UNITED NATIONS UNIVERSAL PERIODIC REVIEW OF GHANA

Sexual and Reproductive Health Rights in Ghana

Submission to the UN Human Rights Council

By the Human Rights Advocacy Centre and the Ghana Coalition of NGOs in Health
House No: F1002/2 Koi Street,
Osu Ako Adjei, Accra.
P.O. Box OS 134, Osu-Ghana
info@hracghana.org / healthcoalition2000@yahoo.co.uk
www.hracghana.org / www.ghanahealthngos.net

1.0 Introduction

The Human Rights Advocacy Centre (HRAC) is a non-profit, independent, research and advocacy organization set up to advance and protect human rights in Ghana. This document is the joint report of the HRAC and the Ghana Coalition of NGOs in Health, on the situation of Sexual and Reproductive Health Rights (SRHR) in Ghana from 2017-2021, pursuant to Human Rights Council resolution 5/1, reaffirmed in resolution 16/21. The Ghana Coalition of NGOs in Health (GCNH) is a Health Civil Society Organization (CSO) established as an umbrella and coordinating body for health interventions of NGOs/FBOs/CBOs in the health sector in Ghana. GCNH currently has a membership of over 417 NGOs/FBOs/CBOs from all the 10 regions of Ghana.

2.0 Preparation for the report: Methodology and Consultation

The HRAC met with the Ghana Coalition of NGOs in Health and the National Population Council for a consultative meeting regarding the submission. The report has been prepared using information collated from HRAC research, stakeholder consultations, and information obtained from partner NGO's and the media.

3.0 Comprehensive Abortion Care

Comprehensive abortion care consists of abortion services that provide safe and legal induced abortions, pre-abortion counseling, treatment of incomplete and safe abortions, and other reproductive health services.[1] Although comprehensive abortion care is provided in Ghana, access to safe abortion remains a challenge to the majority of Ghanaian women.

3.1 National Law and Policies on Abortion

The current law on abortion in Ghana was enacted in 1985 (Law No. 102 of 22 February). Under this law, abortion is only permitted in specific instances, including conception resulting from rape, defilement of a female idiot or incest, when there is risk to the life of the woman or likely injury to her mental or physical health, or where there is substantial risk or serious abnormality or disease with the foetus. The abortion must be performed in a government hospital or a registered private hospital or registered clinic or any other place that is registered under the private hospital and maternity Act, 1958 (for example, registered private maternity

[1] World Health Organization. (2012). Safe abortion: technical and policy guidance for health systems – 2nd edition. Retrieved from http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf

homes). Abortion is not, however, available for economic or social reasons or upon request, leading to many unsafe abortions.[2] Under the law, any person who administers poison or other noxious substance to a woman or using any instruments or other means with the intent to cause an abortion is guilty of an offence and is liable to imprisonment for a term not exceeding five years, regardless of whether the woman is pregnant or has given her consent. Also, any person who induces a woman to attempt or undergo an abortion or who supply a woman with poison, drugs or instruments when the person has knowledge that it will be used to carry out an abortion commits an offence.

Additionally to the law, the Ghanaian Ministry of Health has developed various reproductive health policies. In 2000, the Adolescent Reproductive Health Policy was published including the implementation of programs that will help to either reduce or eliminate unsafe abortion.[3] In 2003, the National Reproductive Health Service Policy and Standards were revised to include protocols such as permitting midwives to provide post-abortion care.[4] The protocols on safe abortions were adopted in 2006 and they include components of comprehensive abortion care.

3.2 Safe and Unsafe Abortions

According to the WHO, when performed by well-trained providers and in a clean environment, abortions are very safe with complications in 1 out of 100,000.[5] However, the lack of knowledge on the law, socially and culturally driven perceptions to abortion, and the cost of abortion services hinder women from accessing safe abortions. Consequently, abortion is often performed underground using unsafe procedures, which increases the risk of severe health complications and in far too many situations death.

In 2016, it was reported that 55% of the abortions carried out in Ghana are unsafe.[6] Additionally, unsafe abortions occur because the pregnant woman is not eligible for safe abortions when the reasons for seeking abortion are economic or social. As a result, unsafe

[2] Aniteye P & Mayhew SH. (2013). Shaping legal abortion provision in Ghana: using policy theory to understand provider-related obstacles to policy implementation. Health Research Policy and Systems. doi: 10.1186/1478-4505-11-23

[3] Republic of Ghana. (2000). Adolescent Reproductive Health Policy. *National Population Council,* p.1-22. https://s3.amazonaws.com/ndpc-static/pubication/AdolescentReproductiveHealth+Policy_Oct2000.pdf

[4] Ghana Health Service. (2005). *Strategic Plan for the Implementation of Comprehensive Abortion Care Services in Ghana*. Accra: Ghana Health Service.

[5] World Health Organization. (2007). *Unsafe abortion: Global and regional estimates of incidence of unsafe abortion and associated mortality in 2003*. Geneva: World Health Organization.

[6] Kuorsoh, P.K. (2016). Don't stigmatise women who opt for safe abortion – NGO. Retrieved from http://www.ghananewsagency.org/health/don-t-stigmatise-women-who-opt-for-safe-abortion-ngo-108595

abortions are the second most common cause of maternal mortality, making up 11% of maternal deaths in Ghana.[7] And for every woman that dies from an unsafe abortion in Ghana, at least 15 suffer short or long-term morbidities.[8]

3.3 Accessibility and Affordability

Despite progress in the provision of comprehensive abortion care, access to safe and legal abortion services for women remains a problem in Ghana. For most women, abortion services for serious medical conditions, such as hypertensive disorders and renal failure, are available in nearly all public and private hospitals in Ghana. Accessibility becomes problematic when the abortion is on medico-social grounds, such as rape, because such services are not available in all national health institutions across the country as they are mainly found in urban centers.[9]

Poor women are often forced to rely on poorly trained practitioners or having to carry it out themselves, since they cannot afford safe abortion care. Additionally, women who live in remote parts of the country might have difficulties in accessing safe abortion care in their communities. Unaffordability and inaccessibility of abortion care services strips women of their reproductive rights and the right to have safe abortion services.

3.4 Young Women

Teenage girls and young women in their 20s are more likely than women aged 30 and older to have an unsafe abortion.[10] However, for 15-19 year olds, the number of the adolescents having abortions decreased slightly from 21.4% in 2012 to 19.8% in 2015.[11] The reasons for young women seeking unsafe abortions include unplanned pregnancies, disownment of the pregnancy by the partner and partner's family, financial insecurity, being ostracized by the community, and stigma associated with pre-marital sex and abortion. In addition to the risk of unsafe abortions, teenagers who experience post-abortion complications do not seek treatment until the situation has worsened due to the same factors.

---

[7] Sedgh, G., Ashford, L.S., & Hussain, R. (2016). *Unmet Need for Contraception in Developing Countries: Examining Women's Reasons for Not Using a Method*. New York: Guttmacher Institute.
[8] Rominski, S. D. & Lori, J. R. (2014). Review: Abortion care in Ghana: A critical review of the literature. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4465587/
[9] Morhee, R. & Morhee, E. (2006). Overview of the Law and Availability of Abortion Services in Ghana. *Ghana Medical Journal, vol. 40(3),* p.80-86. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1790853/pdf/GMJ4003-0080.pdf
[10] Sundaram, A., Juarez, F., Bankole, A., & Singh, S. (2012). Factors associated with abortion-seeking and obtaining a safe abortion in Ghana. *Studies in Family Planning, vol. 43(4),* p.273–286. doi: 10.1111/j.1728-4465.2012.00326.x
[11] Ministry of Health. (2016). Adolescent Health Service Policy and Strategy (2016-2020).

3.5 Programs Addressing Gaps in CAC

In 2006, Ghana Health Services and the Ministry of Health partnered with international health organizations, including Ipas, Engender Health, Marie Stopes International, the Population Council, and Willows Foundation to launch the initiative "Reducing Maternal Mortality and Morbidity" (R3M) aimed at improving comprehensive abortion care. The R3M program primarily targets health care providers and focuses on increasing access to comprehensive abortion care to reduce morbidity and mortality caused by unsafe abortion. It also sought to expand access to family planning services to reduce the unwanted pregnancies that lead to abortions.[12] The R3M program was initiated in seven districts within the three regions of Greater Accra, Ashanti, and Eastern.

Presently, the program provides services to healthcare providers, communities and facilities, such as training in abortion techniques and contraceptive services, sensitizing the community and health care providers to the needs of individuals seeking the care, and providing equipment and products to facilities. The types of services that are provided vary depending on the organizations.

An evaluation of the program shows that the provision of safe abortion services and post-abortion care was greater among health providers who were aware of the R3M program than health providers who were not aware of the program.[13] Therefore, the R3M program is significantly aiding in improving comprehensive abortion care in Ghana.

Challenges

- Abortion law in Ghana is not fully interpreted which makes the provision of abortion care concerning physical and mental health unclear.
- Inaccessibility to abortion care services throughout the country also due to health provider bias which further limits access to services.
- Unaffordable abortion care services that exclude members of a lower economic class
- Lack of education on the Ghanaian abortion law by women, men, adolescents and health providers.

[12] EngenderHealth. (2009). COPE for Comprehensive Abortion Care Services: A Toolbook to Accompany the COPE Handbook. New York: EngenderHealth.

[13] Sundaram, A., Juarez, F., Ahiadeke, C., Bankole, A., & Blades, N. (2015). The impact of Ghana's R3M programme on the provision of safe abortions and postabortion care. *Health Policy and Planning, vol. 30(8),* p.1017-1031.

- High stigma is associated with abortion on account of traditional, religious and cultural beliefs.

Recommendations

The HRAC and the Ghana Coalition of NGOs in Health recommend that;

1. The Government of Ghana should make the risk to physical and mental health explicit in the abortion law. The law could be interpreted in a way that threat to mental health also includes psychological distress caused by any factor that makes pregnancy difficult to carry, for example unstable relationship with the male partner, career development, poverty, fear of parents, lack of social support, the need to care for other young children in the family, or health problems.
2. The Ghana Health Services should expand the R3M program throughout Ghana.
3. The Ministry of Health and other relevant agencies should educate religious and traditional leaders on abortion law to address stigma associated with legal and safe abortions.
4. The Ministry of Gender, Children and Social Protection, National Population Council, and relevant civil society organizations must collaborate with health institutions to create more awareness on the abortion law.
5. Collaboration between the Ghana Education Services and Ghana Health Services should increase access to Comprehensive Sexuality Education and contraceptive use in order to decrease the rate of abortions.

4.0 Family Planning

Family Planning includes the timing, spacing and limiting of births. Young people, however, are often not seen as old enough to use services and facilities that offer family planning (FP), or they simply do not know that such services exist for them. Despite adolescent women (age 15-19) being in the focus of family planning, the service applies to all women in their reproductive years (age 15-49).

4.1 Legal Provisions of Family Planning

Family Planning is a component of Sexual and Reproductive Health Rights (SRHR), which are protected in Ghana by the African Charter on Human and People's Rights and the Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African

Charter on Human and Peoples' Rights published by the African Commission on Human and People's Rights. Although there is no sole legal provision of family planning in Ghana, various national policies and strategy plans address the topic of family planning.

4.2 Family Planning Policies in Ghana

Family Planning (FP) has been a key strategy by Ghana for nearly 50 years as a way to deal with the country's health, social and economic issues because of high population growth. The National Population Policy specifically outlined targets on fertility and contraceptive use. These targets were, reducing the total fertility rate (average number of children who would be born per woman) from 5.5 to 5.0 by 2000, to 4.0 by 2010, and to 3.0 by the year 2020; achieving a contraceptive prevalence rate of 15% for modern family planning methods by 2000 and 50% by 2020; and lastly, reducing the current annual population growth rate of about 3% to 1.5% by 2020.[14] Although the total fertility rate decreased from 6.4 in 1988 to 4.0 in 2008 and thus surpassed the goal of 4.0 by 2010, data from the 2014 Ghana Demographic and Health Survey report show that the total fertility rate increased from 4.0 in 2008 to 4.2 in 2014.[15]

In 2010, "Ghana Shared Growth and Development Agenda 2010-2013" was adopted which recognized family planning as a top priority for inclusion in national development plans and activities at all levels. This was followed by "Ghana Shared Growth and Development Agenda II 2014-2017" which focused on describing health service delivery intent and on HIV, STI and family planning in Ghana. The current policy is "Ghana Family Planning Costed Implementation Plan 2016-2020" (GFCIP). GFPCIP's main objectives are to increase the use of contraceptives among married women to 30% and unmarried women to 40% by 2020. Ghana plans to implement this change through the financial resources of development partners amounting to $235 million (USD) between 2016 and 2020, to invest in community education, maternal and infant health care, infrastructure, contraceptives and counselling on family planning.

4.3 Total Demand and Unmet Need for Family Planning

In Ghana, the total demand for family planning among women in their reproductive years is 51%. This includes women who are currently using contraceptive methods (17%) and those not

[14] GAP. (2012). *Resource Requirements for Family Planning in Ghana: Policy Brief*. Washington: Health Policy Project.
http://www.healthpolicyinitiative.com/Publications/Groups/group_33/33_GhanaGAPbrief_HPP_508.pdf
[15] Ardayfio, R.N.K. (2015). Improving Family Planning uptake in Ghana. Retrieved from http://www.graphic.com.gh/news/health/improving-family-planning-uptake-in-ghana.html

using any contraceptive methods (34%). Out of the 34%, 12% want to limit births (prefer to stop having children), and 22% want to space births (want to wait at least 2 more years before having a child). The data show that only 34% of Ghana's total demand for family planning is satisfied (17 % /51 %). [16]

4.4 Contraceptive Use and Choice of Methods

According to the Ghana Democratic Health Survey of 2014, 89.9% of unmarried adolescent girls who are sexually active do not want to have a child within the next few years. Yet, 66.4% are not using any method to prevent pregnancy. The main reasons behind this high number are fear of side effects or health concerns (37.4%), infrequent sex (22.7%), and not being married (17.1%). For the 33.6% who are using methods to prevent pregnancy, the most common ones are male condoms (10.4%) and followed by injectable contraceptives (5.4%). The traditional methods used are periodic abstinence (5.1%) and withdrawal (3.9%).

The numbers change when looking at adolescent girls in a union (married or living together). For this group, 66.3% do not want to become pregnant within the next few years, but 81.4% do not use a method of contraception because of infrequent sex, fear of side effects or health concerns, or breastfeeding. Here, the most common used methods are injectable contraceptives (6.7%) and implants (6.1%); only 1.9% use traditional methods.[17]

4.5 Traditional Belief and Religion

A study found that in many communities in Sub-Sahara Africa, faith and religious leaders are trusted more than national governments.[18] Therefore, faith-based organizations and religious leaders have an immense opportunity in educating communities about family planning. However, without giving faith and religious leaders the right education on family planning, these leaders often resist educating communities on the matter. Education is especially important to highlight the fact that family planning includes abortion, which is a practice totally contrary to theological beliefs.[19] Some religious leaders also believe that educating adolescents

[16] Gribble, J. (2008). Family Planning in Ghana, Burkina Faso, and Mali. Retrieved from http://www.prb.org/Publications/Articles/2008/westafricafamilyplanning2.aspx
[17] WHO. (2016). Republic of Ghana: Adolescent Contraceptive Use in Ghana. Retrieved from http://apps.who.int/iris/bitstream/10665/252327/1/WHO-RHR-16.27-eng.pdf?ua=1
[18] Tortora, B. (2007). Africans' Confidence in Institutions: Which Country Stands Out? Retrieved from http://www.gallup.com/poll/26176/Africans-Confidence-Institutions-Which-Country-Stands-Out.aspx?g_source=position7&g_medium=related&g_campaign=tiles#!mn-world
[19] Allison, A. & Foulke, E. (2014). *Engaging Faith Leaders in Family Planning*. Federal Way, WA: World Vision US.

about family planning leads to more sexual activity.[20] Between 2002 and 2005, the African Youth Alliance in collaboration with the Christian Health Association of Ghana (CHAG) started a program to provide services to young people, including education about and distribution of contraceptives. Over 152 health institutions from all over Ghana with different faith and ethos were reached. In Ghana, around 35% of healthcare services are carried out by the 152 and other religious institutions. With those packages of "youth-focused services", the project had reached around 450,000 adolescents and distributed 118,000 condoms until 2005. However, the handing out of contraceptives resulted in disagreement among a number of CHAG members that at the time did not take part in the program, because they claimed that educating and distributing contraceptives would motivate the youth to engage in sexual intimacy before marriage, which is contrary to Christian beliefs. The members that took part shared the belief that there is a religious need to respond to the health reality of Ghana's modern youth.[21] In a policy that was carried out between 2007 and 2015, the Ghana Ministry of Health emphasized the inclusion of community leaders and religious organizations in promoting community awareness on family planning.[22]

4.6 Accessibility and Affordability

Adolescent girls, especially unmarried ones, face difficulties in accessing family planning, including contraceptive information, education and services. Often, lack of accessibility has to do with the socioeconomic status of women, educational level, religious beliefs and simply misinformation about family planning, such as family planning is only for married couples. Reaching out to family planning services as a young or unmarried woman also includes the fear to be seen as promiscuous.[23] Data from 2014 shows that out of all married adolescent (age 15-19) that were visited by health care providers in the last year, only 6% had discussions on family planning; and all married adolescents that visited health facilities, only 5% were informed about

[19] Tortora, B. (2007). Africans' Confidence in Institutions: Which Country Stands Out? Retrieved from http://www.gallup.com/poll/26176/Africans-Confidence-Institutions-Which-Country-Stands-Out.aspx?g_source=position7&g_medium=related&g_campaign=tiles#!mn-world

[20] World Faiths Development Dialogue. (2014). *Faith & International Family Planning*. Washington, DC: World Faiths Development Dialogue.

[21] Pathfinder International. (2005). *Building Partnership with Faith-Based Organizations: Integrating Youth-Friendly Services into the Health Delivery System of the Christian Health Association of Ghana.* Watertown, MA: Pathfinder International.

[22] Allison, A. & Foulke, E. (2014). *Engaging Faith Leaders in Family Planning*. Federal Way, WA: World Vision US.

[23] Benarkuu, G. G. (n.d.). *CSOs Assessment Report on SRHR Policies and Indicators in Ghana*. Accra: Ghana Coalition of NGOs in Health.

family planning. Females between 20 and 24 years received family planning information in 10% (when being visited) and 17% (when visiting) of the cases.[24]

In addition to accessibility, the cost for family planning services remains a challenge for many adolescents or poor women in their reproductive age. 9% of the poorest use either traditional or modern ways of family planning, 19% of the middle and 26% of the wealthiest.[25] Compared to the region of West Africa, Ghana's numbers are much higher. In West Africa, only 4% of the poorest and only 20% of the wealthiest use family planning.[26] In order to prevent a woman's economic status from hindering her access to family planning, the legislation on National Health Insurance Scheme reform, passed in 2012, states that: "natal, delivery and neonatal healthcare services provided by the Schemes established under the National Health Insurance Act, (Act 650) shall continue to be provided under the Scheme."[27] In other words, family planning education and services are included in the NHIS package of free maternal healthcare. However, the distribution of contraceptives and other commodities is not explicitly included in this package.[28]

4.7 Funding for Family Planning Services

Over the past decade, several stakeholders and the government have invested a significant amount of money to improve Ghana's family planning service. This includes training service providers to improve the accessibility and quality of the service delivery, demanding creation activities, and procuring and distributing contraceptives. However, the gains made are below expectations. The Ministry of Health/Ghana Health Service and United Nations Population Fund see the strong dependency on international donor support as a critical reason for the minimal commitment from the higher levels of government. Hence, they urge the Ghanaian government to increase efforts and own investments in order to intensify advocacy for family planning.[29]

---

[24] Ministry of Health. (2016). Adolescent Health Service Policy and Strategy (2016-2020).
[25] Gribble, J. (2008). Family Planning in Ghana, Burkina Faso, and Mali. Retrieved from http://www.prb.org/Publications/Articles/2008/westafricafamilyplanning2.aspx
[26] Gribble, J. (2008). Family Planning in West Africa. Retrieved from http://www.prb.org/Publications/Articles/2008/westafricafamilyplanning.aspx
[27] National Health Insurance Act 2012, Act 852, of the Republic of Ghana. Retrieved from http://www.moh.gov.gh/wp-content/uploads/2016/02/National-Health-Insurance-ACT-2012-ACT-852.pdf
[28] Benarkuu, G. G. (n.d.). *CSOs Assessment Report on SRHR Policies and Indicators in Ghana*. Accra: Ghana Coalition of NGOs in Health.
[29] Ardayfio, R. N. K. (2015). Improving Family Planning uptake in Ghana. Retrieved from http://www.graphic.com.gh/news/health/improving-family-planning-uptake-in-ghana.html

Challenges

- The absence of a legal provision of family planning services in Ghana to support the implementation of the FP policies.
- Low percentage of the total demand of family planning dissatisfied due to lack of understanding of contraceptive methods, inaccessibility and/or unaffordability of FP services.
- The skepticism of religious leaders towards FP that influences communities.
- Lack of integrated and coordinated FP programs by the Ministry of Health/Ghanaian Health Society and National Population Council.
- Inadequate funding by the Ghanaian government.

Recommendations

To address these issues, HRAC and the Coalition recommend that:

1. Parliament should enact a legal provision to regulate FP services.
2. Ghana Health Services and the National Population Council should FP programs to reach out to potential providers of FP and to educate communities in order to increase the contraceptive prevalence rate.
3. The National Health Insurance Authority must include modern contraceptive methods in the National Health Insurance Scheme coverage to increase availability.

5.0 Child Marriage

In Ghana, many children get married before the age of 18. Child marriage can be forced or it can occur with the expressed consent of a person younger than 18 years. The reason for child marriage is very often poverty. Other reasons include parental irresponsibility, gender inequalities, or religious/cultural traditions that are gender biased.

5.1 Legal Provisions on Child Marriage

The African Charter on the Rights and Welfare of the Child expressly states that child marriage and the betrothal of girls and boys should be strictly prohibited, and that the minimum age for marriage should be 18 years.[30] That minimum age is also provided in the Maputo Protocol.[31]

[30] African Charter on the Rights and Welfare of the Child 1999, art. 21(2).
[31] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa 2003, art. 6.

In Ghana, child marriage is illegal. Ghana's Children's Act(Act. 560) of 1998 is more detailed, providing the right of the child to refuse betrothal and marriage, and setting the minimum age of marriage to be 18 years.[32] Additionally, it states that forcing a child into betrothal or marriage is a criminal offence that will be charged with financial compensation or imprisonment.[33]

5.2 Numbers of Current Situation in Ghana

Child marriage in Ghana by far affects more girls than boys. Among women aged between 15 and 49, 27% were married as girls compared to 5% of men between 15 and 49 who married as boys.[34] Despite the law prohibiting child marriage, more than 1 in 4 Ghanaian women (26%) aged between 20 and 24 years were married before the age of 18. Out of the 26%, 5% of the women were married even before they were 15 years old.[35] Child marriage is more common in rural areas compared to urban areas. The percentage of women aged 20 to 49 who were married before the age of 18 in rural areas is almost 40% compared to less than 20% in urban areas.[36] The percentage of women aged between 15 and 49 years who were married before the age of 18 varies from region to region.

On average, 1 out of 5 girls in Ghana is married before their 18th birthday. In other words, the percentage of girls between 20-24 years, who are married or in a union by the age 18 is 21%.[37] This amounts to approximately 256,780 affected girls in the country.[38] However, for girls living in the three Northern Regions of Ghana, this number increases to 1 out of 3 girls (34%). The national prevalence of child marriage in Ghana for girls aged 20-24 years has remained stable at 21% between 2011 and 2014. However, the regional trends show variations, with a progressive widening gap between the Northern zone (26%) and Central/Southern zones (19%) of the country.[39]

[32] The Children's Act 1998, Act 560, of the Parliament of the Republic of Ghana, section 14.
[33] The Children's Act 1998, Act 560, of the Parliament of the Republic of Ghana, section 15.
[34] UNICEF Ghana. (2015). Really Simple Stats - Child Marriage. *UNICEF Ghana Internal Statistical Bulletin*. Retrieved from https://www.unicef.org/ghana/REALLY_SIMPLE_STATS_-_Issue_5(3).pdf
[35] UNICEF. (2016). *The State of the World's Children 2016: A fair chance for every child.* New York: United Nation Children's Fund.
[36] UNICEF. (2014). *Ending Child Marriage: Progress and prospects*. New York: United Nation Children's Fund.
[37] DHS 2014
[38] This is based on the 2010 Census and the DHS 2014
[39] Ghana MICS 2011 and DHS 2014

Young girls from wealthier households are less likely to be married before they turn 18. Among the poorest women in Ghana, the number who marry before 18 is more than 40% compared to a little more than 10% of the richest women.[40] Closely linked to economic status is the level of education. Less than 5% of young girls with higher education are likely to get married before 18, compared to almost 42% of women with no education.[41]

5.3 Customary Practices

In addition to the socio-economic reasons behind child marriage, there are special customary practices that stand in the way of protecting young girls from marriage. The *trokosi* (meaning "slave to the gods") system is a penal system in Ghana's southeast practiced by the Ewe tribe. It requires an offender's family to make reparation by providing a female family member to serve in a shrine, which automatically leads to the marriage to the priest of the shrine. These young wives are subjected to hard labor, have no leisure time, no access to reproductive health care and in general no power over their sexual relation. Due to the support of the Commission for Human Rights and Administrative Justice and various NGOs, there has been more awareness about traditional practices, which have led to the liberation of *trokosi* victims.[42]

5.4 Consequences of Child Marriage

Child marriage bears many risks and consequences for young girls. When marrying at a young age, young girls often face health problems. The severity of health consequences experienced by young girls due to early pregnancy and childbirth varies from case to case. For instance, many girls experience Vaginal Fistula during childbirth, while in other cases the consequences of early pregnancy and childbirth result in death. The health consequences of early pregnancy and childbirth are the leading cause for death among girls between 15 and 19.[43] Pregnancy also undermines the development of adolescent girls in regards to their growth and nutritional status. In addition to the girl, the born child is likely to have low birth weight, which could lead to long-term health impacts. Furthermore, the risk of stillborn baby or the baby dying soon after birth is higher when an adolescent girl gives birth.[44]

---

[40] Ibid.
[41] UNICEF. (2014). *Ending Child Marriage: Progress and prospects*. New York, NY: United Nation Children's Fund.
[42] Unknown, (n.d.). The Legal and Policy Framework for the Prohibition of. Early and Forced Marriage in Ghana - Prospects and. Challenges. Retrieved from http://www.pgaction.org/pdf/The-Legal-and-Policy-Framework-for-Prohibition-of-Early-and-Forced-Marriage-in-Ghana-Prospects-and-Challenges.pdf
[43] UNICEF Ghana. (2015). Really Simple Stats - Child Marriage. *UNICEF Ghana Internal Statistical Bulletin*. Retrieved from https://www.unicef.org/ghana/REALLY_SIMPLE_STATS_-_Issue_5(3).pdf
[44] Ibid.

On the other hand, child marriage is also a threat to attending and completing education, which then automatically limits the participation in social spheres and the economic autonomy of young girls. This is also impacted by the fact that married girls have to take over household work that older women are traditionally responsible for and are therefore not allowed to go to school. Moreover, if a young married girl gets pregnant out of her marriage, many schools in Ghana will not accept her because of the non-acceptance of pregnant girls. Furthermore, many girls do not return to school after given birth, as they are both shy and afraid of the stigma surrounding their underage pregnancy.

UNICEF Ghana reports that girls who marry before 18 are more likely to experience violence perpetrated by their partner, and they have a higher risk of contracting HIV/AIDS and STIs, especially if the spouse is much older than the girl. Early marriage not only increases the likeliness of domestic violence and contraction of sexual diseases, it also increases the likelihood that the girl will face social isolation and gender inequality.[45]

5.5 Initiatives to Fight Child Marriage

In 2014, the Ministry of Gender, Children and Social Protection established an Ending Child Marriage Unit of the Domestic Violence Secretariat in cooperation with UNICEF to promote and coordinate initiatives to end child marriage in Ghana. The Government of Ghana was partnering with other stakeholders and ambassadors when they officially launched the Ending Child Marriage campaign in 2016.[46] In the same year, ActionAid Ghana announced a two-year program, which targets 3,600 girls below 18 years directly, and includes 110,000 people from 120 communities as indirect beneficiaries. The program will be carried out in 12 districts in the Upper East, Upper West, Brong-Ahafo and Greater Accra regions.[47]

The Domestic Violence and Victims Support Unit of the Ghana Police Service with RISE-Ghana and with support and cooperation of Canada Fund for Local Initiatives, Department of Social Welfare and Community Development, and the Ghana Education Service, have helped

[45] Ibid.
[46] Daily Graphic. (2016). Ghana to launch 'Ending Child Marriage' campaign. Retrieved from http://www.graphic.com.gh/news/general-news/ghana-to-launch-ending-child-marriage-campaign.html.
[47] Abdul-Hamid, A. (2016). ActionAid, UNICEF collaborate: To end child marriage in Ghana. Retrieved from http://www.graphic.com.gh/news/general-news/actionaid-unicef-collaborate-to-end-child-marriage-in-ghana.html

to complement the efforts in curbing child marriage and have managed to rescue 6 girls in 2015, their first year of doing so.[48]

Youth Harvest Foundation teaches through local peer educators that marriage is not the only way. Because of the huge influence these peer educators have in their own communities, many cases of child marriage are brought to light, girls have been assisted in returning to school after pregnancy, and perpetrators of forced child marriage got arrested.[49]

Currently, the Ministry of Gender, Children and Social Protection is developing a three-year National Strategic Framework to End Child Marriage with the help of UNICEF. The framework is supposed to set out national goals, objectives and strategies, roles and accountabilities, key interventions, resources and national targets in order to end child marriage in Ghana.[50]

Challenges

- The existing Child and Family Welfare Policy states that social protection interventions would reduce practices like child marriage, but it fails to give clear guidance or strategies on how to protect children specifically against early marriage.
- In adequate education about the negative effects of child marriage to children, but also to their parents and communities in general.
- Lack of reporting cases of child marriage to authorities and the police since people are unaware of the reporting mechanism.
- Existing traditional and cultural practices foster child marriage.

Recommendations

The HRAC and the GCNH recommend to the Government to:

1. The Ministry of Gender, Children and Social Protection hasten to complete its strategic plan on ending child marriage in Ghana and publish it to guide stakeholders efforts at ending child marriage.

[48] Akapule, S. A. (2016). Ending child, early and forced marriages in Ghana. Retrieved from http://www.ghanaweb.com/GhanaHomePage/features/Ending-child-early-and-forced-marriages-in-Ghana-452641
[49] UNICEF. (2015). From child bride to child champion - Matilda Agambire. Retrieved from https://www.unicef.org/ghana/media_10229.html
[50] Doudu, S. (2016). Strategic framework to end child marriage underway. Retrieved from http://www.graphic.com.gh/news/general-news/strategic-framework-to-end-child-marriage-underway.html

2. The Ministry of Gender, Children and Social Protection in collaboration with the Ministry of Education upscale programs to educate girls and boys about sexual and reproductive health in schools with an emphasis on the disadvantages of early marriage.
3. The Ministry of Gender, Children and Social Protection coordinates a multi-sector approach to undertaking public awareness campaigns for communities including traditional and religious leaders in order to educate them about the danger and harmful effects of child marriage and other cultural practices such as *trokosi*.
4. Ministry Of Gender, Children and Social Protection should upscale vocational and skill training for girls in order to empower them economically and delay early marriage.
5. The Commission on Human Rights and Administrative Justice should encourage the reporting of cases of child marriage to the police and prosecuting all persons, also parents and caretakers who pushed children into child marriage. This includes offering resources to women and girls to seek legal redress.
6. Provide shelters for girls who escape child marriage or domestic violence in general, and equipping the Department of Social Welfare, the Police, Ministry of Education and Health and the Courts to address child marriage cases with the urgency it deserves.
7. The Education Ministry and Ghana Education Services have to change school policies so that pregnant girls are allowed to attend school as long as they can before delivery.