Barriers to Contraceptive Use and Medication Abortion in the Ga East District of Greater Accra, Ghana

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Background: A recent DHS report from Ghana shows that both the contraceptive prevalence and total fertility rate have declined over the past five years. At the same time, Ghana is one of few African nations where abortion is legal. Despite this fact, few people in Ghana are aware of its legality. The use of Cytotec (a restricted Class A ulcer medication) as an abortifacient has been documented in nationally representative surveys in Ghana, yet little is known about the way in which pregnant women obtain this drug. Though it seems likely that abortion is increasing as a means of fertility control in Ghana, little is known about potential new barriers to contraceptive use in the country.

Objective: To examine facility-level barriers to contraceptive use and to explore facility- and provider-level provision of Cytotec in a peri-urban district of Greater Accra.

Methods: Using a semi-structured questionnaire derived from the DHS Service Provision Assessment (SPA), we collected facility-level data on contraceptive stocks, logistics, use, cost, and other quality-of-care measures from 12 clinics and 11 pharmacies/chemical shops. Additional non-SPA questions were added to the questionnaire to probe providers regarding the request for and provision of Cytotec, as well as its associated cost and regimen. Clinics and pharmacies/chemical shops were sampled from all four sub-districts of the Ga East district. Seven of the clinics were purposively sampled because of their status as government-funded clinics. An additional four clinics and one maternity home were sampled from a total pool of 24 private clinics in the district. No enumerated list of pharmacies was available within the district, therefore we created an enumeration and sampling scheme for each sub-district to provide some element of random sampling. A total of 24 facilities were approached, 23 of which agreed to participate in the survey, producing a response rate of 96%. Of the 23 attempted interviews, 21 were completed in full, a completion rate of 91%. The following table depicts the distribution of facilities across sub-districts:

Table 1: Facility count by sub-district and type

	Danfa	Dome	Madina	Taifa
Govt. clinic	3	1	3	N/A
Private clinic	0	1	2	1
Maternity home	0	0	1	0
Pharmacy	2	2	4	1
Chemical shop	1	0	0	1

Results:

Contraceptives—

Eighty-six percent of government clinics offer at least one modern contraceptive compared to only 60 percent of private clinics. Government clinics also have a much greater method-mix, with an average of 6.3 methods offered at each government clinic compared to an average of 2.0 methods at each private clinic. Government clinics charge no money for family planning consultations, while private clinics charge an average of 8.75 cedis (6.03 US dollars) for new clients and 5.5 cedis (3.79 US dollars) for returning clients. The cost of purchasing a method following this consultation also varies greatly depending on public versus private sector. For example, IUDs cost 31 cedis (21.38 US dollars) on average in a private clinic compared to 1.5 cedis (1.03 US dollars) in a government clinic.

Eighty-nine percent of pharmacies report selling contraceptives, with male condoms being the fastest-selling method, followed by emergency contraception (EC). The majority of pharmacies and chemical shops stock an identical milieu of contraceptives, including socially-marketed male condoms, socially-marketed combined oral contraceptive pills (OCPs), spermicide, and emergency contraception. The female condom is no longer sold in Ga East pharmacies and chemical shops due to low patronage and a reported misuse of the product by teenage girls. Aside from the combined OCP, which is equally well-patronized at pharmacies and government clinics alike, there appears to be a stark partitioning of methods between healthcare outlets. For example, pharmacies and chemical shops do not stock progestin-only pills and rarely stock Depo-Provera, while conversely, clinics either do not stock or report very low patronage of male condoms, spermicide, and emergency contraception. Aside from the partitioning of methods, poor information may also serve as a barrier to some women's use of family planning. Medical counter assistants (MCAs) acting in place of an on-site pharmacist often provided misinformation regarding correct usage of the OCP.

Table 2: Percentage of facilities providing each method by facility-type (%)

	COCP	PO-OCP	IUD	3-mo. inject.	1-mo. inject.	Jadelle	Male Condom	Fem. Condom	Sperm.	EC	Rhythm	Fem. Ster.
Government Clinic	86	86	43	86	86	14	71	57	14	29	43	14
Private Clinic	0	0	25	25	0	0	25	0	0	0	50	50
Maternity Home	100	0	100	100	0	0	0	0	0	0	0	0
Pharmacy	89	0	0	22	0	0	89	0	89	89	56	0
Chemical Shop	100	0	0	0	0	0	100	0	100	50	0	0

Abortion—
Pharmacies report an increasing number of non-prescription/off-label Cytotec requests, with inquiries ranging from two to 20 per week. Some employees described a cyclical nature to the Cytotec requests, claiming that the first and last weeks of the month appear to be busiest. Although few pharmacy employees admit to selling Cytotec without a prescription (due to its Class A protection), the "hearsay" cost of an off-label regimen ranges from 15 to 60 cedis (10.3 to 41.4 US dollars), compared to 4 cedis (2.8 dollars) for the on-label cost of the same number of pills. Class A drugs are restricted to sale by licensed pharmacies in Ghana, but some pharmacy employees report that it is "common knowledge" that drug wholesalers distribute Cytotec (and many other Class A drugs) illegally to less-regulated chemical shops. All pharmacy employees spontaneously reported the same four-pill regimen for abortion-related Cytotec use, describing two pills as oral and two as vaginal. Cytotec is predominantly requested by females, but men account for anywhere between 25 to 40 percent of the inquiries. Despite the legal status of abortion in Ghana, some providers at both the pharmacy- and clinic-level report trying to dissuade pregnant women from aborting, often citing religious convictions as their reason for doing so.

Conclusion:
Private clinics may be a large source of missed-opportunities for contraceptive provision. Government clinics are an excellent source for middle- and long-term contraceptive methods, though they may also be missing some opportunities for short-term contraceptive provision. Pharmacies are an affordable and accessible source of family planning, though their lacking method mix may result in unachieved potential. Cytotec requests are widely prevalent at the pharmacy-level, though final sales are difficult to determine. Further study is needed to see whether women are at-risk or well-served by this possible point-of-sale. Healthcare providers at various levels may be serving as barriers to safe abortion in Ghana.

Further analysis:
A significant amount of qualitative data was obtained from the interviews regarding the use of Cytotec and the advice that healthcare providers might give a woman seeking to terminate a pregnancy. This information has not yet been analyzed in full but remains a top priority in developing this paper.