textsuperscript{23}.

Further, since midwives have been shown to safely and effectively provide post-abortion care in South Africa\textsuperscript{24} and Ghana\textsuperscript{19} a 1996 policy reform has allowed midlevel providers with midwifery skills to perform this service in Ghana\textsuperscript{25}. To ensure these providers have the skills necessary to perform the service, in 2009, Manual Vacuum Aspiration (MVA) was added to the national curriculum for midwifery education to train additional providers in this life-saving technique.

However, even with the liberalization of the law and the training of additional providers, abortion-related complications remain a problem. This integrated literature review aims to present findings from empirical research directly related to abortion provision, complete abortion care, or post-abortion care in Ghana and identify gaps for future research.

**Search Strategy**

The Pubmed, Ovid Medline, Global Health and Popline databases were searched with the keywords “Ghana & abortion”. Pubmed returned 80 articles, Ovid Medline returned 70, Global Health returned 40 articles and Popline returned 78 articles, many of which overlapped. All titles and
abstracts were reviewed. Inclusion criteria were: 1) English-language research articles; 2) published in a peer-reviewed journal after 1995; and 3) directly measured abortion services or provision. Manuscripts that only briefly mentioned abortion, commentaries, and literature reviews were not included in the final sample. A total of 39 articles met inclusion criteria and are included in this review (Figure 1).

Figure 1. Search result

Results

Complications and Admissions to Gynecology Ward: Abortion-related complications are repeatedly found to represent a large component of admissions to gynecological wards in hospitals in Ghana. Abortion complications resulted in 38.8%, 40.7%, 42.7% and 51% of all admissions to these wards in the articles reviewed for this paper. The majority of admissions were for the treatment of spontaneous abortion, although induced abortion is notoriously under-reported\(^4,12,26,30\), and many women who reported spontaneous abortions had history that indicated induced abortion\(^31\). Sundaram and colleagues\(^32\) estimated that only 40% of abortions were reported in the 2007 Ghana Maternal Health Survey, even when participants were explicitly asked about their experiences with induced abortions. Full results are provided in Table 1.
<table>
<thead>
<tr>
<th>Authors and Year</th>
<th>Title, Journal</th>
<th>Findings</th>
<th>Study Design</th>
<th>Study Setting</th>
<th>Strengths and limitations</th>
<th>Database retrieved from</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Morhe ESK, Tagbor HK, Ankobea F, Danso KA. 2012</td>
<td>Reproductive experiences of teenagers in the Ejisu-Juabeng district of Ghana. <em>International Journal of Gynecology and Obstetrics</em></td>
<td>Teenagers have their sexual debut at young ages, 36.7% of the females have had at least one abortion.</td>
<td>Cross-sectional survey community-based survey.</td>
<td>Ejisu-Juabeng district of Ghana.</td>
<td>There were no questions asked as to the processes undertaken to obtain abortions.</td>
<td>Global Health, Popline</td>
</tr>
<tr>
<td>2. Lee QY, Odoi AT, Opare-Addo H, Dassah ET. 2012</td>
<td>Maternal mortality in Ghana: a hospital-based review. <em>Acta Obstetricia et Gynecologica Scandinavica</em></td>
<td>Genital tract sepsis, often as a result of an abortion, had the highest case-fatality rate of all the causes of maternal death in this study.</td>
<td>Secondary data analysis of patient charts</td>
<td>Komfo Anokye Teaching Hospital</td>
<td>Comments are made that are not supported by data or references, such as, “Social stigma plays a role in preventing vulnerable women from accessing safe abortion services.” Reasons behind not accessing safe abortion services need to be investigated.</td>
<td>Reference List</td>
</tr>
<tr>
<td>3. Ganyaglo GYK, Hill WC. 2012</td>
<td>A 6-year (2004-2009) review of maternal mortality at the East Regional Hospital, Koforidua, Ghana. <em>Seminars in Perinatology</em></td>
<td>Abortion complications were the second leading cause of maternal mortality, behind post-partum hemorrhage. The largest proportions of post-abortion deaths were due to sepsis (29 of the 37 post-abortion deaths).</td>
<td>Secondary analysis of Obstetrics and Gynecology ward admission and discharge books, triangulated against minutes from maternal death audit meetings and midwifery returns. Patient folders were available for 2009 only.</td>
<td>Koforidua Regional Hospital, Eastern Region</td>
<td>This is the first hospital-based study outside a major teaching hospital.</td>
<td>Global Health</td>
</tr>
<tr>
<td>4. Sundaram A, Juarez F, Bankole A, Singh S. 2012</td>
<td>Factors associated with abortion-seeking and obtaining an unsafe abortion in Ghana. <em>Studies in</em></td>
<td>Almost half of all reported abortions were conducted unsafely. The profile of women who seek an abortion is: unmarried, in their 20s, have no children, have terminated a pregnancy.</td>
<td>Nationally representative survey</td>
<td>Maternal Health Survey</td>
<td>This study uses nationally-representative data to investigate safe and unsafe abortion seeking. However, abortion is under-reported, and</td>
<td>Ovid Medline, Global Health PubMed</td>
</tr>
</tbody>
</table>
### Abortion Care in Ghana

**Family Planning**

- Younger women were less likely to seek a safe abortion, as were women of low SES and those in rural areas. A partner paying for the procedure was associated with seeking a safe abortion.

<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>Methods</th>
<th>Setting</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Krakowiak-Redd D, Ansong D, Otupiri E, Tran S, Klandemad D, Boakye I, Dickerson T, Crookston B 2011</td>
<td>Family planning in a sub-district near Kumasi, Ghana: Side effect fears, unintended pregnancies and misuse of medication as emergency contraception. <em>African Journal of Reproductive Health</em></td>
<td>Cross-sectional community-based survey</td>
<td>Barekese sub-distict in the Ashanti Region</td>
<td>A relatively small sample size (n=85) of only women. There was a qualitative component, but not about abortion-related issues.</td>
</tr>
<tr>
<td>6. Aniteye P, Mayhew S. 2011</td>
<td>Attitudes and experiences of women admitted to hospital with abortion complications in Ghana. <em>African Journal of Reproductive Health</em></td>
<td>Structured survey with 131 women with incomplete abortions.</td>
<td>Gynecology ward, Korle Bu and Ridge Hospitals.</td>
<td>The great majority of women were young and single. The majority of women had help performing their abortion and most accessed post-abortion care at a health facility shortly after experiencing complications.</td>
</tr>
<tr>
<td>7. Gumanga SK, Kolbila DZ, Gandau BBN, Munkaila A, Malechi H, Kyei-Aboagye K 2011</td>
<td>Tends in maternal mortality in Tamale Teaching Hospital, Ghana. <em>Ghana Medical Journal</em></td>
<td>Hospital records from January 1 2006-December 2010.</td>
<td>Tamale Teaching Hospital</td>
<td>The institutional maternal mortality rate was 1018 per 100,000 live births was recorded between 2006 and 2010. Complications from unsafe abortion was the leading cause of maternal death for youngest women, and the 4th leading cause overall.</td>
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**Notes:**
- Cross-sectional community-based survey
- Barekese sub-distict in the Ashanti Region
- A relatively small sample size (n=85) of only women. There was a qualitative component, but not about abortion-related issues.
- Structured survey with 131 women with incomplete abortions.
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<th>Reference</th>
<th>Title</th>
<th>Description</th>
<th>Journal/Database</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Biney AAE 2011</td>
<td>Exploring contraception knowledge and use among women experiencing induced abortion in the Greater Accra region, Ghana. African Journal of Reproductive Health</td>
<td>Many respondents noted that prior to their induced abortion, they had no knowledge about contraception, but since the abortion they had been using it. Women also mentioned feeling contraception was more dangerous to their health than was induced abortion. 24 semi-structured individual interviews were conducted with women who were being treated and reported having experience with induced abortion.</td>
<td>Gynecology wards, Tema General Hospital and Korle Bu Teaching Hospital. This study was mainly about contraception, and so access to abortion services were not investigated. Ovid Medline, Global Health, PubMed, Popline</td>
</tr>
<tr>
<td>10. Mac Domhnaill B, Hutchinson G, Milev A, Milev Y. 2011</td>
<td>The social context of school girl pregnancy in Ghana, Vulnerable Children and Youth Studies</td>
<td>Student’s knowledge of abortive methods was considerably more detailed than their knowledge of contraception. Many explicitly mentioned not using contraception because they knew how to abort a pregnancy if necessary. Participants note local and herbal methods of abortions, although they admitted they were dangerous. Abortion is seen by these participants as an unfortunate fact of being sexually active. Focus group discussions in both rural and peri-urban settings.</td>
<td>Ho, Ghana. The focus-group methodology enables students to talk among themselves about sexual relationships. Global Health</td>
</tr>
<tr>
<td>11. Schwandt HM, Creanga AA, Danso KA, Adanu RMK, Agbenyega T, Hindin MJ 2011</td>
<td>A comparison of women with induced abortion, spontaneous abortion and ectopic pregnancy in Ghana. Contraception</td>
<td>N= 585. Majority reported spontaneous abortion between June and July 2008. Those with reported induced abortion were more likely to have more power in their relationships and to have not disclosed the index pregnancy to their partners. Surveys administered by nursing and midwifery students with women being treated for abortion complications.</td>
<td>Gynecology emergency wards, Korle Bu and KATH. This is one of the only studies to look at male-female relationships and how these impact reproductive health decision making. Ovid Medline, Global Health, PubMed</td>
</tr>
<tr>
<td>12. Mote CV, Otupiri E, Hindin MJ. 2011</td>
<td>Factors associated with induced abortion among women in 408 community-based surveys</td>
<td>One-fifth (21.3%) of respondents reported having had an induced abortion. Most common reasons for 408 community-based surveys</td>
<td>Hohoe, Volta Region. Using community-based surveys gets a broader population than hospital-based. Global Health, PubMed</td>
</tr>
<tr>
<td>Year</td>
<td>Location</td>
<td>Study Details</td>
<td>Results/Findings</td>
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<tr>
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<td>2010</td>
<td>Hohoe, Ghana</td>
<td>&quot;not to disrupt education or employment&quot; and &quot;too young to have a child.&quot; 65.5% performed by a medical doctor, 31% by partners or friends. 60.9% in a hospital, 29.9% at home. 50.6% used sharps or hospital instruments, 31% used herbs.</td>
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<td>2010</td>
<td>Hohoe, Ghana</td>
<td>Only 18.9% of the tutors surveyed knew all the legal indications under which safe abortion could be provided. These tutors were not taught manual vacuum aspiration during their training.</td>
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<td>2010</td>
<td>Midwifery tutors’ capacity and willingness to teach contraception, post-abortion care, and legal pregnancy termination in Ghana.</td>
<td></td>
<td>74 midwifery tutors from all 14 public midwifery schools were surveyed.</td>
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<td>2010</td>
<td>74 of 123 selected tutors returned the survey, giving a response rate of 60.2%. Importantly documented the lack of complete knowledge of the law, even among midwifery tutors.</td>
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<tr>
<td>2010</td>
<td>Family planning, abortion and HIV in Ghanaian print media: A 15-month content analysis of a national Ghanaian newspaper.</td>
<td>This analysis showed that family planning, abortion and HIV received less than 1% of total newspaper coverage in one national Ghanaian newspaper.</td>
<td>Content analysis of the Daily Graphic newspaper.</td>
</tr>
<tr>
<td>2010</td>
<td></td>
<td>This analysis shows that local speculations that the quantity and prominence of reproductive health issues are neglected in local newspapers are warranted.</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>Return on investment for essential obstetric care training in Ghana: Do trained public sector midwives deliver postabortion care?</td>
<td>The availability of PAC in Ghana remains limited. Far fewer midwives than physicians offer PAC, even after having received PAC clinical training, although an analysis of the curriculum and training was outside the scope of this study.</td>
<td>Secondary data analysis of 2002 Ghana Service Provision Assessment survey. 428 health facilities working in 1448 health facilities were surveyed.</td>
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<td>2010</td>
<td></td>
<td>Nationally-representative sample of health facilities and health providers</td>
<td>Information about supplies available at the clinics, as well as whether the providers were offering CAC services, were not available in the dataset.</td>
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<td>2010</td>
<td>Interviews with 24 midwives and 16</td>
<td>Data gathered in seven of the ten regions of the country. Interviews with a wide range of stakeholders is a major concern.</td>
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<td>74 of 123 selected tutors returned the survey, giving a response rate of 60.2%. Importantly documented the lack of complete knowledge of the law, even among midwifery tutors.</td>
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<td>2010</td>
<td>Family planning, abortion and HIV in Ghanaian print media: A 15-month content analysis of a national Ghanaian newspaper.</td>
<td>This analysis showed that family planning, abortion and HIV received less than 1% of total newspaper coverage in one national Ghanaian newspaper.</td>
<td>Content analysis of the Daily Graphic newspaper.</td>
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<td>2009</td>
<td>Rominski &amp; Lori</td>
<td><strong>Abortion Care in Ghana</strong></td>
<td>Low-volume, low-income providers. Although many of the midwives in rural areas had the skills to provide MVA, they did not have the equipment and thus continued to refer women to district or regional hospitals.</td>
</tr>
<tr>
<td>2009</td>
<td>Hill ZE, Tawiah-Agyemang C, Kirkwood B.</td>
<td>The context of informal abortions in rural Ghana. <em>Journal of Women’s Health.</em></td>
<td>Key themes were related to the perception of abortions as illegal, dangerous, and bringing public shame and stigma but also being perceived as common, understandable, and necessary. None of the respondents knew the legal status of abortion, with most reporting that it was illegal.</td>
</tr>
<tr>
<td>2009</td>
<td>Konney TO, Danso KA, Odoi AT, Opare-Addo HS, Morhe ESK.</td>
<td>Attitudes of women with abortion-related complications toward provision of safe abortion services in Ghana. <em>Journal of Women’s Health.</em></td>
<td>Abortion-related complications accounted for 42.7% of admissions to the gynecological ward at KATH, 28% of whom indicated an induced abortion. 92% of the women interviewed were not aware of the law regarding abortion in Ghana. Most felt that there was a need to establish safe abortion services in Ghana.</td>
</tr>
<tr>
<td>2009</td>
<td>Oliveras E, Ahiadeke C, Adanu RM, Hill AG</td>
<td>Clinic-based surveillance of adverse pregnancy outcomes to identify induced abortion in Accra, Ghana. <em>Studies in Family Planning.</em></td>
<td>1,636 women completed the questions. Younger, better educated and unmarried women are more likely to have had an induced abortion. Between 10-17.6% of women report having had an abortion. Women seeking care at a private facility were more than twice as likely to have ended their previous pregnancy by induced abortion.</td>
</tr>
<tr>
<td>2009</td>
<td>Mills S, Williams JE</td>
<td>Maternal Mortality Decline in the Northern Region</td>
<td>Abortion-related deaths were the most frequent cause of maternal deaths in family members of all maternal deaths between 2005-2007. The first study to investigate the attitudes of women being treated for abortion complications towards the provision of safe abortion services in Ghana. Although this technique does not measure prevalence or lifetime exposure to abortion, it is another way to investigate abortion. Further work to elucidate differential responses based on healthcare provider asking is important.</td>
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<td>21. Morhe ESK, Morhe RAS, Danso KA 2007</td>
<td>Attitudes of doctors toward establishing safe abortion units in Ghana</td>
<td>Most physicians were supportive of playing some role in developing safe abortion units in hospitals in Ghana. However, only 54% of maternal and child health-related health workers were aware of the true nature of the abortion law, with 35% believing that the law permits abortion only to save the life of the woman. More than 50% of the workers reported they would be unwilling to play a role in performing pregnancy terminations.</td>
<td>Cross sectional survey of 74 physicians at KATH Komfo Anoye Teaching Hospital, Kumasi. The attitudes of health care providers is an important area to investigate due to the barriers these people can represent.</td>
</tr>
<tr>
<td>22. Adanu RMK, Ntumy MN, Tweneboah E. 2005</td>
<td>Profile of women with abortion complications in Ghana</td>
<td>31% of the study population presented for complications from induced abortion. Those seeking care for induced abortion were younger, or lower parity, more education, less likely to be engaged in income-generating activity, in less stable relationships and had more knowledge of modern contraception than those presenting for treatment from spontaneous abortion.</td>
<td>Cross-sectional survey of 150 patients being treated for abortion complications. The determination of induced versus spontaneous abortion was reliant on self-report, which the authors note may be under-reported.</td>
</tr>
<tr>
<td>23. Baiden F, Amponsa-Achiano K, Oduro AR, Melsah TA, Baiden R, Hodgson A. 2008</td>
<td>Unmet need for essential obstetric services in a rural district northern Ghana: Complications of unsafe abortions remain a major cause</td>
<td>Complications from abortion were the leading cause of maternal mortality. Although abortion is considered taboo in NKD, according to clinic evidence, there is a high incidence of backstreet and unsafe practices. The district hospital did not have any access to secondary data analysis from chart review of all maternal deaths from January 2001 to December 2003 at the district hospital in Kassena-Nankana. Established abortion-related deaths are the leading cause of maternal deaths. Further research including all members of a woman’s community needs to be conducted to fully understand the social and</td>
<td>Secondary data analysis from chart review of all maternal deaths from January 2001 to December 2003 at the district hospital in Kassena-Nankana district in the Northern Region.</td>
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