

**UNIVERSITY OF CAPE COAST**

**VIEWS OF PROFESSIONAL HEALTH WORKERS ON UNSAFE ABORTION IN ACCRA**

**METROPOLIS, GHANA**

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**UNIVERSITY OF CAPE COAST**

**VIEWS OF PROFESSIONAL HEALTH WORKERS ON UNSAFE ABORTION IN ACCRA  
METROPOLIS, GHANA**

**BY**

**EUGENIA DONKOH**

**THESIS SUBMITTED TO THE DEPARTMENT OF POPULATION AND HEALTH OF THE  
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OF THE REQUIREMENTS FOR AWARD OF MASTER OF PHILOSOPHY DEGREE IN  
POPULATION AND HEALTH.**

**DECEMBER, 2013**

## **DECLARATION**

### **Candidate's Declaration**

I hereby declare that this thesis is the result of my own original work and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature: ..... Date: .....

Eugenia Donkoh

### **Supervisors' Declaration**

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Principal Supervisor's Signature: ..... Date: .....

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Co-Supervisor's Signature: ..... Date: .....

Mr. Eugene K. M. Darteh

## **ABSTRACT**

This thesis seeks to appraise the views of professional health workers on unsafe abortion in the Accra Metropolis, Ghana. The main data for the study were obtained from 30 professional health workers with at least two years working experience in Obstetrics and Gynaecology, in three health facilities in the Accra Metropolis (La General Hospital, Ridge Hospital and Marie Stopes International). In-depth interviews were used to obtain data.

Stigmatisation from friends, family, community and religious groups was the main barrier that affected women's choice of access to safe abortion services. On the issue of methods used, women mostly used misoprostol (cytotec) to terminate unwanted pregnancies. The reason was that misoprostol presents fewer complications. Others resort to herbal mixtures and other concoctions made from several items. The most common complications that were usually presented to the facilities were incomplete abortions, severe bleeding and infections.

The professional health workers interviewed knew about the abortion law and could mention at least one condition stipulated in the legal framework. Among the interventions suggested to address unsafe abortion was public education, particularly on the abortion laws of Ghana. The main reason was that people, including some professional health workers lack understanding and interpretation of the abortion.

The findings show that there is the need to promote access to comprehensive abortion care. This would help prevent unwanted pregnancies and also manage complications associated with unsafe abortion.

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## **DEDICATION**

To my parents Mr. and Mrs. Donkoh and Matilda Ayiney Commey.

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## LIST OF ACRONYMS

CAC	Comprehensive Abortion Care
D&C	Dilation and Curettage
D&E	Dilation and Evacuation
D&X	Dilation and Extraction
GHS	Ghana Health Service
GDHS	Ghana Demographic and Health Survey
GMHS	Ghana Maternal Health Survey
GSS	Ghana Statistical Service
Ipas	International Pregnancy Advisory Services
KATH	Komfo Anokye Teaching Hospital
KBTH	Korle Bu Teaching Hospital
MDGs	Millennium Development Goals
MI	Macro International Incorporated
MVA	Manual Vacuum Aspiration
NGO	Non-Government Organisation
O&G	Obstetrics and Gynaecology
OTC drugs	On the counter drugs
PAC	Post Abortion Complication
PHW	Professional Health Workers
PNDC	Provisional National Defence Council
PPAG	Planned Parenthood Association of Ghana
RTI	Reproductive Tract Infection

SMI	Safe Motherhood Initiative
STI	Sexually Transmitted Infection
USA	United States of America
WHO	World Health Organisation

# **CHAPTER ONE**

## **INTRODUCTION**

### **Background to the Study**

Issues concerning women and their health (specifically their reproductive health) have gained much recognition in the world today. The health of women and girls is of particular concern because they are mostly underprivileged by some socio-cultural factors which include poverty and illiteracy in most societies (WHO, 2013; Thomsen, Hoa, Malqvist, Sanneving, Saxena, et al, 2011). These socio-cultural factors affect their accessibility to health care. Women who suffer these disadvantages are found in developing countries and mostly in rural settings. Improving maternal health is a necessity to all countries, hence their coming together to ensure improved women's health and access to reproductive health to be achieved by 2015 (Westervelt, Turner, Borjesson & Mulligan, 2011). This is stated in the Millennium Development Goals (specifically goal 5 which is to improve maternal health by 2015). The targets of this goal are to attain universal access to reproductive health care for all and to reduce maternal mortality by 75 per cent by 2015 (UNDP, Ghana & NDPC/GOG, 2012).

A report by World Health Organisation (2012b) estimated that about 800 women die every day from pregnancy and childbirth related causes which could have been prevented. Also, women in developing countries are the most affected as compared to those in the developed world. In this same report, the global maternal mortality rate was estimated at 210 deaths per 100, 000 live births in 2010, with developing countries contributing to almost 240 per 100,000 live births (99%) and developed countries contributing 16 per

100,000 live births of all deaths worldwide. Sub-Saharan Africa also contributed to about 50% of the 99%. Ghana has maternal mortality ratio (MMR) of about 350 deaths per 100,000 live births, which is greater than the global estimate. Maternal death is defined in the International Classification of Diseases, as one which occurs while a woman is pregnant or within forty-two days of the termination of the pregnancy, irrespective of the outcome (abortion, miscarriage, or delivery) and anatomical site of the pregnancy, where the death is considered to be caused by a disease related to or worsened by the pregnancy or its management, excluding incidental deaths (Lori & Starke, 2012; Lokko, 2009). Also, mortalities due to abortion are higher than mortalities caused by childbirth among women in their reproductive years worldwide (Lokko, 2009).

About 79 million unintended pregnancies occur worldwide and about 42 million out of the 79 million end up aborted every year with more than half of which is unsafe (Biney, 2011; Haddad & Nour, 2009). Globally, abortion rate has decreased from 35 abortions per every 1000 women of reproductive age in 1995 to 29 and had been stable till 2008. Six million and 38 million abortions occurred in the developed and the developing regions respectively in 2008. In Asia, an estimated number of about 25.9 to 27.3 million abortion cases were recorded in 2003 and 2008. The overall abortion rate in Africa (where the vast majority of abortions are illegal and unsafe takes place) showed no decline between 2003 and 2008, holding at 29 abortions per 1,000 women of childbearing age (Sedgh, Singh, Henshaw, Bankole, Shah et al, 2012). On sub-regional basis, according to a study by Shah and Ahman (2009), the abortion rate for West Africa was 28 unsafe abortions per 1000

women with East Africa and South Africa recording the highest (39) and least (18) rates respectively.

Unwanted pregnancy and unsafe abortion currently pose some of the greatest challenges associated with women's reproductive health in sub-Saharan Africa. Abortion, as well as haemorrhage, sepsis, pregnancy induced hypertension and obstructed labour, is the leading cause of deaths among women in their reproductive years (Walls, Arrowsmith, Briggs, Browning & Lassey, 2005). Unsafe abortion contributes to 47000 (13%) of maternal deaths worldwide with an estimate of 90 (11%) and 47000 (13%) for developed and developing countries (WHO, 2011).

In Ghana, more than 1 in 10 maternal deaths (11%) is as a result of unsafe abortion (Sedgh, 2010). The estimate of unsafe abortion rate cannot be relied upon and the reason is that most of unsafe abortions are believed to take place outside the health facilities with only the severe complications presented to these facilities. This is a problem not only in Ghana or the developing world but also in the developed world (Huntington, Mensch, & Miller, 1996). There are two forms of termination of pregnancies or abortions. These are spontaneous and induced abortions. Spontaneous, which may also be termed as miscarriage or natural abortion, means unintentional termination (or the expulsion) of a pregnancy (or foetus) before the completion of its gestation period. Here, the foetus is not capable of living independently from its mother. Induced abortion (otherwise called therapeutic abortion or elective abortion depending on the situation in which the woman may be), on other hand, is the intentional termination of an unwanted, unplanned and or dangerous pregnancy.

Unsafe abortion as defined by the World Health Organisation is the procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards (Banerjee & Clarke, 2009; Grimes, 2003). In a report by the World Health Organisation in 2011, “unsafe abortions are frequently performed by providers who lack qualifications and skills to perform induced abortion. Unsafe induced abortions do not meet officially prescribed circumstances and safeguards; they are worsened by unhygienic conditions, risky interventions or improper administration of medication”. Unsafe abortion may also be termed as septic abortion when there is the presence of infections (Buck, 2004). Barot (2011) explained further that unsafe abortion may include, “those performed by unskilled providers under unhygienic conditions, those that are self-induced by a woman inserting a foreign object into her uterus or consuming toxic products, and those instigated by physical trauma to a woman's abdomen”.

Post-abortion care or post-abortion complication care is the care given to a woman experiencing spontaneous, self-induced abortion or medical termination of pregnancy with the aim of minimising or preventing the undesirable outcomes of abortion (Matsheza, 2010). Post abortion clients are those individuals who have been taken to an authorised facility or health centre and may have tampered with their pregnancies but were not successful. This is mostly caused by the clients themselves, friends or relatives and quack doctors. Such persons more often than not lack essential skills in abortion procedures. There are some conditions outlined by the WHO (2012b) to characterise abortion as unsafe and these include the following: the lack of counselling before and after procedure; the unskilled nature of the provider;



unsophisticated methods and equipment used and the lack of post abortion treatment that would be given when the need arises.

Abortion was legalised in most European countries in the 1900s, particularly in Eastern and Western Europe. By the end of the twentieth century, most countries in England and Asia also made their laws on induced abortion less restrictive. On the contrary, most African and Southern American countries have restrictive laws or legally bound abortion laws (Sedgh et al, 2012). In countries where there is legal restrictions surrounding abortion, there is the likelihood of many engaging in unsafe abortions. Particularly in the developing countries where abortion is legally restricted, most women and girls end up dying or developing incomplete abortions and other post abortion complications. These deaths are attributed to the unsafe conditions such as out-of-date equipment and methods for undertaking such procedures. In most developed countries, there are less legal restrictions on abortion and also, conditions are safer and with the use of modern methods enhance minimal risk of morbidity and mortality.

In an attempt to reduce pregnancy related deaths among Ghanaian women, abortion was made legal on certain grounds. Abortion is permitted in Ghana if the woman or the unborn child's life is at risk; also when the pregnancy was as a result of rape; incest; or the pregnant woman is mentally handicapped; and also the procedure should be done in an authorised facility by an authorised person. Also, in Ghana, there is a wide range of services that the Ghana Health Services have brought on board to help reduce the hazards of induced abortion and maternal mortality. This includes the following: family planning services to reduce the incidence of unwanted pregnancies and

hence induced abortion; abortion services which are only included in the abortion laws of the country; post abortion complication services (PAC services); and education or the provision of information on abortion issues (Ghana Health Service, 2007).

### **Problem Statement**

Safe abortion remains inaccessible due to stigma (Norris, Bessett, Steinberg, Kavanaugh, De Zordo, & Becker, 2011), high cost of safe abortion services and lack of knowledge of the abortion law. Cultural, religious and traditional stigma against abortion is prevalent in most developing countries like Ghana. Stigma; high cost of safe abortion services; abortion law and culture do not only affect women, but also abortion providers and abortion activists (Herold, 2011; Shah et al, 2009). Studies have shown that one other reason that deters women from going in for safe abortion services is the high cost associated with it. Women who are found in the low wealth quintile (poor women) cannot afford legal abortion and may be forced to procure quack services (Sedgh, 2010).

Unsafe abortion has the likelihood of affecting women's health, reducing their chances for future childbearing, and contributing to maternal morbidities (disabilities) and mortalities. Abortion-related deaths contribute significantly to the high rates of maternal mortality and morbidity in Ghana (Darko, 2010).

Sedgh (2010) reported that pregnancy-related deaths (350 deaths per 1000 live births) are the second highest cause of death among Ghanaian women in their reproductive years. Induced abortion accounted for second

highest direct cause of maternal death (11 per cent) with haemorrhage being the highest (Sedge, 2010). There are a number of studies on abortion in Ghana (Ahiadeke, 2002; Sundaram, Juarez, Bankole, & Sedgh, 2010; Konney, Danso, Odoi, Opare-Addo & Morhe, 2009; Mote, Otupiri & Hindin, 2010; Aniteye & Mayhew, 2011, Adanu, Seffah, Anarfi, Lince & Blanchard, 2012) which focus on the socio-demographics of women who have undergone abortion. Few studies have paid attention to issues like barriers to safe abortion services, outcomes of unsafe abortion and methods of unsafe abortion in Ghana (Bleek, 1981; Lithur, 2004; Morhee, Morhee, & Danso, 2007; Nyarko, Adohinzin, RamaRao, Tapsoba & Ajayi, 2008; Rominski, Nakua, Ageyi-Baffour, Gyakobo, & Lori, 2012). This study therefore explores the views of medical practitioners on the incidence of unsafe abortion and what can be done to address the problem.

### **Objectives of the Study**

The general objective of the study is to appraise the views of professional health workers on unsafe abortion in the Accra Metropolis, Ghana. The specific objectives are expressed in the following:

1. Explore the perceived barriers that hinder women from seeking safe abortion services;
2. Discuss methods commonly used for unsafe abortion;
3. Explore outcomes of unsafe abortion;
4. Assess the perceptions of professional health workers on the abortion law and;

5. Explore the views of professional health workers on the appropriate interventions to curb unsafe abortion.

### **Research Questions**

1. What are the main barriers that affect women's decision to seek safe abortion services?
2. What are the implications of the abortion law on women's access to safe abortion services?
3. What is the frequently used method for terminating pregnancies among women in the metropolis?

### **Rationale of the Study**

On issues such as abortion, it would be best for women who had undergone abortion particularly the unsafe ones to give account on their experiences for people to better understand and be informed about unsafe abortion and the effects of it. This in a way could possibly deter others from having unsafe abortions. It is impossible for such women to come out openly to do so, mainly because of issues of religion, ethics, moral standards, the abortion law and above all, stigma. On the other hand, since professional health workers provide care for such women and face lesser restrictions, they are free to give clear account on unsafe abortion and hence help to provide a holistic approach to address the issue of unsafe abortion.

The study would also provide some form of information for policy makers as regards policies and strategies to deal with matters relating to unwanted and mistimed pregnancies and unsafe abortion. This study would

also inform other stakeholders such as the government of Ghana, non-governmental organisations like International pregnancy advisory services (Ipas), Planned Parenthood Association of Ghana (PPAG), Pathfinder International and Marie Stopes International Ghana, to increase their effort in the battle against unsafe-abortion related deaths and morbidities.

The outcome of this study will be of immense importance to other researchers by serving as baseline information for future studies.

### **Organisation of the Study**

This study is organised into five chapters. Chapter One covers the introduction to the study including the background, statement of problem, objectives of the study, research questions and rationale of the study.

Chapter Two covers review of literature categorised under subtopics namely, outcomes of unsafe abortion, barriers of safe abortion, legality and the interventions to curb unsafe abortion; empirical review on abortion studies in Ghana; and theoretical and conceptual frameworks.

Chapter Three describes the methods employed in conducting this study. This includes the study area; research philosophy; research design, data and source; study population; sampling procedure; data collection method, research instrument; methods of data analysis; experiences from the fieldwork and ethical consideration.

Chapter Four presents the findings and discussion of the results. The findings and discussion are presented under thematic areas namely barriers of safe abortion; methods of abortion, outcomes of unsafe abortion, perception on the abortion law, and interventions to curb unsafe abortion. Chapter Five

concludes the study with the summary of the findings, conclusions and some recommendations.

## **CHAPTER TWO**

### **REVIEW OF RELATED LITERATURE**

#### **Introduction**

This chapter reviews literature on issues concerning unsafe abortion under the following headings: barriers of safe abortion; legal issues on abortion; outcomes of unsafe abortion; interventions to reduce unsafe abortion; theoretical framework; conceptual framework and studies on abortion in Ghana.

#### **Barriers to Safe Abortion**

The act of terminating pregnancies is not a new practice in our society. The need for abortion arises from several compelling reasons by which women would want to terminate pregnancies. Abortion has been practised in several eras the world has gone through. It is a controversial issue touching on religious, cultural, moral and traditional values. Unfortunately, these issues currently outweigh its health implications in Ghana. The low availability of hospitals that provide abortion services; socio-cultural beliefs governing abortion (Huntington et al, 1996); fear of treatment and legal punishment and the costly nature of the service also affect women's choice to have an abortion.

Geographic barrier also affects women's choice of safe abortion services (Cohen, 2008). This is because most health facilities that render safe abortion services are located in urban areas. In situations like this, women who reside farther from urban areas are forced to seek help from quacks who provide cheaper but unsafe abortions in facilities closer to them. The problem of proximity presents itself with issues of high cost of services (Sedgh, 2010).

The author was also specific that the cost of safe abortion was about GHc30 in Accra, which is relatively high. He went ahead by further stating that though it may be problematic for some women to foot such bills, some would go every length to find money to undergo such relatively 'expensive' services. The money for transportation may also affect women's need for safe abortion. So proximity and poverty work hand in hand when considering barriers to safe abortion.

Kumar, Hessini & Mitchell (2009) gave clear explanation that stigma can be produced and reproduced through social processes. They explained further thus: "people distinguish and label human differences. Secondly, dominant cultural beliefs link labelled persons to undesirable characteristics – to undesirable stereotypes. In the third, labelled persons are placed in distinct categories so as to accomplish some degree of separation of 'us' from 'them'. In the fourth, labelled person's experience status loss and discrimination that lead to unequal outcomes". In some communities women who abort pregnancies are likely to be excluded from community for life (Hessini, 2011). Kumar et al (2009) gave an account of how stigma affects women's choice of accessing appropriate medical care. Silence and fear of social exclusion prevent women from openly discussing their abortion ordeal and even those who have had abortions may deny ever having an abortion.

Abortion-related stigma has a negative effect on women with evidence in women denying accurate medical information, being charged expensive service fees, verbal or physical abuse, expulsion from school or employment, ridicule, endangerment of marital prospects, community ostracism, poor quality of services or the use of untrained providers in unsafe conditions. It is



perceived that those who perform abortions are criminals, breaking the law of such communities. However, the fear of being stigmatised in itself can push a woman to have an abortion or deter her from the act. In her quest to shy away from suffering some level of discrimination and stigmatisation, a woman with an unplanned and unwanted pregnancy in a community where abortion is greatly abhorred, would try all means to get rid of the pregnancy. This relieves her of the social segregation she would have encountered for being pregnant out of wedlock.

Abortion stigma is defined as a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood (Kumar et al, 2009). The fear of being stigmatised may play a role in making women extra-cautious when having unprotected sexual intercourse. This helps women to save both their personal and family dignity. Grimes, Benson, Singh, Romero, Ganatra et al (2006) also stated firmly that “the underlying causes of both maternal deaths and morbidity are not loss of blood and infection but rather apathy and disdain to women”. This assertion was long-established by Bleek (1981) that ridicule, fear and shame demoralise individuals in communities. These either stop people from doing things which make them ashamed or embarrassed; or encouraged them to commit these things that they are not supposed to do in secret. Bleek added that an activity may be shameful only when people get to know about it.

According to Mundigo (2006) sexual relations among unmarried people are seen as taboo. For this reason, contraception is not allowed among unmarried people especially young people who may be sexually active. It was

stated in a study by Mundigo that, “the social stigma against such (sexual relations among unmarried people) is so strong that it also prevents them from securing a method of contraception, so that if they do have premarital sexual relations and gets pregnant, abortion becomes their only way out”.

In some communities in Ghana, abortion is deemed a shameful act and a taboo and so anybody who undergoes abortion is mocked (Mack, 2010). For example, in Ghana, among the Gas, in families where women are known to have performed abortions are labelled as ‘the family where its womenfolk remove pregnancies’. This shows how the actions taken by some women do not only affect them but their families as well (Lithur, 2004; Yeboah & Kom, 2003). Stigmatisation further affects the availability, accuracy and reliability of information on induced abortion and its practices (Ahman, Dolea & Shah, 2006). In other words, people are more likely to underreport or not talk about induced abortion at all (Mote, Otupiri & Hindin, 2010).

### **Legality of Abortion**

A customary rule recognised as allowing or prohibiting certain actions and the collection of such rules according to which people live or a country or state is governed is a definition of law (Sanderson, 2004). Considering the definition above the Abortion law is a set of rules which pertains to the provision of abortion, which could be allowed or not allowed. Almost all women currently reside in countries where abortion may be obtained on request for a variety of social, economic or personal reasons. Issues pertaining to abortion globally come with certain forms of ethical, moral, religious and political accompaniment. Some countries have restrictive laws whereas others

have flexible laws. The situation or circumstances with which abortion may be legal or illegal may vary from country to country. In addition, abortion may be legal or illegal depending on the period of gestation.

The variations may include the age of the pregnancy (gestational); the age of the woman; number of children already born to a woman; the effect of the pregnancy on the woman's health and sometimes the foetus; either woman or girl was raped or got pregnant through incest; where and when the procedure was undertaken. Many countries in Europe in the early 20<sup>th</sup> century saw the need to loosen their restrictive abortion laws with the exception of Poland, Ireland and Malta (Cohen, 2009; European Green Party, 2011). The ultimate goal of all countries is to preserve human life and most of its rules are set to ensure that. However, as argued by the pro-abortionists, restrictive abortion laws in one way or the other is not helping to preserve human life, thus women in countries with such laws resort to the services of the back alley providers.

The main ideas behind countries setting restrictive abortion laws may be to deter women from engaging in indecent sexual life. Humans do not always allow themselves to be restricted. Human behaviour has the propensity to change over time within certain environments (either change to what is accepted or to fall outside the acceptable range). These changes, according to Olaitan (2009: 85), "are influenced by culture, attitudes, emotions, values, ethics, authority, rapport, hypnosis, persuasion, coercion and or genetics". This explains why when women are restricted by abortion laws they tend to find other means to get rid of unintended pregnancies. These means are getting rid of such pregnancies by themselves and or through the services of quacks.

Some countries in sub-Saharan Africa permit induced abortion on medical grounds; which is when the mother and or the baby's health are at stake. According to Okonofua, Odimegwu, Aina, Daru, and Johnson (1996), in Nigeria for example, termination of pregnancy is only permitted when it is needed to save the life of a woman. Nigerian women frequently resorted to clandestine abortion performed by 'back alley' practitioners, leading to increased rates of maternal mortality and morbidity in the country. They went further by concluding that induced abortion had been drawn in as a cause of chronic pelvic inflammatory diseases (PIDs), ectopic pregnancies, secondary infertility, secondary amenorrhea (the absence of menstruation), spontaneous abortion or miscarriage, and prematurity of subsequent births among Nigerian women.

Ghana like any other country has placed higher priority on improving health more particularly on women's health. Despite the 'relatively' liberalisation of the 'abortion law' in Ghana in 1985 (Sundaram, Juarez, Bankole & Singh; 2012), many abortions continue to be induced illegally under unhygienic conditions by providers who are either untrained or inadequately trained to provide such services.

Boseley (2012) explained that "banning abortion is not reducing the numbers of women who attempt abortion" but on the other hand increasing clandestine ones. Banning abortion is not helping solve this pandemic as also stated by Grimes (2006), and then legalising abortion on request is necessary but an insufficient step towards improving women's health. So considering these two statements much needs to be done to curb the incidence of unsafe abortion (refer to interventions). The two scholars also stated that the

availability of modern contraception can reduce unsafe abortion but can never eliminate women's need for abortion. Abortion rates are higher in regions where it is legally restricted, hence its unsafe nature. Worldwide unsafe abortion related deaths in 1990 was 69 000 and dropped to 56 000 in 2003 and again it further declined to 47 000 in 2008. But the overall number of maternal deaths was 546 000 in 1990 and declined to 358 000 in 2008 (WHO, 2011).

The European countries that saw the need to liberalise their abortion laws did so because to them, it was obvious that restrictive abortion laws were not solving abortion issues (Cohen, 2009). Moreover, following this bold step to liberalise restrictive abortion laws, there was a positive change in the abortion related mortality and morbidity in such countries. In South Africa, a fall in the rate of abortion-related deaths was recorded a year after their safe abortion services were legally rendered (Sedgh et al, 2012). This assertion was rebutted by Douthat (2012) that countries like France, Italy, Spain and Germany who are mostly influenced by the Catholic Faith have more restrictions on abortion and yet has relatively lower abortion rates than other Scandinavian countries.

In a cross-country comparison study by Mills, Bos, Lule, Ramana and Bulatao (2007), it was evident in Kassena-Nankana District in Ghana and Uttar Pradesh of India that legalisation of abortion, especially when many women are not knowledgeable about the laws is not helping matters. To solve this, a lot more advocacy and awareness should be created to educate individuals on legal abortion. Legal restrictions on abortion have a link with unsafe abortion (Reardon, Strahan, Thorp, & Shuping, 2004). Legal

restrictions have contributed to deaths of some young girls in the United States of America in the 1980s.

The examples of countries that have liberal laws on abortion are the United States of America (1973), China (1957), Cuba (1965), Singapore (1970), India (1971), Zambia (1972), Ethiopia, and many others. Countries like Benin, Sierra Leone, Burkina Faso, Gambia, Ghana, Mali, Liberia, Guinea, Nigeria and Togo have abortion laws that only allow abortion explicitly to save the mothers' lives and other reasons. In countries like Cote d'Ivoire, Mauritania, Guinea Bissau, Niger and Senegal abortion is allowed only when the mothers' lives are at risk. Cape Verde is the only West African country which allows abortion when it is requested by a woman (Singh, Wulf, Hussain, Bankole & Sedgh, 2009).

Some countries may 'flexibly' consent to abortion but some conditions must be fulfilled before the service can be rendered. Examples of such conditions are; the approval by a panel of doctors, approval by a psychologist; a state residency requirement for the woman for a specific period of time, parental or spousal consent and state sanctioned consent. Zambia and the United States of America are examples.

### **Legal Context of Abortion in Ghana**

Ghana has experienced two major amendments in the laws governing individuals on their reproductive health between 1960 and 2008. Before the law was amended in 1985, Ghana had an abortion law which prohibits women from seeking abortion services irrespective of the women's or foetus' life being at risk. Currently, the act of inducing abortion without going through the

appropriate procedure outlined by the laws of Ghana is deemed a criminal act. This is regulated by Act 29, section 58 of the Criminal Code of 1960, amended by PNDC Law 102 of 1985 (Government of Ghana & Ghana Health Service, 2012). It is enshrined in the law that:

1. Subject to the provisions of subsection (2) of this section;

a) Any woman who with the intent to cause abortion or miscarriage administers to herself or consent to be administered to her any poison, drug or other noxious thing or uses any instrument or other means or whatsoever; or

b) Any person;

i. Administers to a woman any poison, drug or other noxious thing or uses any instrument or other means whatsoever with the intent to cause abortion or miscarriage, whether or not the woman is pregnant or has given her consent.

ii. Induces a woman to cause or consent to causing abortion or miscarriage.

iii. Aids and abets a woman to cause abortion or miscarriage.

iv. Attempts to cause abortion or miscarriage; or

v. Supplies or procures any poison, drug, instrument or other thing knowing that it is intended to be used or employed to cause abortion or miscarriage; shall be guilty of an offence and liable on conviction to imprisonment for a term not exceeding five years.

2. It is not an offence under section (1) if an abortion or miscarriage is caused in any of the following circumstances by a registered medical practitioner specialising in gynaecology or any other registered medical practitioner in a government hospital or a private hospital or clinic registered under the private Hospital and Maternity Home Act, 1958 (No.9) or in any place approved for the purpose by legislative instrument made by the secretary:
  - a) Where pregnancy as a result of rape or defilement of a female idiot or incest and abortion or miscarriage is requested by the victim or her next of kin or the person in loco parentis, if she lacks the capacity to make such request;
  - b) Where the continuance of the pregnancy would involve risk to the life of the pregnant women or injury to her physical or mental health such as a woman's consent to it or if she lacks the capacity to give such consent it is given on her behalf by her next of kin or the person in loco parentis.
  - c) Where there is substantial risk that if the child is born it may suffer from or later develop a serious physical abnormality or disease.
3. For the purpose of this section, abortion or miscarriage means premature expulsion or removal of conception from the uterus or womb before the period of gestation is completed.

Though Ghana has fairly liberal abortion laws, socio-economic reasons to terminate pregnancies are not indicated in (Mills et al., 2007). This means that



women cannot give socio-economic reasons as appropriate for terminating pregnancies.

### **Methods of Abortion**

Women are mostly compelled to terminate pregnancies that they are not ready to have and would go every length and breadth to end such pregnancies. This is supported by Sundaram et al (2012) that “the need to seek abortion is most often driven by an unintended pregnancy, which occurs when women who want to space or limit childbearing are not able to prevent an unplanned pregnancy”. Kumar et al (2009) also asserted that “the decision to terminate a pregnancy does not take place in a vacuum; instead it is a result of a particular set of often quite complex circumstances”.

In developing countries where abortion is illegal or highly restricted, various methods are used to induce abortion. Despite the increased usage of modern contraceptive methods among married women of reproductive age, the overall rate of usage remains low and the unmet need for contraception in Ghana remains high (at about 35 per cent of married women and 20 per cent for sexually active unmarried women). The reason could be that Ghanaian women may be resorting to abortion to prevent unwanted and unplanned pregnancies. Their quest to terminate such pregnancies would not be fulfilled without the use of abortifacients and other surgical means. Abortifacients are drugs either herbal or chemical agents or substances that cause abortion (Miller, Lehman, Campbell, Hemmerling, Anderson et al, 2005). They could also be termed as aborticides or abortion-inducing-drugs. Some other means of terminating pregnancies may include insertion of objects; herbs or other

substances in the vagina or vaginal suppositories; receiving an injection; and drinking herbal concoction (GSS, GHS & MI, 2009).

Medical abortion as defined by the National Abortion Federation (2010) “is one that is brought about by taking medications that will end a pregnancy. The alternative is surgical abortion, which ends a pregnancy by emptying the uterus (or womb) with special instruments. Either of the two medications, mifepristone or methotrexate, can be used for medical abortion. Each of these medications is taken together with another medication, misoprostol, to induce an abortion”. Some surgical termination methods as outlined by Goldman, Occhiuto, Peterson, Zapka and Palmer (2004) include Manual Vacuum Aspiration (MVA), Standard Vacuum Aspiration, Dilation and Curettage (D&C), Dilation and Evacuation (D&E), Dilation and Extraction (D&X), Osmotic Dilation.

Menstrual regulation, the use of Cytotec (Misoprostol) and Mifepristone tablets (WHO, 2012a; Tautz, 2004; Hessini, 2004) and intra-amniotic injections such as hypertonic saline solution [otherwise called instillation abortion] are methods of terminating pregnancies (Buck, 2004; Mundigo, 2006; American Pregnancy Association, 2013). In Ghana, Mills et al (2007) highlighted more on the recognition given in the National Reproductive Health Service Policy and Standards to midwives (medical professionals) to provide treatment of abortion complications using MVA.

Crude methods used for illegal abortion may include intake of ground up broken bottles mixed with sea water and ‘blue’, washing detergents, melted sugar with Guinness and ground paracetamol tablets mixed with local liquor (Bokpe, 2011). Also according WHO (2012a), some crude handling of

pregnancies by some traditional abortion providers is by exerting excessive pressure on the abdominal area thereby causing the expulsion of the foetus (this sometimes causes death).

In Bleek's study in the 1980s, he found out that herbs form the largest category of abortifacients used by women in southern Ghana. According to him different parts of the plants (leaves, roots, bark, twigs, seeds and fruits) were used to terminate pregnancies. Examples of plants and trees he outlined included mangoes, pawpaw, pineapple, cotton, lemon, coconut and passion flower. Van Andel, Myrenb, and Van Onselenc (2012) listed some plants or flora that women in Ghana used for all kinds of purposes. The commonly sold medicinal product was the 'Pteleopsis Suberosa' bark. This was used to purify the uterus (that is to: enhance fertility; avoid puerperal fever; and also to induce abortion in the first trimester).

Also, Van der Geest (2007) talked about methods of terminating pregnancies. He stated that, he counted 53 different methods of 'causing' abortion, most of them harmless and ineffective, for example the consumption of extremely sweet drinks. Other methods however were very dangerous, for example the insertion of a twig of a certain tree into the uterus or an overdose of anti-malaria drugs. The fact that the girls knew the risks and yet tried to have the abortion, showed their desperation. Use of crude methods of abortion varies from woman to woman. While some mixed concoctions and drunk in solutions, others used in enemas, and others inserted in the uterus directly (Bleek, 1981). Others also resorted to herbal preparations which cost less than other methods (Badasu, 2001).

## **Outcomes of Unsafe Abortion**

The health outcomes associated with the act of termination of pregnancies could be measured by some standards set by the World Health Organisations (WHO, 2012a). The following standards outlined below need to be critically assessed before a woman can undergo a safe abortion procedure:

- The facility or institution where the procedure is carried out
- The skill of the service provider
- The method of abortion used
- The general health of the woman
- The gestational age of the pregnancy

All of the above are necessary but the latter, which is the gestational age of pregnancy, could be considered as one which should have greater concern. This is because every gestational age comes with the appropriate method of termination, and the risk of abortion related complications increases with gestational age (WHO, 2012a; Shadigian, 2005).

The outcomes of unsafe abortions may be grouped into three categories and these are physical, psychological or mental and social outcomes. Also, each of the categories may be divided into immediate or short-term and long-term outcomes. Shadigian (2005) explained short-term or immediate outcomes of abortion as the effects that are visible or present within six weeks after the procedure, whereas the long-term effects are those that are seen as persistent after six weeks after the procedure. These long-term effects may also be seen as life threatening. Induced abortions within the first trimester of pregnancy are of minimal risk to experience any complication as compared to those in the second trimester. In other words those in the first trimester tend to be the

safest, when all other things remain the same, as compared to the ones done in the second and third trimesters (Reardon et al, 2004). Based on some arguments by both anti-abortionists and pro-abortionists, abortion is known to have both slight and intense effects on the mental, physical and social wellbeing of some women if not all. The magnitude of the effect might be different from woman to woman.

Abortion, either safe or unsafe, may present itself with some form of outcomes or consequences. These outcomes may not be termed as complication unless the occurrence becomes unbearable and persist for a relatively longer duration. When this happens then the need for urgent medical attention becomes necessary. These physical outcomes may present themselves depending on the method used for the termination of pregnancies. This was confirmed in a study by Kruse, Poppema, Creinin and Paul (2000). It was clear in their study that there are some major aftermaths no matter the method used. These are heavy vaginal bleeding; pelvic cramping; dizziness and headaches.

There is also the tendency of permanent disabilities, like chronic pelvic pains, pelvic inflammatory disease, infertility, genital fistula and deaths (Achilles & Reeves, 2011; Kruse et al, 2000). There are various forms of physical complications which may include: cramping; fever; abdominal pain; haemorrhage (often termed as severe bleeding); bladder injury; sepsis; pelvic inflammatory diseases; upper genital infection; endometriosis; placenta previa; cervical laceration; uterine perforation; amniotic fluid embolism and loss of some internal organs such as the fallopian tube, uterus (technically called hysterectomy), and ovaries.

According to Shadigian (2005), abortion generally has adverse effect on the health of women and these conditions present themselves mostly after unsafe or clandestine abortions. One of the key findings that unfolded was 10 percent of women undergoing abortion will suffer immediate complications of which two percent are considered life threatening. The scholar also asserted that complications may become higher with greater gestational age.

Complications of abortion were categorised into immediate and long terms in this study. Immediate complications include infections such as fever; abdominal pains or cramping; amniotic fluid embolism; injury to the cervix, vagina, uterus, fallopian tubes and many others. Some also experience unsuccessful or complete abortions (Kabore, Bankole, Rossier, & Sedgh, 2011). Long term complications which have a higher likelihood to be caused by surgical abortion than caused by medical abortion may include breast cancer, placenta previa and preterm births. Findings from this study also objected the view of some researchers that there are associations between abortion and subsequent miscarriages, ectopic and infertility.

It was also evident in a study by Bartz and Goldberg (2009), by ranking abdominal pain or cramping the frequently reported effect (56%), followed by nausea (54%), then tiredness (50%), breast pain (28%), and heavy vaginal bleeding (10%). Also some may suffer eating disorders; which may either be anorexia disorder (loss of appetite) or bulimia (compulsive overeating), though this might be related to some form of depression (Reardon et al, 2004). Some even suffer anaesthesia complications.

Aside these immediate health complications, there are others likely to manifest later on in women's reproductive life. Examples of such are breast,

fistula; cervical, endometrial and ovarian cancers; poor general health; handicapped neonates in later pregnancies; likelihood of future ectopic pregnancies; infertility and other forms of disability and death. Other physical effects of all forms of abortion either spontaneous or induced (both safe and unsafe) are exhaustion and nervousness.

There have been some arguments on whether there is a link between psychological imbalance (or which may be termed as post-abortion traumatic stress syndrome) after abortion or not. This argument is again between anti-abortionist and pro-abortionist. Anti-abortionists do not only say abortion is unethical and morally wrong, they say it also affects the mental health of women who have ever had an abortion (Cohen, 2006).

Studies on the relationship between abortion and mental disorders given by Coleman, Coyle, Shuping and Rue (2009) and Colbert (2003) revealed that; panic disorders and attacks, post-traumatic stress and disorder, agoraphobia (fear of open space), bipolar disorder, mania and long term depression and also behavioural disorders; which includes alcohol abuse, drug abuse and promiscuous sexual behaviour are possible psychological outcomes of abortion (being it safe or unsafe). Some women even experience self-hatred; others too experience delusions and recurrent dreams of the whole abortion process and memory impairment (Burns, 2006). Explicitly according to Coleman et al (2009), though it is possible to connect abortion with psychological imbalance, abortion may not be the only trigger of such mental inconsistencies. In other words, there should be other stimuli or contributory factors (as in woman may have been widowed, or have financial problems, or had ever suffered sexual trauma in childhood and adulthood) present to add up

to the problems that come with unwanted pregnancy and abortion. It was found out that those who abused alcohol after abortions may not necessarily be because of the abortion but due to boredom, rebelliousness, curiosity and the like.

Looking at the assertion by Coleman et al (2009) that abortion dependent on other factors presents itself with high risks of anxiety, mood and substance abuse disorders, Steinberg and Finer (2010) on the other hand, explains why that cannot be accepted. They refuted findings of Coleman et al (2009) by reconducting the research using the same data. They conceptualised abortion as a traumatic experience independent on other stimuli, as in the case of rape and wars.

It is evident that some women go through psychological problems and some go further by proving the relationship between abortion (Reardon et al, 2004) and the state of minds of women who have ever experienced either spontaneous or induced abortion in their lifetime. Women may not have imbalance mental health after an abortion but only when they start to experience some form of discrimination and stigmatisation. Others may be relieved immediately after getting rid of unwanted pregnancies (Johnson, 2011). They may later on in life experience regret, most especially when they start encountering difficulty in getting pregnant and or carrying pregnancies to term (Charles, Polis, Sridhara & Blum, 2008). Steinberg et al (2010) and Reardon et al (2004) added that abortion may or may not be the only cause of mental health problems of women without including other factors which could be structural, personal, psychological or social.



In Ghana, much like other sub-Saharan African countries, there is a big premium placed on fertility and ability to have children. The performance of an abortion is perceived as limiting a woman's chance of childbirth. Traditionally, the community may give a woman who has caused abortion derogatory names, which sometimes connote immorality. Consequences of stigmatisation alone affect the psychological well-being of women who have or ever had an abortion in most areas where they believe in high fertility. There are other forms of psychological impacts that abortion is perceived to have on some women and some of them are as follows: regret and remorse; inability to forgive oneself; intense interest in babies; child abuse; low self-esteem and many others. Research conducted by Reardon et al (2004) in California highlighted that women who had abortions were three times more likely to die from causes attributed to mental disease than women who carried to term.

In Ghana, Asamani (2013) reported that health providers were arrested because the police thought that abortion is illegal and those who gave that service were seen as criminals. This created a form of embarrassment to such health providers. One other reason they were arrested was that the police had little or no idea about the abortion law and so arrested the wrong 'culprits' and leaving the quacks. Health providers as well as women face stigma from their societies and even from other colleagues;

There are various ways in which women suffer from stigmatisation and discrimination in the societies in which they live. Women in the first place may suffer self-rejection. This may be connected to the psychological effects of abortion. This may further affect the relationship with her partner, if the

pressure came from him; and may also destroy her parent-child relationship, if the parents coerced her to abort. Some women may even abuse their own children. Women may become negative about life in general and avoid people and situations that may remind them of the abortion.

Treatment of post-abortion complications places a significant financial burden on public health care systems in the developing world, of which Ghana is part (Kinoti, Gaffikin, Benson & Nicholson, 1996). A study by Sedgh et al (2012) brought to light that the minimum annual estimated cost of providing post-abortion care in the developing world is \$341 million.

In the Cameroon Grassfields (Schuster, 2005), there was the evidence that an 18 year old woman died from abortion related complication. In avoidance of being shamed and facing discrimination, she gave misleading information that she was down with malaria after being rushed to the hospital. In the actual sense she was suffering from acute abdominal pain, heavy vaginal discharge and tested positive for pregnancy. This woman died before she could be given post abortion care. In this region, abortion is used as a method of preserving secrecy in order to prevent church and local moral condemnation. Furthermore, Bleek (1981) found out in a study conducted in southern Ghana that when a woman dies of abortion, her funeral is not celebrated. Traditions forbid families from burying a woman if her abortion escapade is publicly known. A woman would hide abortion as a great secret even if she needs immediate post abortion complication care, just to save her face and that of her family and the society at large.

In developing countries, though women have access to family planning services, yet poor women have the least access and usage (Prata, 2009). They

also have the fewest resources to pay for safe abortion procedures when faced with unwanted pregnancies. Hence, they are the most likely to experience complications related to unsafe abortion: when they suffer these complications it invariably affects their households (Sedgh, 2010). Unsafe abortion has significant negative consequences beyond its immediate effects on women's wellbeing. For instance, complications from unsafe abortion (whether treated or not) may reduce a woman's productivity during illnesses and recovery. This according to Vlassoff, Shearer, Walker and Lucas (2008) could happen whether or not she suffered a disability or not. Also, permanent disability and death may increase the economic burden on poor families thereby leading to intergenerational cost to children.

### **Interventions to Curb the Incidence of Unsafe Abortion**

Although unsafe abortions are preventable, they remain risky to women's health. The causes of unsafe induced abortions are entrenched in a complex set of socio-demographic circumstances. Shadigian (2005) asserted that there is high risk of deaths among women who have induced abortion than those who give birth; and the risk of death related to abortion is three times higher than the risk associated with childbirth. In this case unsafely induced abortion should be critically given the attention deemed it. Interventions, according to Asamani (2013), should not only be targeted at individuals but should also affect interpersonal, organisational, and environmental factors influencing health behaviour.

Reduction in the rate of abortion remains one of the objectives of the World Health Organisation Regional Strategy on Sexual and Reproductive

Health. This could be achieved by providing adequate reproductive health services; that is by including family planning into primary health care policies and programmes (Lazdane, 2005). Another is to remove all barriers surrounding the type of contraceptive one chooses. Family planning services must be made more available, accessible and affordable to all and counselling strategies should be adapted to help our circumstances in order to eliminate the induced abortion disasters.

Stigmatisation has contributed to unsafe abortions in Ghana especially in the rural areas (Sundaram et al, 2012) and other parts of the world. Certain Ghanaian customary practices highly resort women to unsafe abortion. For example, in some tribes, a marriage ceremony cannot be performed for a pregnant woman. Also, it is considered a taboo when a woman gets pregnant before puberty rites are performed for her. For the sake of saving lives, traditional leaders may have to be provided with information on the implications of unsafe abortion and its contribution to maternal mortality, and encouraged to incorporate information on consequences of unsafe abortion in puberty and initiation rites.

For this same cause, political and religious leaders should be encouraged to make safe abortion less controversial, as stated by Lithur (2004) that, “religious leaders should be made to understand that providing sexuality education on abortion would not promote promiscuity”. In all, abortion stigma is a social construct used to control women and abortion providers, and it's a way that we punish women who deviate from social norms for what a woman should be. One of the first steps is to recognise it, own it and discuss it. And

then let's deconstruct what we've learned, what people believe to be true and create something different” (Hessini, 2011).

Social and religious beliefs of health professionals play an important role in the provision of health care service delivery. If possible, personal beliefs should not control the care a client seeking abortion receives. Nonetheless, ethical, religious and cultural values influence the teaching and provision of abortion services as granted under the Ghanaian law. Ipas Ghana has initiated the Mentor Provider Network; which is to aid build a network of highly skilled abortion providers and mentors to ensure the safety of Ghanaian women in receiving the best of reproductive care. Service providers in this programme work against all odds to save lives (Ipas Ghana, 2011).

Most skilled health professionals capable of managing abortion complications remain in urban areas. In the rural areas, midwives are the main service providers, therefore preparing them to provide comprehensive abortion care is of great importance and much needed. In Ghana, strategies to address this gap have been largely limited to in-service approaches. Pre-service training has been more limited. The components of Comprehensive Abortion Care (CAC) are options counselling, induced abortion, post abortion care and post abortion contraception (Voetagbe et al, 2010; Rominski et al, 2012).

According to the Ghana MDG Acceleration Framework and Country Action Plan in 2011, effective family planning usage is of high potentials likely to reduce the high risk of maternal deaths and illnesses as a result of pregnancies and induced abortions especially the unsafe ones. But as indicated in the 2008 Ghana Demographic Health Survey (GDHS), the contraceptive prevalent rate is still low, which was 13% in 1988 and 23.5% in

2008. Abortion related deaths and morbidities may continue to rise unless most women if not all, have access to safe abortion and contraception services. Programmes of women empowerment should further be reinforced in order to support women in knowing their rights and freedom to decide whether and when to have a child. Incidence and associated complications of illegally induced abortions can be reduced through effective family planning services by improving women's educational and social status, mass health education and legal sanction against backdoor abortionists.

Also, according to Mills et al (2007) and Nyarko et al (2008), improving obstetric care services is likely to reduce maternal mortality. They suggested that this could be done by using a three-pronged approach which includes the following: improving safe abortion and family planning services; increasing financial and physical access to obstetric care; and upgrading obstetric services by training nurses and doctors on abortion services, comprehensive post-abortion care, including treatment of abortion complications, family planning counselling, and referral when necessary. Furthermore, health facilities should be equipped with the needed instruments and medication so that treatment would be given early enough to reduce preventable maternal deaths.

These interventions that are likely to address the problem of unsafe abortion were summarised by Sai (2010) that, "it will be good practice to get to know the laws and interpreted them with compassion. The tragedy resulting from unsafe abortion can be prevented through sex education, proper use of contraceptives and provision of safe abortion services within the law, and competent post-abortion care".

## **Abortion Studies in Ghana**

A number of studies have been conducted on abortion in Ghana which brings out issues on the barriers to safe abortion services, outcomes of unsafe abortion, and issues relating to the abortion laws of Ghana.

Among the studies that bring out some barriers that hinder some women from accessing safe abortion services are as follows:

A research by Aniteye and Mayhew (2011) entitled “attitudes and experiences of women admitted to hospital with abortion complications in Ghana”, was conducted in the Korle Bu Teaching Hospital and the Ridge Hospital. The total of abortion cases recorded at KorleBu was 1874 and at Ridge was 246 during the data collection period in 2002. The researchers employed structured questionnaire form data collection among 131 women who had been admitted in these hospitals with incomplete abortions.

The majority of respondents were young and single, with no children or just one child. Most respondents had had middle-school education or higher and were employed, much like their partners. Also, the knowledge of family planning was high but knowledge on specific methods was barely moderate with only 17% (approximately 22) respondents who had ever used any. There was also evidence of the misconceptions of family planning and about 60 women said they were afraid of side effects associated with family planning. About 14 women said their pregnancies were planned and about 41 of the women mentioned ever wanting the pregnancies but were pressured by partners or families to abort. Overall, about one-third of respondents said they aborted because they were not married and two-thirds said they aborted because of socio-cultural pressures. This study highlights clear on-going

failings of the family planning programme which needs to be revamped, as well as an urgent need for improving public knowledge about access to safe, legal abortion services.

A study was conducted by Nyarko et al (2008) in the Greater Accra Region on profile of abortion seekers in Ghana and their decision-making processes. The study provides a profile of beneficiaries; their need for information and services; their decision-making processes to seek care; their knowledge of service points; and the quality of care they received.

Data were collected from four health facilities in the region. These facilities were made up of two public and private sector facilities. The data collection method included the review of hospital records, interviews and observations. The interviews were carried out among 12 service providers and 146 clients who had undergone an abortion procedure and had recuperated.

The key findings of the study were that women in Ghana who sought abortion were mostly young adults from ages 20 to 24 years (accounting for 41%). Also, women who were categorised under “well educated” were mostly those who sought for abortion services, with 37% in the middle or junior secondary school education and approximately 19% in the senior secondary or higher level education. Thirty-six per cent of the women were engaged in sales and 23% in service occupations. Deducing from the interviews with the women, various reasons were cited by women to be why they aborted their pregnancies. The reasons given included: pregnancies were mistimed and unwanted (39%); their partners and family members not in support of the pregnancies (20%); to continue work or education (16%). On the issue of final decision-making, 32% of the women said they took the final decisions to seek



the service from a particular facility. Twenty-four per cent also mentioned that the final decision was made by themselves and their partners. From the interviews, providers were asked about their views on the Ghana Standard and Protocols on Comprehensive Abortion Care. It was found out that 33% of the providers knew about the Ghana Standards and Protocols on Comprehensive Abortion Care very well. On the observations of the interactions between providers and clients, it was realised that the interactions between providers and clients at the private facilities were better than those of the providers and clients at the public facilities. Cases presented in the public facilities were mainly post abortion complications whereas cases presented at the private facilities were mostly elective abortion services.

It was concluded that there are available safe abortion services in both private and public sector facilities. They also identified some problems with the interactions providers had with clients. The problem was that providers did not seek vital information that would in turn help them give appropriate information to clients. Suggestions were made to help improve services rendered to clients and these included; training more providers offering comprehensive abortion care, improving the quality of existing services to avoid unwanted pregnancies and repeat abortions, educating community members on the location of existing facilities that provide safe and confidential services to increase access to such facilities.

A study which focused on women who are likely to seek abortion services was conducted by Ahiadike (2002) with the title “The incidence of self-induced abortion in Ghana: what are the facts?” He used data from the Ghana Maternal Health Survey conducted over 1997/1998 period. The study

was conducted in eight study communities where 1689 pregnant women identified. Out of this number, 1187 women carried their pregnancies to term, nine died, 317 aborted their pregnancies, 21 miscarried and 15 had stillbirths.

Ahiadike (2002) identified that the abortion rate were 22 and 28 induced abortions per 1000 women of reproductive years in 1997 and 1998 respectively. It was also identified that abortion was higher among women younger than age 30 and those with no child to two children. A result from the study suggested that women who were employed, urban dwellers, single, women who have had previous abortions, women with levels of education beyond Middle/JSS and Christians rather than Muslims are the ones likely to have an abortion. Reasons for which women terminated pregnancies included among others financial constraints; means of postponing childbearing; fear of losing education and relationship problems. On the issue of the type of provider of abortion service, it was identified that 121 women resorted to the services of pharmacists, 64 the services of nurses or midwives, 39 the services of physicians, 34 self-medication, 51 the services of quacks and the remaining 8 were specified as others. The laws of abortion were also considered in this study. He stated that the effects of legalising abortion may only bring about little changes to the overall abortion levels.

He concluded that should abortion be legalised, who should bear the cost of the service, particularly for women who are impoverished and are not able to access such services.

An additional study was conducted by Mote et al (2010) in Hohoe in the Volta Region of Ghana. The study was entitled “factors associated with induced abortion among women in Hohoe”. The aim was to describe factors

influencing induced abortion among 408 randomly selected women who were aged 15-49 years. The study was a community-based cross-sectional survey which was undertaken over the period of July to October 2008. Multistage sampling technique was used to select seven sub districts and a total of 408 study participants/households from urban, peri-urban, and rural communities. This was done using the probability proportionate to population size technique. Households were randomly selected. In cases where there were more than one woman who met the selection criteria (aged 15 to 49 irrespective of marital status) for the study, then only one was chosen using simple random sampling to select one woman.

The key findings of the study were as follows: 21% (which is 86 out of 408) of the women had had an abortion. Out of the 86, 36% (approximately 30 women) said they did not want to disrupt their education or employment; 66% (approximately 57 women) of the abortions were performed by doctors. A bivariate logistic regression comparing women's educational levels revealed that uneducated women were significantly less likely to have had an abortion compared to women with secondary and basic education levels. Also, women who were married, peri-urban residents and women with formal employment were more likely to have an abortion.

They recommended that stakeholders should improve on access to effective contraception to lower the chance of needing an abortion and target education programmes at those with unmet need for contraception. They also suggested that policies and programmes to target affordable avenues for safe and comprehensive abortion services, particularly for single, peri-urban residents older than 25 who have formal employment.

Sundaram et al (2012) conducted a research on factors associated with abortion-seeking and obtaining a safe abortion in Ghana. The main objective of the study was to identify the socio-demographic profiles of persons who seek to induce abortion and those who are able to obtain safe abortion services. Data were extracted from the 2007 Ghana Maternal Health Survey. The study was cross-sectional and nationally representative. Data were collected in two phases, using multistage, stratified, clustered sample design among women aged 12 to 49.

The key findings of the study were that, among religious groups, Pentecostals/Charismatic and Protestant women had the greatest likelihood of terminating pregnancies than women who were found in the other religious groups. Also, women who were younger, had many children, in the lower socioeconomic category and had unsupportive partners were more likely to terminate pregnancies as compared to those who were either of the same age or older but had fewer children, in a higher socioeconomic level and had supportive partners are not likely to terminate pregnancies. Another finding was that women in their 20s were more likely to seek abortion services more than those who were in their 30s. Also, stigma was also likely to affect the younger women who were found in the lower socioeconomic status. Lastly, one finding of interest is the fact that there exists a strong association between the role of partners and abortion safety.

The authors concluded that aside the less restrictions of the abortion law, there still exists the problem of women seeking for safer abortion services. They suggested that the availability of and accessibility to contraceptives could help reduce unintended pregnancies. Women would only

access if they have knowledge about contraception, hence the need to strengthen advocacy and promotion of contraception and the ability to reduce maternal morbidities and mortalities. Another out of the many is that, partners of women should be encouraged to be responsible in the decisions concerning pregnancy and childbearing.

Another study was conducted by Adanu, Seffah, Anarfi, Lince and Blanchard (2012) on sexual and reproductive health in Accra, Ghana. The objective of the study was to describe sexual and reproductive health among women in Accra and explore the burden of sexual and reproductive ill health among this urban population.

It was a cross-sectional study. They analysed data from the Women's Health Study of Accra II (WHSa II). The survey used a sample size of 2814 women, a cross-sectional household survey on women's health. They also used a supplemental data from an in-depth survey with sample of 400 women. Again, focus groups discussions were organised among 22 women to document community norms and knowledge regarding contraception and abortion. as well as in-depth interviews (for 20 respondents) were conducted among a subsample of women which focused specifically on exploring experiences of abortion among women who reported having had an abortion in the WHSA-II survey.

The key findings for this particular study revealed that modern contraceptive use was uncommon. More than one third of women reported ever using abstinence; condoms, most women reported using injectables and the pill. The total fertility rate among the sample of women was just 2.5 births. The authors found out that there was a considerable burden of sexual and

reproductive ill health. They further explained that one in 10 women reported menstrual irregularities and almost one quarter of women reported symptoms of a Sexually Transmitted Infection (STI) or Reproductive Tract Infection (RTI) in the previous six months. Focus group results and in-depth interviews reveal misperceptions about contraception side-effects and a lack of information. They defined reproductive ill health as including menstrual irregularity or RTI and STI symptoms. The women mentioned abortion as a traditional method of contraception that was used to prevent pregnancy. On the issue of abortion, 10 out the 22 women had had abortion since 2003.

In their conclusion, it was revealed that in urban Ghana, modern contraceptive use was low and a significant proportion of women experienced reproductive ill health. They suggested that increased access to information, products and services for preventive care and contraception could improve reproductive health. Furthermore, more research on healthy sexuality and the impact of reproductive ill health on sexual experience is needed.

Bleek (1981) also examined another aspect of abortion in Ghana, entitled 'avoiding shame: the ethical context of abortion in Ghana'. The study was carried out among Ghanaian rural towns focusing on the Akans. Bleek used in-depth interviews, questionnaire, projective tests and observations as data collection tools. The subject under investigation was "sexual relationships and birth control including abortion". The study carried out by Asante-Darko focused on the "consequences of unwanted pregnancy and abortion for the education of young women". Bleek interviewed and observed 100 men and 179 women. Asante-Darko used mail questionnaires to collect data from 206

schools (from two regions and two districts) in southern Ghana. He also interviewed a number of 55 cases of abortion including female school pupils.

Among 42 members of a lineage, 29 cases of abortion and 10 out of 19 interrupted pregnancies were recorded. It was implied that for about every 100 pregnancies, 15 ended up in abortion and more than half of the women under study had ever terminated at least one pregnancy. Also there was the evidence that abortions were occurring in the school situations. Among the reason for termination, women mentioned issues related to pregnancies resulted from premarital and extramarital relationships. Another reason was pregnancies that were not planned. Among the social 'push factors' cited as reasons to abort were fear, shame and ridicule associated with having unwanted and unplanned pregnancies.

They concluded that though abortion was illegal, it was still practised in secret in the communities the study was undertaken. In such societies, so long as abortion is successfully done, there was nothing wrong with the act. On the other hand, when information about an abortion is made known publicly, then such women would be ridiculed and condemned greatly.

Some studies conducted in Ghana also outlines outcomes of unsafe abortion that women experience, some are as follows:

Lithur (2004) conducted a study on, destigmatising abortion (expanding community awareness of abortion as a reproductive health issue in Ghana). Traditional and cultural values, social perceptions, religious teachings and criminalisation of abortion have brought about stigmatisation of abortion in Ghana. Abortion is illegal in Ghana except in three instances (when pregnancy is likely to affect mothers' health and that of the foetus, and when

the pregnancy is as a result of rape, incest and when it involves a female idiot).

Though the law allows for the carrying out of abortion in these instances, the Ghana Reproductive Health Service Policy did not have any induced legal abortion services component to cover the three exceptions until it was revised in 2003. The policy only had 'unsafe and postabortion' care components, and abortions performed in health facilities operated by the Ghana Health Service were performed under this component. Though the policy has been amended, women and girls who need abortion services in Ghana more often resort to the unsafe means and procedures. Criminalisation of abortion and those who perform abortions has contributed to unsafe abortion, the second leading cause of maternal deaths in Ghana. Most of these are performed outside the formal health service settings. Usually, abortion is a shameful act and our society stigmatises women who have caused abortion and ridicule them as well.

The researcher concluded that Ghanaians should be made aware of the reproductive health benefits of providing safe abortion services. Three key approaches that is likely to help to destigmatise abortion in communities were suggested. They are as follows: the liberal interpretation of the three exceptions to the law on abortion; expanding community awareness of its reproductive health benefits; and improving and increasing access to legal abortion services within the formal health facilities.

The following are some studies that bring out issues relating to perception of the abortion law in Ghana:

A study was conducted on attitudes of doctors towards establishing safe abortion units in Ghana by Morhe, Morhe and Danso (2007) in August



2003. The objective of the study was to assess physician's knowledge on the then current legal status of abortion in Ghana. Another was to determine the proposition of physicians in favour of establishing units where safe abortion services would be provided and the proportion willing to offer the services. The study was conducted in the Komfo Anokye Teaching Hospital (KATH). The study population was made up of 74 physicians who were randomly selected. The study was quantitative in nature. The data collection instrument employed was self-administered questionnaires.

The key findings were as follows. Fifty-nine (59) out of the 74 respondents supported the view that abortion units should be established in the health facilities in Ghana. Twenty-seven (27) indicated their willingness to take part in counselling only, with 33 accepting to carry out the procedure. However, 14 were not willing to offer any service should the units be established.

They concluded by stating that although 80 per cent favoured the idea that abortion units should be established, not all of them were willing to offer services. This could be that these individuals saw abortion as a problem in the country and attention should be given to it.

The study lacks representativeness. This is because it only took samples from only one health facility. Samples could have been drawn from other facilities in all the 10 regions of Ghana. Again, in-depth interviews could have been the best instrument for the study. This is because; interviews may give room for further probing to understand the views of respondents but questionnaires may cause respondents to give restrictive answers, hence limiting what the respondents wants to express.

Konney, Danso, Odoi, Opare-Addo and Morhe (2009) conducted a study on attitude of women with abortion complications toward the provision of safe abortion services in Ghana. The aim was to determine the attitude of women towards safe abortion services; their socio-demographic characteristics; and their awareness of the abortion law.

The study was a cross-sectional one using a standardised questionnaire to collect data within two months. Responses were sought from women admitted with abortion-related complications at Komfo Anokye Teaching Hospital (KATH), in Kumasi, Ghana.

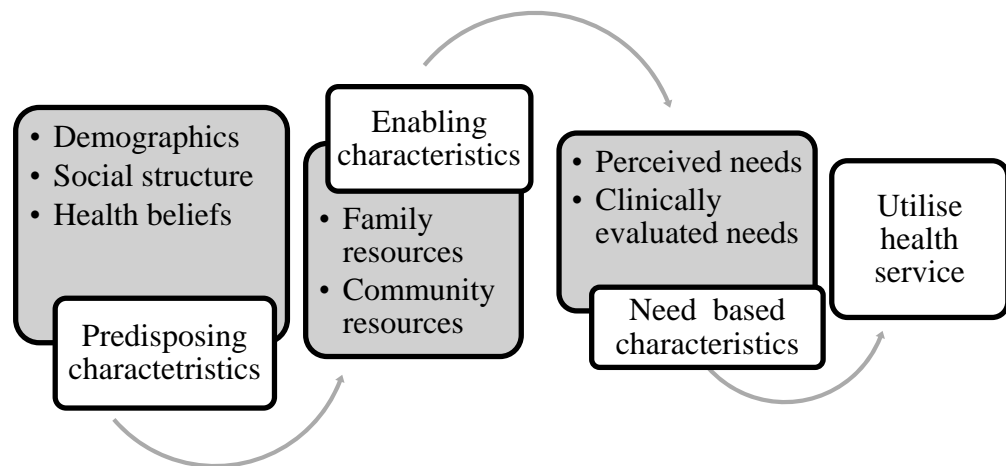
It was found out that abortion-related complications accounted for about 42% of admissions to the gynaecological ward. The average age of the women was 26 years. Twenty-eight per cent (28%) of the 296 patients interviewed presented cases of induced abortion. About 29% were not married; 30% had no formal education, and 92% had no knowledge about the then current legal status of abortion in Ghana. They accepted that safe abortion services are necessary and almost all of them were agreeable to utilise such services.

These researchers concluded that knowledge about the current legal framework of abortion was absent among women with abortion-related complications accessing health services at the Komfo Anokye Teaching Hospital. Hence, there is the need to provide safe abortion services; for women to utilise the service; and the need to create extensive awareness on safe abortion services and the law.

## Theoretical Frameworks

### *Andersen's Model of Health Services Utilisation*

According to Rebhan (2010), Andersen's Behavioural Health Utilisation Model was developed in 1968. This model of health care utilization looked at three categories of determinants. These components were predisposing characteristics, enabling characteristics and need based characteristics (Figure 1). First, predisposing characteristics explained the tendency for an individual to utilise health care services. Andersen postulated that an individual is more or less likely to use health services based on demographics, the individual's position within the social structure, and his or her beliefs of health services benefits.



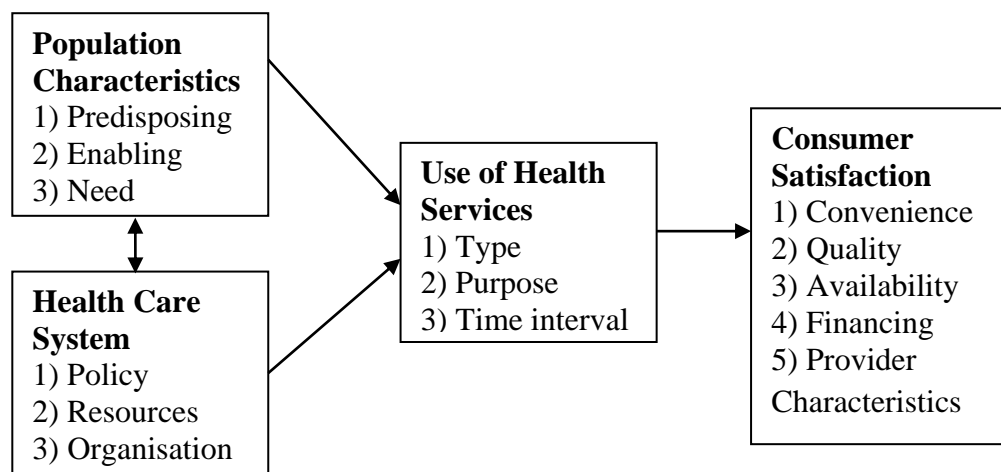
**Figure1: Andersen's Phase-1 Model of Health Services Utilisation**

Source: Rebhan (2010)

To explain further, an individual who believes health services are useful for treatment of a particular illness is more likely to utilise health care services. Secondly, considering enabling characteristics, these include resources found within an individual's family and the community in which he

or she lives. Family resources include economic status and the location of residence (either in an urban or rural setting). Community resources incorporate access to health care facilities and the availability of persons for assistance. The last category is the need based characteristics, which express the perceptions that individuals have about the need to seek for health services.

Andersen’s model was later used in the 1970s, again expanded and refined to include the health care system. The health care system includes health policy, resources, and organisation, as well as the changes in these over time. Resources comprise the volume and distribution of both labour and capital, including education of health care personnel and available equipment. Organisation refers to how a health care system manages its resources, which ultimately influences access to and structure of health services. According to this level of the revised model, how an organisation distributes its resources and whether or not the organisation has adequate labour volumes will determine if an individual uses health services.



## **Figure 2: Andersen's Phase-2 Model of Health Services Utilisation**

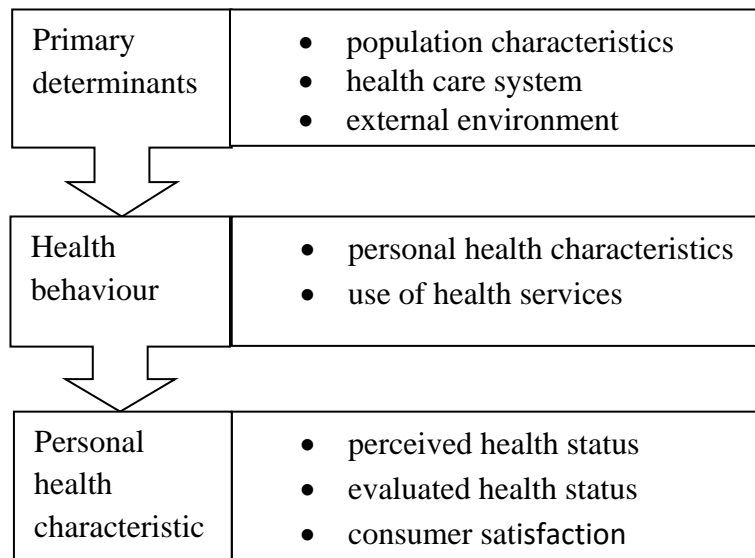
Source: Rebhan (2010)

In addition, this revised model included recognition that consumer satisfaction reflects health care use. Furthermore, the model includes the notion that there are several health services available, and both the type of service available (in this case services of quacks and that of pharmacist or chemical sellers) and the purpose of the health care service (i.e. primary or secondary care) will determine the type of service utilised. As a result, according to the revised model, whether or not a specific health care service is utilised and the frequency a service is utilised will have different determinants based on characteristics of the population and the health services.

During the 1980's -1990's, Andersen's model was again revised during the 80s and 90s to form three components with a linear relationship. These components are primary determinants; health behaviours; and health outcomes. Primary determinants are explained as the direct cause of health behaviours which may include characteristics of the population (that is age, sex, marital status, income level, etc.), the health care system (i.e. resources and organisation), and the external environment (i.e. political (abortion law), physical (family, peers and society), and economic (low or high income bracket) influences of utilisation. In addition, the model explains that health behaviours determine health outcomes. Health behaviours include personal health practices (i.e. diet and exercise) and the use of health services. Lastly, the model indicates that health behaviours are the direct cause of health outcomes. Health outcomes include perceived health status, evaluated health status, and consumer satisfaction.

Andersen's model is adapted to help explain why some women utilise or do not utilise appropriate health facilities that provide safe abortion services and the factors that drive their decision to seek or not to seek such services. Andersen's model has gone through several modifications since it was postulated. According to this model, there are three components which affect an individual's choice to access a health facility. These are primary determinants; health behaviours; and health outcomes.

Primary determinants are explained as the direct cause of health behaviours which include characteristics of the population (that is age, sex, marital status, income level, etc.), the health care system (this may include the providers and the services that they render), and the external environment (i.e. political, physical, and economic influences of utilisation).



### **Figure 3: Andersen's Phase-3 Model of Health Services Utilisation**

Source: Rebhan (2010)

To make this model best fit the study, external environment may be characterised by interpretation of the abortion law in Ghana (political environment); the social relations of women who undergo abortion, including family, partners, religious bodies and the society as a whole (physical environment). When women do not practise these personal health practices, then they tend to stand the risk of having unplanned and unwanted pregnancies.

Lastly, the model indicates that health behaviours are the direct cause of health outcomes. This could be explained that when a sexually active woman uses contraceptives effectively and consistently there is a lower likelihood of having an unplanned and an unwanted pregnancy (Ong, Temple-Smith, Wong, McNamee & Fairley, 2012), even though there are instances of contraceptive failure (Goulard, Moreau, Gilbert, Job-Spira, Bajos et al, 2006). On the other hand, a woman who does not use contraceptive stands a higher chance of having an unplanned and an unwanted pregnancy. Such pregnancies, in both the developing and developed world, mostly end up being aborted. The decision to abort unwanted and unplanned pregnancy coupled with other factors may push a woman to either have a safe or unsafe abortion.

In Africa, and Ghana to be precise, clandestine abortions which mostly are unsafe are the last resort for women (Grimes, 2006) who find themselves against their personal goals, societal norms and cultural regulation. Health outcomes include perceived health status, evaluated health status, and consumer satisfaction. Again to make the model suitable for this study, health

outcomes (which include perceived health status, evaluated health status, and consumer satisfaction) may be grouped into one, just health outcomes. Health outcomes of unsafe abortion are many which may be categorised into physical, mental or psychological and social. Some examples of physical outcomes of unsafe abortion are severe abdominal pains, haemorrhage, infections, infertility and sometimes death (Bartz et al, 2009; Voetagbe et al, 2010). Examples of mental or psychological outcomes are depressions, guilt, panic attacks and agoraphobia (Coleman et al, 2009). Social outcomes may also include stigmatisation (Lithur, 2004), loss of productivity, economic burden on poor families and many others.

### **Framework on Unsafe Abortion Complications**

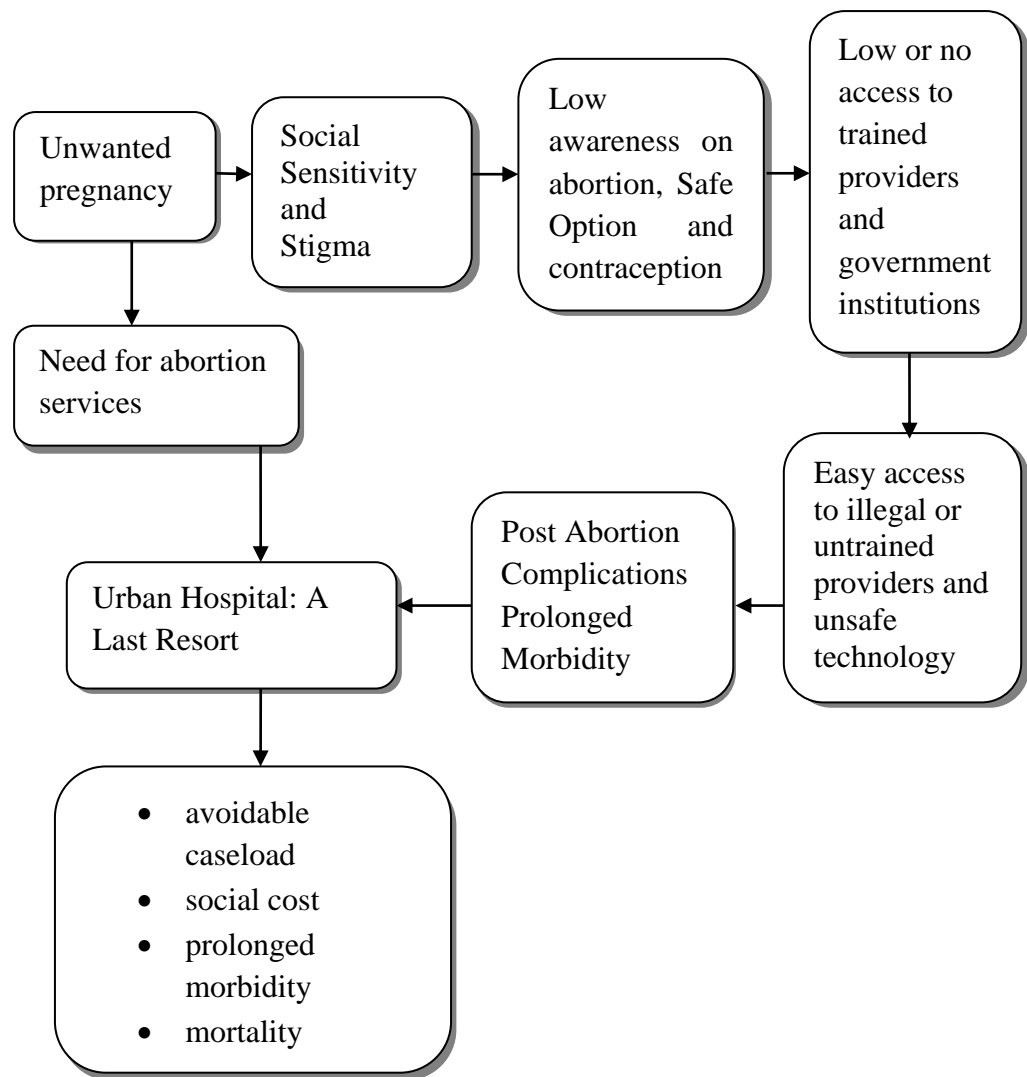
This conceptual framework explains the issues that come to play with a woman who experiences complications that emanate from unsafe abortion practices. Figure 4 show that when a woman is faced with an unwanted pregnancy, a wide variety of factors, affects her decision to access safe abortion services. Such decisions increase her risk of morbidity and mortality. Stigma, lack of knowledge about safe services, and a paucity of accessible and trained providers may lead her to seek care from more convenient, but illegal, providers who use unsafe technology.

Moreover, a woman without access to information may not be prepared to weigh safety of unsafe abortion methods, which may include insertion of intrauterine foreign body (e.g., stick, root, leaf, wire), a vaginal abortifacient (e.g., herbal preparations, misprescribed medications for medical abortion), or sharp curettage. The likelihood of experiencing post-abortion



complications depends on the training and skill of the abortion provider, procedures used, and conditions under which the procedure is performed.

The authors also identified late visit to a health facility coupled with the complications of unsafe abortion as major contributory factors of maternal mortality. Regardless of the above, more detailed information about common abortion technologies, types and severity of complications, and perceived symptoms or signs of complications is unavailable. These conditions are to prompt women that there is the need to access obstetric care. Such information could help identify appropriate action and policy responses to increase accessibility and quality of safe abortion services. On the other hand, the ideal thing for a woman to do when she is faced with unwanted pregnancy, is to seek safe abortion services from a health facility. By doing so, there is the likelihood of she experiencing no or less complications.



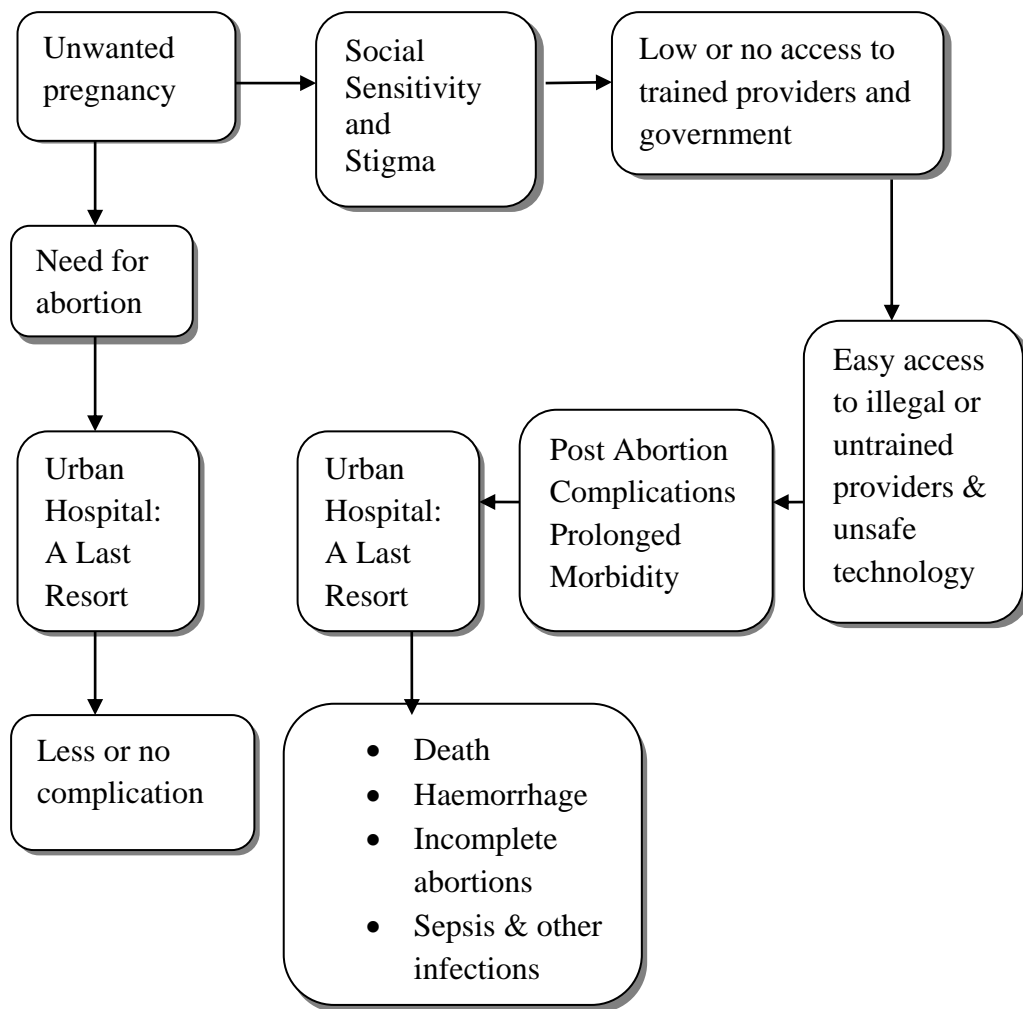
**Figure 4: Framework on Unsafe Abortion Complications**

Source: Banerjee and Clarke (2009)

**Conceptual Framework**

This conceptual framework was adapted from the framework on unsafe abortion complication by Banerjee and Clarke (2009). The original framework was modified to suit the objectives of this study.

As shown in Figure 5, when a woman is faced with an unwanted pregnancy, a wide variety of factors affects her decision to access unsafe abortion services and increase her chances of morbidity and mortality.



**Figure 5: Conceptual Framework**

Source: Adapted from Banerjee and Clark (2009)

Factors such as stigma, unsupportive partner and a paucity of accessible and trained providers may ‘push’ her to seek care from more convenient, but illegal, providers who use unsafe technology.

A woman without access to information may not see anything wrong with seeking the services of an unprofessional provider who will render the service at a relatively lower cost and the appropriate time. She may not be interested in what constitutes safe abortion methods, all such a person would want is to get rid of the unwanted pregnancy. Quack services are given by the woman herself and other persons (e.g. friends, chemist sellers, and herbalist). These methods are usually less difficult to access, in terms of geographic and financial convenience. Methods mostly used include insertion of intrauterine foreign body (Bleek, 1981), vaginal abortifacients, or sharp curettage.

The likelihood of experiencing post-abortion complications depends on the training and skill of the abortion provider, procedures used, and conditions under which the procedure is performed. The likelihood that this woman would suffer from at least a complication is high, when procedure is performed by unprofessional, using inappropriate instruments and the general conditions around.

Unsafe abortion complication becomes an issue when its occurrence is unbearable and persists for a relatively longer duration. Some of the abortion related deaths are preventable when complications are treated urgently (Geelhoed, Visser, Asare, van Leeuwen & van Roosmalen, 2003; Ohene, Tetey & Kumoji, 2011). This was confirmed by Cham (2003) that timing proves to be critical in preventing maternal deaths and mortalities. These deaths and disabilities (complication) may be affected by the Three Delays (Senah, 2003). The first has to do with decision of a woman to seek medical care on recognising a problem. The second delay is the delay in making decision to take appropriate action. This is mostly affected by

financial resources and the means of transportation available to women. The third is the delay in arriving at a health facility. Furthermore, even after reaching an appropriate health care facility, the possibility of receiving the appropriate care is another issue. When the complication becomes life-threatening, this woman is then transferred to urban hospitals where she could be taken care of with the sophisticated technology and services.

In an ideal world, a woman is to seek safe abortion services in health facilities with skilled health workers in providing safe abortion, when she is faced with an unwanted pregnancy. This becomes impossible when factors like stigma, 'restrictive' abortion law, and high cost of safe abortion service are present.

## **CHAPTER THREE**

### **METHODOLOGY**

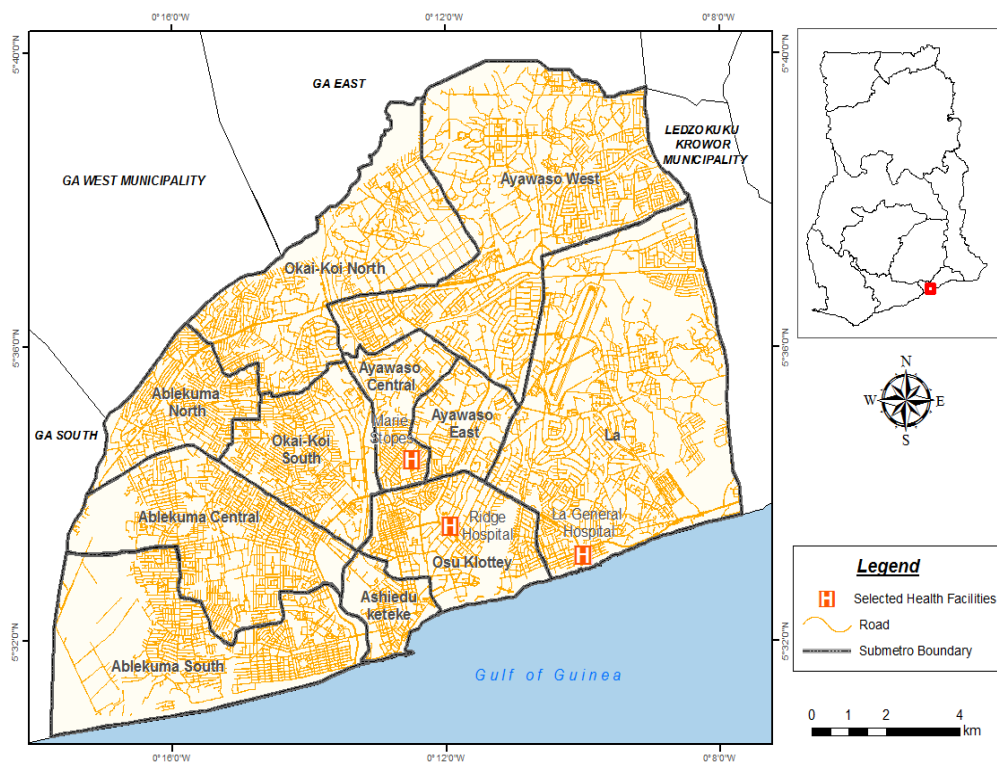
#### **Introduction**

This chapter outlines the profile of the study area, the research philosophy, research design, sources of data and methods. Furthermore, it covers the instruments used for data collection, study population and sampling techniques. It presents how data were collected, organised and analysed for the study. It deals with the description of procedures adopted in carrying out the study. The chapter also describes challenges during the fieldwork and the ethical considerations for the study.

### **Study Area**

The study was conducted in the Accra Metropolitan Area, in the Greater Accra Region. Greater Accra Region lies in the south-eastern part of the country. The Greater Accra Region is bordered by parts of the Eastern, Volta, Central regions and the Gulf of Guinea. This region being the seat of government and the national capital has a population of about 4,010,054 with 1,938,225 being males and 2,071,829 being females (GSS, 2012). The region is divided into six administrative districts: that is, Accra Metropolitan Area, Tema Metropolitan Area, Ga East, Ga West, Dangme East and Dangme West. In Figure 6, Accra Metropolitan Area is bordered by parts of Ga West, Ga East and the Adentan municipalities on its northern part. It has Ledzekuku Krowor and the Gulf of Guinea on the eastern and southern parts respectively. The Accra Metropolis is divided into sub areas which are Ayawaso West, Ayawaso East, Ayawaso Central, Ablekuma Central, Ablekuma North, Ablekuma South, La, Okai-Koi South, Okai-Koi North, Osu Klorthey and Ashiedu Keteke. Marie Stopes is located in Ayawaso Central, with Ridge Hospital and La General Hospital in Osu Klorthey and La respectively (see Figure 6).

There are a number of hospitals in the Accra Metropolitan Area namely, Achimota Hospital, Ridge Hospital, Princess Marie Louise Children’s Hospital, 37 Military Hospital, Police Hospital and the La General Hospital. There are other health facilities that provide reproductive health services; and are owned by non-governmental organisations. Examples of such are Marie Stopes International and Planned Parenthood Association of Ghana (See Appendix 1).



**Figure 6: Map of Accra Metropolis**

Source: GIS Unit, UCC

La General Hospital, Ridge Hospital and Marie Stopes International were selected for the study because they are part of the R3M (Reducing Maternal Mortality and Morbidity) project. The R3M project is spearheaded by organisations like Engender Health, Ipas, Marie Stopes International, Population Council and Willows Foundation and collaborating with Ghana



Health Service to provide information on reproductive health and increase women's utilisation of existing family planning and other reproductive health services. Also these three facilities provide reproductive health care among which is safe abortion and post-abortion services. They recorded about 4,000 abortion-related cases from January to December, 2010; specifically Ridge Hospital, La General Hospital and Marie Stopes International Ghana recorded 1350, 995 and 1574 cases respectively.

### **Research Philosophy**

The philosophy guiding the research is the interpretivist or antipositivist school of thought. The interpretive school measures basically why things happen and not the when and what, which are basically done according to Positivism. This philosophy is based on the fact that people constantly change views about the environment or the things around them (Creswell, 2007; Mertens, 2005). Interpretivists believe that people are able to describe reality in a language they understand (subjectively) and not what others think might be the case (objectively). In the view of Creswell (2007), the interpretive researchers mostly depend on "participants' views of the situation" being studied. The approach gathers mostly qualitative data in a natural setting, a method which is referred to as naturalistic inquiry. In a much narrow sense, positivists do not put themselves in the shoes of the respondents as interpretivists do (Hesse-Biber & Leavy, 2004).

Qualitative research is a system of inquiry which looks for a holistic, mostly narrated and described by a respondent. The essence of this method is to inform researchers on issues pertaining to social or cultural happenings

(Draper, 2004; Williams, 2007). Furthermore, qualitative research takes place in natural settings employing a combination of observations, document reviews and interviews.

There are various qualitative research strategies which are based on interpretivism viewpoint and few are mentioned: case study, focus group, phenomenology, ethnographic, grounded theory, and historical research perspectives (Williams, 2007). Out of the many research processes such as phenomenology, ethnographic research process, grounded theory, the present study is looking at lived experiences, hence phenomenology was the best choice. This was done with the reason that it has the advantage for events or occurrences to place.

One of the criticisms aimed at interpretivist research is that the case under study is not necessarily representative of similar cases and therefore the results of the research are not generalisable (Maxwell, 2008). Hancock (2002) asserts that the lack of generalisability does not lessen the value of the service in the area where it is based. Therefore, generalisability is not normally an issue for the researcher who is involved in studying a specific situation. Nonetheless, Williams (2000) claims that “generalisability is inevitable, desirable and possible”. Burnard (2004) also added by saying “it is sometimes a temptation for the researcher to project his or her findings into the future and to attempt to predict the implications of it through generalisation out to a larger population”. This indicates that interpretivism may have the limit of generalisability, but it may not be totally impossible to generalise findings.

## **Research Design**

This study used the exploratory research design with the main characteristic of discovering ideas and giving insight into a phenomenon or an event. According to Baxter and Jack (2008) exploratory research involves collecting information for the purpose of answering research questions concerning the current status of phenomena. Exploratory research design seeks to find out how people get along in the setting under question, what implications they give to their actions, and what issues concern them. The focus of exploratory design is on gaining insights and familiarity on social phenomena. A key limitation of exploratory design is that findings are not typically generalisable to the population at large. Thus in this study, the exploratory design will be applied to only professional health workers who provide safe abortion and post-abortion care. Again, findings from the study will apply to professional health workers in the Accra Metropolis and not the whole of Ghana. This technique is appropriate for obtaining a better understanding of complex contextual, attitudinal or behavioural issues (Draper, 2004). On the other hand, Shuttleworth (2008) claims that qualitative methods require a lot more careful thoughts and planning (as compared to quantitative methods) to bring out more accurate results as compared to quantitative research techniques.

### **Data Source**

The source of data for this study is entirely primary, with responses derived from in-depth interviews (IDIs). The IDIs were conducted for professional health workers (both medical doctors and nurses or midwives) in

three health facilities- Ridge Hospital; La General Hospital and Marie Stopes International, all in the Accra Metropolitan Area (see Figure 6).

This study is part of a project dubbed “The Relationship Between the use of Misoprostol and the Type and Severity of Abortion Symptoms: A Multi-country Study” which is being conducted by World Health Organisation (WHO). The project is a multi-country study of the use of misoprostol in affecting the type and severity of symptoms from unsafe abortion. Misoprostol is a prostaglandin E1 analogue that is legally available in over 80 countries. Misoprostol is currently listed in the WHO Essential Medicines List for the induction of labour; prevention of postpartum haemorrhage, where oxytocin is not available or cannot be safely used; management of incomplete abortion and miscarriage; and for the termination of pregnancy (in combination with mifepristone, where abortion is permitted under national law and where culturally acceptable).

This involves five countries (Bhutan, Ghana, Lao PDR, Myanmar and Nigeria) where abortion is legally restricted and the majority of abortion is unsafe, the number of women presenting at hospitals with symptoms resulting from an abortion is relatively high, and misoprostol is available and reportedly used for the termination of pregnancy. The study is among the first to examine the type and severity of symptoms resulting from abortion and link this to methods of abortion: misoprostol, other methods of induced abortion, and miscarriage.

The project is being organised in phases. The first phase of the study involves in-depth interviews of 30 providers of post-abortion care in each country, focusing on the perception of providers about change in the number

and type of symptoms from abortion that have occurred over the last several years and the reasons for this change and a review of retrospective hospital records. Hospital records will be analysed retrospectively for a period of five years before the start of the Phase 2 study.

The second phase of the study involves the recruitment of all women aged 18 years and over coming with symptoms of an abortion who are examined in the obstetrics and gynaecology wards of the selected hospitals in each of the countries. Women who come for a therapeutic abortion and those women who are diagnosed with a threatened abortion without a history of interference will be excluded. It is anticipated that this phase of data collection would last six months and will result in approximately 800 women in each country being recruited.

The third phase of the study involves in-depth interview of 30 women in each country. Fifteen women will be identified as having induced the abortion through taking misoprostol and fifteen who induced an abortion using another method. This interview will focus on understanding the pathways to the decision on seeking care at hospital. The women will also be asked to describe how they induced the abortion, the costs involved and their experience and knowledge of the method. If they used misoprostol, questions will be asked in terms of the source of supply, information they received and whether they expected the misoprostol to complete the abortion or to induce bleeding so that they could obtain hospital care to complete the abortion and for post-abortion care.

### **Study Population**

The study was carried out among professional health workers who offer comprehensive abortion and post-abortion complication services at three medical facilities (at the above mentioned health facilities). The sampling frame included all medical personnel with experience in providing post-abortion care in the Obstetrics and Gynaecology (O&G) wards in the three health centres.

Thirty professional health workers who have served at least for two years in the various O&G departments in these three health facilities were involved in this study. Professional health workers (PHW) here may not only refer to medical doctors but also senior nurses. Equal numbers of respondents (ten) were drawn from each of the health facilities with no attention paid to the background characteristics (sex, age etc.) of the health workers selected. In recruiting the respondents, a list of all the names of the PHW in each health facility was made. From this list, those with at least two years working experiences in the various O&G departments were selected. In all fourteen medical doctors and sixteen senior nurses were selected for the study.

### **Sampling Procedure**

Selection was done using purposive sampling technique. Purposive sampling which is a non-probability sampling procedure does not give respondents the equal chances of being selected and does not also claim representativeness (Sarantakos, 1998). Sarantakos stated that purposive sampling is an appropriate technique because it aids researchers to purposely choose respondents who are thought to be more relevant to the research topic.

This informed the selection of professional health workers with at least two years working experience in the O&G.

### **Data Collection Method**

The study used in-depth interview which is one of the frequently mentioned techniques when discussing qualitative data collection methods (Mach, Woodsong, MacQueen, Guest & Namey, 2005). In-depth interviews normally, are more like conversations. Using this method helps to uncover the participant's views but respects how the participant frames and structures the responses. This method is based on a fundamental assumption to qualitative research. The participant's perspective on the phenomenon of interest should unfold as the participant views it. The interviewer's success will depend on how well he has anticipated and practiced his role in ethical issues. Interviews involve time consuming personal interaction. Interviews have particular strengths and weaknesses. Combined with observation, interviews allow a researcher to further understand events and actions. Examples of its weaknesses are as follows: respondents may be unwilling or may be uncomfortable sharing all that the interviewer hopes to explore. The interviewer may not ask questions that suggest long narratives from participants. This can be attributed to lack of skills or familiarity with a particular language. The IDIs was employed for the present study because of its strength.

### **Research Instrument**

The main instrument used was an interview guide. This was used because, looking at the nature of the study, one-on-one interaction is the best way to get the respondents to give detailed information about their experiences in the O&G wards or department. Questions like why things happened were asked, which in other terms is termed as open-ended questions. This type of questions help probe further into issues as stated by Hancock (2002). Examples of questions asked were: What are the barriers that hinder women from obtaining safer abortion services?; how do these barriers affect their access to safe abortion services?; what is your views on the abortion law in Ghana?; and what solutions can curb unsafe abortion? These interactions were tape recorded for analysis. Notes were taken to complement the tape recording. The interview guide was pre-tested before its implementation.

### **Data Processing and Analysis**

Qualitative data are mainly made up of words, phrases, statements and or unspoken words that are observed by the researcher (Meadows, 2003). These were collected either by interviews (i.e. one-on-one), observation and focus group discussions. Data collection was aided by the use of tape recorders (either audio or visual), field notes, documents and the like (Taylor-Powell & Renner, 2003). Interviews were recorded and were later transcribed. Transcription is the procedure for producing written versions of the interview (Halcomb & Davidson, 2006). All the transcripts were edited but the editing was done in such a manner that the original responses were not distorted.

In qualitative research, data analysis involves summarising the data that has been collected and presenting the results in a way that well



communicates the most important findings. A written text of the information presented by the respondents during the interviews was created. The transcribed data were typed and manually reported and discussed. The findings were used to develop thematic areas. This qualitative method is often used when sensitive topics are explored (Klingberg-Allvin, Nga, Ransjö-Arvidson & Johansson, 2006).

### **Experience from the Field**

A number of challenges were encountered in the course of this study. The challenges faced in the field, however, would not affect the quality of data collected and or information sought for. They only affected the duration of the data collection exercise.

The main challenge was time. The respondents, by nature of their job, have busy schedules. There was limited time that respondents could spare for the interviews. This led to a number of revisits to the facilities to conduct the interviews.

Another challenge was that clients (waiting to access services) were agitated that the interviewers were taking much time in consulting rooms. Some showed their agitations by their frequent knocks on the doors of the consulting rooms. This created inconvenience for the interviewers, clients and the PHWs.

### **Ethical Considerations**

Ethical approval was obtained from the Ghana Health Service and the University of Cape Coast Ethical Review Board (See Appendix 5). Institutional approval was sought from the three health centres (Ridge

Hospital, La General Hospital and Marie Stopes International). Individual consent for participation was also obtained from the respondents. Also, confidentiality and anonymity were highly assured and observed.

## **CHAPTER FOUR**

### **RESULTS AND DISCUSSION**

#### **Introduction**

This chapter discusses several issues that providers of safe abortion services know about unsafe abortions in the Accra Metropolis. It includes issues relating to the barriers that affect women's decision to seek safe abortion services; the outcomes of unsafe abortion that women who access their services present; the methods that these women resort to; the interventions that they think can help solve the menace as well as their views of the abortion law in Ghana.

### **Barriers to Safe Abortion Services**

There are certain barriers that affect women's decision to seek safe abortion services. According to Rebhan (2010), there are external environmental factors that affect an individual's choice to utilise a particular health service. These factors include political factors (abortion laws and policies), physical factors (the actions of the social relations of the individual usually leading to stigmatisation) and lastly the economic factors (the income level of women).

#### *Religion, Moral Standards and Culture*

Some respondents mentioned that religion, moral standards and culture are one of the barriers that affect women's decision to access comprehensive abortion services. This is illustrated in the following quotations:

*“The second thing is hypocrisy in our society, what it means is that you have people who will talk against abortion but when they are in trouble they come for it here so they prevent others from coming by what they say. Ghanaians are overly religious, that is where you have*

*pastors coming for an abortion but they will preach against it in public...*” (Medical doctor)

*Ghana is a very religious country, our major religions namely, Christianity and Muslim have frowned on abortion and I believe that is the root cause and even our traditional religion also rejects...*”  
(Medical doctor)

Religion as identified by Sundaram et al (2012) affects the decision to seek safe abortion services. Some respondents mentioned that religion, moral standards and culture are hindrances that affect safe abortion practices among women in Accra. It is known that the various religious doctrines preach against abortion. When those who condemn such acts are faced with unplanned and unwanted pregnancies, they tend to terminate such pregnancies in secret. People (including religious leaders) are not always practicing what they preach.

#### *Stigma and Fear*

Almost all respondents mentioned stigma to be playing a major role in women’s decision to access unsafe abortions. Women are not able to access health care services because they are afraid that they would be stigmatised by their family, relatives, society and by some health care providers. This is illustrated in the following quotes:

*“May be fear. They are afraid that when they come, we may not do it for them. They think about what people will say about them when they come to the hospital. So they feel shy to go to the right place to do it...”* (Nurse)

*“The opinions are different but personally, I think the number one issue is the stigma the word ‘abortion’ itself puts across. You know, it paints somebody ‘black’ so most of the clients are afraid to walk into a medical facility and ask for an abortion service...”* (Medical doctor)

*“What I think is that at times they feel shy and afraid to do the abortion. They sometimes think a lot about what people will say. For instance, they think about what the nurses will say about them...”*

(Nurse)

Stigma comes about as a result of an individual going contrary to what are ‘right’ or the rules and regulation of a particular social group (which may include family, friends, religious groups and communities). Stigmatisation usually occurs within the social network or relations of women who end up with unwanted pregnancies and abort to the realisation of their social relations (Sundaram et al, 2012). Banerjee and Clarke (2009) and Rebhan (2010) identified stigma to be one of the factors that allows women to seek convenient but unsafe abortion services.

This was also evident in a study by Bleek (1981). According to his study, not only is the decision to seek a particular health service affected by social relations but also health care system. Most of the respondents, if not all, mentioned that stigma plays a lot role in women’s decision of unsafe abortion. They believe that because the Ghanaian society praises childbearing only in wedlock, unmarried women who are faced with these unwanted pregnancies and are not married would swerve this stigma that would be put on them by

secretly terminating such pregnancies. However, married women who engage in extramarital affairs and are faced with unplanned pregnancies also resort to unsafe abortion. They do this to get rid of any punitive measures (ridicule and stigmatisation) that would be placed on them.

In the case of stigma, it does not matter if women have knowledge or information about safe abortion. The fact that abortion is looked down upon would affect women's decision of accessing safe services at private and public facilities. In other words, stigma coupled with the abortion law, cost and others affect the decision of abortion. Also, not only does stigma affect women's decision to seek safe abortion services, it tends to overshadow legitimate medical procedure, shames those who provide or procure it and also weakens the activities of safe abortion advocates (Kumar et al, 2009). In this case, so long as one undergoes such an act and has become public, then she would definitely suffer some form of stigmatisation, as indicated by a respondent.

*“Stigmatisation is one of the key barriers. People know there are open services available in various hospitals but people don't want to be associated with abortion officially or openly, everybody knows that the services are there but people will like it to be more clandestine...”*

(Medical doctor)

*Poverty and high cost of safe abortion services*

Some of the respondents mentioned poverty among other factors as being a barrier that hinders women to seek for safe abortion services. These are what some respondents had to say:

*“Other factors like lack of resources, on the side of women who find themselves pregnant, affect their choice of safe abortion service. These women may not utilise health service in the private facility, because services tend to be expensive. So women who are from the lower income bracket may not have the necessary resources than to resort to cheaper means and methods...”* (Medical doctor)

*“At times too, financial problems. This is because they cannot afford the amount charged for having the procedure done at a health facility, though it is not expensive. They go and buy some herbal concoctions, which to them is cheaper and use them for the abortions...”* (nurse)

From the 2007 GMHS, women who were found in the lowest quintile had the lowest abortion rate (0.2 per woman) as compared to those in the highest wealth quintile (0.6 per woman). In other words women who are impoverished may have difficulties in accessing both safe and unsafe abortion and so are likely to keep such pregnancies to term as compared to those women who are financially sound and can afford an abortion service. However, poorer women are more likely to seek the services of quack providers than richer women who have the resources to seek the service of professionals. Economic environment which is a component of the primary determinants of Andersen’s model considers income levels of individuals, thus it affects women’s choice to seek a particular healthcare (Rebhan, 2010).

### *Attitude of Parents and Partners*

Respondents identified that parents and partners of women play a role in the choice to seek for a particular kind of health service. Mostly, some women who are still dependent on their parents usually get frightened when they are faced with premarital pregnancies. They either are afraid their parents would be disappointed and probably disown them or would refuse to cater for their educational needs. This is what some respondents had to say:

*“When they get pregnant, they wouldn’t like their parents to know so they seek information from their friends. These friends introduce them to either quack doctors or drugs and other herbal medicine in the market. At times too, it is as a result of pressure from their parents, especially the mother, because the mother wouldn’t like the father to know of the pregnancy. The mother herself goes to buy the drugs from the market or prepare some concoction and give it to her daughter to terminate the pregnancy.”* (Nurse)

*“May be the person is in school and realised that she is pregnant. If her parents find out they will kill her. This affects them; they can’t learn and they can’t do anything.”* (nurse)

This was also explained in Rebhan’s (2010) work, social relations (which may include family, partners, religious bodies and the communities they live in) have an effect on women’s choice to access or utilise a particular health facility. The decision to abort a pregnancy does not only depend on women but also the men who got them pregnant (Nyarko et al, 2008; Sundaram et al, 2012) and the parents or caregivers (if there are). Sometimes



partners and guardians are the main drivers of women's decision to abort pregnancies.

Moreover, the irresponsible attitudes shown by some partners of women also drive them to seek unsafe abortion services. Irresponsible attitudes may include not accepting paternity of such pregnancies and running away from their pregnant women. So in such a condition coupled with poverty (inadequate resources) and stigma, women are forced to abort secretly. This could be seen in what these respondents expounded:

*“Some people (clients) engage in unsafe abortion may be due to poverty, rape, incest, and the fact that their partners just do not want the pregnancy. Thus, irresponsible persons have impregnated them and had run away, and when such women haven't got money to help themselves, they get an abortion done to have their peace of mind.”*

(Nurse)

*“Some too it is due to the pressure from their fiancés. Because abortion is not legalised in Ghana, women are usually afraid to go to the hospital to have it done. When the lady gets pregnant the guy goes to buy some drugs or herbal tonic and force the lady to consume for the pregnancy to be terminated.”* (Nurse)

#### *Attitudes of Some Health Workers*

Also, judgmental attitude of some health workers towards women, especially those who are not married and those aged 15 to 19, affected their decision to seek safe abortion services. Women are mostly judged based on

traditions and religious beliefs of some professional health providers. This was stated by some respondents as follows:

*“The first thing is that there is always the tendency to impose their beliefs on the client, that is not professional but they still do it. I mean if a 16 or 17 year old girl gets pregnant and goes to the hospital to seek abortion, the kind of reception she gets deters her from going back. They are not welcoming enough or because they do not understand the plight these girls are going through. They simply want to impose what they believe in on them...”* (Medical doctor)

*“I will say one major barrier to safe abortion is our attitude. Some of the health workers’ beliefs and attitudes towards the clients who come in to seek medical termination is questionable. The health professionals tend to look down on them and see them as sinners.”* (Medical doctor)

*“...some people too are afraid and also feel shy, at times because of the attitude of the health workers.”* (Nurse)

Nyarko et al (2008) confirmed that the attitude of some providers and the type of services they provide do not create user-friendly environment for most women (clients). They identified certain variations between the kind of abortion services that were rendered to women in the public sector health facility and at private sector health facility. The authors realised that women presented issues of post abortion complications to the public sector and sought for elective abortion service at the private facilities. This was because providers from the private facilities rendered better abortion services as

compared to those from the public sector. Health care system includes providers and the services they render (Rebhan, 2010). When providers and the services they provide is user friendly, women would access the services more than when providers and the services they render are not user-friendly.

A respondent testified that he or she was a perpetrator of such judgmental attitude towards clients.

*“Sometimes I will not blame them because I have had occasions where I have faulted. Our attitudes towards people who come seeking for abortion services are sometimes based on our moral and religious beliefs. This makes people feel they are bad but these are people who need real counselling...”* (Medical doctor)

#### *Abortion Law as a Barrier*

Some respondents also think that the abortion law is a barrier that affects women’s decision. The fear of being arrested for seeking safe abortion services, especially with reasons that fall outside the conditions under which women must seek legal abortion services was cited by some providers.

*“I feel it is another barrier because since there is no concrete law guiding or allowing you to come out plainly to say that I want to have an abortion. This coupled with stigmatisation are... that is why at the end of the day people end up with the quack doctors or inducing the abortion themselves...”* (Medical doctor)

*“The restrictive nature of the abortion law is making people do it in secret and as a result go to quack doctors or use some herbal concoctions, which results in many serious complications. So in order*

*to curb or reduce unsafe abortion the law on abortion should be amended...” (Nurse)*

The external environment in Andersen’s phase-three health care utilisation model included among other things, political environment (Rebhan, 2010). Political environment was explained in the context of the study as the abortion law. For this reason, the abortion law is seen as a factor that affects the type of health facility that a woman would utilise. The interpretation and the understanding of the abortion law also affect the choice of the type of care a woman would seek.

Some of the respondents were of the view that abortion law per se is not a barrier but the understanding of it is. This is seen in the following quotes:

*“The law does not say that abortion is illegal or every abortion is illegal, it says that under certain circumstances. A lot of people do not even know the circumstances so let the people know the law. Let them know the circumstances then if we are still having the numerous cases, then we can say that the law falls short of certain aspects. This would indicate whether to tighten the law or loosen the law or add certain aspect...” (Medical doctor)*

*“I don’t think so; I don’t think the legal framework poses any challenge. I think what rather needs to be done is that people need to be educated on the legal framework and the new interpretation of the law as it stands now must be given...” (Medical doctor)*

*“I think there should be more education about the abortion law in Ghana. We should clearly state out where people can go for safe abortion. At the moment the law is only allowed under certain conditions but I think it should be open to all whoever wants to have an abortion...”* (Nurse)

### **Abortion Methods**

There are two methods, according to respondents, that women usually resort to namely, orthodox and crude methods. Orthodox methods may include (as reported by the respondents) the use of pills or medication (Misoprostol or Cytotec or ‘two up two down’, mediprest, meddaborn), and surgical method which includes Manual Vacuum Aspiration (MVA), Dilation and Curettage (D&C) and Dilation and Evacuation (D&E). Surgical methods like MVA and D&C are done in authorised facilities by professionals. These according to respondents were done when given post-abortion care mostly for women who suffered incomplete abortions, as was stated by Mills et al (2007) and Etuk, Ebong and Okonofua (2003), that MVA be used to treat post abortion complications.

It was reported that most women are now resorting to misoprostol or cytotec or two up two down more than the crude means. The reason given was that as compared to other methods easily accessible to women, cytotec was the one with less side effects (complications), thus it does not cause much bleeding, as pointed out by some respondents:

*“... Cytotec use is the most predominant...”* (Medical doctor)

*“Well the commonest one is using misoprostol and the others include: taking broken bottles, inserting herbs and a whole lot...”* (Medical doctor)

*“Yes I think so because in the past people were not really into using cytotec I don’t know maybe I might be wrong but right now it looks like more of them using the cytotec as opposed to those things that they were using previously...”* (Medical doctor)

*“I think the commonest one that they use is misoprostol. They will say I have inserted two and I have ingested two that is two up two down...”* (Medical doctor)

Crude methods include the use of concoctions which may include herbal preparation, inserting foreign materials into the uterus and application of external trauma on the abdomen or the uterus. These methods of terminations are dated as far back as the 1980s (Bleek, 1981; Van der Geest, 2007) but now are decreasing with misoprostol being the most used. The respondents mentioned some of the herbal preparations that women usually used. This includes ‘mighty power’, ‘Agbeve Tonic’, ‘Taabea Herbal Mixture’ and ‘Wofa Kissi’. These were pointed out by the following respondents:

*“The next to it is those who go to the quacks and they try to do DNC (derivational and cue rectal), the next to this is curettage but then the other thing is that some use concoctions...”* (Medical doctor)

*“Some employ herbs and some herbal preparations such as ‘Mighty Power’ or ‘Agbeve Tonic’ and the rest. When they take it some have it*

*aborted successfully while others have incomplete abortions...”*

(Medical doctor)

*“There is a new drug called S.D.A that they (women) actually smear around their navel even though I do not know the scientific bases, it does work. This is because I have more than twice used this particular drug...”* (Medical doctor)

*“Some people also take laxative or anything that it is written on ‘not good for pregnant women’ then they know that thing might be good for abortion. There is one local laxative they call ‘Wofa Kissi’. It’s so strong and so women take overdose of this herbal mixture to terminate their unwanted pregnancies.”* (Nurse)

*“Some too take in some concoctions which I don’t know what it is made of. Others use alcoholic drinks together with other herbs and then some also use enemas...”* (Nurse)

Some women also insert foreign materials in their uterus to presumably get rid of their unwanted pregnancies. Examples of such materials were sticks, ‘Chorkor Bomb’ and bicycle spokes. Some of these materials are mentioned in the following statements:

*“One which was quite unfortunate is that the boyfriend inserted a stick to dilate the womb and it ended in the uterus getting damaged...”*

(Medical doctor)

*“We’ve had instances where people have tried all sorts of concoctions. There is a popular ‘Chorkor bomb’ which is ostensibly inserted into the vagina to more or less blast out the foetus...”* (Medical doctor)

*“They also have a stick which they insert into the mouth of the womb, [which is the cervix], just to dilate it for the product to come out, and the thing will be there. Sometimes they leave the stick in the vagina for a while. Since it is a foreign body, it starts eroding the mouth of the womb and it causes a whole lot of problems.”* (Nurse)

*“They use a lot of crude ways. They use bicycle spokes, they use pencils. I have taken out a pencil from a vagina before. They use so many ways...”* (Medical doctor)

Also some mix concoctions made up of two or more of the following items: paracetamol, ‘washing bluing’, Guinness, liquor, tobacco, salt, sugar, grounded broken bottles or glasses, charcoal and ashes. This was indicated in the following statements:

*“In fact, personally I have never gotten to know the right mixture, but sometimes they will tell you that they have grounded bottles and Coca Cola or grounded bottles and Guinness, high doses of sugar and Guinness and others also use herbs they insert them there. Those are the ones who come with severe infections, that is, those who use the herbs...”* (Medical doctor)



*“I attended to a girl who grounded louver blades, added water to it and drunk to terminate her pregnancy. So these are some of the few methods...”* (Medical doctor)

*“They use hot tobacco; they boil it and drink it. Some use hot Guinness with sugar and some herbs too. In fact these are the crude ways; they are just too many...”* (Medical doctor)

*“Some also use concoctions of grinded bottles, others use salt water, and they drink some and insert some vaginally to cause abortion...”*  
(Medical doctor)

Some individuals believe that putting extreme pressure on the abdomen or cervix would actually cause abortion. The comments of some providers are as follows:

*“Some people also come to tell you that another way is to have hot sex. I don’t know how true that one is, because people think over stimulating the cervix may open it...”* (Medical doctor)

*“There has been a story where a lady thought she was pregnant and asked the boyfriend to stamp on her tummy to expel the foetus. Then she came in with rupture of the liver but eventually lost her life...”*  
(Medical doctor)

The type of technology used to terminate pregnancy is of much importance. The type of technology or equipments used in abortion determines the safety of the patient or the outcome (Banerjee & Clarke, 2009). Women who are faced with unwanted and unplanned pregnancies would seek all

means to get rid of such pregnancies (Sundaram, Juarez, Bankole & Singh, 2012).

### **Outcomes of Unsafe Abortion**

There are many types of complications (physical outcomes of unsafe abortion) that women usually presented in these health facilities under study. Some of the outcomes were iatrogenic (i.e. injuries or illnesses resulting from medical treatment or examination). The physical outcomes outlined by respondents are death, haemorrhage, incomplete abortions, sepsis and other infections, uterine perforation, infertility and ectopic. Physical outcomes of unsafe abortion may happen in sequel.

There are various complications of abortion, but complications associated with unsafe ones are increasing (Mote et al, 2010). These outcomes are grouped into three categories which are physical, social and psychological. While a lot was said on the physical outcome category, a little was said on both social and psychological categories.

Rebhan (2010) further explained that an individual's health behaviour determines his or her health outcomes. In other words, what a person practises in terms of his or her health, there are certain health outcomes that may present themselves. For instance, when a woman goes for safe abortion service from a medical professional under authorised conditions, there is the likelihood of her developing fewer complications. On the other hand, according to Banerjee and Clarke (2009), when a woman goes in for the services of a quack provider or from a friend or by her, there is a higher likelihood of ending up with severe complications which may threaten her life.

## *Death*

Deaths related to unsafe abortion usually occur when there is delay in reaching health facilities or a woman not accessing post-abortion complication care at all. Again, women do not report the actual medical history before reaching facilities and that also results in their deaths. All respondents stated that unsafe abortion may lead to death when patients fail to give the real history of what she had done already before getting to their facilities. The respondents added that some also died because they did not seek attention as early as they ought to as expressed in the following quotes:

*“If as a result of unsafe abortion, one contracts infections, it can lead to septicaemia, that is, blood poisoning and if care is not giving you can die...”* (Nurse)

*“Some of the outcomes of unsafe abortion are severe bleeding, at times death...”* (Nurse)

*“Well, the outcome, first of all is death, it is the worst outcome, and people actually lose their lives when they are involved in unsafe abortion...”* (Medical doctor)

*“Death is one and at times if they delay too much and the womb is infected they may not be able to have children in the future, thus making them barren...”* (Nurse)

## *Haemorrhage*

Haemorrhage, also termed as profuse bleeding, is one of the common outcomes of unsafe abortions. Haemorrhage has the tendency to be

problematic when proper medication is not given and leads to anaemic conditions. According to the respondents women who had had an unsafe abortion most of the time suffered haemorrhage (severe bleeding), as indicated in these statements:

*“Most of them bleed profusely and that finally leads to infertility because most of the organs, the way God have created it when it moves a bit, it creates a lot of problems, then anaemia and normally deaths...”* (Nurse)

*“The major complication that they report to us is about 99% is the bleeding that is what will bring them to the hospital...”* (Medical doctor)

*“So the number one case in Ghana here is haemorrhage. People bleed and they die out of it. Some people get so infectious that in the end you might even take out their uterus or end up with certain sub-infections that might cause them not to have children in the future.”* (Medical doctor)

*“They usually end up with bleeding or complications of haemorrhage because it’s not in a controlled environment. All these things are shrouded in secrecy because the person doesn’t want anyone to know that such a thing is going on. So even when it becomes perilous to the person’s life, they still are hiding there in their rooms until it becomes increasingly unbearable. That is when they seek medical help by coming to the hospital...”* (Medical doctor)

### *Incomplete Abortions*

Among the major complications that were mentioned is incomplete abortion. This usually happens when a pregnancy was not fully terminated and becomes life threatening when proper care is not given. To treat this complication, the health professionals mentioned surgical abortion methods like Manual Vacuum Aspiration (MVA) is used. According to the respondents women usually presented issues relating to incomplete abortions. This is where women have already taken some form of medication (either herbal or orthodox) and the foetal product could come out completely. This brings with it excruciating pain and sometimes may lead to infection or sepsis. Some providers gave the accounts as follows:

*“Another complication is infections because most unsafe abortions turn out to be incomplete abortion. Incomplete abortion in the sense that some products are retained in the uterus and whatever is left in there will be infected and the infection at the end of the day will travel in the system which will lead to septicaemia...”* (Nurse)

*“Another is that those leftover products in the womb may get infected. Because they are young girls, they may hide it for so long and may not inform their parents to seek hospital care on time. So when you get infected you develop what we called septicaemia, which is bacteria poisoning their blood and that most at the time lead to death...”*  
(Medical doctor)

*“There could be retained product, that is, if they are not able to take everything out of the uterus, and they just leave these mothers there. And usually they do not put these mothers on antibiotics so there could*

*be retained product which could become septic or infected. This can even go from that local place of the uterus throughout the blood and it can spread to the whole body and it can even affect this woman and eventually cause death.” (Medical doctor)*

#### *Sepsis and other Infections*

Sepsis and other infections caused by unsafe abortions also contribute to maternal mortality and morbidity in developing countries. According to responses given, sepsis and other infections are very likely when one engages in an unsafe abortion, and most women presented cases of the sort to their facilities. Sepsis or septicaemia is the poisoning of the blood which occurs (as stated by the health professionals) when bleeding and injuries are not well taken care of. Other infections include Pelvic Inflammatory Diseases (PID), infection in the uterus as well as sepsis is likely to occur after an unsafe abortion. As some respondents pointed out:

*“I will say the commonest ones. Number one is bleeding; two is infections. That is, if I insert some concoctions into my vagina, certainly I introduce unhealthy bacteria into my vagina which might climb up and infect my whole pelvic area. We call something Pelvic Inflammatory Diseases (PIDs), and it can go so extensively to infect even your whole body; you become so septic and then you might probably lose your life in the end...” (Medical doctor)*

*“We also have quite a number of people who come with complications that is septic when they have tried some herbal concoction...” (Medical doctor)*

*“At times and perforation of the uterus, and infections like pelvic inflammatory diseases that leads some to get ectopic pregnancy in the future because some spread to the fallopian tube...” (Nurse)*

#### *Uterine Perforation*

Uterine perforation was also mentioned to be one of the outcomes women experienced after engaging in unsafe abortions.

*“You can die, you can have a lot of complications; infections, perforation of the uterus when it (abortion) is not done well or the person uses an instrument, because the womb is like a balloon), and there will be bleeding into the abdominal or pelvic cavity... the womb becomes gangrenous and you are rushed to the hospital, it means we have to take away a whole uterus; and if you are 18 or 20 years, then it means you’re not going to have any child anymore...” (Nurse)*

*“Usually there can even be perforation of the uterus depending on what they are using because you are cleaning or evacuating everything from the uterus so sometimes there could be perforation of the uterus. There could be retained product, that is, if they are not able to take everything out of the uterus, and they just leave these mothers there... and become septic or infected...” (Medical doctor)*

#### *Ectopic Pregnancy*

Ectopic pregnancy though may be an unsafe abortion outcome, may not be a direct outcome. It is not clear whether there is a link between ectopic pregnancy among others (including breast cancer) and unsafe abortion.

Respondents also made mention of ectopic pregnancy as being a likely outcome of unsafe abortion among women. They mentioned that ectopic pregnancy occurs when the fallopian tubes are partially blocked and this has the potency of causing infertility among such women. Some respondents also mentioned that ectopic pregnancy comes about when an infection in the uterus spreads out to other parts like the fallopian tubes.

*“Sometimes it is not a direct complication but because they do not seek professional treatment. Sometimes it is not even a pregnancy that is in the uterus, it is on the outside and they come with ectopic pregnancy ...”* (Medical doctor)

*“Talking about infertility in future and tubes that are partially blocked could lead to ectopic pregnancy in the future...”* (Medical doctor)

### *Infertility*

Most providers interviewed said unsafe abortions had the likelihood of ending up in infertility among women. These following quotes are some of the statements made by some of the participants.

*“Some of them also come for infertility treatment and when you investigate it normally as a result of some previous abortion...”*  
(Nurse)

*“I have had this experience before, and that prompted me to come to Marie Stopes. In a certain general hospital I used to be, a similar thing happened. In this hospital, an 18 year old was rushed to the hospital and she was having a severe abdominal pain; from investigation, we*



*found that she had had an unsafe abortion with some concoction, and when she was taken to the theatre where I was, and her uterus was open, it was very gangrenous and we had to take everything. That means this girl is not going to have a child anymore...” (Nurse)*

*“The second one is infertility, their womb may be damaged. This may be iatrogenic sometimes if the evacuation is not done well their period may even cease which we called ashamed syndrome (cessation of their menses). And in some cases if the womb is damaged beyond repair they have to even remove your womb.” (Medical doctor)*

*“Unsafe abortion can also result in long term infertility because they get scar tissues forming in the uterus after various equipment have been used in attempting abortion...” (Medical doctor)*

### **Perception of the Abortion Law**

Some providers mentioned that the abortion laws acted as barriers that prevented women from accessing safe abortion services. This was because women were frightened that when they go the health facilities with reasons outside the stipulated conditions by law, they would be arrested. Their knowledge of the abortion law was sought. Some providers knew about the law and could mention at least one of the conditions under which it could be deemed as safe or legal, as pointed out by some respondents:

*“It poses a barrier in quote in that it says that under normal circumstance abortion is illegal but then the circumstances under which abortion can be done but those ones allow you to put in because*

*of the fact that the patient's psychological wellbeing is added to it. Then you can always put in whatever reasons the mother has under that. In quote, that is the way I say to some extent it's a barrier..."*

(Medical doctor)

*"Yes, under certain circumstances, by trained professional and safe environment. Some of the circumstances include, if the pregnancy is due to incest, rape; or if it is going to be detrimental to the health of the mother, or if it is going to cause abnormality to the foetus, then it can be done..."* (Medical doctor)

*"I think in sub-Saharan Africa, I would say Ghana has one of the most liberal legal framework for abortion because, one, it provides for any minor if there is the case of defilement, rape, and incest. All of those things if the person is a minor below 16 years the parents can ask for an abortion, too, if the person is above 16 years and gets herself pregnant through rape or incest then she can have access to it but that is what most people do not know. Also, if the pregnancy is inimical to the mother or the one carrying the pregnancy she is entitled to receive the abortion. The difficulty sometimes that some providers or even the general public is that they forget that there is mental health as well... but that is dangerous"* (Medical doctor)

*"And it is legal when it is done by trained people in accredited institutions. Yes, I can be a trained person to perform abortions, but if am doing it in my house, it becomes illegal. So I think the law is liberal and should be maintained as it is..."* (Medical doctor)

*“I know many talk about the abortion law for example the instance that you can have the abortion...if for instance the pregnancy can cause a health threat to the mother... I know if there is incest, the law allows abortion, and if there is what we call consanguinity – some metabolic diseases that may come about as a result of you having a child out of incest or sharing a blood with somebody. If the pregnancy was as a result of rape, psychologically, it may affect the mother and even the child when he/she is born. There might be so much hatred and guilt attached to it because it didn’t come through the normal channel...” (Medical doctor)*

Abortion is legal in Ghana only for pregnancies that resulted from rape, incest or defilement and also involving a female idiot, where there is a high risk that the child would suffer from a serious deformity, or if the pregnancy threatens the woman’s physical or mental health.

A health professional mentioned she had no knowledge about the abortion law.

*“...For the abortion law, I don’t know anything about it...” (Nurse)*

A provider mentioned that abortion should not be legalised. This is because he thinks the disadvantages of legalised abortion outweigh its advantages.

*“I don’t think it should be legalised. The problems associated with legalising abortion overwhelm the positives that we will gain from it. If we were all honest and noble people, legalising it wouldn’t have been a problem, but the negatives that we will generate from it are so much. By this, I am hitting toward contraception. That is, if there is enough*

*education on contraceptives, and that are more promoted, there would not be issues of unwanted pregnancies. So contraception should be promoted to the highest level, and made very readily available because abstinence in our dynamic world is not working.” (Medical doctor)*

Some respondents mentioned that the law should be maintained:

*“Ghana’s abortion law is probably the most liberal on the continent. There is a portion of the law that people exploit the most, and that is the continuous keeping of the pregnancy can affect the person’s mental or social wellbeing; and health itself is a very broad definition. And once the person is able to invoke that, it becomes legal...” (Medical doctor)*

*“To me, the abortion law of Ghana is fair, just that people don’t know that’s why they hide which results in unsafe abortion. But if they should know, then I don’t think these problems will come about. If they get to know the law, no, it will not promote promiscuity. Once they say they will do it, nothing can stop them. So why don’t we let them know that it is allowed under certain conditions to avoid all these problems...” (Nurse)*

*“So I think the law is liberal and should be maintained as it is. People are only scared that if you go out there to say that it is legal in Ghana, you’re inviting people to do it...” (Medical doctor)*

A respondent mentioned that the law should be changed. She indicated thus:

*“I think that the current law should be changed. Abortion should be legalised so that people will find the need to come to the facility to perform proper abortion. This, I think will save lives just like the Millennium Development Goal 5 wants to reduce maternal mortality. What is the use of keeping it a secret and making people die, when you can make it legal to save lives?”* (Nurse)

On this subject of professional health workers' perception on the abortion law, it was identified that some of the nurses interviewed had little or no knowledge about it. The reason could be that the nurses only work under instructions given to them by medical doctors. In other words, nurses may not have been well trained to offer comprehensive abortion services. These are illustrated in the following statements:

*“For the abortion law, I don't know anything about it...”* (Nurse)

*“I don't know whether we are legitimate to do abortion. Sometimes you hear on radio that abortion is illegal but liberal, so I don't really know...”* (Nurse)

*“My little knowledge is I learnt a law has been passed so that if you want to do abortion you can come and do it...”* (Nurse)

However, others were knowledgeable of the law and could state most of the conditions under the law. Their expressed knowledge is as follows:

*“Yes, what I know is that if the pregnancy is going to have any side effect on the woman, it can be done for her or if the person was raped .... Apart from these ones somebody cannot just walk into the hospital*

*for our services... and if the pregnancy is going to have any mental effect on the patient it can as well be done... ” (Nurse)*

*“Yes, under certain circumstances, by trained professional and in an authorised environment. Some of the circumstances include, if the pregnancy is due to incest, rape; or if it is going to be detrimental to the health of the mother, or if it is going to cause abnormality to the foetus, then it can be done...” (Nurse)*

On the other hand, all the medical doctors were knowledgeable about the law and could state most conditions under which abortion is legal in Ghana. This is illustrated in the following quotations:

*“Yeah, we are permitted by law to undertake abortion here. We have the permit, but only do it under certain conditions... we don't have any choice than to offer the care to the patient. But if you think it will not cause any harm to the patient, then I don't think it will be necessary to do it. And to the foetus too, if there is going to be any harm to it, we do the abortion. Somebody may be pregnant with a 'syndromic' foetus as determined by laboratory test will have some down syndrome; will be mentally retarded and you wouldn't want such a baby to be a burden to society, then such babies will have to be taken out.”*

(Medical doctor)

*“Am not an advocate for terminating pregnancy simply because you don't feel like having the baby. But if for instance the pregnancy can cause a health threat to the mother, then you can save the mother's life than having both die. I know if there is incest, the law allows*

*abortion, and if there is what we call consanguinity – some metabolic diseases that may come about as a result of you having a child out of incest or sharing a blood with somebody. If the pregnancy was as a result of rape, psychologically, it may affect the mother and even the child when he/she is born. There might be so much hatred and guilt attached to it because it didn't come through the normal channel...”*

(Medical doctor)

*“The law in summary says that, an abortion must be undertaken by an expert, health professional in qualified health facility...”* (Medical doctor)

*“Generally, the principle is that under certain circumstances where the pregnancy would not favour mothers' life you are allowed to perform abortion. If you would base on your own personal or moral or religious background, you are obliged to refer... and also if someone becomes pregnant through rape or defilement. There is an aspect of the law that says that if the psychology of the woman will be unstable an abortion should be done. If the person is willing to terminate the pregnancy, it is always the task of the doctor to counsel the patient, let the patient go through a whole psychological test and everything documented...”* (Medical doctor)

### **Interventions to Curb Unsafe Abortion**

Based on the information given by the health providers interviewed, a lot of suggestions were made with regard to their stand on unsafe abortion and what they consider appropriate solutions for unsafe abortion in Accra and

Ghana as a whole. Some mentioned the need for counselling before and after; education on reproductive health; family planning; awareness of the abortion law, campaign against stigma and ridicule; improving on client-provider relationship and user-friendly facilities. Interventions should not only be targeted at individuals but should also affect interpersonal, organisational and environmental factors influencing health behaviours (as stated in Asamani's study).

### *Education*

The respondents believe that when the public is given much information or education on issues relevant to reproductive health, there is the likelihood that the unsafe abortion menace would be reduced. They explained that though women are the ones who suffer the complications of unsafe abortion, men or males are the ones who impregnate them and so must as well be educated. Their concerns are as follows:

*“There should be intensive education on the importance of safe abortion and the dangers of unsafe abortion. People who had complications for causing an abortion before should be made to talk about it or you get them the statistics to know what is happening...”*

(Medical doctor)

*“I think it is awareness. You know, it is not easy to talk about abortion in the general public. So we started working towards it gradually and we have been able to create some awareness, now people know that when they come here they will get safe abortion services. That is the reason though we haven't done any survey to find out this but we*



*believe that it is because people are aware that we provide quality services here. So they may want to shun away from those quacks. We have established a link with other maternity homes and so far we have about 150 clinics that we are working with so that they can refer clients to us. We are also working with some pharmacy shops so that they can refer clients to us because we realised those are the places they go for abortifacients.”* (Medical doctor)

Education is not only directed to clients and their partners but the health workers as well. They have to go through education on how to take care of clients or women in need, as stated by these medical doctors:

*“We ourselves [health professionals] have to go through CPD (continuous professional development) education to know how to deal with patients, to understand the psyche of the patient who comes in or the 18 or 20 year old who does not want to keep the pregnancy...”*  
(Medical doctor)

*“I think that the entire public needs to be educated about the dangers of unsafe abortion. Even the health care personnel also need education...”* (Medical doctor)

### *Family Planning Services*

The respondents saw the need to offer family planning services to women who have undergone an abortion. They stated that family planning services should be readily given to women irrespective of their age. They said younger or adolescent girls as well as older women seek abortion services

from their facilities. Family planning, in short, should be available and accessible to the general public, as illustrated in the following quotations:

*“It is the matter of giving health talks, explaining the procedures to people outside the medical field, talking much about family planning and letting people change their mentality against family planning. If you have more women using family planning, it will reduce unwanted pregnancies...”* (Nurse)

*“So it is a whole step-wise process in the prevention of unsafe abortion. How do you prevent unwanted pregnancy? Ultimately in every program. In every policy that you want to get out to people, education plays a role but then how do we prevent unwanted pregnancy? Family planning...”* (Medical doctor)

*“...let people know the kinds of family planning methods that are available and it should be friendly. It is very difficult for someone to walk into a chemist shop and say I am buying a condom how much more saying I am going to buy birth control pill, especially when she is a teenager. I mean it should be very friendly in such a way you can actually purchase it without somebody asking. We should really tackle the family planning so that if you are protected and do not get pregnant you will definitely not go in for an induced abortion.”*  
(Medical doctor)

*“Also, people should be made to understand family planning well, because so many negative things have been said about family planning*

*which makes people feel reluctant to use. But if they understand it well, all these unplanned pregnancies will stop...*” (Nurse)

Respondents shared their views on the need to give women (who seek safe abortion services) counselling both before and after an abortion. They said they deem pre and post abortion counselling appropriate and they practise it as well. They commented thus:

*“Just come to the medical facility. We don’t just get up and do abortion: you come and you go through procedures... There is voluntary counselling test (VCT) available. So you don’t just end up in the procedure room, you go through counselling and probably after the counselling, you might change your mind; to come to the realisation that it’s not bad after all to have a baby...”* (Medical doctor)

*“We counsel them, help them, and after counseling we give them options. So what they opt for we do for them. So people opt to keep the pregnancy; that means that when somebody walks in here and says am pregnant we just go ahead and terminate it. No we don’t do that. We counsel them, and maybe after counselling she changes her mind.”* (Nurse)

*“When these young ladies come for abortion, we counsel them before we do it for them. After the process has been completed, we educate them on the use of family planning contraceptives so not to get pregnant unwillingly.”* (Nurse)

### *Awareness of the Abortion Law*

Some respondents think the abortion law is one of the barriers that prevent women from accessing safe abortion services. This is because people (including some of their colleagues) do not have enough knowledge about the law. For this reason, they suggested that there should be increased awareness of the abortion laws. They believe when women know about the law, they would use the right channel to access abortion, as indicated in these comments:

*“The first thing that I will say is that we need to do is to increase awareness of the legality of abortion services. Oh yes it is, that is why I said that there is a legal framework covering abortion so if you make people aware of it then those that are qualified for abortion can come for it...”* (Medical doctor)

*“Let me take it from the grass root, for example, we should make everybody understands the law and be aware of the law and family planning methods...”* (Medical doctor)

Not only did some suggest that awareness be created about the abortion law, some also suggested it should as well be amended to make it less restrictive, as pointed out by some respondents:

*“Like I said, from the beginning that the law should not be so restricted to these things that they said that is allowed. I think they should make it open so that every woman, every girl who think she has a problem can just go the hospital freely talk about it and get an*

*assistance. I think that when we do these things, the incidence of unsafe abortion will stop. If I know that when I go to the hospital I will get the treatment, why will have to go the pharmacy shop?” (Nurse)*

*“Abortion should be legalised and everybody should be made to know about it, and to have easy access to it. And it must also go hand-in-hand with family planning. It will get to a point in time where abortion will reduce drastically and family planning will rather increase...” (Nurse)*

#### *Improving on Client-Provider Relationship (user-friendly facilities)*

Some respondents saw the need to improve the services they provide to their clients. They acknowledged that the judgmental attitude of some of their colleagues towards clients deterred women from accessing health and resorting to unsafe abortion practices. They suggested the following:

*“The second thing is that we have to make our hospitals friendlier, that is, we need to work on our health personnel to change their attitude towards people coming to seek abortion and education about the hazard of unsafe abortion...” (Medical doctor)*

*“I think the facilities should be friendly in terms of the staff...so if we should deal with these things I think people will have the courage to come and it will be done for them...” (Medical doctor)*

#### *Appropriate Institutions*

The issue of government setting up institutions purposely for safe abortion services was mentioned, though there are some privately owned

facilities. This is because the existing facilities which offer safe abortion services are instituted in family planning units. This is mentioned by some respondents:

*“I think if there are recognised institutions available, it will stop people from going to the quacks and from doing it themselves by every means...”* (Nurse)

*“People out there should be made aware of the health facilities which provide abortion services because as it stands, people are not aware that such services are provided in some hospitals. Few know about it, but they don’t know specifically which those facilities are, and so they go ahead to use misoprostol and other herbal concoctions to do it unsafely and consequently suffer complications...”* (Medical doctor)

*“So there should be some facilities that should be recognised so that if somebody wants to have an abortion, she can go there for a comprehensive abortion care...”* (Nurse)

#### *Punitive Measures against Culprits*

The activities of persons who do not qualify to give abortion services should be monitored and arrests must be made where necessary. It is stipulated in the law that anyone who with the intent to administer to herself or consents to any drug to terminate pregnancy, both she and the person who aided are guilty of the law. Respondents were quiet on the fact that women too must be arrested when they try or commit illegal abortion. On the other hand, they suggested that the quack providers rather must be arrested. Maybe they should

consider that these women gave them the permission to carry out such acts on them. This problem was pointed out by a medical doctor:

*“You know when quacks are apprehended too, they have to be seen to be punished. For instance, the guy who was caught recently, we have not heard of what has happened to the case. I mean apart from the initial hullabaloo that came, if such actions are seen to be punished it will do us a lot of good...”* (Medical doctor)

### *Collective Responsibility*

Unsafe abortion is a public health problem and everybody informed to contribute their quota to curb this menace. It must not be the work of the health professionals. It is the task of the government, non-governmental organisations, media, parents, teachers, healthcare providers, religious leaders and the entire citizenry, to help improve maternal health in the country. The following comments came from them:

*“All hands should be on deck to try to educate the entire population because the health personnel alone cannot do it. The message will then go out; people will start getting in for these things to be done under safe conditions...”* (Nurse)

*“Also, in churches and other places, there can be dramas and role plays showing the effects of abortion and unsafe abortion. This will make people think twice whether to go in for unsafe abortion or not...”*  
(Medical doctor)

*“The media needs to be used to spread the message on unsafe abortion. Now everywhere you go you’ll access an FM station so the Ministry of Health has to sponsor programmes on the FM stations to educate and counsel people on the dangers of unsafe abortion. Also, there have to be outreach programmes by the Ministry of Health to go to schools, churches and even markets to counsel the youth who are those who mostly do abortion...” (Nurse)*



## **CHAPTER FIVE**

### **SUMMARY, CONCLUSIONS AND RECOMMENDATIONS**

#### **Introduction**

This chapter presents the summary, conclusions and recommendations of the study. It summarises the key findings of the study, draws conclusions on the findings and provides recommendations to curb unsafe abortion in the Accra Metropolis.

#### **Summary**

The general objective of the study was to appraise the views of professional health workers on unsafe abortion in the Accra Metropolis, Ghana. The specific objectives were to explore the barriers that hinder women from seeking safe abortion services; discuss methods used for unsafe abortion; explore outcomes of unsafe abortion; assess the perceptions of professional health workers on the abortion law, and explore the views of professional health workers on the appropriate interventions to curb unsafe abortion.

The study was qualitative in nature, and it used primary data. Data were collected using an in-depth interview guide. Thirty professional health workers with two years working experience in Obstetrics and Gynaecology were selected. Purposive sampling technique was employed in sampling respondents. Data were analysed manually.

The responses given by the PHWs on the barriers that deter women from accessing safe abortion services were issues relating to religion, moral standards and culture. Stigma and fear were two of the main factors mentioned. Stigma is one of the outcomes when people go contrary to the

doctrines of their various religious groups, moral standards and cultural practices set aside by communities and organisations.

Poverty and relatively high cost of safe abortion services were mentioned as a determinant of unsafe abortion practices among women (particularly those in the lowest wealth quintile). As stated in the 2007 GMHS and confirming what the respondents mentioned that women in the lowest wealth quintile are more likely to undergo a cheaper and unsafe abortion as against women in the highest wealth quintile. However, those in the highest quintile are more likely to terminate unwanted pregnancies but likely to have safe ones as compared to those in the lowest quintile who would keep unwanted pregnancies and if not would seek for cheaper and unsafe abortions,

On the issues of attitudes of some health workers, some respondents stated that part of the blame should be directed to them (PHW). They explained further that some of their colleagues provided care and treated clients based on their personal and religious beliefs, culture and traditions. They use judgmental ways in offering care to their clients. This according to the respondents is not helping matters and they suggested health workers should have an attitudinal and behavioural change. Also, there was an instance where a respondent accepted the blame of ever committing this judgmental act.

Also it was mentioned that the abortion law was seen as a barrier that deterred women from seeking safe abortion services. The abortion law was seen as such because the law, to the respondents, is made public and some PHW are not aware of it. Misinterpretation of the law was also mentioned, in that the law was not easy to understand by the lay person in the society. While

some of the respondents mentioned that the law should be amended (to include abortion on request), others also stood their ground that the law is very liberal and should be maintained.

The decision to abort does not only depend on women but their partners and the parents (when it involves a pregnant minor). Women, according to respondents, may be pushed by their partners who may be irresponsible or had denied the pregnancy. This coupled with other factors like poverty, the fear of losing education; the fear of being stigmatized among others may enhance women's choice of aborting and hence ending up in clandestine and unsafe abortions.

An issue pertaining to the methods for terminating pregnancies before seeking professional care was discussed. Respondents mentioned that methods that are generally used for abortion, which were categorised into two broad areas, are orthodox and crude. Under orthodox methods, respondents mentioned medical and surgical methods. Under medical, it included the use of medications like misoprostol (popularly called cytotec or "two-up two-down"), meddaborn and mediprest. For the surgical methods, it included MVA, D&C and D&E. The orthodox methods according to respondents are used for complete unsuccessful abortions or for post-abortion complication treatments.

Under crude methods, women resorted to the preparation of concoction made from various materials ranging from grounded up broken bottles; Guinness; sugar; 'blue'; paracetamol etc. Also, some resorted to herbal preparation or mixtures which are not to be consumed by pregnant women. Examples of such mixtures are 'Wofa Kissi', 'Agbeve' Tonic and 'Taabea'

Herbal Mixtures. According to the respondents, some women who reported at their facilities resorted to putting objects like bicycle spokes, sticks and ‘chorkor bomb’ into the uterus to terminate pregnancies. Others also exerted extreme pressure on the uterus and some use vigorous sexual intercourse with the idea that they would terminate their pregnancies.

There are some forms of complications that may occur after abortion. Respondents mentioned that the level of severity may depend on the type of service used, which is either safe or unsafe. They shared that unsafe abortion has the likelihood of bringing about outcomes that the researcher termed as physical outcomes. These physical outcomes (listed in order of severity and likelihood) included: death; haemorrhage (otherwise known as severe bleeding); incomplete abortions or retained products of conception; sepsis and other infections; uterine perforation, ectopic pregnancy and infertility.

Issues concerning whether or not respondents had some form of knowledge of the abortion law was also discussed. Most of the health workers had some knowledge, with the medical doctors having much knowledge as compared to the nurses. The nurses could only mention some of the conditions under the law but the medical doctors could mention all conditions.

Respondents acknowledged that unsafe abortion is a problem and suggested some solutions to control it. They mentioned the need for education, improvement in a provider-client relationship, improving family planning services and many others.

The findings of this study also suggest that there is the need to render information and education on abortion issues to pharmacy and drug store operators.

## **Conclusions**

This study seeks to appraise the views of professional health workers on unsafe abortion. It is then concluded that from the PHWs' point of view, women usually encounter several barriers that deter them from seeking safe abortion services. The barriers come in the forms of socioeconomic, health care delivery, cultural and religious. Stigmatisation and poverty mainly affect women's choice to seek abortion (particularly the unsafe ones). This study also makes it clear that women consider being stigmatised as more painful to suffering a health outcome and so would trade their health for a 'good name'.

Barriers to safe abortion tend to expose women to several health outcomes usually depending on the type of method used. Although, most women resort to medications like misoprostol (cytotec), other resort to herbal mixtures and concoction made from various materials to end pregnancies. The use of misoprostol or cytotec is on the increase while the crude methods are decreasing.

Again, the abortion law has not gained much publicity and there is the need for it to be made public, for the ignorance of the law can be fatal. The abortion law lacks proper interpretation which is sometimes a problem for some health providers. The criminalisation of abortion together with traditional values, social perceptions and religious teachings had produced a situation where quacks carry out abortions in clandestine and risky ways.

The findings show that there is the need to strengthen efforts to promote access to post abortion services. This would help in the management of side effects and complications of unsafe abortion. Health services in remote areas should be reinforced to cater for women in such areas.

This study shows that the abortion law (which lacks full implementation) alone cannot deal with the issue of unsafe abortion. On the other hand, full implementation of the law, de-stigmatisation of abortion clients, easy access to safe and legal abortion services, decentralising abortion services and others are likely to reduce abortion-related morbidity and mortality in the metropolis.

### **Recommendations**

A lot needs to be done to address the challenges affecting sexual and reproductive health in order to achieve the MDG 5. Based on the major findings of the study, some recommendations were made with regard to what should be done to reduce this incidence in the Accra Metropolis. These are as follows;

1. Ministry of Health and Ministry of Education should collaborate with the Willows Foundation (whose aim is promoting community-based behaviour change among women) to educate the general public on issues relating to reproductive health, particularly on unsafe abortion and the dangers associated with it. This is likely to help enlighten them on the dangers of unsafe abortion; hence it is likely to reduce unsafe abortion-related mortalities and morbidities.
2. Ipas Ghana, Pathfinder International, Willows Foundation and Marie Stopes International should increase the number of training programmes for professional health workers on the behavioural change communication in service delivery. This is likely to improve

upon attitudinal and organisational barriers that obstruct the quality of services rendered to clients. In other words, creating more user-friendly facilities has a step ahead of reducing the incidence of unsafe abortion.

3. Abortion law was seen as one of the barriers that prevent women from accessing safe abortion services. National Commission for Civic Education should educate the general public on the abortion law. Not only is the publicity necessary, but giving interpretations for lay people to understand is likely to help fight the menace. Also, health workers should be trained particularly on the legal framework of abortion in the country. Pharmaceutical professionals, human rights advocates, police officers, local leaders and other stakeholders should be involved.
4. Ghana Health Service should promote access to comprehensive abortion care which includes making family planning services available, accessible and affordable to all; promoting safe abortion services and post-abortion care.
5. Ghana Health Service should establish quality monitoring programmes to check activities of private health providers who have the license to offer abortion services. Monitoring could be done in the environment of the facility, infrastructure (i.e. service providers and technologies used) and services provision (i.e. measuring compliance with the legal framework). When such programmes are put in place, there is the likelihood that certain errors would be reduced, hence the likelihood of improving health care delivery as

the quality of services delivered is vital to enhancing health system performance.



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## APPENDICES

### Appendix 1

#### Health facilities in the Greater Accra Region

Hospital	City / Town / Village	District
District Hospital	Abokobi	Ga East Municipal
Gbegbe Royal Community Clinic	Agege Last Stop, Gbegbeyise, Accra	Accra Metropolitan
Korle Bu Teaching Hospital	KorleGonno, Accra	Accra Metropolitan
LEKMA Hospital	Accra	Accra Metropolitan
C&J General Hospital	Accra	Accra Metropolitan
Lapaz Community Hospital	Abeka-Lapaz	Accra Metropolitan
Lister Hospital	Airport Hills, Accra	Accra Metropolitan
Manna Mission Hospital	Teshie-Nungua	Ledzokuku-Krowor Municipal
Martin Memorial Hospital	Dzorwulu	Accra Metropolitan
Military Hospital	Accra Airport Residential Area, Accra	Accra Metropolitan
Nyaho Medical Centre	Area, Accra	Accra Metropolitan
Pantang Hospital	Pantang	Ga East Municipal
Police Hospital	Cantonments	Accra Metropolitan
Prilway Specialist Clinic	Madina	Ga East Municipal
Prime Care Medical Centre	Accra	Accra Metropolitan
Princess Marie Louise Hospital	Accra	Accra Metropolitan
Health care center& Clinic of Cantonments	Cantonments	Accra Metropolitan
Raphal Medical Center	Community 10, Tema	Tema Metropolitan
Ridge Regional Hospital	North Ridge	Accra Metropolitan
1st Global Hospital	Nungua	Ledzokuku-Krowor Municipal
Tema General Hospital	Tema	Tema Metropolitan
Tema Polyclinic	Tema	Tema Metropolitan
Tema Women's Hospital	Tema	Tema Metropolitan
Trust Hospital	Accra	Accra Metropolitan
University Hospital	Legon	Accra Metropolitan
Valco Hospital	Tema	Tema Metropolitan
Provita Specialist Hospital	Tema	Tema Metropolitan
Holy Trinity hospital	Accra	Accra Metropolitan
Jubail Specialist Hospital	Sakumono	Tema Metropolitan
Justap Hospital	Accra	Accra Metropolitan
Atta Quarshie Memorial Hospital	Odogono, Accra	Accra Metropolitan
Efah Victory Clinic	Pig Farm, Accra	Accra Metropolitan
North Legon Hospital	North Legon(Off Hatso Road)	Accra Metropolitan

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Sakumono Community Multiplex Hospital	Sakumono	Tema Metropolitan
The Community Hospital	Ashongman	Ga East Municipal
King David Hospital	Accra	Accra Metropolitan
New Hope Hospital	Accra	Accra Metropolitan
Kalbi Hospital	Accra	Accra Metropolitan
Greater Grace Hospital	Pantang	Accra Metropolitan
New Ashongman Hospital	Ashongman	Ga East Municipal
Sam J Specialist Hospital	Accra	Accra Metropolitan
International Health Care Centre	Accra	Accra Metropolitan
Pentecost Hospital, Madina	Accra	Accra Metropolitan
Akai House Clinic	Accra	Accra Metropolitan
VRA Hospital	Accra	Accra Metropolitan
Kumoji Hospital	Accra	Accra Metropolitan
Cantonments Hospital	Cantonments	Accra Metropolitan
Medifem Hospital	Westlands/West Legon- Haatso road, Legon	Accra Metropolitan
Inkoom Hospital	Accra	Accra Metropolitan
Bengali Hospital	Tema	Tema Metropolitan
Caiquo Hospital	Accra	Accra Metropolitan
Sinel Specialist Hospital	Tema	Tema Metropolitan
New Crystal Hospital	Accra	Accra Metropolitan
Rofhi Hospital	Accra	Accra Metropolitan
Baatsona Good Shepherd Medical Centre	Accra	Accra Metropolitan
VEBS Medical Centre	Accra	Accra Metropolitan
Family Health Hospital	Teshie	Ledzokuku-Krowor Municipal
Bethel Hospital	Tema	Tema Metropolitan
KariKariBrobbey Hospital	Accra	Accra Metropolitan
Gbegbe Royal Community Clinic	Gbegbe	Ga South Municipal
Vicom Specialist Hospital	Accra	Accra Metropolitan
LightHouseMision Hospital	Accra	Accra Metropolitan
Otobia Memorial Hospital	Accra	Accra Metropolitan
Royal Good Shepherd Hospital	Accra	Accra Metropolitan
Obengfo Hospital	Accra	Accra Metropolitan

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## **Appendix 2**

### **In-depth Interview Guide**

#### **Introduction**

We would like to conduct a short interview with you because of your experience in providing post-abortion care. We are interested in obtaining information about the termination of pregnancy. We hope that the information that you provide will shed some light on this topic. The study is being conducted by the Department of Population and Health, University of Cape Coast and will provide valuable information on the changing type and severity of abortion complications. If you are interested in participating in the study I will ask for your consent. Would you like to participate? [If yes, read the informed consent form]. Do you have any questions?

#### **Topics**

##### a). Introductory questions (warm-up)

- Experience in hospital
- Experience working in obstetrics and gynaecology
- Type of care provided
- Barriers to safe abortion
- Outcomes of unsafe abortion
- Views about abortion law in Ghana

##### b). Change in the number of women presenting complications

- Change in percentage of women presenting with symptoms who are admitted to the ward
- Change in percentage over last three years, five years, and ten years

- Change in number presenting with symptoms (three, five and ten years)

- Reason for change

c) Change in the severity of complications

- Severity of complications now

- Change in severity of complications that have occurred over the last three years, five years, and ten years

- Reasons for change

d) Role of misoprostol

- Can they tell from an examination that an abortion has been induced

- What are the main methods of inducing an abortion?

- Have they changed?

- What is the role of misoprostol in inducing abortions?

- Has the use of misoprostol become more frequent or less frequent?

- Where is the drug obtained?

- Knowledge of drug

e) Suggested solutions to unsafe abortion

### **Appendix 3**

#### **Informed consent form for participation in in-depth interview of providers**

(Greeting) My name is ..... I am working for the research project which is looking at the type and severity of symptoms resulting from abortion and how these are related to methods of abortion. This research is carried out by the University of Cape Coast in collaboration with this hospital.

Would you be interested to hear more about this research with a view to your possible participation in it? IF THE RESPONDENT SAYS "YES", INTERVIEWER, PLEASE PROCEED. IF SHE/HE SAYS "NO", PLEASE THANK HIM/HER AND STOP THE INTERVIEW.

I like to provide you more information about the study and what this interview entails.

#### *Purpose*

We are gathering information about complications of pregnancy termination and miscarriage in order to document the nature, severity and extent of its occurrence and how it can be better addressed. We hope that the results of this study will inform the public as well as health policy makers and programme managers so that they can design and implement appropriate interventions to reduce this problem.

#### *Procedure and right to refuse to answer or withdraw*

We are talking with providers in order to obtain their views about how the severity of complications of abortion may have changed. The discussion will take place in a private room where you will share your views with me.

We wish to record the interview with you. You can ask that we not record the interview and in that case we will take notes of the conversation.

Your participation in this interview is voluntary. You can stop and withdraw from the discussion at any point without any effects on your position. The discussion will take about 30 minutes of your time.

#### *Confidentiality*

The information that you share with me will be kept confidential; it will be used strictly for research only. The report will use the collective responses and will not reveal names or any identifiers that may be linked back to the person who gave the information. Nor will any one who is not directly involved in this research be allowed to access the information that we obtain from you. Your response will be recorded but no identifying information will be collected on the recording. This consent form has your name on it but will be kept separate from information that you provide and will be destroyed in one year by the investigator.

The tape of the interview will be kept under lock and key and will not be accessed except by the principal investigator or her/his designee. The recording and a transcript of the recording will be destroyed by the principal five years after the study is completed.

As you might know, abortion is legally restricted in Ghana, but providing care to a woman presenting with induced or incomplete abortion is legally permitted. We would like to reassure you that the information you provide will not be provided to any other person and will be used only for research purpose.

#### *Risk and Benefit*

You are free to decline answering any questions or not to participate in the study altogether. The information you provide us today will be useful for understanding an important aspect of the women's health which can benefit women in our country. There is no direct benefit to you, but we hope the results from the study will inform policy makers and programme managers to design and implement appropriate strategies.

We foresee no risks due to your participation in the study, but it is possible that you find some questions embarrassing or difficult to answer. Should this happen, you are free not to answer or to stop the interview. It is also possible that your participation in the study raise interests and questions among your colleagues.

#### *Contact*

This project is being carried out by the University of Cape Coast. Should you need to contact this research project at a later date, you may contact Akwasi Kumi-Kyereme (0244255234) and Eugene Maafo Darteh (0243717014) both of the Department of Population and Health.

If the information I give you is unclear or if you have questions about this research, you may ask me now. Do you want to ask me any questions?

(Interviewer: Wait to see if the respondent has any question to ask. Answer those questions as clearly as possible. Begin interview only when the respondent has a clear understanding of what she/he is asked to do and she/he has given consent for interview.)

#### *Certificate of Consent*

I have been informed about this research which focuses on pregnancy termination and miscarriage among Ghanaian women. I have read the

informed consent form or it has been read to me; I have had opportunity to ask questions about the research and my questions have been explained clearly to my satisfaction. I am aware that I will be asked to provide my personal information. It has been guaranteed that the information I provide will remain confidential. I realize that I have the right to decline answering any question and to stop or withdraw from interview any time, if I wish, without in any way affecting my position at the hospital. I consent voluntarily to participate, as a subject, in this study.

Signature: .....

Date: .....



## **Appendix 4**

### **Important Organisations and Networks for Reproductive Health**

Alan Guttmacher Institute

International Centre for Research on Women (ICRW)

International Planned Parenthood Federation (IPPF)

International Pregnancy Advisory Service (Ipas)

Global Health Council

International Consortium for Emergency Contraception

International Consortium for Medical Abortion (ICMA)

Marie Stopes International

Pathfinder International

Centre for Reproductive Rights

World Health Organisation

Willows Foundation

EngenderHealth

GHANA HEALTH SERVICE ETHICAL REVIEW COMMITTEE

*In case of reply the  
number and date of this  
Letter should be quoted.*

*My Ref. :GHS-ERC: 3  
Your Ref. No.*



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12<sup>th</sup> June, 2012

**AKWASI KUMI-KYEREME, Principal Investigator**  
Department of Population and Health  
PMB  
University of Cape Coast  
Cape Coast  
Ghana

**ETHICAL CLEARANCE - ID NO: GHS-ERC:12/11/11**

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol titled:

“The Relationship Between the use of Misoprostol and the Type and Severity of Abortion Symptoms: A Multi-country Study”

This approval requires that you submit periodic review of the protocol to the Committee and a final full review to the Ethical Review Committee (ERC) on completion of the study. The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Please note that any modification of the project must be submitted to the ERC for review and approval before its implementation.

You are also required to report all serious adverse events related to this study to the ERC within seven days verbally and fourteen days in writing.

You are requested to submit a final report on the study to assure the ERC that the project was implemented as per approved protocol. You are also to inform the ERC and your mother organization before any publication of the research findings.

Please always quote the protocol identification number in all future correspondence in relation to this protocol

SIGNED.....

DR. CYNTHIA BANNNERMAN  
(GHS-ERC VICE-CHAIRMAN)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra