

Social and Cultural Norms of Abortion Seeking in Ghana

by

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Dedication

This dissertation is dedicated to the women who have their choice limited by others and to all those fighting to protect every woman's right and ability to choose.

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Abstract

Ghanaian women are dying from complications resulting from unsafe abortions. This is despite a law referred to one of the most liberal in sub-Saharan Africa and a policy and regulatory situation that closely mirrors what international agencies call for to eliminate the complications from unsafe abortion. This study sought to answer the question, if safe abortions are available to Ghanaian women legally, why do so many continue to self-induce unsafely? While agencies such as the World Health Organization conclude that women resort to self-induction only if they are not able to access safe services, the women I interviewed suggested a different situation. Ghanaian women are engaging in transactional sexual relationship and are not using contraception. When pregnancies result, these women chose to self-induce not because they could not access a facility-based option but rather on the advice from their social networks. They know of friends who have been treated badly by healthcare providers or they themselves have been treated badly; they are shamed for their promiscuity and for falling pregnant. Some providers have told them that abortions are not available legally in facilities. Women know of others who have successfully self-induced an abortion using Misoprostol, a drug which is widely and inexpensively available in Ghana. It is for these reasons that Ghanaian women choose to

self-induce and only seek care for complications. To engage women with the formal healthcare system, major investment into improving the quality of care patients receive is absolutely necessary. Investing in peer education, using these social networks to communicate positive messages about contraception and how to access safe abortion services, are potential interventions to reduce unsafe abortion. When individuals receive poor quality care, they are less likely to seek care in the future, and their entire social networks are likewise unlikely to come for care, relying instead on this system only in case complications arise.

Chapter 1: Abortions done in the house

Abena is 16 years old, and has a boyfriend with whom she is having sex. She is not on any form of contraception, and has never used any form of contraception. Recently, she noticed her period had stopped coming and she was feeling nauseated all the time. She bought urine pregnancy test strips at a local pharmacy and the result was positive. Abena is a student and recognized that she cannot have a baby and stay in school. It is important to her future that she remains in school. In her own words, "I wanted to continue to maybe secondary school. And I thought that with the pregnancy I can't continue again. So I knew to abort it." She told her boyfriend and her friend about the pregnancy. Her friend told her to go to the pharmacy to get pills. When asked how her friend knew to go to this pharmacy, Abena replied, "I don't know. She just showed me there's a drugstore, and she thinks I can get some of the drugs there."

She went to the pharmacy and purchased two tablets which she was told would end her pregnancy. Soon after taking the tablets orally she began to bleed and it seemed the tablets had worked. However, a few days later, she began bleeding again, this time heavily and she had

serious abdominal pain. She went to a local clinic where they referred her to the district hospital. The ultrasound detected retained products of conception; her abortion was not complete and surgical intervention was recommended. Her family was called before she went to surgery.

When asked about telling her family, she said that her sister, “was not angry, but they asked me, why did I want to do the abortion without their knowledge, without them knowing anything about my pregnancy, and nothing? They were very angry, and very anxious, why I took that step without telling them.” When asked about why she did not tell her family about the pregnancy, why she did this alone, she said, “When I tell my parents, they wouldn't allow me to do the abortion. That's why I took it by myself.” In her mind, she acted illegally and she was not aware of any way for a Ghanaian woman in her situation to access an abortion legally. She mentioned that she knows it is against Ghanaian law for a woman to end her pregnancy.

Juliette is a 27 year-old woman who has completed senior secondary school. She is unemployed and supported by her partner. She has been pregnant three times, but does not have any children. She has self-induced three abortions; the first two she “did...in the house”. She agreed that she has experience inducing abortions, “considering the number of times that I have had induced abortions”. She knows that abortion is against the law in Ghana; “At least with my little knowledge that I have I know it is against the laws of Ghana”. She received this information from hearing about it on the radio. When she discovered she was pregnant, she was alone. “Firstly there was no one around and I also didn't have anyone that I trust to tell the person such news. So I thought to myself that if I hide it, it will be helpful to me. Because I didn't want

the pregnancy to develop or mature, I took an oral drug. I bought it from a drugstore. They showed me how to use it, but because I wanted to quickly get rid of the pregnancy, I didn't follow the dosage advice I was given." When asked how women get information about how to end their pregnancies, she noted, "They go to people who have done abortion before and then they inquire about how they manage to get rid of their pregnancies and if they have any help that they can give to them so that they too can get rid of their pregnancy." When asked about using contraception, Juliette notes, "All those that I have interacted with, they know where to access these services but because of the fear that most of them have, they are unable to go and access these services...Some of them are also misinformed by people who have previously used some of the methods. So with all these most women are not even encouraged to go seek family planning methods." When asked if she has ever used any family planning method, she says, "Please no. It has not occurred to me to use any".

Sandra is 13 years old. She has been pregnant twice and is currently in junior high school. She has never used any form of contraception and isn't sure she wants to now. When she discovered she was pregnant she told her friend. Together they went to an "elderly person" who gave her a "local herb" which she "took...myself and prepared it". When she took the herb, "I will bleed a little then it will stop, so on Sunday I started experiencing abdominal pains." When she began experiencing these symptoms, she told her mother who took her to the local hospital. She knew to go to that facility because "I have had a previous abortion there". From that hospital she was referred to the tertiary care center because, "they realized my situation was complicated so they transferred me to Komfo Anokye." When asked about whose decision it was to end the pregnancy, Sandra said, "It was my decision because I didn't want to have a

baby.” Sandra knows that “abortions are against the law in Ghana” and she knows this “from the radio and also friends”. She has also been told “a number of times” by providers that abortion is against the law. When asked why she did her abortion in her home with local herbs rather than going to a facility, Sandra said, “When they go to the health facilities, the behavior of some of the nurses intimidates them so they choose to do it at home.”

The stories of Abena, Juliette, and Sandra are not unique. These are the kinds of stories which are common in district hospitals in Kumasi, Ghana. This book will explain why women such as Abena, Juliette and Sandra self-induce their abortions with drugs procured from unlicensed “chemical sellers” rather than seek care at a facility for such a procedure. In Chapter 2, I will contextualize abortion-related morbidity and mortality into the wider topic of maternal death and disability. I will also describe the international consensus on unsafe abortion, which drives international guidance and interventions. In Chapter 3, I review some theories of health seeking which are applicable to abortion-seeking in Ghana. In Chapter 4, I will describe the policy and legal framework of abortion in Ghana and present the work which has been conducted in the country on the topic of abortion. I will also show that, despite following international guidance, unsafe abortions are common in Ghana and the country has not managed to stem unsafe abortions. I will explain in Chapter 5 how urban Ghanaian women end up with unplanned and unwanted pregnancies. In Chapter 6, I will describe the process by which these women seek abortion care, some in facilities and some in their homes. In Chapter 7, I will make policy recommendations based on these findings.

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Chapter 2: International Consensus

Maternal Mortality—Public Health Crisis

Although most of this book will focus on abortion-related care, death and disability resulting from unsafe abortions are a component of maternal mortality, and abortion-related deaths are almost always contextualized as part of the larger problem of preventable maternal death. A maternal death is defined by the World Health Organization as the death of a woman while pregnant or within 42 days of termination of pregnancy, regardless of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (WHO 2012). Over 287,000 women died from maternal causes in 2010, more than 800 per day around the world (WHO, 2012). The majority of these deaths occur in low- and middle-income countries where health services are limited and women do not have access to high quality services. Measuring maternal mortality is also important as it serves as more than an individual-level cause of death; maternal mortality, as well as under-five mortality, is widely acknowledged as a general indicator of the overall health of a population as well as a measure of the status of women in society, and of the functioning of the health system (Muldoon *et al.*, 2011). High maternal mortality ratios are therefore used

as markers of wider problems of women's status in society and the strength of the health system in a country.

The persistently high rate of maternal death in many developing parts of the world is a public health crisis. The recognition of this public health crisis developed over many decades beginning in the 1970s. The International Safe Motherhood Conference held in Nairobi, Kenya in 1987 sought to raise awareness about the numbers of women dying each year from complications of pregnancy and childbirth, and to challenge the world to do something. This conference launched an international movement to address the high rates of maternal mortality in much of the developing world (Jowett, 2000). Bringing maternal health to the international aid agenda and dedicating resources to the improvement of maternal health culminated in the development of Millennium Development Goal 5, to reduce by two-thirds their maternal mortality rate between 1990 and 2015. In 2000, at the Millennium Summit, member States resolved to improve maternal health as one of the eight Millennium Development Goals. This goal, along with the other seven MDGs, has come to define international development programs (Hunt & Bueno de Mezquita, 2010). The lack of progress on MDG5 has highlighted the failure of some States to address these issues and have made these countries aware of their shortcomings (Berer, 2013).

The literature which describes maternal mortality can generally be broken up into three categories; 1) explanations of the biomedical or clinical causes of maternal death; 2) models and theories describing why women in some parts of the world die from these, while in other places they do not. These models and theories note the social aspect of seeking care and

different levels of quality of care across locales; and 3) large-scale theories where maternal death is used as a general marker of development rather than a clinical or biomedical cause of death.

The clinical causes of maternal death are widely known and, for the most part, treatable.

According to the most recent estimates, the leading causes of maternal death are hemorrhage, elevated blood pressure, complications from unsafe abortion, and sepsis (Say *et al.*, 2014). If women have access to good quality healthcare, almost all maternal deaths are preventable (Benagiano & Thomas, 2003). This is evident by the huge discrepancy that exists in maternal death rates in developed versus developing countries. Women in the global North (countries with high per capita income in North America, Europe, and much of Asia) face an almost negligible risk of dying from maternal causes. Compare this situation to the global South, where women face a real chance of death when they become pregnant.

The maternal mortality rate in developed countries is 16 per 100,000 live births while in developing countries it is 240 per 100,000. The lifelong risk of dying from a maternal cause for a woman who resides in Sweden is approximately 1 in 30,000. For women in sub-Saharan Africa, this risk is 1 in 16 (Ronsmans *et al.*, 2006). The discrepancy between those rates is not due to genetic differences nor is the persistently high rates of maternal death in developing countries because the scientific community does not know how to prevent these deaths. Rather, the high risk of death for women in low-and-middle-income countries is due to the inability of these countries to reach women in need of services, the unwillingness of women and their communities to access maternal health care, and a devaluing of maternal life by society,

administrations and aid agencies. The disparity in rates of maternal death between rich and poor countries is greater than for any other indicator of public health (Shen *et al.*, 1999).

While between-country differences shed light on areas of the world where interventions to reduce unnecessary death are needed, within-country differences also exist. Women who reside in low-income countries are not at equal risk of dying from maternal causes. Women with means (including money, education, and access to well-stocked hospitals staffed by well-trained personnel) are able to access care to safely deliver their babies or terminate their pregnancies (Ronsmans *et al.*, 2006). The differences in maternal mortality rates by wealth quintile and those who reside in urban versus rural areas are stark. For example, in Ghana, according to the 2008 Demographic and Health Survey, 89% of maternal death occurred in women with less than secondary education, and 64% occurred in women who lived in rural areas (Asamoah *et al.*, 2011).

In most countries, citizens have the right to the highest attainable standard of health protected by their constitution. Almost all countries in Africa have joined the international community in agreeing that all humans are born free and equal in dignity and rights, and that these rights are unalienable and indivisible (WHO, 2012). According to the WHO constitution (1946) and other bodies such as the International Covenant on Economic, Social and Cultural Rights, "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being..." From this human rights perspective, preventable maternal mortality is a violation of the basic human right of women to achieve this highest standard of health. The right to health requires that political, economic, social and cultural barriers that prevent women

from achieving total health be first identified and acknowledged, and then broken down. The reduction of maternal mortality will also require States to be held accountable for the preventable deaths of their women (Hunt & Bueno de Mesquita, 2010).

This human rights perspective relates directly to family planning as well. In 1968 at a UN review of the Universal Declaration of Human Rights in Tehran, member States agreed that parents have a basic right to determine freely and responsibly the number and spacing of their children, without endangering their health. The high numbers of women, especially young women, who are treated every year in African hospitals for complications resulting from unsafe abortion, is indicative of a public health crisis as well as a violation of women's human rights (Hessini *et al.*, 2006).

Strategies to Reduce Maternal Mortality

Strategies to reduce maternal mortality are primarily health system focused. The World Health Organization states that to prevent women from dying, "All women need access to antenatal care in pregnancy, skilled care during childbirth, and care and support in the weeks after childbirth." (WHO, 2012, pg. 2) The reasons women do not get the care they need to prevent maternal mortality, according to WHO (2012), are because of too few health providers, poverty, distance, lack of information, inadequate services and cultural practices. Countries which have been successful at reducing very high levels of maternal mortality, for example Sri Lanka, have done so by a combination of controlling infectious diseases, ensuring access to hospital care,

liberalizing of abortion laws, and improving the provision of midwifery care (Ronsmans *et al.*, 2006).

As a reminder, WHO has identified the leading clinical causes of maternal death as hemorrhage, elevated blood pressure, sepsis, and unsafe abortion (Say *et al.*, 2014). Hemorrhage has long been known to be the “one major cause of maternal mortality in which women were dying needlessly for want of common skills that every midwife and practitioner should possess” (Louden, 1992). Likewise, high blood pressure, resulting in pre-eclampsia or eclampsia, can be easily treated using magnesium sulfate, a drug that is included on the WHO’s essential drugs list (Say *et al.*, 2014). Sepsis is caused by unclean delivery practices, including during cesarean sections, which allow infection to take place (van Dillan *et al.*, 2010). These biomedical causes of death are fairly easily treated and reasons for continued death, according to this health-system focus, are because there are too few highly-supported practitioners in the places where women can access them (JLI, 2004).

Unsafe Abortion

Unsafe abortion is a major cause of maternal mortality. Complications from unsafe abortion cause approximately 10% of maternal deaths in sub-Saharan Africa (Say *et al.*, 2014), although these numbers are likely underreported in areas where abortion is illegal and/or highly stigmatized (Nieburg, 2012). Further, since unsafe abortions often lead to sepsis, some women whose death is classified as being from sepsis are actually dying of complications from unsafe abortion. Additionally, women who die before anyone is aware of them being pregnant may not be included as a maternal death. Deaths resulting from unsafe abortion exist almost

exclusively in low-income countries where there are often highly restrictive laws governing abortion provision and where there are scant providers trained and willing to provide safe procedures. These deaths occur because societies and countries, and the agencies that fund much of the health sectors in the countries which are most affected, either ignore the issue of unsafe abortion, or refuse to address it (Braam & Hessini, 2004). In high resource settings where abortions are available and safe, death and disability from unsafe abortion are nonexistent. The discrepancy between rich and poor countries as it relates to abortion is even more striking than for other causes of maternal mortality.

Although no contraceptive method is completely effective and human error will continue to occur, and therefore the need for safe abortion services will always exist (Cohen, 2012), an added dimension of the deaths and disability resulting from unsafe abortion is that of primary prevention. Women who die from complications resulting from unsafe abortion are almost exclusively terminating an unwanted pregnancy (Warriner IK *et al.*, 2006). Therefore, if women were able to access and accept modern contraception, many of the index pregnancies resulting in the disability or death would not occur, negating the need for the unsafe abortion.

Investments in preventing unsafe abortion (making family planning and safe abortion information and services accessible) can dramatically decrease the incidence as well as the negative health consequences of these procedures (Vlassoff *et al.*, 2012). Further, these investments can reduce the high costs associated with treating and managing abortion complications, which tax the health systems in resource-poor countries (Vlassoff *et al.*, 2012).

The root causes of unsafe abortion include a lack of access to comprehensive reproductive health information and services, women's lack of decision-making power related to sex and reproduction and health systems which do not prioritize access to safe abortion services (Warriner *et al.*, 2006). Acknowledging and addressing these root causes can have a positive impact on a range of related health and social problems (Braam & Hessini, 2004). It is ironic that while men often dominate the decision-making about women's bodies, educational interventions to reduce unsafe abortion have historically targeted women, or health care providers and ignored men. Engaging with men and other power-holders on issues relating to sexual and reproductive health needs to be undertaken to address the issues of access to safe abortion and other reproductive health services (Braam & Hessini, 2004).

International Organization Guidance

There are a myriad of barriers that keep women from accessing safe abortion services in developing countries. International documents note the lack of an enabling legal environment, the paucity of well-trained and willing providers and the shortage of necessary supplies (WHO 2012b). The lack of providers and supplies are also causes of other causes of maternal mortality. The legal environment is a main difference for death resulting from unsafe abortion, with some going as far to state, "Restrictive legislation...is the main determinant of unsafe abortion." (Warriner *et al.*, 2006) Recommendations for interventions to decrease mortality and morbidity associated with unsafe abortion include ways to overcome these supply-side issues in order to enable women full access to safe abortion services.

In countries with restrictive laws, the international community has called for these legal restrictions to be removed. In countries where the drugs to provide medication abortion, which is safer and easier to provide than surgical abortion for early terminations, are not available, international agencies have called on countries to add these to their formularies. In countries where there are no trained providers, interventions have aimed to provide in-service trainings for nurses, midwives and physicians to provide safe abortions. When reading these documents, one is left to believe that if these obstacles are overcome, which is no small feat, the complications from unsafe abortions that plague women in many of the world's low income countries will be mitigated and thousands of maternal lives, and much more morbidity, will be saved each year. However, the evidence does not support these assertions.

There are countries which have made many of these strides. South Africa passed a termination on demand law in 1996, removing all legal barriers to early abortion and allowing mid-level providers (i.e. midwives) to provide abortion services. Ghana liberalized its law in 1985 and made safe abortion part of the national reproductive health policy in 2003. Building on the evidence of midwives safely and effectively providing post-abortion care in South Africa (Sibuyi 2004) and Ghana (Billings *et al.*, 1999), a 1996 policy reform has allowed midlevel providers with midwifery skills to perform this service in Ghana (Clark *et al.*, 2010). To ensure these providers have the skills necessary to perform the service, in 2009, Manual Vacuum Aspiration (MVA) was added to the national curriculum for midwifery education to train additional providers in this life-saving technique. Ethiopia liberalized the abortion law in 2005 and released guidelines and protocols to support providers in 2006. In these three countries, complications from unsafe abortions continue to be among the leading causes of admission to

hospital gynecological wards and women continue to die from preventable complications (Moodley & Akinsooto, 2003).

Perhaps it is simply that not enough time has passed to see the effects of the law and policy changes in sub-Saharan Africa. However, intervening only on the supply side of the equation, by increasing the number of trained providers, misses the truly important intervention point in these communities. With an issue such as abortion, which is highly tied to the role of women in society, as well as the traditional role of women in families and the status of reproductive health in development strategies (Braam & Hessini, 2004), providing the structural needs are not enough to overcome the socio-cultural barriers to enable women to limit their childbearing out in the open. Overcoming these supply-side issues is, like so much in public health, necessary but not sufficient to reduce the avoidable death and disability resulting from unsafe abortion.

The role of the World Health Organization

As with many issues of health in developing countries, the World Health Organization (WHO) plays a major role in the assessment of the problem of unsafe abortion and the promotion of strategies to begin to mitigate these issues. A review of the impact of the guidance from WHO on women's access to safe abortion in Africa points to the very important aspects of guidance the WHO has provided on technical aspects of providing safe abortion services (WHO 2003, WHO 2012). Further there have been important strides that have been made by following WHO guidance in such areas as writing protocols which enable safe abortion services as allowable to the fullest extent of the laws as written, providing an impetus to change more restrictive laws,

and establishing committees to translate existing laws into policies so health workers understand how the law regulates their practice (van Look & Cottingham 2013).

In 1967, the World Health Assembly, the forum through which the World Health Organization is governed, recognized unsafe abortion as a problem for many women around the world (WHO 1967). However, it was not until 1989 that the full scale of this public health problem was known, when the first estimates of abortion-related deaths was published (Royston *et al.* 1989). In 1999, WHO estimated that 13% of all maternal deaths were due to complications from unsafe abortions (WHO 2011). Outside the general reporting of abortion-related mortality, however, WHO generally resisted advocating for any intervention to prevent unsafe and clandestine abortion through the provision of safe legal abortion (van Look & Cottingham 2013).

During the 1990s the effects of unsafe abortion on women's health were increasingly well-documented (Dixon-Mueller 1990). It was with this backdrop that WHO formulated managerial guidelines for improving the quality and availability of abortion and care for its complications as part of a primary health care system. It was also during this time that guidelines for planning the location and content of emergency abortion care at each level of the health care system, not just in tertiary care centers, were disseminated (WHO 1995).

Although national laws were generally moving to be more liberal, especially in North America and Western and Eastern Europe, in many countries abortion was still deemed undesirable and unacceptable, mainly through the continuation of colonial-era legislation (Boland & Katzive, 2008). As an intergovernmental organization, WHO had to navigate between positions

upholding the deplorability of abortion and the documented need for safe services. Its 1995 managerial guidelines for improving the quality and availability of abortion and care for its complications specifically state, “National authorities are responsible for deciding whether and under what circumstances to provide services for the medical termination of pregnancy. **WHO takes no position on the matter**” (emphasis added)(WHO 1995).

Not long before the publication of these WHO managerial guidelines (WHO 1995), the Programme of Action (POA) of the 1994 International Conference on Population and Development (ICPD), which were adopted by 179 governments (UNFP) included an entire paragraph on abortion. The final wording was the subject of long, tense negotiations between delegations (van Look & Cottingham 2013). These delegates agreed that “in circumstances where abortion is not against the law, such abortion should be safe. In all cases women should have access to the management of complications arising from abortion” (United Nations, 1994).

In the five-year review of the ICPD POA in 1999, it was stated that, “in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible. Additional measures should be taken to safeguard women’s health.” (UN 1999).

In 1998, a new Director General of WHO was elected. Gro Harlem Brundtland, the former prime minister of Norway and well-known advocate of reproductive rights, urged the organization to publish the guidance that health systems needed to provide safe abortion (van Look & Cottingham 2013). WHO staff and partners agreed that these guidelines needed to include guidance on how safe abortion services be provided, and clinical recommendations (WHO

2003). It says, “This document provides technical guidance to Governments, policy-makers, programme managers and health workers on how to implement” safe abortion services where it is not prohibited by law (WHO 2003, pg. 11). The document also contains a full chapter on abortion laws and policies and encourages States to “ensure that every woman legally eligible has ready access to safe abortion services” (WHO 2003, pg. 88).

The authors of this document state,

When we started working at WHO in the 1980s, it seemed impossible that the organization would publish guidance for governments on how to provide safe abortion services. However, the recognition of the devastating impact of unsafe abortion on women’s health and survival, the impetus of the International Conference on Population and Development and its five-year follow-up, and the progressive leadership at WHO at the end of the century opened up windows of opportunity for WHO to address the issue of women’s access to safe abortion.--van Look & Cottingham 2013

This document, published in 2003, *Safe abortion: Technical and policy guidance for health systems* was the first time WHO explicitly waded into making recommendations about how to provide safe abortion services. However, the language of the report highlights the tricky position WHO is in when discussing abortion-related death and disability. Due to abortion still being illegal in many areas, the report focuses on health system interventions and clinical best-practices, while staying away from advocating for the removal of legal barriers women encounter. The clinical guidelines were an important addition to the literature, though, as many practices were unnecessarily invasive and put women at more risk than was necessary.

In this document, WHO recommended the use of manual or electric vacuum aspiration and medication abortion for the termination of pregnancies before 12 and 9 weeks respectively (replacing more invasive techniques such as dilation and cutterage (D&C) which requires higher

levels of skills and more resources), the availability of abortion services at all levels of the health system (including primary levels), the ability of midlevel providers (including midwives and nurses) to provide abortion services, and for health systems to eliminate barriers such as mandatory waiting periods and multiple signatures by committees (WHO, 2003). All of these recommendations are made within a country's legal framework.

A further area of expertise coming from WHO is a framework for conducting health system evaluations as it relates to providing safe abortion services, such as the second edition of the above noted document, published in 2012 (WHO, 2012). The health systems challenges facing the provision of basic health services are explored and discussed in this document. The ability of a health system to provide safe abortion services is not in isolation to its ability to provide other services. It is noted that many health systems in Africa have stagnated or are declining. Many countries are also dealing with HIV/AIDS epidemics, which have decimated the healthcare workforce as well as been a major consumer of health system resources. Further, the active recruitment of qualified health workers from developing countries to developed countries such as the US and UK, known as "brain drain", has taken health workers, whose education is funded by their countries of origin, away from the places they are needed most. Added to this, many countries are experiencing a double burden of disease: the traditional tropical infectious diseases, such as malaria, are still a major factor affecting the health of populations. However, added to this are the emerging non-communicable diseases such as cancers and diabetes that are necessitating further investments. The paucity of health information systems in many parts of Africa is another challenge that needs large investments to improve the delivery of comprehensive health care. These factors combine to form health

systems that struggle to provide essential care, including safe abortion services (WHO 2012).

There is a huge need to strengthen health systems and to support health workers in the delivery of countless health services, including safe abortion services.

In this view, women's use of unsafe methods to terminate their unwanted pregnancies is a symptom of a broken healthcare system. In the health system guidance document introduced above, it states, "In countries where induced abortion is legally highly restricted and/or unavailable, safe abortion has frequently become the privilege of the rich, while poor women have little choice but to *resort to* unsafe providers, causing deaths and morbidities that become the social and financial responsibility of the public health system." (Emphasis added) (WHO, 2012, pg. 18) Further in this same document it is noted, "Advances in medical practice in general, and the advent of safe and effective technologies and skills to perform induced abortion in particular, could eliminate unsafe abortions and related deaths entirely, providing universal access to these services is available." (pg. 17) In the section that follows, the document reads, "In the absence of safe abortion services, some (women with unwanted pregnancies) *may resort to unskilled providers* and others may end up having unwanted births." (pg. 23) (Emphasis added) This document suggests women will use safe abortion services if they are legal, available and accessible to them, and will only *resort to* unsafe methods if these safe methods are not available and accessible.

According to the WHO (2012), women and girls resort to unsafe abortion when they encounter barriers to safe abortion services. These barriers include: restrictive laws, poor availability of services, high cost, stigma, conscientious objection of health-care providers, and unnecessary

requirements such as mandatory waiting periods, mandatory counselling, provision of misleading information, third-party authorization, and medically unnecessary tests, that delay care (WHO, 2012).

Of these barriers all but one is supply-side: stigma. Stigma is such a large and complex issue that simply naming it does not begin to highlight the important role this phenomenon plays. I will delve more fully into the role that stigma plays in abortion later in this chapter. However, there are many other barriers which are notably missing from this list. Women's role in society is not on this list, nor are other important socio-cultural barriers such as the importance of fertility and women's ability to access correct information. Certainly, in places where there are restrictive laws and no providers exist, these are high barriers that are difficult to overcome.

In 2013, a high level task force of the United Nations working on access to safe abortion wrote, "Where abortion laws are liberal there is generally no or very little evidence of unsafe abortion and related morbidity and mortality. In contrast, legal restrictions result in women self-inducing abortion or seeking it clandestinely. These abortions are unlawful and generally unsafe." (Shah *et al.*, 2013, pg. 2) This document goes on to say that women "resort" to unsafe methods only when they have to, stating, "Legal restrictions and lack of services expose women who are young, poor, and living in rural areas disproportionately more to the risk of unsafe abortion than those who are well-off and living in urban areas." (pg. 5) And further, "This trend (of more legally restrictive laws in the world's developing regions) impacts on women's access to safe abortions, resulting in reliance on unsafe procedures and resultant deaths and disability that are confined almost entirely to developing regions." (pg. 8) This document concludes with the

following statement, “Access to safe and legal abortion improves women’s health and wellbeing and those of their children and families. Therefore, provisions should be made for the availability of and access to safe abortion for all women who need it. The returns for women’s health, and the benefits for families, for public health and for countries, will be very high.” (pg. 12) Access to safe and legal abortion will immediately translate into health benefits not only for women, but for their families and communities as well.

The Alan Guttmacher Institute, a non-governmental organization whose mission is “Advancing sexual and reproductive health worldwide through research, policy analysis and public education” published a paper and wrote, “Liberalizing abortion laws and enabling abortion services to be provided openly by skilled practitioners...is the most effective way for a country to ensure that abortion is safe for women while simultaneously reducing its incidence” (Cohen, 2007, pg. 2). Further in the document it reads, “The evidence is incontrovertible that the surest way to reduce the death and disability associated with unsafe abortion is to legalize it and bring it into the open” (Cohen, 2007, pg. 4). Further, this document reads, “Removing legal barriers to abortion not only protects women’s health, but restores their dignity and vindicates their basic human rights” (pg. 2).

The Guttmacher Institute has been instrumental in bringing attention to the need for States to reduce the legal and health system barriers to abortion and their advocacy on behalf of women in low- and middle-income countries and this work is highly commendable. However, with statements such as those above, there is a risk of simplifying complex issues and making

promises that cannot be kept. If women do not access services, even when available, women will continue to suffer from complications due to unsafe abortion.

Ipas, an international non-governmental organization (NGO) focusing on increasing women's access to comprehensive reproductive health care including safe abortion services, has worked in many low-resource countries for decades. This NGO trains providers and provides equipment and supplies for the provision of safe abortion. In one of their documents they write, "Ghana's abortion law is one of the continent's most progressive." (Ipas website) Ghana's law allows for abortion if the pregnancy is the result of rape or incest, if the fetus is malformed or if continuation of the pregnancy threatens the life, or the physical or mental health of the mother, provided it is performed in a licensed medical facility by a trained provider.

Recognition of the need to address unsafe abortion to meet the Millennium Development Goals has become more widespread as the time to reach this goal approaches. At the African Union meeting in Maputo, Mozambique in 2006, African Ministers of Health signed the Plan of Action, which included the following statement; "African countries are not likely to achieve the [MDGs] without significant improvements in the sexual and reproductive health of the people of Africa" (African Union, 2006. pg. 2). Included in the plan are a wide range of interventions, including reducing the incidence of unsafe abortion by reducing unintended pregnancies through greater uptake of contraception, reforming laws and policies which relate to abortion, and improving provider training in abortion services. While increasing the utilization of contraception will reduce the demand for abortion services by reducing unplanned and

unwanted pregnancies, this document also has a heavy reliance on supply-side approaches to reduce unsafe abortion.

The combination of liberalizing laws and training providers is the most popular intervention promoted to reduce unsafe abortions. The thinking continues to be that if the supply of safe abortion services is increased, women will utilize these services because they only resort to unsafe methods when safe methods are not available, or they are not able to access them due to stigma, or other barriers, including financial and sociocultural.

There are abortion rights advocates who support a Human Rights approach when discussing abortion services and advocate to make them more accessible and available to women. In the Human Rights approach, it is recognized that women have a fundamental right to the provision of essential maternal health. In fact, from this perspective, States have an obligation to provide these services, including safe abortion services, where they are permitted by law (Hunt & Bueno de Mezquita, 2010). In this line of reasoning, it is noted that women have, “an entitlement to health goods, services and facilities which are available in adequate numbers, accessible, acceptable and good medical quality” (Hunt & Bueno de Mezquita, 2010, pg. 6). There are indications of the importance of the acceptability of health interventions and that many interventions will fail to result in measurable health improvement if available health services are not utilized. This is one document which does place importance on the demand side of the equation; if women do not seek services, health benefits will not be realized. However, this is the minority opinion, not as loudly heard or as widely written about.

Technical guidance continues to dominate the literature, without appropriate or sufficient focus on whether communities will use health services if they are available and affordable. When these documents do include provisions for tackling the social and cultural factors that hinder women's access to health services, they talk about women as sole actors. For example, "States must take steps to ensure women can access maternal health care and other relevant sexual and reproductive health services. This may require actions including...addressing social (and) cultural...reasons why women do not access services" (Hunt & Bueno de Mezquita, 2010, pg. 9). At the International Conference on Population and Development (ICPD) in 1994, member States agreed to the statement that: "In all cases, women should have access to quality services for the management of complications arising from abortion." (UN, 1994, paragraph 8.25).

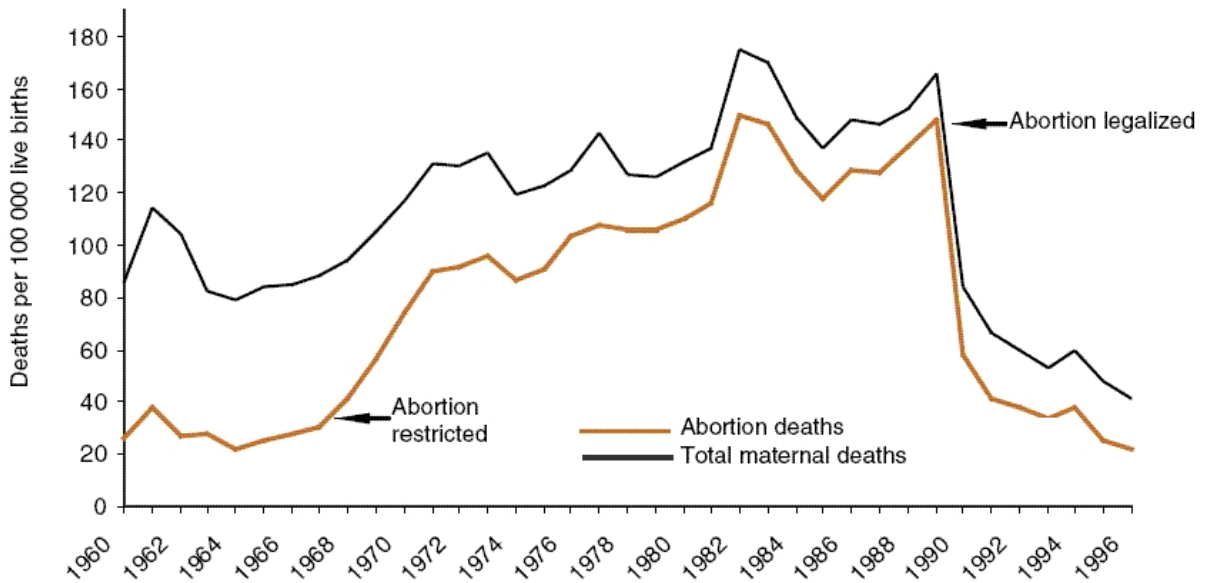
This is the puzzle my dissertation is seeking to answer: if Ghana's abortion law is liberal, and abortions are available, then there should be "no or very little evidence of unsafe abortion", as the High Level Task Force of the UN stated. However, this is not the experience of women in Ghana or of providers in this region, who have vast experience treating women for complications from unsafe abortion. These providers note that women seeking care for unsafe abortion complications are a large part of their clinical load with many cases every week.

Experience from Romania

The expectation, that women will use safe abortion services if they are available, may come out of the experience in Romania where maternal mortality rates were an unusually high (for Europe) at 159 per 100,000 live births in 1989. Once the highly restrictive abortion law was

liberalized, the abortion rate increased dramatically and the maternal mortality rate fell to 83 per 100,000 live births in 1991 (Hord *et al.*, 1991). The maternal mortality rate over time in Romania follows almost exactly the unsafe abortion mortality rate, and almost immediately after the law was liberalized, both fell dramatically (see Figure 1). It may be that international agencies expect this phenomenon to replicate itself in other parts of the world where abortion laws have been generally highly restrictive.

However, Romania is a distinct example, socially and culturally very different from sub-Saharan Africa. During the reign of Ceausescu, Romanian women became used to using abortion as their form of contraception. No contraceptive methods were accessible in the country due to the communist leader's highly restrictive reproductive health policies. The Ceaușescu regime declared pro-natalist policies the law of the land for political and economic reasons. As part of these policies, induced abortions were strictly illegal for almost all indications. However, it is important to note that this was not because of moral objection to abortion, but because of the desire to increase the population of Romania for the future of the communist state. It has been estimated that by the time Ceaușescu's policies were firmly in place, the average Romanian woman had 5 abortions by age 40. All of these abortions were illegal and this is a main reason that by the 1980s, over 80% of Romania's maternal mortality was due to complications from unsafe abortion. Once the legal restrictions were removed, women were able to access safe abortion procedures in health centers. They were already accustomed to using abortion as their preferred method of family planning, and thus the stigma that is associated with abortion in many pro-natalist cultures was not in place in Romania.



Source: *World health statistics annual*, various years

Figure 1. Maternal Mortality in Romania

Experience from South Africa

South Africa is an example of a country in sub-Saharan Africa which is held up as a pioneer in the move to liberalize abortion laws in order to prevent unsafe abortion. In 2006, South Africa passed the Choice of Termination of Pregnancy (CTOP) Act, by far more liberal than the law governing abortion in Ghana. The CTOP allows for abortion on request up to 12 weeks at any licensed facility, free of charge, by a physician, trained nurse, or midwife. Early indications were of huge successes. Maternal mortality decreased 91% after the passage of this law, and abortion-related mortality decreased by 50%. However, in recent years, it has become clear that for some women access is becoming more difficult. Many providers are claiming

conscientious objection and refusing to provide the service. In an article describing some of the challenges with the implementation of the CTOP, Trueman and Magwentshu (2013) conclude by saying, “A liberal abortion law in a country does not mean that there is automatic access to safe abortion services. In order for the law to be effective, it has to be implemented. In order for it to be implemented there have to be willing parties” (pg. 399). Although these authors are referring mainly to providers (there must be providers willing to provide the service), the willing parties must also include women themselves; women must be willing to utilize safe abortion methods.

I am not suggesting these legal, regulatory, and health system issues are not important. Rather, I am suggesting once a community or country has accomplished those, it is time to move past the supply side and begin to focus on the demand side, or to tackle both sides simultaneously. Obviously, if the services are available but not utilized, health benefits will not be realized. Further, if health policy makers do not take into account the issues of the demand for these services, expected health benefits will fall short of projections, potentially reducing the impact of policy changes. Especially in places where resources are scant, if expected benefits are not realized, these scarce resources could be reallocated to other sectors.

The importance of women’s social circumstances

I am not the first to recognize the importance of socio-cultural factors in reproductive health in general and abortion care in particular. International documents note the potential of socio-

cultural barriers, some more than others. They use words such as "stigma" and "restrictive society" (Cohen, 2009).

However, many documents describe the majority of women who encounter barriers to accessing abortion services as: adolescents, unmarried women, women living outside of urban centers, and women who are displaced or refugees (Hessini *et al.*, 2006). It is as if a woman, based on some demographic characteristics, is more likely to encounter these barriers, and be less likely to be able to overcome them, than others who do not have these individual-level circumstances. If we were to move all women to an urban center where they were in closer to proximity to health services, for example, these models would suggest a drop in the unsafe abortion rate. Making note of individual-level differences in accessing of services is not a trivial or unimportant line of inquiry. Defining the problem, and identifying women who have more trouble than others accessing safe services is an important initial step to fully grasping the breadth of the problem.

However, it is vitally important to note that these women are not isolated actors, but rather members of families, communities and cultures. Women's individual-level differences may go part of the way to describing differential ability to access care, but it certainly does not answer everything. The differences found may simply be an artifact of the kind of society in which a more highly educated woman lives. Women who are urban dwellers are more likely to achieve higher levels of education, and to have access to education and all of the health benefits education brings. Education of a female child may be more acceptable and seen as the norm more often in urban households than in rural ones. Therefore, the individual-level differences

documented in previous research can potentially be explained by larger society-level differences of these women. The societies in which these women live are as important in their ability to access safe abortion services as their demographics (age, place of residence, or marital status). In societies that are highly patriarchal, many reproductive health issues, including abortion, are marginalized. When women are not equal members of society, their needs are not central to development agendas and abortion is talked about in legal and moral terms instead of in health needs (Braam & Hessini, 2004).

It is certainly important to ensure the clinical and human resources are available to provide safe abortion services, and these services are legal and available where women live. If the services are not available, women will not be able to obtain safe abortions. First legal barriers must be removed and then health service barriers must be tackled. If these are accomplished, we are led to believe, the problem of unsafe abortion will disappear in a country. However, focus has been placed almost exclusively on reducing these supply-side barriers, often without spending sufficient time on the demand side of the equation. In the next Chapter, I will discuss some theories which are used to describe maternal mortality more generally and then apply these to a theory I believe is more able to predict Ghanaian women's use or non-use of clinic-based abortion services.

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Chapter 3: Theories and Models to Understand Maternal Mortality

As I mentioned in the previous chapter, abortion-related mortality is one component of maternal mortality. Maternal mortality has been a focus of research for decades. The literature around maternal mortality can be described as falling into one of three categories: 1) There is a large and robust literature around the biomedical and clinical causes of maternal mortality. 2) There are theories and models to conceptualize and explain why women die from causes which are treatable in many settings. This literature often returns to the choice of place of delivery; some women choose to deliver in their homes rather than in a facility. These models are also used to plan interventions to reduce barriers to facility-based delivery and to increase the proportion of women who deliver in facilities. 3) Finally, there are theories which attempt to explain why maternal mortality is so disparately distributed across the world. In these cases, maternal mortality is used as a general measure of development, rather than an individual-level cause of death. Some of the major models and theories are discussed below.

The Three Delays Model (Thaddeus & Maine, 1994), one of the seminal theoretical models for the causes of maternal death, suggests that approximately 75% of maternal deaths that could be avoided by timely care are a result of one of three delays. These delays are categorized into three phases. Phase I delays are those that occur when a woman and/or her family delays seeking care. Phase II delays are caused by delays in reaching adequate healthcare facilities.

Phase III delays are delays in receiving adequate care once a health facility is reached. As written by Thaddeus and Maine, “sociocultural factors” can be barriers integrated into the first delay. They note, as others do, that due to many of these factors, building more health facilities and even reducing the associated costs of using these services may not be enough to improve utilization if these sociocultural barriers are not also addressed. This model starts with the premise that if prompt, high quality obstetric care is accessed during an episode of obstetric complication, a good outcome can be expected. Therefore, it is a delay or delays that cause maternal death.

The Three Delays Model has not been applied to abortion research, although, as complications from abortion are a large contributor to most county’s maternal mortality rate, it certainly could be. For example, if a woman delays the recognition that she is pregnant until past 9 weeks, medication abortion is no longer an option. Now she must access care at a health center and have a surgical abortion, for the best clinical outcomes to be expected. Or, if she has induced an abortion with an unknown drug or herb and is bleeding heavily, and she, or those who are caring for her, delay the seeking of care, either because they do not recognize that there is a problem or because they are afraid of consequences from seeking care (if they believe they have acted illegally and will be prosecuted, or shamed by clinic staff), this delay could cause serious problems that could have otherwise been avoided.

The second delay, as it relates to complications from unsafe abortion, is more straightforward. If a woman does not have access to transportation to reach a health facility, she will encounter another large delay which could be detrimental to her health.

The third delay can manifest itself in many ways. When clinic staff are unwilling to provide an abortion, or there are no providers available to provide the service, this is an indication of a third delay. It is plausible that staff at public facilities may be unwilling to provide an abortion. Although they are, per the policies of the Ghana Health Service, supposed to refer to a colleague to provide the service, there are indications from other settings where the abortion law has been liberalized that this does not always happen. In South Africa, providers did not refer patients. Further, Anitye, in Ghana, found the providers she interviewed admitted to acting as a barrier to a woman seeking a safe abortion.

In the case of post-abortion complications, if the supplies and equipment needed to provide the evacuation of the uterus are not available, or the staff is not trained in the provision of this service, a woman's complications are liable to worsen.

A framework for analyzing the determinants of maternal mortality (McCarthy & Maine, 1992).

Prior to the below framework being disseminated in 1992, few reports or programs, explicitly or systematically considered the mechanisms or pathways through which diverse factors, such as the status of women, the use (or non-use) of family planning, health services and biological, influence maternal mortality. The below framework was an early attempt to bring all the various factors that end in a maternal death into the picture to be examined. This framework is an understanding that there is a process of events that eventually culminates in a maternal death. These deaths do not affect various populations in the same way or at the same rates.

The authors of this framework conclude that improving family planning services to prevent women from becoming pregnant, ensuring women have access to safe abortion services and improving the quality of care given during labor and delivery are the interventions most likely to have the greatest impact on maternal mortality worldwide.

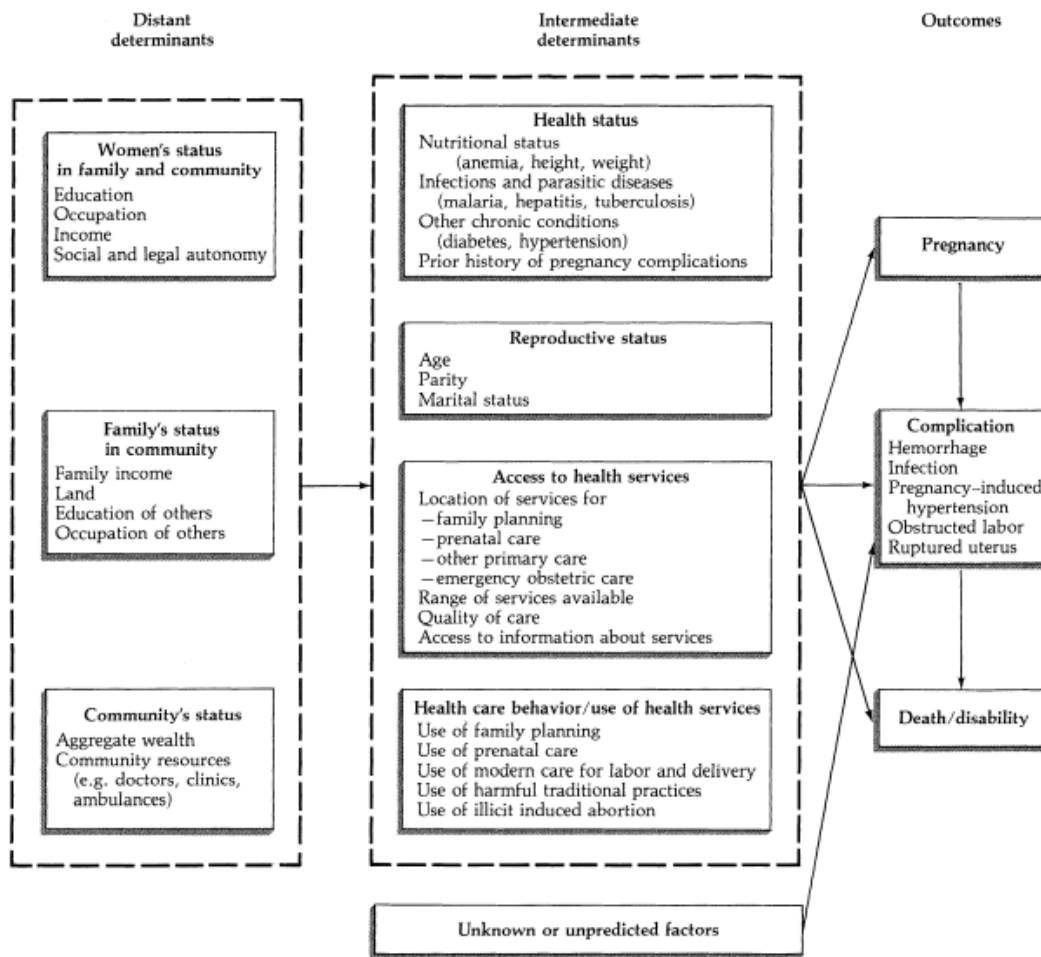


Figure 2. A framework for analyzing the determinants of maternal mortality (McCarthy & Maine, 1992).

Modernization Theory As mentioned above, there is a huge discrepancy in the rate of maternal death in developed versus developing countries. Modernization theory holds that the

important difference between developed and less-developed countries as it relates to any number of indicators, including maternal deaths, is economic development, similar to neoclassical economic theory (Shen & Williamson 1999). In this view, fertility and maternal mortality are intimately linked; in societies where fertility is high, maternal mortality is also high. Through economic development, higher standards of living are achieved by large swaths of the population. According to this theory, from industrialization, urbanization and higher levels of education, the health of the population will improve and one indicator of the health of the population, maternal mortality, will decrease. Capital investment is of paramount importance to modernization theorists and capital scarcity is a major impediment to development in less-developed nations. According to modernization theorists, maternal health will improve, along with many other indicators, as countries “modernize” and develop.

Modernization theory has been criticized for looking almost exclusively at economic development and not focusing on inequality within societies, including economic inequality as well as class and gender inequalities (Shen & Williamson 1999). High levels of inequality and gender discrimination are often highly correlated with low levels of development, although these issues are likely related to high levels of maternal health and therefore the type of development a country goes through will be as important as the overall rise in per capita income for reductions in maternal mortality.

There is a group of researchers who use a part of modernization theory to explain not only maternal mortality, but also the movement from traditional to “modern” views of sexuality and

gender relations. For example, van der Geugten and colleagues (2013) report findings from rural northern Ghana where participants note the influence of technology on the sexuality of their youth. Specifically, as even rural areas have become wired, youth are able to engage with international media and internalize the more modern and western views of sexuality and behaviors. These authors found that social elders no longer wielded such power over the youth in their communities; as it has become normative to educate even the female children, these girls are becoming more influenced by their peers than by their familial elders. This is especially true in areas where boarding school is the norm. In these cases, youth spend the majority of their adolescence away from their families living with peers and without familial oversight.

Modernization theory does not specifically address the social and cultural norms which render women an inferior class of citizen in many settings, which is especially important in abortion-related maternal mortality.

Gender Stratification Theory In this theory (Blumberg 1984), it is argued that in societies where women are more equal to men, and where they have more autonomy, there are lower levels of maternal mortality. Gender stratification theory helps to explain some of the failings of modernization theory as it relates to women. While modernization theorists expect to see women's status in society improve as the result of overall economic growth, this is not always the case. Gender stratification theorists explain this by showing that women are often the victims of development; it is the jobs of women that are discarded as economies "develop". Women are then relegated to the informal sector doing menial jobs without any protections.

Female status in society has been measured by looking at various measures, including education (especially as it relates to men in the same society), health status and reproductive autonomy (Shen & Williamsion 1999). This theory is supported by observations that women with higher levels of education, more access to contraception and more employment opportunities have fewer children than their less-educated, under-employed counterparts (United Nations 1997). It is not possible to separate power relations, including gender and sexual power, from the discussion of abortion (Hardacre 1997). The relative status of women in society is indeed of paramount importance when discussing access to safe abortion services.

Stigma and abortion research An emerging area of study as it relates to abortion behavior is the role that stigma plays. Stigma is a concept that is often used to describe both women's experience with accessing an abortion as well as providers' experience providing services. There is no documentation of or research into the initial emergence of abortion stigma (Kumar *et al* 2009). Goffman (1963) describes stigma as a factor or "attribute that is deeply discrediting". This attribute in turn changes the person who holds it into an "other", distinct from the norm. It is important to note that the stigmatizing characteristic does not need to be visible to be stigmatized. This is especially important as it relates to abortion behavior. Once an abortion is complete, there is no external physical evidence separating a woman who has had an abortion from one who has not. However, the woman may feel the stigma and may experience all the negative feelings of being stigmatized. Further, if others around her know that she has undergone an abortion, she may be stigmatized for past behavior.

Similarly, stigma may be applied to the healthcare providers who provide abortion services. This is a field of study especially in the US where abortion providers are highly visible on the front lines of the battle over the legality and availability of abortion.

There are people who say that women who seek abortions are bucking the social norms of women as givers of life and innate motherhood, and for this reason abortion is stigmatized. In this view of stigma, there are normative constructs of what defines essential “womanhood” which cut across cultures including sexuality for procreation, motherhood, biological destiny, sustenance of and deference to others (Gold *et al.* 2007). Therefore, women who choose to have an abortion are transgressing these normative behaviors, challenging the “essential nature” of what it means to be a woman (Kumar *et al.* 2009) and therefore she will feel or experience stigmatization (Shellenberg *et al.* 2011). Women are supposed to be subservient, and put the needs of the culture above her own needs. A woman who has an abortion is using her agency to end a potential life and she is therefore challenging the moral order (Kumar *et al.* 2009). However, the girls interviewed for this project presented a different reasoning behind their choice to have an abortion. Rather than feeling that abortion is stigmatized because it is a woman taking agency of her own body and refusing to give birth, these girls are behaving in ways to maintain their socially mandated roles. Education is highly regarded, and pregnancy is grounds for expulsion from many schools. Chastity and purity are valued. An unwed mother is outwardly neither chaste nor pure. There are other places where the stigma of abortion is questionable. For example, Whittaker’s (2002) work in Thailand explored instances where,

although highly restricted legally and against Buddhist teachings, abortion is conceptualized as potentially a reasonable act, given other social values.

Agency Carter (1995), in ethnographic work on decision making on fertility decisions, speaks of two forms of agency. These are 'passive' decision making in which individual's decisions are formed by societal and cultural norms and institutions. While in 'active' decision making, individuals make deliberate choices through a utility maximizing process. Carter argues that both of these are insufficient when discussing reproductive choices, and instead argues for a more nuanced view which sees these decisions made as "the reflexive monitoring and rationalization of a continuous flow of conduct." This view argues that the cultural concepts which underlie individual's values, and the political economy in which people live, as part of the actions that are made, rather than being external to these actions. The findings from my study would certainly support this assertion. Women are using their individual agency to decide how to terminate their unwanted pregnancy.

Social Network Theory The biomedical reasons for maternal mortality are well known, as has been noted. To some extent, the health systems challenges that lead to preventable maternal mortality are also known. What is less well documented, and perhaps harder to tackle, are the socio-cultural factors associated with who gets sick, who seeks care, who recovers and why (Pescosolido 2006). Many of the socio-demographic factors, such as age, marital status and previous utilization of health services, associated with abortion care have been widely documented. However, proponents of a network perspective argue for the replacement of

these individual-level characteristics in favor of investigation into the ties surrounding individuals. This network perspective notes that these ties shape a medical encounter as well as the social reaction to it. It has been shown that illnesses, as well as health-seeking behavior, can spread through social networks, in much the same way that infectious diseases can (Smith & Christakis 2008). Health behaviors that can spread within social networks include propensity to have medical screenings, complying with doctors' recommendations and even visits to particular hospitals or providers (ibid). Similar to the Three Delays Model, social networks are increasingly being seen as important as to when an episode is identified as a problem and the response to it, whether to seek care from within the medical community or not. This framework recognizes that individuals, when responding to an event, are pragmatic, dynamic and above all, social. Individual-level analyses are quick to see the former two (pragmatic and dynamic), but often leave out the social reaction. The structure and function of individuals' social networks interact with cultural norms and contexts to influence how individuals react to the onset and course of a medical event. These social networks determine how individuals evaluate the need for treatment, gather information about how to seek care and how well available options fit within the socio-cultural environment.

This social network analysis may be especially relevant to abortion research. For example, when speaking about their decisions to seek abortions, women in rural Thailand constantly spoke of their social context and relationships (Whittaker 2002). In discussing whether the Diffusion of Health Innovations model fits with family planning adoption in 1973, Rogers noted, "family planning diffusion is almost entirely via interpersonal channels." (1973, p. 23).

Many investigations around unsafe abortion in sub-Saharan Africa implicitly rely on health behavior models such as the Health Belief Model (Becker, 1974; Janz & Becker, 1984; Rosenstock, 1966), the Theory of Reasoned Action (Ajzen & Fishbein, 1970), the Theory of Planned Behavior (Ajzen, 1985) and Social Cognitive Learning Theory (Bandura, 1986, 1991). These theories, while different, share the qualities of predicting behavior based on an individual's beliefs and subjective evaluations. For example, an individual weighs their perceived risk against the perceived severity of the disease as well as the likelihood that their changed behavior will avoid the risk; their ability to change their behavior and the costs they will incur to change this behavior. In terms of avoiding unwanted pregnancy, this would mean a woman would weigh the costs to herself, both financially and perhaps socially, and to her health if she believes contraception is deleterious to her health, of effectively using contraception against her fear of an unwanted pregnancy and the severity of this pregnancy. If a woman is pregnant and wants to avoid an unsafe abortion, she will weigh how risky a self-induced abortion is versus one in a facility against the cost of a facility-based abortion and her ability to access a facility-based abortion.

However, these theories, which were all developed in Western societies, have limited applicability in many settings, including sub-Saharan Africa. The inability of these theories to predict behavior in sub-Saharan Africa has been recognized in the HIV/AIDS community (Webb, 1997). Researchers in this community have made clear some very important aspects these theories all leave out. Namely, these theories do not put as much influence in objective aspects

of social influences. For example, the social, political, cultural and economic situations that are very different from the West do not have a place in these theories.

Ecological Models Ecological models of behavior emphasize the importance of many contextual levels and explicitly demonstrate multiple levels of influence on individual behavior. For example, an individual's behavior is influenced not only by her own beliefs or motivations, but also by the social context in which she lives, the physical environment in which lives and the legal and health policy context which governs her society. In these models, it is expected that behavior will be most effectively changed when the environment and policies are supportive of the change, when social norms and culture support the behavior and when individuals are motivated and capable of making choices.

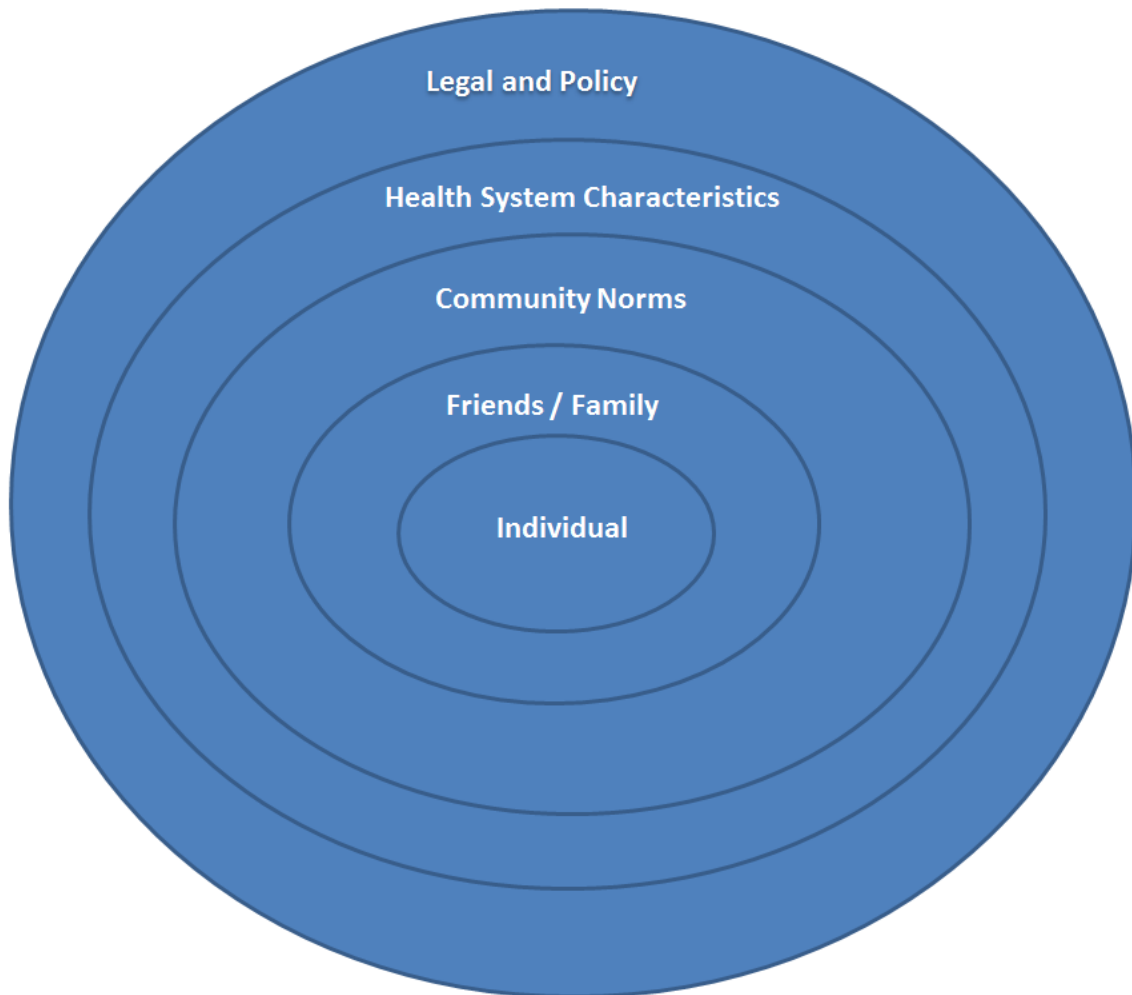


Figure 3. Ecological model of abortion-care seeking.

Ecological models have been most commonly applied to the area of health behavior as it relates to “healthy lifestyle” choices in Western contexts. For example, *Healthy People 2010* (US Department of Health and Human Services, 2000), an initiative to improve the health of the American people, is based on an ecological model. It is recognized that encouraging individuals to engage in more physical activity or eat healthier foods is not possible if there are not sidewalks, or fresh foods available, for example.

I will argue that investigating the continuing phenomenon of unsafe abortion in Ghana from an ecological perspective, with heavy reliance on social network perspective will allow for a different understanding of the situation and will point to the necessity of including not only supply-side interventions, or individual-level analysis, but to take into account the social and cultural experiences of women, as their actions fit into the expectations of their social networks. Further, since women experiencing a need for an abortion will engage with their social network for information, if this social network is not made aware of the availability of safe and legal abortion services, when women need the service, they will not access these services. Further, it is important to keep in mind women have multiple social goals, and their social networks are fully aware of these often competing goals; reproduction is one of them. However, there are times in their lives when other social goals take precedence over reproductive goals. For example, when young women are in school or they are aiming to uphold the view of themselves as not promiscuous. In these cases, having a child would not allow them to maintain their socially desirable goals. I will use metropolitan Kumasi, Ghana, as a case study of this phenomenon.

In the next chapter I will present a review of the literature of abortion in Ghana and then the method by which I investigated the main research question of this dissertation. That chapter will be followed by two chapters of results and a conclusion chapter.

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Chapter 4: Abortion in Ghana

Ghana is a country in West Africa with a population of approximately 25 million people. The average per capita income is approximately \$1858 (World Bank, 2013), placing Ghana in the lower-middle income bracket. Ghana has a similar pattern of health as other countries in the region, characterized by a persistent burden of infectious disease among poor and rural populations, and growing non-communicable illness among the urban middle class. Following generalized progress in child vaccination rates through the 1980s and 1990s, and corresponding declines in infant and child mortality (from 120/1000 in 1965 to 66/1000 in 1990), progress has stalled maternal and under 5 indicators in rural areas in the past decade. The national under-five mortality rate remains at 78 deaths/1,000 live births (UNICEF, 2014). Maternal death is currently estimated at 350 per 100,000 live births (SOWM, 2011).

In Ghana, abortion complications are a large contributor to maternal morbidity and mortality. According to the Ghana Medical Association, abortion is the leading cause of maternal mortality, accounting for 15-30% of maternal deaths (Asamoah *et al.*, 2011, Billings *et al.*, 1999). Further, for every woman who dies from an unsafe abortion, it is estimated that 15 suffer short and long-term morbidities (Eades *et al.*, 1993). It is important to remember that when performed by well-trained providers in a clean environment, abortion is one of the safest medical procedures, with complications estimated at 1 in 100,000 (WHO 2007).

Compared to other countries in the region, the laws governing abortion in Ghana are relatively liberal. Safe abortion, performed by a qualified healthcare provider, has been part of the Reproductive Health Strategy since 2003 (Sedge 2010, Morhe & Morhe 2006). Abortion in Ghana is against the law, except under certain, broad, circumstances. Currently in Ghana, abortion is a criminal offense regulated by Act 29, section 58 of the Criminal code of 1960, amended by PNDCL 102 of 1985 (Morhe & Morhe 2006). However, section 2 of this law states abortion may be performed by a registered medical practitioner when; the pregnancy is the result of rape or incest, to protect the mental or physical health of the mother, or when there is a malformation of the fetus. The government of Ghana has taken steps to mitigate the negative effects of unsafe abortion by developing a comprehensive reproductive health strategy that specifically addresses maternal morbidity and mortality associated with unsafe abortion (Taylor et al., 2011). The Ghanaian parliament, however, has not explicitly discussed or debated access to abortion. This may be due to abortion being seen as a volatile issue that could compromise electoral support from key constituencies (Braam & Hessini, 2004). Therefore, abortion remains in the criminal code of the country. Abortion is illegal in Ghana, except when the circumstances around the procedure fall into one of a few broad categories. Compared with other countries in the region where abortion is allowed only to save a woman's life, and multiple physicians must agree to this, as is the case in Liberia, for example, the law governing abortion in Ghana is liberal. However, abortion is not legal.

As with other countries in Africa, the current law governing abortion is a vestige of the colonial era. In the ruling powers, in this case Great Britain, it was against the law to either seek or provide an abortion. Women were penalized and criminalized if they sought abortions, as were

abortion providers. These laws reflected the thinking in Europe at the time. Contemporary abortion laws in Africa, including in Ghana, are mostly either direct or slight modifications of colonial laws. Of course, in subsequent years, these former colonial powers have themselves liberalized their own abortion laws (Culwell & Hurwitz, 2013).

These abortion laws were generally reinforced by family and cultural codes that emphasized women's roles within the family as mainly reproductive. A woman's value was measured by her ability to reproduce. Even though these colonial laws were for the most part unsuitable, the new African governments maintained them at independence. The new governments of Africa (Ghana was the first to receive independence in 1957) were faced with major socio-economic obstacles and were not able to invest the time, nor did they have the resources or political will to undertake full scale legal reform as it pertained to the laws that govern abortion (Braam & Hessini, 2004).

Ghana is a religious country, with more than 95% of the population in the 2010 census noting they adhere to some religion (GSS 2012). Over 70% of Ghanaians identify as some form of Christian religion, while about 19% are Muslim and 5.2% practice traditional religion. Religious ideology and practices have institutionalized male-dominated decision-making, including around topics of reproduction. Deeply held religio-cultural beliefs, practices, and norms provide the incentives for the Africa's relatively high fertility levels (Takyi *et al.*, 2006). Religious identification has been found to be associated with maternal health seeking in Ghana, suggesting associations between religiosity and health outcomes and behavior (Gyimah *et al.*, 2006).

The interaction between religious and social networks, through the diffusion of health-related ideas as well as the normalizing of seeking Western versus traditional medical care, is an important line of inquiry. To the furthest extreme, if children are seen as God-given and women are merely the vessels to carry the life, then women have no right to interfere with the pregnancy (Braam & Hessini, 2004). In pro-natalist societies, including Ghana, women still bear the burden of reconciling social, cultural and familial expectations of high fertility with surviving pregnancy, childbirth and childrearing in an economically and otherwise challenging environment (Braam & Hessini, 2004).

Even as abortion becomes more frequent, it is more often morally condemned in the context of religiously conservative and pro-natalist cultural belief systems. Ghanaian women see their roles as very different from that of men, not necessarily lower, but different (Pellow, 1977). Male dominance is the accepted norm.

There has been much research around abortion care in Ghana, and there is a fairly robust research community, consisting mainly on Obstetrician Gynecologists, working in the country documenting abortion care. In 2010, a Family Planning Fellowship was accredited by the Ghana College of Physicians and Surgeons for Ob/Gyns (Dalton *et al.*, 2013) and work has been conducted with midwifery tutors to increase their skills and teaching abilities around abortion care.

Even with those providers of abortion care, however, licensed chemical sellers are the first place from where many Ghanaians seek health care, especially in areas where there are few health clinics, such as rural areas (Sudhinaraset *et al.*, 2013). These private sector drug shops

are independent businesses operated by non-pharmacists who are licensed by the Pharmacy Council to sell some over-the-counter medication (Lebetkin *et al.*, 2014). These operators must have at least a secondary education and receive some training from the Licensed Chemical Seller Association and Pharmacy Council, although this training is not required for licensing. These chemical sellers are accessible to women; they outnumber pharmacies five to one nationwide (Ghana Pharmacy Council, 2012). These chemical sellers are open more hours than public health facilities, have shorter wait times and have staff who clients perceive as friendlier than those who staff the public health clinics (Brieger *et al.*, 2004). These shops are where the majority of oral contraceptives are sold in the country (Lebetkin *et al.*, 2014). Previous work with chemical sellers has determined that while they often dispense misoprostol to clients requesting medication abortion, dispensing information is not always correct (Levandowski 2012).

The following section will provide a review of the literature around abortion care in Ghana, reviewing literature published between 1995-2014.

Previous Research in Ghana

Complications and Admissions to Gynecology Ward: Abortion-related complications are repeatedly found to represent a large component of admissions to gynecological wards in hospitals in Ghana. Abortion complications resulted in 38.8%, 40.7%, 42.7% and 51% (Konney *et al.*, 2006; Srofenyok *et al.*, 2003; Turpin *et al.*, 2002; Yeboah & Kom, 2003) of all admissions to these gynecology wards. The majority of admissions were for the treatment of spontaneous abortion, although induced abortion is notoriously under-reported (Singh 2006; Lithur 2004;

Konney *et al.*, 2006; Cohen 2012), and many women who reported spontaneous abortions had a history that indicated induced abortion (Adanu & Tweneboah, 2004). Sundaram and colleagues (2012) estimated only 40% of abortions were reported in the 2007 Ghana Maternal Health Survey, even when participants were explicitly asked about their experiences with induced abortions. This work documenting the large burden of disease of abortion-related complications was instrumental in bringing this issue to the attention of policy makers, both inside Ghana and from international organizations.

Demographic Factors Associated with Abortion Care: Many studies investigated demographic factors associated with abortion-care seeking with conflicting results. Several manuscripts found women of higher socioeconomic status, with more education, who are married, older, and living in urban areas to be more likely to obtain induced abortions. However, others reported younger, unmarried women were more likely to obtain induced abortions, when compared to women seeking care for spontaneous abortion (Adanu *et al.*, 2005; Adanu & Tweneboah 2004; Oliveras *et al.*, 2009; Schwandt *et al.*, 2011; Turpin *et al.*, 2002; Ahiadeke 2002).

These investigations were almost always log book reviews or chart abstractions, and were all quantitative in nature. None of these studies attempted to identify any social or cultural factors associated with abortion care, and all focused on individual-level demographic factors.

Prevalence of Induced Abortion: The prevalence of obtaining an induced abortion varies greatly in published research. The highest rate reported was by Agyei and colleagues (2000) who found 47% of the female respondents in their study reporting at least one pregnancy underwent an

abortion sometime in her life. Morhe *et al.* (2012) found 36.7% of the adolescents in their sample outside of Kumasi had experienced an abortion. Ahiadeke (2002, 2001) reports an abortion rate of 27 per 100 live births using data from the Maternal Survey Project. Krakowiak-Reed *et al.* (2011) found 20% of their community-based sample outside Kumasi had had at least one abortion. Oliveras *et al.* (2009) found between 10% and 17.6% of women in their study reported their previous pregnancy ended in induced abortion. Geelhoed and colleagues (2002) found a prevalence of induced abortion of 22.6%, which falls in the range reported elsewhere (Mote *et al.*, 2010). Glover *et al.* (2003) found that 70% of ever-pregnant youth in their sample reported attempting an abortion. Sundaram *et al.* (2012) state approximately 10% of the sample for the 2007 Maternal Health Survey reported having had an abortion in the five years prior to the survey. However, the authors note that this rate is likely highly under-reported.

In general, these studies have shown that abortion is common for Ghanaian women.

Abortion and Maternal Mortality: Many studies have sought to estimate the proportion of maternal mortality associated with unsafe abortion. Mills and colleagues (2008) found abortion-related causes to be the leading cause of maternal death in rural northern Ghana, as did Baiden and colleagues (2006). Ohene *et al.* (2011) discovered the majority of adolescent maternal deaths at Korle Bu Teaching Hospital in Accra were due to complications from unsafe abortion. Abortion complications were the leading cause of death among the youngest women in a sample of maternal deaths at Tamale Teaching Hospital, and the fourth leading cause overall (Gumanga *et al.*, 2011). Abortion complications were the second leading cause of death due to maternal causes, behind post-partum hemorrhage, between 2004-2009, a period which

spans the introduction of the policy changes around abortion care, in the Eastern region (Ganyaglo 2012). Lee *et al.* (2012) discovered that genital tract sepsis, often as a result of an abortion, had the highest case-fatality rate of all the causes of maternal death in their study. In the Brong Ahafo region, Geelhoed *et al.* (2002) found that abortion complications were the leading cause of maternal death at the Berekum District Hospital.

Abortion Law: Although the law governing abortion in Ghana is relatively liberal, and the 2006 policy change has made abortion services part of the national reproductive health strategy, no literature was found evaluating the impact of that policy change. The fact that admissions to the gynecological wards due to complications from abortion does not appear to have dramatically declined since the implementation of the 2006 policy suggests that women are not accessing safe abortion services, if they exist (Konney *et al.*, 2009; Henaku *et al.*, 2007).

Different cadres of health providers were found to be unsure of the law governing abortion services (Morhe *et al.*, 2007; Voetagbe *et al.*, 2010) and women who were interviewed were also unsure of the law (Konney *et al.*, 2009; Hill *et al.*, 2009). In the Brong Ahafo region, Hill and colleagues (2009) found that abortion was deemed illegal, dangerous and bringing public shame, but also being perceived as common, understandable, and necessary. Although Clark *et al.* (2010) found that post-abortion care (PAC) services remain limited, despite wide-spread training in the service, Baird *et al.* (2000) report that PAC training for midwives is an effective way to increase access to the service. Including post-abortion care as part of comprehensive family planning training for midwives has the potential to empower these providers and the women they serve to make choices about contraception (Fullerton *et al.*, 2002). Graff & Amoyaw (2009) identified sustainable access to MVA equipment as a major barrier to MVA

services. Laar (2010) found in an analysis of Ghanaian print media that less than 1% of total newspaper coverage was dedicated to family planning, abortion, and HIV, underscoring the dearth of information available to many in the Ghanaian public.

Abortion and Contraception: One of the main findings in many of the papers about abortion in Ghana is the lack of modern contraception being used by the majority of Ghanaian women. Many of the papers found a high unmet need for contraception defined as currently engaging in sexual activity without using contraception but without intending to get pregnant (Aniteye & Mayhew 2011; Sundaram *et al.*, 2012; Adanu *et al.*, 2005; Biney 2011). These studies conclude there is an urgent need to improve access to reliable contraception for Ghanaian women. Many Ghanaian women report being wary of using contraception for fear of side effects that may impair future fertility (Aniteye & Mayhew 2011). Biney (2011) noted that women in her study viewed contraception as more harmful to their health than abortion. Obed & Wilson (1999) reported 81% of their sample of women being treated for abortion complications desired further children, although almost one-third had to have a hysterectomy to treat the complications from their abortion and were thus unable to have further children. Mac Domhnaill and colleagues (2011) found schoolgirls in their sample were much more aware of abortion methods than of contraception and many explicitly mentioned not using contraception because they knew how to abort if necessary. Adanu and colleagues (2005) reported women seeking care for induced abortion were more aware of modern contraception than their counterparts seeking care for spontaneous abortion, although this did not translate into higher usage rates.

Identified Gaps for Further Research: Several gaps have been identified in the above reported research. The biggest is the experiences of women with securing an induced abortion to end an unwanted pregnancy. Hospital-based chart reviews are important to understand the types of cases being treated. Surveys examining the reasons for securing an induced abortion shed some light on this issue. However, information regarding the process by which a woman seeks an induced abortion is still lacking. Gathering information from women regarding their experiences securing safe and legal abortions and reasons for using unsafe methods will enable policy makers to pinpoint interventions to prevent life-threatening complications. Specifically, why do women use less safe or dangerous methods of aborting unwanted pregnancies?

Methods of the study

I am an almost six foot tall white woman with blond hair and blue eyes. I grew up in Princeton, NJ, and attended Princeton Day School. In college, at Miami University in Ohio, I was a zoology major and did not become interested in public health until after I had graduated. To say I had a privileged upbringing is an understatement. I became interested in issues of social justice broadly during my undergraduate career when I was first introduced to the issues of poverty in the US through a social work class. After graduating from my master's program, I was lucky to land the job I have still; I work as a research associate at Global REACH, the international initiative at the University of Michigan medical school.

In 2009, the group with which I worked was awarded a grant from the Bill and Melinda Gates Foundation to work with colleagues in Ghana to assess the medical education system in Ghana, and undertake some small research projects. It was during my work with this program that I

became interested in returning to school to complete my PhD. It was also through one of these projects that I began to work in the field of access to reproductive health in general, and abortion care specifically. Thirty years ago, the University of Michigan partnered with institutions in Ghana to create the first ever in-country residency training program for obstetrics and gynecology. The Primary Investigator on that grant, Tim Johnson, is now the head of the department of obstetrics and gynecology at Michigan and was one of the PIs on the grant from the Gates Foundation. As such, much of our work has focused on maternal health and the global health community at Michigan has a strong maternal health component.

As the junior person on the research team, I was not involved in conceptualizing the research topics, but was asked to complete many parts of the research studies. As part of a team, I worked on a discrete choice experiment which surveyed final year midwifery students at two of the country's public midwifery training colleges (Agyei-Baffour, *et al.*, 2012).

One of the members of the team had been asked to add a few questions to this survey about manual vacuum aspiration, a method of surgical abortion, which had been added to the midwifery curriculum a few years prior. In the summer before I began my doctoral work, I was involved in publishing the manuscript which resulted from those questions (Rominski *et al.*, 2012). It was from the background research which I did to prepare that manuscript that I became aware of and interested in the issues surrounding access to safe abortion care in Ghana. What I learned, through that process and subsequent work, was that much work has been conducted in Ghana around abortion and that there is a robust abortion research community in Ghana, many of whom have strong ties to University of Michigan. What I also

realized during the time I was conducting a literature review was the lack of qualitative work with Ghanaian women to fully understand how they decided to terminate their pregnancies and why they chose the method which they used.

Approach

From initial conversations with members of this research community, I developed my approach. My approach for studying the phenomenon of unsafe abortion in Ghana rested on talking to the women who chose to terminate their pregnancies unsafely, as well as those who had chosen to end their pregnancies in a manner we deem “safe”. Hearing these women’s stories was the most important aspect of this research to me. In all of the work I read, these stories of how women navigate the healthcare system to obtain an abortion was missing.

Due to constraints on my time (I have an elementary school-aged son who lives in Michigan) as well as my limited language skills (the local language, Twi, is all but completely foreign to me), I opted to hire research assistants to conduct interviews and focus groups for me. While this choice was driven mainly by the two limitations mentioned above, it was also made because, even if I had opted to live in Kumasi for the entirety of data collection, and had learned to be conversant in Twi, I never would have been seen as an insider. I felt local women would have more skill in encouraging women to talk about their experiences. Women were, for the most part, willing to discuss their experiences with my research assistants.

Due to the sensitive nature of this topic, multiple data sources were used. These include a quantitative analysis of the KATH post-abortion log book to describe a year of women seeking care for complications arising from abortions as background information (Rominski *et al.* 2014),

interviews with women seeking care for complications arising from a self-induced abortion, interviews with women seeking care for comprehensive abortion care, interviews with healthcare providers and focus group discussions with community members. The focus groups were designed to elucidate how the community conceptualizes pregnancy and abortion and social norms that exist around sexual debuts and pregnancy among young women. These focus groups were held with both men and women, separately.

For example, from the Demographic and Health Survey (DHS), it is known that there is near universal knowledge about contraception and that most Ghanaians know how to access various contraceptive methods, but many fewer use contraception regularly. However, these quantitative studies have focused almost exclusively on individual-level determinants of unsafe abortion and sexual behavior. Sexuality is a complex phenomenon and focusing on individual-level data fails to investigate the important societal, normative and cultural components of sexuality. Individual-level investigation presupposes that decision-making around sexuality is rational and based on knowledge. This is not the reality of sexuality for many people. Rather, decisions about sexuality are based on experience and beliefs which are shaped through individuals' own experiences and those of the societies and cultures of which they are part (MacPhail *et al.* 2001). In order to gain a deeper understanding of the process by which these individuals access an abortion, I decided to conduct a qualitative investigation. I decided a variety of opinions were important to elucidate. Firstly, and perhaps most importantly, I wanted to understand the opinions of the women themselves. How did they feel when they became pregnant? With whom did they talk to about their pregnancy? How did they decide to terminate? Was this decision taken by themselves, or did they talk it through with others? Did

anyone try to prevent them from terminating? Once the decision was made to end the pregnancy, where did they go to seek services? Why was this choice made and not a different choice? How do they understand the law on abortion in Ghana? From where have they gotten this information? Have they had previous abortions? Had they been using contraception when they became pregnant with this pregnancy? If not, why not? What do they know about contraception and where to access it?

Many of these questions were conceptualized out of previous work. For example, many of the studies reviewed in the previous section found that women were not aware of the abortion law in Ghana, but they did not have follow-up questions about where women had learned about the law or how they viewed it.

In order to investigate difference between women who choose to terminate in facilities versus at home, I also thought it was important to talk to women who were seeking services for comprehensive abortion care. These women would be asked many of the same questions above. I hoped this would point to potential intervention points as some Ghanaian women are aware of their ability to access induced abortions safely at facilities.

I also thought it was important to interview healthcare providers because they are the ones who treat these women and they might have interesting and different views of the women they have seen. Finally, I wanted to talk to people outside healthcare facilities. I wanted to know how men conceptualize pregnancy and abortion. I wanted to know how parents talk to their children about matters around sexual and reproductive health and how these individuals know about how women navigate their social worlds and the healthcare system to terminate their

pregnancies. Many of the focus groups loosely followed the guides I developed. The groups, and some of the interviews, deviated into areas I had not anticipated and had not thought to ask about explicitly, which is one of the main benefits of qualitative methods, in my opinion.

Instrument Development

From previous work conducted in Ghana, it is known that abortion complications are a leading cause of admissions to emergency gynecology wards in many of the country's hospitals. From the Demographic and Health Survey (DHS), it is also known that there is near universal knowledge about contraception and that most Ghanaians know how to access various contraceptive methods. Previous quantitative work has been instrumental in determining that complications from unsafe abortions are a big problem for Ghanaian women, and important factors have been identified which are associated with unsafe abortion. However, these quantitative studies have focused almost exclusively on individual-level determinants of unsafe abortion. Sexuality is a complex phenomenon and focusing on individual-level data fails to investigate the important societal, normative and cultural components of sexuality. Individual-level investigation presupposes that decision-making around sexuality is rational and based on knowledge. This is not the reality of sexuality for many people. Rather, decisions about sexuality are based on experience and beliefs which are shaped through individuals' own experiences and those of the societies and cultures of which they are part (MacPhail & Campbell 2001). It was through this lens, therefore, that I sought to develop the interview and focus group guides.

I circulated initial drafts of these guides to colleagues in both the US and Ghana who have worked in the field of abortion for input. After multiple rounds of revisions, I pilot tested the guides in Ghana at one of the study hospitals. Pilot testing suggested some revisions to the guides were necessary, and that it would be harder to enroll women who were seeking services for complications resulting from an induced abortion. During the pilot testing phase, only women seeking services from a miscarriage presented for post-abortion care, and enrolling women during the data collection period resulted in fewer interviews than I had initially thought. It was thus necessary to extend data collection in order to be sure to capture women presenting to the hospital for the treatment of complications resulting from self-induced abortion.

Participant Recruitment

Women who presented for treatment at the three study hospitals who met the inclusion criteria were invited to be part of the research study by the nurse or midwife treating them. If they agreed to participate, the midwife called the interviewer. The interviewer also called the nurses and midwives at each of the facilities daily to ensure they contacted her when a woman who met the inclusion criteria presented for treatment.

Study sites

There were three hospitals used as study sites for this research: the teaching hospital which is the referral site for the Ashanti region and two district hospitals located within the Kumasi Metropolitan Area (see figures below). The three hospitals are geographically close together. Kumasi is not a large city, and these facilities are all in fairly close proximity to one another.

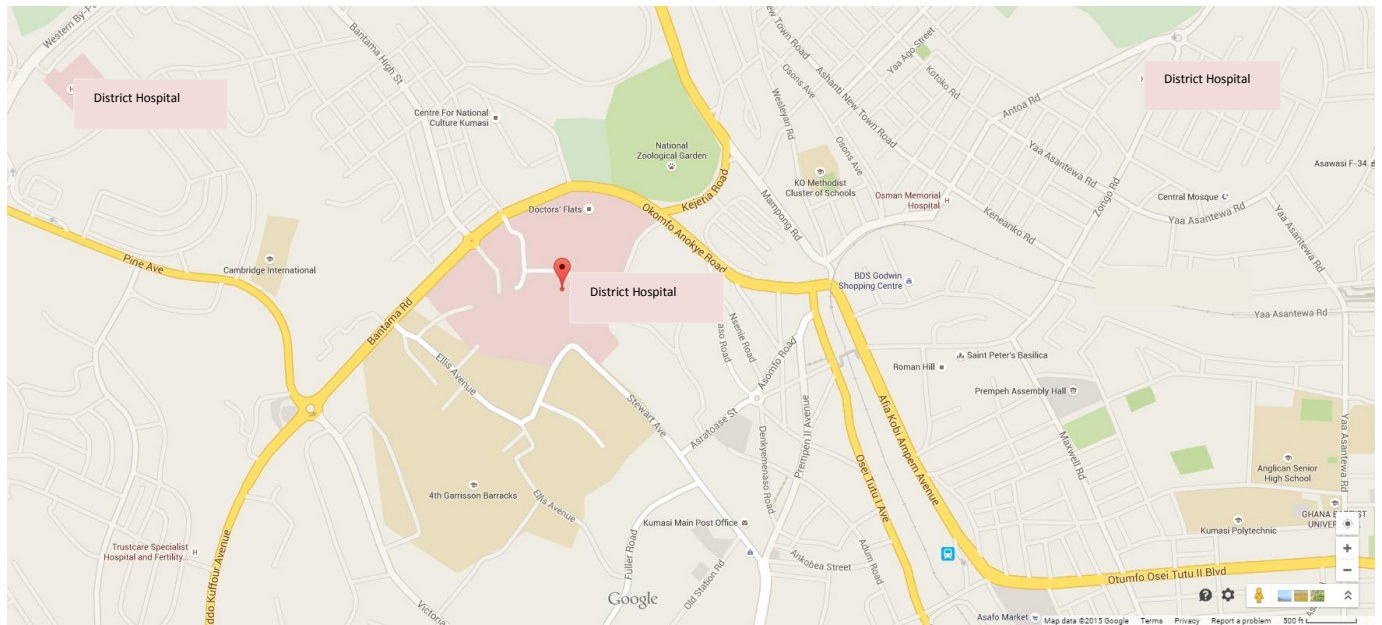


Figure 4. Study sites for the research—one teaching hospital, 2 district hospitals.

The interviews with women were complimented by interviews with healthcare providers at the same three hospitals.

Community-based focus groups discussions were held to further contextualize how members of the community conceptualize contraception usage.

Interviewing process

The interviews with women took place in a private area of the gynecology ward after their treatment was complete, but before discharge. The interviews were all conducted in Twi, the local language, and recorded on digital voice recorders. Provider interviews were conducted in private areas of the hospitals either before or after the providers' shifts. These interviews were also conducted in Twi, recorded on a voice recorder and transcribed and translated verbatim.

Patients were assured their participation or not would not impact their clinical care and their care providers were not made aware of who participated in the study and who declined to participate. However, the sampling strategy did rely on the women's providers to contact the interviewer when eligible women were interested in participating, so it is not unfathomable that the care the women received biased them to either participate or not. Due to this potential bias, as well as the bias introduced by the setting of the interviews (in the hospitals), there were very few questions asking the women to comment on the quality of care they received.

Although quality of care is an important aspect of the decision making process, I did not believe women would answer honestly or fully if they were dissatisfied with their care given that they were being interviewed in the facilities.

The focus groups were held with women and men separately. These focus groups were held in three (3) market areas surrounding the hospitals. Some of these were conducted by just the research assistant and I accompanied her for 4 of them. We approached community members in their places of work in the markets to invite participation. Participants were recruited individually, and if they were interested in taking part in the groups, they were taken to a private location away from their business. Individuals were approached until a sufficient number had agreed to participate. The focus groups which I took part in were comprised of: male taxi drivers waiting in the dispatch location; male fire and emergency personnel just outside the Komfo Anokye grounds; female seamstresses; and female hairdressers and their clients. The seamstresses worked all in the same part of the market and after the first woman (in the photo below, she's the one wearing the pink shirt) agreed to participate, she recruited the other 5 women from stalls nearby.



Figure 5. Seamstresses participating in a focus group discussion.

For the hairdressers and their clients, we approached a booth where there were 4 women working and 3 having their hair done and asked if they would like to talk to us and participate in our group. They agreed and the women talked either as they worked or as they had their hair worked on.



Figure 6. A hairdresser and her client participating in a focus group discussion.

Study bias

That all interviews were conducted with women who suffered complications from their self-induced abortion is another potentially biasing component of this study. It is reasonable to consider that women who suffer from complications from unsafe abortions are different than women who are able to safely self-induce. Although misoprostol effectively terminates about 85% of pregnancies when taken as indicated, the study guide did not address the women's

gestational ages or the dosage of the medication they took. Perhaps women with less education are less able to correctly take the drug themselves or less likely to accurately date their pregnancies. It is also feasible that women of lower socioeconomic status may have purchased less of the drug and therefore been more likely to suffer from complications. All of these factors may bias the sample and make it less generalizable to all Ghanaians.

Further, this study took place in Kumasi, an urban area where health centers, pharmacies and chemical sellers are plentiful. The findings which come out of this study may be less applicable to less urban areas where health services are more limited. The women in this study may not be a representative sample of Ghanaian women and may not seek services for induced abortion in the same manner that their rural counterparts do.

Data analysis

All transcripts were read and re-read in order to generate explanations to the main research question of why women engage in unsafe abortions when the means for safe abortions exist in their community. Specifically, why do women continue to engage in this potentially life-threatening behavior? The second stage of data analysis aimed to generate broad themes. I conducted a line-by-line coding of the transcripts, after initial high level reading of all the transcripts. As this research was inductive in nature, codes were derived from the transcripts, rather than deductively from the formative stage of the research. Recurrent issues in the texts were brought together to form these initial codes. From the initial coding, a large number of codes emerged. These codes were then reviewed together to decide which were speaking to similar topics and how they were related to one another. From this large number of initial

codes, reappearing and similar codes were identified and consolidated. These higher-level codes organized the initial codes into clusters. These codes were then raised to the level of categories and the categories were grouped together with similar categories into themes. Quotes that were particularly illustrative of these themes were selected and will be presented. Using this thematic analysis approach (Joffe & Yardley, 2003), there were six broad themes which emerged, some individual-level in nature, some which are health system-related and some which are cultural. These broad themes which emerged from the data were: 1. engaging in transactional sex; 2. not using contraception; 3. abortion is illegal; 4. systems challenges; 5. attitudes of health workers; and 6. the influence of a woman's social network on where to terminate. The first two themes will be discussed in the next chapter, as they fit under the umbrella of factors placing women at high risk for unplanned pregnancy. The following four themes will be discussed in chapter 5, as they are about the kinds of services women access.

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Chapter 5: The context of premarital sex in Ghana

With the background of the previous three chapters, I now turn to the results of my study. This will begin with the quantitative results, followed by the first portion of the qualitative results, explaining the context of premarital sex in Ghana and why more women are not using contraception. The next chapter will present the rest of the qualitative data.

Quantitative Results

There were a total of 33 women interviewed as part of this study. 22 of them were being treated for complications from self-induced abortion, and 11 were seeking care for an induced abortion. The majority of the women were unmarried (n=20) and under 30 years of age (see Table 1 below). The majority of the women in this study were either unsure of the abortion law or believed abortion is illegal in Ghana.

Table 1. Select demographic information for women

Marital status	Married	12
	Not married	20
Age	13-19	5
	20-24	10
	25-30	9

	31-39	9
Seeking care for	PAC	22
	CAC	11
Highest level of education	None	1
	Primary	2
	Junior Secondary School	12
	Senior Secondary School	12
	Higher	1
	Missing	5
Perceived Legality of Abortion	Illegal	14
	Legal	8
	Unsure	11

Generally, the women seeking care for an induced abortion were older than those who needed care for complications from a self-induced abortion (see Table 2 below).

Table 2. Age against type of services being sought

PAC or CAC	Age 13-19	Age 20-24	Age 25-30	Age 31-39
PAC	5	7	7	3
CAC	0	3	2	6

While the majority of the participants in this study were either unsure of the legal status of abortion in Ghana or thought it was illegal, this was not evenly distributed amongst them. Not surprisingly, no participants seeking care for an induced abortion (CAC) thought abortions are against the law, while only two of the participants seeking care for complications from a self-induced abortion were of the mind that abortion is legally available.

Table 3. Knowledge of Legal status versus type of abortion

	Legal	Don't know	Illegal
PAC	2	6	13
CAC	6	5	0

Although the data are too limited to do many quantitative analyses, it seems that thinking abortions are legally available in Ghana is associated with different abortion-seeking behavior (chi-square, $p > .0001$). Further, young age (below age 24) seems to be associated with seeking service for post-abortion care rather than comprehensive abortion care. Interestingly, no women in the age range 13-19 were seeking care for an induced abortion, suggesting that in this population, young women are less likely to seek comprehensive abortion care than their older counterparts.

A total of 17 health care providers at three hospitals were interviewed. There were 2 doctors, 9 nurses and 6 midwives interviewed. These providers ranged in age from 25 to 58 years of age and had been practicing from 6 months to 33 years. The sample is skewed toward younger nurses and midwives who have been practicing for fewer than 5 years. Although I do not have hospital-wide data with which to compare this sample, from my observations, this sample is not too different from the population. Most of the providers in the hospitals are nurses and midwives, and these providers are young.

Table 4. Select demographic information for health care providers

Position	Doctor	2
	Nurse	9
	Midwife	6
Age	25-35	11
	36-45	4

	45-58	2
Years Practicing	0-5	12
	6-15	3
	15-33	2

Qualitative Results

From the qualitative data, the first set of results show there are many factors which place women at risk for unplanned pregnancy. The below figure shows the overall framework of the qualitative results of this study.

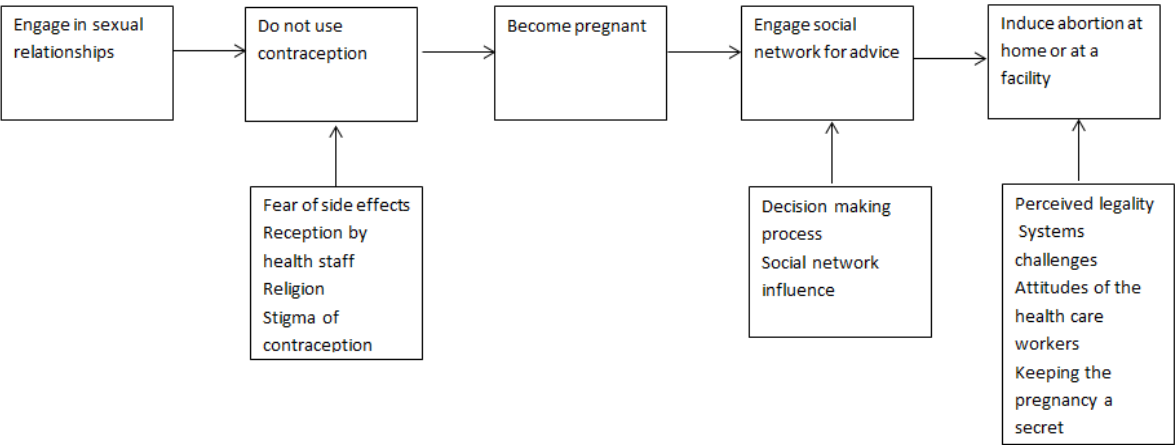


Figure 7. The process of unwanted pregnancy in Ghana.

The themes which I will discuss now are 1) sex for money and; 2) not using contraception. The not using contraception theme has 4 sub-themes under it; 1) side effects; 2) reception by health staff; 3) religion and 4) stigma of contraception. Each of these themes and sub-themes are explored further below.

Factors Placing Women at High Risk for Unplanned Pregnancy

Sex for money

The idea of transactional sex, the exchange of sex for money or other goods, is one that is foreign to the everyday existence of many Westerners. However, research and advocacy conducted especially around the topic of the HIV/AIDS epidemic in sub-Saharan Africa has begun to shed light on this widespread phenomenon. As Ankomah (1992) writes, “The consumerist nature of sexual relationships at present is generally acceptable in Ghana, but what some Western researchers (Bleek 1976) find difficult to understand is that the transactional element involved is different from prostitution in the classic Western sense.” (page 137) Although many have portrayed transactional sex as a necessity brought about by poverty on the part of the woman, others have discovered the integrated nature of these relationships and the societal and cultural factors that normalize and accept this behavior. Working in rural Malawi, Swidler and Watkins (2007) describe transactional sex as simply one example of pervasive client-patron relationships which are common in sub-Saharan Africa. While previous work has conceptualized transactional sex as women being forced into these relationships in order to keep a meager existence, more recent work has demonstrated that transactional sex is common not only among the poorest women, but among the wealthier strata in societies. Rather than relying on favors and income generated from sexual relationships, women are able to secure luxuries rather than necessities from these relationships (Ankomah, 1992, Lecler-Madlala, 2003). Beyond simple consumer goods, these relationships also allow women to make social contacts which enable them to secure economic independence (Ankomah, 1999).

Previous work in Ghana by Ankomah (1999) has suggested that young Ghanaian women often enter into romantic and sexual relationships in exchange for material goods; “young men are expected to provide women with cash or other material support, and consequently the relationships are woven round the notion of material recompense for sex”. Although to a Western audience this may sound like prostitution, there is an important distinction; while material resources in exchange for sex is common and seen as socially acceptable, formal prostitution is not. Women who are girlfriends expect and are given gifts as part of their sexual relationships; she “sells herself to the highest bidder; the price corresponds to the bargain contracted” (Pellow, 1977; pg. 34). In Ghana, a lack of material recompense from a boyfriend to his girlfriend would be considered abnormal (Pellow, 1977). Transactional sex has been described as an assertion of power, rather than an abdication of power, in societies where female sexuality is highly regarded and as a socially acceptable way for Ghanaian women to “improve their status” (Baba-Djara *et al* 2013). Figure 1 represents the continuum of sexual agency. On the left side is fully voluntary sex, characterized by love and desire as the drivers. As we move from the left side of the figure to the right, the drivers become more external until the far right side of the figure which depicts fully coerced sex. However, in between those two extremes, there is a large territory where transactional sex fits. Women are given material comforts, security, gifts favors or improved grades in exchange for engaging in a sexual relationship.

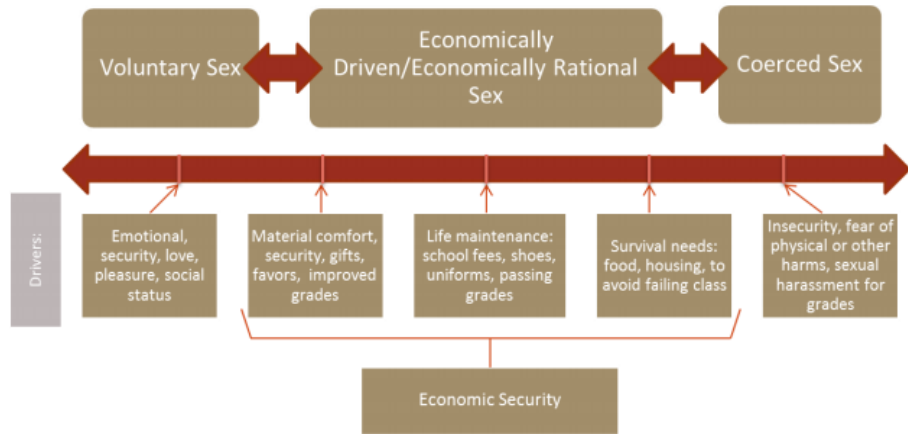


Figure 8. Sexual agency continuum. From Baba-Djara *et al* 2013.

Women who are unemployed may enter into sexual relationships with a main purpose to gain financial support. As one of the study participants noted, “A lot of them (premarital sexual relationships) are as a result of economic hardships. Times have become so hard so when a child is going to school, she might not get enough money to go to school, so if she comes across any boy who offers to give her money, she will follow and the next thing you will realize is that she is pregnant.” (Male Focus Group) This kind of transactional sex, which to many in a Western audience will seem foreign and somehow morally wrong, is accepted as normal in many situations. This phenomenon was not one I originally set out to investigate. In fact, it was not something I realized was happening. The comments in the focus groups were spontaneous and not specifically prompted or probed, suggesting how widespread and accepted these practices are.

It is important to note most of the women interviewed for this study were young, ranging in age from 13 to 39, with the majority being below the age of 30. The younger women especially were mainly students and were not at a time in their life course when a pregnancy and having a

child fits in to their socially expected roles. At this time in their life, the purpose of having sex is to fulfill emotional or economic needs, rather than to become pregnant. The idea of an unwanted pregnancy may seem unusual in a pro-natalist society such as Ghana, but it is perhaps indicative of the changing roles of women in Ghanaian society. While work done in the 1970s (Pellow 1973) suggest there were no such outcomes as truly unwanted pregnancies, given the large proportion of women and girls who have had an abortion, it appears there are now truly unwanted pregnancies. Finishing school, whether this is primary or secondary school, or staying in their technical training or finish their diploma or degree, is highly important for Ghanaian women, and while engaging in sex for a multitude of reasons is accepted, becoming pregnant was not one of them. The WHO (2012) recognized four major stages in the life course for Ghanaian women: 1) girl child; 2) adolescence; 3) adult woman in the reproductive years; and 4) a woman beyond the reproductive years (see Figure below). The young women included in this study seem to fall somewhere between the stages of adolescence and that of the adult. This model does not have a space for the post-adolescent who is not yet ready to bear children.





Females at various stages of the life course	Key interventions
1) Girl child 	Education; nutrition; protection against harmful traditional practices; protection against gender-based violence, child abuse, trafficking and slavery; immunization
2) Adolescent girl 	Primary and secondary school education; protection against early marriage, exploitation, abuse, sexual violence; establishment of youth centres for girls; adolescent-friendly health care services; encouragement of healthy lifestyles; life-skills and sex education; livelihood skills training; and, if affordable, HPV immunization
3) Adult woman in the reproductive years 	Family planning services; comprehensive abortion care services; pregnancy care including antenatal, delivery and postpartum care, and care for the newborn; screening and treatment for STIs including HIV; maternity leave protection; protection against domestic violence; female empowerment programmes; cancer screening
4) A woman beyond the reproductive years 	Healthy nutrition; cancer prevention services (e.g. cervical and breast cancers); protection against gender-related violence; screening for chronic noncommunicable diseases; mental health support

Figure 9. WHO Ghanaian women life course from the Report of the Commission on Women's Health in the African Region, 2012.

The blurring of the line between adolescence and adult women in the reproductive years is striking in this study. Although age cut-offs would put many of the participants in the category of adolescents, their actions, and their needs, are those of adults. They are desperately in need of family planning and comprehensive abortion services.

The issues of transactional sex were mentioned more frequently in focus group discussion by community members than in the interviews in the hospitals with the women themselves. This may be because although this practice is widespread and accepted, it is still surrounded by ambivalence and not without stigma, and also because the focus group discussions deviated more from the guide and participants talked more freely than did the women in the hospitals. Women are described by their peers as both victims and perpetrators for engaging in transactional sex (Baba-Djara *et al.*, 2013). For example, one participant said, "What I can say about it is that the young girls here haven't reached the age that they are supposed to give birth or even cohabit with a man, but because of financial constraints and difficulties they go in for men who will be able to provide them with money for their upkeep." Another participant in this same focus group said, "They start moving in with friends who later find boyfriends for them who will be providing some assistance to them. In the long run they become sexually active and then the next thing is pregnancy." Other participants were even more direct: "sometimes too their mothers teach them. For instance a mother can teach her daughter how to fish for men, sleep with them and charge them a fee." The language used to talk about these

relationships is both accepting of the practice while also acknowledging this is shameful and problematic.

Along with the phenomenon of transactional sex, and often related to it, are the issues of multiple partners and men who “deny responsibility” for a pregnancy. According to Anarfi and Antwi (1994), having multiple simultaneous partners is also a common occurrence, for both men and women. When it is known that a woman has multiple partners, it is easy for a man to “deny responsibility” for a pregnancy. As one focus-group participant said, “The men responsible for these pregnancies refuse to take responsibility for their actions, so it leaves the ladies no other option than to go and abort the pregnancy.” (Community interview no. 4) As one woman who was being treated for complications resulting from a self-induced abortion answered when asked whether her partners knew she had had an abortion, “he said he wasn’t the one responsible for the pregnancy”. This left her alone to decide what to do about her unplanned pregnancy, which she was worried about: “I was not happy at all because the time I got pregnant wasn’t a good time for me to get pregnant. I spoke to my friend who said she had a drug that she will want to give me.” (28 year-old PAC Client, Teaching Hospital). This participant was left to handle the unwanted pregnancy without the help from her partner because he decided it was not his responsibility. She turned to her social network, her friend, to help her.

Other participants were even blunter. For example, in one of the focus groups, a participant said, “If a man impregnates a woman and sees that he has no future with the woman, he can easily deny being responsible for the pregnancy.” (Female FGD). If a man denies responsibility

for the pregnancy, the woman has two options: she can choose to raise the child on her own or she can have a termination. If she chooses the later, she is also on her own to finance the abortion. The issues of bearing children outside of marriage, or without a father are beyond the scope of this analysis, but they are large and worthy of full investigation.

The literature is full of examples of women who engage in transactional sex, and the implications for these women's ability to negotiate condom usage. Given that most of this literature is grounded in the HIV/AIDS literature, it is not surprising that this is the focus of those investigations. The consensus is that women who engage in transactional sex, regardless of whether one views this as an expression of agency or as a victimization of women, are less likely to use condoms. Some men so prefer sex without a condom that they will pay their "girlfriend" more if she is willing to have unprotected sex. Many women simply feel unable to demand a condom given that they are extracting payment for the sexual act.

Of course, condoms are only one form of contraception, and given that in the focus of this study was on avoiding unplanned and unwanted pregnancies, condoms were only one of the options discussed in the interviews and focus groups. None of the women included in this study were using contraception when they got pregnant, even though they all knew about it and most knew they had access to it in their communities, and some had experience using various forms of contraception previously. The reasons they avoided using contraception are multiple and complicated. The women included in this study fit global trends seen in contraceptive usage. While two-thirds of women of reproductive age in Europe use modern contraception, in 2007 only 21% of women residing in sub-Saharan Africa use a modern method (UN, 2009). In

the most recent Ghana DHS, knowledge about contraception is almost universal; 95% of those surveyed knew of at least one form of modern contraception. The proportion of women who have ever used contraception is also high, suggesting that women try different forms of contraception and are familiar with them. However, current use is lower than would be expected given the fertility inclinations of women; women report not wanting a pregnancy in the next five years at higher rates than are using contraception (GSS, 2015). The so-called unmet need, women who are currently sexually active but not wanting to become pregnant and not using contraception, is currently estimated at 29.9% with 39% of contraceptive need being met by modern methods (GSS, 2015). Regardless of how it is calculated or measured, there are many more women engaging in sex who do not want to get pregnant than who are using highly effective methods of contraception.

Not using contraception

While women are beginning to desire fewer children and longer birth interval between their children, the rate of contraception usage has not kept pace. While knowledge of two or more forms of contraception is almost universal and 50% of Ghanaian women reported ever having used a form of contraception in the 2014 DHS, only 22% of currently married and 32% of sexually active unmarried women were currently using a modern form of contraception. This equates to 30% of married women and 42% of sexually active unmarried women having an unmet need for contraception, defined as being sexually active and not wanting to become pregnant, but not using contraception (GSS, 2015). There have been many reasons explored for why women do not use modern contraception when it is available, affordable and they are

aware of it. Some reasons suggested by my sample are a fear of side effects, which includes both real side effects that are associated with various forms of contraception (such as bleeding changes with implants) and fears of health effects which are due more to misinformation than being based in reality, reception by health staff, religion and stigma of contraception.

Side Effects

Reasons for non-use of contraception are complex, but one major reason that emerges is a fear of side effects. In national-level surveys such as the DHS, fear of side effects is noted as a main reason for not using contraception by many women. However, a deeper understanding of what women classify as “side effects” is not possible due to the limited nature of the data available. Although questions about contraception and the kinds of side effects women experienced were not included in the interview guides developed for this dissertation, this issue was spontaneously mentioned and therefore discussions ensued.

Not surprisingly, many of the participants in this study were afraid of side effects. They had heard from their friends of losing weight due to being on contraception, or gaining weight, or having a period all the time, or not having a period at all. One woman, a 20 year-old being treated for post-abortion complications said, “I know of a woman who was using some (family planning) but complained about persistent weight loss. She was using the implant, so she went back to the hospital to have it removed for her.” This young woman decided to use contraception from now on; “I even chose condom after the family planning education” (20 year-old PAC Client, Teaching Hospital). However, condom usage is a notoriously unreliable form of contraception and is dependent on consistent usage. As discussed above, effective

condom use is also dependent on the woman being able to negotiate with her partner to use the condom, which may be unrealistic for many women.

A young man who was part of a focus group, when asked about family planning, answered, “I have heard a couple of them say that if you go in for it (family planning), you might not be able to give birth again and some also say that it will give you certain infections and illness. So the alternative is that they will sit down and not try it at all.” (Male FGD) When asked if he and his wife use family planning, he said, “As for me, I will not even use family planning methods. Once she gets pregnant, she must give birth.” (Male FGD). This perhaps reflects the pro-natalist views of some Ghanaians. Having an unplanned pregnancy is a better outcome than being potentially made infertile due to contraception. Although there are delays in return to fertility due to some methods, this is certainly not universal and an overall dismissal of using contraception due to an unfounded fear underscores the lack of general knowledge about family planning and contraception.

A 28 year-old being treated for post-abortion complications says about family planning, “I have heard that it helps you to space out your children in terms of child birth...I have heard a couple of women who said that if you use family planning methods, you will be prone to illness.” She had been using condoms, which she purchased at a drug store, before she became pregnant this time, although she had stopped using them. When asked why she did not use other methods that were available at a clinic, she said, “I was afraid of side effects such as illness; that is why I avoided the hospital.” (28 year-old PAC client, Teaching Hospital). It is notable that her distrust of modern forms of contraception caused her to not use them, which played a role in

her pregnancy which she aborted in a manner that then caused major complications which required treatment at a hospital. This is not the first time that the phenomenon of women feeling more comfortable with abortion than contraception has been documented in Ghana, regardless of the high burden of unsafe abortion in the country (Biney, 2011). After her treatment for the complications, this woman was educated about family planning methods and chose the implant. She was asked if she is expecting any side effects and she replied, "Please, no. I just want to know if really the family planning methods will not make me sick." That she is not expecting side effects is troubling, as menstrual changes are almost universal in users of hormonal contraception (Hubacher *et al.*, 2009). These side effects are a completely normal event with this method of contraception and if she is not expecting these, experiencing them could cause her to think something is wrong. Improved counseling for women about what they can expect from contraception and what constitutes an abnormal side effect which needs to be addressed is an important line of inquiry for future work.

Women report hearing about side effects from friends and family members and while they are often vague, they were nonetheless troubling enough to the participants as to prevent them from using them. An older woman who participated in a community focus group said, "As the side effects that are associated with the use of family planning methods even me who am seated here, I am very much afraid of its side effects by listening to what people say. A sister of mine came to tell me that, she has taken the injection and for about three months now, she has had her menses and on top of it, she is continually bloating and growing bigger every time. So I think your family planning medications or methods are not good. So please find something and do about it." (Female FGD).

Some of the side effects women feared were extreme. For example, a 28 year-old woman being treated for post-abortion complications said, "I have heard of it (family planning) but I have also heard that if you do it, it comes to stay inside your heart. A lady told me she went for the injection and after that she lost a considerable amount of weight." (28 year-old PAC-client, District Hospital).

A 32 year-old woman being treated for post abortion complications said, "It was a friend talking about it (family planning). She said she did family planning to protect herself from getting pregnant. I can say it helped because ever since she did, she hasn't become pregnant yet. For me, I am afraid. Because I have heard other people say that if they do it, they get a lot of side effects like hypertension and the others." (32 year-old PAC client, District Hospital). So, while this women had second-hand experience with the effectiveness of family planning (a friend who had successfully avoided becoming pregnant while using contraception), her fears of side effects, especially nebulous and vague fears, were still too much for her to accept it herself.

Similar to a fear of side effects is the lack of education by the general population about family planning and contraception. Women and their male partners hear things from friends or family members and because they have not had comprehensive sexual education, they are apt to believe what they hear. Throughout this investigation, the role of people's social networks has been shown to be hugely important. This extends to the promulgation of incorrect ideas about family planning and contraception. As one participant in a focus group said,

I think the most important thing here is education. How many people decide to go the hospital to find out what family planning entails? Majority of people just base their knowledge on hearsay or sometimes someone comes on the radio and say some few words about family planning and then that is it. But I think that form of education is very

scanty and unhelpful. The education should rather start from the churches, the mosques or the schools. When this is done, it can eliminate the multitude of misinformation out there. I think the education is not widespread and also the main problem is that in Africa here, the institutions that have been tasked to these jobs just don't do it...because of the scanty knowledge out there they are often misled. (Female FGD).

As another participant of a focus group answered, when asked about why women do not go to the facilities to be educated about family planning,

The problem is that, within small communities like ours, people tend to listen to and believe what their friends and cronies tell them [rather] than what they would be told at the hospital. Once someone who has done it before come[s] to say that it is not good, you can trust them they will believe that than any other person. (Female FGD)

Reception by health staff

Some of the participants were afraid of the reaction from healthcare workers. When asked if people in her community use family planning, one woman said, "Yes, they are just a few. They are usually people who are married. But for the young girls they are afraid that when they visit the clinic, they will be shouted upon." Power differentials between the midwives who staff the health facilities and the women who seek services are a major problem. Previously, the way health workers interact with patients has been described as a reason women choose to deliver their babies at home rather than using facilities (Moyer *et al.*, 2013). Recently, WHO has published a report, "The prevention and elimination of disrespect and abuse during facility-based childbirth" which, for the first time, identifies inappropriate behavior of health workers towards women as a reason for the disparity between antenatal care attendance and facility-based delivery rates. The report focuses on the period of childbirth because, "while disrespectful and abusive treatment of women may occur throughout pregnancy, childbirth and

the postpartum period, women are particularly vulnerable during childbirth” (WHO, 2014, pg. 1). It is clear however, that for the women included in this study the disrespectful behavior of health workers, or at least a fear of being treated in a disrespectful manner, is also hindering the utilization of family planning services.

One woman who was part of a community-based focus group mentioned, “My niece died about a week ago. She was pregnant, her boyfriend gave her some drug to take and after taking it, she died in the room of this boy. But according to what I heard, they said if you are a student and you go to the clinic to seek for family planning services, you are turned away because they consider you as a child.” (Female FGD). Although the Ghana Health Service has as one of its missions the, “Provision of adolescent-focused services including counseling, Information, Education and Communication (IE&C) and Reproductive Health in general” (GHS 2013), it is clear that the consumers of much of this care do not see this as occurring. The Ghana Health Services is committed to providing high quality comprehensive reproductive health care to all citizens. However some of the frontline staff appears to feel differently, or to interpret what that mission means in terms of the mode of service delivery differently. In a study aimed at assessing the extent to which adolescents were using reproductive health services in rural Kintampo, Ghana, Enuameh *et al.* (2012) found almost universal knowledge about family planning, but less use. They also found that in key informant interviews, decision-makers felt health workers did their jobs well and provided services to adolescents in a fair and equitable manner, while the adolescents themselves felt very differently.

In answer to the question, why do women not go to the clinic for contraception services, one participant said, “They are sometimes afraid of reaction from the healthcare providers.” (Male FGD).

One woman who was included as part of a focus group knew this about family planning; “For me I know that there are drugs you can take or apply that can protect you against unwanted pregnancies.” Although she had heard of side effects from friends as well as media sources, she did not believe them and still wanted to be using a method. When asked why she did not go to the facility in her community to accept a method of family planning, she reported, “The truth is that I am afraid of the nurses and healthcare attendants there.” (Female FGD)

Religion

Although not mentioned as frequently as other reasons not to use family planning, religion was noted by some of the participants, although not the women themselves. Male members of the community, as well as healthcare providers, felt religion was a reason why couples and women did not use family planning methods. For example, when asked why more post-abortion clients do not accept family planning methods, one nurse from a teaching hospital said, “Some of them are because of religious beliefs. It might be due to their religion.” (Midwife, Teaching Hospital)

As another said, “Some are as a result of poor education and also sometimes religious beliefs” (Midwife, Teaching Hospital). Another midwife said, “Some of them think that when they use family planning methods, they will get certain diseases. Some of them also apply religious connotations to it saying that their religion does not allow the use of contraception” (Midwife, District Hospital).

Some of the men included in the focus group mentioned they would not allow their wives to use family planning because of their religion. One woman stated, “With us the Christians and the Muslims, there are sections that say that family planning is not good. Based on that, we have some of the husbands not agreeing to it.” (Female FGD)

Another woman in a focus group said, “There are some churches that kick against the use of family planning.” (Female FGD). Another woman in a different focus group said, “There are some churches that do not approve of the use of family planning by their members. It has been tagged there as a sin. I for instance go to the Pentecost Church. The elders of the church has kicked vehemently against family planning.” (Female FGD). Given how religious a country Ghana is, and what an integral part of people’s lives their religious community is, even a slightly negative message from a religious leader could negatively impact the use of contraception for many people.

Stigma of contraception

Although this was also not as prevalent as the other reasons for contraception non-use among sexually active women who do not wish to be pregnant, some women do not accept family planning methods because of the fear of people seeing them with these methods and then knowing they are sexually active. A family planning counselor said when asked why more women do not accept post-abortion contraception, “because those who come here, most of them are teenagers. They will just tell me that they are going to abstain. They won’t do it [sex] again. So they won’t accept the methods because if they accept the method and their parents see, it going to be a problem for them. So they will prefer to stop going after men. Some of

them are able to adhere to it but some do not and come here again with another pregnancy.”
(Midwife, Teaching Hospital).

Conclusions

International family planning efforts continue to make gains in improving women’s access to and knowledge of contraception methods. Far more women in low income countries know of multiple methods and are aware of where in their communities they can go to access these services. However, many women are still choosing not to use methods of highly effective contraception, and levels of use in West Africa are low (Cleland et al., 2011). None of the women included in this study who were seeking care either for complications arising from self-induced abortions or for an induced abortion were using contraception at the time the index pregnancy occurred. All of the pregnancies were unwanted and some of the women went to extreme measures to terminate the pregnancy. On the surface, it seems counterintuitive that women who did not want to become pregnant were not being proactive in preventing these pregnancies from occurring, especially since they were knowledgeable about contraception and had physical access to it. However, Ghanaian women have been found to be less fearful of abortion than they are of contraception (Biney 2006).

Worries about side effects were, by far, the most common reason women cited for not using contraception. Some of these fears, such as menstrual irregularities from the injection and the IUD, are factually-based. Others, such as an IUD migrating from the uterus to be lodged in the heart, are not. These sorts of fears of the IUD have been noted in other low-income settings (Rustagi et al., 2010) and can be hard to counteract. Most contraceptives do, in fact, have side

effects, however, the perception women have of the side effects they can expect are often informed by inaccurate information from friends and trusted family members and lead to disproportionate fear of contraception (Campbell et al. 2006). Although fear of the side effects of contraception is not a new phenomenon, and it has been mentioned as a barrier for women accepting modern contraception in many previous studies, family planning programs in many settings have not addressed these fears (Hindin et al., 2014).

Previous work has shown that personal experiences and stories from social networks are more salient than medical opinions in shaping women's perceptions of the safety of contraceptive devices including the IUD (Rustagi et al., 2010). Similar to the findings presented here, in their qualitative study in Accra, Ghana, Hindin and colleagues (2014) found fear of side effects, especially menstrual changes and future infertility, were the main reasons for non-use of contraception, especially for young women.

Women included in this study seemed, for the most part, willing to accept some form of contraception after being treated for complications arising from self-induced abortions; many reported they did in fact accept a form of contraception. They required intensive education about the various methods of family planning available to them and were curious to learn more about contraception methods from the interviewer. Somewhat worrying, though, is that many of the women who accepted hormonal forms of contraception from the treatment facility were not expecting any side effects.

Many women who state they are not using contraception because of side effects are, in fact, not using contraception because of misinformation (Campbell et al. 2006). These women would

benefit from appropriate and comprehensive sexual education, including education about contraception. For some women, the education they had received as part of their post-abortion care was enough to encourage them to adopt highly effective forms of contraception.

There were multiple mentions in the current study of participants knowing someone who, after using contraception, was not able to become pregnant when they so desired. Even if women do not currently desire to become pregnant, maintaining their fertility is hugely important to their future goals and they want to have children once their social situation determines that it is time to do so (Campbell et al. 2006).

Women formed their opinions about the side effects they were expecting often from the accounts of friends and / or family. This underscores the importance of women's social networks in their interest in and ability to access health services. In a large-scale cross-national study using DHS data, Sedgh & Hussain (2014) found women were significantly more likely to report non-use of contraception due to concerns regarding side effects and health risks in countries having the highest levels of unmet need for contraception. In that study, Ghana had the highest level of unmet need of any country in sub-Saharan Africa at 36.1% of married women. Nearly 20% of those women cited fears of side effects as the reason they were not using contraception even though they were fecund, having sex and wishing to delay their next pregnancy by at least two years.

Misconceptions about the danger of using hormonal forms of birth control are often reported to be community-wide (Campbell et al. 2006). In the current study, women and men of all ages

reported hearing of side effects from friends and family members, and these were often the reason why women were not using contraception.

The large number of women in this study who were not using contraception because of a fear of side effects, some real and some perceived, highlights the need for increased education and improved counseling for women on the modes of action of contraception, what side effects are normal and safe, and what to expect when initiating a new method of contraception. Women also need to be aware of available alternatives should side effects become untenable. An important distinction needs to be made during counseling or education sessions between actual side-effects, such as irregular bleeding, and misinformation as these can both be deterrents to use, but are different (Diamond-Smith et al., 2012).

A lack of understanding of the mode of action for contraception and what side effects are not harmful is imperative for women to fully understand before they begin any method of contraception. There is some indication that even when young women do receive information about contraception, more often than not, it reinforces rather than eliminates misconception (Wood & Jewkes 2006). Ensuring women receive correct information from people they trust is therefore highly important. This study did not assess to what extent providers themselves have misinformation about contraception, but previous work has found this to be another significant barrier to women using contraception (Campbell et al. 2006).

Further, these educational campaigns need to be extended beyond just the women themselves. Given the large impact of a woman's social network on her decision to use or not use contraception, addressing misconceptions on a societal level is hugely important.

Although women in Ghana have wide access to contraception methods in all Ghana Health Service facilities, and all recent indications suggest that knowledge of contraception is high, if healthcare providers are not willing to provide non-judgmental services especially to young women in need of services, women's access will be hampered. Physical access is not enough to ensure women experience access. Knowledge about where they can access the services will not be sufficient to increase utilization if women are afraid of the treatment they will receive when they attempt to access services. This finding is not unique to Ghana. In their review of qualitative literature investigating limits to modern contraceptive use, Williamson and colleagues (2009) note that young women have limited access to contraceptive services in many settings not because physical inaccessibility, but because of fears of receiving a negative reception from clinic staff. In settings where culture manifests itself through providers' biases (Campbell et al. 2006), and where social disapproval of pre-marital sex is high (Williamson *et al.*, 2009), intensive work with family planning providers to offer nonjudgmental services, or even having special adolescent days, could increase the ability of Ghanaian women to access contraception.

In previous work in Ghana, Stanback & Twum-Baah (2001) found that providers put up many barriers for women wishing to access family planning services, including marriage and minimum-age requirements, which reflected the providers' own personal attitudes. Ensuring that all policies are medically-based rather than being based on provider bias, and ensuring these policies are put into practice, can help to ensure women receive the care they are entitled to.

In all, there are many reasons why women engage in sexual relationships and why they do not use contraception. Sex is common for unmarried women who are not trying to become pregnant, but using contraception is not, and so unplanned and unwanted pregnancies are common. How use or nonuse of contraception is related to transactional sexual relationships is an important area of future study. While there has been some investigation into this phenomenon as it relates to HIV and condom usage, there is very little work investigating other forms of contraception in transactional relationships.

Women who are engaging in sexual relationships without using contraception are likely to become pregnant. Due to this, induced abortions are common in Ghana. How women deal with an unwanted pregnancy determines to what extent the procedure is safe. That is the discussion of the next chapter.

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Chapter 6: Abortion-seeking behavior

As I demonstrated in the previous chapter, Ghanaian women are engaging in sexual relationships while not using contraception at high rates. Consequently, unplanned and unwanted pregnancies occur. When this happens, women must decide their course of action. They do not usually make this decision alone, but rather speak with their partners, their friends and less often their families about their situation. As with their decision to use or not use contraception, these women rarely act alone or seek advice initially from within the formal healthcare system. Rather, they seek advice from friends or others in their communities whom they know have dealt with a similar situation to get advice and help.

As a reminder, the overall motivating question to this research was, given the liberal law governing abortion in Ghana, what the Guttmacher Institute calls “one of the most liberal on the continent”, why do so many Ghanaian women decide to terminate their pregnancies in a manner the World Health Organization and other international organizations would classify as unsafe? Why are complications from unsafe abortion still a high proportion of admission to emergency gynecology wards in the country’s hospitals? I argue that, contrary to what is written in many international documents, it is not that women **resort** to unsafe methods because safe methods are not available to them. For many of these women and the women

from whom they seek advice, it is simply the normal and preferred course of action to terminate the pregnancy in their home, using drugs procured from pharmacies, chemical sellers, or less often local herbs. Terminating a pregnancy at home is has been normalized, and for many women, it brings about an abortion without complication. As one participant of a community-based focus group said, “[Women] are of the view that if they take the medication at home, it wouldn’t bring any problem to them.” (Female FGD) If complications do arise, women seek care from a health facility, but do not think to seek care for the initial stages of the termination for many reasons. This does not hold true for all women, as some women are choosing to seek an induced abortion at facilities. However, there are still many women who are inducing their abortions themselves, or with the help of friends. While this work demonstrates that some of this has to do with a lack of knowledge about what services are available to them, as well as what they are legally entitled to, for most women in this study, it was simply the norm to do this at home and it was preferable, given their personal experiences with the health system, or experiences of their friends. The women who chose to seek services for an induction offer a different perspective, and it is important to remember that for some women, seeking an abortion at a facility was possible and preferable. What these data show, though, is that women are not resorting to clandestine abortions, but are rather choosing to terminate with medication at home because this is what they have done in the past, or their friends have done.

While some women are not aware of termination services at hospitals, it appears all are aware of their ability to seek care if they develop complications. This may be a result of the sample interviewed for this study (made up of women who were being treated either for complications

from a self-induced abortion or for an abortion), but this phenomenon was also widely mentioned in the community-based focus groups. As one participant of a focus group said in response to a question of whether the local health facility provides abortion services, “No. But usually when ladies suffer complications, they are rushed there and given treatment.” Many women prefer to induce their abortion with the help of friends at home, and only seek services at the health facilities if there is a problem. When asked how she knew to seek services for the treatment of her complications, one woman being treated for post-abortion complications said, “I have heard a lot of talk about how well they perform here and also from my friends.” (27 year-old PAC client, District Hospital) Even though the District Hospital has a positive reputation among this woman’s friends, she did not elect to induce her abortion at the facility, opting instead to induce at home and seek care for complications.

The reasons for self-inducing among some women are grouped into 6 themes. These themes are: 1) Abortion is illegal; 2) Systems challenges; 3) Attitudes of the health care workers; 4) Keeping the pregnancy a secret; 5) Decision making process and; 6) Social network influence.

Abortion is Illegal

Part of the reason for the increased comfort of treating oneself at home especially among those who were seeking services for complications arising from a self-induced abortion is because women feel they would be acting illegally and, less frequently, would potentially face prosecution if they seek services for an induced abortion in a health facility. When asked for what reasons a woman in Ghana can have a legal abortion, a woman being treated for post-abortion complications said, “Well, I know abortions are against the law in Ghana.” (PAC client,

Teaching Hospital) None of the women who were interviewed as part of this research who had self-induced their abortion thought differently. As one midwife succinctly put it, “The (women) think that it is illegal to come to the hospital so they try to avoid it.” (Midwife, Teaching Hospital). When asked from where they received information about abortion and its legality, one woman said, “it is from our friends”, and further, when asked if she had been told by any providers that abortion is illegal in Ghana, this same woman responded, “Yes, I have heard it a number of times.” (27 year-old PAC client, District Hospital). One of the younger participants, a 13 year-old, said that she knew abortions were against the law in Ghana, and she knew this, “from the radio and also friends.” (13 year-old PAC client, Teaching Hospital). A 20-year old responded, “[women] are fully aware it is against the law.” (20 year-old PAC client, Teaching Hospital) While none of the patients interviewed as part of this study knew of women being prosecuted for trying to secure an induced abortion at a facility, the women who had self-induced were all absolutely sure abortion is against the law. Although prosecution of women, or their providers, due to inducing an abortion is rare (Kumi-Kyereme *et al.*2014), this does not mean women are not afraid of this potentiality. As one woman said, “If they had seen me, then I would have been arrested but now that no one has seen me, I think I am safe.” (32 year-old PAC client, district hospital)

It is not only the women who feel that abortions are illegal in Ghana. Many of the nurses and midwives who were interviewed held incorrect views of the legality of abortion services. A nurse at the tertiary care center said, “as far as I know, abortions are not legal in Ghana yet.” (Nurse, Teaching Hospital). Both of the physicians interviewed were aware of the full provisions

and the reasons for which abortion is legally available, but many of the nurses and midwives, the far more plentiful cadres of health worker, who women will most likely encounter first if they were to seek services, were unaware of the law. This is problematic and, as one nurse said, “we should try to educate health workers about abortion and its complications so that in the event that a patient walks in to seek such services, we can efficiently help them out. There should be general training for everybody because for the patients, when they enter the hospital, everybody they see is a nurse.” (Nurse, District Hospital). This nurse seems to be cognizant of the problem of health care providers relaying incorrect information to women and the negative impact this can have on women’s willingness to seek services. As the following exchange indicates, some nurses are fully aware of the lack of knowledge on the parts of both the providers and the women:

Interviewer: Do women feel that they are acting illegally if they seek care for abortion services?

Answer: Yes. So most times they will hide. They would take concoctions for the bleeding to start to make it look like a miscarriage before coming to the hospital.

Interviewer: Do healthcare providers feel that they are acting illegally if they provide abortion services?

Answer: Some but not all. At least those of them that have gone through the MVA training don’t feel that way. But others who have not gone through the training feel like they are committing an illegality. (Nurse, District Hospital Hospital)

Training in Manual Vacuum Aspiration (MVA), the low-cost, highly effective form of surgical uterine evacuation, was added to the midwifery training curriculum a few years ago and so those who received this as part of their pre-service training may be better informed about the law, as well as the technical aspects of providing a surgical abortion. However, the quality of their pre-service training has not been evaluated and in a nation-wide survey I recently

conducted with a team of researchers, there are indications of major deficiencies in this training with few of the final year midwifery students having received a full education in the procedure (Rominski *et al.*, under review). The practicing midwives who had graduated before the change in the policy of the Ghana Health Service have been offered in-service trainings in surgical abortion, although the penetration rate of these trainings has not been evaluated, and it is not clear if these trainings focus only on the technical aspect of abortion or if they also have components about the social nature of abortion and clarification of the law. Given the high numbers of nurses and midwives involved in this study who are unaware of the law as it pertains to abortion, it seems that a focus on these providers is important. Of course, the law is not straightforward, as discussed in the background. Knowing the full law means realizing the vagueness with which it is written. A midwife who works at the referral hospital correctly explained the abortion law in Ghana, speaking of the times an abortion can be legally provided; “When the mother’s health is at stake and when it can bring complications to the fetus itself. Also in the case of rape when a woman happens to get pregnant as a result of this, she is allowed to abort the pregnancy if she wants to.” (Midwife, Teaching Hospital) She went on further to say, “The law of the country does not allow that you end your pregnancy because you can’t care for the baby. There are social services agencies that can help you, if you think that it will be difficult caring for the baby. If you end the pregnancy because you can’t care for the baby, it is not allowed by the laws of the land.” Given this correct interpretation of the law, this midwife would most likely not be willing to provide an abortion for a woman who felt unable to carry a pregnancy to term.

However, an exchange with a midwife from a the same institution highlights the ambiguity with which the law is interpreted and applied;

Interviewer: If a young woman within your community becomes pregnant and she thinks that she cannot care for the baby, how can she seek for abortion services?

Answer: If the person is bold enough to come to me, I will counsel her then provide her the service. Midwife, Teaching Hospital.

This means that, depending on with whom a woman speaks at a facility, she may be told that she can obtain an abortion after counseling, or she may be told that she is not eligible for an abortion because not wanting to continue with the pregnancy absent a health threat or a rape, it is not allowed to be legally performed.

Not all women are of the mind that abortion is illegal. Not surprisingly, many of the women who were seeking care for comprehensive abortion care, an induced abortion, were either unsure of the legality or of the mind that abortions are legal in Ghana. As one woman said, “I have not heard or seen of women who fear that they are acting illegally seeking abortion care. I don’t know if it’s against the law.” (32 year-old, CAC client) As another client seeking care for an induced abortion said, “I don’t think so (that abortion is illegal) because I know at the hospitals one can obtain the service.” (22 year-old CAC client, District Hospital) Another patient was even more sure; “Abortion is legal...most women don’t know. I had information from a druggist who is a nurse.” (27 year-old CAC client, District Hospital) Another said, “I have heard about the legality of abortion...through health talks at the post natal and child welfare clinic.” (35 year-old, CAC client) As reported in Chapter 3, this seems to be a major difference between those women seeking care for an abortion and those seeking care for complications from a self-induced abortion. Some women seeking care for an induced abortion are of the mind that

abortion is legally available, and they have heard this from healthcare workers they know (the druggist who is a nurse) or from clinic-based talks they have attended (the postnatal clinic). For these women, the health system fits into their lives in a seemingly different way than for those who chose to self-induce.

A nurse at a district hospital shows again the vagueness of the law, and how this interacts with a lack of standardization at facilities. There is, for many people, uncertainty that surrounds the law as written and how it is enforced.

Interviewer: What do you know about the law about abortion in Ghana?

Answer: It is not legal.

Interviewer: Do you think healthcare providers think they are acting illegally when they provide abortion services?

Answer: I think that it is an individual thing. For me, I know that some doctors have accepted it and are doing it as if it is legal. But usually because there are no problems they go free. But when there is a problem that is when the law will catch up with them.
(Nurse, District Hospital Hospital).

This nurse is highly confident that abortion is not legal in Ghana and that if a problem arises in a patient, the physician providing the abortion will be prosecuted. This exchange illustrates the difference in the 'de jure' and 'de facto' nature of the abortion law in Ghana. 'De jure' means "according to law; by right; legal" while 'de facto' means "done in fact but without strict legal authority" (Vekemans *et al.*, 2008). By many accounts, abortions are available in Ghanaian health facilities in a de facto manner, while they are not protected, de jure. This exchange also shows the interaction between the vagueness of the law and the systems challenges which can arise.

Systems challenges

Some of the participants, especially the doctors, noted health systems challenges and the negative consequences this has on women's willingness to patronize health facilities for termination services. For example, one physician who works at the regional referral hospital said, "It (abortion) is not well regularized by the Ghana health service protocol. We are supposed to offer comprehensive abortion care but it is not well regularized. So because of that, women are not comfortable walking in to access such a service." (Doctor, Teaching Hospital). The lack of coordination and standardization of abortion services is a huge problem and a deterrent for women to seek services at a facility. As is clear from the previous section, depending on who a woman speaks with when she arrives at a facility, she may or may not be under the impression that she can be helped at the facility.

A nurse working at a district hospital speaks about the discomfort women feel when they are not sure where in the hospital to access services; "Some of the patients know where to go when they come here, but others do not have to ask before they are shown the department. Because of the stigma that is attached to people who seek such services, it is hard for them to ask." (Nurse, District Hospital Hospital) The hesitancy women feel about openly asking health care workers in the facility for help is well-founded, based on the reports by some of the providers interviewed as part of this research. The woman may very well be told she is breaking the law and that she is not allowed an abortion. Further, due to the lack of private areas at many health centers, it is likely that others will overhear what she is asking for, and in tight-knit

communities, she may see people she knows at the facility; people she would rather not know that she is seeking an abortion.

Another nurse at the same facility further explains the problem of some women knowing they have the ability to access an abortion at a facility, while others do not; “Most of them go to quack doctors, chemists, pharmacists, who give them all sorts of medicines to terminate their pregnancies. We have few of them that know that if they walk to any health facility, it can be done for them.” (Nurse, District Hospital)

Attitudes of the health workers

As with contraception services, many participants note the “attitude” of the health workers and how clients are treated by the staff at the facilities as it relates to client willingness to patronize services. This also interacts, and may be a part of the systems challenges. Individual providers are able to place their own views on the clients seeking services and are not held accountable for the service they provide.

First of all, it is the attitude of the health workers towards these women when they come to the facilities for such services. Sometimes they feel they are welcome to these facilities that provide this comprehensive abortion services. So they will first listen to their friends, pick information from inappropriate sources and then they go by it. However, when they complications arise, they have no other option than to come to the hospital for intervention. (Doctor, Teaching Hospital).

As one woman being treated for complications from a self-induced abortion said, “Even for me it [maltreatment by healthcare providers] is the reason why I stayed away from the hospital.” (28 year-old, PAC client, district hospital)

The providers who were included in this study not only mentioned that the attitudes of health workers are a problem, but also that the way women are treated is a reason why they seek unsafe services. As one midwife said, “Most of them, because of the attitude of us the health care workers, so they don’t come to the hospital. They passed through the quack doctors before they come in with bleeding and other complications.” (Midwife, Teaching Hospital)

It is not only the providers who note the problem of the women fearing poor quality of care at the facilities and being treated badly by the staff. As one exchange during a focus groups shows;

Interviewer: When they go to the hospital, are they mistreated?

Answer: Yes. There was a case recently where the girl was afraid of being mistreated so she resorted to taking drugs and unfortunately she died. (Female FGD)

While participants being treated for complications resulting from a self-induced abortion said they did not know they could access abortion services at facilities, some community members are aware of services being available at facilities. One participant of a male focus group responded, “I think that she should go to the hospital” in response to a question about what a woman with an unwanted pregnancy should do. However, he further stated;

Interviewer: Do you think that the girls are afraid of going to the health facility?

Answer: Yes they are often scared, because if they go there, they are usually mistreated by the nurses. (Male FGD)

Interestingly, problems with the attitudes of health workers were noted nearly as often by the health workers themselves as the community members. Not surprisingly, the women who were being interviewed in the facility did not mention being mistreated, and all were highly complimentary of the staff and the treatment they received. While all provisions possible to ensure their privacy were taken, it is not surprising that women were not eager to disclose if

they felt they had received poor service. It is not possible to know whether community members who were interviewed were speaking of personal experiences they had, or were relating stories of others they have known when discussing the care young women receive at the hospitals. What is clear, though, is the pervasive expectation of mistreatment at facilities. Details were not given, but being “shouted upon” or health workers having poor attitudes towards women seeking services for abortion care were mentioned regularly. This was not a topic which I specifically asked about in the interview and focus group guides, but which was mentioned spontaneously by all groups of participants as a reason for low utilization of facility-based care.

A particular attitude or behavior of health care providers mentioned by participants was the idea that women are judged by providers for seeking an abortion and that women have to make a case to the providers to have the service provided. There is an idea of a woman “deserving” an abortion, based on specific criteria, which may be linked to the way the law is worded. Women cannot simply enter a facility and expect judgment-free care. Many participants, especially health care providers, made note of some providers feeling they are able to provide abortion services, while others do not feel able to provide these services. As the following interaction shows, women are aware that they may not be given an abortion at a facility and are understandably less than eager to be at the mercy of a provider who may or may not provide them with an abortion;

Interviewer: Do ladies go to the health facility here to access abortion services?

Answer: As for the doctor in charge here, if you go there to seek for such services, he will sit you down and advise you to go and have the child

Interviewer: Even if she cannot take care of the child?

Answer: Yes, that is the main reason you will have to protect yourself. (Female Focus Group)

This participant seems to be saying women know the doctor at the local hospital will not provide an abortion for them, so they are left to take care of themselves. When women are subject to a confusing and vague law and at the mercy of how a particular health workers interprets this law, it is no wonder that they would rather avoid the situation altogether.

As another midwife explains, if the doctor feels that the woman has a “good enough reason” for needing an abortion, it will be done, but otherwise it will not.

Interviewer: If a woman becomes pregnant and does not feel that she can care for the baby, how can she legally end her pregnancy?

Answer: She should see a doctor and discuss her problems and if the doctor feels like it can be done, then it will be done for her.

Interviewer: So the doctor does it based on his feelings or what he thinks but not automatic that it will be done for her?

Answer: Yes, if he thinks the reason you are giving is a good enough reason, then he will do it. (Nurse, Teaching Hospital)

Another nurse at the same facility answered the same question with, “she can come to the hospital with further questions and if we feel the problem is relevant that we conduct the abortion for her, we will do so.” (Nurse, Teaching Hospital). This nurse seems to be implying that a woman must in effect state her case why she needs an abortion and if they health workers decide it is a justifiable reason, they will provide the abortion.

It is not that providers are not aware of the problem of unsafe abortion and how the women of Kumasi are impacted by unsafe abortion. All of the providers interviewed as part of this study

agreed that unsafe abortions are a big problem in Kumasi and all could tell of many patients they had taken care of who were suffering from complications from unsafe abortions. For example,

There was a young girl about a month ago who came in with serious bleeding and was in shock after inserting some herbs into her vagina. Unfortunately she died. (Nurse, Teaching Hospital)

A midwife at the same facility recalled a patient she took care of;

One came in with septic abortion; she took this organophosphate chemical, and I learnt it is a fertilizer used for farming. When she was brought in, we tried our best to resuscitate her but unfortunately, she died. (Midwife, Teaching Hospital)

Even those women who do not die of the complications suffer morbidity, some of which are permanent;

Interviewer: Have you recorded any cases where a woman or girls goes to do abortion and rather ended up terminating her own life?

Answer: Yes, there are numerous cases like that. There are occasions that if they don't die trying to do it, they suffer a lot of organ damage that leads to the inability of the woman to have any children in the near future. (Female Focus Group)

Providers are often conflicted when it comes to abortion services, recognizing on the one hand that women are in need of services, while at the same time, feeling the need to balance their own and moral and religious beliefs. As one nurse said,

With the services, some providers...think 'my religious belief does not allow me to do such things'. Sometimes they think that they are killing the baby and will be guilty. Some also feel that it is the patient's right and will have to help the patient to avoid quack attempts and post-abortion complications. (Nurse, Teaching Hospital)

This nurse expressed what many participants noted; while health care providers recognize there is a serious need to help women avoid unsafe abortions, they are not themselves willing

to provide the service because they feel they are taking a life. A midwife at a district hospital said, “Some of the clients, when they come, they will say they are looking for the woman who does abortion as if that is the only thing I have been doing, but still I offer services.” (Midwife, District Hospital) While she does not like being associated only with providing abortion services, she continues to do them to help women. This personal dilemma for providers is real and should not be discounted. Just because someone has been provided with the technical skill to provide a service and there are people needing the service does not mean they should be compelled to do so if it is against their moral or religious convictions. Ensuring that providers do not push his or her own judgments onto a client is an integral component of values clarification training in which providers go through exercises to understand their own biases and learn strategies to provide non-judgmental care even if they do not feel they are able to provide termination services (Mitchell *et al.*, 2005).

While most nurses did not feel there was stigma surrounding those who provide family planning services, including abortions, some of the nurses do feel pressure because they offer services. As one nurse said, “Day in and day out, I have some people tell me that when I offer such services, I am helping that person be promiscuous.” (Nurse, District Hospital). It does not matter that research points again and again to comprehensive sexual education and services reducing risky sexual behaviors, even among adolescents, rather than, as critics fear, increasing it (Kirby *et al.*, 2007). In settings such as Ghana, where conservative social norms are loudly voiced and have permeated all interactions, providers who are providing these services for women are sometimes disparaged and ridiculed.

Another midwife who is a self-described “comprehensive abortion care provider” at the same facility said, “Yes, for that one they even give us mockery names in the hospital as soon as they see you coming. Some of them also call us killers and all sorts of names.” (Midwife, District Hospital)

Many of the providers, however, have reasons they provide family planning and abortion services. For example:

Interviewer: Why do you provide these services?

Answer: It is needed to reduce maternal mortality especially, because most of these women come with a lot of complications which usually leads to deaths. So we provide it because it is needed and it also our duty to provide it. (Midwife, Teaching Hospital)

It is important to make clear that most health care providers entered their field in order to help women be healthy and to reduce maternal and child mortality. The high rates of mortality among these groups are well known and everyone with whom I have spoken is highly dedicated to helping the situation. While the quality of care women receive when they seek services for an induced abortion, or contraception, is of the utmost importance, simply blaming frontline healthcare workers is simplistic and naïve. Providers must be trained, supported, and held accountable for their actions. Without those systems in place, it is not surprising that there is documented poor quality of care and that this is negatively impacting women’s willingness to seek abortion and contraception services.

Keeping the pregnancy a secret

The idea that women who are faced with an unwanted pregnancy desire to keep the pregnancy and the abortion a secret, at least from becoming general information, is not new information. However, how this desire interacts with other factors to cause some women to self-induce their abortion, and others to use a facility, has not previously been investigated in Ghana. For example, a woman seeking services for post-abortion complications said, "I didn't want my mother to know that is why I tried to terminate myself." (23 year-old, PAC client, district hospital) This client had used drugs from a chemical seller before to induce an abortion successfully. As one nurse from a District Hospital said;

Interviewer: The women who visit your facility, where do they start their abortions?

Answer: They start from their house. First and foremost, she doesn't want anyone to know of her pregnancy, so she will do it secretly. It is only when things become complicated, when she has to choose between hiding the pregnancy or losing her life. (Nurse, District Hospital).

While some women know they can get an abortion from a clinic, because they want to do it privately without many people knowing, they are more likely to induce at home, and seek care if there are complications. The following interaction during one of the community focus groups shows this;

Interviewer: When the girls or ladies want to abort their pregnancies, what do they do?

Answer: In my community, there are some individuals who are believed to have special skills when it comes to aborting pregnancies, so they go to them and then some herbal mixtures and concoctions are prepared for them.

Interviewer: Do they ever remember that there is a clinic there that they can seek help from?

Answer: Yes they know that there is a clinic available, but because they don't want any soul to know of their state, they sneak to these people for the procedure. (Female FGD)

A midwife from the Teaching Hospital says there is more than one reason why women begin their abortions at home;

Interviewer: We know that many women start their abortion in their homes. Why do you think they do this?

Answer: They have so many reasons. Some of them say that they don't want to come to a bigger hospital like this to see other parents or friends who will know that they are coming here for abortion. Some of them also think that it is too costly and some do not want to be seen by anyone that they are pregnant. That is why they start it at home thinking that it's all going to be well with them. (Midwife, Teaching Hospital)

Cost was not mentioned nearly as much as many of the other factors influencing women from seeking care at hospitals or clinics, although there is some indication women are aware that if they begin an abortion at home and present to the facility with complications, their treatment will be covered by the National Health Insurance Scheme. There is some evidence for the assertion that individuals move from self-medication or informal healthcare provision to formal healthcare when they are insured and their care is covered by insurance (Fenny *et al.*, 2015). A nurse from the Teaching Hospital was one of the few in this study to refer to this responding to a question about whose responsibility it is to pay for the treatment of post-abortion complications, saying, "The health insurance; that is if the person is having it. But if she doesn't have [insurance], she pays it herself." (Nurse, Teaching Hospital). In conversations with family planning leaders in Ghana, this issue was raised frequently, although not surprisingly, none of the women who are included in this study mentioned reduced cost as a reason to self-induce. They may have felt this was something they should not talk about; that by beginning the abortion at home and then presenting once they had started bleeding, they avoided the costs associated with an elective abortion. However, presenting to the facility once bleeding has

begun is another way to keep an abortion secret. If bleeding has begun, the complications are indistinguishable from a miscarriage. By initiating an abortion at home with drugs and then presenting to a hospital, it is possible for women to indicate they are suffering a spontaneous rather than induced abortion.

Interestingly, keeping the pregnancy a secret was also a reason noted by women seeking services for an induced abortion for having it done at a facility. As one woman said, "I can't tell anybody but will only go to the hospital for solution." (27 year-old, CAC client) When asked how she knew she could access an abortion at this facility she said, "This is where I attend clinic...when I came I asked and was told I could end the pregnancy here." This was one participant who did not want to engage her social network; she was not willing to disclose to anyone that she was pregnant and so chose to come to the facility.

The Decision to Have an Abortion

While international documents and agencies stress the need for women to have autonomy over their reproductive health care, and suggest that if women are able to act autonomously they will seek safe rather than unsafe abortions, the women in my study appear to be acting with full agency when they decide to terminate their pregnancies. Many of the participants in my study suggested that women are acting autonomously and are not clandestinely aborting, but choose, of their own volition, and with the help of their friends, to terminate their pregnancies in their homes. For example, a nurse from a District Hospital said;

Interviewer: Who decides where a woman should seek for abortion services?

Answer: It is the lady herself. After all she is the one carrying the baby. About 80% of these girls go in for abortion even without their parent knowing that they were pregnant. (Nurse, District Hospital)

These women were not controlled by even their husbands, when they had husbands, in their decisions to act. A 27 year-old who was being treated for post-abortion complications at a District Hospital answered a similar question, suggesting she was able to act completely autonomously;

Interviewer: Whose decision was it to end this pregnancy?

Answer: It was solely my decision to end the pregnancy. My husband was not aware of it. I also had my personal money on me. (27 year-old PAC client, District Hospital)

Many of the women interviewed as part of this study were encouraged by some to keep the pregnancies, but this does not discourage women once they have decided on a course of action. As one participant of a focus group said, "The girls are very stubborn. Even if they go and do it, they won't even bother to tell you." (Male FGD) A woman seeking care for post-abortion complications said that when she told her partner about the pregnancy, "he said that even though it wasn't planned he did not want me to do an abortion." (20 year-old PAC-client) Another woman said, "I had a couple of people telling me not to do it [terminate], but because I didn't want it, I terminated it." (32 year-old PAC client).

Women are willing to oppose the wishes of nearly everyone once they have decided they do not want to continue a pregnancy. The following exchange between a 20 year-old and the interviewer shows this;

Interviewer: Who was with you when you realized that you were pregnant?

Answer: It was my mother

Interviewer: Did you discuss with her about aborting the pregnancy?

Answer: Yes

Question: Did she agree with you about aborting the pregnancy?

Answer: No, she refused to allow me to do it.

Question: So who showed you how to abort the pregnancy?

Answer: It was a friend that I was discussing it with her. 20 year-old PAC client, District Hospital.

When her mother would not allow her to have an abortion, she instead talked to a friend about it and was able to terminate the pregnancy. These girls and women are acting with a lot of agency and are deciding themselves, sometimes against the wishes of those closest to them, to end their pregnancies. Of course this sample is biased; women who were convinced or coerced to keep their pregnancies would not be captured in these data. However, these women suggest that it is not a lack of agency or autonomy which is causing them to opt to self-induce rather than seek care at a facility. The women included in this study sometimes had help in ending their pregnancies, but even if they encountered resistance from someone they had engaged to help them, this did not deter them. Rather, the women still went ahead with the termination, just without the knowledge of those who they knew were not supportive.

This is not to discount the influence of others on a woman's ability to induce an abortion in a facility. If, for example, women were able to advocate for their rights to an abortion, or had other advocating on their behalf, perhaps they would not choose to self-induce rather than face the treatment they might receive at a facility. However, the women in this study did not report feeling that they had self-induced because of a lack of choice or agency. They rather reported the decision to self-induce as a decision they, or their friends, made.

The Influence of a Woman's Social Network on Where to Terminate

Due in part to the legal and health systems reasons for women deciding to induce their abortions at home, and negative experiences that friends have, women learn of how to terminate their pregnancies while avoiding the formal healthcare system from their friends or others in their social network. Women discuss their unwanted pregnancies with others they know have also had unwanted pregnancies, seeking advice and guidance. As a nurse at a district hospital said, "Most of them [women seeking abortion services] get these informations from their friends who may have gone through such procedure before." (Nurse, District Hospital) The consultation of a woman's social network is not isolated to matters of reproductive health. In her work among urban Accra market women, Pellow (1977) wrote, "the idea of working out the problem independently is not to be considered." (pg. 136). It is imperative to remember that the decisions of where to seek treatment start well before treatment is begun. How the health system fits into women's social and cultural lives will determine to what extent it is used. Even in places like Ghana, where health services of a reasonable quality exist, they may not be used because other factors are taken into account when potential clients are deciding how to deal with a health crisis. Just as important as whether the services exist are issues such as client knowledge about what services are offered, education about when it is appropriate to use health services and the cultural norms around treatment (Ensor & Cooper, 2004). The women who were seeking services for an induced abortion reported more interactions with the formal health system than did the women seeking services for complications resulting from a self-induced abortion. For example, the women seeking services for an induced abortion had heard that it was available during post-natal visits, or other visits to the facilities. For these women,

the health system fits into their lives in a different way than for the women who opted instead to self-induce.

In this setting, and among many of the women interviewed for this study, it is culturally more acceptable to induce an abortion at home and seek care for any complications that might arise, than to seek care for comprehensive abortion care at a health facility.

The girls involved in abortion get their information from friends, neighbors and all manner of people. All that a girl needs is to tell her problem to someone and the next time, she is being shown where she can get help from. They tell them to buy all sorts of things. (Female FGD)

These women and girls know whom to speak with and are generally willing to follow the advice they receive. Since these other women were successful at terminating their pregnancies, women trust the advice they are given.

They go to people who have done abortion before and then they inquire about how they manage to get rid of their pregnancies and if they have any help that they can give to them so that they too can get rid of their pregnancy. (27 year-old PAC client, District Hospital)

Although most participants self-induced using a medication abortion regime they acquired from a pharmacy or chemical seller, there were some allusions to quack doctors or lay people who provide abortion services. When there are individuals in communities who provide these services, others hear of their success and patronize them when they need the service. For example, a nurse at a District Hospital said,

We have some people in the community who believe they can do everything. They even pose as doctors in the community, so in situations like that they will want to offer help.

Because they have been successful with one or two people, the people within the community look up to them for such services. (Nurse, District Hospital).

One woman tried *adutwumwaa bitters* to abort her pregnancy, but when it did not work, she sought services at a facility. As Adongo *et al.* (2013) says, “These herbal preparations have been licensed by the Food and Drug Authority in Ghana for the management of other diseases but are contraindicated in pregnancy. Adverts for these herbal preparations specifically mentions that women who are pregnant should avoid taking them, and so these drugs have been misconstrued as abortifacients and used by community members to induce abortion.” (pg. 8) I could find no references to the efficacy of *adutwumwaa bitters* in aborting a pregnancy, which suggests this has not been studied.

Many women use a combination of advice from friends and covert purchase from a chemical seller. Friends are often enlisted to do the actual purchasing and perhaps even the dispensing of advice on how to take the drug;

Interviewer: Who in the community provides abortion services?

Answer: It is the pharmacists and the quack doctors.

Interviewer: Do women have access to misoprostol in the community?

Answer: Yes they do.

Interviewer: Where do they get it from?

Answer: From the pharmacy shops.

Interviewer: How do they know how to use it?

Answer: The pharmacist gives them the instructions. Some also gets the instructions from their friends who have used it previously. Their friends prescribe it for them and they also go for it. (Midwife, Teaching Hospital)

Friends take the place of the givers of professional advice, as well as procuring the drug from pharmacies or chemical sellers.

In most of the cases, such services are from friends. You tell a friend that you are pregnant and the next thing she will tell you is that “oh, you can take this drug”. The

person won't actually seek professional advice, but rather from a friend. (Nurse, Teaching Hospital)

A young client also being treated for post-abortion complications tells of how she obtained the drug she used;

Interviewer: What drug did you use?

Answer: I don't know the name.

Interviewer: Where did you buy it from?

Answer: It was my friend who bought it for me... My friend who bought it for me, she has had an abortion before. (20 year-old PAC client, District Hospital).

This young woman does not know the name of the medication she used and she did not herself receive information on how to use it. She relied completely on her friend buying the drug and relaying its dosage and usage.

While many of the participants in this study did mention women wanting to keep their pregnancies and abortions a secret, and the stigma associated with unwanted pregnancies and abortions, the following exchange shows that, in the experience of this midwife, it is ignorance more than stigma that causes women to induce at home. Women take drugs without knowing what they are, only that their friend or boyfriend has told them it will terminate the pregnancy;

Interviewer: Are women in Kumasi suffering from unsafe abortion?

Answer: Oh yes.

Interviewer: Why do you think so?

Answer: I think ignorance, not because of stigma. From most of the cases that come to our facility, when you talk to them, you will realize that they are so ignorant about the drug that they have used. (Midwife, Teaching Hospital)

While some of the women interviewed knew the name of the drug they took (Citotec), many did not.

Interviewer: What is the most common way that women or girls within your community get rid of their pregnancies?

Answer: Over here I have heard that some of the girls grind broken bottles and then they mix it with Malta Guinness then they drink it. I hear of late they use a certain drug that is white in color and round in shape. They say that it works quicker than any other method. Some of them take it orally whilst others also insert it into their private parts. I have seen a number of them do this. (Male FGD)

While members of the community know what the drug looks like, and even how it is used, they do not know the name, and while the regimen is to both take it orally and to insert it vaginally, this community member seems to be saying that people know it as one or the other.

Women who have themselves accessed safe abortion services from a facility recognize their position now as a giver of advice. As one 19 year-old who was seeking care for complications from a self-induced abortion at the district hospital said;

Me for instance if someone ask me about it I will ask her to go for Family Planning and prevent unwanted pregnancy. If she becomes pregnant too, I can direct to the right place. (19 year-old PAC client)

While she may not be willing to offer her knowledge unless asked, if asked she will direct others to the facility where she received care.

Those participants who had come to the facilities for an induced abortion also reported learning about where to go from friends or others in their social networks. For example,

I discussed with my sister and husband. My sister said a certain lady also once had an unwanted pregnancy and told her she went to <District Hospital> for the termination so she would take me to that person. My sister's friend as I have already told you, showed me the place because she also had her problem solved here (32 year-old CAC client, District Hospital)

Many of those patients seeking care for induced abortions were directed to the facilities by their friends or sisters. As one said, “A friend asked me to come to this facility because she has been helped out before.” (27 year-old CAC client, District Hospital).

Conclusion

Women faced with an unwanted pregnancy consult many people about their predicament. They often make a decision to abort with their male partner, although if they want to abort and their partner does not want them to, they will do it without telling him. How the decision-making process to induce an unwanted pregnancy interacts with the nature of the relationship (i.e. was it mainly transactional in nature?) was not an area that this study initially set out to investigate and could use further explicit study.

Women with an unwanted pregnancy discuss their pregnancy with friends and less often, family members. Friends tell them where they can go to get a drug to induce the abortion, or which facilities they should access to have an abortion. These friends are often the ones who purchase the drug and have the interaction with the pharmacist or chemical seller, or who accompany the woman to the facility. The experience of the friends or others in the social network of the pregnant woman whom she engages to assist her with her termination in large part determines where and how she induces her abortion. For many women, inducing at home is the normal course of action, and this then diffuses out through a social network.

These findings have resulted in the development of the Theory of Abortion-Seeking, presented below in Figure 8.

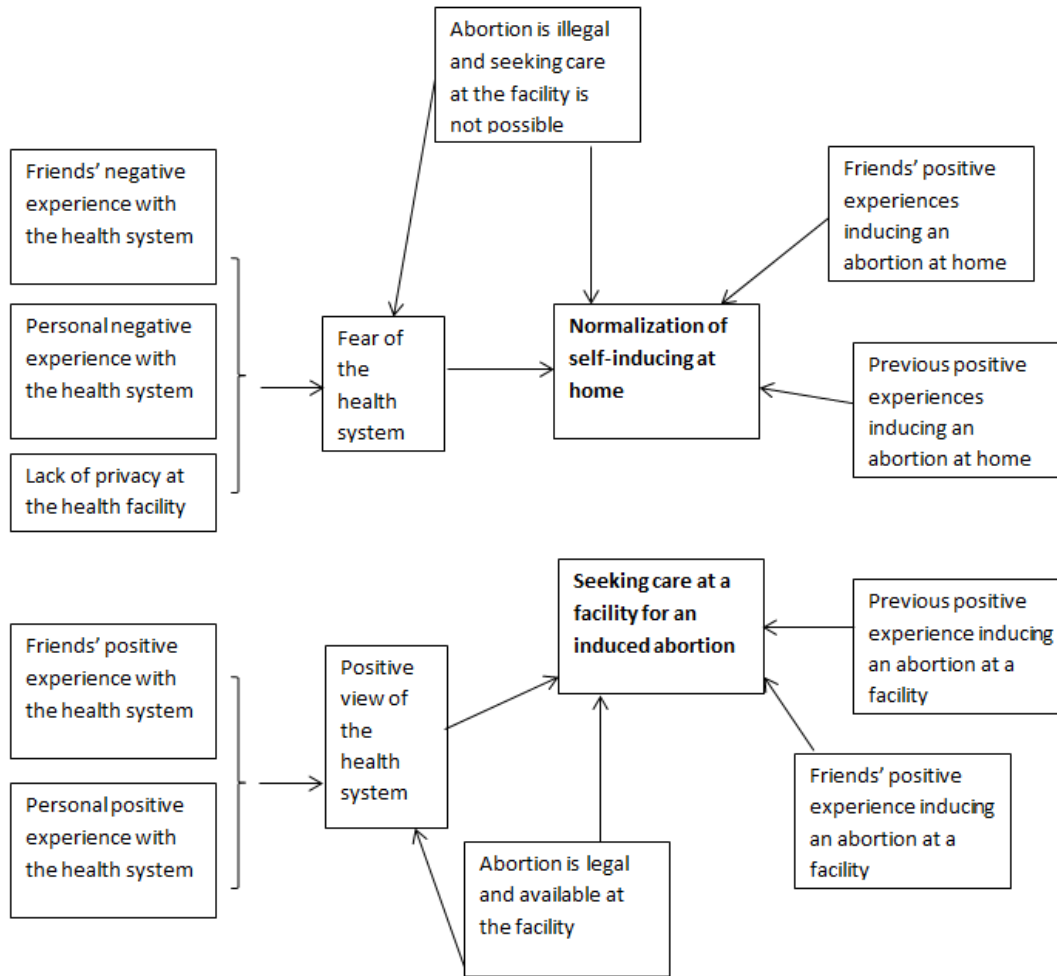


Figure 10. Theory of abortion-seeking

For those women who are more comfortable inducing at home than in a facility, this phenomenon has come about for many reasons. Many of these reasons can be discussed in terms of quality of care, including the reputation health workers have for shaming women seeking care for abortion services and a lack of coordination in the facilities. Other reasons are discussed in terms of personality of the woman herself, such as being shy about asking where in a facility to obtain the service. However, even this is a health system issue brought about by a

lack of high quality care for women. Those factors interact to induce some women to develop a negative view of the health system and to fear seeking services from health facilities.

Improving the quality of care patients receive when they access health services has been a Ministry of Health priority since at least 2002 (MOH 2002). However, it seems there is still much work to be done in this area. The quality of care issues around abortion are highly interlinked with the issue of the legal status of abortion.

The legal status of abortion in Ghana is a murky area even for healthcare providers who have been trained in the procedure. There are some who provide the service as if it is fully legal and there are those who know that unless a pregnancy is the result of a rape or incest, or it is endangering the woman's life or health, it is not possible for them to induce an abortion legally. Young women who will not be able to continue schooling due to a pregnancy, or cannot afford to raise a, or another, child may encounter a provider who tells them they are unable to help end their pregnancy as it does not technically fall into one of the allowable categories. This level of uncertainty, coupled with health care providers who may or may not be sympathetic and may blame a woman for becoming pregnant, is enough to deter some women from seeking services at a facility.

Further, due to the social nature of how Ghanaian women seek health care services, when one woman has a negative experience with the formal healthcare system, she is likely to recount that to her peers and friends who find themselves in a similar position. Further, when women in

the community have a positive experience aborting their pregnancy at home, their social network hears of this. It is through this process that inducing an abortion at home, and seeking care for complications if they arise, has been normalized for many of these women.

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Chapter 7: Implications and conclusions

This study grew out of a desire to answer the question, if abortion is legal and available in Ghana, why do so many women end up in the emergency gynecology wards of the nation's hospitals with complications from unsafe and self-induced abortion? What I discovered, as I expected, was there is not a simple, straightforward answer to that question. If there were a simple answer, and a simple solution, the problem would have been solved years ago. What I found throughout the duration of this study is the decision women make to terminate in a facility versus at home via self-induction is not made in isolation, nor is this decision separate from how decisions to seek any kind of healthcare are made. Issues around reproduction, including sexual behavior, the decision to use or not use contraception, and what type, and what to do in the event of an unwanted pregnancy, are highly intertwined with the role of women in society, the societal and cultural norms around sexuality and sexual behavior, the power women have and wield over their bodies and their lives, and importantly how the formal healthcare system does or does not fit into a woman's life. Abortion in Ghana is not a singular issue disconnected from all of these other issues. I reported the reasons why some women choose to terminate via self-induction rather than in a facility in the previous chapter. In the

paragraphs below, I will report on strategies to reduce the negative health effects of unsafe self-induction and how these findings are relevant not only to the issue of abortion in Ghana, but also the issue of unsafe abortion in other countries, and wider issues of health services utilization in many settings.

Unsafe abortion in Ghana is widely recognized as an issue which needs to be addressed and the types of interventions needed to address the problem are multifaceted and widespread. Most of the participants in this study knew someone personally who had suffered complications following an abortion and they had many opinions about what can be done to combat the problem of unsafe abortion in Ghana. I will add to these ideas a few ideas of my own which I gained from this experience. These interventions include outreach from the healthcare facilities and community education around issues of sexuality and contraception, for women as well as men. Some participants even believe it is time to include comprehensive sexual education in schools. There is an urgent need to improve the quality of care women receive at facilities, for all reasons including the seeking of contraception and abortion services.

Abortion in Ghana is a regular occurrence, something everyone knows about, yet few people like to discuss explicitly or openly. It is, as Rossier (2007) said of abortion in nearby Burkina Faso, an “open secret”. However, even though it is widespread, public discourse and societal acceptance has not kept pace with behavior changes. While premarital sex is common, the culture of seeking and using contraception has not caught up with the norm of engaging in these premarital sexual relationships. Even though openly discussing and accessing abortion is

not socially acceptable, everyone with whom I spoke as part of this research knows that Ghanaian women have abortions and have them frequently. Most knew of at least one person who has had an abortion, and many knew of women who had been severely injured, or even who died, because of complications from an abortion. While women make the decision to keep or end a pregnancy for many reasons, sometimes contrary to what people in their lives would like, it is not that they act alone. Women discuss their decision to terminate with others they know have successfully had an abortion and whom they trust to keep their secret. Women also discuss their unwanted pregnancy with others in their social circles, including mothers and partners. However, when these individuals urge them not to engage in the abortion, the women navigate other means to secure their abortion. If they have made the decision to terminate, they are not dissuaded by parental or partner desire or expectation to carry the baby to term. Naturally, the women with whom I spoke fit this picture as they have all engaged in pregnancy termination. The women who were convinced by their friends, family or male partner to continue their pregnancy were not captured in these data. However, this idea of women making this decision was emphasized in the focus groups discussion as well. As one of the participants said, “You see, once a woman decides that she doesn’t want the pregnancy, anything you do, she will abort it.” (Male FGD). Once women have made the choice to end their pregnancy, some choose to engage the formal healthcare system to obtain a safe abortion in a facility. However, there are many women who, for multiple reasons, choose instead to acquire medication from a pharmacy or chemical seller, or less frequently herbs from a traditional healer, and induce their abortion at home, choosing to seek services at a health facility only if complications arise.

Much of the existing literature on interventions to address the sexual and reproductive health needs of people living in Africa comes from the HIV/AIDS literature. While some of it is not relevant to my study, much of it is. I will draw on that literature to frame some of my findings and some potential interventions.

While the issues around unsafe abortion in Ghana are multifaceted and complex, they are not intractable. Some of the ways to combat this problem, as raised by my participants and augmented by my own conclusions, are presented below.

Public Discussion and Community Education

While the culture of secrecy surrounding abortion in Ghana is well known, there are few who think it is a situation which should continue as it currently stands. There are some who insist Ghanaian culture is not ready to accept the changing situation and that adolescents should be kept from information which they fear will encourage them to engage in premarital sex.

However, this assertion is not supported by much of my data. Rather, many of the participants in this study expressed ways to help women gain access to services for both contraception and safe abortion. The following exchange during a community-based focus group shows a recurring theme of these findings:

Interviewer: What do you understand by abortion?

Answer: In my opinion, when we talk about abortion, it means getting rid of a pregnancy that you don't want, either by taking in some drugs or going to the hospital and have a doctor remove the pregnancy for you.

Interviewer: Where do you think that most of the abortions are done?

Answer: Most of them are afraid of going to the hospital, so they do it at home. So in the case that they are bleeding profusely, that is when they are rushed to the hospital.

Interviewer: why don't the girls go to the hospital?

Answer: They are afraid as a result of mistreatment that is often meted out to them anytime they want to access such services. Some also say that it is very expensive.

Interviewer: So why do you think that these girls want to terminate their pregnancies?

Answer: A lot of them are not prepared to be mothers, some of the boys or men refuse responsibility for the pregnancy

Interviewer: In your community, do you often have girls dying as a result of unsafe abortions?

Answer: Yes, a lot of girls have died as result of unsafe abortions.

Interviewer: What can we do to prevent all these untimely deaths?

Participant: I think you have to talk to the children.

Interviewer: We rather?

Answer: yes, because in our setting here, mothers and their daughters are not able to talk when it comes issues of sex and pregnancies because they are shy. So if the healthcare providers can move from community to community, to educate them about the dangers of abortions and also the benefits of family planning, I think they will listen to you more. (Female FGD)

This excerpt outlines the issues which I will be delving into further in this final and concluding chapter. This participant knows what abortion is and knows there are different ways to bring an abortion about (either by taking drugs or going to a hospital). She knows of young girls who have died because of complications from unsafe abortion. In her opinion, women abort for varied reasons; they are too young or they are on their own to raise the baby because the father will not "take responsibility". She thinks women are afraid to seek services at the hospital because of the way they are treated by the staff, but she also sees the health system as part of the solution. She further acknowledges the inability of parents to talk to their children explicitly about sex and contraception and implores health workers for help. So, while she is not happy with the care that women in her community receive at the facilities, she is asking for

help from these same people to educate the young women in her community about family planning and safe abortion methods.

There are examples of community-based delivery of family planning services where health workers take contraceptive services into the villages, or even into the households, of potential users. These interventions can counter multiple barriers including misinformation, ignorance, reluctance to seek services in health facilities and cost (Ensor & Cooper 2004). These interventions can overcome some of the major demand-side barriers, such as fear of side effects and reluctance to seek services at facilities, with a supply-side, health system-focused intervention. A model like that could be helpful in Ghana, even in an urban area where there are family planning methods available at facilities, but some women are hesitant to patronize them.

The need for high quality education. As was discussed in an earlier chapter, many of the participants in this study had serious misgivings about using contraception, which were often not evidence-based. Some of the participants of my study, while echoing that abstinence is the ideal, are aware that this is perhaps not realistic. The following exchange during a male focus group demonstrates this:

Interviewer: what do you think can be done to salvage the situation?

Answer: I think that they have to be more careful. If they think they cannot abstain, then they should go in for family planning methods. And also the men, they should also try and use condoms.

Interviewer: Is there anything else you would want to say?

Answer: Ok, what I will like to say is that if there is any benefit or any side effects associated with family planning, you should come out and educate us on it. Because there is so much speculations out there that we do not even know which to believe.
(Male FGD)

While this participant seems to think that abstinence before marriage is what is best, he realizes many young people are going to engage in sex. They therefore need better education about how to protect themselves from unwanted pregnancy, both men and women. There are a few of the participants who chose highly effective forms of contraception after being treated for their complications and going through counseling, which is an important part of the treatment for post-abortion complications. One client being treated for complications after a self-induced abortion, who has had three previous abortions and, when asked if she had even used family planning, said, "Please no. It has not occurred to me to use any", and who, after counseling this time, chose the IUD said this about the current situation in Ghana:

For now what I can say is that if you are able to use family planning it will be better for you but the education on the use of family planning has not gone far so there are still a large percentage of us who are not aware of family planning methods and some doubt the efficacy of some of these methods. Some of the women are of the notion that when it is time for you to give birth, if you were on family planning method, it becomes very difficult for you to conceive hence their reluctance in the use of family planning methods. Some are also afraid to use it. Some of them are also misinformed by people who have previously used some of the methods. So with all these most women are not even encouraged to go seek family planning methods. (27 year-old PAC client, district hospital)

Although she has had three previous abortions, contraception did not occur to her before.

While she mentioned that some of her peers are not aware of family planning methods, many had been influenced by what they heard from friends about negative experiences with contraception. She went on to say, "no please, there are no side effects associated with the use of family planning methods. I believe that my fellow sisters out there should also come here so that they can be educated on the use and benefits of family planning." While this is overall heartening, it is also somewhat concerning, as the IUD is associated with side effects which are

totally normal, such as menstrual changes (Jarin *et al.*, 2015). This woman has, for the first time, accepted a family planning method, and a highly effective one, potentially saving her from needing to unsafely terminating any pregnancies in the future. She finished her interview by saying, “I would like to say that the education on family planning should be intensified so as to sensitize women about the benefits of family planning. And also it will help reduce unwanted pregnancies and reduce maternal deaths.” This is undoubtedly a positive outcome. However, I believe it should be regarded with a bit of caution; if this woman experiences side effects she is not expecting, she may think there is something wrong with the IUD and may decide to stop using it, and may even tell her friends about the negative side effects she experienced. It would be better if she were fully counseled as to what side effects she could expect and for how long she should anticipate these lasting. However, perhaps she will continue to use the IUD she had inserted and will not have any more unwanted pregnancies, or if she does experience side effects, now that she has had a positive experience with the health system, perhaps she will return to this facility to discuss with a healthcare provider the issues she is experiencing.

One midwife said, “I think what most of them [women] need is a series of education of contraceptive use, because most of them don’t even know anything about contraceptives.”

(Nurse, Teaching Hospital) The setting for this kind of education is somewhat controversial.

Although many of the women who were counseled as part of their treatment for post-abortion complications adopted contraception, surely there are ways to educate women before they are being treated for complications which can be life threatening. Maintaining health workers as the educators of choice is potentially problematic. For sensitive topics, and family planning is

certainly a sensitive topic, there are indications that peer educators are potentially a higher yield investment (Brieger *et al.*, 2001). Given the importance of women's social networks found in this investigation, these findings would support the use of women's peers to educate them about where to access services. In a hierarchical society, such as Ghana, women may struggle to ask questions they have for fear of looking stupid to healthcare workers, who are afforded respect in Ghanaian culture (Andersen 2004).

A 27 year-old woman being treated for post-abortion complications chose the implant after this experience. She said, "The things I have heard about family planning have really helped me. I will want to urge my fellow women to, as a matter of urgency, come to this facility to seek help in times of trouble." Hopefully this woman takes this upon herself and talks widely about her positive experience.

Ensuring young women have access to the information they need to understand how their bodies work and to make informed decisions about whether to use contraception is imperative. There are indications that many Ghanaian women do not receive education about their bodies and how ovulation and fertilization occur (Mac Domhnaill *et al.*, 2011). A multi-pronged approach may be the best way to address the needs of Ghanaian women and their male partners to reduce the burden of unwanted pregnancy. In a large, multi-country evaluation, Agha (2002) found coupling mass media with peer education and establishing youth-friendly services was the best way to improve the health behavior of youth. My study has deepened the understanding of how women conceptualize unwanted pregnancy and how they navigate the

health system to end their pregnancies. Previous work has identified potential areas of intervention at the individual level. For example, educating women about the legal status of abortion in Ghana (Konney *et al.*, 2009), or sensitizing and training healthcare workers on the provision of safe abortion (Morhe *et al.*, 2007) are strategies promoted by this previous work.

Schools as the health education delivery point. Community education is not a new idea and not one which is easy to implement, especially in conservative and religious contexts. However, perhaps in a setting such as Ghana where people know personally of women who have died due to complications from unsafe abortion, communities are ready to adopt comprehensive sexual and reproductive health education. According to UNESCO (2012), primary school enrollment in sub-Saharan Africa as a whole reached 77% in 2010, and in Ghana in 2013, this number stood at 87% (World Development Indicators). As such, schools could be an ideal location for health promotion education to take place. According to Ganle and colleagues (2012), sex education has been incorporated into the formal curriculum of the public schools of the country. However, teachers use language which avoids sensitive words and many youth end up more confused by the lessons. Aaro and colleagues (2006) note the importance in implementing school-based programs to improve adolescents' sexual health of cooperation among those designing the intervention and those delivering the intervention, i.e. teachers, school administrators and policy makers. If teachers are uncomfortable with the material or unwilling to engage in delivering the intervention, the students will not receive the education, no matter how well planned it is. There are some participants in my study who were of the mind that improving sex education in schools was a viable option. As one man said, "There is a need to introduce effective sex education into the curriculum of the Ghana education service."

When this is done, I believe that the cases of teenage pregnancy will be reduced.” (Male FGD).

While this may not be a widely held viewpoint, perhaps Ghanaians are not as conservative as has been portrayed and would be supportive of some of this material being discussed with their children in schools.

Targeting Adolescents. Discussing matters of sexual and reproductive health with children is not easy for many adults. As one participant answered when asked if she had spoken to her children about family planning methods, “I have never done anything like that. I am unable to talk to them about such things. I assume they are already aware of such things. It is their friends that drag them into such things. Because I am not able to talk to them, they easily pick what their friends tell them and the books that they read, it exposes them to all manner of things.” (Female FGD). There are issues of embarrassment and traditional norms, as well as the common misperception that talking about these matters encourages adolescents to engage in sexual activity (Jejeebhoy *et al.*, 2013). Although this assertion is not supported by evidence, many adults are wary of discussing sex and contraception with children.

Adolescents have been a priority population for agencies such as WHO, and improving their access to and use of health services has received particular attention, especially in specific priority disease areas such as HIV. For many of these programs, adolescents are defined as those between the ages of 13-24. In a review of the literature determining effective strategies to improve the ability of adolescents to use health services especially to prevent and treat HIV, the following strategies were identified as effective: “improving the knowledge and skills of service providers and other clinic staff; making facilities more responsive to the specific needs

of young people; reaching out from the facility into the community to provide information, generate demand and create community support; and involving other sectors, such as school and the media, to provide information and mobilize community support.” (UNAIDS 2006). I would suggest, though, that these interventions might be useful to improve the ability of all Ghanaian women to access reproductive health services. Although some of the women included in this study were adolescents, and many were under the age of 24, there were also major need in older women, and even those who are married, for improved education about and access to reproductive health supplies and information. The average age of the women in my study was just over 25 and 7 of the women who were seeking care for complications from an unsafe abortion were married. Improving the quality of services and reaching out from the facilities into the communities would benefit more than just adolescent women, in my opinion, and would benefit women even in Ghana where HIV is not as prevalent as in many countries who have been hit hard by the virus.

Abortion as it relates to HIV/AIDS Prevention

Since President Bush implemented the President’s Plan for AIDS Relief (PEPFAR), international aid for sexual and reproductive health has been largely dictated by PEPFAR’s aims and goals. Ghana has, like many African countries, taught the ABC’s of AIDS prevention: Abstinence, Be faithful and Condoms. The policy aims for citizens to abstain from premarital sex, or if they cannot abstain, to be faithful, and if they are unable to be faithful, to use condoms. This message of the ABC’s is pervasive across the country in both urban and rural areas. There have been sayings created to reflect the ABC’s including ‘preventing HIV/AIDs is as simple as ABC’, ‘just say no to casual sex’, ‘love life, stop AIDS’, ‘if you cannot abstain, use the condom’, ‘if it is

not on, it is not in', 'love life, use condom' and 'know your partner'. These messages are heard on the radio and television, are taught in peer education campaigns, and are on posters and billboard advertisements. (Ganle et al 2012). However, this policy has not been effective in stopping the spread of HIV and AIDs in the country, nor in many other countries in sub-Saharan Africa, the area most impacted by the HIV/AIDs epidemic. There are some indications that this policy has in fact been counterproductive as using condoms is condoned if one is not able to abstain or be faithful. Thus, the implicit message is that those who use condoms have multiple partners. There are indications that this has led to condoms being even further stigmatized and shunned (MacPhail & Campbell 2001). Moreover, this policy does little to prevent unwanted pregnancies, since condoms are only advocated if the user is engaging with more than one sexual partner, and other forms of contraception are not explicitly mentioned. The men who were included in the focus groups often shared negative perceptions of condoms. For example, one man said, when asked about using condoms:

Interviewer: Are condoms also a form of family planning? Do people patronize them?

Participant 1: yes, they use it a lot. But the married people don't use it.

Participant 2: Ahh! But why should be with your wife and using condoms? Condoms are used for our girlfriends and concubines, but not your wife. (Male FGD)

Given that a substantial proportion of the participants in my study who had sought an unsafe abortion were married, it is important to remember that all women need access to family planning and if men see condoms as what they use with their girlfriends, and not their wives,

there is a need for more outreach to married couples if they are not wanting to become pregnant but are reluctant to use hormonal contraception. Condoms are widely available and are known by a vast majority of Ghanaians, but it is important to stress their contraceptive function, not just their STI-prevention function.

The ABC policy certainly has not kept pace with the changing norms around premarital sexuality in much of sub-Saharan Africa. Modernization has brought about new sexual mores and realities. While on one hand, there are cultural and religious emphases on sexual abstinence before marriage especially for girls, on the other hand, there is now a segment of the society which views sex and sexual relations irrespective of marital status as normal and expected. Therefore, a policy which stresses abstinence as the ideal, being faithful as the fall back and condoms as a last resort is out of touch with reality and is, in fact, detrimental to the health of many. Family planning programs need to move beyond this abstinence-based education in order to empower individuals and couples to be able to reach their reproductive health goals.

Risk reduction—Misoprostol availability

Estimates by the WHO suggest there were fewer deaths resulting from unsafe abortion in 2008 than there were in 2003, even though there were more unsafe abortions worldwide in 2008 than 2003. The reduction in death from unsafe abortion without a corresponding decrease in procedures has been largely attributed to the availability of misoprostol in many localities (Sherris et al., 2005). Many women can and do safely induce an abortion at home using a regime of medications. In fact, this is a well-accepted and highly successful option for women who terminate with medication in many settings, including the US (Fiala et al., 2004). After and

initial counseling session, women are given the pills and instructions on how to use them and then they are sent home. This might indicate that the WHO definition of an “unsafe” abortion is outdated, and that rather than a dichotomy of safe versus unsafe abortion, there is a continuum of less safe to more safe. What is perhaps more important than who is present during the abortion or the location of the abortion, the two components of the WHO “unsafe” definition, is proper education around how to correctly administer the drug, what constitutes a complication and where to go to receive treatment if a complication should arise. This is where the health system is important.

As misoprostol has become available in the communities of Ghana, cheaply, women are increasingly using this drug to induce their abortions rather than relying on local herbs or crude surgical methods performed by untrained personnel, moving from more dangerous methods to methods which are, in many cases, safe and effective (Payne *et al.*, 2013). In a recent study conducted at the University of Ghana, all of the participants had personal experience with an abortion; either they themselves had induced an abortion, had a close family member or friend whom they helped induce an abortion or, among the men, had a female partner who had. However, less than 10% of these occurred in a health facility. Almost 65% of the abortions were self-induced by the students and over one quarter (26.1%) were helped by an untrained medical provider (Appiah-Agyekum, 2014). In this group of students, abortion was commonplace but held highly secret. Most of the students included in the Appiah-Agyekum study did not have complications from their self-induced abortion; they had successfully and

safely self-induced abortions using misoprostol which was procured from chemical sellers or pharmacists without ever engaging with local health facilities.

This is not to suggest that having misoprostol widely available is enough to eliminate post-abortion complications completely. Even when used correctly at the correct gestational age (i.e. below 9 weeks), misoprostol is effective in about 85% of cases. Thus, 15% of women will need follow-up care, usually a surgical evacuation, even if they use the drug completely correctly and at the right gestational age. If they do not receive this care, they are likely to suffer life threatening complications. Therefore, they will need to know what constitutes a condition which necessitates treatment and where to go in the case of a complication.

Misoprostol is less effective in later pregnancies, or when taken at lower doses. The women included in this study had purchased the Cytotec at pharmacies or from chemical sellers. Many of the women did not themselves purchase the drug, but had someone else do it for them. If pharmacists and chemical sellers are dispensing misoprostol, they need to be sure they are correctly calculating gestational age and they are adequately counseling patients about the side effects they may encounter and when to seek medical treatment. Although it is not the policy of the Ghana Health Service for pharmacists and chemical sellers to dispense this drug without a prescription, this is, according to these data, what is happening on the ground. Either these chemical sellers need to be more firmly regulated so they cannot sell this drug or they need to be given training so they are not putting the health of Ghanaian women at risk. Again, it is important to note that the setting of the abortion is not what makes it safe or unsafe. Plenty of

safe abortions happen in a patient's home. The important distinction is the engagement with the health system to procure and monitor the usage of the drug.

Discussion of enabling women to self-induce using misoprostol has been brought up as a "risk reduction" technique especially in localities where abortions are highly restricted, but also in places where women do not want to use legal abortion facilities (De Bruyn 2015). The most widely discussed strategy for this harm-reduction approach is known as the Uruguay Model which was developed before abortion was decriminalized in that country (Erdman 2011). In this model, women have two visits with a provider. During the first visit, they have a physical examination and receive information on the legality of abortion, abortion methods, and specific information on misoprostol use to end a pregnancy: the dosages, administration routes, mechanism of action, effectiveness, side effects and symptoms warranting follow-up care, and problems which can occur at later gestational ages.

Since the providers have no legal involvement in the abortion itself (they do not indicate where women should obtain the drug nor do they do not participate in administration of the drugs), they are shielded from prosecution. The women must obtain misoprostol on their own and can then visit the provider after the self-induction to obtain confirmation that the pregnancy ended and to receive contraceptive counselling. While this model has been lauded as a means to help women safely induce a pregnancy even in legally constraining environments (Fiol *et al.*, 2012), it has been criticized as maintaining a paternalistic health-care system where women have to endure the burden of an illegal act (Erdman 2011).

While there is limited applicability of the Uruguay Model to the current situation in Ghana (it is the interaction with facility-based care, specifically the two counseling sessions which women seem most interested in avoiding), there are other initiatives aiming to help women safely self-induce abortions with medication. These mainly use various websites for women to access information about how to safely use medication to induce an abortion (Ibis 2014). However, there are also websites which link women to willing providers in their geographic location where they can access medication and counseling (Gomperts 2014).

Given the importance of the women's social networks in deciding how to terminate their unwanted pregnancy, potential interventions could couple education about willing providers and information about misoprostol. Encouraging peer educators or outreach personnel into communities to encourage women to access correct information from nonjudgmental and willing providers could be an effective way of increasing the number of women who interact with the health system at some point during their induced abortion.

In this highly digital age, utilizing social media or smart phones to connect women with information and access to misoprostol is another potential area. Most Ghanaians have cell phones and given the reluctance women have to access care from local health facilities, if they could find information digitally, they may be more willing to interact with the health system in that manner.

Empowering women to safely self-induce is a promising way to reduce unsafe abortions, even if women remain reluctant to access facility-based services. It will be important that women engage with the health system at some point during their treatment for an abortion and it is this engagement with the healthcare system, in my opinion, which differentiates a safe from an unsafe abortion. Women can safely self-induce an abortion at home, given that they know how to take the appropriate medications and how to access care if a complication arises. This leads then to a need to induce women to seek care from the health system at some point, and, if my data are to be believed, this necessitates a change in the culture of care women receive at the facilities.

Health System Culture Change

While some women may continue to prefer to self-induce at home, in order to have a safe abortion, they will still need some interaction with the health care system. Therefore it is important to improve the quality of care women receive in facilities. As noted earlier, the women who participated in this study reported positive experiences with their treatment. However, there was no objective assessment of the quality of care women received, and the reported high levels of quality of care may be due more to the setting of the interviews than that they were truly highly satisfied.

As indicated from the focus group discussions, there are some large-scale culture-of-care changes that could increase the rate of change from one where health matters are dealt with at

home and care at facilities is sought if complications arise. This sort of culture change is not easy nor can it be expected to happen quickly, and it will require cross-sector interventions. When the formal healthcare system has not, historically, offered high quality care and has not been responsive to the needs of its people, populations tend to use informal means of healthcare at higher rates, and they tend to use a combination of Western and traditional medicine (Scrimshaw *et al.*, 1992). There are many indications that the participants in this study had previous negative interactions with the formal healthcare system. While many participants were hopeful that the health system could offer some support to reduce deaths from unsafe abortion, some participants were comfortable placing the blame in their assessment of problem squarely on the shoulders of healthcare workers:

Interviewer: Is there something also you would want me to know?

Answer: You should talk to the nurses here so that they stop driving people away from the facility with their attitudes. (Female FGD)

Improving the quality of care that women receive when they come to facilities is a hugely important issue, and one that is increasingly getting attention from the international community. Beginning a few years ago, Disrespect and Abuse (D&A) during childbirth was widely documented and noted to be a violation of women's basic human rights (Bowsver & Hill 2010). Although shocking to many Western audiences, the idea of women being shouted at and sometimes hit or even beaten while delivering has been a normal condition in many places. While D&A during childbirth is most definitely shocking and terrible, childbirth is not the only time this kind of treatment is documented. In South Africa, nurses have attempted to stigmatize teenage sexuality, and scold and treat young women harshly when they seek reproductive health services (Wood & Jewkes 2006).

Women, regardless of their age, need to be able to receive high quality care either for contraception or for abortion care from non-judgmental health workers. Supporting health workers and holding them accountable for how they treat their patients must be tackled. One strategy to improve the ability of young women to access services is a call for having “adolescent-friendly” days at family planning clinics (WHO 2012). If these could be staffed only by those workers who do not think negatively of young women and girls seeking family planning services, and the service were publicized, this could be a way to engage these young women with the health system to prevent the complications from arising. Generally speaking, adolescents want services in which they are treated with respect and which protect their confidentiality (WHO 2012). These “adolescent-friendly” days could help to encourage more young people to seek services. However, this does not address the problems which older patients encountered. It is clear from my data that many women, regardless of age, felt that the care they received was sub-optimal. Encouraging and supporting health workers to provide high quality care for all patients, regardless of age, and holding health workers accountable for their actions, is an imperative implication of these findings.

Law Change

No discussion of abortion seeking would be complete without a discussion of the law. As presented in an earlier chapter, the law governing abortion in Ghana is not straightforward and the analysis of these data have shown that a large number of Ghanaians, both women and the providers from whom they seek healthcare, report that abortion is illegal in Ghana. And given the way the law is written, they are correct. The public act states, “Abortion is unlawful and

both the woman and anyone who abets the offence by facilitating the abortion by whatever means are guilty of an offense of causing an abortion.” (Payne *et al.*, 2013) While subsequent clauses lay out many circumstances under which abortions can be provided legally, including in the case of rape or incest, fetal anomaly or in case where, “the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health” (Morhe & Morhe 2006, Dailard 1999), the legal situation of abortion in Ghana is confusing to many, even those who have been trained to provide abortions and are in positions of power as it relates to abortion provision.

Participants in my study were of different minds about whether the law should be amended. When asked if he thought the law should be liberalized, one participant said, “That will worsen an already bad case. There will be a lot of promiscuity.” (Male FGD) Another participant of the same focus group followed that by saying, “It will be a total disaster.” These assertions, however, are not supported by international data. Unplanned pregnancy rates do not increase when abortion laws are liberalized. Abortion rates do not increase when abortion laws are liberalized. What does happen is a reduction in the number of unsafe procedures and the resultant disability and death. Those areas with the lowest abortion rates (Western and Northern Europe) are those with the most liberal frameworks for abortion provision (Culwell & Hurwitz, 2013).

From my discussions with leaders in reproductive health in Ghana, I have heard of regional directors of health, the heads of the Ghana Health System for one of the ten regions of Ghana,

who are anti-choice. In their regions, programs to increase women's access to safe abortion are not welcome. The NGOs who work in this field, mainly Ipas and Marie Stopes International, know this and stay away from these regions. By having a legal situation which is murky, while it addresses the problem in the short term of a lack of political will and support to tackle this issue in a conservative setting, there are women and providers who are not aware of the legal provisions for providing services. I am not arguing that passing more permissive legislation, like was done in South Africa, will be a silver bullet to solving the problem of unsafe abortion in Ghana (South Africa has been dealing with a backlash of sorts in recent years and many women are still not able to access safe and legal abortions even though the law says they can), but perhaps a national discussion of the issue would raise awareness and would permit this topic to be discussed in the open.

Engaging Men

Beginning to address the issues of forced and coerced sex is also an important area of intervention. Although not mentioned in this study, some work I have recently undertaken is suggesting just how widespread this problem this is in Ghana (among female University of Cape Coast students, almost 30% had been either threatened, coerced or forced to have sex (Rominski & Darteh, manuscript under development). When young women are forced or coerced into having sex, they are less likely to engage in safe sex (Eaton et al. 2003). When women engage in transactional sex, when they trade sex for material goods or money, which was mentioned many times during this research, sex is on the man's terms, and many men do not want their partner to use contraception. This has been investigated more in terms of HIV

prevention than the prevention of unsafe abortion, but I believe it is at least as big a problem in Ghana to prevent unwanted pregnancies, especially given the relatively low HIV burden in the country. These issues require the engagement of men, as interventions directed solely to women will fall short of their stated goals if women are not able to exercise what they have learned.

Involving men and boys in sexual education is also important, and not only in regards to forced or coerced sex. Although changing the culture of young men forcing or coercing sex is highly important, also engaging them in talking to their partners about pregnancy prevention is necessary. Some men felt that contraception was fine, so long as both the husband and wife agreed on it. For example, one man said:

My wife is on a family planning method. She hadn't made up her mind to do it but because all our three children were through cesarean section, the doctor had to put her on family planning to prevent her from getting pregnancy again. So I think that if a woman and her husband will agree on it after they decide not to have any more children, they should go see the doctors so it will be done professionally for them. (Male FGD)

Others were not comfortable with their wives using contraception. Only speaking to and educating women about the benefits of contraception may not be enough to increase the rates of its usage. Counseling couples together, or targeting men, can help to normalize contraception and move it from the realm of women into the realm of couples.

Many interventions which are proposed to improve women's ability to access safe abortion services concentrate on educating the woman herself. Focusing only on this individual level presumes that sexual health decision making is rational based on knowledge. However, I believe my work has shown that more important is the culture of seeking care first from the informal healthcare system and ones' friends and family, and only going to a facility in the case of a complication. In order to change this culture of care seeking, a woman's entire social network, including her male partner, must be aware of where and how safe services can be accessed. This more holistic view, addressing the problem of unsafe abortion from the cultural dimension, is more in line with reality. Sexuality is complex and these women and their male partners conduct their sexual lives through experiences and beliefs that have been generated through lived experiences and membership in certain societies and sub-cultures (MacPahil et al., 2001).

Many of the women included in this study who were being treated for complications from unsafe abortion had discussed their pregnancy with their partners, although not all. Some of their partners were not supportive of the woman having an abortion, while others bought the drug for them. Ensuring that men know of the complications of unsafe abortion, and how their partners can access safe services, will increase the chances of women having a safe versus unsafe abortion.

Reduce premarital sex by increasing economic opportunities

Going back to the discussion of transactional sex, participants think the reason young women becoming sexually active is due to economic constraints. As the following member of a focus groups reported,

For me one way that we can curb this menace of teenage pregnancy is to find jobs for these girls to do. If they have jobs doing, they will avoid the temptations of going in for a boyfriend and that will also inherently control their risk of getting pregnant. (Male FGD)

This participant is referring to young women who are financially dependent on men for their daily needs. Although an improved economy where women are able to be financially independent will not reduce premarital sex completely, it could reduce the number of women who engage in sexual relationships solely for financial benefits. However, this view of women only engaging in premarital sex out of necessity is perhaps not realistic, as even in cases where women do not need to trade sex for material goods, they still engage in romantic relationships, which almost always include a sexual component. Although improving the economic situation of women in the country is a laudable goal, it will not prevent premarital sex or the need for comprehensive sexual and reproductive health education.

The idea that unmarried women only have sex due to financial constraints is outdated and an open and frank discussion in the country about the drivers behind sexual relationships among young people is sorely needed. Steps such as adding questions to the Demographic and Health Survey about engagement in sexual relationships for unmarried women as well as married women could help policy makers and scholars develop a deeper understanding of the culture around sex for young, unmarried women and their male partners.

Conclusion

When I first began this research, I was interested in answering the question, “given the relatively liberal law governing abortion in Ghana, why do women continue to put themselves at risk by self-inducing their abortions?” I had thoroughly reviewed the literature and found that women’s voices, and the stories of these women, had not been reported. While there had been much quantitative work documenting the burden of disease of unsafe abortion, and factors that were associated with this phenomenon, qualitative work was sorely missing, especially among women themselves. This previous quantitative work was imperative to elucidate and contextualize the problem of unsafe abortion as a topic worthy of further investigation. In some areas of Ghana complications from unsafe abortion were found to be the leading cause of death among young women. Without this quantitative base, the scope of the problem would not have been known. However, a true understanding of why women make the decisions they do was not possible with the previous work which had been done. Qualitative work allows for triangulation and provides a much richer understanding of the phenomenon under investigation. Although at the outset I had planned to confine my research to the issues surrounding the healthcare-seeking decision-making process once the decision to abort an unwanted pregnancy was made, many other issues surrounding this process came to light. The reluctance of women to use contraception despite the normalcy of engaging in premarital sex, and the phenomenon of exchanging material goods for sex, or in the context of a sexual relationship, and the undesirability of becoming pregnant was not a topic I had anticipated finding. However, given the qualitative nature of these data, I was able to delve into these highly important and interwoven aspects of reproductive health in Kumasi, Ghana. It is with this

fuller and deeper understanding that I hope to continue working in this area and design, implement and evaluate programs which enable women to safely, effectively, and within their social realities achieve their reproductive health goals.

Implications

This research has implications outside of Ghana, and outside of abortion. As mentioned, the country of Ghana has taken numerous actions to combat the problem of unsafe abortion. In 1985, the law governing abortion was liberalized to include many conditions for which abortion was legally available. More recently, the leadership of the Ghana Health Service implemented policies and protocols ostensibly making safe abortion available in all GHS facilities. These protocols and policies also empowered nurses and midwives to perform surgical abortion using manual vacuum aspiration and prescribing power to dispense medication abortion drugs. These techniques have been added to the curriculum of the midwifery training colleges and in a recent survey of senior midwifery students, almost three-quarters had received classroom education on these topics and 44% had been given an opportunity to practice manual vacuum aspiration in supervised clinical experiences (Rominski *et al.* manuscript under review). The Ghana College of Physicians and Surgeons has, in recent years, accredited a family planning fellowship, graduating the first class of fellowship-trained physicians in 2011. These physicians have become leaders in the field in Ghana, assisting with developing abortion services at district hospitals and acting as consultants for midlevel providers on complicated cases (Dalton *et al.* 2013).

With all these proactive and progressive steps, it is easy to draw the conclusion that the situation on the ground in Ghana would be much worse if not for these actions, and there is some evidence that these actions have, in fact, contributed to fertility decline in the country (Finlay & Fox 2013). However, Ghana can also serve as a cautionary tale for other countries seeking to reduce the burden of unsafe abortion in their locales. These large scale government interventions have all been supply-side. They have aimed to reduce barriers women encounter when they need an abortion. However, while these interventions have probably had an impact on the number of unsafe abortions and the resultant complications that are treated in hospitals, the problem has not been solved in Ghana. While it is true that abortion is no longer strictly illegal in the country, it is also not legal. This legal grey area can be confusing both for the suppliers of abortion (health care workers) and the consumers (women and their male partners). It may not be politically feasible, but a stronger statement from parliament supporting women's health and their human rights by making abortion legal on demand, such as the law in South Africa, would perhaps help reduce this confusion. Reducing the restrictiveness of an abortion law has not, in some places, been immediately followed by a replacement of safe abortions for unsafe ones (Singh 2012). Even in South Africa, 12 years after the passing of the Choice on Termination of Pregnancy Act, evidence suggests the majority of abortions are still unsafe. Studies on the impact of these law changes are, of course, challenging. Accurate data on an illegal procedure are difficult to obtain, and so documenting any kind of change is also challenging. However, dispelling the confusing nature of the law governing abortion in Ghana is, in my opinion, an important action that needs to be taken, if

only as a preliminary step to legitimize termination of pregnancy on demand, rather than it only being a legitimate procedure if some other condition is met.

Compared with other places where abortion is more strictly regulated and where there are fewer provisions for the public provision of safe abortion services, Ghana can be looked upon as a success story, as it was at the Women Deliver conference, a widely attended and important meeting focusing on issues surrounding maternal health, in May 2013. However, I would urge other countries looking to decrease the burden of unsafe abortion to look at some of the shortcomings which were uncovered through this research, and similar research conducted in South Africa, a country with an even more liberal abortion law than Ghana. While the supply-side barriers are important, even imperative, to tackle, this will not be a magic bullet to reducing unsafe abortion in a country. There is a large literature around “demand creation”, especially for contraception in developing countries, but little of this literature touches on demand creation for safe abortion services. The Guttmacher Institute developed a framework to discuss the steps that need to be taken after legal reform to ensure safe abortion services are available to women who need them; a. publicity, to workers in all government health agencies and private health facilities, and with the general public, that the legal status of abortion has changed; b. The formulation, publication and dissemination of guidelines or regulations outlining the eligibility criteria for a legal abortion under the new law, as well as types of facilities and providers legally allowed to perform abortions and the required (or recommended) methods of termination; c. The introduction of new abortion services capable of providing safe abortions to all eligible women in need, and programs to train health workers

assigned to those services; d. Data collection and monitoring systems to evaluate the level, quality and health impact of the new services (Guttmacher Institute, 2012). I do not disagree with any of these. However, the demand creation, and the changing of the culture of seeking care, is totally absent from this list. It is my assertion, based on the data I present in this dissertation, that women in Ghana, and I would presume in other countries as well, prefer, at this time, to induce their abortions at home and seek care for complications if they arise. They do not wish to engage with the formal healthcare system unless they have to. To change this culture of health seeking takes more than education about the new legal status of abortion. It will take more than printing and disseminating protocols. Culture is something which is created by those who live it and so is not immutable. However, it is not easily changed and changing a law is not enough to change the culture of seeking care.

These findings are also relevant to other issues than abortion, for example the choice women make as to where they will give birth (at home or in a facility). There are many countries, including Ghana, where, although women seek care in facilities for antenatal care (ANC), they do not seek care in the same numbers for delivery care. Although there are legitimate concerns about the quality of care that women receive during delivery, and some indications that facility-based delivery is not necessarily safer than delivering at home, it is the opinion of most experts that increasing rates of facility-based deliveries, in order to increase the proportion of women who deliver with a trained birth attendant, will be an important strategy to reduce maternal mortality due to factors in the delivery immediate post-partum period when most complications arise. There have been multimillion dollar projects to increase the ability of

women to access facility-based delivery by reducing barriers, such as cost and distance, by providing free services and building new facilities in rural areas closer to women. However, these initiatives have not had the expected impact. Investigations into why women are not using these services even when they are affordable and physically accessible reveal women do not want to deliver in the facilities for many reasons, including fear of how they will be treated by the workers in the facilities. For some communities, the reluctance to use a service represents a rational and informed choice, rather than a response to barriers (Ensor & Cooper 2004). Fully understanding these choices and why they are being made is incredibly important. While the supply of health services is crucial to usage, improving supply alone is not enough to increase utilization; demand must also be created, and this demand will only be increased once women are sure they will receive high quality care in facilities.

Improving the quality of care patients receive when presenting to facilities is urgently needed.

As a participant in my study said,

Don't even try it. If you go to the hospital, the way the nurses will shout at you. I was there last time with my baby, even that the way I was treated; it wasn't easy for me at all. The attitude of some of the health workers is appalling. I went to the hospital with my son who was very sick. When I said that my son is dying, the nurse there shouted, 'put him on the bed'. I told her that the doctor said he should be given first aid; she shouted back at me and said that I should go and look for the doctor to see if I will find him. They nurses are so rude and heartless, why will these girls want to go there and face such embarrassment?" (Female FGD)

Of course there may be extenuating circumstances for why this woman was treated this way when seeking care for her son, and this study was not designed to assess the overall quality of care patients are receiving at health facilities in Ghana. However, this sentiment speaks to

problems with the health system that are deeper and have a further reach than just in abortion care. Late presentations for care can be linked to poorer outcomes, and if people are reluctant to seek care and hope that the condition will resolve itself so that they do not have to interact with rude and unprofessional health care workers, steps need to be taken to address this, for a wide range of health conditions.

Many of the demand-side barriers are outside the influence of the health system. In a country such as Ghana, while the Ministry of Health can improve a clinic, it cannot, on its own, implement a sexual health education program in the schools of the country. Assistance is required from the Ministry of Education in this example. In terms of the general social hierarchy issues, or women empowerment issues, a singular ministry will likely have little control over these sorts of large scale social and cultural phenomenon. However, documenting the negative impact on women's health of, say, the lack of comprehensive sexual education is necessary to spur other sectors into action. It is my hope that the results of my study will be helpful for sexual health advocates in Ghana and elsewhere to make a case for the necessity of cross-sector collaboration to begin to address some of the problems which lead to women terminate their pregnancies unsafely. There is no simple fix and this will take many years to achieve. However, with thoughtful and careful planning of impactful interventions, it may be possible to address some of the health system and cultural issues which prevent women from achieving the highest level of health.

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