

Availability and prescription of misoprostol for medical abortion in community pharmacies and associated factors in Accra, Ghana

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Abstract

Objective: To assess misoprostol availability at community pharmacies and determine factors affecting misoprostol prescription for medical abortion.

Methods: A cross-sectional quantitative survey of randomly sampled community pharmacies and their corresponding pharmacists/pharmacy workers was conducted in the city of Accra, Ghana. Structured questionnaires were administered to collect data between May 1 and July 28, 2016. Descriptive statistics (frequencies and proportions) and bivariate and logistic regression analysis were used to analyze the data.

Results: Of the 165 community pharmacies surveyed, approximately half (83 [50.3%]) stocked misoprostol. Availability of misoprostol however decreased when moving from first class to third class residential areas. 44 (26.7%) of the respondents had prescribed the drug at some time for medical abortion, but 140 (84.6%) indicated they would not prescribe the drug for medical abortion in future. Factors that significantly predicted misoprostol prescription for medical abortion included sex of the pharmacist/pharmacy worker, demand, and availability of misoprostol.

Conclusions: Demand for misoprostol for medical abortion was found to be high but only half of community pharmacies stocked it, and most pharmacy workers did not wish to prescribe the drug. If community pharmacies are to effectively contribute to expanding access to safe abortion services in Ghana, the disparity between misoprostol provision and demand needs to be addressed.

KEYWORDS

Availability; Community pharmacies; Ghana; Medical abortion; Misoprostol; Prescription

1 | INTRODUCTION

Unsafe abortion is a significant public health problem, accounting for 13% of maternal mortality in low-resource countries.¹ WHO defines unsafe abortion as a procedure for terminating an unplanned pregnancy carried out either by persons lacking the required skills or in an environment that does not conform to minimum medical standards, or both.² It is estimated that unsafe abortion accounts for 70 000 deaths yearly, over 99% of which are in low-income countries.¹ An additional

5.3 million women also suffer temporary or permanent disability as a result of unsafe abortion.²

Medical abortion offers a vital alternative to surgical abortion for women with early pregnancies who wish to avoid a surgical procedure.³ Presently, three regimens exist for medical abortion in Ghana generally, and in the area where the present study was conducted specifically: misoprostol alone, methotrexate followed by misoprostol, and, by far the most commonly used method, mifepristone followed by misoprostol.⁴ Misoprostol, the subject of interest in this

paper, is a synthetic analogue of the prostaglandin E1 that entered the global market in the late 1980s.⁵ Marketed as Cytotec (Pfizer, New York, NY, USA), misoprostol is an effective and progressively popular option for self-administration, especially in low-resource countries.⁶ Mifepristone, followed by a prostaglandin (such as misoprostol), is considered the gold standard for medical abortion.⁷ A regimen of 200 mg mifepristone and 800 µg buccal or vaginal misoprostol is 95%–98% effective.⁸ In several settings where mifepristone is inaccessible, however, misoprostol is commonly used alone for early pregnancy termination.⁷ More importantly, there is evidence that women are capable of safely and effectively self-administering misoprostol either alone or in combination with mifepristone, even in resource-poor settings.⁷

While it is fairly easy to access safe abortion services in most high-income countries, safe abortion has become a privilege of the rich in settings with highly restrictive induced abortion regulations.^{9,10} In Ghana, maternal mortality is the second highest cause of death among women of reproductive age, with approximately 20.8% of maternal deaths resulting from unsafe induced abortions in some major health facilities in the country.¹¹ Notwithstanding the fact that Ghana has a relatively liberal abortion law, access to safe, legal induced abortion in public health institutions is often limited.^{11,12} More recently, one published study¹² reported on the availability of medical termination of pregnancy kits in pharmacies in Ghana. The availability of such products in community pharmacies could potentially expand access to safe abortion services in Ghana.

Several studies have shown that in low-income countries where legal induced abortion services are not easily accessible, community pharmacies are frequently the first line healthcare providers when women seek induced abortion services.^{13–16} In Ghana, community pharmacies have been reported to be the first port of call for the majority of Ghanaians seeking healthcare advice or treatment.^{17,18} Despite this recognition, few studies have been carried out to verify the availability of misoprostol in community pharmacies and factors affecting its prescription for medical abortion. The present study aimed to assess misoprostol availability at community pharmacies and determine factors affecting misoprostol prescription for medical abortion.

2 | MATERIALS AND METHODS

The present cross-sectional quantitative survey collected data between May 1 and July 28, 2016, using structured questionnaires. The study was conducted among pharmacy workers in the Accra Metropolis of the Greater Accra Region of Ghana—the most populated district in Ghana with an estimated total population of 1 665 086, comprising 51.9% females and 48.1% males.¹⁹ Ethical clearance was obtained from the Ghana Health Service ethical review committee. Informed written consent was obtained from all respondents.

According to the Pharmacy Council of Ghana, there were 771 registered retail community pharmacies in good standing (i.e. pharmacies that have renewed their yearly license and therefore are eligible

to conduct business) in the Greater Accra Region at the time of this study.²⁰ Out of this number, 281 (36.4%) were located in the Accra Metropolis. These were distributed across three main residential areas in the city, which differ in socioeconomic characteristics.²¹ First class residential areas are generally well planned, have well developed infrastructure, and expansive, landscaped properties.²¹ The richest segment of society usually occupy these areas. Second class areas are middle-income areas principally occupied by working class people.²¹ These areas are generally better-planned, albeit in need of infrastructure services. Third class areas are generally low-income, heavily populated, and largely unplanned.²¹

The target population was primarily community pharmacists located in the three strata of residential areas. However, the regular absence of pharmacists in community pharmacies in low-income settings is recognized.^{13–18} In the absence of the community pharmacist, pharmacy technicians or medicine counter assistants, or other (on the job trained) pharmacy workers were surveyed.

Since the number of pharmacies were known, Yamane's formula for calculating sample size from a finite population was used.²² A simple random sampling technique was then used to select the requisite sample number from the total of 281 pharmacies. For each of the pharmacies included, one pharmacist/pharmacy worker was selected to take part in the study. In cases where there was only one pharmacist/pharmacy worker, that person was automatically included in the study. However, where there were more than one pharmacist/pharmacy worker, the most senior (in terms of years of practise) was selected to respond to the questionnaire.

Structured questionnaires were designed and administered to the pharmacists/pharmacy workers to collect information on availability of misoprostol in community pharmacies, and factors affecting misoprostol prescription. The questionnaires were pre-tested in an adjoining municipality not included in the study, and all necessary amendments were made to the questionnaires before collection of the study data. The data were collected by a researcher (NTB) between May 1 and July 28, 2016. The questionnaires were both interviewer-administered (a researcher [NTB] asked questions and recorded responses) and self-administered (respondents read the questions, and recorded their responses unsupervised). The researcher personally visited all pharmacies to administer questionnaires or distribute them for self-administration. The researcher also personally revisited all pharmacies to retrieve self-administered questionnaires.

Completed questionnaires were retrieved, checked for completeness, coded, and the data analyzed using Stata version 13.1 (StataCorp, College Station, TX, USA). Descriptive statistics were used to describe the sociodemographic characteristics of respondents, availability of misoprostol, and whether pharmacists/pharmacy workers had prescribed or would prescribe misoprostol for medical abortion. Bivariate analysis using χ^2 test was used to assess the association between different characteristics of the respondents and dispensing of misoprostol. Logistic regression was fitted to further assess the strength of association among variables that were significantly associated with misoprostol dispensing. Confidence level was held at 95% and $P < 0.05$ was considered statistically significant.

3 | RESULTS

A total of 165 pharmacists/pharmacy workers participated in the present study, the number arrived at through the sample size calculation, all of whom completed a questionnaire.

A summary of the sociodemographic characteristics of respondents can be found in Table 1. The majority were female (90 [54.6%]), and 118 (71.5%) had tertiary education. With respect to qualifications, 69 (41.8%) were pharmacists, while 10 (6.0%) were members of staff "trained on the job".

Table 2 provides information on the availability of, and demand for, misoprostol. Approximately half (83 [50.3%]) of the pharmacies surveyed stocked misoprostol. However, availability of misoprostol declined from first class (high-income) to third class (low-income) residential areas. Weekly demand was highest in third class, followed by second class, residential areas. However, monthly demand was highest in the first class, followed by second class, residential areas.

When asked whether or not they had ever prescribed misoprostol for medical abortion, 44 (26.6%) pharmacy workers said they had. Pharmacy technicians and medicine counter assistants were slightly more likely to report ever prescribing misoprostol compared

with pharmacists and "on the job trained" staff (Table 3). However, when asked in a follow-up question whether they would prescribe it to women seeking induced abortion services in the future, the majority (140 [84.6%]) said they would not. Pharmacists and "on the job trained" staff were more likely than other pharmacy workers to report that they would not prescribe misoprostol for medical abortion. The reasons for the decision to prescribe the drug or not are presented in Table S1. The majority of respondents who said they would not prescribe it said it was against their religious belief (71/128 [55.5%]); 21/128 (16.4%) said they were not sure of the dose to give and 36/128 (28.1%) said they would not prescribe it because it was outside their scope of practice.

Tables 4 and 5 show the results of bivariate and logistic regression analyses investigating the association between a number of independent variables and ever prescribing misoprostol. Using bivariate analysis, only the sex of the pharmacy worker ($P=0.005$), availability of misoprostol in the pharmacy (i.e. currently stocks misoprostol) ($P<0.001$), and demand for misoprostol ($P<0.001$) were significantly associated with a pharmacy worker ever prescribing misoprostol (Table 4).

Factors that showed association in the bivariate analysis were further investigated using logistic regression analysis. This was done by estimating crude and adjusted odds ratios, and the results are shown in Table 5. The odds of a female pharmacy worker ever prescribing misoprostol for medical abortion was 0.48 times lower than a male worker (crude odds ratio [cOR] 0.48, 95% confidence interval [CI] 0.23–0.97). When other factors (i.e. currently stock misoprostol and demand for misoprostol) were adjusted for, the odds of a female pharmacy worker having ever dispensed misoprostol compared to males reduced to 0.37 times lower (adjusted odds ratio [aOR] 0.37, 95% CI 0.16–0.85), and the association was no longer statistically significant. Similarly, community pharmacy workers who stocked misoprostol were 4.24 times more likely to indicate they would ever consider dispensing misoprostol when compared with those who did not stock misoprostol (aOR 4.24, 95% CI 1.18–10.0). This association was statistically significant.

TABLE 1 Sociodemographic characteristics of respondents (n=165).

Characteristic	No. (%)
Age, y	
20–24	22 (13.3)
25–29	57 (34.6)
30–34	35 (21.2)
35–39	31 (18.8)
≥40	20 (12.2)
Sex	
Male	75 (45.5)
Female	90 (54.6)
Religion	
Christian	153 (92.7)
Other	12 (7.3)
Marital status	
Married	71 (43.0)
Single	88 (53.3)
Other	6 (3.6)
Education	
Tertiary	118 (71.5)
Secondary	47 (28.5)
Qualification	
Pharmacist	69 (41.8)
Pharmacy technician	27 (16.4)
Medicine counter assistant	59 (35.8)
On the job trained	10 (6.0)
Total	165 (100.0)

4 | DISCUSSION

The present study was one of only a few to assess misoprostol availability in community pharmacies and the factors affecting its prescription for medical abortion in Ghana. The results showed that misoprostol was only available in approximately half of community pharmacies in Accra, with the drug becoming less available in low-income residential areas. Weekly demand was highest in third class residential areas, where the drug was less available. However, monthly demand was highest in first class residential areas where the drug stock was also highest. A little over a quarter (44 [26.7%]) of the respondents had ever given the drug to clients seeking induced abortion services, but the majority (140 [84.6%]) indicated that they would not prescribe the drug for medical abortion in future. The two most significant factors that independently predicted ever dispensing misoprostol were availability of, and demand for, the drug.

TABLE 2 Availability and demand for misoprostol by residential area (n=165).^a

Availability and demand for misoprostol	Residential area			Total
	1st class	2nd class	3rd class	
Currently stock misoprostol				
Yes	17 (68)	55 (47.8)	11 (44.0)	83 (50.3)
No	8 (32)	60 (52.2)	14 (56.0)	82 (49.7)
Demand for misoprostol in facility				
Daily	2 (8.0)	18 (15.7)	1 (4.0)	21 (12.7)
Weekly	4 (16.0)	36 (33.0)	12 (48.0)	54 (32.7)
Monthly	9 (36.0)	25 (21.7)	8 (32.0)	42 (25.5)
Not sure	10 (40.0)	30 (26.1)	3 (12)	43 (26.1)
Never	0	4 (3.5)	1 (4.0)	5 (3.0)
Total	25 (100)	115 (100)	25 (100)	165 (100)

^aAll values are given as number (percentage).

The seeming disparity between high demand for misoprostol at community pharmacies and the limited supply of the drug deserves further commentary. Supply of misoprostol from community pharmacies appears to be limited by two factors: the drug not being stocked at all, and the unwillingness of pharmacy workers to dispense the drug, even in situations where it is stocked and there is demand. Availability of the drug was particularly limited in low-income neighborhoods where weekly demands were relatively high. While this disparity could be related to economic factors such as perceived low purchasing power in low-income neighborhoods which could have led to other drugs being prioritized over misoprostol because of lack of funds,¹⁸ the consequence could be a potential increase in unmet need for safe abortion services in low-income neighborhoods in the city. This in turn could lead to a rise in the number of unsafe abortions. These findings suggest a need for legislative reforms to broaden access to safe legal induced abortion, or to legalize abortion nationally, ensuring widespread provision in public and private facilities in order to bridge the gap between growing demand for induced abortion services on one hand and limited provision on the other hand.

Another important finding relates to the reasons why some community pharmacy workers do not want to dispense misoprostol for

medical abortion. Apart from concerns that induced abortion runs counter to their religious beliefs, many were either unsure of the dose to give, or felt it was outside their scope of practice. While it would not be appropriate to expect someone to change their religious beliefs, it may be possible to address the other two barriers through reforms and education. According to Ghana's abortion law, pharmacists should not undertake induced abortion. This may partly explain why many respondents felt it was beyond their remit to dispense misoprostol for medical abortion. However, given that community pharmacies are increasingly serving as important sources of induced abortion services, there is a need to revise Ghana's abortion legislation to include pharmacists as providers of induced abortion services. If this legislative reform is implemented, community pharmacy workers could be trained via both the regular curriculum and on-the-job training related to appropriate prescription and dispensing of abortion-inducing drugs such as misoprostol. This could empower community pharmacists to effectively respond to the growing unmet need for safe abortion services.

Regarding respondents' limited knowledge on the correct dose of misoprostol to dispense, other than a shortage of pharmacists, this knowledge gap could be a result of insufficient training in the use of misoprostol as an abortion-inducing drug. Insufficient training is more

TABLE 3 Misoprostol prescription for medical abortion by qualification of pharmacy employees (n=165).^a

Variable	Medicine counter				Total
	Pharmacist	Pharmacy technician	assistant	On the job trained	
Ever prescribed misoprostol for induced abortion ^b					
Yes	17 (24.6)	10 (37.0)	15 (26.3)	2 (20.0)	44 (26.7)
No	51 (74.0)	16 (59.3)	42 (73.7)	8 (80.0)	117 (70.9)
Would prescribe misoprostol for induced abortion ^c					
Yes	7 (10.1)	6 (22.2)	9 (15.3)	0 (0.0)	22 (13.3)
No	61 (88.4)	20 (74.1)	50 (84.8)	9 (90.0)	140 (84.6)
Total	69 (100.0)	27 (100.0)	59 (100.0)	10 (100.0)	165 (100.0)

^aAll values are given as number (percentage).

^b4 respondents had missing data on whether they had ever prescribed misoprostol for induced abortion.

^c3 respondents had missing data on whether they would prescribe misoprostol for induced abortion.

TABLE 4 Factors affecting ever prescribing misoprostol by pharmacy workers.

Variable	Ever prescribed misoprostol ^{a,b}			P value
	No (n=117)	Yes (n=44)	Total (n=161)	
Age, y				0.225
20–24	18 (85.7)	3 (14.3)	21	
25–29	43 (78.2)	12 (21.8)	55	
30–34	21 (61.8)	13 (38.2)	34	
35–39	20 (64.5)	11 (35.5)	31	
≥40	15 (75.0)	5 (25.0)	20	
Sex				0.005
Male	48 (64.9)	26 (35.1)	74	
Female	69 (79.3)	18 (20.7)	87	
Religion				1.000
Christian	108 (72.5)	41 (27.5)	149	
Other	9 (75.0)	3 (25.0)	12	
Highest level of education				0.269
Tertiary	80 (70.2)	34 (29.8)	114	
Secondary	37 (78.7)	10 (21.3)	47	
Present qualification				0.577
Pharmacist	51 (75.0)	17 (25)	68	
Pharmacy technician	16 (61.5)	10 (38.5)	26	
Medicine counter assistant	42 (73.7)	15 (26.3)	57	
On the job trained	8 (80.0)	2 (20.0)	10	
Stocks misoprostol in facility				0.001
No	69 (87.3)	10 (12.7)	79	
Yes	48 (58.5)	34 (41.5)	82	
Aware that induced abortion in Ghana is legal in some circumstances				0.203
Yes	64 (68.8)	29 (31.2)	93	
No	28 (84.6)	5 (15.2)	33	
Don't know/not sure	25 (71.4)	10 (28.6)	35	
Demand for misoprostol				0.001
Daily	10 (47.6)	11 (52.4)	21	
Weekly	35 (64.8)	19 (35.2)	54	
Monthly	30 (73.2)	11 (26.8)	41	
Not sure	37 (92.5)	3 (7.5)	40	
Never	5 (100.0)	0	5	
Residential Area				0.106
1st class	22 (88.0)	3 (12.0)	25	
2nd class	77 (68.1)	36 (31.9)	113	
3rd class	18 (78.3)	5 (21.7)	23	

^a4 respondents had missing data on whether they had ever prescribed misoprostol for induced abortion.

^bValues are given as number (percentage) unless indicated otherwise.

likely given that only 41.8% of the community pharmacies surveyed had pharmacists at the time of the study, and the fact that pharmacists are currently not permitted to undertake induced abortions in Ghana. In order to enhance the knowledge and prescription capabilities of community pharmacy workers, the recommendations of the

present study are that Ghana's Pharmacy Council and Food and Drugs Authority consider changing the status of misoprostol and related abortion-inducing drugs, and providing community pharmacists and related workers with the appropriate education and training to support women to safely and effectively self-administer the drug when it

TABLE 5 Logistic regression of factors associated with misoprostol dispensing.

Variable	Ever prescribed misoprostol ^a		cOR (95% CI)	aOR (95% CI)
	No (n=117)	Yes (n=44)		
Sex ^b				
Male (n=74)	48 (64.9)	26 (35.1)	1 (ref)	1 (ref)
Female (n=87)	69 (79.3)	18 (20.7)	0.48 (0.23–0.97)	0.37 (0.16–0.85)
Stock misoprostol ^c				
No (n=79)	69 (87.3)	10 (12.7)	1 (ref)	1 (ref)
Yes (n=82)	48 (58.5)	34 (41.5)	4.89 (2.21–10.83)	4.24 (1.80–10.0)
Demand for misoprostol ^{d,e}				
Daily (n=21)	10 (47.6)	11 (52.4)	1 (ref)	1 (ref)
Weekly (n=54)	35 (64.8)	19 (35.2)	0.46 (0.16–1.30)	0.47 (0.15–1.46)
Monthly (n=41)	30 (73.2)	11 (26.8)	0.30 (0.1–1.23)	0.26 (0.08–0.89)
Not sure (n=40)	37 (92.5)	3 (7.5)	0.67 (0.14–0.29)	0.51 (0.01–0.25)

Abbreviations: aOR, adjusted odds ratio; cOR, crude odds ratio; ref, reference category.

^aValues are given as number (percentage) unless indicated otherwise.

^bAdjusted for stock misoprostol and demand for misoprostol.

^cAdjusted for sex and demand for misoprostol.

^dAdjusted for sex and stock misoprostol.

^eA response of “never” (n=5) was not included in calculating the odds ratios.

is needed. This could contribute to lowering unsafe abortion rates and maternal mortality arising from unsafe abortion.

The present study revealed that demand for misoprostol for medical abortion is high but only half of community pharmacies stock it, and most pharmacy workers do not wish to prescribe the drug. If community pharmacies are to effectively contribute to expanding access to safe abortion services in Ghana, the disparity between misoprostol provision and demand needs to be urgently addressed.

The results of the study should be interpreted in the light of certain limitations. First, the questionnaire used relied on respondents to recall events that may have taken place several years ago, admitting the possibility of recall bias on the part of respondents. Second, given that induced abortion is still a controversial subject in Ghana, it could be questioned whether respondents were honest in reporting stocking the drug or dispensing it for medical abortion. Similarly, responses in relation to future intentions to prescribe the drug as well as correct reporting on demand could be questioned, particularly from respondents who may have indicated that they have never or would not prescribe the drug for medical abortion. A final limitation was that, the study missed an opportunity to learn about provider bias. Provider bias refers to both implicit stereotypes and prejudices about certain personalities, people from certain cultural and socioeconomic backgrounds, as well as understandings of how the world works; healthcare workers could bring provider bias into service provision as well as into their interaction with clients.^{14,15} These biases may be against a particular method of care such as induced abortion, a client characteristic or situation, or both, and they may not be immediately evident to the providers themselves.¹⁶ This has been shown to be a significant barrier to providing reproductive health services, including induced abortion care in

many low-income settings.^{14–16} Notwithstanding these limitations, important lessons could be learned from the results of the present study to inform policy and practice.

AUTHOR CONTRIBUTIONS

NTB contributed to the conception of the study, the collection and analysis of the data, and revising the manuscript. JKG contributed to the design of the study, interpretation of the data, and writing and revising the manuscript. EM contributed to the design of the study, interpretation of the data, and revising the manuscript.

CONFLICTS OF INTEREST

The authors have no conflicts of interest.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

Table S1. Reasons given for decisions surrounding prescribing.