cy and abortion are likely to be underreported or may be unwilling to provide information. To overcome the limitations of self-reported data, study participants were advised that full disclosure regarding their reproductive health history, including the number of previous pregnancies and induced abortions, would help their prenatal care provider in giving them the best care possible and in preventing spontaneous abortions and stillbirths. In essence, full recollection of previous abortions, miscarriages and stillbirths was necessary for successful prenatal care. In addition, nurses served as interviewers to guarantee privacy and to create a sympathetic environment for the discussion of such sensitive topics.

**Analysis**

The abortion ratios (the number of abortions per 100 live births and 100 pregnancies in a given year) and abortion rate (the number of abortions per 1,000 women) were calculated for the pregnant women in the sample. These data were contrasted with the abortion ratio (the number of abortions per 100 live births) and abortion rate for women who had been treated for pregnancy complications at Korle-Bu Teaching Hospital during 1997 and 1998. In addition, percentage distributions for age, parity, length of gestation and location where abortion occurred were examined for the pregnant women in the sample. Percentage distributions of pregnant women’s demographic characteristics and reasons for terminating their pregnancy also were examined.

Finally, a multivariate hazard model was fitted, with the observed spells of survival time being the duration of follow-up on each pregnancy until censoring or abortion (or failure). A number of variables were investigated, including age, parity, sex of previous child, reasons for pregnancy termination, contraceptive use prior to the current pregnancy, education, work status, place of work, study area and pregnancy risk factors, such as malaria and hypertension. These variables were carefully selected based on information recorded on hospital cards during prenatal visits and based on previous research on induced abortion in Ghana. Contraceptive use among the women in our study was marginal: Only 11 women had used contraceptives prior to their current pregnancy. Because of the few cases of contraceptive use, we did not include this variable in our analyses.

**Results**

**Abortion Rates and Ratios**

Of the 1,689 women in the study, 1,187 carried their pregnancies to term, nine died (one as a result of complications related to a self-induced abortion), 317 aborted their pregnancies, 21 miscarried and 15 had stillbirths (Table 1). Of the remaining 140 women, 97 (nearly 6% of pregnant women) were lost to follow-up and 43 (slightly less than 3%) were dropped from the study because they refused to cooperate later in the study. According to the unadjusted data from the Maternal Health Survey Project, the abortion ratios were 19 abortions per 1,000 pregnancies and 27 abortions per 100 live births; the abortion rate was 17 induced abortions per 1,000 women of reproductive age.

According to data compiled from medical records at the Korle-Bu Teaching Hospital, 55,779 and 52,131 women aged 15–49 visited the hospital in 1997 and 1998, respectively, as both inpatients and outpatients. Of these women, 12,137 gave birth in 1997 and 11,412 did so in 1998. The number of women treated for abortion-related complications was 1,775 in 1997 and 1,649 in 1998. These data produce abortion ratios for 1997 and 1998 of 15 and 14 abortions per 100 live births, respectively, and abortion rates of 32 abortions per 1,000 women for both years. These figures are comparable to the World Health Organization’s estimate of 31 abortions per 1,000 Ghanaian women aged 15–49 for 1997 and 1998.

Because the study sample includes just two enumeration areas each in four of Ghana’s 10 regions and because the study team was unable to ascertain the pregnancy outcomes for 140 women (6% of the sample), the rates and ratios in Table 1 are likely lower than actual rates.