FACTORS THAT INFLUENCE WOMEN'S ACCESS TO AND UTILIZATION OF SAFE ABORTION SERVICES IN GHANA

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A thesis submitted in partial fulfilment of the requirement for the degree of

Master of Public Health

by

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Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements. The thesis "Factors that influence women's access to and utilization of safe abortion services in Ghana" is my own work.

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LIST OF ABBREVIATIONS

BCC	Behaviour Change Communication
CAC	Comprehensive Abortion Care
CBO	Community Based Organisation
CHAG	Christian Health Association of Ghana
CSO	Civil Society Organisation
CTOP	Choice on Termination Of Pregnancy
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Neonatal Care
FII	Faith Inspired Institution
GDP	Gross Domestic Product
GHS	Ghana Health Service
GSS	Ghana Statistical Services
IGF	Internally Generated Fund
ICPD	International Conference on Population and Development
LB	Live Birth
MDG	Millennium Development Goal
MHS	Maternal Health Survey
MoF	Ministry of Finance
MoH	Ministry of Health
MVA	Manual Vacuum Aspirator or Manual Vacuum Aspiration
NDPC	National Development Planning Commission
NGO	Non-Governmental Organisation
NHIS	National Health Insurance Scheme
NRHSPS	National Reproductive Health Service Policy and Standards
PNDCL	Provisional National Defence Council Law
R3M	Reducing Maternal Morbidity and Mortality
SAC	Safe Abortion Care
SRHR	Sexual Reproductive Health and Rights
UN	United Nations
US	United States
USA	United States of America
USD	United States Dollar
UNDP	United Nations Population Division
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VU	Vrije Universiteit
WHO	World Health Organisation

GLOSSARY

Maternal Mortality Ratio and Maternal Mortality Rate: It is the ratio of the number of maternal deaths over a certain period of time per 100,000 live births during that period of (United Nations Statistics Division 2015). Mathematically, it is the total number of deaths over a given period divided by total number of live births in the same period, then the result multiplied by 100,000. A maternal death is the death of a female while pregnant or within 42 days of after birth or pregnancy termination, irrespective 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 2015a). Maternal Mortality Rate is similar to Maternal Mortality Ratio except that in calculation, the denominator for Maternal Mortality Rate is the number of women of reproductive age.

Induced abortion: It means the termination of a pregnancy by medical surgical or any other means.

Unsafe abortion: “A procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards or both” (WHO 2015b)

Total Abortion Rate: Total number of induced abortions a woman (within age group 15-49 years) has had in her lifetime

General Abortion Rate: Total number of induced abortions per 1000 women (15-49 years) in a year. It describes the level of induced abortion in a population.

Contraceptive Prevalence Rate: It is defined as the percentage of married or cohabiting women of age group 15–49 years who are using any method of contraception (WHO 2011).

Total Fertility Rate (women aged 15-49 years): It “is the average number of live births a woman would have by the end of her reproductive life if she were subject, throughout her life, to the age-specific fertility rates observed in a given year”(WHO 2011).

Unmet need for contraception: This is broadly defined as women who want to stop child bearing or delay pregnancy but are not using any method of contraception (WHO 2012a). In this case such women are potential contraceptive users.

Maternal Morbidity: It refers to the physical and mental ill health or disability of a woman, directly related to pregnancy or childbirth (Koblinsky et al. 2012).

Clandestine Abortion Services: It means Illegal or unauthorized abortion services. By definition of legal abortion, clandestine abortion services are regarded unsafe. The concept of clandestine abortion services in this literature review means abortion services regarded as unsafe.

Comprehensive Abortion Care: It is an approach that serves the abortion needs of women by taking into account the safety, quality, and accessibility of abortion and post-abortion services (Ipas 2015). It takes into account measures to ensure sound physical and mental health being of the woman with considerations to her context.

Signal functions for basic Safe Abortion Care: These are basic essential actions and procedures that need to be taken to offer safe abortion services (Healy, Otsea, & Benson 2006). It is mostly for minor cases of abortion that can be done for uterine size ≤ 12 weeks and could easily be managed by few required resources and midlevel health providers. A health facility should be in the capacity to perform a number of functions to be qualified as a basic Safe Abortion Care facility.

Signal functions for comprehensive Safe Abortion Care: These are basic essential actions and procedures in addition to more advanced medical procedures that need to be taken to offer safe abortion services for more advanced abortion cases (Healy, Otsea, & Benson 2006). It includes basic functions and more advanced functions and should be able to be done for uterine size > 12 weeks and needs top level providers like physicians to carry out. A health facility should be in the capacity to perform these functions to be qualified as a comprehensive Safe Abortion Care facility.

ABSTRACT

Background: Unsafe abortion is the second leading cause of maternal deaths in Ghana. The country has an induced abortion rate of 15 per 1000 women (15 – 44 years), with 40% carried out by unqualified providers; such abortions are regarded unsafe.

Objective of study: To explore factors that influence women's access to and utilization of safe abortion services in Ghana and to identify evidence based interventions in order to develop recommendations to improve use of safe abortion services in Ghana.

Methodology: The study carried out literature review using peer reviewed articles, other published and unpublished literature. The study adapted, modified and used the framework for evaluating abortion programs by Janie Benson.

Findings: Unsafe abortion is common among women in Ghana especially for young women, rural women, and women of low economic status. This is influenced by contextual factors and other factors like laws and policies, service delivery and women's abortion decisions and choices.

Conclusion: Ghana's abortion law does not reflect the needs of women. Policies, protocols and guidelines for Comprehensive Abortion Care exist but implementation and availability of services is limited. The socio-cultural context dominantly stigmatizes and resists abortion; this hinders policy implementation and access to and utilization of safe abortion services.

Recommendations: Review the law to reflect the needs of women, expand access to Comprehensive Abortion Care services, sensitize and educate women and communities on the law, safe abortion and the human cost unsafe abortion.

Key words: Abortion, abortion law, abortion policy, contextual of abortion and Ghana.

Word count: 12,378

INTRODUCTION AND ORGANISATION OF THESIS

Every year, 800 women die out of preventable causes (WHO 2014). Most of these deaths occur in low resource settings with developing countries accounting for 99% (WHO 2014). The problem of maternal mortality led to a response by the international community in 2000 to improve maternal health through MDG 5 (UN 2015a). Many countries including Ghana committed to the MDG 5 plan of action of reducing maternal mortality by three quarters between 1990 and 2015 (WHO 2014). Statistics over the years have shown a decline in maternal mortality but the pace of decline in some countries including Ghana puts them off track in achieving the target by 2015 (WHO 2014). In response to the slow progress in reducing maternal mortality, the MoH and GHS declared maternal health as an emergency in 2008 (UNDP, Government of Ghana & NDPC 2010).

Through significant efforts, maternal mortality in Ghana has dropped over the years but this did not go with a respective decline in the proportion of maternal deaths due to unsafe abortion, making abortion persistently the second leading causes of maternal deaths (MoH & UNFPA 2014; Der et al. 2013 & Geelhoed et al. 2003).

Preventing unsafe abortion and its related maternal deaths has been linked to improving access to and utilization of safe abortion services, through legal, policy and service delivery measures (Warriner & Shah 2006). Despite this realization, unsafe abortion continues to be a problem in Ghana. It is therefore worth studying to understand women's access to and utilization of safe abortion services in Ghana by identifying and exploring influencing factors.

As a project officer for a Non-Governmental Organization (NGO), I have been working in the field of maternal and reproductive health for about five years. In working with stakeholders including the GHS, I got to learn that abortion significantly contributes to maternal deaths in Ghana. Just before I came to study in KIT, a friend and a member of the Coalition of NGOs in health indicated to me that, unsafe abortion contributes up to 20% of maternal deaths in Ghana. This has since made me concern and curious to further explore the issue which led me to carrying out this study.

This thesis is a literature review which identifies and explores factors that influence women's access to and utilization of safe abortion services in Ghana. Factors are studied based on an adapted and modified conceptual framework from Janie Benson (Benson 2005). The thesis is structured in five chapters.

Chapter one presents the background information of Ghana which is the country of study. Chapter two presents the problem statement, justification, objectives, and methodology for the study. Chapter three identifies and explores factors that influence women's access to and utilization of safe abortion services. Guided by the adapted framework, factors studied include legal, policy, service delivery and contextual factors as well as women's decisions and choices in seeking abortion. Chapter four presents evidence based interventions to prevent unsafe abortion and its related maternal deaths by improving access to and utilization of safe abortion services. Chapter five is the final chapter which discusses findings from Chapter three and four and arrives at conclusions and recommendations.

1 CHAPTER ONE: BACKGROUND INFORMATION OF GHANA

1.1 Geography and Demography

The republic of Ghana is a West African developing country which shares borders with Côte d'Ivoire to the west, Burkina Faso to the north, Togo to the east, and bordered by the Atlantic Ocean to the south (City population 2012). The country has a total land area of 238,537 square kilometres and bound to the south by the Gulf of Guinea (GSS, GHS & Macro International 2009a). The map of Ghana bounded by Burkina Faso, Côte d'Ivoire and Togo is indicated in figure 1 (UN 2015b).

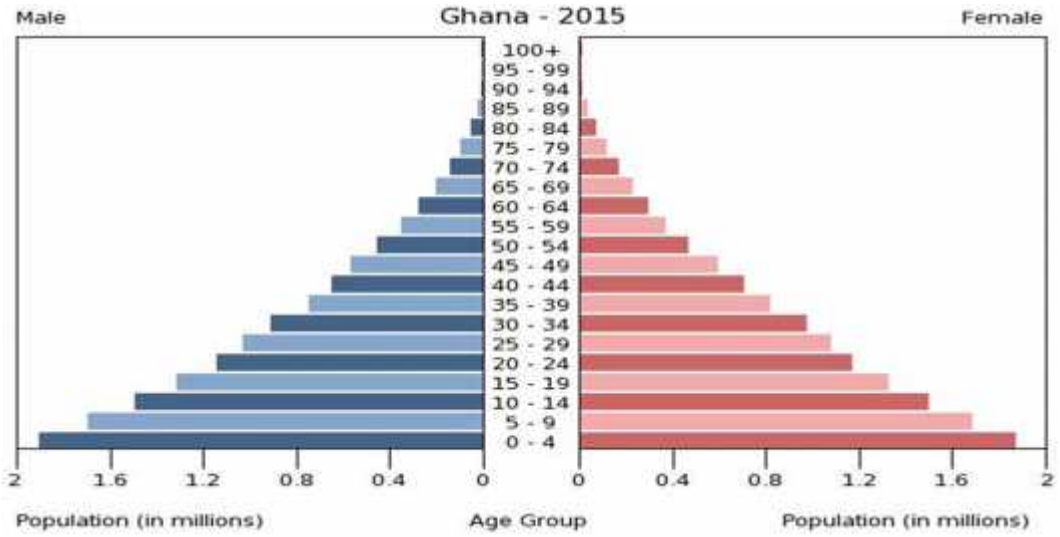
Figure 1 Map of Ghana bounded by neighboring countries

Source: United Nations 2015.

The country is a tropical lowland country (except for some parts of the eastern border) with annual average temperature of 26°C and is divided into three ecological zones: The sandy coastal plains, the heavily forested middle belt and western parts, and a northern savannah (GSS, GHS & Macro International 2009a).

Ghana has a population of about 25 million (Females 50.5% and Male 49.5% according to 2013 estimates), a growth rate of 2.19%, and an urban population constituting 50.9% (GSS 2012). The population structure of Ghana is as indicated in figure 2 (US Census Bureau 2015).

Figure 2: Population (distribution) pyramid of Ghana by age and sex, 2015 estimates



Source: US Census Bureau 2015.

1.2 Socio-cultural setting

Ghana is multi-religious with Christianity (71.2%), Islamic (17.3%) and Traditional believes (5.2%) being the dominant religions; the country is also multi-cultural with diverse ethnicities of various traditional beliefs (GSS, 2012 & GSS, GHS & Macro international 2009a).

1.3 Economy

Ghana has a GDP of (PPP) of $88.5 billion and a GDP per capita of $3,461, with a GDP growth rate of 5.5% per annum. Unemployment is currently at 4.5% and inflation at 11.7% (The Heritage Foundation 2014).

1.4 Education and gender

The total population of age above 15 years who can read and write is 71.5% of which 78.3% are males and 65.3% are females (GSS 2012).

1.5 Socio-political system

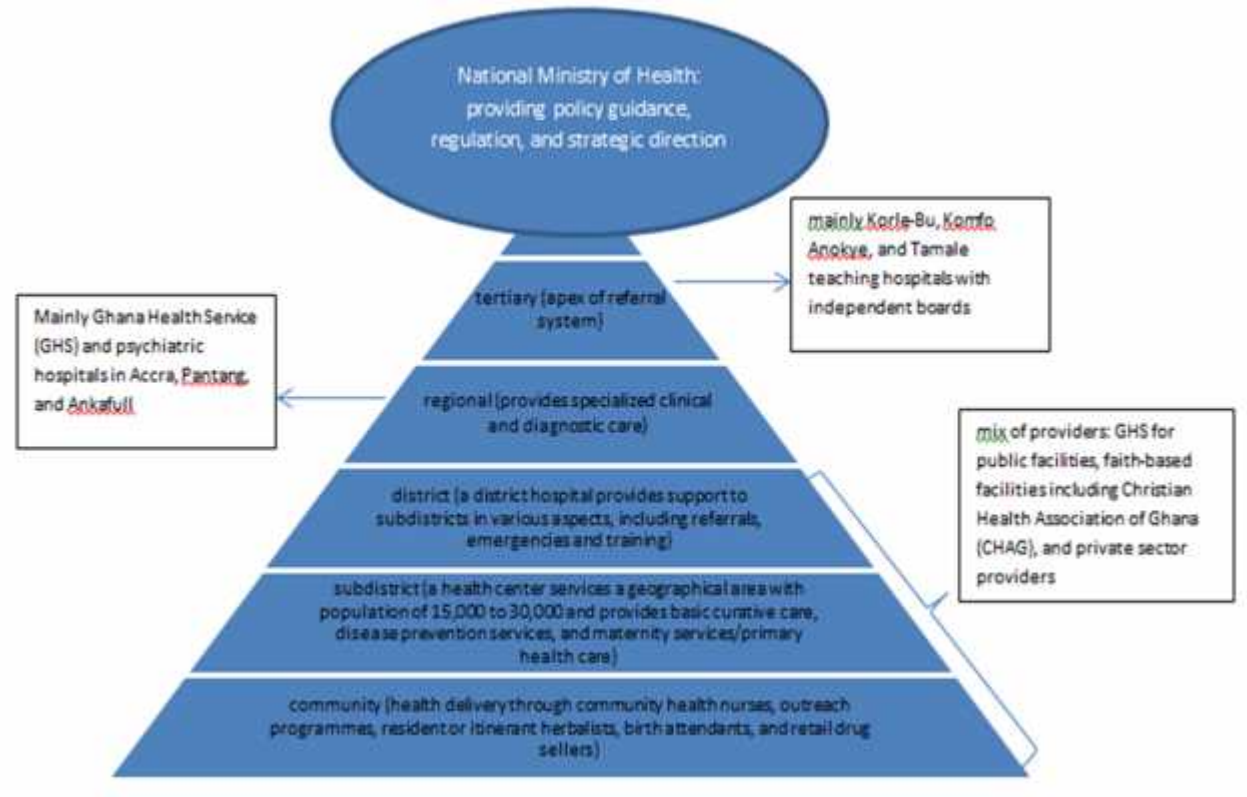
Ghana has a democratic presidential system of governance where a president is elected every four years with two presidential terms of office in rule (GSS, GHS & Macro international 2009a). The country has a functional parliamentary system and an independent judiciary (GSS, GHS & Macro international 2009a). Administratively, Ghana is divided into 10 regions with 216 districts and Greater Accra being the regional capital (City population 2012).

1.6 Health System and financing

In Ghana, the Ministry of Health (MoH) is primarily responsible for making policies and determining priorities of the health sector, whiles the Ghana Health Service is responsible for managing health service delivery by developing and implementing guidelines (MoH 2012).

The GHS by requirements of the 1992 constitution was established under Act 525 of 1996 as a public services body (MoH 2012). The GHS is mandated to "provide and prudently manage comprehensive and accessible health service with special emphasis on primary health care at regional, district and sub-district levels in accordance with approved national policies" (GHS 2015). Ghana runs a decentralized health system where decision making authority and management of healthcare services is given to the regional and district levels from the national level (GHS 2015).

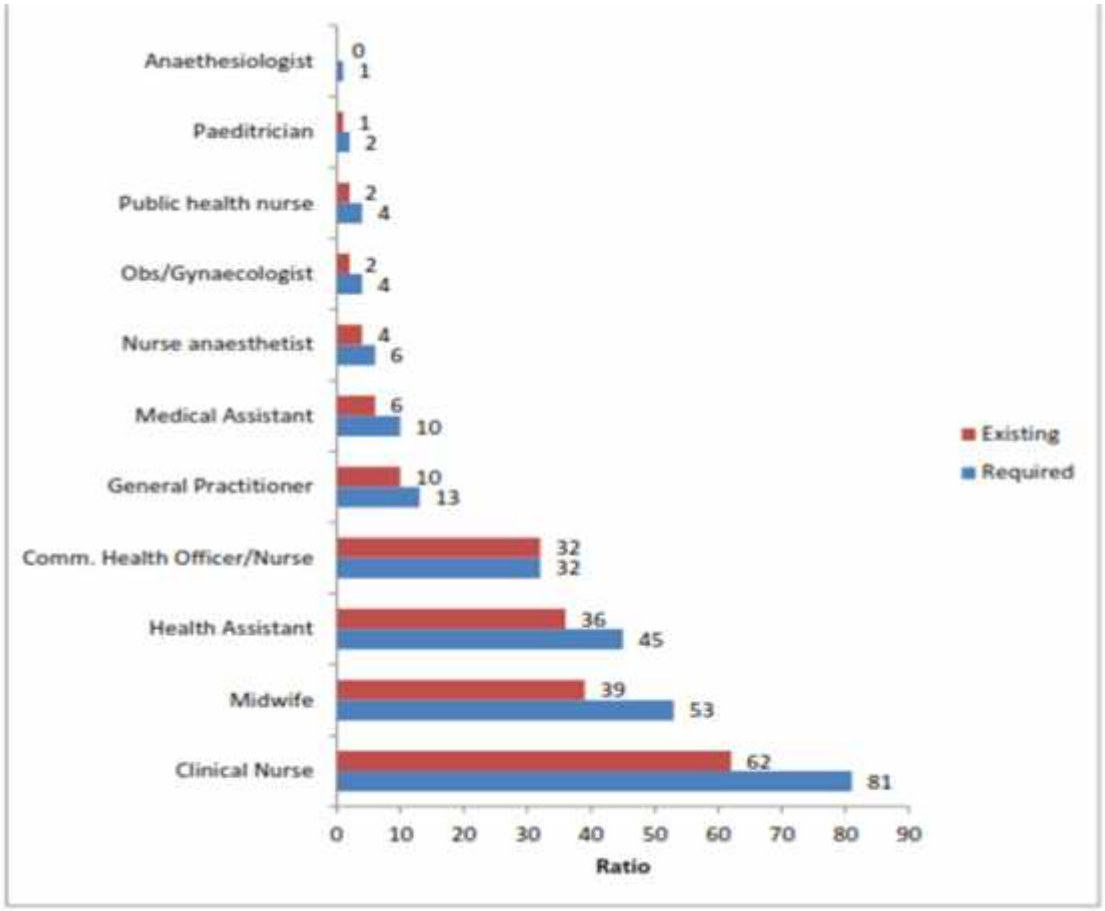
Figure 3: Ghana Health Service delivery system.



Source: Schieber et al. 2012.

Healthcare in Ghana is provided by the government, faith Based institutions and private health facilities (MoH 2012). The government provides health services at five levels as indicated in figure 3 (Schieber et al. 2012). However the healthcare coverage in the country is inadequate and varies geographically with urban centres having more access to healthcare facilities, whilst rural areas are often deprived (Schieber et al. 2012). Figure 4 indicates Ghana's health workforce density from selected health worker cadres per 200,000 population according to a nationwide survey in 2010 (MoH & GHS 2011).

Figure 4: Number of selected active health worker cadre per 200,000 population.

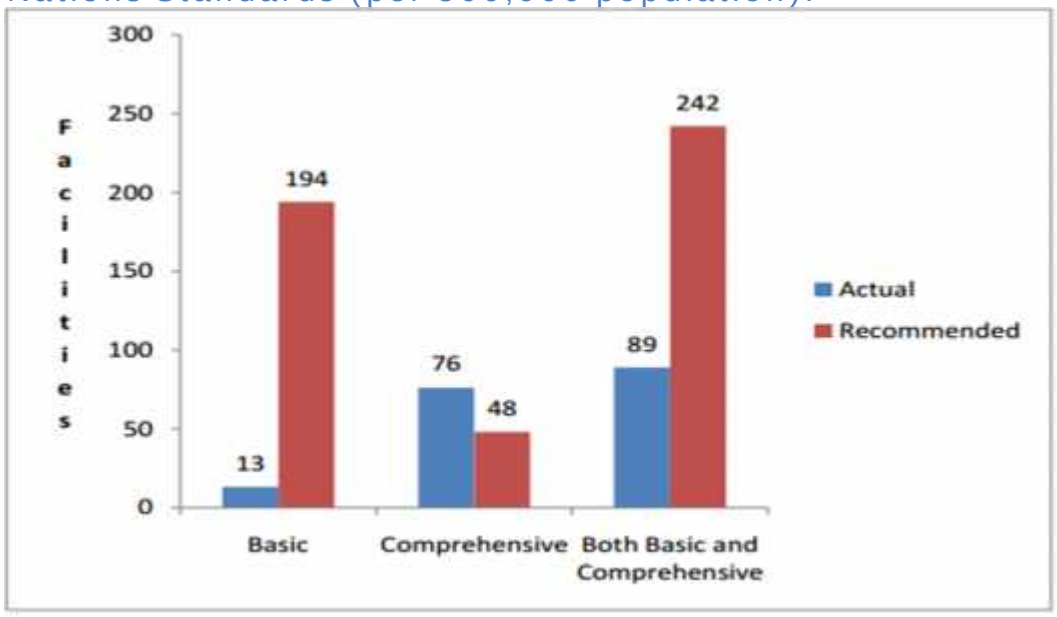


Source: Ministry of Health (MoH) & Ghana Health Service (GHS) 2011

Ghana is one of the countries globally suffering from shortage of health service provider workforce (Doctors, Midwives and Nurses) with a workforce population density below 2.3 per 1000 population which is indicated in Annex 1 (WHO 2010a).

A nationwide assessment in 2010 showed that Ghana has 13 Basic EmONC (BEmONC) facilities and 76 Comprehensive EmONC (CEmONC) facilities per 500,000 population as indicated in figure 5 (MoH & GHS 2011). The criteria which qualifies a health facility as a BEmONC and CEmONC facility is indicated in Annex 2 (MoH & GHS 2011). The distribution of EmONC facilities by region across the country is indicated in Annex 3 (MoH & GHS 2011).

Figure 5: Actual number of EmONC facilities in Ghana against United Nations Standards (per 500,000 population).



Source: MoH & GHS 2011

Healthcare in Ghana is financed with multiple sources of funds including the government budgetary allocations, Internally Generate Funds (IGF) from health institutions (government) and multi-donor support. In 2014, the Government of Ghana contributed 46.77%, IGF contributed 21.67% and donors contributed 31.56% (MoH & MoF 2015). The Total Health Expenditure (percentage of GDP) and health expenditure per capita (US dollars) since 2010 are indicated in the table below;

Table 1: Ghana's Total Health Expenditure and health expenditure per capita of Ghana, 2010 to 2013

Year	2010	2011	2012	2013
Total Health Expenditure (% of GDP)	5.3	4.8	5.2	5.4
Health expenditure per capita (US dollars)	71	77	86	100

Source: MoH & MoF 2015

Ghana has a National Health Insurance Scheme (NHIS), which pools funds from premium contributions of users (NHIS 2013). Active membership constituted 34% of the country's population as at 2012 (NHIS 2013).

1.7 Health Situation

Life expectancy at birth is 65 years; 63 years for males and 68 for females (GhanaWeb 2015). A Multiple Indicator Cluster survey in 2011 showed a total fertility rate of 4.3 with an average of 3.3 in urban areas and 5.5 in rural areas (GSS 2012). Crude birth rate is 31.3 per 1000 population and Crude Death Rate is 8.3 per 1000 population (WHO 2014). Maternal mortality ratio was 380 per 100,000LB and infant mortality rate of 39 per 1000 live births in 2013 (MoH & UNFPA 2014). Adolescent birth rate is 60 children per 1000 women, contraceptive prevalence is about 35% and unmet need for contraception (for women aged 15-49 years) is about 26% (GSS 2012). The country has 34% met need for Emergency Obstetric and Neonatal Care (EmONC) according a nationwide survey in 2010 (MoH and GHS 2011).

Ghana has a General Abortion Rate (GAR) of 15 per 1,000 women 15-44 years, and a Total Abortion Rate (TAR) of 0.4 per 1,000 women 15-44 with abortion GAR being highest among women aged 20-24. Details on abortion rates by age and residence are indicated in Annex 4 (GSS, GHS & Macro International 2009b).

2 CHAPTER TWO: PROBLEM STATEMENT, JUSTIFICATION, OBJECTIVES AND METHODOLOGY

2.1 Problem statement

Induced abortion could either be safe or unsafe with unsafe abortion mostly resulting in maternal mortality and morbidity (Grimes et al. 2006).

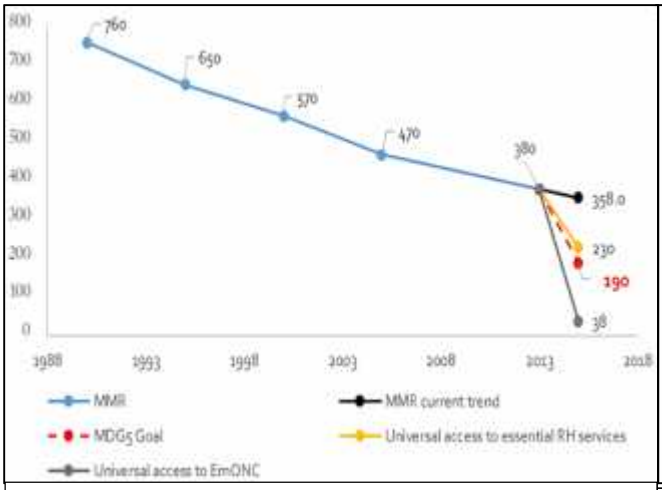
WHO global estimates in 2008 showed that 1 in 5 pregnancies end in induced abortion (WHO 2012b). Estimates in 2008 showed 43.8 million induced abortions globally of which 22.2 million were safe and 21.6 million were unsafe (Sedgh et al. 2012). Unsafe abortion is defined by WHO as, “a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards or both” (WHO 2015b). Though induced abortion is prevalent everywhere globally, it is estimated that 38 million are from developing countries of which 56% are unsafe and 44% are safe (WHO 2011). Estimates show that 47,000 (13%) of maternal deaths annually are due to unsafe abortion, making abortion one of the leading causes of maternal mortality most of which occur in developing countries (WHO 2011).

Unsafe abortion does not only lead to mortality, but also contributes to long term morbidity among women. Estimates show that every year, nearly 5 million of women who survive unsafe abortion end up with long term health problems (Haddad & Nour 2009).

Ghana has a low contraceptive prevalence (35%) and high unmet need for family planning (26%) which mostly results in unwanted pregnancies and the need for induced abortions (GSS 2012). This implies women may seek abortion services. Estimates form the 2007 Ghana Maternal Health Survey (MHS) show a national induced abortion rate of 15 per 1000 women of 15-44 years (GSS, GHS & Macro International 2009b). The same survey shows that the rate is higher among ages 20-24 years, urban residents, educated women and women of high economic quintile.

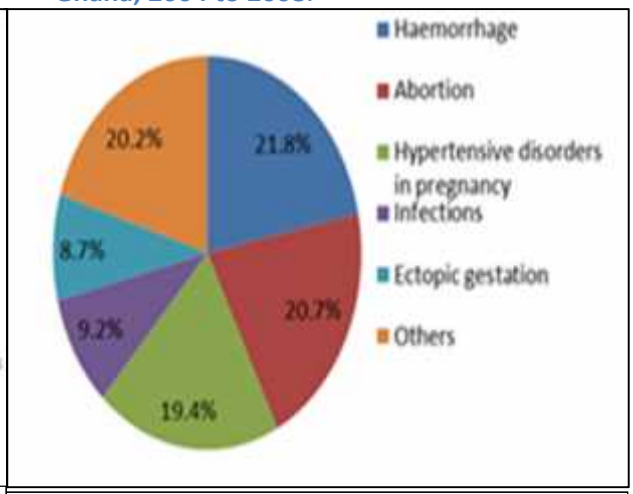
The pace of reduction in maternal mortality in Ghana over the years has been slow which puts the country off-track in meeting MDG 5 target as indicated in figure 6 (MoH & UNFPA 2014). This is partly due to high levels of abortion related maternal deaths (Der et al. 2013). A retrospective study in the Korlebu Teaching Hospital in Ghana showed that, from 2004 to 2008, abortion was the second leading cause of maternal deaths accounting for 20.7% of maternal deaths as indicated in figure 7 (Der et al. 2013).

Figure 6: Trends and scenarios of maternal mortality in Ghana



Source: MoH & UNFPA 2014

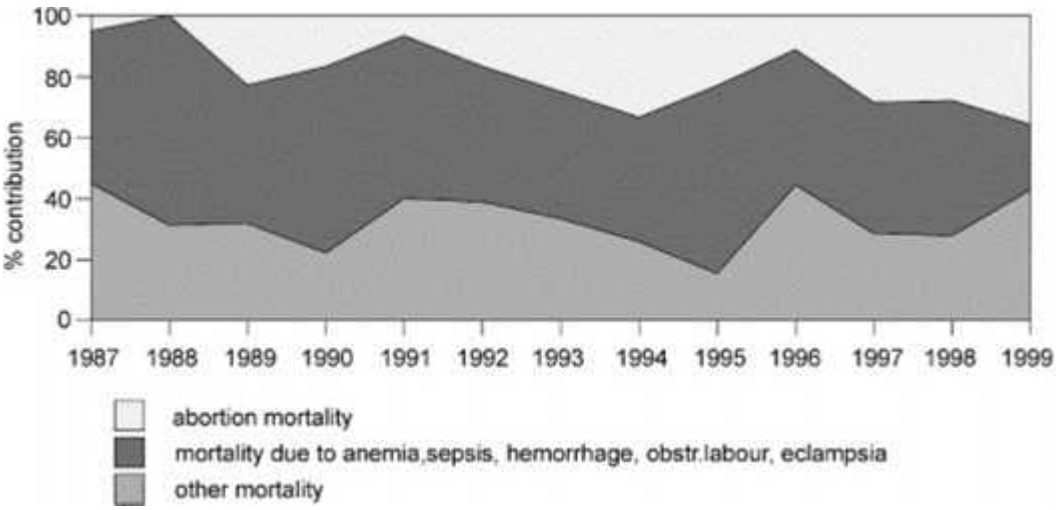
Figure 7: Leading causes of maternal deaths in Ghana; 2004 to 2008.



Source: Der et al. 2013

A previous rural hospital based study by Geelhoed et al. (2003) from 1987 to 1999 also showed that induced abortion was a leading cause of maternal deaths accounting for 18.8% of deaths. According to the study, the trend of induced abortion related maternal deaths continued to remain high over the years as indicated in figure 8 which does not make the 20.7% indicated by Der et al. (2013) surprising.

Figure 8: Changes in relative contributions of causes to overall maternal mortality in Ghana, 1987 to 1999



Source: Geelhoed et al. 2003

One can largely associate these induced abortion related maternal deaths to complications from unsafe abortions. Estimates from the 2007 nationwide MHS show that unsafe abortion is the second leading cause of maternal deaths in the country (GSS, GHS & Macro International 2009b).

Unsafe abortion leads to complications like renal failure, trauma, sepsis, haemorrhage and anaemia among others (Alder et al. 2012). A hospital based study in Ghana showed that abortion related complications accounted for 42.7% of admissions to the gynaecological ward (Konney et al. 2009).

Aside the health consequences, the economic burden of unsafe abortion is something that is evident. It is estimated that the economic cost associated with the medical treatment of abortion complications in developing countries is a minimum amount of $ 341 million per annum (Vlassof et al. 2009). A study in Ghana by Aboagye et al. (2007) shows that treatment from abortion complications has an economic burden of 8.5 million UDS on families annually. It simply implies that unsafe abortion poses an economic burden to health systems, families and the country at large.

In Ghana, unsafe abortion and its related maternal mortality and morbidity are largely associated with women's access to and utilization of safe abortion services (Schwandt et al. 2013). Though there is no much data on the specific levels of unsafe abortions in Ghana, the 2007 MHS shows that 40% of abortions are carried out by unqualified providers; these are largely regarded unsafe (Sundaram et al. 2014; GSS, GHS & Macro International 2009b). One should however interpret this data with caution because Sedgh (2010) in his analysis indicated that, the sensitive nature of abortion in Ghana mostly results in under reporting during surveys.

Some studies have identified various levels of factors that influence women's utilization of safe abortion services. Axel I Mundigo outlines a number of factors including social, economic, health service, religious and policy/legal factors, which he called systemic factors (Mundingo 2006). Janie Benson also established similar factors but a little differently as he outlines factors including laws and policies, women abortion care-seeking behaviour, service delivery, social, economic and political factors (Benson 2005).

2.2 Justification

Though Ghana has been making efforts to reduce maternal mortality ratio, the pace has been slow with a reduction from 760 per 100,000LB in 1990 to 380 per 100,000LB in 2013, which indicates that the target of achieving MDG 5 (190 per 100000LB by 2015) is not possible if the current pace continues (MoH & UNFPA 2014).

In recognizing the contribution of unsafe abortion to maternal mortality in the country, Ghana responded with legal and policy interventions. In 1985, there was a review of the 1960 law which had completely criminalized abortion and was considered to restrict access to safe abortion services (Morhee & Morhee 2006). The review in 1985 however made the law more liberal with the purpose of increasing access to safe abortion services in other to prevent unsafe abortions. Policy responses also included the development of a national reproductive health policy and standards in 2003 followed with protocols for comprehensive abortion care in 2006 (Odoi-Agyarko 2003).

Despite the legal and policy interventions, many unsafe abortions still take place most of which are clandestine and considered unsafe and illegal, contributing to a significant proportion of maternal mortalities as indicate earlier (Sedgh 2010). As also indicated in a trend by Geelhoed et al. (2003), the proportion of abortion related maternal deaths still remained high from 1987 to 1999 and beyond, even after abortion was made legal in 1985.

There are several factors surrounding women's use of safe or unsafe abortion services as earlier on indicated, which are worth researching into. Though there have been a number of researches in Ghana on some of these factors, there is little research which explores all factors together to establish how they relate to each other.

This literature review explores all levels of factors together (including contextual factors) and establishes how these factors interactively relate to each other to influence women's access to and utilization of safe abortion services. The review also identifies gaps and recommends evidence based interventions to improve access to and utilization of safe abortion services.

2.3 Objectives

2.3.1 General Objective:

To explore factors that influence women's access to and utilization of safe abortion services in Ghana and to identify evidence based interventions in order to develop recommendations to improve utilization of safe abortion services in Ghana.

2.3.2 Specific objectives:

1. To analyse the influence of the socio-cultural, political, and economic, contexts on women's access to and utilization of safe abortion services.
2. To Explore legal, policy and service delivery factors that influence access to and utilization of safe abortion services
3. To explore women's decisions and choices in seeking abortion services.
4. To identify evidence based interventions that improve women's access to and utilization of safe abortion services.

2.4 Methodology

2.4.1 Search strategy and data

The methodology for this study is literature review. Data for the study is from the review of unpublished and published literature.

Google was used to find various websites including websites of WHO, UNFPA, Ipas, Guttmacher Institute, Ghana Health Service (GHS), Ministry of Health (MoH) of Ghana and Ghana Statistical Service (GSS). Information from reports, books, fact sheets, policy documents, standards, guidelines and protocols were retrieved from these institutional websites.

Google Scholar, PubMed and the VU e-Library were used to search for published articles, which found a lot of articles from peer reviewed journals. These articles were further screened for relevant ones by reading the abstracts; those that did not suit the study were left out. Bibliographies of relevant articles were also used as means to search for other related articles cited.

Search words were used to find literature for each objective of the review are indicated in table 2.

Table 2: Search Table

Source	Search words used by objective			
	Objective 1	Objective 2	Objective 3	Objective 4
PubMed Google scholar VU e-library	"Religion, culture and abortion in Ghana", "social perception and abortion in Ghana", "Social attitude and abortion in Ghana", "Socio-cultural context and Abortion in Ghana", "Stigma and abortion in Ghana", "abortion and financing in Ghana", "Economic access to abortion in Ghana", "health financing and abortion in Ghana".	"abortion service utilization", "Health service providers and abortion in Ghana", "determinants of unsafe abortion and Ghana", "Abortion law in Ghana", "Abortion policies in Ghana", "Access to safe abortion in Ghana", "Abortion and Ghana", "unsafe abortion and Ghana", "Policies and safe abortion in Ghana", "Laws and access to safe abortion in Ghana"	"Women's attitude and abortion in Ghana", "Abortion choices in Ghana", "Women's abortion decisions in Ghana", "Use of abortion services in Ghana", "women and access to safe abortion in Ghana", "socio-demographic status and abortion in Ghana"	"abortion and interventions", "abortion strategies", "Improving access to safe abortion", "Improving utilization of safe abortion services"
Websites of Ministry of Health and Ghana Health Service, and Ghana Statistical Service	"health expenditure", "financing abortion"	"Abortion", "Abortion law", "Policies and abortion", "abortion programmes", "Abortion interventions", "abortion rates"	"abortion", "abortion statistics"	"abortion programmes", "Abortion interventions"
Websites of Ipas, and Guttmacher Institute	"Stigma and abortion in Ghana", "social perception and abortion"			"abortion programmes", "Abortion interventions", Improving access to safe abortion", preventing unsafe abortions"

Websites of WHO, UNFPA and UN	“Abortion”			“Abortion” “abortion programmes”, “Abortion interventions”, Improving access to safe abortion”, preventing unsafe abortions”, “abortion guidelines”, abortion protocols”,

Inclusion and exclusion criteria: Only literature presented in English was used. Only literature which could be applied in the context of induced abortion was used. All other literatures that did not meet these criteria were excluded. Literature that had data on only spontaneous abortion was not used. Articles that only present abstracts without access to full text versions were also not used.

2.4.2 Conceptual Framework for study

Factors influencing the use of safe abortions services have been identified and explored in various studies using different conceptual frameworks. Different frameworks explore similar factors but with slight differences in the type and number of specific factors depending on the purpose and context of the research. Axel I Mundigo outlines factors into proximate and systemic factors (Mundingo 2006). Proximate factors include women's contraceptive use and contraception practice which characterize women's fertility behaviour and could influence onset of unintended pregnancies and termination of unwanted pregnancies; Systemic factors include social, economic, health service, religious and policy/legal factors (Mundingo 2006). Janie Benson also established similar factors as he outlines factors including laws and policies, women abortion care-seeking behaviour, service delivery, social, economic and political factors (Benson 2005). The difference between the two frameworks is that Benson only considered the case where a woman already has an unwanted pregnancy and needs to terminate it, whiles Axel goes a step back to as well analyse what he called the proximate factors.

The purpose of this thesis is to study factors that influence utilization of safe abortion services considering only the stage a woman already has an unwanted pregnancy and needs to terminate it. Axel's frameworks goes a step back to as well analyse factors that lead to unwanted pregnancies which is not the purpose of this study (Thesis). Janie Benson's conceptual framework for evaluating safe abortion programs is therefore more suitable for the purpose of this study as it presents a range of factors that influence the use of safe abortions services at the stage when an unwanted pregnancy has already occurred and there's the demand for termination.

The framework is flexible as it allows exploration of factors within a context like Ghana. It is also straight forward and specifically illustrates how the factors interact to influence utilization of abortion services. Though the framework has been adapted (modified) for this study, it is worth illustrating the original version which is explained below;

Law and Policies factors: These refer to abortion laws and Health System norms and standards that influence access and quality of services.

Women's abortion care-seeking behavioural factors: This refers to attitudes of women towards services, their knowledge of services and their confidence of obtaining services, which could be influenced by laws, policies, and service delivery factors.

Service delivery factors: The service delivery refers to access to safe abortion services in terms of availability and distribution of services. It also includes quality of services which indicates provider training and support, supplies and equipment, preferred technologies, post abortion contraception, client's satisfaction, provider's attitudes, referral and support, then monitoring and evaluation.

Programs interventions, advocacy, and stakeholder education: this is the main focus of Benson's framework (to evaluate effectiveness of programmes). Benson illustrates in the framework that effective programmes with advocacy and stakeholder education should positively influence laws and policies, women's abortion care-seeking behaviour, and service delivery; these intern should improve utilization of safe abortion services. He also illustrated that utilization of safe abortion services will lead to ultimate outcomes like reduction in maternal mortality and morbidity, increased reproductive health choices, reduced repeat of unintended pregnancies and reduced unsafe abortions.

Context: This refers to the social, cultural, economic, political, and legal contexts which influence women's utilization of safe abortion services. The framework also illustrates that all the above mentioned factors take place under these contexts and therefore are influenced by the contexts.

The original framework is illustrated in Annex 5 (Benson 2005)

2.4.3 Adapted and modified version of Benson's framework for this study

All aspects of Benson's framework have been adopted except the aspect of programme interventions and the outcomes of utilization of safe abortion services (reduction in maternal mortality and morbidity, increase in reproductive choices and reduction in repeated unintended pregnancy and unsafe abortion). This is because the purpose of this study is to generally explores factors influencing utilization of safe abortion services in Ghana, and not to evaluate a specific abortion program or intervention. This study is

however with the assumption that improved utilization of safe abortion services will lead to the ultimate outcomes indicated by Benson.

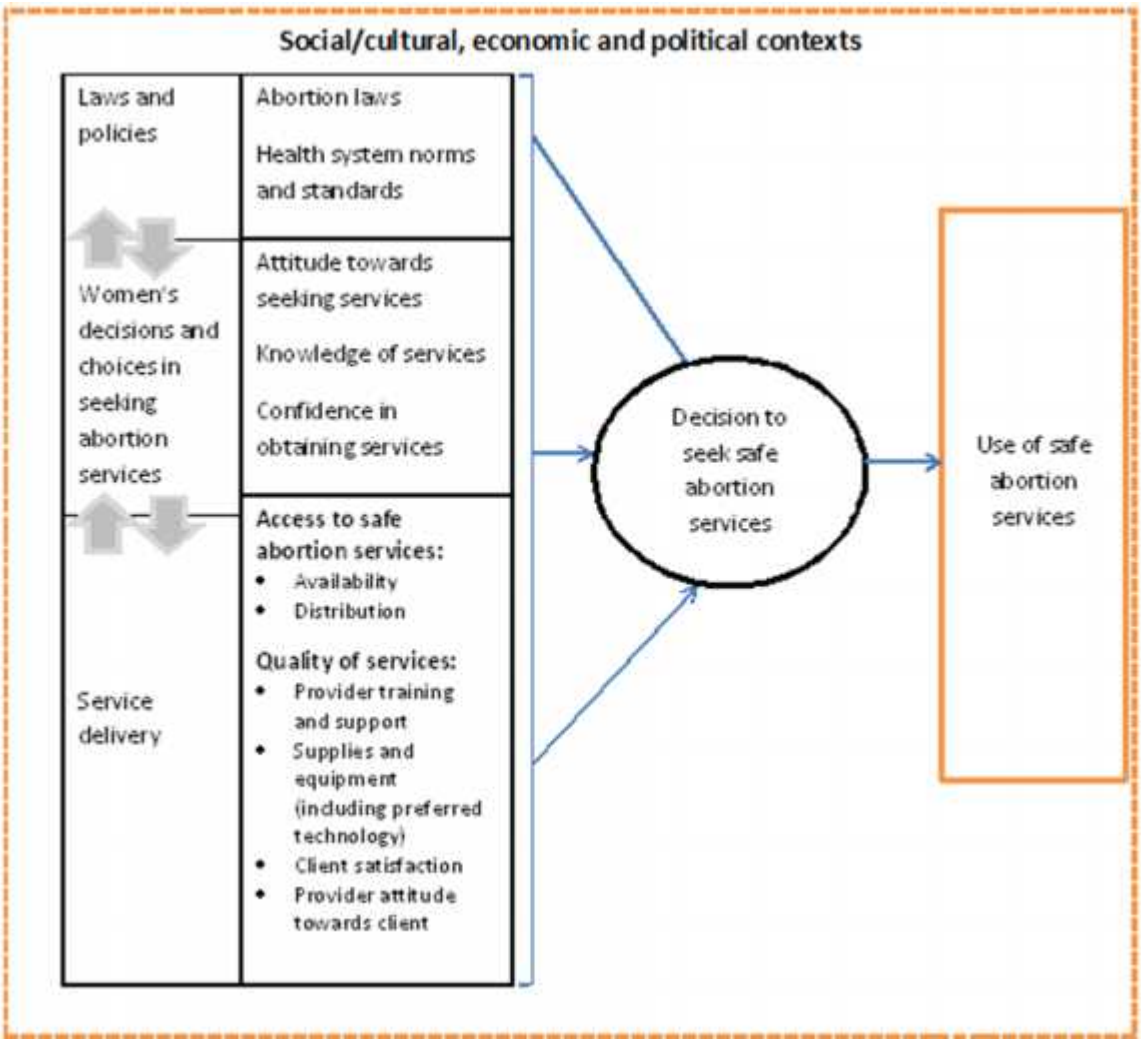
The contexts however remain the same (Social, cultural, political, economic, and legal); this study considers religion as part of the socio-cultural context. This study also replaces “women’s abortion care-seeking behaviour” with “women’s decision and choices in seeking abortion services”. The adapted and modified framework is illustrated in Figure 9.

2.4.4 Limitations of study and analysis

Since the language for the review is only English, relevant literature in other languages will be left out. The sensitive nature of abortion especially in Ghana could result in under reporting of data on abortion used in literatures. Few studies on abortion have been done in Ghana which limits this literature review in terms of triangulation using multiple sources of literature. The literature review had more access to literature online than literature that is not online; this might lead to data biases since much part of the review used online literature.

The above limitations were addressed during the analysis by using multiple sources of data with similar contexts to triangulate. Since there was limited nationwide data, multiple studies done across parts of the country were used to present evidence and to triangulate by using similar studies from either within the country or outside the country. The quality of studies used for this review was ensured by considering the methodologies implored in such studies. Studies published in peer reviewed journals were mostly used.

Figure 9: Framework of factors influencing access to and utilization of safe abortion services: adopted and modified from Janie Benson's framework for evaluating safe abortion programs (Benson 2005).



Source: Benson 2005.

3 CHAPTER THREE: FACTORS INFLUENCING WOMEN'S ACCESS TO AND UTILIZATION OF SAFE ABORTION SERVICES

3.1 The socio-cultural and Political and economic contexts

This section presents findings on the influence of the socio-cultural and economic contexts on access to and utilisation of safe abortion services. The political context is also highlighted to be linked to the socio-cultural context.

3.1.1 Socio-cultural and political contexts

The socio-cultural and political contexts as explained by Benson definitely influence a woman's access to and utilization of abortion services (Benson 2005). For this review, the socio-cultural context has to do with norms, values and beliefs and how they influence social attitude towards abortion. The political context in this review has to do with some social stands on abortion.

The 2008 Ghana Demographic and Health Survey shows that 68%, 18% and 9% of the population are Christians, Muslims and traditionalists respectively (GSS, GHS & Macro International 2009a). These religions are deeply rooted in values and beliefs that influence social attitudes as indicated by Nicole Webster in a qualitative study in Ghana (Webster 2013). Lithur (2004) in her studies indicated that Ghana is characterized by cultural values, and religious beliefs which frown against and stigmatize abortion. The study also revealed that these cultural values and religious beliefs influence social perceptions and attitude towards abortion. Hill et al. (2009) in a study also indicated that Ghanaian communities regard abortion as dangerous and shameful. Women in Ghana are in constant relation with their social environment and are expected to live by shared values and beliefs (Lithur 2004). In that case, since abortion is stigmatized in Ghana, women may utilize clandestine abortion services for the sake of secrecy and confidentiality to avoid public attention. This is evident in the study by Hill et al. (2009) which indicated that, most women in Ghana due to the stigmatized nature of abortion resort to clandestine services for reasons of secrecy and confidentiality.

It is shown that the social stigma on abortion not only prevents women from openly seeking services, but also prevents qualified providers from offering services (Lithur 2004 & Payne et al. 2013). Most health service providers do not want to associate themselves with abortion (Payne et al. 2013). This indicates the influence of the socio-cultural context on abortion policy implementation.

Though this literature review has not come across any specific evidence on the political context of abortion in Ghana, one should not underestimate the social stand on abortion and its influence on the political will of policy makers and implementers (providers). An example is the Catholic Church and other religious bodies who do not belief in abortion from the religious and moral perspectives. It is however to be noted that Faith Inspired Institutions (FII) form part of the health system in Ghana. The Christian Health Association of Ghana (CHAG) provides about 42% of health services in Ghana (Christian Medical Fellowship 2015). It is also estimated that the Catholic Church provides about 27% of services in the in Ghana (Olivier, Shojo, & Wodon 2014). This has an implication on access to safe abortion services since health facilities under the jurisdiction of FII will not offer abortion services.

3.1.2 Economic context

Schieber et al. (2012) in a comprehensive study (for the World Bank) in Ghana indicated that, the country has over the years been grappling with inadequate financing for health services and infrastructure. In terms of access to abortion services, the country has been supported by Non-Governmental organisations (Pathfinder, Ipas, EngenderHealth, and others) in expanding access to abortion services (Population council 2015).The country's NHIS does not cover abortion services which means women will have to pay fees at point of service delivery (Payne et al. 2013). From evidence, the economic burden on families for treating complications from unsafe abortion is about USD 8.5 Million annually (Aboagye et al., 2007).

The economic influence on women's access to and utilization of safe abortion services is well indicated in a study by Hill et al. (2009), which shows that most women of low income statuses try multiple methods of abortion, starting from cheaper ones and working up to expensive methods when initial methods fail. Frank Baiden in a study also explained that, majority of women and school going age youth in Ghana face economic barriers in obtaining safe abortion services and therefore resort to clandestine services out of desperation (Baiden, 2009). Baiden termed this as an "inequity" in accessing available safe abortion services (Baiden, 2009).

3.2 Laws and Policies

3.2.1 The law and abortion/legal context

The provision of abortion services has always been an issue of debate in the public discourse over the years, which has led to varied legal responses and reforms in different countries (United Nations 2002). All over the world women seek to induce abortions for similar reasons, but their access to such services vary depending on the legal context (Warriner & Shah 2006; Boland & Katzive 2008).

Evidence which show that restrictive abortion laws do not prevent unsafe abortions and may rather compound the problem, has led to the liberalization of abortion laws in many countries over the years (Warriner & Shah 2006; Boland & Katzive 2008). Some countries however still have restrictive abortion laws with about 60% (103 countries) of the world's population living in countries where abortion is either prohibited or restricted by law (Boland & Katzive 2008).

Before 1985, Abortion in Ghana was regulated under the "criminal code of 1960 (Act 29, sections 58-59 and 67)" where abortion was not permitted on any grounds except for the reason of medical procedure to provide medical treatment for the woman (Schwandt et al. 2013). This law placed much restriction on access to safe abortion services until 1985, when the law was amended under PNDCL 102 of 1985 (Morhee & Morhee 2006).

The 1985 law, only broadened the grounds on which abortion would be considered legal but still with restrictions (Parliament of the Republic of Ghana 2003). The law for instance states that abortion is legal only on the grounds of saving the life, preserving physical and mental health of the woman, and in cases of rape, incest and foetal impairment. The law also states that abortion should be performed by a qualified and registered physician, in a legally approved and registered health facility with consent of the pregnant woman or guardian/next of kin if the woman is not capable of giving consent (Parliament of the Republic of Ghana 2003). The law however does not allow economic and social reasons for abortion and does not allow abortion on request for any other reason than stipulated; this characterizes it as a restrictive law (Boland & Katzive 2008). The law also needs consent from parents/guardians before offering abortion services to girls below 16 years (Morhee & Morhee 2006). The law implies that women with socio-economic reasons or any other reasons to terminate pregnancy cannot access legal abortion services and this can make such women resort to clandestine services or other unsafe means.

Ghana's abortion law is one of the most liberal in Africa according to research (Boland & Katzive 2008). However, most providers find it challenging to interpret in services provision (Payne et al. 2013). Studies showed that most services providers find the law ambiguous and difficult to interpret and this made them hesitant in providing services (Morhee & Morhee 2006; Payne et al. 2013).

Awareness on the law is also something that is worth noting as this may influence providers and clients attitudes towards abortion services. A study in a teaching hospital in Ghana showed that 92% of post abortion care patients did not know of the legal status of abortion (Konney et al. 2009). Another qualitative, study also conducted by Payne et al. (2013) in Ghana showed that most women who use unsafe abortion services did so because they were not aware one could obtain legal abortion services. The implication is that, women who may think abortion is illegal are likely to seek available clandestine services or resort to other unsafe means.

3.2.2 Policies and Abortion

Health system norms and standards

Ghana in response to improving Reproductive Health committed to the 1994 International Conference on Population and Development (ICPD) conference in Cairo (UNFPA 2014 & Hessini et al. 2006). The ICPD conference came out with a Programme of Action for prevention of unsafe abortion and encouraged countries to expand access to quality family planning, abortion and post abortion care (UNFPA 2014).

Ghana currently has a National Reproductive Health Service Policy and Standards (NRHSPS) document which was first produced in 1996 and reviewed in 2003 (Odoi-Agyarko 2003). The set norm on this policy is to provide comprehensive abortion services. The service policy outlines: "General rules and regulations governing reproductive health services and training; Components of reproductive health services, targets and priority groups for services; and those eligible for services, the providers of the services, and how training, logistics, supervision and evaluation activities shall be planned and implemented" (Odoi-Agyarko 2003).

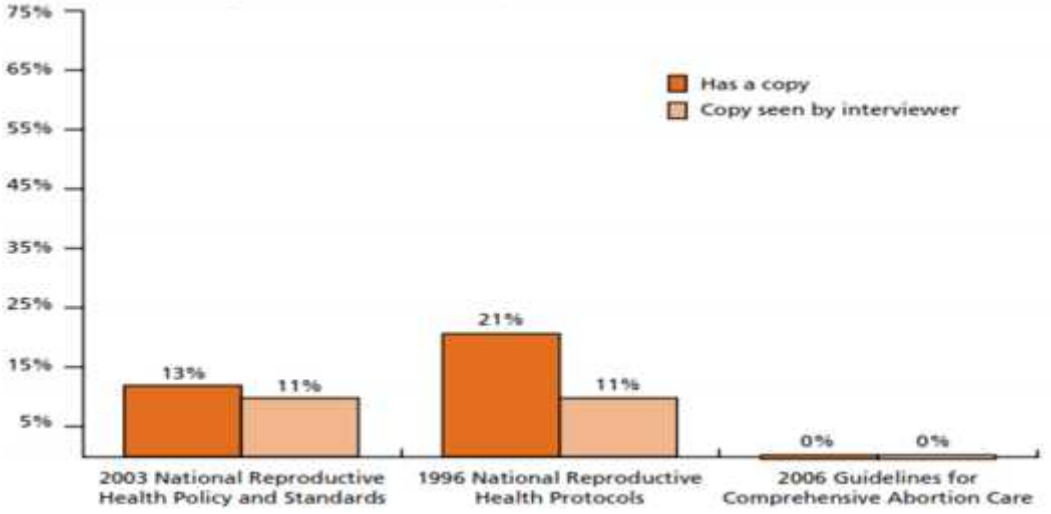
The service standard spells out: The minimum acceptable level of performance and expectations for each component of the reproductive health services; Expected functions of service providers at the various level of service delivery; and the basic training content required for the performance of these functions (Odoi-Agyarko 2003). A National

Reproductive Health Protocols was also produced in 1996, to guide the implementation of all components of the policy (Odoi-Agyarko 2003).

As a result of the policy provision Ghana has adopted a Comprehensive Abortion Care services standards and protocols to provide safe-abortion and post-abortion services including effective management of complications of unsafe abortion (Ipas 2013 & Aboagye et al. 2007). Guidelines have also been developed to guide safe abortion provision by standards (Aboagye et al. 2007). It is however to be noted that abortion policies, protocols and guidelines operate under the stipulated provisions of the 1985 abortion law (Morhee & Morhee 2006).

Despite the policy provision with protocols and guidelines, dissemination and provider knowledge of these documents is inadequate which hinders service provision (Aboagye et al. 2007). A study conducted by Aboagye et al. (2007) on behalf of Ipas in three regions of Ghana (Greater Accra, Eastern, and Ashanti regions), show's provider's little exposure to policy and standard documents as indicated in figure 10 .

Figure 10: Percentage of health facilities possessing Policy documents, guidelines and protocols



Source: Aboagye et al. 2007

The inadequate exposure of providers to policy documents as illustrated could limit appropriate provision and access to CAC services. This probably could be one of the reasons why despite legal and policy provisions, studies still show that women continue to use unsafe abortion services (Aniteye & Mayhew 2011; Morhee & Morhee 2006). It also implies that making provisions for significant abortion policies alone does not necessarily lead to effective implementation. The insufficient policy implementation is also linked to the fact that most health providers are hindered by the socio-

cultural resistance on abortion as indicated in earlier sections. The study by Aboagye et al. (2007) also shows that limited resources (supplies and equipment) hinder abortion policy implementation in Ghana; much on this is presented in later sections.

As part of efforts to improve the implementation of the 2003 Reproductive Health Service Policy and Standards, the GHS with a team of organizations started implementing a “Reducing Maternal Mortality and Morbidity (R3M)” programme in 2006 (Population Council 2015). One of the objectives of the programme is to “Reduce mortality and morbidity due to unsafe abortion in the three focus regions and contribute to the achievement of MDG 5 for Ghana” (Population Council 2015). The programme which is being piloted in three regions (Greater Accra, Eastern, and Ashanti regions) as in 2012 trained midwives and physicians on CAC, upgraded GHS infrastructure making them client-friendly, supported pre-service training institutions in improving curriculums for CAC and so forth (Population Council 2015).

In conclusion, the findings so far in this section point out that Ghana has adopted good policy measures to improve access to and utilization of safe abortion services, but implementation remains inadequate.

3.3 Service Delivery

3.3.1 Access to safe abortion services

WHO findings show that women with limited access to safe abortion services mostly resort to unsafe means of pregnancy termination (WHO 2015b). Though there are several dimensions of access, this section will focus on availability and distribution of services as spelled out by the framework for the study.

3.3.1.1 Availability and distribution of Safe Abortion Care (SAC)

Availability and distribution of health services in general is regarded as inadequate Ghana with the rural areas suffering the most (Population Council 2015). In terms of availability and distribution of SAC, a study in three regions of Ghana showed that only 12 (13.3%) health facilities out of 90 offered legal abortion services whiles 22 (26.6%) out of 90 offered PAC (Aboagye et al. 2007). This implies that women have more access to PAC than abortion care, though access to both services is limited. It also raises a

question of why some facilities offer PAC and not induced abortion services. The 2007 MHS showed that only 12% of women perceive they have access to abortion services (GSS, GHS and Macro international 2009b). This data however should be interpreted with caution because the survey did not indicate the type of abortion provider women perceive to have access to.

A study adopted UN's recommended signal functions for Emergency Obstetric Care (EmOC) and came out with required signal functions for SAC (Maine et al. 2009 & Healy et al. 2006). The signal functions for EmOC services are indicated in Annex 2. The table below shows the required signal functions a health facility should provide as a Basic SAC and Comprehensive SAC as adopted by Healy et al. (2006). Annex 6 further indicates the signal functions for SAC with respective indicators (Ipas 2009).

Table 3: Signal functions for Safe Abortion Care

Signal functions for basic SAC services	Signal functions for comprehensive SAC services
	Perform all basic functions
Available during regular outpatient hours: • Perform induced abortion for uterine size ≤12 weeks for all legal indications • Provide post abortion contraception	Available during regular outpatient hours: • Perform induced abortion for uterine size > 12 weeks, for all legal indications
Available 24 h per day, 7 days per week: • Administer essential antibiotics • Administer intravenous replacement fluids • Administer oxytocics • Perform removal of retained products for uterine size ≤ 12 weeks • Provide post abortion contraception	Available 24 h per day, 7 days per week: • Perform removal of retained products for uterine size > 12 weeks • Perform blood transfusion • Perform laparotomy

Source: Healy, Otsea & Benson 2006.

In terms of availability of services, it is recommended that there should be 5 SAC facilities per every 500,000 population with at least one offering comprehensive SAC , whiles for distribution of SAC services, there should be 100% of sub-national level facilities meeting this recommendation (Healy, Otsea, & Benson 2006).

As mentioned earlier, a study in three regions of Ghana showed that 12 (13.3%) out of 90 facilities offered basic SAC whiles 8 (8.8%) offered comprehensive SAC (Aboagye et al. 2007). This indicates that only 13.3% and 8.8% of health facilities are considered to render basic SAC and comprehensive SAC respectively by requirements. With regards to availability and distribution of SAC, none of the regions met the requirement of 5 facilities per 500,000 population for basic SAC with the highest being 3.42 per 500,000 population. The evidence on the above SAC indicators implies limited access to SAC services for women in Ghana. This literature review did not come across anymore recent evidence that describes access to SAC using these recommended indicators. It is therefore worth noting that despite legal and policy provisions for SAC in Ghana, the challenge of access to SAC remain a problem.

3.3.2 Quality of services

The quality of safe abortion services is a complex but significant factor that influences women's access to and utilization of safe abortion services. As highlighted by Janie Benson, aspects that form part of quality of services include provider training and support, supplies and equipment, provider attitude and client satisfaction (Benson 2005).

3.3.2.1 Provider training and support

Until 2006 the policy only permitted registered medical doctors to provide both abortion services and post-abortion care, whiles midwives were only permitted to provide post-abortion care (Aniteye & Mayhew 2013). In 2006, the policy expanded the provider cadre by permitting midwives to as well provide abortion services by establishing a pre-service training curriculum in midwifery training institution (Aniteye & Mayhew 2013). The country currently however has inadequate number of medical doctors and midwives unevenly distributed (mostly located in urban areas) across the country (Dennis-Antwi, Matthews, & Campbell 2015). This has a negative implication on access to qualified safe abortion service providers and limited access to qualified providers could make women turn to clandestine services (Aniteye & Mayhew 2013).

For a health system to be able to provide quality abortion services, providers should be trained to have the required competences per national standards and guidelines (Berer 2009). Studies in Ghana indicate that most Physicians have knowledge of the abortion law and policy and are more confident in providing CAC than midlevel providers such as midwives (Aniteye, Mayhew &

O'Brien 2014). Also among physicians, only those who have been further exposed to international treaties and conventions on abortion are capable of interpreting the law and appropriately conforming to the policy with clear value clarification (Aniteye, Mayhew & O'Brien 2014).

Midwives are more accessible especially in rural areas and offer a much proportion of services to women as compared to physicians, yet they mostly lack the competence to offer comprehensive abortion services (Voetagbe et al. 2010 & Payne et al. 2013). Their competence to offer quality comprehensive abortion services may be limited due to limited training. In a study to assess the willingness and capacity of midwifery tutors to offer quality of CAC trainings to midwives, Voetagbe et al. (2010) realized only 18.9% of midwifery tutors knew all the legal indications of abortion. The study also revealed that most tutors were hesitant to teach abortion due to their limited knowledge of the law and policy, religious barriers, and uncertainty about their clinical competencies. This indicates inadequate level of trainings received by midwives to offer quality abortion services. The study also showed that most of the midwifery tutors lack adequate pre-service training on comprehensive care as shown in Table 4 (Voetagbe et al. 2010).

Table 4: Training Elements of CAC received as responded by midwifery tutors.

Categories	%
Gestational dating	
Last menstrual period	90.5
Bimanual exam	52.7
Ultrasound	18.9
Contraception	
Short-term methods	91.9
Intrauterine device insertion (IUCD)	77.0
Tubal ligation	48.6
Counseling	
Abortion counseling	52.7
Post abortion counseling	59.5
Uterine evacuation	
D&C	36.5
MVA	23.0
Medication abortion	27.0
Others	
Infection prevention	91.9
Management of incomplete abortion	77.0
Referral of abortion complications	68.9
Community to prevent unsafe abortion	51.4
Pain management for uterine evacuation	48.6
Confirming completeness of an abortion	48.6
MVA instrument facts and features	27.0
Monitoring quality of abortion services	17.6
Ghanaian Abortion laws & GHS policies	25.7

Source: Voetagbe et al., 2010

3.3.2.2 Supplies and equipment

A study conducted in Ghana to assess the availability of required equipment to ensure comprehensive abortion care revealed that up to three-quarters of health facilities lack required medical equipment and infection prevention commodities (Aboagye et al. 2007). The same study showed that supplies and equipment for CAC were more available at the hospital level than the primary-care facility level (for instance 50% of hospitals had two or more

functional manual vacuum aspirators as compared to 8.1% primary-care facilities who had one or more). This indicates multiple levels of inadequacies in terms of availability of appropriate equipment and technology to provide safe abortion.

Another study done by Payne et al. (2013) in Ghana revealed narratives from most physicians explaining that, most facilities lack equipment like ultrasound machines, proper forceps, laminaria, and other equipment to safely provide second trimester abortions. This may make abortion services at that stage not accessible to women in legal facilities and might make women resort to self-termination or clandestine services.

3.3.2.3 Provider attitude and Client satisfaction

Health care provider attitude to safe abortion service provision impacts either negatively or positively on the quality of services (Lipp 2008). In countries where the laws and policies permit induced abortion, the role of health care providers is very vital in influencing women's access to and utilization of quality and safe abortion services (Loi et al. 2015).

Even with Ghana's liberal abortion law and training of providers to offer safe abortion services, religious, cultural, and other social barriers significantly influence attitudes in providing services (Lipp 2008 & Schwandt et al. 2013). Abortion is highly stigmatized in Ghana which impacts negatively on provider's attitudes to abortion services, which is even worse for providers with strong religious convictions (Schwandt et al. 2013 & Payne et al. 2013). A physician in an interview during a qualitative study conducted by Payne et al in 2013 in Ghana stated "Our society is a highly religious one... we used to do elective terminations in some of our [surgical] theatres. ... Gradually, the nurses decided, 'No, we are not setting the trolley (i.e., surgical cart with instruments) for you to do [the abortion], because I go to church and [I] don't do this" (Payne et al. 2013p122). Another study in Ghana also indicate that Most abortion care providers hesitate to offer abortion services to women due to several reasons including conflicts with religious backgrounds, lack of administrative support, fear due to legal restrictions, and limited clarity on protocols (Aboagye et al. 2007).

The restrictive nature of the law also makes providers and the society perceive abortion to be highly prohibited which could lead to what Schwandt et al termed as "legal stigma" (Schwandt et al. 2013). A study indicated that confidentiality is poor in most health facilities where safe and legal abortion could be obtained and this drives women to seek clandestine services which are regarded highly confidential (Payne et al. 2013). Another study in Ghana

also indicated that poor attitude of providers could negatively impact on client satisfaction, and could scare away women from seeking safe and legal abortion services (Aniteye & Mayhew 2013).

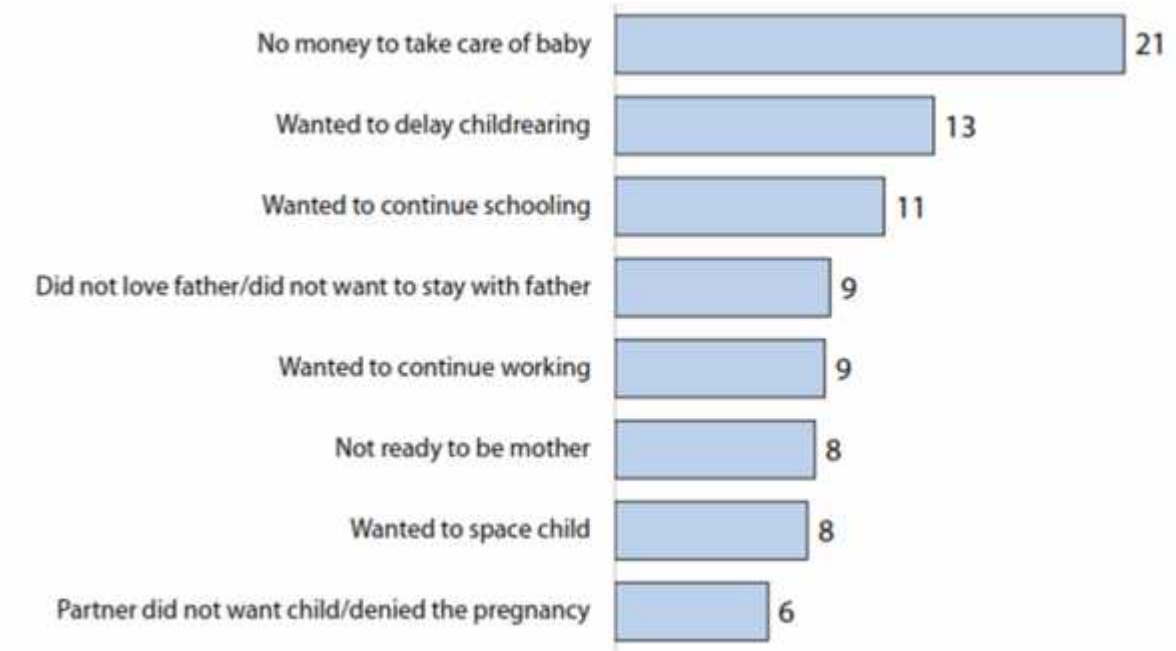
3.4 Women's decisions and choices when seeking abortion

Women's use of safe or unsafe abortion services is determined by a range of factors that characterizes their behaviour towards seeking abortion services. This review looks at women's attitudes, knowledge and confidence and how these influence their decisions to either utilize safe or unsafe abortion services.

3.4.1 Attitude towards seeking services

Morhee and Morhee (2006) in their study stated that when decided, a woman can go any length to terminate her pregnancy, regardless of whether the procedure is safe or not and regardless of the legal implications. A research conducted in the Kintampo District of Ghana showed that most women first start to seek for abortion care through friends and close ones based on trust for the sake of secrecy and confidentiality (Hill et al. 2009). The same research in a focus group discussion with women revealed that, most women who want to terminate a pregnancy first go in for clandestine or unsafe methods and then go in for safe and qualified services when all available clandestine options fail. Also, Aniteye and Mayhew (2011) in a hospital-based survey in Ghana realized that most women with abortion complications first sought for clandestine services or other unsafe methods. With regards to reasons why women decide to terminate their pregnancy, the 2007 maternal health survey indicate various reasons of which majority indicated financial constraints to take care of baby (21%) as indicated in figure 11 (GSS, GHS & Macro International 2009b).

Figure 11: Reasons for inducing abortion among women (15-49 years) who have had an abortion



Source: GSS, GHS & Macro International 2009b.

For further understanding of women's choices and decisions in seeking abortion, it is worth exploring the influence of socio-demographic status.

Socio-demographic status of women and use of abortion services

The socio-demographic characteristics considered in this literature review include women's age, economic status, marital status (married and unmarried), religious status, residence (urban and rural) and educational status.

Age: A cross-sectional study conducted in Ghana drawing from the 2007 MHS indicated that 56.5%, 43.2% and 35% of women of ages less than 20, 20-29, and 30+ use unsafe abortion services(GSS, GHS & Macro International 2009b & Sundaram et al. 2012). This indicates that most young women and adolescents use unsafe means of pregnancy termination. This is supported by another study on women on admission for complications of abortion which revealed the median age of admission to be 26 years (Konney et al. 2009). These conclusions further verify earlier global findings that suggest that in Africa, adolescents (15-19 years) account for 25% of unsafe abortions whiles women under age 25 years in total account for 60% of global unsafe abortions(Shah & Ahman 2009).

Economic status and residence: It is globally indicated that poor and rural women are more likely to use unsafe abortion services than urban women and women of higher income status (Singh et al. 2009). This is mostly common where safe abortion services are costly and more available in urban areas than rural areas.

A nationwide study in Ghana shows that only 37.8% of women in the lowest wealth quintile use safe abortion services as compared to 71% of women of the highest quintile (GSS, GHS & Macro International 2009b & Sundaram et al. 2012). This indicates that poor women in Ghana are more likely to use unsafe abortion services as compared to women of high economic status. This is supported by other studies which suggest that the economic cost of safe abortion (and post abortion) services deter many women (especially of low income group) from seeking/utilizing available services (Borgi et al. 2003 & Sundaram et al. 2012). Most Ghanaian women especially those in rural settings and school going aged youth find themselves in a low income group and therefore face financial barriers in accessing safe abortion services (Baiden 2009).

Also, the study of Sundaram et al. (2012) indicated that 43.1% of rural women use safe abortion services as against 63.3% of urban women. This could be due to limited access to safe abortion facilities in rural areas as compared to urban areas. As Webster also indicated in his study, rural women are more likely to be influenced by traditional beliefs and values that stigmatize abortion and will therefore limit their access to and utilization of safe abortion services (Webster 2013).

Marital and religious statuses: Sundaram et al. (2012) in their studies in Ghana did not establish any significant difference in utilization of safe abortion services between women of different marital status and religious status. This implies that women of different marital status and different religious backgrounds in Ghana have similar attitudes towards abortion services. In line with marital status, a hospital based study of women admitted for complications from abortion indicated that, majority of them aborted the pregnancy because they were not married (Aniteye & Mayhew 2011). This however is not evident enough to establish a relationship between marital status and use of safe abortion services, since the study only accounts for the reason for pregnancy termination.

Educational status: Studies have established an association between education and reproductive health, which suggested that education offers an individual the required knowledge for healthy life styles and the ability to manage factors in one's environment to access healthcare (Backlund, Sorlie, & Johnson 1999; Elo & Preston 1996; Gabrysch & Campbell 2009).

Again drawing from the 2007 Ghana MHS data, Sundaram et al. (2012) established in their studies that, 60.5% of women with middle or higher school education used safe abortion services, as compared to 43.5% for women with none or primary education.

3.4.2 Women's Knowledge and confidence in seeking safe abortion services

Studies have shown an association between individual's knowledge and their utilization of available health services (Ensor & Cooper 2004; Yar'zever & Said 2013).

In certain contexts, most women may not know the existence of legal abortion services and their rights to obtain such services (Benson 2005). In this case, their lack of knowledge of the availability of legal and safe abortion services could hinder them or lessen their confidence in using such services.

A study in two regions of Ghana (Upper East and Upper West Regions) showed that most women lacked knowledge about the availability of abortion services and generally had ill perceptions concerning abortion (Paul, Marlow & Antobam 2015). The study indicates that, 66% of women thought abortion was totally illegal whiles 20% were unsure of the legal status (Paul, Marlow & Antobam 2015). This implies that women may end up seeking clandestine services due to their perception that, legal abortion services cannot be obtained. The same study also revealed that 90% of women felt abortion is a sin, whiles 71% felt abortion was a shameful act (Paul, Marlow & Antobam 2015). This could mean that, such women when having the need to terminate a pregnancy may not have the confidence to go for legal services; they will prefer using clandestine services in other to conceal the act. Sundaram et al. (2012) in a study indicated that 69.9% of women who had knowledge on the legal status of abortion used safe abortion services as compared to 54.2% among women who did not have this knowledge.

4 CHAPTER FOUR: EVIDENCE-BASED INTERVENTIONS TO IMPROVE ACCESS TO AND UTILIZATION OF SAFE ABORTION SERVICE

From the findings, Ghana has made efforts in improving access to and utilization of safe abortion services. There however still exist legal barriers regarding restrictiveness of the law; policy and service delivery gaps such as provider's limited exposure to policy documents and trainings which affects implementation; and service delivery gaps due to inadequate CAC facilities.

Socio-cultural and economic barriers seem to also strongly hinder women's access to and utilization of safe abortion services in Ghana. The socio-cultural context also has a strong influence on policy makers, providers and clients of abortion services.

The evidence also suggests young women and adolescents account for the larger proportion of unsafe abortions in Ghana.

This section presents evidence-based interventions at the various levels to improve access to and utilization of safe abortion services. Evidence is drawn from WHO recommended strategies and interventions which could serve as standards for developing countries like Ghana. Proven interventions from country examples are also presented addressing the issue of unsafe abortion at various levels (legal/Policy, Service delivery and community level). Cases from South Africa, Mozambique, India, and Zambia are used due to some similarities in contexts; these countries are all developing countries like Ghana, and are also made up of religious and cultural contexts with also beliefs and social norms.

The example from South Africa is used to present proven interventions to address legal and policy barriers; the example of India is used to present proven interventions to address socio-cultural barriers using a community level approach; Mozambique is used to further highlight community mobilization in addressing socio-cultural barriers; whiles the example of Zambia is used to serve as a complementary intervention to address limited access to and utilization of safe abortion services faced by the youth.

4.1 Strategies and interventions of WHO

WHO applies the following inter-related strategies in order to improve women's access to and utilization of safe abortion services (WHO 2015c);

- Conduct evidence based assessment on the situation of abortion; It includes unsafe abortion prevalence, practices, and related issues

- Translate evidence into policies (including standards, norms, tools and guidelines)
- Develop improved technologies and implement interventions to make abortion safer
- Develop and implement programmes and policies that reduce unsafe abortion and improve access to safe abortion and high-quality post abortion care.

It is however to be noted that countries (especially developing countries) might need technical assistance from WHO and other development partners in developing and implementing the above strategies.

WHO recommended a package of services for safe abortion interventions at three levels as indicated in table 5 (WHO 2010). The implementation should go with Policy/Legal and Service delivery requirements as follows (WHO, 2010);

- Policy and legal requirements: Broadening legal grounds for safe abortion; Ensuring universal access to safe abortion services; Ensuring universal knowledge about the law and services and importance of safe abortion care.
- Service delivery requirements: Putting in place and ensuring providers' access to evidence-based national standards and guidelines for safe abortion care; Ensuring adequate skilled providers and equipped facilities; Addressing financial barriers by ensuring social safety net for poor women.

Table 5 WHO package of interventions to safe abortion care

INTERVENTIONS AT HOME/COMMUNITY LEVEL	KEY SUPPLIES AND COMMODITIES NEEDED
• Health education to women, men, families and community on SRH and Abortion, the legality and availability of safe abortion services and unsafe abortion and its consequences. • Distribution of methods of contraception, including emergency contraception • Identification of signs of domestic and sexual violence and referral • Identification, first aid and prompt referral of women with signs of complications of unsafe abortion	• Counselling, health education and health promotion materials • Job aids • Contraceptive methods
INTERVENTIONS AT FIRST LEVEL HEALTH FACILITIES	KEY COMMODITIES NEEDED
All of the above plus: • Counselling for contraceptive methods • Uterine evacuation for first-trimester and, incomplete abortions • Diagnosis and treatment of common complications of abortion including infection, bleeding or injury • Referral mechanisms for timely treatment of abortion-related complications • Diagnosis and treatment of STIs/HIV	All of the above plus: • Vacuum aspiration equipment • Medications for induced abortion (mifepristone + • misoprostol) • Analgesics and local anaesthetics • Antibiotics • Uterotonics • Full range of contraceptive methods (including vasectomy)
INTERVENTIONS AT REFERRAL FACILITIES	KEY COMMODITIES NEEDED
All of the above plus: • Uterine evacuation for pregnancies beyond the first trimester • Management of women with any complication of abortion • Management of ectopic pregnancy • Provision of all contraceptive methods including tubal ligation	All of the above plus: • Parenteral and oral antibiotics • Intravenous fluids • Oxygen • Blood and transfusion sets • Operating theatre drugs, and equipment

Source: WHO 2010.

Benefits: The above recommended interventions have been known to have cost benefits and able to prevent nearly all deaths and disabilities due to unsafe abortions (WHO 2010).

4.2 Creating an enabling legal and policy environment: the case of South Arica

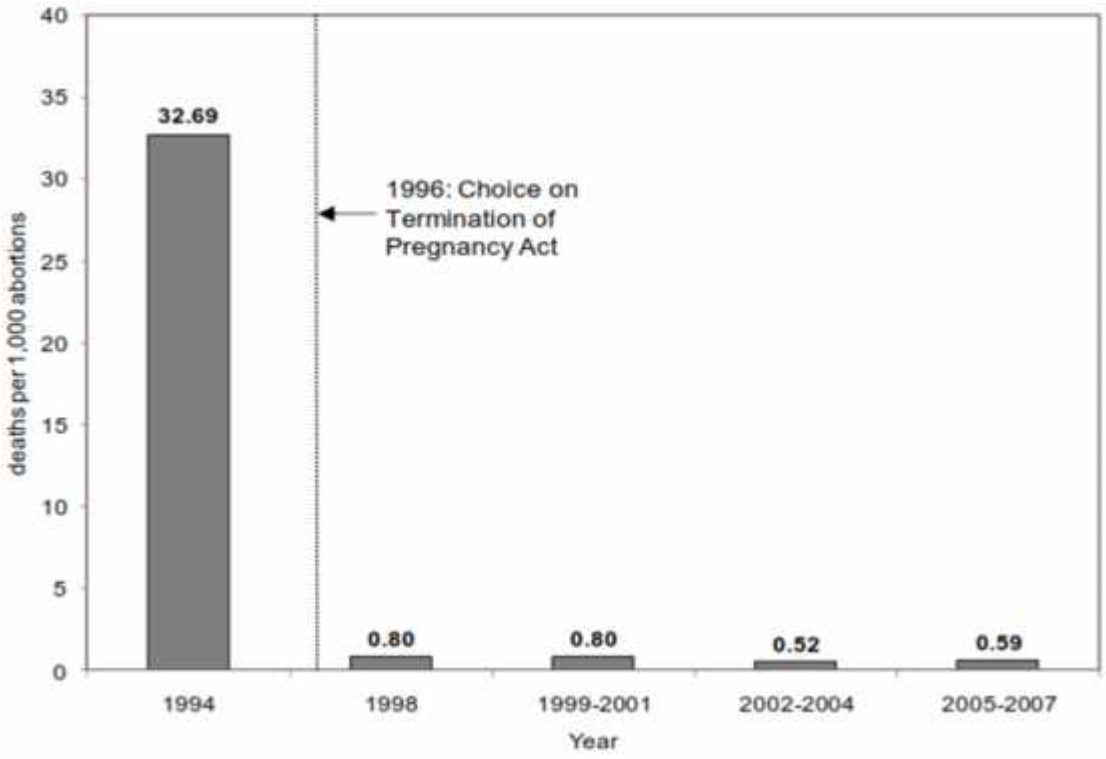
Prior to 1996, the abortion law in South Africa did not allow abortion on request and on socio-economic reasons (Althaus 2000). In realizing the law did not reflect the needs of women and that there were high incidents of unsafe abortion, there was a legal reform in 1996; the 1996 law is called the Choice on Termination of Pregnancy (CTOP) Act, which permitted abortion on socio-economic reasons and on request (Benson et al. 2011; Rahman, Katzive, & Henshaw 1998). The law also permitted abortion for minors without required consent from parents or guardians.

Some interventions that led to the legal reform: CSOs with the support of research and academic institutions advocated and debated based on evidence of high levels of unsafe abortion and its consequences (Mhlanga 2003). The right of women to sexual reproductive health including safe abortion was also considered. Health providers supported by indicating the positive impact of easier access to safe abortion services. Traditional leaders were engaged in discussions to solicit their views and support. The country followed up with improvement in abortion service delivery as indicated in table 6 (Althaus 2000; Dickson-Tetteh & Billings 2002).

South Africa also addressed economic barriers by offering free abortion services (for pregnancy gestations up to 12 weeks) in state facilities (Althaus 2000). A summary of the interventions is in table 6.

A combination of legal and services delivery interventions led to a positive impact which led to a drastic reduction in abortion deaths as indicated in figure 12 (Benson et al. 2011). Mhlanga (2003) in her studies suggested that South Africa's interventions as indicated above can be adopted by low resource countries. A summary of the interventions is in table 6.

Figure 12: Changes in Abortion-Related Maternal Deaths per 1,000 abortions in South Africa, 1994- 2007: the figure illustrates a drastic change following the legalization of abortion in 1996, of which also gave rise to several interventions.



Source: Benson et al. 2011.

4.3 Community level intervention to address socio-cultural barriers to safe abortion services: the case of India (state of Jharkhand)

The intervention in India was implemented in the state of Jharkhand which was a low resource context (Banerjee et al. 2014). Similarly to Ghana, the use of safe abortion services especially in public health facilities was low (Banerjee et al. 2014). The social context of Jharkhand similar to that of Ghana is made of tribes with beliefs and norms which hinder women's access and utilization of abortion services.

The intervention which was implemented by Ipas with support from the Jharkhand government used awareness creation and BCC campaign interventions to create an enabling social environment for women to access and utilize safe abortion services (Banerjee et al. 2014). The intervention carried out a number of activities from 2007 to 2009 which led to increased awareness on abortion, the law on abortion and the availability of safe abortion services. The intervention also led to a reduction of the social stigma on abortion. Activities and success of the intervention are further illustrated in table 6.

4.4 Community mobilization to address socio-cultural barriers to safe abortion services: The case of Mozambique

Mozambique is a developing country with also a socio-cultural context made up of norms and beliefs just as in the case Ghana (Machungo 2004). Overcoming socio-cultural barriers to safe abortion services involves a strategic intervention to involve communities and their leaders in addressing the problem. Pathfinder in Mozambique carried out an intervention that mobilized the support of communities to address the situation and consequences of unsafe abortion (Pathfinder International 2010). The intervention sensitized and trained men, women and community/traditional leaders (including dialogues) on relevant issues of abortion (Pathfinder International 2010).

The intervention sensitized more than 1,300 community leaders and trained 400 traditional healers and peer educators. The peer educators also trained more than 34,000 community members through home visits, and community meetings. The intervention led to marked improvement in community support and uptake of CAC services in 24 health facilities (Pathfinder International 2010).

4.5 Improving access to and utilization of safe abortion services by young women and adolescents: the case of Zambia

Zambia's abortion law permits abortion on socioeconomic grounds. Similar to the situation in Ghana, young women and adolescents in Zambia are limited by socio-cultural and service delivery barriers in accessing safe abortion services (Ipas 2014).

Ipas Zambia implemented a CAC for Young Women project in Lusaka Province from 2012 to 2014 in involving five health facilities. The project implemented youth content interventions by involving the youth in designing the project. Specific interventions carried out include but not limited to the following (Ipas 2014);

- Facility sensitizations: Value clarification discussions and provision of accurate information concerning provision of CAC especially to the youth to demystify provider's misconceptions on abortion.
- Trainings for providers: Value clarification workshops, and training on youth friendly CAC.
- Partnership-defined Quality for Youth workshop and Quality Improvement action Plans: This brought the youth and service

providers together where there was a dialogue and plans were tentatively developed to improve quality of CAC especially to the youth.

- Community sensitizations: Communities were engaged in dialogues and provided information on abortion and the law, consequences of unsafe abortion and the availability of safe abortion services.
- On-site orientation for Youth friendly Corner volunteers: Built capacities of community volunteers and used them to reach out to youth-friendly corners to raise awareness and enable referrals for safe abortion services.
- Multi-disciplinary advisory Council: This intervention solicited the support of government and stakeholders in implementing the intervention.

The project successfully led to improved quality of CAC and responsiveness to young women, improved provider attitude towards abortion service provision to youth, and reduced fear and stigma on abortion among youth and in communities respectively (Ipas 2014). The intervention and its successes are indicated in table 6.

Table 6 Country examples of evidence based interventions to improve utilization of safe abortion services

Area of intervention	Intervention	Example of country	Success/impact
Law and policy	Advocacies and debates for Legal and policy reforms: abortion available on request, Non-mandatory consent from adolescent girls, free abortion services in state health facilities, development of guidelines, and protocols for CAC, expansion of provider cadre (to qualify midlevel providers) in abortion service provision, integration of CAC into primary healthcare	South Africa	Improved access to safe abortion services (availability, less legal restriction of women, limited financial barriers) and reduction in abortion related maternal deaths by over 90%
Service delivery	Expansion of CAC facilities all over the country (made available facilities in both high resource and low resource settings), Pre-service training of midwives on CAC (midwifery training curriculum was reviewed to include CAC within full extent of the law and policy), Value clarification training for providers to enable them disentangle conflictions between personal and profession beliefs on abortion	South Africa	Increase in number of facilities offering CAC services (for example from 32% in 2000 to 62% in 2003), improved provider attitude towards abortion services provision, Reduction in unsafe abortion and its related maternal deaths
Community level and other interventions to address socio-cultural barriers	Awareness creation: use of community intermediaries to provide information on safe abortion, legality of abortion, availability of abortion services. BCC campaigns: Use of wall signs, posters, street drama and interpersonal communication to improve individual and community attitude towards abortion.	India (state of Jharkhand)	Increased awareness on legality of abortion among women (from 19.7% to 57.6%), beneficiaries knew at least one place where safe abortion can be obtained, decreased use of unsafe abortion services, decrease in social stigma on abortion
Improving access to safe abortion services for young women and adolescents	Training, mentoring and value clarification interventions for providers, health facility sensitization, youth-provider partnership to define and implement quality CAC services, community sensitization and Multi-advisory council to solicit support from government and other stakeholders in implementing strategic interventions	Zambia	Improved quality CAC and responsiveness to young women, improved provider attitude towards abortion service provision to youth, reduced fear and stigma on abortion among youth and in communities respectively

Sources: Banerjee et al. 2014; Ipas 2014; Benson et al. 2011; Mitchell et al. 2005; Dickson-Tetteh & Billings 2002 & Althaus 2000.

5 CHAPTER FIVE: DISCUSSION, CONCLUSION AND RECOMMENDATIONS

The findings indicate multi-layered and multi-dimensional factors that influence women's access to and utilization of safe abortion services. These include laws and policy factors, individual level factors (women's choices and decisions), and service delivery factors. The evidence also indicated the influence of contextual factors like the social/cultural, economic, and legal contexts on policies, service delivery and women's abortion care-seeking decisions. From the evidence, the socio-cultural context is integral as it strongly cuts across all factors to influence women's access to and utilization of safe abortion services.

I arrive at four main themes discussed here below in light of evidence from the findings. And building on the findings from chapters 3 and 4, I articulate recommendations towards improving utilization of safe abortion services. Though the interventions in section 4 are evidence based in similar contexts such as Ghana, specific recommendations after the discussion may not strictly be the same as the interventions identified.

Usefulness of the framework to the study: The adopted and modified framework used for the study has been very helpful for the purpose of the study. It has been able to answer the research objectives by presenting the factors that the study sought to explore. It also helped in the analysis as it presented the interaction between factors. It was also flexible and that enabled the study to explore women's decisions and choices in seeking abortion services. However the challenges were limited literature on the political context and also limited nationwide data on abortion.

5.1 Laws and Policies

5.1.1 Discussion

The construct of the law which criminalizes abortion in the exception of some circumstances could make society perceive abortion to generally be a socially unacceptable act. This adds up to the social stigma on abortion as society perceives that the law also frowns on abortion. However criminalizing aspects of abortion on the other hand is a proper thing to do in other to regulate its safety and appropriate use. It is however worth noting that whether criminal or not, women will have the need for abortion as the findings suggest.

Though Ghana's abortion law is regarded as liberal, its restrictiveness on socio-economic reasons, and on request, drives most women to use clandestine services. This could explain why clandestine services are flourishing since the evidence indicates that most women seek abortions because of socio-economic challenges in child bearing. This is confirmed from a study in Ghana which indicated that women can be desperate to terminate their pregnancy without regard to the legality and safety of the procedure/method (Payne et al. 2013).

Also, in cases of rape, the process (including legal processes) to ascertain whether the pregnancy resulted from rape could be long (Morhee & Morhee 2006). This may be perceived by the woman to be inconveniencing and complex, which can make her seek readily available clandestine services.

The law also limits adolescents from accessing and utilizing safe abortion services since it requires consent from parents. In cases where the girl is afraid to involve her parents, she might secretly seek clandestine services. This probably explains why young women and adolescents account for the largest proportion of unsafe abortions in Ghana as the evidence indicate.

From the findings, most providers find lack of clarity of the law as a challenge in comfortably providing services on appropriate legal interpretations. This to some extent makes qualified providers hesitant in providing services. For instance the law lacks clarity as it permits abortion to preserve the woman's mental health but does not define what it means by mental health. Mental health could be interpreted by anyone to include mental stress from pregnancy bearing, relationship problems, economic burden of bearing pregnancy, and impediment to education and carrier advancement as a result of the pregnancy (Morhee & Morhee 2006). If we go by this definition of mental health, then the law seems to be more liberal than it is; the good thing about this in services provision is that, smart providers could rely on that to interpret the law in providing services on much broader ground.

In terms of policy response, the findings show that Ghana has adopted relevant policy documents over the years, yet only few providers actually possess them and have adequate knowledge on them. A study in Ghana shows that, limited exposure of providers to abortion information makes them less confident and less competent in providing services (Aniteye, Mayhew & O'Brien 2014). This obviously translates into poor implementation.

The reason for limited possession and knowledge of abortion documents by health facilities could partly be due to limited political interest to disseminate abortion information; this is influenced by the already negative social attitude towards abortion. Webster explains that whiles international abortion guidelines and standards can be endorsed and adopted through

policies, deep-rooted believes and values in the Ghanaian social environment influence implementation (Webster 2013).

Referring to the evidence based legal interventions in the case of South Africa, Ghana could further broaden the grounds of abortion to reflect the needs of women. Some may argue that making the law more liberal will increase induced abortion rates. Evidence however shows that countries with more liberal abortion laws have less rates of induced abortion (Haddad & Nour 2009). This review has not come across any evidence which suggests abortion rate increases if laws are made liberal. Also as in the case example of India, communities could be sensitized more on the law and abortion to increase knowledge and awareness.

5.1.2 Conclusion

The law in Ghana does not reflect the needs of women. Liberalizing abortion laws creates favourable grounds for abortion-friendly policy interventions and improves women's access to and utilization of safe abortion services. However legal and policy interventions alone are not sufficient as they do not automatically translate into effective implementation; the situation in Ghana goes beyond legal and policy measures. The strong social stand on abortion should be well addressed as well.

5.1.3 Recommendation

- For Policy makers and stakeholders: MoH should collaborate with GSS and other research institutions to periodically research and document the impact of the law and policies on access to and utilization of safe abortion services. Findings from the research could be used for legal and policy reforms. CSOs should also carry out short to medium term evidence based research to advocate for the revision of the law to reflect the real needs of women.
- For Service providers and stakeholders: CSOs and GHS should sensitize communities on the legal indications of abortion and engage traditional and religious leaders in a dialogue for acceptance and understanding of the law. This could be short to medium term.

5.2 The Contextual factors

5.2.1 Discussion

Ghana is faced with strong social resistance and stigma on abortion which is deeply rooted in religion and traditions as indicated in the findings. Policy makers, implementers (services providers), and services users are part of these communities and therefore are persistently influenced by common beliefs, values and norms which stigmatize abortion as also indicated by Webster in his studies (Webster 2013). This implies that, the negative social attitude towards abortion inevitably affects abortion policy making, implementation (service provision) and services use. In this case women hide to use unsafe means of pregnancy termination, whiles qualified providers are hesitant to provide services. The social resistance and stigma on abortion could also be one of the reasons why abortion policy documents (including guidelines and protocols) are not well known and implemented by providers. It simply means that most providers are less motivated to associate themselves with issues of abortion due to the social stigma on it.
The social attitude on abortion could serve as grounds for which clandestine services flourish; the logic is that, clandestine providers fear the stigma just as much as their clients, so confidentiality is highly assured and business goes on with mutual benefits.

The findings also show that the social stand of the Catholic Church and other Christian institutions against abortion should not be underestimated since a significant proportion of health services in the country are offered by FIIs. The situation is even worse due to the inadequate infrastructure in the public services.

5.2.1.1 The discourse and rationale for social resistance on abortion

As indicated in the findings, the social context of Ghana upholds to beliefs, values and norms which characterize the identity of societies. Conforming to these believes, values and norms make's one's identity much valued by the society one lives in. Societies are entitled to their beliefs and views and this is applied as well in the context of abortion. The social identity of the Ghanaian society as the findings indicate is strong as compared to external laws and policies which are adopted from international standards and recommendations. Even though international recommendations and evidence suggest the legalization and policy provision for abortion, it does not mean one should neglect the perspective of the socio-cultural context when applying such evidence and recommendations. The social resistance on abortion in Ghana does not mean that the society is comfortable with

women seeking unsafe abortions and dying from it. And if that is the case, could they have effective solutions?

In light of the social resistance on abortion which has its negative toll on legal and policy provisions for safe abortion, debates could be avenues for handling such a discourse. This has been done in countries like USA, Spain, and South Africa (Cambronero-Saiz et al. 2007 & Mhlanga 2003).

It is however surprising that the issue of abortion in Ghana is regarded sensitive and kept silent whiles the social stigma thrives, clandestine services flourish and women keep dying. There have been some few actions by some individuals and institutions to break the silence but the situation remained as it is. For instance in 2011, Rojo Mettle-Nunoo the then deputy minister of Health speaking to City News, called for a national debate on the legal stand of abortion, but his action remained as news (Citifmonline, 2011). Also there has been a recent news report of a medical director of a health facility in Ghana, who strongly opposed the call by a public health nurse for a more liberal abortion law (Apprey 2015). The medical doctor's opposition was supported by a Christian leader as the news reported (Apprey 2015). All these point to the fact that the discourse on abortion in Ghana needs to be addressed in a more strategic way in other to find effective and sustainable measures to prevent unsafe abortions.

With regards to the economic context, the findings indicate inadequate health financing in Ghana which subsequently has a negative toll on expanding abortion services and improving access. This is the reason why NGOs and other private sectors come in to help the situation. Also, since the NHIS does not cover abortion services, most women especially those of low income status will have financial challenges in utilizing legal abortion services; no wonder women alternatively use cheaper clandestine and unsafe methods of pregnancy termination.

In addressing the social resistance and socio-cultural barriers to safe abortion services, Ghana could learn from the cases of India, South Africa and Mozambique as presented in Chapter four. Communities could be mobilized to address the problem by sensitizing communities and their leaders (including religious leaders) and continuously engaging the leaders in dialogues. To address the economic barriers, the free abortion service intervention in South Africa can be translated to the context of Ghana by at least making the NHIS cover CAC. Respective institutions can also engage the issue in debates to break the silence.

5.2.2 Conclusion

Ghana has socio-cultural context which is deeply rooted in beliefs, values and norms that strongly oppose abortion. This makes it challenging to expanding safe abortion services by legal and policy provisions and also has a negative effect on mobilizing political will and community support to promote safe abortion services. The issue of abortion is sensitive in such a context and will therefore need strategic interventions including dialogues, debates, and advocacy programmes involving all stakeholders to appropriately address the problem.

The country too is faced with inadequate health financing which subsequently affects the expansion of safe abortion programmes. There is therefore the need to put in place measures to improve funding for safe abortion interventions.

5.2.3 Recommendations

- For Policy makers, service providers and other stakeholders: CSOs, MoH, and GHS should sensitize and engage traditional and religious leaders, policy makers, services providers, other medical institutions, women groups, NGOs and legal institutions in dialogues and debates to break the silence on abortion. A platform should be presented to enable development of innovative and strategic measures to addressing the problem of unsafe abortions.
- For MoF and Office of the president: Should prioritize funding of abortion interventions through government budget and donor support. There could be a medium to long term funding strategy/mechanism to address the problem of unsafe abortion and this should involve partnering for donor support interventions. Could also work on covering CAC under the NHIS so as to address the financial barriers in seeking abortion services.

5.3 Service delivery factors

5.3.1 Discussion

In terms of service delivery, the evidence show inadequate availability and distribution of CAC services especially in rural areas; this implies that most women have limited access to safe abortion services and therefore are likely to utilize available unsafe means of abortion. The country in general suffers inadequate health infrastructure which makes the situation of limited CAC not so surprising.

Quality of legal abortion services seem to be compromised by providers' personal beliefs due to the influence of the socio-cultural context as discussed earlier.

The quality of pre-service trainings received by providers also is questionable. For instance if midwifery tutors feel hesitant to teach CAC and also lack the competence to do so, then the quality of midwives produced to provide CAC services is compromised. This draws back gains the country has made in expanding CAC service providers' cadre (to include midwives). One should also bear in mind that, the hesitance of tutors to teach CAC is due to influence of the socio-cultural context as the findings suggest.

In addressing the problem of inadequate CAC services, the cases of South Africa, and recommendations from WHO could be used where technology for low resource setting such as MVA and medical abortion could be used at the community level and primary care level. Also as in the case of South Africa and Zambia, training of providers could include value clarification to improve quality of CAC.

5.3.2 Conclusion

Ghana is faced with inadequacies in safe abortion service provision which limit access to and utilization of safe abortion services. The expansion of provider cadre to allow midwives provide abortion services is a significant step in expanding access to safe abortion services. However, most providers find it difficult to disentangle the conflict between their beliefs and professional requirements in offering abortion services. The socio-cultural resistance on abortion also has a negative influence on the quality of midwives produced for CAC.

5.3.3 Recommendations

- For policy bodies and service providers: MoH and GHS should periodically evaluate the training needs of service providers, medical and midwifery tutors on CAC and to provide appropriate level of trainings.
- For policy body: MoH should establish a long term strategy for continuous training and supervision of service providers in the areas of
    - CAC and the law
    - The use of appropriate technology for safe abortion
    - Value clarification
    - Youth-friendly service provision and responsiveness
- Policy body and service providers: GHS and MoH should expand the use of low resource certain abortion technology like the MVA to rural health facilities, and ensure supply of logistics and dissemination of protocols and guidelines for CAC to facilities.

5.4 Women's decisions and choices

5.4.1 Discussion

The evidence point out that most women tend to use unsafe means of pregnancy termination as first options and they do so with influence from close ones (friends, partners, and other close relations). This establishes the influence of the immediate social environment.

From the findings, one can establish the influence of socio-demographic characteristics on access to and utilization of safe abortion services. Addressing the negative influence of these socio-demographic characteristic could be done by drawing ideas from the case examples of Zambia, Mozambique and India, where women are empowered by providing them with accurate and relevant information on accessing and utilizing CAC; this is done through trainings and sensitization. The case of Zambia too could be used to improve access to CAC services to the youth.

5.4.2 Conclusion

The findings indicate that most women in Ghana are likely to choose abortion services based on the influence of their social environment and socio-demographic statuses. Young women largely account for a large proportion of unsafe abortions which reflects their limited access to safe

services. Low income status, low education and limited knowledge on abortion limit women's access to and utilization of safe abortion services.

5.4.3 Recommendations

- For Service providers and stakeholders: CSOs and GHS should sensitize women and communities on unsafe abortion and the availability of safe abortion services by law. This should be short to medium term depending on impact progress.
- For Non-governmental Stakeholders: CSOs, CBOs and NGOs should engage women groups (including youth) and service providers to define quality of services and to develop and implement strategies to improve quality of services for all women. This should go with the establishment of mechanisms to monitor and evaluate quality of service provision.
- For policy body and service providers: MoH and GHS should work with traditional healers and community based practitioners in referring women who seek abortion to qualified facilities.

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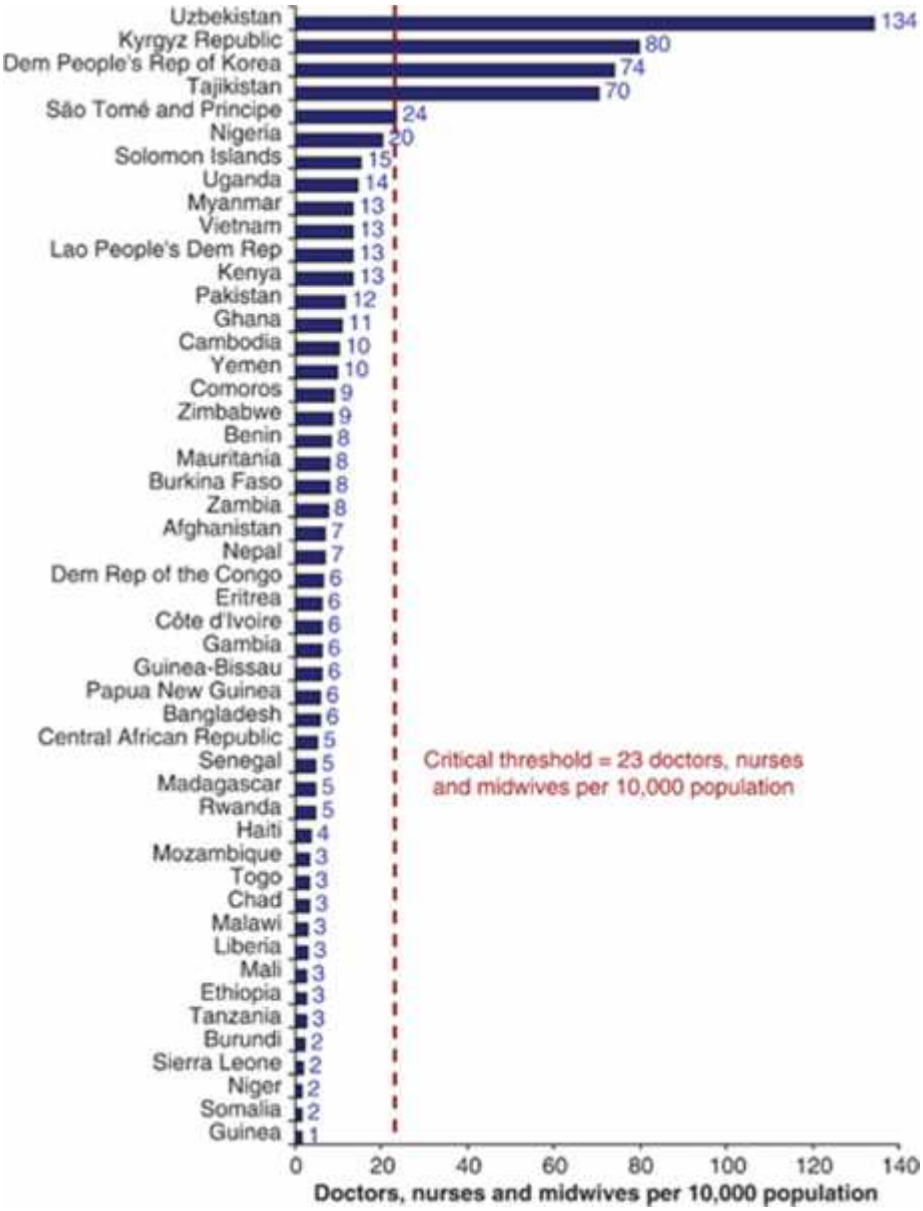
7 Annexes

7.1 Annex 1: Health worker density in selected countries inclusing Ghana



Source: WHO, 2010

7.2 Annex 2: Signal functions for EmONC services.

Basic services	Comprehensive services
(1) Administer parenteral antibiotics	(1) Administer parenteral antibiotics
(2) Administer a uterotonic (for example, parenteral oxytocin)	(2) Administer a uterotonic (for example, parenteral oxytocin)
(3) Administer parenteral anticonvulsants for preeclampsia and eclampsia (for example, magnesium sulphate)	(3) Administer parenteral anticonvulsants for preeclampsia and eclampsia (for example, magnesium sulphate)
(4) Remove placenta manually	(4) Remove placenta manually
(5) Remove retained products (for example, manual vacuum extraction; dilatation and curettage)	(5) Remove retained products (for example, manual vacuum extraction; dilatation and curettage)
(6) Perform assisted vaginal delivery for example, vacuum extraction)	(6) Perform assisted vaginal delivery (for example, vacuum extraction)
(7) Perform basic neonatal resuscitation (for example, with bag and mask)	(7) Perform basic neonatal resuscitation (for example, with bag and mask)
	(8) Perform surgery (for example, caesarean section)
	(9) Perform blood transfusion

Source: WHO, 2009.

7.3 Annex 3: EmONC facilities by regions in Ghana

	EmONC status*				Total number of facilities
	Non-EmONC	*Partial*	*Basic*	*Compre-hensive*	
	n	n	n	n	n
Ghana	792	278	13	76	1159
Region					
Western	69	46	2	3	120
Central	71	30	0	4	105
Greater Accra	90	37	2	9	138
Volta	44	33	1	3	81
Eastern	90	16	1	14	121
Ashanti	146	47	3	18	214
Brong Ahafo	88	21	1	10	120
Northern	68	29	3	8	108
Upper East	69	13	0	3	85
Upper West	57	6	0	4	67

Source: MoH and GHS, 2011

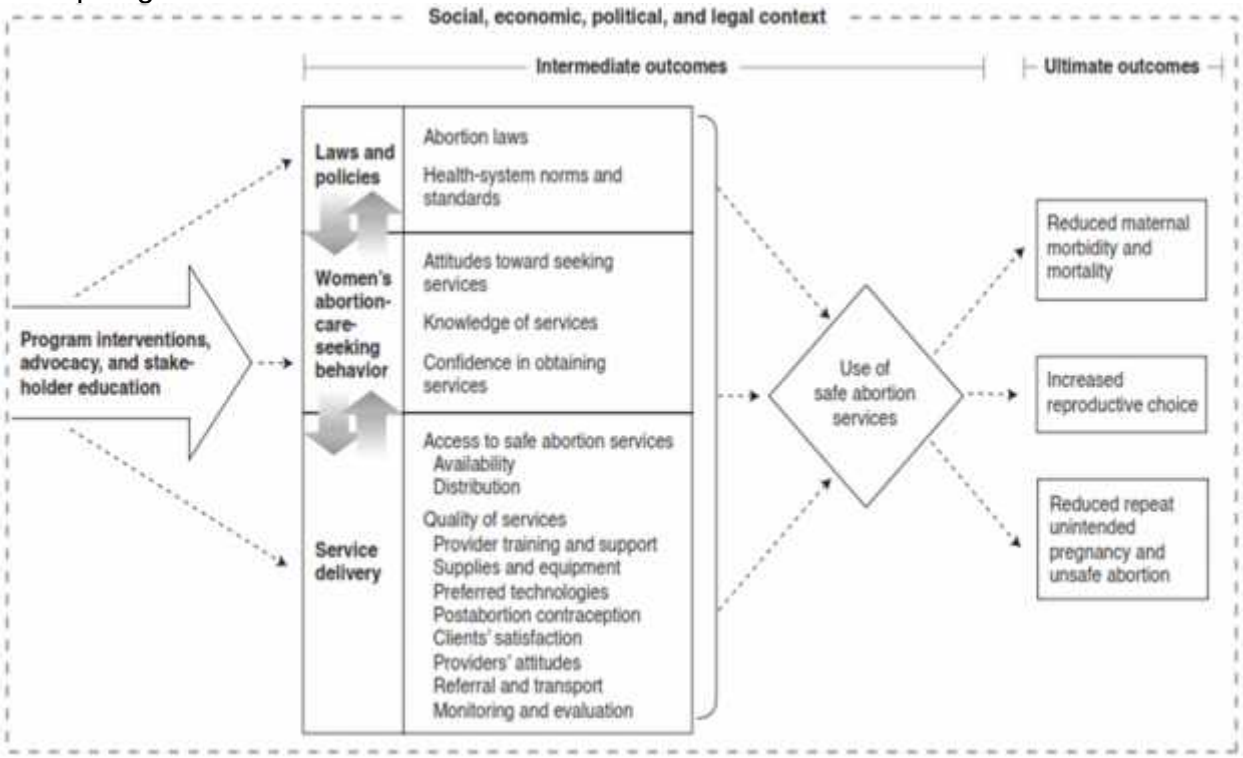
7.4 Annex 4: Abortion rates in Ghana by age group and residence according to the 2007 MHS

Age group	Residence		Total
	Urban	Rural	
15-19	22	13	17
20-24	34	17	25
25-29	22	11	16
30-34	12	10	11
35-39	15	5	9
40-44	5	1	3
45-49	3	1	1
TAR 15-49	0.6	0.3	0.4
TAR 15-44	0.6	0.3	0.4
GAR	21	10	15

Note: Total abortion rate (TAR) expressed per woman. General abortion rate (GAR) (abortions divided by number of women 15-44) expressed per 1,000 women.

Source: GSS, GHS and Macro international, 2009.

7.5 Annex 5: Conceptual framework for evaluating safe abortion programmes



Source: Benson, 2005.

7.6 Annex 6: Signal functions and indicators for Safe Abortion Care (SAC)

SAC SIGNAL FUNCTIONS	SAC INDICATORS
For BASIC SAC services • Administer essential antibiotics • Administer intravenous replacement fluids • Administer oxytoxics • Perform removal of retained products for uterine size ≤ 12 weeks • Perform induced abortion for uterine size ≤ 12 weeks for all legal indications • Provide postabortion contraception	1. Amount of SAC services available (number of facilities providing basic and comprehensive SAC). 2. Distribution of SAC services. 3. Proportion of women treated for abortion-related obstetric complications. 4. Proportion of women treated for serious abortion complications. 5. Proportion of women who receive abortion services that are induced procedures. 6. Proportion of UE procedures performed with recommended technologies. 7. Proportion of women receiving abortion services who obtain contraception.
Additional functions for COMPREHENSIVE SAC services • Perform removal of retained products for uterine size > 12 weeks • Perform blood transfusion • Perform laparotomy • Perform induced abortion for uterine size > 12 weeks for all legal indications	

Source: Ipas, 2009.