ORIGINAL RESEARCH ARTICLE

Attitudes and Experiences of Women Admitted to Hospital with Abortion Complications in Ghana

Patience Aniteye[1,2] and Susannah Mayhew[2]*

[1]University of Ghana; [2]London School of Hygiene and Tropical Medicine

***For correspondence:** *Email:* Patience.Aniteye@lshtm.ac.uk

Abstract

Unsafe abortion is one of the major contributors to high levels of maternal mortality in Ghana, despite a relatively liberal legal environment. This paper presents findings from a semi-structured hospital-based survey of 131 Ghanaian women who had experienced unsafe abortion. The majority of respondents were young and single, with no children or just one child. Most had middle-school education or higher and were employed, as were their partners. While knowledge of family planning was high, knowledge of specific methods was barely moderate and only 17% respondents had ever used it – much lower than the national ever-use of 39%. There were widespread misunderstandings about who could use family planning and 41% said they were afraid of side-effects.Eleven percent said their pregnancy was planned and 31% that they wanted their pregnancy but were pressured by partners or families to abort. Overall, about one-third of respondents said they aborted because they were not married and two-thirds said they aborted because of socio-cultural pressures. This study highlights clear ongoing failings of the family planning programme which needs to be revamped, as well as an urgent need for improving public knowledge about access to safe, legal abortion services (*Afr J Reprod Health 2011; 15[1]: 47-55).*

Résumé

Attitudes et expériences des femmes hospitalisées pour des complications de l'avortement au Ghana. L'avortement dangereux est un des principaux contributeurs aux niveaux élevés de la mortalité maternelle au Ghana, malgré un milieu légal relativement libéral. Cette communication présente des résultats à partir d'une enquête semi structurée basée à l'hôpital, des 131 femmes ghanéennes qui ont vécu l'expérience de l'avortement dangereux. La plupart des interviewées étaient jeunes et célibataires, sans enfants ou bien avaient un seul enfant. La plupart ont fait jusqu'au premier cycle du secondaire ou plus et étaient des employées comme leurs partenaires. Tandis que la connaissance de la planification familiale était bonne, la connaissance des méthodes spécifiques étaient plutôt modérée et seules 17% des interviewées l'avaient jamais utilisé, ce qui est bien inférieur à 39% des jamais sur le plan national. Il y avait des malentendus très répandus par rapport à qui doit utiliser la planification familiale et 41% ont déclaré qu'elles avaient peur des effets secondaires. Onze pourcent ont déclaré que leurs grossesses ont été planifiées et 31% ont fait savoir qu'elles désiraient leurs grossesses mais qu'elles ont subi la pression de la part des partenaires ou de la famille pour se faire avorter. Dans l'ensemble, à peu près un tiers des interviewées ont dit qu'elles se sont faites avorter parce qu'elles n'étaient pas mariées et deux tiers ont déclaré qu'elles se sont faites avorter à cause des pressions socioculturelles. Cette ♪0tude souligne les échecs actuels évidents du programme de la planification familiale qu'on doit réorganiser aussi bien qu'une nécessité urgente pour améliorer la connaissance chez le public en matière de l'accès aux services de l'avortement légal non dangereux (*Afr J Reprod Health 2011; 15[1]: 47-55).*

Keywords: Norethisterone; Primolut N tablet; Pre-coital oral contraceptive

Introduction

In Ghana, as in many African countries, unsafe abortion is one of the major contributors to high levels of maternal mortality. Abortion is highly stigmatised and is widely interpreted as being illegal in the country, though it *is* legally permitted in a wide variety of cases:

> *"…It is not an offence…if an abortion or miscarriage is caused in any of the following circumstances by a registered medical practitioner… where the pregnancy is the result of rape…incest…where the continuation of the pregnancy would involve risk to the life of the pregnant mother or injury to her physical or mental health …where there is a substantial risk that if the child is born it may suffer from or later develop a serious physical abnormality or disease…"* [The Criminal Code (Amendment) Law, PNDC. Law 102, 1985: para 58(2).[1]]

There have been increasing debates and activities around abortion in Ghana in recent years. These seem to have been motivated by a meeting by Ipas for African Ministers of Health in Addis Ababa in 2003, where African states were charged to reduce maternal mortalities due to unsafe abortions. Following this meeting the Government of Ghana engaged in a number

of activities including commissioning of a task force by the Ghana Health Service (GHS) to carry out a needs assessment on the preparedness of health facilities to provide comprehensive abortion care. With support from Ipas, trainings have been initiated for health providers on "values clarification" (dealing with examining one's basic values and reasoning for the purpose of understanding oneself) and the use of manual vacuum aspiration (MVA) to evacuate the uterus. In addition, periodic sensitization workshops for journalists by the Population Reference Bureau and African Women Lawyers Association have motivated journalists to publish articles on abortion in local papers. There have also been two local publications on abortion and the law by two female medical and legal practitioners[2]. Although there is an upsurge of the use of medical abortion in the country, the drug used has yet to be registered for that purpose. Findings from a pilot study on medical abortion recently conducted in two hospitals in Ghana found an overwhelming up-take of both Mifepristone and Misoprostol, which may influence the decision on registration of the drug[3].

In the same year as the Addis meeting, 2003, safe abortion finally appeared in the Ministry of Health's guiding Reproductive Health Service Policy & Standards document, and comprehensive service protocols were developed in 2006 but have yet to be properly disseminated. This and a widespread misunderstanding of the law mean that most women seeking abortion still seek clandestine abortions which are usually unsafe[4],[2]. While the rich can pay for a skilled practitioner, this practitioner may not conduct the abortion in a hygienic or licensed facility. The poor seek a wide range of providers and methods, almost always unsafe.

The toll of unsafe abortion is huge. The complications include infection, profuse bleeding, genital and abdominal trauma, perforated uterus, damage to internal organs and septicaemia. Death may also result from a range of serious complications including haemorrhage and sepsis[5]. According to a national needs assessment on abortion care conducted by the Ghana Health Service in 2005, abortion-related deaths contributed between 22-30% maternal deaths, constituting the single largest contributor to maternal mortality[6]. In the two Teaching hospitals in Ghana, the Korle-Bu and Komfo Anokye Teaching Hospitals, abortion complications make up to 50% of all gynaecological admissions[7],[8],[9]. Thirty per cent of maternal deaths are due to unsafe abortions according to data from studies at Korle-Bu Teaching Hospital in Accra, the capital city of Ghana[10]. A recent post abortion care project by Planned Parenthood Association of Ghana indicated that over 90 percent of women in Accra seeking care after abortion went to the gynaecological unit of Korle-Bu Teaching Hospital[11]. According to the gynaecological records unit at Korle-Bu abortion cases have constituted well over 50 percent of all cases admitted for over three decades. The national institutional maternal mortality ratio is quoted as 214/100,000 live births[12] while that of the population is 540/100,000 live births[13]. This disparity may be attributable to under-reporting, poor record keeping and poor registration of deaths among others.

Since the 1970s a number of papers have been published about abortion in Ghana, most of them hospital based. Some have sought to document the prevalence of unsafe abortion in hospital admissions [3,8,10]. Others have looked at the epidemiological and socio-economic characteristics of women undergoing abortion [7,8] and the methods used to induce abortion[14],[15]. To date, no studies in Ghana have explored the reasons why women terminate their pregnancies nor their experiences of seeking services. Understanding these issues is an important step in understanding what needs to be done to prevent unsafe abortion in Ghana.

This paper presents findings from a semi-structured hospital-based survey of 131 Ghanaian women who had been admitted with complications from induced abortion. After describing the background characteristics of the respondents, and their family planning knowledge and use, we analyse their attitudes towards children and childbearing and the reasons they gave for terminating their pregnancies. We then explore their experiences and consequences of seeking unsafe abortions. Finally, we discuss the implications of these findings for policies and programmes in Ghana.

Methods

The Korle-Bu Teaching Hospital and Ridge Hospital, both in Accra, were selected for this study. The Department of Obstetrics and Gynaecology is one of the nineteen departments of the Korle-Bu Teaching hospital, the Premier hospital in Ghana with a bed capacity of 1,685. The department was selected because it provides specialized maternity and other gynaecological care and serves as the referral point for various hospitals and health centres throughout the country – it therefore offers a more representative sample of admissions than other hospitals might. The Ridge Hospital was also included because this is used as the 'spill-over' hospital when Korle-Bu is full. Of the top ten causes of out-patient morbidity, pregnancy and related complications ranked fifth (In service unit, 2001). During 2002 when the data collection took place the total number of abortions seen at Korle-Bu was1874 and at Ridge was 246.

The main form of data collection was a structured questionnaire (with some open questions) administered to 131 women admitted to the hospitals with "incomplete abortions". These are classified as situations where 'part of the products of conception, usually chorionic or placental tissue is retained.' Women presenting with incomplete abortions were chosen for two reasons: first, this is almost always the result of unsafely induced abortion; second, incomplete abortions make up the largest proportion of abortion types seen at both Korle-Bu (1547 of the total 1874 cases – or about 70%) and

Ridge Hospitals (106 of the total 246 cases). Ethical permission for the study was obtained from the Heads of Nursing and Heads of the Department of Obstetrics and Gynaecology at each of the study hospitals.

Women were initially identified from the 'Admissions and Discharges book' by the researcher who then got permission from the doctor or matron in charge of the ward to talk to the individuals if they consented. Women were approached for preliminary questioning, to ascertain whether the abortion was induced or spontaneous – most were induced. All but four of those approached agreed to be interviewed and a total of 131 interviews were conducted. The high response rate can be attributed to the fact that the interviewer spent time getting to know the respondents and explaining the project before conducting the interview. Before each interview informed consent was obtained from all women. While the respondents agreeing to participate were happy to be interviewed, they did not want to be recorded, so each questionnaire was filled in manually with as much detail as possible, at the time of the interview. No personal details were recorded and confidentiality was ensured at all times. The data collection took place between June-December 2002.

Before beginning the questionnaire administration, the researcher established a relationship with the patient. The researcher always preceded the questionnaire administration with an explanation of the process, its purpose and requested the patients' permission to proceed. The researcher provided for the patients' privacy, closing doors and pulling curtains or using screens where necessary. On occasions where patients got visitors, the researcher checked with the patients and asked if they would prefer if their visitors waited outside the ward. Their comfort was ensured before and during questionnaire administration and counselling was employed where necessary. While it was important to establish a relationship with the patient prior to the questionnaire administration, the process itself became a tool for showing concern and enhancing the relationship.

Administered questionnaires were checked for clarity, consistency, completeness and comprehensiveness. These were numbered and packaged into a labelled envelope. Data from the questionnaires were later coded and entered into the computer and analysed using the SPSS Software, Version 10.

Results

Background characteristics

Key characteristics of the 131 respondents are shown in Table 1. The great majority of respondents were under 30 and two-thirds under 25. Seventy-eight percent were single and two-thirds had no children or only one child. Most had some education and their reported partners' educational levels were practically the same as those of the respondents.

Table 1: Background Characteristics

Characteristics	Frequency of responses (n=131)	Percent
Age		
<15	2	1.5
15-19	34	26
20-24	52	40
25-29	28	21
>29	15	11.5
Parity		
0 children	28	21
1 child	57	44
2-4 children	39	30
>4 children	7	5
Marital Status		
Married	29	22
Single	102	78
Education		
No education	24	18
Primary	18	14
Middle-School	71	54
Secondary School	17	13
Tertiary education	1	<1

A total of 77% (n=101) of respondents and 83% of their partners were service workers according to the Ghana Statistical Services categorisation of economic activity (this covers a range of low-paid jobs including: hairdressing, dress-making, petty trading and truck-pushing). Twelve percent of the respondents were unemployed as were 4% of their partners. Eight percent of the respondents and 5% their partners were students. In the higher-waged clerical category there were just 2.5% respondents and 7% of their partners. Two respondents as well as two partners were in the agricultural category, constituting 1.5 percent each. The vast majority of respondents were Christians, with a few Muslims and 12% reporting no religious affiliation.

Respondents' Knowledge and Practice of Family Planning

Almost all respondents (n=123) had heard about family planning (Table 2). When asked to explain what they understood by family planning (FP), 55% said FP is a measure for child spacing for women who have had children. One third of the respondents said FP is an injection that prevents pregnancy. Another nine percent respondents who said they had heard about FP admitted they did not know exactly what it is. The remaining respondents (3%) said FP had to do with male/female issues, it was a measure that helps individuals to have the number of children they can cater for or it was something that helps one to have time for his or her job. When asked what methods they knew, 48% mentioned oral contraceptives, 36% injectables, 17% condoms and 7% IUD. Sterilisation, norplant and 'natural' FP were only mentioned once each.

The sources from which respondents heard about FP methods (Table 2) were primarily through friends/ relatives and television. Health facilities or staff were only mentioned by nine respondents.

Table 2: Knowledge, practice and source of information for family planning

Knowledge, practice and source of information	Frequency of Respondents	Percentage
Heard of FP (n=131)	123	94
Practice (n=122):		
Ever used FP	22	17
Never used FP	100	76
Source of Information (n= 131):		
Friends/relatives	63	48
TV	43	33
Health facilities/staff	9	7
Radio	9	7
Other	7	5

As found in other studies there was a dramatic difference between levels of knowledge and actual use of FP. More than three quarters of respondents had never used FP (Table 2) while just 17% had used at least one method. Nine (7%) respondents did not answer the question.

Of the 22 respondents who had used FP, the method used reflected the general knowledge of the method types: 41% (n=9) had used oral contraceptives, 32% (n=7) injectables, 9% (n=2) the IUD, 9% (n=2) condoms and 2 respondents natural or herbal methods.

The 100 respondents who had never used FP methods were asked for the main reason why they had never used it. They gave a variety of responses, shown in Table 3. The highest responses, 41% of the respondents, said they were afraid of side effects. Twenty-four percent said they do not know how FP is done. Sixteen percent thought FP was only for non-students, married women or those with children.

Table 3: Reasons for never use of family planning (n=100)

Reason Given	Frequency of response among respondents who never used FP	Percentage (%)
Fear of side effects	41	41
Does not know how it is done	24	24
Student status	10	10
Never occurred to her	8	8
FP is for those with children	3	3
FP is for the married people	3	3
Lack of funds	3	3
Not sexually active	2	2
No response	6	6

Attitudes to Child-bearing and Pregnancy & reasons for termination

All except one of the respondents said they wanted to have children later. Almost 54% said they wanted just two or three children while 27% wanted 4 or more. Nineteen percent had no preference or stated that children are given by God, hence they would have the number God grants them.

Respondents were asked a series of questions about whether their pregnancies were planned/unplanned, wanted/unwanted and whether their partners were happy with the pregnancy. The results are shown in Figures 1 – 3.

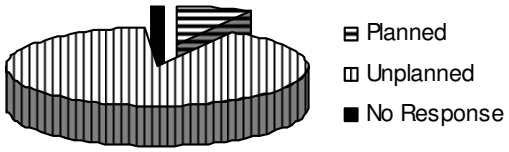

Figure 1: Aborted pregnancies planned and unplanned

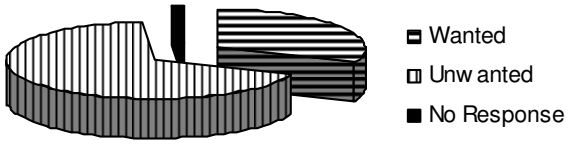

Figure 2: Respondents' attitudes to their aborted pregnancy

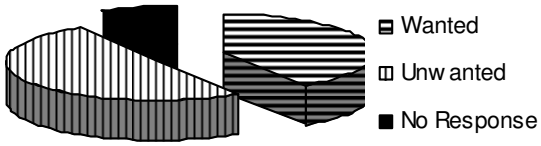

Figure 3: Partners' attitudes to their aborted pregnancy

Almost all respondents said their pregnancies were unplanned and two-thirds said their pregnancy was unwanted. When asked for what reason the pregnancy was unwanted, socio-cultural reasons were the leading answer (75% of those not wanting the pregnancy) followed by economic reasons (25%).

Almost one-third of respondents, however, said they *did* want their pregnancy. Of these, 66% had faced pressure from others to abort because of the social stigma, while the remaining 34% said that they had aborted it because of economic problems (Figure 4).

When asked what their partners' reaction to the pregnancy was, more than half of respondents said their partners did not like the pregnancy. The 67 women who said their partners were not happy with the pregnancy were asked whether they knew the reasons for their partners' reaction. Almost half of these respondents said their partners feared the reaction of the girls' parents and other socio-cultural problems. One third mentioned

financial constraints, 12% said it was to avoid disrupting the girls' educational or career opportunities and 6% said their partners doubted their paternity.

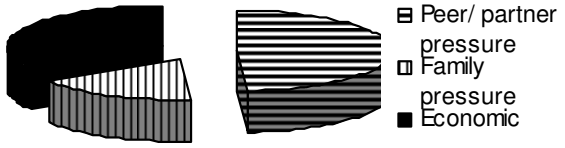

Figure 4: Reasons for termination given by respondents who wanted their pregnancy

The 53 respondents who reported their partners were happy with the pregnancy were asked the reasons why they terminated their pregnancy despite this (Figure 5). Fifteen percent said they aborted because they were not yet ready to have a child or they were nursing another child. Other reasons given were similar to those cited for the partners not wanting the pregnancy: financial constraints, academic/career pursuits, and a range of socio-cultural issues like not being married to the man responsible for the pregnancy, not ready to be second wives, unstable marriages and having different religious inclinations from partners. In some cases where both partners wanted the pregnancy pressure from relatives was cited as the reason they took a decision to abort. In other cases where the men were happy about the pregnancy but the women were not the women said it was because they felt that the men had neglected them after they became pregnant so they aborted.

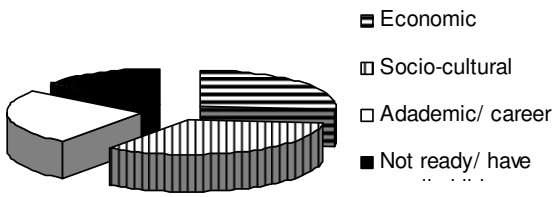

Figure 5: Reasons for termination given by respondents whose partners wanted the pregnancy

When asked for further explanations, some of the respondents said that by being pregnant they thought their partners would marry them only to realize that their thoughts were fallacies. Also, a number of their boyfriends were married men who found themselves entangled in extra-marital relationships resulting in unwanted pregnancies. Those respondents who did not want to be second wives obtained abortions. For some respondents, the pregnancy brought no peace in their relationship and resulted in quarrels between them and their partners. Other respondents felt that they had been fooled by their partners into getting pregnant only to be maltreated afterwards. In some cases, due to different religious affiliation (i.e. Christian and Moslem) of respondents and their partners, parents were not in favour of their relationships hence the girls were forced to terminate their pregnancies in order to end the relationships.

Abortion experiences and consequences

Respondents were asked about the dates for their last menstrual periods in order to ascertain the gestational period of the pregnancies terminated. Two-thirds of the respondents were able to give dates. The remaining third either did not know or could not remember the dates for their last menses. Nevertheless, respondents did give answers on the probable gestation of their pregnancies. The great majority of respondents (85.5%) had terminated their pregnancies within twelve weeks and for almost two-thirds this was their first abortion though 22% had had a previous abortion and 14% had had multiple abortions.

Respondents were asked whether they terminated the pregnancies themselves or were assisted by others to do so. A variety of people assisted the respondents to terminate their pregnancies, especially 'doctors' though it is unclear whether they were qualified or not (and there is a widespread assumption that 'white coated' people must be doctors), herbalists and peers or friends. Just four respondents said they had a termination in hospitals and a further five said it was by pharmacists (using drugs that included Menstrogen, Gynaecosid and Ergometrine). Details are shown in Table 4.

Respondents were asked about the methods used for terminating their pregnancy (shown in Table 4). The most frequent answer was herbal preparations, used in different ways. For maximum efficacy, some of the respondents used a combination of methods like alcoholic beverages consumed orally and use of herbs vaginally. In some cases where one method failed, another was applied.

Respondents were asked about their experiences within 24-48 hours following the termination of pregnancy and where they first sought help. Table 4 shows the complications of abortion suffered by the respondents and where they sought help for the complications.

The most common consequence reported by more than three-quarters of respondents was lower abdominal pain with moderate or profuse bleeding. In seeking remedies for these sequelae of abortion, two thirds of respondents sought help from health centres. In all, 85.5% (n=112) respondents sought immediate post-abortion help from a medical practitioner. Of these 59% were given emergency care and managed based on their presenting complaints while 38% were referred to bigger health facilities. Those respondents who went back to the original abortion providers were given additional herbal concoctions for consumption before eventually ending up in hospital.

Table 4: Sources of abortion assistance; methods; complications and health seeking

	Frequency of Respondents	Percentage
Abortion provider (n=131):		
'Doctors'	55	42
Herbalists	31	24
Peers/friends	26	20
Partners' sister	6	5
Pharmacists	5	4
Hospital	4	<3
Boyfriends gave herbs/drugs	4	<3
Abortion Methods (n=157 due to multiple methods used):		
Herbal preparations		
Intra-uterine instruments	47	30
Sugary/alcoholic solutions	35	22
Pharmaceuticals	23	15
Stick inserted into vagina (to dilate cervix)	21	13
Suction	17	11
	14	9
Abortion complications experienced within 48 hours (n=131):		
Lower abdominal pain with bleeding		
No apparent effects (abortion failed)	99	76
Lost consciousness	9	7
Other	8	6
	15	11
Care-seeking after complications (n=131):		
Health centres	87	66
Delay then to hospital	19	14.5
Chemical shops	13	10
Returned to abortion providers	6	5
Midwife	4	3
Home remedies	2	1.5

Discussion

The great majority of respondents were young and single presenting a typical pattern, found in other studies, of younger women wanting to delay childbearing until they are married or have furthered their education [14, 16]. Not surprisingly then two-thirds had no children or just one child, though all but one wanted children at a later time and desired family size was high with just a quarter saying two was enough. A small minority said God would decide – an interesting view given their direct attempts to intervene to decide to limit their children. This type of contradiction of beliefs held simultaneously has been documented elsewhere[17,18]. Most respondents and their partners were employed and had at least middle-school education, suggesting that unsafe abortion is not the preserve of the poor and illiterate.

In a country where Christian morals are strong the high proportion of respondents who were single is significant because the social stigma of bearing children out of wedlock is great. Reflecting this, about one third of respondents said they aborted because they were not married and two-thirds said they aborted because of socio-cultural pressures. Nevertheless, it is also interesting that although 78% were single, 79% already had at least one child, suggesting that despite social stigma, childbearing outside marriage is actually widespread.

Although 94% respondents claimed to have heard of FP their sources were unreliable – mostly from friends, relatives and the TV – and many could therefore not describe the methods and their understanding of FP was mixed. There was also wide-spread misunderstanding about who FP was for. About half of the respondents said FP is for those who already have children and others thought it was only for married women. A mere 17% had ever used FP with most using pills or injectables. This is significantly lower than the national average of ever use of modern contraceptives which stands at 39% for all women and 64% for sexually active, unmarried women[19]. This is worrying especially given the high levels of knowledge, and suggests the need for more qualitative research among women undergoing unsafe abortions to find out more about why they are not using family planning.

Among our sample, the most commonly cited reason for not using FP was fear of side-effects followed by ignorance in 'how it is done'. This is disheartening given the 40 year-long FP programme in the country and long-term donor support. The Programme has, though, been dogged by political apathy[20,21,22] and these results indicate a clear and urgent need for a proper and widespread information campaign on FP – something the latest DHS also recommends[18]. Indeed all the reasons

given for non-use of FP (except lack of funds mentioned by just three) could be addressed through effective FP education. Given the high numbers of people accessing FP information through TV this could be a focus for future information campaigns. In addition, however, providers of FP need to be open about, and talk through, possible side-effects and help clients who experience them to switch to a different method – mis-informed fears or rumours of side-effects are often spread by word of mouth after an individual has had a bad experience and it is important that the potential for this is minimised. Other studies, including some by the Ministry of Health, have indicated the autocratic approach of many service providers and the reluctance to discuss side-effects of FP openly; the 2003 DHS reports that only half of FP clients receive any information on side-effects and what to do if they experience them[18]. The consequence of this is that when clients experience side-effects, they are exaggerated and give rise to rumours, leading to contraceptive stopping or non-use rather than switching to more suitable methods.

The questions on whether the pregnancy that had been terminated was planned or wanted threw up some disturbing findings. While just 11% respondents said their pregnancy was planned, one-third said they had wanted the pregnancy. The reasons given by these respondents for why they terminated their pregnancies pointed to marital, family and social pressures that effectively coerced them into unsafely aborting the pregnancy. The partners' view seems important since those whose partners were happy with the pregnancy (40% respondents) did not cite family/peer/partner pressure or coercion as a reason they aborted, though some said it was because of social stigma.

The main limitation of this study was its small sample size, however this needs to be balanced against the richer, and more reliable, data to be gained from a more qualitative, personal approach (i.e. the use of interviews rather than questionnaires). Interviews allowed for probing and follow up and clarification where apparent contradictions were evident. For an interview sample, ours was quite large. What is needed now is a large-scale survey to quantify some of our findings. Nevertheless, since many of the important issues raised by this research are corroborated elsewhere, as discussed above and below, the implications of the findings do have wider ramifications and it is these that we discuss now.

Policy and programme implications

The findings of this study corroborate those of many others that have found high levels of basic knowledge of FP, moderate levels of specific knowledge but very low levels of FP use. This underlines the critical need for the Government of Ghana to *revamp its FP programme* and show a high level of political commitment to investing in a public information campaign to raise awareness of what FP is, how it can help, where it is available and, in particular, *tackle the fears of side-effects* associated with poor knowledge and lack of information. In addition a dedicated in-service *training for FP providers* is needed to ensure they *properly inform clients about possible side-effects* and encourage contraceptive switching if side-effects are experienced – this will help to minimise bad experiences and subsequent rumours and mis-information.

The very low percentage of women interviewed who had ever used FP shows a major entry point for FP among women undergoing abortion, which must include open discussion of both benefits and side-effects, as part of post-abortion contraception counselling. Management of abortion, including post-abortion contraception, is detailed in the "Prevention and management of unsafe abortion: comprehensive abortion care services, Standards and Protocols" published by the Ghana Health Service in June 2006. Even in 2008, however, most providers have not seen them, the MOH did not have a copy it was willing to share and we eventually tracked one down via Ipas, who were heavily involved in its development. These guidelines are indeed comprehensive. They include some guiding principles for the implementation of comprehensive abortion services in line with the law and make it clear that "*each client has the right to access the service, as an integral part of comprehensive integrated reproductive health service provision*" and that while partner consent is encouraged, it is not mandatory[23]. It notes that legal evidence of 'rape' is not required in order to proceed with an abortion and that no psychiatric assessment is required in order to obtain a legal abortion – it is up to the service provider to determine the client's 'mental distress'. In the case of minors (under 18 years) the guidelines ask that service providers 'encourage minors to consult a parent or trusted adult if they have not already done so', but notes that pregnancy in under 16s constitutes statutory rape and such clients are therefore clearly entitled to abortion services by law. In practical terms, the guidelines include detailed procedures on how to safely conduct abortions in the first and second trimester together with details on post-abortion care which must include contraceptive counselling. These guidelines are critically important to ensuring legal access to safe abortion and it is imperative that *the Standards and Protocols document is disseminated immediately to all health facilities and hospitals*.

Although the majority of respondents undergoing abortion did not want their pregnancies, one third did want them but felt coerced by others into having an abortion. This needs to be addressed. *Public debate on abortion to increase the knowledge and acceptability of its legal status* would improve access of women or their partners and families seeking an abortion to qualified counsellors who should provide counselling not just to the women but their partners and families too. Tackling social norms that stigmatise out-of-marriage childbearing also need to be tackled since it is this that often drives families to insist on an abortion despite the

fact that childbearing outside wedlock is frequent. Social support mechanisms are also needed, however, to help women who decide to keep their pregnancy in the face of family, social or economic difficulties.

High levels of unsafe abortion practice are apparent from this study, corroborating other studies in Ghana and supporting the high maternal mortality figures. More research is needed into who the 'doctors' are who are providing abortions, whether they are qualified and why they are not conducting abortions in proper health facilities. There needs to be a *public education campaign on the dangers of using non-qualified abortionists* to reduce morbidity and mortality from inserting herbs and non-medical instruments or conducting abortions in unhygienic conditions. In addition, *access to safe, legal abortion needs to be ensured* through public information campaigns, education and training of doctors and nurses in registered facilities and dissemination of the guidelines, noted above. If unsafe abortions are ever to be reduced, women need to know they can legally access safe abortion services at proper health facilities and to know that they will receive non-judgemental treatment by providers. Increasing knowledge about and availability of post-abortion care is also important so that women who have had an unsafe abortion can access care quickly without further discrimination and trauma. Another important way of reducing unsafe abortions is to *make medical abortion widely (but safely) available*, for example through pharmacists trained to give proper instructions and advice, so that women know they can go to a pharmacist for pills they can take at home in the early weeks of pregnancy, instead of resorting to herbal concoctions and treatment from quacks.

Reducing unsafe abortions will not be easy in Ghana. It requires high-level commitment from political leaders to increasing access to family planning *and* where this fails or cannot be used, access to medical abortion and safe, legal abortion services to the full extent of the law, which allows abortion to safeguard both the 'physical and mental health' of the pregnant woman [1,3]. Only in this way will women be empowered to take choices that will not needlessly endanger their lives.

Acknowledgements

We acknowledge the inputs of Clement Ahiadeke and E.Y. Kwawukume for guidance on designing and implementing this study, and UNFPA for financial support in conducting the study.

References

1 Government of Ghana. The Criminal Code (Amendment) Law, 1985. PNDC L 102. The Gazette. Ghana Publishing Corporation, Accra and Tema. 1985.

2 Lithur, N.O. Destigmatising Abortion: Expanding Community Awareness of Abortion as a reproductive Health Issue in Ghana. African Journal of Reproductive Health 2004:8(1):70-74.

3 Blum J, Diop A, Frimpong P and Taylor J. Medical Abortion in Ghana: Feasibility and Acceptability of Mifepristone and Misoprostal in low resourced areas'. Unpublished study conducted in La General Hospital and Koforidua Government Hospital 2005-2007: Gynity Health Projects, New York, 2007.

4 Lassey AT. Complications of induced abortions and their preventions in Ghana. East African Medical Journal. 1995:72(12):774-777.

5 Grimes DA, Benson , Singh S. et al. 'Unsafe abortion: the preventable pandemic' The Lancet: Sexual and Reproductive Health – October 2006: 65-76.

6 Ghana Health Service (GHS) A Strategic Assessment of Comprehensive Abortion Care in Ghana. GHS, 2005.

7 Ampofo D A 330 cases of abortion treated at Korle-Bu Hospital: The epidemiological and medical characteristics, Ghana Medical Journal 1970:9(3):156-162.

8 Turpin CA, Danso KA, Odoi, AT. Abortion at Komfo Anokye Teaching Hospital. Ghana Medical Journal. 2000:6(2):60-64.

9 Aniteye P. Reasons, Methods and Health Outcomes of Induced Abortion; A study of women on admission with Abortion Complications. MPhil.Thesis: School of Public Health, University of Ghana. 2002.

10 Aboagye B, Akosa, AB. An Autopsy study of maternal deaths. Ghana Medical Journal. 2000:34(3):152-156.

11 PPAG (Planned Parenthood Association of Ghana) Post-Abortion care in Accra. Unpublished Report, PPAG: 2001

12 Ministry of Health/Ghana Health Service. An assessment of the provision of comprehensive abortion care to the full extent of the law. Supported by IPAS with the technical assistance of the World Health Organization. 2005.

13 World Health Organization. Unsafe Abortion: global and regional estimates of incidence of unsafe abortion and associated mortality in 2000. 4th ed. Geneva: WHO. 2004.

14 Ampofo, D A The dynamics of induced abortion and the social implications in Ghana. Ghana Medical Journal 1970:9(4):295-302.

15 Ahiadeke C. Incidence of Induced Abortion in Southern Ghana. International Family Planning Perspectives. 2001:27(2):96-101.

16 Bankole A, Singh S, Haas T. Reasons why women have induced abortions: evidence from 27 countries. International Family Planning Perspectives. 1998:24 (3) 117-127.

17 Lockwood M. Structure and Behavior in the Social Demography of Africa. 1995; Population Development Review 21(1):1-32.

18 Wight D, Plummer ML, Mshana G et al. Contradictory sexual norms and expectations for young people in rural Northern Tanzania. Social Science & Medicine 2006; 62(4):987-997.

19 Ghana Statistical Service (GSS), Noguchi Memorial Institute for Medical Research (NMIMR), and ORC Macro. 2004. Ghana Demographic and Health

Survey 2003. Calverton, Maryland: GSS, NMIMR, and ORC Macro.

20 Owusu JY and Baste Z. 'Family Planning Services in Ghana' in Report of the National Population Conference 1991:158-183. National Population Council: Accra, 1991.

21 IPPF Fred Sai Speaks Out, second edition published by Banson Publications, Cambridge, for IPPF: 2001.

22 Parr N. 'Family planning promotion, contraceptive use and fertility decline in Ghana' African Population Studies 17(1):83-101

23 Ghana Health Service (GHS) Prevention and Management of Unsafe Abortion: Comprehensive Abortion Care Services. Standards and Protocols. GHS: Accra, June 2006.