

**'Understanding the Barriers to and Opportunities for
Improving Access to Safe, Legal Abortion Services in
Ghana: A Policy Analysis'**

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**Thesis submitted for the degree of Doctor of
Philosophy of the University of London**



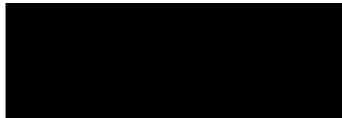
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September, 2011

Declaration

I, Patience Aniteye confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

PATIENCE ANITEYE (MRS)



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Abstract

Unsafe abortion continues to be a major public health problem in Ghana. It accounts for 22-30% of the maternal mortality in the country. Although Ghana is one of the countries in sub-Saharan Africa with a liberal abortion law, access to safe, legal abortion in public health facilities is limited. Women with unwanted pregnancies resort to unsafe abortion with the resultant heavy toll on their health and lives.

This study set out to understand the barriers to and opportunities for improving access to safe, legal abortion services in Ghana. The study employed in-depth interviews with key stakeholders and analysis of relevant documents with a view to unravelling different dimensions of the problem for a deeper understanding of the situation.

Key findings included the observation that Ghana's abortion law is relatively liberal but has gaps and inconsistencies making it liable for misinterpretation. There is need to provide safe, legal services; evaluation of these services might help to improve the law. Two main barriers confront provision of safe abortions: the service-related barriers constitute legal and policy ambiguities and inconsistencies, provider attitudes and lack of training. Important socio-cultural barriers were cultural values, social norms, moral and religious objection which create dilemmas in professional practice. Midwives were found to be conservative and reluctant to provide comprehensive abortion care. Most respondents, including religious people, saw '*medical grounds*' as legitimate for comprehensive abortion care. Medicalising abortion may help lift it out of the moral/religious sphere in people's minds, and therefore make it more acceptable.

In conclusion, efforts should be aimed at future law reform to take care of its current ambiguities that challenge application. In the short term, it would be better to sensitize medical practitioners to the flexibility of the law. It is essential for the Ghana Health Service to assist health providers and key stakeholders to re-examine their values and change their attitudes towards abortion care to ensure that legal abortions are provided in public hospitals to help women in need of the services.

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“The bud may have a bitter taste, but sweet will be the flower”.

Definition of terms

Actors: - These constitute the stakeholders and may include the State (national politicians; international organizations), the market (pharmaceutical industry; social marketing companies), providers (doctors and nurses), civil society (national interest/professional groups; NGOs; media) and the general public.

Advocacy: - This refers to public support or recommendation for safe abortion services. These may be in the form of campaigns, programmes, educational activities, media releases and use of advocacy tactics such as dialoguing, negotiation, lobbying and sensitization.

Behaviour:-The conversion of an intention or perceived behavioural control into action.

Behavioural intention:-An indication of the extent to which people are willing to try as well as the efforts they plan to make towards performing behaviour.

Attitudes:- The degree to which a person has a favourable or unfavourable evaluation of a behaviour. It is an individual's positive or negative belief about performing behaviour; an individual will intend to perform behaviour when he/she evaluates it positively.

Subjective norms: - Beliefs that significant or important others approve or disapprove of performing a behaviour.

Perceived behavioural control: - An individual's belief concerning the ease or difficulty of performing behaviour.

Beliefs: - Religious beliefs are statements to which members of a particular religion adhere.

Code of ethics:- The standards of acceptable behaviour developed by and for members of a profession.

Conscientious objection: - The right of a health provider to refuse to be involved in provision of abortion services on conscientious grounds

Counselling:- A planned interaction which enables an individual to voluntarily receive emotional support and guidance from a trained person in an environment that promotes or facilitates open sharing of thoughts, feelings and perceptions.

Content: - This refers to the contents of the abortion law of Ghana and the national reproductive health service policy and standards document.

Context: - This constitutes the situational, structural, cultural and international factors that influence policy formulation and promulgation of the abortion law.

Implementation: - Provision of comprehensive abortion care (CAC) at all levels of healthcare delivery from health centres upwards to women on request in cases of rape, incest, foetal impairment, physical and mental ill health as required by the law. This refers to the part of the law that deals with service provision.

Norms: - They are established standards of behaviour maintained by a society.

Process: - This embodies the iterative policy process that involves problem identification, policy formulation and implementation. It also covers the processes involved with promulgation of the law.

Values: - These are collective conceptions of what a culture considers good, desirable and proper or bad, undesirable and improper.

Values clarification: - A process whereby an individual critically assesses his/her values, reflects on them, rationalizes and evaluates those values to help change his/her attitudes about something.

Views: - Refers to the particular way in which an individual sees or regards something.

List of abbreviations

ACF	Advocacy Coalition Framework
ACNM	American College of Nurse Midwives
AGI	Alan Guttmacher Institute
AOGA	Aburi Old Girls Association
AWLA	African Women Lawyers' Association
BCC	Behavioural Change Communication
CAC	Comprehensive Abortion Care
CESCR	Committee for Social Cultural and Economic Research
CHAG	Christian Health Association of Ghana
CHO	Community Health Officer
CTOP	Choice on termination of pregnancy
D & C	Dilatation and Curettage
D & E	Dilatation and Evacuation
DG	Director General
DIY	Do It Yourself
EHC	Emergency Hormonal Contraception
EOU	Evacuation of the Uterus
FGD	Focus Group Discussion
FIGO	International Federation of Gynaecologists and Obstetricians
FP	Family Planning
GDHS	Ghana Demographic and Health Survey
GDP	Gross Domestic Product
GETFund	Ghana Education Trust Fund
GHS	Ghana Health Service

GLSS	Ghana Living Standards Survey
GMA	Ghana Medical Association
GMHS	Ghana Maternal Health Survey
GP	General Practitioner
GPMM	Ghana Prevention of Maternal Mortality
GRMA	Ghana Registered Midwives Association
GSMF	Ghana Social Marketing Foundation
GSS	Ghana Statistical Services
HIV/AIDS	Human Immune-Deficiency Virus/Acquired Immune-Deficiency Syndrome
ICPD	International Conference on Population and Development
IEC	Information Education and Communication
IHCAR	International Health (Karolinska Institutet)
IPPF	International Planned Parenthood Federation
JICA	Japan International Cooperation Agency
KATH	Komfo Anokye Teaching Hospital
KBTH	Korle-Bu Teaching Hospital
LSS	Life Saving Skills
MDG	Millennium Development Goal
MMR	Maternal Mortality Rate
MOH	Ministry of Health
MPs	Medical Practitioners
MPs	Members of Parliament
MR	Menstrual Regulation
MVA	Manual Vacuum Aspiration
MWs	Midwives

N&MC	Nurses and Midwives' Council
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
PAC	Post Abortion Care
PHC	Population and Housing Census
PI	Principal Investigator
PNC	Post Natal Care
PNDC	Provisional National Defence Council
PNO	Principal Nursing Officer
POW	Programme of Work
PPAG	Planned Parenthood Association of Ghana
R3M	Reducing Maternal Mortality and Morbidity
RCH	Reproductive and Child Health
RH	Reproductive Health
RPMM	Regional Prevention of Maternal Mortality
RTIs	Reproductive Tract Infections
SAS	Safe Abortion Services
SMC	Supreme Military Council
STIs	Sexually Transmitted Infections
TFR	Total Fertility Rate
TOP	Termination of Pregnancy
TPB	Theory of Planned Behaviour
TRA	Theory of Reasoned Action
UK	United Kingdom
UN	United Nations
UNICEF	United Nations Emergency Children's Fund

USAID United Nations Aid for International Development

WHO World Health Organization

WIFA Women in Fertile Age

CHAPTER ONE

INTRODUCTION

1. 1 Introduction

Unsafe abortion is a leading cause of maternal morbidity and mortality worldwide (WHO 2004a). Global estimates indicate that about 20 million unsafe abortions occur every year with approximately 95% of these occurring in low-income countries (WHO, 1998). In Ghana, unsafe abortion is a public health issue of major concern. Complications of unsafe abortion contribute 22 to 30%¹ of all maternal deaths (Aboagye and Akosa 2000). This clearly exceeds the WHO's global estimate of 13% (WHO 2004).

In response to the Programme of Action from the International Conference on Population and Development (ICPD), the Platform for Action of the Fourth World Conference on Women in Beijing, the ICPD+5 Meeting and other International Consensus Meetings such as the Conference of African Union Ministers of Health and the African Regional Conference on unsafe abortion, governments were called upon to show commitment in addressing the problem of unsafe abortions by ensuring access to safe abortion within the framework of national laws (Hessini et al. 2006).

To facilitate this task, the World Health Organization (WHO) developed norms and standards for providing quality abortion services entitled: '*Safe abortion: Technical and Policy Guidance for Health Systems*'. Drawing on this guidance, countries have instituted pragmatic strategies and interventions geared towards combating unsafe abortions and to ensure that women's right to reproductive health are realized (Hessini et al. 2006).

These efforts to make abortion services accessible include liberalization of laws governing abortion and the formulation of relevant policies since abortion laws in sub-Saharan Africa have been described as restrictive (Morhee et al. 2007; Crane et al. 2006; Okonofua, 1997). Ironically, these laws have been inherited from colonial countries that have all altered their laws from former punitive ones to help protect

¹ This study is widely quoted in most studies on abortion in Ghana in peer-reviewed journals as basis for action in reducing maternal deaths.

women and save their lives to current liberalized ones to safeguard the health of women (Brookman-Amissah et al. 2004; Sai 1996). This liberalization has not been swift in sub-Saharan Africa. South Africa is described as the only African country with a truly liberal policy (Hessini et al. 2006). Zambia also has a relatively liberal law (Brookman-Amissah et al. 2004; Okonofua 2004).

In the West African sub-region, Ghana is noted as the country with an abortion law that is relatively liberal, however, even though the law permits abortion on broad grounds including physical and mental health, there is limited access to safe, legal abortion services. This is due in part to the lack of policies translating the law into services, which is also influenced by the lack of clarity in the law (Aboagye et al. 2007; Morhee and Morhee 2006; Lithur, 2004). In a review of the National Reproductive Health Policy and Standards document in 2003, there was an addition of the objective '*to provide abortion care services as permitted by law*'. This was captured under the section: '*Prevention and management of unsafe abortion and post abortion care*'.

The need therefore arises for safe abortion services to be provided to the extent permitted by the law. To do this, a strategic assessment of abortion and abortion care services was carried out by the Ghana Health Service (GHS) in 2005. The findings of the assessment portrayed a lack of knowledge about the abortion law by both the public and health providers. There is also a culture of silence surrounding abortion. Abortion services that are currently provided were described as clandestine and fees charged for abortion services were said to be high. Furthermore, there is an unmet need for contraception and the upsurge of medical abortion in urban areas.

Also, the Ministry of Health (MOH) in collaboration with the GHS developed a programme in September, 2006 called '*Reducing Maternal Mortality and Morbidity*' (R3M). This programme was made up of a consortium of six agencies namely: i) Engender Health ii) Ipas iii) Marie Stopes International, iv) ORC Macro International, v) Population Council and vi) Willow's Foundation. The purpose of R3M was to provide the required resources (financial and technical) to help increase women's access to modern contraceptives and comprehensive abortion care (CAC) in order to avert the morbidity and mortality due to unsafe abortion.

The MOH/GHS tested the (R3M) programme with a study to ascertain, among other issues, the preparedness of 90 public health facilities (in terms of infrastructure and staff capacity) to provide CAC. The study showed how public health facilities in 10 districts within three highly populated regions (Greater Accra, Eastern and Ashanti) are willing to offer some aspects of CAC. The health workers surveyed showed commitment to the identification of pragmatic and comprehensive ways to reduce maternal mortality, but primarily through post abortion care.

Post abortion care (PAC) is one such measure of reducing maternal morbidity and mortality (GHS 2003). It constitutes a package of curative, preventive and psychosocial services for the treatment of incomplete abortions and prevention of unwanted pregnancy. Through PAC, patients are able to obtain services for sexual and reproductive health problems (Aboagye et al. 2007).

The MOH offers PAC to women who report to its health facilities with complications of unsafe abortion. However, there are no formal structures and processes in place for the provision of safe, legal abortion services (i.e. comprehensive abortion care or CAC) in public health facilities even though the Ghana law on abortion allows termination of pregnancy in many cases.

1.2 Rationale for the Study

Ghana has high maternal mortality ratios despite the good health and economic indicators. This is thought to be due in part to unsafe abortion whose prevalence in the country is a matter of concern (Aboagye and Akosa 2000).

Maternal deaths resulting from abortions could best be reduced by preventing unintended pregnancies through contraception. The second-best measure is the provision of safe abortion services. Lastly, effective management of complications of unsafe abortion can also help (Brookman-Amissah et al. 2004; Rutter 1996; Lassey 1995). These measures have all been captured in the National Reproductive Health Service Policy and Standards of the MOH/GHS. According to this policy document, unintended pregnancies are to be prevented through family planning counselling and services; safe abortion services are to be provided where permitted by law and abortion complications are to be managed or referred. There is evidence (RCH/MOH

Annual Reports) from the public and private health facilities that the first and third measures are being carried out to help reduce the high maternal deaths. However, there is little evidence showing that safe abortion services (i.e. CAC) are being carried out in public health institutions to the extent allowed by the law. Why is this so?

According to Sai (1996), the abortion laws in African countries are inherited from their colonial masters. Hence, Ghana's abortion law is similar in most respects to the law on abortion in Britain. Despite this similarity, access to abortion services in the two countries varies considerably. Women in need of the services are more likely to be able to obtain them in Britain than in Ghana. This observed disparity may be largely due to the way the laws are interpreted in the two countries. In Britain, the law (mental health clause) is widely interpreted to give women the chance to end unintended pregnancies. Whereas in Ghana, women are most unlikely to obtain abortion services in public health facilities even to the extent permitted by law which includes the grounds of mental health. There is little indication of use of the mental health clause in Ghana, and there are no clear guidelines as to who determines the mental state of the woman in these circumstances. In Britain, the doctor/provider of the service has the responsibility to take such decisions. The law requires two doctors to take the decision for abortion but in reality this is just a formality. Seeking to change or reward a law on a sensitive topic like abortion is highly problematic. By identifying the way providers and other key actors interpret the law in Ghana; more light may be thrown on barriers to a broader interpretation and implementation of the existing law. Examining the possibility of reinterpretation could provide a more realistic way of increasing access to safe abortion services.

Little is also known about the knowledge, attitudes and moral stance of health providers and other key actors concerning the abortion law, policy and provision of abortion services in the country - particularly with respect to CAC. These may also present barriers to service provision and therefore research is needed to identify the attitudes and moral values of these actors and the underlying reasons for these. Findings from this study will allow proper identification of the barriers to and opportunities for expanding access to safe abortion services in Ghana. This may

facilitate the development of appropriate mechanisms to address the problem of access to safe abortion services.

1.3 Organization of the Thesis

The thesis is in two parts. The first part constitutes the background to the study, research context, literature review, theoretical perspectives and methods. The second part presents the findings, discussion, summary, conclusion and recommendations. Altogether, there are nine chapters.

Chapter one (this chapter) describes the problem, its dimensions and the basis for the study. The aim and objectives of the study are outlined. The research approach and some of its benefits are presented. Then the reasons which led to the conduction of this study are highlighted.

Chapter two provides a short overview of the Republic of Ghana, the country context in which this research took place, and the position of women's reproductive health and status of abortion services in the country.

Review of the literature forms chapter three. This section covers the magnitude of the burden of unsafe abortion. It looks at policy and legal issues surrounding abortion and the abortion situation in selected countries of interest. Other areas of focus are service-related factors including provider attitudes, socio-cultural norms and other factors that challenge implementation of abortion laws and finally strategies some countries used to improve provider attitudes and expand access to safe, legal abortion services.

Chapter four focuses on theoretical perspectives. The theories and concepts that informed the study are highlighted and explained. The contribution of each theory is described and the conceptual framework is presented and described. In chapter five, the research methods are described and reasons for their selection outlined. The process of data analysis is outlined and measures employed to ensure validity and reliability are described.

Part two of the thesis presents the research findings. Chapter six focuses on the abortion law and reproductive health (RH) policy. It outlines respondents' perspectives of the law and policy with respect to access to safe, legal abortion

services. A critical analysis of the abortion law and policy documents by the principal investigator (PI) is also presented. Chapter seven traces the origin of CAC and highlights events and processes that occurred. The service-related and socio-cultural barriers that prevent access to abortion services are outlined. Chapter eight concentrates on arguments forwarded for and against abortion/abortion care and their complexities, the dilemmas between providers' religious beliefs and professional obligations and their attitudes towards abortion service provision. The various measures adopted by health providers as street level bureaucrats to cope with abortion service provision are outlined. Chapter nine presents and discusses major issues that emerged throughout the entire study in the light of the literature reviewed and the theories that were drawn on. It outlines the summary of key issues and presents the conclusions and recommendations for the study. The final reflections are presented.

1.4 Research Aim and Objectives

1.4.1 Aim of Research

The aim of this study is to understand the barriers to and opportunities for improving access to safe, legal abortion services in Ghana.

1.4.2 Specific Objectives

The specific objectives of the study are to:

1. Analyze the content of the abortion law and policy.
2. Examine the process of promulgation of the law and identify the actors involved and the roles they played.
3. Identify the service-related and socio-cultural factors including social norms, cultural values, religion and morality that act as barriers to provision of safe, legal abortion services.
4. Determine the differences in actors' knowledge, attitudes, and views concerning abortion in general, the abortion law in particular, its implementation and the underlying reasons for actors' attitude and views.

5. Consider implications of the research findings for policy and practice.

1.5 The Research Approach

This research was a qualitative inquiry. It sought to identify, delve into and bring to the fore the barriers that confronted provision of safe, legal abortion services in Ghana. In-depth interviews with key stakeholders were the main methods used. Some documents including the sections on abortion in the Criminal Code and the reproductive health policies of 1996 and 2003 were analyzed to complement data collected through the interviews for purposes of triangulation.

Abortion is a sensitive issue. It is also a very emotive and controversial subject. In-depth interviews offer the best channel, atmosphere and platform for getting the information from people who can provide them. Use of surveys may not provide the same results. During in-depth interviewing, the rapport and trust that is built allow respondents to open up and talk. There is opportunity for further exploration or probing for clarification which may be lacking with questionnaires. The methods used allowed the principal investigator to see beyond words what the attitudes of respondents were. What people were probably unable to put down in writing was adequately captured.

1.6 Motivation for the Research

I am a nurse/midwife by profession and of all the subjects I studied during my training in the University of Ghana, midwifery was my favourite; a subject in which I also excelled. I did my national service with the MOH between the departments of surgery and that of obstetrics and gynaecology of the premiere teaching hospital in Accra, the capital. I worked for almost a year at the maternity out-patients' department where working as a team, we looked after women throughout the obstetric cycle, (pregnancy, delivery and post natal) including women with obstetric emergencies like bleeding. I was later offered a job at the University of Ghana Medical School and continued to work at the same department (obstetrics and gynaecology) but then as a research assistant. I worked there for almost fifteen years (1988-2002).

My work involved collection, collation, compilation and sometimes analysis of obstetric and gynaecological data for monthly clinical meetings, maternal mortality audits and research purposes. This exercise included a compilation of all maternal deaths and their causes. For all the years I worked there, the data collected showed that '*incomplete abortions*' topped the gynaecological admissions. This puzzled me hence for my Master of Philosophy (MPhil) dissertation; I looked at the reasons why women have abortions, the methods they use and the health outcomes. This study introduced me to the law on abortion in Ghana. This exposure made me wonder whether the law on abortion contributed to the abortion situation that puzzles me. I therefore decided that in any future study, I would critically examine the abortion law via the lens of key stakeholders to help unravel the contributory factors to the morbidity and mortality arising from unsafe abortions.

Secondly, I was a member (secretary) of an NGO in Ghana; the Ghana Prevention of Maternal Mortality (GPMM) an affiliate of RPMM (Regional Prevention of Maternal Mortality) an international network of countries which undertook a ten-year operations research to address the major causes of maternal mortality in Ghana and other African countries using simple practical measures. As a member of this research team that sought to reduce maternal mortality, I had opportunity to visit other research sites in Ghana and some African countries to share experiences of the interventions used to reduce maternal mortality and how these have worked. Coupled with my own experience at the department where I worked, I developed an interest in helping in whatever way I could to save the lives of women. Compiling the deaths and suffering (diseases and operations - sometimes removal of the wombs of women and girls who are yet to have children) of women year after year and seeing them go through their experiences as I went round the various wards and theatres to collect data moved me to do something about it.

CHAPTER TWO

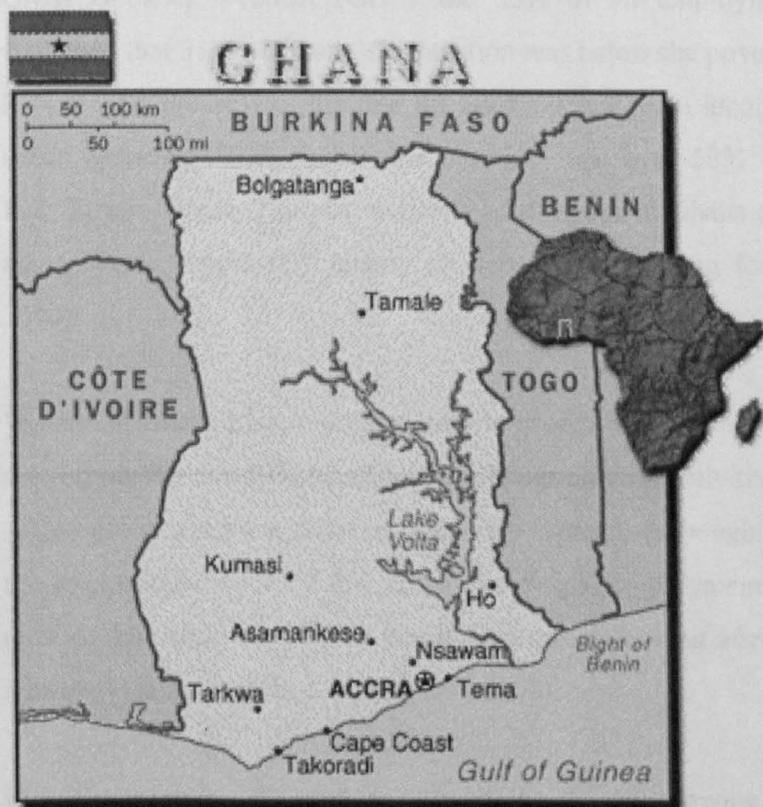
RESEARCH CONTEXT: THE REPUBLIC OF GHANA

2.1 Introduction

This chapter introduces and describes the context (the Republic of Ghana) in which the research was carried out. The location, history and political administration of the country are presented. This is followed by a description of the demographic characteristics of Ghanaians. It concludes with an overview of the healthcare system including access to reproductive health services.

The research was conducted in the Republic of Ghana. Ghana is centrally located in West Africa and has, as its borders, Burkina Faso on the North and Northwest, Togo on the East, Côte d'Ivoire on the West and the Atlantic Ocean on the South (see figure 2.1). It has a total land area of 238,537 square kilometres.

Figure 2.1 Map of the Republic of Ghana



Source: <http://www.ghanaweb.com/GhanaHomePage/geogr>

2.2 History, Politics and Economy

Ghana gained independence from British colonial rule in March, 1957. It was the first country in sub-Saharan Africa to gain its independence. In July 1960, its status changed to a Republic within the British Commonwealth of nations. For many decades following independence, Ghana was politically unstable with military rule in 1966-69, 72-79, and 81-91). It was during the last period of military rule, in 1985, that the abortion law, Act 29 of 1960, was amended to become P.N.D.C. Law 102.

In 1992, the country successfully returned to constitutional rule and multi-party democracy. There are ten administrative regions which are sub-divided into 170 districts. The districts constitute the basic units of planning and political administration. Ghana is currently one of the most peaceful countries in Africa. It is politically stable and has a relatively sound economy.

Ghana's economy depends largely on agriculture which accounts for nearly 40% of Gross Domestic Product (GDP) and 50% of all employment. In 1992, it was estimated that 31% of Ghana's population was below the poverty line of US\$1 a day. People who are below this line do not have adequate income to meet their basic needs including food, shelter and clothing. Just over 50% of Ghana's population lives in rural areas. The vast majority of the poor in Ghana are located in the rural areas. These people rely mainly on subsistence farming for their livelihood (UN 2000).

Women in Ghana play important roles in economic activities. In the rural areas, they are responsible for 40% of all household agricultural activities. About 6 in 10 small scale farmers are poor, most of whom are women. Although women form 51.3% of the total population very few are in the waged-employment sector. Women spend most of their time working in family businesses, looking after children, and in other household tasks such as cooking (GSS 2008).

Ghana's economy is rated as one of the fastest growing economies in Africa. Statistically, the country has now attained the standards of a middle income economy, specifically, a lower middle income economy GSS (2010).

2.3 Demographic Characteristics

Ghana's population at independence was about 6 million. In 1970, the population had increased to about 8.6 million with an annual rate of growth of about 2.4%. The Population and Housing Census (PHC) held in 2000 recorded a population of 18,912,079. The provisional results of the 2010 PHC showed that the total population of Ghana is now 24,223,431; thus the population has increased by 28.1% from 18,912,079 in 2000 to 24,223,431 in 2010. The population density which shows the number of people per square kilometre has also increased from 79 in 2000 to 102 in 2010. The Ashanti (19.5%) and Greater Accra (16.1%) regions constitute 35.6% of the total population. Males make up 48.7% and females constitute 51.3% of the population. There are 95 males per 100 females (PHC 2010).

Ghana's population is described as youthful because the proportion of the population aged less than 15 years has remained around 45% and those aged between 15-24 years have constituted about 30% of the total population of the country for about four decades (National Population Council, 2000).

2.4 Socio-cultural context in which abortions are discussed and provided

2.4.1 Ethnic groups and religion

Ghana is a multi-ethnic country and has more than 50 ethnic groups. These comprise the Akans (49%) the Mole-Dagbani (17%) the Ewe (13%) and the Ga-Adangbe (8.5%) (PHC 2000). The country is highly religious and predominantly Christian. Of the three main religious groups, Christians constitute more than two-thirds of the total population (68.8%). Muslims form 15.9% and the traditionalists are about 8.5% of the total population. The remaining (6.8%) are made up of religions from outside Ghana (PHC 2000). Religion forms part of every sphere of the Ghanaian's life and even transcends officialdom. Almost all important national programmes (e.g. inauguration of new presidents) begin and end with prayers from the three main religious groups. On occasions when the country faces crises like drought or water crises; religious leaders of the country call on the entire nation for religious intervention. Religious programmes and activities form characteristic features of most educational facilities; primary, secondary or tertiary. The mass media,

Ghanaian music and our artefacts all portray the country's strong religious beliefs. It is commonplace to find religious groups or individuals preaching in health facilities (with permission and usually on Sundays), offices (during breaks) and even on public transport (particularly on long journeys). Most public transport and shops all over the country have religious inscriptions on them. Most ethnic groups in Ghana (e.g. Ewes, Akans and Gas) give traditional names that have religious connotations to their children. For instance, among the Ewes names such as '*Elikem*' and '*Esinam*' mean '*God is with me*' and '*God has heard me*' respectively; among the Akans the name '*Nyamekye*' means '*God's gift*'. The name '*Dromo*' among the Gas means '*Grace or God's grace*'. Even ordinary, day-to-day exchange of greetings amongst some Ghanaians is done with a religious backing. Most religious organizations in Ghana do not condone abortion. Senah (2003) underscores the contentious nature of induced abortion and observes how religion and culture, among other factors, impinge on its practice.

2.4.2 Abortion and Related Discussions

In Ghana, sexual issues are not discussed openly in homes and public places; it is not the norm. It is a taboo to openly discuss issues of sex, including abortion. Mayhew (2004) described Ghana as a conservative country, where discussions of sexual issues (including abortion) are forbidden. Currently, the prevalence of HIV/AIDS and its ramifications, recent advocacy efforts by some female lawyers and efforts by the MOH/GHS to scale up comprehensive abortion care might have paved the way for reproductive health issues and sexuality including abortion to be discussed publicly. For instance, issues specifically on abortion published in the print media include:

- 1) '*GHS ready to provide safe, legal abortion services*'.

In this article, (published in the 08/01/04 edition of '*The Mirror*') some of the clauses of the abortion law were briefly discussed as well as the need for the GHS to use strategies to achieve the Millennium Development Goals based on WHO's recommendations for safe abortion (Ardayfio, 2004).

2) '*Make law on abortion functional*'.

This article highlighted the problems associated with and deaths caused by unsafe abortions as well as efforts by the GHS to ensure proper interpretation and implementation of the abortion law in the full interest of women (Ardayfio, 2005).

3) '*Female lawyers' group demands safe abortion services for women*'.

In this publication, the determinants, complications and effects of abortion on families and communities were highlighted. The advocacy efforts of the group to ensure among others, the implementation of policies to regulate abortion in the country were outlined (Abayie, 2005).

All the articles were published in '*The Mirror*', a popular Ghanaian newspaper widely read throughout the country. It has covered issues on abortion over the last four years. Below are some pictures of the press cuttings from 2004-5 on abortion and the abortion law:

Figure 2.2 Press Cuttings on Abortion

a.



b.



c.



Besides the print media, reproductive health issues including abortion are also being periodically discussed in the electronic media and even sometimes during religious programmes at church meetings. However, on occasions when induced abortion is discussed in churches, the practice is highly condemned and forbidden by the religious leaders. Abortion is considered a sin and an act of killing children. In the religious and even traditional sense, children are considered as gifts from God.

2.4.3 The Value of Children

As in other African countries, children are most treasured in Ghana and the country's characteristic kinship system encourages adult members to have many children (Senah 2003). This may partly account for the country's previous high total fertility rates (TFRs). According to Agyei-Mensah (2005), Ghana's historically high fertility levels are for the purposes of perpetuating man's lineage, prestige and for economic support in old age amongst others. Thus, for instance in Southern Ghana among the Akans, women who bear ten children are highly congratulated with big ceremonies. The Gas of Southern Ghana also have a similar practice.

Couples who do not have children find themselves under pressure from relatives and society to bear children. Women usually bear the brunt of the 'shame' and stigma of childlessness and thus either look for help from religious sources, the health system or traditional healers. For these reasons, abortion is profoundly stigmatized in Ghana. Those who provide abortion services, and women who seek such services, are not respected in Ghanaian society. To avoid shame and stigma, abortion is usually carried out clandestinely (Aboagye et al. 2007, GMHS 2007, GHS 2005).

2.4.4 Health

Ghana's national health policy is currently referred to as the Medium Term Health Strategy (MOH 1999). Its main objectives are to provide universal access to primary health care and to improve the quality of services. The objectives of Ghana's health policy in the medium-term are to: increase access to health services, especially in rural areas; reorient the health system toward delivery of public health services; reduce rates of infant, child and maternal mortality; and control risk factors that expose individuals to major communicable diseases.

The government has given some attention to reproductive health matters, as demonstrated by the MOH's introduction in 1996 of the Reproductive Health Service Policy and Standards ('Reproductive Health Service Policy'). This policy document was reviewed in 2003 to include the provision of safe abortion services to the full extent of the law. In 2006, a standards, protocol and guidelines document was produced to spell out who, where and how safe abortion services are to be provided. These will be discussed in detail under section three (on 'the policy') in chapter six.

i. Maternal Health

Historically, fertility levels have been quite high in Ghana, ranging between 6.0 and 7.0 children per woman (Agyei-Mensah 2005). There has been a decline in total fertility rate (TFR) from 6.4 children per woman in 1988 to 4.4 children in 2003 Ghana Demographic and Health Survey (GDHS, 2003). According to the GDHS 2008, unplanned pregnancies are common in Ghana and the percentage of unplanned births is 37%. Data from the GDHS 2003 indicate that knowledge about contraceptives is almost universal but use is relatively low. Contraceptive prevalence is 25% for all methods and 19% for modern methods. Unmet need for family planning is 34%.

Many women are reluctant to report having had an abortion. This tends to compromise the accuracy of induced abortion estimates. The Ghana Maternal Health Survey(GMHS 2007) shows that 7% of all pregnancies end in abortion and 15% of women aged 15 – 49 have ever had an abortion The survey further indicated that about 15 abortions are performed for every 1,000 women of reproductive age(15-44) each year. Furthermore, as indicated in the background section, one of the few

community-based studies on abortion conducted in Southern Ghana observed that 17 abortions are performed for every 1,000 women of reproductive age (Ahiadeke 2001). Abortion is acknowledged to be one of the drivers of fertility decline in Ghana; the high rate of unsafe abortion is a known contributor to the maternal mortality rate in the country (Jehu-Appiah 2009). Maternal mortality rates have remained high. The maternal mortality ratio was estimated to be 580 per 100,000 live births (GMHS 2007).

ii. Health Services

In Ghana, the health system provides a range of services namely promotive, preventive, curative and rehabilitative. These health services are organized at the community, sub-district, district, regional, tertiary and national levels (MOH 1999). At the community level, services are provided through static and outreach programmes by Community Health Officers (CHOs), resident or itinerant herbalists, traditional birth attendants as well as drug peddlers. Health centres provide basic preventive, curative and maternity services (primary health care) at the sub-district level covering a geographical area with population of 15,000 to 30,000. District hospitals (district level) provide support for sub-districts in terms of disease prevention and control, health promotion and public health education, training and supervision. They serve as referral points for sub-districts. Regional hospitals provide specialized clinical and diagnostic care including management of high-risk pregnancies and complications of pregnancy. Regional hospitals are also involved in research and training. There are two government-owned teaching hospitals which offer specialized services, undertake research and provide training for undergraduates and post graduates in health and related areas. At the national level, there is development of national health policies, strategic directions for service delivery, coordination and monitoring.

There are a total of 2,264 health facilities in Ghana of which 1,110 are government owned and are under the Ghana Health Service whilst two are autonomous teaching hospitals, 48 are quasi-government, 184 are owned by religious organizations i.e. Christian Health Association of Ghana (CHAG), 477 belong to the private sector and 443 to other organizations (MOH 2007-2011).

The country spends a total of US\$252 million (4.2% of the GDP of US\$ 6billion) annually on health. About 53.5% of this expenditure is incurred by the government and 4.6% is borne by households through out-of-pocket expenses. Clients who use public health facilities either pay as services are provided or use their National Health Insurance cards (NHIS) if enrolled. The total per capita expenditure on health at an average exchange rate is US\$ 11(WHO 2002).

a. Access to reproductive healthcare services

Since maternal deaths are relatively high in Ghana, reducing maternal mortality is a major objective under the Ghana Reproductive Health Strategic Plan (2007-2011). Among the measures by the GHS to achieve this objective are efforts to increase antenatal care and the proportion of deliveries conducted by skilled attendants. Expanding post natal care coverage is another consideration.

b. Access to ANC, supervised delivery and PNC

The data from the survey (GMHS, 2007) indicate that the majority of pregnant women (96%) received antenatal care for births that occurred in the five years before the survey from a trained provider such as a doctor, nurse/midwife or auxiliary midwife. Also data from Ghana Demographic and Health Surveys show a steady increase of antenatal care coverage from 82% in 1988, 92% in 2003 and 96% in 2007. About 55% of women in Ghana are delivered by a skilled provider (a doctor, nurse/midwife or auxiliary midwife). Also about 55% of women receive post natal care after delivery. A substantial minority of women still access traditional health services rather than medical health care. Whilst antenatal care coverage is relatively high, less women access skilled attendance at delivery or postnatal care.

c. Access to Comprehensive Abortion Care

Access to comprehensive abortion care is limited in Ghana. Traditional Ghanaian societies frown on abortion and the law generally criminalizes abortion (Senah 2003). There is also a lot of stigma associated with abortion in Ghana (Sedge 2010); health providers who offer abortion services as well as women who procure these services are highly stigmatized. Thus the provision of abortion services is shrouded in secrecy. Any abortion, whether it is performed by the trained, untrained doctor or

other health professional is carried out clandestinely (Morhee et al. 2007). It is not open or transparent and the public is not aware that public health facilities provide abortion services. Where these services are provided in public hospitals, they are not available to the full extent permitted by the law (Morhee et al. 2007); they are done unofficially and the procedures are not usually documented as expected. Where records are kept, induced abortions carried out are misclassified usually as ‘evacuation of the uterus’ (EOU). This issue is discussed in chapter 8 under how health providers as street level bureaucrats shape implementation of abortion policy.

Data from a recent baseline study of the MOH/GHS to ascertain the level of readiness of facilities and health providers to offer contraceptives and comprehensive abortion care in three regions in Ghana indicated that there is limited availability of post abortion care and especially legal abortion services in the selected regions of the study. Of the 90 facilities studied (hospitals, polyclinics and health centres) 26.6% offer PAC and 13.3% offer abortion services (Aboagye et al. 2007). The limited availability of safe abortion services in the public sector is attributed to the tendency of interpreting the abortion law as prohibiting abortion (GMHS 2007). There are indications that women do not also know where to obtain services. According to the GMHS (2007), 59% of women who had not had an abortion were not aware of where to obtain services, 29% said they thought they could get services from government hospitals and polyclinics; 14% cited private hospitals and clinics and about 5% mentioned other sources for obtaining abortion services.

d. Cost of comprehensive abortion care (PAC and CAC)

There is paucity of research in Ghana on the cost of abortion (Sedgh 2010). This may be due to the sensitive nature of abortion research. Information from an international NGO (Ipas) indicates that the cost of abortion care in Ghana is high, given Ghana’s per capita income of US\$600. Services cost between US\$30 and US\$40 in public health facilities (Jehu-Appiah 2009). In the MOH/GHS assessment discussed above, similar information was obtained on cost of comprehensive abortion care from only five out of 90 institutions (Aboagye et al. 2007). These findings need to be interpreted with caution. A qualitative study (Henry and Fayorsey 2002) in Accra, the capital city of Ghana, of adolescent girls also revealed a cost of between US\$ 2

and US\$15 (three and 30 Ghana Cedis) in private clinics or hospitals. The cost of services was reportedly prohibitive because the few doctors who were available to provide services charged heavily. This may force women who could not afford such service to resort to abortion from unskilled providers with implications for their health and lives. Many doctors charge women heavily since they consider it professionally risky to perform abortion under the given circumstances. This makes safe abortion services inaccessible to poor women and especially adolescents (Jehu-Appiah 2009).

CHAPTER THREE

LITERATURE REVIEW

3.1 Introduction

My review begins with a discussion of the burden of unsafe abortion around the world, in Africa and Ghana in order to situate the problem in perspective globally, regionally and in the study country. The review then discusses three major issues that emerged as influencing access to safe abortion services and which will be important to inform my own study. First, *legal* issues are discussed since the legal environment in countries influences availability, safety and use of services. Content, legislative-location and interpretation of the law are important issues covered. This is followed by a discussion of *service-related* issues that have been found to affect access to abortion services, including availability of designated facilities, equipment, trained staff and very importantly provider attitudes. Thirdly, *religion and morality* are defined and discussed as key components of broader socio-cultural norms affecting attitudes to, and practices of, abortion. Finally, the review considers strategies that have been used elsewhere to improve provider attitudes and expand access to safe abortion services that may have relevance for Ghana.

The review was based on a wide range of articles from data bases such as PubMed, Popline, JSTOR and Web of Science using search words such as ‘abortion studies AND Africa’, ‘abortion studies AND Ghana’, ‘abortion AND access’, ‘abortion AND implementation’, ‘abortion and religion’, ‘abortion AND morality’. Publications from UN organizations such as the WHO were also used as well as publications from the Alan Guttmacher Institute. Two journals that focus on reproductive health issues namely: ‘*Reproductive Health Matters*’ and ‘*Africa Journal of Reproductive Health*’ were hand searched as well as journals on qualitative research known as ‘*Qualitative Health Research*’. An electronic journal, ‘*Health Policy and Planning*’ was also used. The websites of organizations like the WHO and Ipas (international NGO) were also used for information.

3.2 The Burden of Unsafe Abortion

Each year, all around the world, about 210 million women become pregnant. As many as 80 million pregnancies are unintended, resulting mainly from contraceptive non-use, inconsistent or incorrect use of contraceptives or both, contraceptive failure or poor access to contraceptives. Some of these pregnancies are carried to term, while others end in spontaneous or induced abortion. Induced abortions have been carried out for a very long time all over the world. It is a very controversial issue in reproductive health characterized by stigma, criminalization as well as moral and religious condemnation (Mundigo and Indriso 1999).

Due to the controversial and sensitive nature of abortion, its incidence as well as abortion-related morbidity and mortality are difficult to establish. It is estimated that 46 million pregnancies are deliberately terminated each year- 27 million legally and 19 million outside the legal system (WHO 2004). According to estimates by Sedgh et al. (2007), the global figure for induced abortion decreased from 46 million in 1995 to 42 million in 2003. They further observed that between 1995 and 2003, the induced abortion rate decreased from 35 to 29 per 1,000 women aged 15-44. The decrease in abortion rates was more marked in developed than in developing countries. Even though the overall incidence and rate of induced abortion declined worldwide between 1995 and 2003, the proportion of unsafe abortions increased from 44% to 48% with the vast majority occurring in developing countries. These estimates were based on reports from official national reporting systems, nationally representative surveys and published studies. The unsafe abortion rates in 2003 were estimated from hospital data, surveys and other published data. UN estimates of female populations and live births were used as denominators for rates and ratios respectively. Given the sources of the data, the information may be reliable.

3.2.1 Estimates of Unsafe Abortion

Unsafe abortion has been defined as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both (Ahman et al. 2004, WHO 1998). Unsafe abortions are usually performed by unskilled providers who use dangerous techniques in facilities lacking proper sanitation. They constitute a major neglected reproductive health problem in developing countries (WHO, 2004 1998). Data on

unsafe abortions are particularly difficult to obtain since most happen outside legally provided services and are therefore not officially recorded. Table 3.1 shows the best available data from WHO.

Table 3.1: Global and Regional estimates of number of unsafe abortions and of mortality due to unsafe abortion, around the year 2000^a

	Unsafe abortion incidence			Mortality due to unsafe abortion		
	Number of unsafe abortions (thousands)	Unsafe abortions to 100 live births	Unsafe abortions per 1000 women aged 15-44	Number of maternal deaths due to unsafe abortion	% of all maternal deaths	Unsafe abortion deaths to 100 000 live births
World	19 000	14	14	67 900	13	50
Developed countries*	500	4	2	300	14	3
Developing countries	18 400	15	16	67 500	13	60
Africa	4200	14	24	29 800	12	100
Eastern Africa	1700	16	31	15 300	14	140
Middle Africa	400	9	22	4900	10	110
Northern Africa	700	15	17	600	6	10
Southern Africa	200	16	17	400	11	30
Western Africa	1200	13	25	8700	10	90
Asia*	10 500	14	13	34 000	13	40
Eastern Asia*	-	-	-	-	-	-
South-central Asia	7200	18	22	28 700	14	70
South-eastern Asia	2700	23	21	4700	19	40
Western Asia	500	10	12	600	6	10

Europe	500	7	3	300	20	5
Eastern Europe	400	14	6	300	26	10
Northern Europe	10	1	1	-	4	-
Southern Europe	100	7	3	<100	13	1
Western Europe	-	-	-	-	-	-
Latin America and the Caribbean	3700	32	29	3700	17	30
Caribbean	100	15	12	300	13	40
Central America	700	20	21	400	11	10
South America	2900	39	34	3000	19	40
Northern America	-	-	-	-	-	-
Oceania*	30	12	17	<100	7	20

Source: *Adapted from WHO 2004*

a Figures may not exactly add up to totals because of rounding.

* Japan, Australia and New Zealand have been excluded from the regional estimates, but are included in the total for developed countries.

- No estimates are shown for regions where the incidence is negligible.

Of the 19-20 million unsafe abortions that occur each year in the world, about 68,000 result in death. According to the WHO (1998), about 95 percent of the unsafe abortions that occur in the world, occur in developing countries under illegal conditions. The World Health Organization estimated that the death rate from unsafe abortion in Africa is 100/100,000 live births and considers it to be the highest in the world. In the US the death rate from abortion is 0.6/100,000. The WHO concluded that reducing unwanted pregnancies in Africa would reduce the number of deaths from unsafe abortion. The WHO notes that death from unsafe abortion is the easiest to prevent and treat of all the causes of maternal mortality.

Unsafe abortion is a very common experience in Africa (Hord and Wolf 2004, Braam and Hessini 2004). Women in sub-Saharan Africa face the highest risk of death and injury from abortion complications worldwide and 43% of the 68,000 women who die from these complications each year are from Africa (Hessini et al. 2006). Recent studies from Kenya, Uganda and Nigeria of women in public health facilities with complications of unsafe abortion show the magnitude of the burden of unsafe abortion which Hessini et al. (2006) describe as a public health crisis, a social injustice and a violation of women's human rights and dignity.

3.2.2 Abortion and Unsafe Abortion in Ghana

The Ghana Maternal Health Survey (GMHS 2007) shows that at least 7 % of all pregnancies in Ghana end in abortion, and 15 % of women aged 15–49 admitted to having had an abortion. Abortion rates were highest among 20–24-year-olds, educated and wealthier women, and those living in urban areas. The survey further indicated that just over half of Ghanaian women who admitted having had an abortion sought help from a doctor, while others turned to pharmacists or traditional midwives to induce abortion. Almost one in five women induced the abortion themselves or had the help of a friend.

It is believed that unsafe abortion contributes significantly to the burden of maternal morbidity and mortality, especially among adolescents (Aboagye et al. 2007; Mayhew 2004). Ghana's maternal mortality stands at 580 per 100,000 live births (GMHS 2007). Complications of unsafe abortion are thought to constitute 22 to 30% of all maternal deaths thus making unsafe abortion the highest contributor to maternal mortality in Ghana (Ghana Health Service 2004-2008; Aboagye and Akosa 2000).

Other sources indicate that unsafe abortion contributes 12% to 15% of maternal mortality in Ghana (Ministry of Health and Ghana Statistical Service 2003, Geelhoed et al. 2003, Baird et al. 2000). These discrepancies make data on abortion unreliable. According to Ahiadeke (2001), data on abortion in Ghana is generally scarce, fragmented and unreliable. He observed that most studies on induced abortion in Ghana are hospital-based; that all but one of the 22 studies on abortion carried out between 1972 and 1994 were hospital-based and as many as 19 took place in Korle-

Bu Teaching Hospital, Ghana's largest teaching hospital. In his view, since induced abortion is perceived as illegal in the Ghanaian context, women admitted to hospital with complications of induced abortion are likely to be documented as women hospitalized with complications from spontaneous abortion. He identified factors such as poor record-keeping, inaccurate classification of type of abortions done by doctors and the lack of policies that demand accurate classification of abortion as accounting for unreliable data on induced abortion and also making hospital data inadequate for estimating Ghana's nation-wide incidence of induced abortion. In his study on the incidence of induced abortion in Southern Ghana (one of the few community-based studies in Ghana), there were 27 abortions for every 100 live births. The vast majority of the women who had an abortion (60%) were younger than 30; about one-third of women obtained an abortion from within the health system whilst the remaining 68% reported having obtained an abortion from pharmacists (38%), by self medication (11%), from an untrained provider (16%) or by other means (3%).

In terms of morbidity, unsafe abortion exacts a heavy toll. It leads to complications such as infection, profuse bleeding, perforated womb, and damage to internal organs (Grimes et al. 2006, WHO 2004). In Ghana studies have documented similar complications (Adanu 2005; Aniteye 2002; Obed and Wilson 1999; Lassey 1995). In the two main teaching hospitals in Ghana, the Korle-Bu and Komfo Anokye Teaching Hospitals, abortion complications constitute about 50% of gynaecological admissions (Aniteye 2002, Turpin et al. 2000).

The commonest reason why women sought an abortion was not having the financial means to take care of a child. Other reasons reported included wanting to delay childbearing or complete school. The GMHS (2007) which took place almost a decade after Ahiadeke's study (1997/98) showed some similar findings; most women having abortions are young and women seek abortion services from both orthodox and traditional sources. It appears relatively more women sought help from a doctor in the nationally representative survey than in the study that concentrated in Southern Ghana. This may be due to a growing awareness of the need for safe abortion although the continuing high level of maternal mortality in Ghana suggests that access to safe abortion is still being constrained. I now turn to consideration of

factors influencing access to safe abortion services in order to understand what may be important factors to consider in Ghana.

3.3. Access to safe abortion

From the literature reviewed there appear to be three overriding issues regarding access to safe abortion services. First, legality of abortion appears to affect availability of services and use of safe services. Second, services and resources available (infrastructure, equipment and training) are important for ensuring legal services are in fact provided. Third, social acceptability and social access issues – related especially to religion and morality – are critical influences on whether potential clients are willing and able to use them. Each of these issues is now discussed in turn.

3.3.1 Legal Issues

Public discussions on abortion and its legality are rare but the 1994 International Conference on Population and Development held in Cairo and the 1995 Fourth World Conference on Women held in Beijing discussed abortion at length (Crane and Hord Smith 2006; Rosoff 1999). These two conferences are important for a number of reasons. They created awareness among nations, and initiated global discussion on the burden of unsafe abortion and the need for action. Furthermore, the ICPD included safe abortion services as a reproductive right in countries where they were legal and post-abortion care as a reproductive right in countries where abortion per se was not legal, creating obligations on governments that signed the declaration.

Reforming national abortion laws and making them less punitive is one step towards ensuring availability of services. In addition to the ICPD declaration, the WHO also holds that where legal, abortion services should be safe, and where not legal, post-abortion care must be provided (ICPD 1994; WHO 1998). This implies a global acknowledgement that in the absence of safe, legal abortions, women are likely to resort to illegal, unsafe abortion. There is plenty of evidence to show that where laws are restrictive, abortions are clandestine and unsafe; as for example, in Brazil, Nigeria and Kenya (Faundes et al. 2004, Okonofua 2004, Oye-Adeniran et al. 2004, Brookman-Amissah and Moyo 2004). Even though abortion is legally restricted in

Brazil, it is a common practice. The law in Brazil allows a physician to perform abortion only in cases of rape or if there is no other way of saving the woman's life. Apart from these instances, abortion is illegal and the woman and abortion provider could face prison sentences of up to 10 years. Abortion is also condemned by the Catholic Church and the vast majority of women are denied access to safe abortion services even where permitted by law. Despite these restrictions, illegal abortions occur. An estimated 940,660 illegal abortions were reported in Brazil in 1998 (Faundes et al. 2004.)

The abortion law in Nigeria is highly restrictive. The law criminalizes abortion unless the pregnancy threatens the woman's life. Due to these legal restrictions, religious and social norms that prohibit abortion and the social stigma associated with abortion in Nigeria, its practice is shrouded in secrecy; many unskilled providers perform abortions clandestinely often in dangerous and unhygienic settings (Makinwa-Adebusoye et al. 1997). Okonofua (2004) highlights how legal restrictions lead to underground abortion practices that severely compromise the safety of the procedure.

Abortion is also restricted in Kenya and safe abortion is only accessible to wealthy women, an indication of gross health inequity. Maternal mortality in Kenya is very high; about 590 deaths per 100,000 live births (similar to Ghana) of which about 30% are attributable to unsafe abortion (Brookman-Amissah and Moyo 2004). A national assessment of the magnitude and consequences of unsafe abortion in 2003 showed that more than 300,000 women have unsafe abortions every year. Also more than 20,000 women suffer from complications of unsafe abortion yearly of which an estimated 2,000 women die. There are public debates and proposals to liberalize the law (Brookman-Amissah and Moyo 2004).

In the United States of America and Romania, available data indicate that the number of deaths from abortion decrease when restrictions on abortion are minimized. In America, death rates due to abortion plummeted by 85% after five years of legalization (Tietze 1981). Whilst in Romania, evidence shows that during a period of repressive abortion legislation between 1966 and 1984, the number of deaths due

to abortion went up by 600%. When abortion was legalized in 1990, the abortion deaths decreased by 67% in a year (Romania Ministry of Health 1991).

Most countries have laws and policies governing induced abortion and there is wide variation in terms of their restrictiveness (see Appendix 1 for a summary of countries in which abortion is legal and the grounds on which it is permitted). Only in Chile, El Salvador and Malta, is abortion not allowed under any circumstances. In about 98% of the countries in the world, a woman is allowed by law to terminate her pregnancy if the continuation of that pregnancy will endanger her life. In 62% of countries, a woman may also have an abortion to preserve her physical or mental health (Ahman et al. 2004). In developing countries abortion laws are more restrictive, resulting in inequitable access to safe abortion where rich clients pay for private abortions by doctors in secret (Crane et al. 2006). In Africa the laws that govern abortion tend to be highly restrictive (Okonofua 2004, Brookman-Amissah and Moyo 2004); only three out of 54 countries allow abortion on request in the first 12 weeks of pregnancy (Braam and Hessini 2004). Since this study was conducted, Kenya has also changed its law (in 2010) to legalise abortion. This is ironic given that many abortion laws in developing countries originated from the laws of European countries which have long liberalized their own laws. Also the laws adopted by the low resource countries from their colonial masters did not match cultural norms (Crane et al. 2006). The authors were not explicit about the cultural norms of the low resource countries. However, even though most African countries are highly pronatalistic and believe in having many children, acknowledging women's gendered role as that of bearing children, some traditional African countries in pre-colonial times used abortion to control pregnancies that were considered shameful and undesirable such as those due to rape or from pre-marital sex (Braam and Hessini 2004). For instance, Bleek (1981) found in his ethnographic study of the Akans (ethnic group) in Ghana that abortions and even infanticide were practised on deformed children and a child was given recognition as human only after eight days.

i. ‘Liberal’ abortion laws of UK, South Africa and Zambia

Given that decriminalisation, or full-legalisation, of abortion is a necessary first step to ensure access to safe abortion, I reviewed the laws of the UK, South Africa and

Zambia, all of which are considered to have ‘liberal’ laws, to examine what makes them *‘liberal’* on paper. What makes the UK law relatively liberal is that the law permits abortion on the following grounds: “i) that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family; or ii) that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or iii) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or iv) that there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.” Most abortions in the UK are reportedly done under these provisions (Ingham et al. 2008) when the doctor confirms that continuation of the pregnancy would damage the woman’s mental wellbeing. The doctor also takes the pregnant woman’s real or potential environment into consideration and this covers her social and economic circumstances. These clauses in the law apparently give more room for women with unwanted pregnancies to have terminations and the UK, as most developed countries, has a very low maternal mortality rate. But it is important to note that what a law provides on paper is not necessarily implemented by health services (Berer 2004) particularly in developing countries where culturally conservative societies and poor health infrastructures may restrict access.

South Africa’s 1996 law is also liberal since i) a woman can request termination of an unwanted pregnancy in the first 12 weeks of gestation ii) termination of pregnancy is also permitted if the woman’s physical or mental health would be in jeopardy if she continues with the pregnancy and iii) registered midwives with requisite training are permitted by law to offer termination of pregnancies during the first 12 weeks of pregnancy. However, Whitaker and Germain (1999) observed that limited access to abortion services in South Africa despite its liberal law was due to factors including the dearth of healthcare providers with necessary skills, providers’ objection to increased workload with the change in law and objection to service provision by others due to their own personal beliefs. Indeed South Africa’s maternal mortality rate (MMR) has actually been increasing again from 380/100,000 in 2000

to 410/100,000 live births in 2008 according to estimates by WHO, UNICEF, UNFPA & WORLD BANK; this raises questions about the impact of the liberal law.

The liberality of Zambia's abortion law lies in the fact that the law allows abortions to be carried out on broad health as well as socio-economic grounds. The law also permits abortion where continuation of the pregnancy would involve risk to the life or injury to the physical or mental health of the pregnant woman or any existing children of the pregnant woman. Although Zambia's MMR has declined since abortion was legalised from 729/100,000 in 2001 to 591/100,000 live births as of 2007, the reduction is considered insignificant (Mbewe, 2010). Barriers to safe abortion still exist in Zambia. For example, restrictive administrative policies still render abortion services inaccessible (Berer 2002; Whitaker and Germaine 1999); three doctors are required to approve a woman's request for an abortion. This is a very difficult requirement to meet given the scarcity of doctors especially in rural areas. Other barriers to service provision in Zambia (Berer 2002) are reluctant providers, lack of trained providers and other resources and failure to authorise providers and facilities. Okonofua (2004) reiterates that despite these liberal legal provisions, women still have limited access to safe abortion due to an array of socio-cultural and services-related barriers. The author did not state the barriers but these are likely to include social disapproval and stigma, cultural norms, religious beliefs and moral values; lack of trained staff, equipment and provider attitudes as the literature is showing. Appendix 2 gives a more detailed overview of the laws in these three countries.

In the case of Ghana, which also has a relatively liberal law in the sense that it allows abortion to preserve 'physical and mental health', it is puzzling that there has been little impact on MMR since the law was introduced in 1985. This suggests that while having a liberal law in place is important, and a necessary first step, a lot also depends on how that law is interpreted and implemented. This is discussed in the next section.

ii. Legal Interpretation and Implementation

In some cases, laws may be very similar on paper, but interpreted and applied differently in practice (e.g. Britain and Ghana). Abortion laws differ from country to

country according to the way in which they are formulated within the national legislation (United Nations 2001a, 2001b 2002). Abortion may be captured in the criminal code, in civil law, public health codes or medical ethics codes. In Ghana it appears in the criminal code. In some countries, these documents clearly show how abortion laws should be interpreted. However in many countries there are no guidelines for interpretation. This omission may give rise to problems with implementation. Also, in countries where the laws and policies have many ambiguous clauses, this lack of clarity makes the law difficult to comprehend resulting in problems with interpretation and implementation. Cook et al. (2003) also observe that in countries with restrictive laws there are hardly any guidelines for interpreting clauses that are not explicit but prone to multiple interpretations as in the definition of the concept of 'risk'. This lack of clarity in their view makes health providers brand all abortions illegal and then provide it in secrecy. Furthermore, Whitaker and Germain (1999) consider abortion laws as difficult to interpret, frequently unknown to women and health providers hence restricting access to legal abortion in most African countries. All these factors affect the availability of, and women's access to, safe, legal abortion services (WHO 2003) and decriminalising the law must be accompanied by measures to ensure its implementation (Hessini 2005). Recognising this, the ICPD programme of action, its five year review and the Fourth World Conference on Women in Beijing recommended that health systems should make safe, legal abortion services accessible (Hessini et al. 2006, Faundes 2004, Sai 2002, AGI 1999, Gerhardt 1997). To this end, the WHO developed norms and standards for quality abortion services - *Safe abortion: Technical and Policy Guidance for health systems* (WHO 2003). In recent years therefore some countries including Brazil, Vietnam, Nepal, India and Thailand have started developing guidelines for legal abortion services with inspiration from the WHO guidance on safe abortion (Crane et al. 2006, WHO 2003). Notably, this has not yet occurred in most African countries.

iii. Interpretation and implementation in Ghana

Even though abortion is legal in Ghana under certain conditions (See Appendix1), only 4 % of Ghanaian women are aware of this and among these women, 17% are not aware of the circumstances under which abortion is legal (GMHS 2007). Not

being aware that they are legally entitled to safe abortion when the need arises, many women have recourse to unsafe abortion.

Lithur (2004) in her case study on abortion as a reproductive health issue in Ghana described how the absence of abortion in the reproductive health policy influenced availability of services to cover the three exceptions for which abortions are allowed:

- i) Where the pregnancy is due to rape, defilement of a female idiot or incest and the abortion is requested by the victim or her next of kin;
- ii) Where continuation of the pregnancy constitutes a risk to the life of the pregnant woman or injury to her physical or mental health and;
- iii) Where there is a substantial risk that the unborn child is likely to suffer from or later develop a serious abnormality or disease after birth.

In addition, she observed that the inclusion of abortion in the criminal code creates the false perception in Ghana that all abortions are criminal. Criminalisation of abortion and failure to interpret the law liberally has been noted as influencing service availability. Two recent studies in Ghana focussing on the abortion law and availability of services in the country showed the lack of clarity in the law, the need for reform and authorization of mid-level providers to offer safe abortion services (Morhee and Morhee 2006; Morhee et al. 2007). The first study, a qualitative inquiry, reviewed relevant literature with critical analysis of sections of the criminal code of Ghana from medico-legal perspectives. Findings revealed a lack of clarity in the definition of ‘abortion and miscarriage’, no defined gestational limits for abortion; implicit provisions that make the law liable to multiple interpretations include the mental health clause. The authors noted a shift from a prohibitive and punitive law (pre-1985) to the current liberal one. The latter study, a hospital-based one, interviewed 74 respondents, who were all physicians. Seventy-six percent of the respondents surveyed thought the law was not clear enough and 62% thought the law needed further amendment to make it simpler and clearer. On the question of who should be trained to perform abortions, 97% said only physicians and 3% cited physicians, midwives and medical assistants. The finding that most respondents think that only physicians should provide abortions reflects the existing controversy about authorizing mid-level cadres of health providers to offer abortions.

Lack of clarity in the abortion law and the multiple interpretations demonstrated in these studies may be among the factors that account for the observed partial implementation of the law and limited service availability in Ghana. The two studies cited above only looked at issues of access through the law from the perspectives of lawyers (authors of first study) and physicians (second study). There is a need for studies that also consider the views and interpretations of a wider range of stakeholders who influence service provision and uptake. Besides the clarity of the law, this study examines the processes of its promulgation, the context within which it is applied and how these influence availability and accessibility of abortion from the perspectives of a wider range of actors, for example, health providers, policy makers, parliamentarians and religious leaders. Use of a wider range of actors will shed more light on different dimensions of the problem of abortion in Ghana and service availability.

3.3.2 Services, Staff and Resources

Even where abortion is legal, safe services are not equitably accessible to all women and unsafe abortion may still occur. The second major group of factors identified in the literature as limiting access to safe abortion services are service-related. Many studies have demonstrated that across a range of countries, women who require safe abortion services that are legal are not able to access them for reasons such as paucity of approved facilities, inadequacy of trained providers who are willing to provide the service, and poor quality of services including long waiting times (delays) are also common (Warriner et al. 2011; Kumar et al. 2009; Jones et al. 2008; Harries et al. 2007; Benson 2005; Prada 2005; Duggal and Ramachandran 2004; Garcia 2004; Dickson 2003; Berer 2002; Iyengar et al. 2002; United Nations 2001a, 2001b, 2002; Althaus 2000; Henshaw 1998; Koster-Oyekan 1998; Gupre et al. 1997). Finally, provider attitudes emerged as a major influence to access. These issues are now discussed in turn.

i. Lack of approved facilities

In India abortion is legal but due to lack of designated facilities, many terminations of pregnancies are still performed clandestinely, often in unapproved facilities and by untrained people, resulting in high numbers of unsafe abortions (Duggal and

Ramachandran 2004; Berer 2002). This implies that legalization per se does not prevent unsafe abortions. Services must be available, accessible, affordable and socially acceptable. Even though South Africa has been described in the literature as one with a model abortion law, there has not been much progress in service provision and availability. Following its 1996 legal reform that liberalized women's access to termination of pregnancy, Dickson et al. (2003) conducted a survey to describe the availability and accessibility of abortion services in 1999. Findings showed that only 32% of the 292 designated facilities were providing services, 27 % of which were private facilities. Among the barriers to abortion service provision was gross inequitable rural/urban geographic distribution of services among the provinces. The services were mainly available in two urbanized provinces. The authors suggested extension of services to rural areas with more services established at the primary care levels. They highlighted the potential role of the private sector and that of general practitioners in service provision to help expand access.

ii. Lack of trained staff

The dearth of trained staff for provision of abortion services was not uncommon in many countries. This may be because most countries' legal provisions permit only doctors to provide abortions. Even where trained, not all doctors are willing to provide abortion services. Some providers desist from offering abortions to avert negative attitudes from colleagues, for fear of prosecution, stigmatization, violence from anti-abortionists and for personal, moral and religious reasons as well as on grounds of conscientious objection (Harries et al. 2009; 2007; Curlin et al. 2007; Mhlanga 2003). This shortage of abortion providers limits women's access to safe, legal abortion services with implications for their health and health services in general. Lack of trained healthcare providers, willing to perform abortions or to assist those performing abortions in designated public sector health facilities was a major problem identified in South Africa following the enactment of the Choice on Termination of Pregnancy Act in 1996 (Harries et al. 2009). Also a survey of 35 Peruvian doctors (Pace et al. 2006) to examine their knowledge, attitudes and practices regarding legal abortion revealed that their knowledge about abortion techniques was lower for induced abortion than for management of incomplete abortion. Lack of training, administrative and professional support were major

barriers to legal abortion provision. They called for improved training of health professionals, better institutional support and the development of administrative and legal procedures to guide management of women seeking abortions.

Furthermore, to enhance access to abortion services, a growing body of evidence shows that nurses, midwives and other mid-level health cadres can provide safe and effective abortion care (both surgical and medical) with proper training and supervision (Hessini 2005, Hord and Wolf 2004, Sibiyu 2004, Mhlanga 2003, WHO 2003, Ipas and IHCAR 2002), but the issue remains contentious in countries such as the USA. The controversy is due to physicians' (including those who provide abortions) perception that certain procedures are solely in their domain and thus would want to protect their interests in relation to their special skills, caseloads and income (Berer 2009); opposition by physicians is a way of protecting their professional domain or turf Chong and Mattar (2006). Also, most countries' laws permit only doctors to provide abortion services hence mid-level providers are not trained and doctors are reluctant to delegate authority to offer abortion services to mid-level providers (Hessini 2005, Hord and Wolf 2004).

However, a review of research articles (Berer 2009) on the provision of first-trimester abortion by mid-level providers showed that suitably-trained mid-level health-care providers such as nurses, midwives and other non-physician clinicians can safely provide abortion services (vacuum aspirations and medical abortions) in the first 12 weeks of pregnancy. Involving mid-level providers in comprehensive abortion care is posited to expand availability and accessibility and lower costs. South Africa is the only African country where the law permits mid-level providers to offer surgical abortions via aspirations. Well trained mid-level providers could competently provide vacuum aspirations and medical abortions within the first trimester. The reality of service provision challenges requires that policies put in place nationally are appropriate to the service provision issues faced on the ground. In a review of the evidence, Berer (2009) identified four areas where policy could address the problem of lack of trained staff very directly. These are: 1) authorization of qualified health providers to offer relevant abortion care; 2) getting rid of policy restrictions allowing only doctors to perform abortion; 3) institution of regulations and training programmes that will allow mid-level providers to play major roles in

providing abortions and 4) integrate training in abortion care into basic training for all nurses, midwives and medical students doing rotations in obstetrics and gynaecology as well as in in-service training and refresher courses.

iii. Perceived poor quality of services

Many studies explored the issue of quality in abortion care in both developed and developing countries. Most methods employed in these studies were mixed, comprising surveys, individual and group interviews and observation using health providers mainly doctors and midwives as well as patients. The use of both providers and users to assess quality ensures that biases from either perspective are removed to give clearer insights into the situation. The areas of focus or the indicators of quality included interaction between providers and women seeking abortion, knowledge, skills and technical performance of health professionals, provision of privacy and confidentiality and the quality and adequacy of counselling. Some constraints identified in relation to quality abortion care were lack of training, lack of staff accountability (Nguyen et al. 2007) poor supervision and regulation (Dovlo 2004), individual-level barriers and organizational constraints (Say and Foy, 2005); for instance as part of initiatives to enhance quality of care in abortion care in Scotland (Say and Foy 2005), findings from interviews with several key informants to identify factors that enable or militate against the provision of high quality care showed that individual-level barriers to quality care included provider attitudes; however the major constraints to improvement in quality of care lay in organizational and social culture. The authors suggested a multi-level approach to tackle the problems identified.

Surveys in South Africa (Engelbrecht et al. 2000) have revealed that some health care workers obstruct the referral system by refusing to refer women to facilities for TOP. This results in delays. One such survey (Jewkes et al. 2005) with 46 women in hospital with abortion complications showed that in some cases women were turned away because of long waiting lists or their pregnancies were too advanced for termination. Having pregnancies that were too advanced for termination may be due to the long search by women for approved facilities and providers who are willing to offer services. It could also be because the women were not referred to facilities where they could obtain services. Similar findings of inappropriate referrals and long

waiting periods were obtained in a qualitative study in South Africa (Harries et al. 2007). A survey in England by Finnie et al. (2006) which investigated women's experiences and general practitioners attitudes to induced abortion also revealed some delays and barriers women face when seeking abortion care. Some women (15%) had to make more than one appointment before getting general practitioners (GPs) who were willing to refer them and 32% waited for 2 or more days to receive hospital appointments. This puts the lives of women at risk as it is more dangerous to have termination of pregnancies that are far advanced (Bartlett et al. 2004, WHO, 2004).

iv. Specific service-related issues in Ghana

A facility assessment conducted by the GHS Aboagye et al. (2007) showed that in the regions where the census was carried out, only one health centre offers CAC out of 74 and 11 out of 16 hospitals. The study also found that availability of MVA kits in the hospitals and primary care facilities was limited given the recommended value of six aspirators per hospital and two per health centre (Aboagye et al. 2007). The need for MVA instruments was great and both private and public health sectors have challenges in ensuring sustainable access to these instruments. To improve access and/or supply, it was recommended that a revolving purchase mechanism be instituted for associations like the Ghana Registered Midwives Association (Graff and Amoyaw 2009).

A contentious issue in Ghana is the question of who may legally provide abortions. Even though in Ghana the abortion law specifies only medical practitioners as those qualified to offer abortion services, a few midwives have also been trained to offer post abortion care using manual vacuum aspirations as recommended by WHO (Otsea et al. 1997). The GHS currently authorizes midwives and medical assistants with midwifery training to provide early abortion in accordance with the law and the 2006 GHS Standards and Protocols. Despite advocacy meetings held with the Nurses and Midwives' Council (N&MC) the issue remains contentious. The GHS facility assessment (Aboagye et al. 2007) described earlier in this section found that many managers (62%) and health workers (55%) were strongly opposed to provision of early safe abortion by midwives and medical assistants. This was also revealed in a study in Ghana (Morhee et al. 2007) where the vast majority of doctors (97%) said

only physicians should be trained to perform pregnancy terminations; reflecting a lack of awareness of the GHS standards and protocols. Having looked at some of the barriers to abortion service provision in the health system, the review now further looks at provider attitudes, which emerged as a major service-related barrier to abortion service provision.

v. Provider Attitudes

An issue that emerged to be of particular importance from the literature is the influence of health service providers' attitudes on access to services in general, and abortion services in particular. The attitude of health providers, including managers is an issue of concern raised by many authors and many studies have reported poor provider attitudes (Harries et al. 2009; Hill et al. 2009; Hessini et al. 2006, Cooper et al. 2005, Jewkes et al. 2005, Gallo et al. 2004, Dickson et al. 2003, Varkey 2000, Whitaker and Germain 1999, Lassey 1995). These range from judgemental attitudes, abusive, rude, discriminatory, punitive, negative, conservative and unsympathetic. Some providers refuse to provide services for fear of prosecution, on religious grounds or due to social stigmatization. Others fail to refer women to appropriate facilities for services or to provide correct information about legal services whilst others object based on their right to conscientious objection (Harries et al. 2009, Harrison et al. 2000). In the following sections I discuss a range of studies that give examples of a) the attitudes displayed by providers which influence their behaviour and b) the factors that appear to influence these attitudes.

a. Attitudes and how they influence behaviour

Studies in South Africa have portrayed some negative provider attitudes such as verbal and physical abuse, lack of compassion, rudeness and coercion of patients to change their decisions. In a qualitative inquiry (Jewkes et al. 1998) with patients, staff and managers on health seeking practices in maternity services using in-depth interviews, group discussions, participant and non-participant observation, nurses were described by patients as rude, not caring, harsh, confrontational and inhuman. The nurse-patient relationship was characterized by abuse and neglect. Nurses had some illusions of power and superiority over the patients and this reflected in treatments meted out to them. Since managers and higher levels of the profession

failed to sanction midwives who treated patients badly, the latter tended to think their practices were normal and acceptable. Holding the interviews with women at the antenatal clinic was not the best, given the fact that one objective was to assess the quality of care received by patients but efforts by researchers to ensure validity (i.e. by discussing drafts of findings with participants) were positive.

Varkey (2000) studied women's experiences in obtaining abortion services and showed that providers at referral centres sometimes create barriers for women seeking services. Some women were forced to go from one clinic to another looking for a health worker who would be compassionate enough to refer them for abortion services. Others were sometimes obliged to listen to providers' personal opinions about abortion. The slow implementation of the 1996 Choice of Termination of Pregnancy Act has also been attributed to provider attitudes. Varkey (2000) further found that out of 248 public health facilities designated to provide abortion services, only 73 do so and only 10% of the reported abortions occur in the province with the largest proportion of the country's female population; findings indicated that health providers were reluctant to provide services. Also, second trimester abortions were discontinued in some facilities because managers could not get their staff to provide services. Fear of hospital staff rudeness was a major barrier to access to services. A survey with 46 women in hospital with abortion complications showed that 17% knew where to access legal services but feared rude staff (Jewkes et al. 2005). The authors concluded that lack of knowledge of abortion rights and perceived poor quality of care (including providers' attitude) influenced women's choices.

Most of the above studies were surveys. The use of surveys to study attitudes is problematic. This is because measuring attitudes is a difficult undertaking and even more difficult when attitudes towards the issue such as abortion are controversial. Abortion brings many concerns including personal, emotive, religious, moral, ethical, gender and power to the fore hence surveys are not well suited to detect and interpret subtle differences and nuances (Everatt 1999). There is a need for qualitative studies exploring provider attitudes and the influences that underlie them. My study, a qualitative one, will look at providers' attitudes towards abortion care and further explore the underlying reasons for their attitudes.

A study in Bangladesh (Bhandari 2008) on clients' interaction with providers showed evidence of poor provider attitudes but in different perspectives. Providers' perception of clients' characteristics such as marital, social and economic standing influenced the quality of care provided. Some providers tried to change clients' minds about their request for menstrual regulation (MR) because in that context, the role of women is largely to bear children. Poor quality of care, ineffective counselling and preferential treatment of the elite resulted in women resorting to unsafe abortions from informal traditional healers or other clandestine services. Other studies showed that women would prefer to stay home and resort to medical abortion (using mifepristone) because they were concerned about health professionals' negative attitude and lack of privacy in public health facilities (Lie et al. 2008). These attitudes and behaviours of providers were unprofessional and raise concerns about quality of care. The underlying reasons for providers' attitudes are now explored.

b. What influences provider attitudes?

The literature shows that implementation of policies in the health system is a factor that influences providers' attitudes. Two studies in South Africa (Walker and Gilson 2004; Penn-Kekana et al. 2004) looked at the experiences of a group of nurses and midwives during implementation of two policies. Both studies found that frontline staff were not involved in decision-making about changes to policy and practice and subsequently felt under-appreciated and disempowered which meant that they ignored implementation requirements.

Though not related to abortion services, these studies are useful and important because they demonstrate the complexities of policy implementation and the challenges that confront frontline health workers (implementers) and its effects on them and in turn on their patients. In conclusion, the authors highlighted the importance of understanding the context of the policy process and the need to manage people as well as the policy change. The need for frontline staff to be consulted and be made a part of the process was stressed. The importance of communication and consultation in policy change was highlighted. Seeking providers' professional support is crucial for provision of abortion services that have the additional challenge of being socially controversial.

Some studies have demonstrated that nurses' attitudes in the nurse-patient relationship are partly due to poor working conditions and other factors such as lack of accountability on the part of staff and services (Gilson et al. 1994). Although not many studies have been done on healthcare providers' attitudes towards abortion in South Africa (Harries et al. 2009), there is evidence that religious, political, organizational and other issues relating to the nursing profession underpin the behaviours that nurses display. Findings from a qualitative study which explored knowledge, attitudes and opinions of healthcare providers and healthcare managers across a range of facilities that provide reproductive healthcare services showed complex patterns of service delivery due to providers' claim of conscientious objection. Service provision was fragmented because providers were willing to offer different aspects of abortion care. Among the factors that influenced providers' decision for abortion care were i) religious beliefs ii) moral iii) personal and iv) indication for the abortion. Also, Jewkes' (1998) study which investigated health seeking practices of women in one part of South Africa made important revelations of some influences of nurses' attitudes. These included perceptions of professional insecurities regarding nurses' position and identities, organizational issues, perceived need to control patients as well as the environment, sanctioning nurses' use of punitive means to exert power over patients, the need for creation of social distance between nurses and patients and notions of patient inferiority. The behaviours of nurses are also attributable to their training and socialization. Knowledge of these factors that determine providers' decision to provide abortion care is crucial for planning comprehensive abortion care services. Exploring provider attitudes and factors that underpin them in my study would provide the MOH/GHS useful data to help in scaling up comprehensive abortion care in health facilities in Ghana.

Two other studies have showed that the attitudes of providers towards abortion and other reproductive health services are not always negative but could be mixed depending on their personal experiences and education. Findings from a survey (Gogna et al. 2002) of 467 obstetrician/gynaecologists from public hospitals in Argentina indicated that physicians who had firsthand experience of dealing with abortion complications were more likely to be sympathetic to women coming for abortion services. Warenius et al. (2006) in a study to determine the attitudes of 820

Kenyan and Zambian nurse-midwives towards adolescent sexual and reproductive health problems found that staff who had been exposed to training or higher education in sexual and reproductive health issues were far more sympathetic to adolescents seeking services.

In addition to involving front-line staff in decisions affecting their practice, and in ensuring they have adequate knowledge and information on the relevant services they are expected to provide, the most important influence on providers' attitudes is the prevailing religious and moral milieu in which they operate. This is taken up in the next section.

3.3.3 Religion and Morality

The final group of factors identified in the literature that hamper implementation of the abortion law are religious beliefs and moral values. Most authors understand 'religion' and 'morality' as closely linked to and influenced by prevailing socio-cultural 'norms'. To set religious and moral issues in context this section will first briefly discuss socio-cultural 'norms' and 'values', then detail specific socio-cultural norms regarding childbearing and abortion that are prevalent in Ghana. The main part of this section will then define and discuss issues of religion and morality in relation to abortion and service-provision.

i. Cultural values and social norms

Cultural values are concepts of what a culture deems good, desirable and proper on one hand and bad, undesirable and improper on the other. The values held in a culture show what the people of that culture like and what they consider important and morally right or wrong (Schaefer and Lamm 1997). Values influence people's behaviour and are therefore used for evaluating people's actions. Norms are behavioural standards maintained by a society. (Schaefer and Lamm 1997). Many values and norms are defined by prevailing religious norms in a country, though there are other influences relevant to abortion discussions. The next section outlines the prevailing values and norms in Ghana that are relevant to abortion.

a. The value of children and Ghana's Pronatalism

In terms of culture, Ghana is made up of many ethnic groups (as described in the background section of the thesis) with diverse beliefs, norms, moral values and practices however; there are some similarities of beliefs and practices in the Ghanaian society. The most outstanding of such beliefs and practices that transcends all the ethnic groups is their pronatalistic stance (Kenyah 2000). Ghana is a deeply pronatalistic society. The value of children in Ghana is phenomenal. Children are highly valued and considered the most precious of family possessions (Gyekye 1996). Traditionally, families encourage young men and women in gainful employment to marry and one main reason is for them to have children. Where they delay unduly their families worry and even interfere in their private lives (Gyekye 1996).

The Ghanaian society perceives women's main gender role as one of child-bearing. Women who fail to have children are not respected and may even be ridiculed in society. In Ghana, women are expected to have children immediately they marry. Those who do not marry or delay to do so are sometimes advised by family members to have children even if it means having one out of wedlock. The question of having illegitimate children is not a problem especially among the Akans. Kinship ties and the value of communalism are such that members of the extended family help to care for such children where the mothers are not able to care for them (Kenyah 2000). The premium placed on children is so high that ideally all pregnancies are expected to go to term and the babies delivered. There is prestige associated with having many children as previously discussed and a practical need for children as source of labour, wealth and care for the elderly as well as the importance of carrying on the family lineage (Braam and Hessini 2004).

b. Social norms concerning abortion

Owing to the pronatalistic stance of Ghanaian society, abortion is socially disapproved of and practised in secret. Among the Akans in rural Ghana, a widely studied Ghanaian ethnic group, abortions are considered socially reprehensible and potentially shameful when its results are known and are fraught with complications (Bleek 1981). However, when the abortion is successful and unknown the shame is

avoided. Also, since the Ghanaian culture censures abortion, if a woman dies from the complications of abortion she is denied burial once abortion is known to be the cause of death (Bleek 1981). This in effect brings a lot of shame to the family hence botched abortions are kept as secret as possible (Bleek 1981).

Current popular discourse in the electronic media such as essays on the internet equates abortion with demoralized Western values (Sarah 2007). Some radio discussions in Ghana and informal discussions I had with colleagues during my fieldwork also attest to this claim. Abortion is said to reflect moral decadence in Ghana. However, this view could be considered hypocritical since the practice of abortion and infanticide has been in Ghana for a long time. Currently, there appears to be a rise of a two-pronged modern view of abortion in the Ghanaian society. Despite the wide stigmatization of abortion (Sedgh 2010), some qualitative studies have shown that although most adolescents oppose abortion, in situations such as unstable relationships abortions may be considered necessary (Henry and Fayorsey 2002); also communities on one hand perceive abortions as dangerous and shameful if they are known by the public and on the other hand as necessary for some women under certain circumstances provided the abortions are kept a secret (Hill et al. 2009). As noted, one of the biggest ‘socio-cultural’ influences is religion and associated moral values. It is to a consideration of these that the discussion now turns.

ii. Abortion and Religion

From a sociological perspective, Nukunya (2003) defined religion as a system of beliefs and practices associated with the supernatural. Embers (1973) also views religion as a set of attitudes, beliefs and practices pertaining to the supernatural power which may be forces, gods, spirits or other powers. In an exposition on belief systems, Oke (1984) acknowledged how anthropologists view all religions as characterized by belief in the supernatural and in their ability to help or harm man. Based on the definitions of religion discussed, in this study religion will be considered as people’s belief in the supernatural and how this belief influences their behaviour in relation to abortion and abortion care.

Religion is considered a universal practice found in every culture. According to Gyekye (1996) African traditional religion forms an integral part of the culture of African people and is therefore a way of life. Assimeng (2006) also notes how the everyday life of the African is intertwined with religious beliefs and practices and described religious beliefs as statements to which members of a particular religion adhere. Notably, religion performs certain basic social and psychological functions which include integrating people into the society, providing social support and for social control. In relation to social control, Assimeng (2006) considers religious institutions as powerful agents. He observed that through religion key positive values such as morality, honesty and truth are always taught to adherents and this serves to maintain order in societies. Since religion serves to control people's behaviour in society, it appears to be one of the determinants of abortion service provision. This section therefore explores the nature of the influence of religion on abortion and its implications for service delivery and access to services.

Meanwhile Gyekye (1996) describes morality as a collection of social rules and norms for guiding the conduct of people in a society. The rules and norms originate from people's beliefs about right and wrong conduct and good and bad character (which are influenced by prevailing religious norms). Furthermore, he views morality as a social phenomenon in whose meaning and practice is embedded the consideration for the interests of others and a sense of duty to others. Morality forms an essential feature of all human cultures, though moral values differ from one culture to another. Moral values are patterns of conduct that are considered most worthwhile and thus highly cherished in society.

Given the above descriptions of some dimensions of religion and morality, there appears to be a relation between religion and morality especially from the African perspective. Firstly for Africans, doing the right thing is basically a moral obligation and to some extent a religious one thus a moral value also becomes a religious value because there is the belief that supernatural beings reward those who do good and punish those who get involved in unethical behaviour. Secondly, religion plays an important role (Gyekye 1996) in the moral life of African people in that it provides sanctions that control the moral lives of people. For instance, when people face misfortunes, these are interpreted as punishment from supernatural powers for bad

conduct or warnings for people to examine their moral conduct. Religion therefore controls moral behaviour via sanctions by the supernatural powers. Among the Akan ethnic group in Ghana for instance, it is believed that God will punish those who do things that are morally wrong. These moral considerations are paramount regarding issues on abortion.

The morality of abortion is a widely-debated issue and one of major concern to many people. Experience in Ghana and other African countries show how abortion evokes religious as well as moral considerations. These considerations affect providers' decisions to provide abortion services or not. In the discussion of the ensuing studies therefore, the influence of people's religious beliefs and moral values and how these influence provision of abortion services are highlighted. These will inform policy makers in Ghana and help streamline efforts to roll up comprehensive abortion care in the country.

Many authors have discussed the influence of religion on abortion and provision of abortion services (Harries et al. 2009, Okonofua et al. 2009, de Roubaix 2007, Ravindran 2003, Senah 2003, Hunt 1999, Makinwa-Adebayo et al. 1997, Lassey 1995). As mentioned earlier, the authors think induced abortion evokes a great deal of passion and controversy world-wide for cultural, ethical, religious, and moral reasons. Some effects of religion and morality on providing and seeking abortion are described.

a. How religious beliefs affect abortion provision

Religions differ in their attitudes towards abortion with each having varying moral implications. Some pro-life Christians support their views with references from the Bible such as Luke 1:15; Jeremiah 1:4–5; Genesis 25:21–23; Matthew 1:18; and Psalm 139:13–16. The Roman Catholics' view is one that considers the embryo as a human being from conception. They believe in the right to life and consider abortion as immoral and a violation of the Fifth Commandment: "You shall not kill" (Exodus 20:13) thus strictly forbidding abortion. Although the Church of England also considers abortion to be morally wrong, their position is not as firm as that of Roman Catholics. The Islamic religion usually only forbids abortion after 120 days gestation (about 3 months) and also allows it in cases where the mother's health is endangered

but does not consider economic hardships and difficulties of rearing children as justification for abortion (Abdel-Aziz et al. 2004). Judaism forbids abortion on demand but may allow it to save a mother's life (Schenker, 2000); Judaism is largely pro-choice but most Christian sects are pro-life. Abortion is strongly prohibited in the Buddhist tradition however modern Buddhists in Japan and the US permit it under exceptional circumstances (Barnhart 1997).

Studies have found a correlation between religious beliefs and provision of abortion. In the US many surveys of doctors have shown that religion is one of the most important factors that influence doctors' attitudes towards abortion (Freedman et al. 2010; Freedman et al. 2008; Curlin et al. 2007; Aiyer et al. 1999). In a study in Britain, Abdel-Aziz et al. (2004) explored the effect of religion on the attitudes of general practitioners to termination of pregnancy. They carried out a cross-sectional survey of 140 GPs with a response rate of 51.4%. Most respondents (48.5%) belonged to the Church of England and (35.3%) were of no stated religion. Of those who stated their religion, just 14.5% attached great importance to religion when it comes to issues concerning abortion, whilst 42% gave it some importance. None of the GPs, including those whose religion was of great importance, refused to see patients requesting abortion and a few of them referred patients to see colleagues with no conscientious objection in line with the requirements of the General Medical Council(1998). The authors noted the difficulty in reconciling health providers' beliefs and patients' rights and concluded that an association does exist between GPs' attitudes towards abortions and their religious beliefs; Christians being more pro-life than non-religious ones. Similarly, when 300 UK medical students were surveyed regarding their attitudes towards abortion (Gleeson et al. 2008), students' views correlated with holding a religious belief. Students who practise a faith ranked themselves as more pro-life than those who did not. This was attributed to the belief central to most religions - the sanctity of life.

A survey by Faundes et al. (2004) though similar to that of Abdel-Aziz, showed that the effect of religion was tempered by personal experience. They surveyed 4,261 obstetrician/gynaecologists in Brazil to ascertain not only the doctors' opinions regarding abortion but the decisions they take when confronted *personally* with an unwanted pregnancy or with a request for abortion from a patient or relative. The

authors identified a correlation between how important religion was perceived to be by the respondent and their behaviour when confronted with an unwanted pregnancy. The difference, however, was found to be greater when it was a patient or relative who had an unwanted pregnancy than when it was their own. The proportion of doctors who helped patients or relatives to abort was twice as high among those with no religious beliefs as with those for whom religion was very important. In contrast when it was the doctor herself or the doctor's partner faced with an unwanted pregnancy, the proportion who had an abortion was about 70% among those who perceived religion as very important. Religion thus became less important when the problem was their own. This suggests that a problem is only truly appreciated once it has been experienced and one can best show empathy and understanding if one has had a firsthand experience of the matter as was also shown in the study by Gogna et al. (2002) discussed in the Provider Attitudes section above. These findings also portray elements of human nature as depicted in a Ghanaian proverb which literally means: '*When someone else has a problem, it is a tree's problem. It is when it is your own problem, that you feel the pinch*'.

In Nigeria, a study to explore the knowledge, attitude and practice of private medical practitioners towards comprehensive abortion care (Onah et al. 2009) showed that some doctors who do not terminate unwanted pregnancies cited religious reasons and not adherence to the Nigerian abortion law. The authors concluded that the vast majority of private practitioners in Enugu in South-eastern Nigeria do not terminate unwanted pregnancies due to their religious beliefs.

A study by Schuster in Cameroon (though looking at women and not providers) goes further to explore the dichotomy between religious beliefs and actual practices regarding abortion. Using a qualitative approach, Schuster (2005) sought to gain insight into the motivations of women seeking abortion; she used a triangulation of methods and sources including medical personnel. As in the Faundes study, Schuster also found contradictory attitudes in her respondents. The women openly condemned abortions done by others but not their own and their condemnation was contrary to their own behaviour. Furthermore, although most of the women in the study were Catholics or Presbyterians, they rarely condemned induced abortion as criminal on a religious basis but did so due to the adverse health consequences. Schuster argues

that what people say concerning their values may represent their ideals and what society expects; whereas what people actually do when confronted with situations reveal their genuine attitudes. These findings show that people tend to say one thing and do another when faced with certain circumstances.

These studies indicate the complexity of individual religious beliefs which have an impact on their actions – in complex ways that are often context specific and influenced by personal experience. Another point to note is that the Abdel-Aziz and Faundes studies of health providers were both surveys – richer data can be obtained on attitudes and beliefs, and the interplay of religion and personal experience and values, through qualitative methods. There is a need for in depth qualitative studies that explore these issues among providers. My study seeks to do this.

iii. Abortion and Morality

The morality of abortion is a complicated subject. A qualitative study in South Africa (Harries et al. 2009) that determined the factors that shape health professionals' attitudes towards induced abortion found that abortion was considered a moral choice and this influenced the extent to which providers got involved in the procedure. Some providers disliked abortion care and were vehement about this. Others would only offer certain parts of abortion care such as pre and post abortion counselling or basic nursing duties and would not provide direct abortion care (Harries et al. 2009). Also studies in Nigeria showed how moral values influence attitudes towards abortion (Onah et al. 2009, Okonofua et al. 2009). One such study on the perception of policymakers toward unsafe abortion and maternal mortality (Okonofua et al. 2009) showed that besides the influence of their religion, policymakers were guided by moral considerations as opposed to evidence-based approaches. Overall the literature on abortion and morality revealed two prominent issues: ethical principles that relate to abortion and the issue of conscientious objection. These are now discussed in turn.

a. Some Ethical Principles in Medical Care

Ethical conflicts or dilemmas appear to be inevitable between health professionals and the people they are called to treat (Adams, 2003 Iyalomhe 2009, Koch and Jones,

2010). These conflicts are pronounced where abortion is concerned. Knowledge of the principles that guide medical practice would increase understanding of providers' attitudes and practices. Four main principles were identified in the literature. These were the principles of beneficence, non-maleficence, autonomy and justice. These principles hold that in their interaction with their patients, health professionals should ensure that all they do is in the interest and of maximum benefit to their patients (beneficence), not causing them any harm (non-maleficence), having respect for patients' rights, self-determination, decisions, privacy and confidentiality (autonomy) and being fair to all their patients (justice).

Koch and Jones (2010) studied the doctor/patient relationship and described the profound ethical nature of medical professionalism. They highlighted the confusion that emanates from the responsibilities professionals have in the medical encounter and their personal roles which in their view may contribute to early physician burnout. They suggested on-line discussions of the issues as an avenue for physicians to share views on how they cope.

Iyalomhe (2009) highlights the importance of the 4 ethical principles (beneficence, non-maleficence, autonomy and justice) in guiding doctors in conflict situations. He notes that doctors' knowledge of these principles, relevant laws, their training and experience are among factors that help them tackle the dilemmas they face. He suggested early training in ethics in homes, medical training institutions and thereafter, possibly as in-service education to ensure that doctors are better equipped to handle ethical dilemmas. Indeed, ethical issues in the medical encounter could be problematic and difficult to resolve especially where provision of abortion services is concerned. Although this is not the focus of my study, it would be expedient to explore what ethical issues confront health providers and how they resolve them. The findings may be useful for training, policy and future research.

b. The issue of conscientious objection

Two moral arguments come into play in abortion care. People who are pro-life argue that all life is precious and that it must be preserved right from the foetal stage. Meanwhile those who are pro-choice affirm that life should be respected, but the focus is respect for the life of the living person, the pregnant woman (Adams 2003).

Based on these arguments, antagonists think that providing an abortion service is murder and morally wrong whilst proponents of abortion also consider withholding the service from a woman with an unwanted pregnancy as equally immoral. Conscientious objection allows health professionals to opt out of practices in the medical encounter that conflict with their personal morality. In her discussion of moral issues and conscientious objection in the provision of abortion services, Adams (2003) highlights what physicians can do when services requested by their patients violate their personal moral code. The physician may counsel on options available or refer the patient to another provider who is willing to provide the service. However there are problems with these choices; the objecting doctor may feel he/she is facilitating an evil act. The doctor may also delay, withhold or taint valuable clinical information. Adams suggests all doctors should critically examine their own morality in the light of their professional obligations and that those doctors with moral objections to abortion service provision who do not also want to provide counselling should consider working in other areas where their beliefs would not compromise service quality.

Also the findings from a US study (Curlin, et al. 2007) illuminate this debatable issue of whether health professionals can refuse to provide care to which they object on moral grounds. In a cross-sectional survey of a stratified random sample of 2000 practising physicians, their judgements about their ethical rights and obligations when patients request legal medical procedures such as abortion and prescribing contraceptives to adolescents without parental consent were ascertained. Most physicians (63%) thought it is ethically permissible for doctors to explain their moral objections to patients. The vast majority (86%) also believed that doctors are obliged to present all options and to refer (71%) the patient to a non-objecting physician. Meanwhile, male doctors, as well as those who were religious and those who had moral objections to certain controversial clinical practices were less likely to report that doctors must disclose information about or refer patients for medical procedures to which the doctor objected on moral grounds. The authors considered it the responsibility of the patients to find out their doctors' stance on such procedures.

The doctors' unwillingness to give information or refer patients for procedures they morally object to may be right however this stance also depends on the requirements

of the standards that guide their practice. The document analysis undertaken by the principal investigator for this study showed that the Standards and Protocols of CAC (GHS 2006) requires that doctors in Ghana offer counselling on all options and also refer patients to colleagues who are willing to offer the services they morally object to. Even those who are objectors in Ghana are duty-bound to provide the service in emergency situations. The ensuing discussion focuses on provision of abortion services in the Ghanaian context.

iv. Religion and morality in Ghana

This section discusses abortion service provision within the religious and moral context of the Ghanaian society. According to the 1992 Constitution, Ghana is a secular state. The Constitution does not permit any religious organization to be considered a state religion but it recognizes religious organizations as important civil society organizations and allows their representation on certain constitutional bodies. Due to the tremendous Christian influence of the British colonial masters and missionaries, Christianity dominates in Ghana and permeates social and public life as well as governmental activity to date. There is religious freedom in Ghana and all individuals living in Ghana are free to worship in accordance with their religious beliefs (Dickson 2003). Religious beliefs and practices are characteristic features of the Ghanaian's life (Pobee 1992). There has not been much open debate about abortion in Ghana, possibly because it is a very religious country (secular de jure but religious de facto) and due to the topic's sensitive nature. There is also paucity of qualitative research on abortion in the country especially studies involving its socio-cultural aspects which is one area my study investigates.

A strategic assessment by the GHS (2005) that covered six out of the ten administrative regions in Ghana involved discussions among stakeholders and various communities on issues relating to unwanted pregnancies, contraception, abortion and how to reduce abortion-related deaths among others. In-depth interviews and focus group discussions were held with a wide range of people including Policy makers, Regional and District Directors of Health Services, Parliamentarians, Religious leaders and Community leaders and other members. Findings showed the influence of strong religious beliefs prevalent amongst

respondents of all categories. Religion was cited as one of the factors hindering access to comprehensive abortion care. Religion prevented health providers from offering services and women from seeking services. There were suggestions to involve religious leaders in a dialogue on safe abortion. This is one instance in Ghana of the use of qualitative methods to study abortion; there was triangulation of sources which represents a good mix of diverse perspectives on the issue of abortion and also for comprehensiveness. In another assessment by the GHS and Ipas, an attitudinal survey was used to ascertain the readiness of 90 public health facilities to offer contraceptives and comprehensive abortion care in three regions in Ghana. Similarly in this assessment (Aboagye et al. 2007), the most frequent concern health workers expressed about providing CAC to the extent permitted by law was perceived religious conflict (50.2%). Religion appears to be an important factor that militates against abortion service provision in Ghana and many other countries as the previous review shows.

A recent national study by Voetagbe et al. (2010) assessed the capacity and willingness of 74 midwifery tutors (from all 14 midwifery training schools in the country) to teach contraception, post abortion care and legal termination, using structured self-administered questionnaires. Areas of interest investigated were respondents' knowledge about the abortion law, their personal beliefs and professional responsibility and factors that motivate or inhibit their teaching of CAC. The findings revealed that the vast majority of respondents (97.3%) were Christians. Concerning their personal beliefs and professional responsibility (an important dimension of abortion care), the researchers found that 18.9% of respondents found provision of abortion in accordance with the law as personally objectionable; 37.8% said abortion was contrary to their religious beliefs and would inhibit their teaching of CAC. The authors noted that even though providers' personal beliefs need not influence the care they render, ethical, religious and cultural values affect the teaching and provision of abortion services. They suggested expansion of the curriculum of midwifery tutors' training programme to include various methods of safe abortion care provision. To deal with the influence of their personal beliefs and their professional responsibilities, education of the tutors on teaching of abortion care in accordance with the law was suggested. Given the benefits of values clarification

described in the ensuing section of this review, its use for the midwifery tutors may be helpful. The use of structured self - administered questionnaires in the study in question is an observed weakness. Even though the sample size (74) was big for a qualitative study, with the number of researchers involved, the use of in-depth interviews would have provided richer insights into the areas investigated.

In Ghana, there is limited research that focuses on the moral aspects of abortion. A few researchers highlighted the moral dimensions of abortion when discussing the Ghanaian society in general and health providers' attitudes towards abortion (Voetagbe 2010; Morhee et al. 2007; Lithur 2004; Senah, 2003; Henry and Fayorsey 2002). Although there is no organized force against abortion and abortion providers are not vandalized as occurs for instance in the United States of America, they are the objects of stigma and the subjects of gossip where they live and/or work. To make safe abortion services accessible to women who need it, measures must be undertaken to address the barriers. An important barrier identified in the review is provider attitudes invariably informed by religion. Understanding precisely how this plays out, through an in-depth study of provider and other stakeholder attitudes such as this study, is critical in order to understand the attitudes – and influences of key stakeholders. Once these attitudes have been understood, tools for influencing negative attitudes need to be employed. Values clarification has been highlighted in the literature as a useful tool in changing attitudes – this is reviewed in the final section of this literature review.

3.4 Strategies to ensure access to safe, legal abortion: transforming attitudes of stakeholders using values clarification

In order to help address the attitudes of health providers towards abortion and improve access to safe abortion, some authors have proposed values clarification for stakeholders, to help transform negative attitudes (Turner et al. 2007, Hessini et al. 2006, Chapman et al. 2006, Mitchell et al. 2005, MOH, Ghana and WHO 2005). They defined values clarification as a process of self examination which requires one to examine his/her values critically to help the person understand him/herself and to identify what is important, meaningful and worthwhile. Thus, Turner et al. (2007) shared experiences from workshops on values clarification in Viet Nam, Nepal and South Africa.

In Viet Nam, training and provision of protocols and service delivery guidelines were put in place before safe abortion services were introduced. However, no values clarification was done to ascertain concerns of the providers so trained providers stopped providing abortion services because they felt uncomfortable with the procedure. In Nepal, values clarification workshops were done for clinicians, administrators and policy makers before clinical training and introduction of services; the physicians were better prepared to offer abortion services and they all offered services. The intervention enabled them to deal with conflicts they had had between their personal beliefs and professional obligations. Also, administrators showed support for the services and policy makers identified potential barriers to services and started to work on them. In South Africa, workshops were held for stakeholders including facility managers, midwives, and religious organizations. The workshops increased respondents' awareness about their own personal feelings about abortion. Positive behavioural changes were noted such as increased compassion for women seeking abortion and providers. However, in the case of those who were initially against TOP, although their views did not change, they developed a better understanding of the need for services. Due to omission of the assessment of pre intervention attitudes and behaviours the authors could not establish causality. They concluded that values clarification may not solve all problems related to access to safe, legal abortion services, but may provide a conducive atmosphere for improving access and yield some positive trends. They called for integration of values clarification activities into pre-service and in-service training to help create awareness in providers of their own feelings and beliefs about abortion and to ensure they are knowledgeable about their professional obligations within the framework of existing policies and laws.

These three countries' experiences demonstrate the potential usefulness of values clarification for attitude transformation. Furthermore, other countries' experience with values clarification suggest that the intervention enables health workers to explore and consider various dimensions of abortion, fosters a better and deeper understanding of the legal indications of abortion and motivates health providers to offer abortion services (Hessini et al. 2006). However, values clarification may not be 100% effective. Not all stakeholders' attitudes and behaviours will alter desirably

for abortion services. One may also be sceptical about the use of values clarification as being equal to '*brain washing*'. Values clarification thus cannot be considered the perfect solution for attitude change since there is no simple remedy for dealing with provider attitudes (Hessini et al. 2006). I chose to discuss it because of the indications in the literature of its usefulness and efficacy in attitude transformation. With respect to literature on abortion service provision and the formidable challenge of provider attitudes, values clarification was a prominent measure cited.

Varkey et al. (2000) mentioned the usefulness of another tool known as *Health Workers for Change: A Manual to Improve Quality of Care*. In their view, this manual has helped health providers to examine and change their attitudes towards clients. Following research in South Africa, the authors developed two interventions, one of which was based on information drawn from the Manual. The interventions were meant to help change judgmental views on abortion by health service providers and community members. The intervention the authors developed with providers was known as *Health Workers for Change- A*, whilst that of the community was referred to as *Communities for Choice: Working to Improve Access to Abortion Services*. In both interventions, a series of workshops were organized and participants were allowed to choose their own contents of workshop activity (e.g. role-plays) based on their experiences. The activities had a positive impact on both health workers and community members. For instance, the intervention with the health providers enhanced their understanding the relationship between gender-based power relations and unwanted pregnancy, making providers reconsider their prejudices about women in search for abortion services. Among community members, the intervention appeared to have helped them weigh the experiences (feelings, thoughts and actions) of women with unwanted pregnancy. This appeared to make them more empathic and increased their motivation towards attitude change. Evaluation of the provider intervention showed trends towards increased support for abortion services; health providers were more willing to be involved in abortion services especially referring patients for services. The 'interventions' described by Varkey et al. (2000) appear to be very similar in principle and practice to values clarification although they were not called so.

Chapman et al. (2006) distinguished between values clarification exercises that take participants through a process of values identification and clarification without situating values in any defined social context (probably generic) and those that highlight a specific agenda. In the second instance, the processes of values clarification are purposefully designed to transform values, attitudes and behaviours in order to promote reproductive healthcare delivery and improve access to comprehensive abortion care. Evaluations from workshops in South Africa have documented the successes chalked by values clarification (Mitchell et al. 2005 and Marais 1996). It would be worthwhile to know what respondents in my study know and have to say about values clarification. This concept appears to be new and has not been widely explored in Ghana.

3. 5 Summary of the review

Given the magnitude of the burden of unsafe abortions globally and in sub-Saharan Africa especially, national health systems are mandated by international consensus meetings and treaties to institute measures to reduce its adverse consequences. The review shows that in countries where abortions are legal, implementation of the law coupled with other measures put in place are more likely to make services accessible and available. However, this is not straightforward.

Implementation of abortion laws is fraught with challenges including interpretation of the law; some national laws have multiple ambiguous clauses for instance ‘definition of risk’ making interpretation and implementation an arduous task and creating confusion among providers. In addition relevant policies are not often in place to translate laws into services and availability of regulations and guidelines to help providers on the ground are also lacking. Legal provisions in some countries do not permit mid-level health cadres to provide services despite suggestions that this could increase access to services.

Besides the legal challenges, access to abortion services depends on health systems’ preparedness in terms of resources for service provision. There are either few or no designated facilities for providing services and facilities have paucity of trained staff and other resources such as the needed equipment (MVA kits). Where trained staff are available, they may not be willing or well motivated to provide services due to

problems such as poor working conditions, lack of support from managers, no recognition and involvement in policy decisions by managers at the central level, no communication and consultation with those who implement the law at the peripheries.

A critical issue that emerged was provider attitudes and the socio-cultural context in which these attitudes are played out. This review cited studies that demonstrated how religion and morality in particular influence health providers' attitude towards provision of abortion services.

Most of the studies in the review which focussed on the abortion laws and their implementation and factors that impinge on the process both in developed and developing countries were mainly based on surveys. Although some studies used both quantitative and qualitative approaches, the qualitative studies were few. In Ghana the few studies done on abortion were mostly hospital based with few MOH/GHS assessments to determine how prepared facilities are to take up comprehensive abortion care. Qualitative studies are few and little has been studied about the multiplicity of factors that hinder implementation of the law in the country, in particular there is a dearth of studies exploring how the religious and moral context in which providers operate affects providers' provision of services.

Although it is important to have a policy in place as a first step to achieving access to safe abortion, implementation does not automatically follow. Implementation of policy is very complex and the literature suggests that frontline health workers play an important role in whether policies actually become reality in terms of service provision, since they can block as well as facilitate access to services. Social and religious contexts have been shown to be critically important in understanding how and why health providers act in the way they do with regard to implementing abortion service provision. Implementation is context specific and in Ghana there has been little research to understand the reasons why the policy that allows access to safe abortion services is not being implemented. To date, there are only a few studies that have investigated these dimensions in depth, particularly in sub-Saharan Africa. The current study is a contribution to filling these gaps. The findings will inform policy. With the on-going efforts of the Ghana Health Service to ensure full

implementation of the law, the findings of the study will help streamline these efforts.

The next chapter presents an overview of the theories on implementation to set the context for the theoretical underpinnings of my study. The theoretical perspectives and findings from the literature will together be used to interpret and explain data from this study.

CHAPTER FOUR

THEORETICAL PERSPECTIVE AND CONCEPTUAL FRAMEWORK

4.1 Introduction

This chapter is divided into two sections. First, a discussion of the theoretical underpinnings of the research and second a discussion of the conceptual framework developed for this research. In order to inform the study of the abortion situation in Ghana and the level of implementation of the abortion law and policy, this chapter focuses on policy implementation and factors that influence this dynamic and complex process. To put implementation in its right perspective, the chapter begins by reviewing literature that summarises the broad and complex field of policy analysis, then goes into the critical understanding of ‘stages’, including implementation as a stage (which is the primary focus of this work) and finally discusses the theories and concepts of implementation that apply to my case study.

4.2 Definition of Policy

The concept of policy has been defined in several ways. A policy may be described as a course of action or inaction (Hill 1972) and not specific decisions or actions. Anderson (1975) views the phenomenon as a purposive course of action an actor or actors may employ to address a problem; his view of public policies being policies formulated by government officials, purposive in nature and in response to problems in society. Policy is further considered as a deliberate choice of action or inaction; including both decisions which bring about change and those in which change is resisted (Smith, 1976). Hogwood and Gunn (1984) provide a broad definition of public policy; that policies are a group of related decisions made through many interactions of a range of actors who may be individuals, groups or organizations in processes that span a length of time. In addition, policy aims change over time and are sometimes defined in retrospect. Policies also have outcomes which may differ from the intentions of policy makers and involves behaviour - that is action or inaction. Public policies are those policies formulated with inputs from governmental organizations (Hogwood and Gunn 1984).

In her definition of health policy, (Walt 1994) also considers the concept as the courses of action and inaction taken by a range of actors intended to impact on health. A health policy covers courses of action as well as inaction within the health system that influence its institutions, organizations, services and funding. Public policies on health are also regarded as health policies; including policies of organizations whose activities impinge on health. Furthermore, health policy has an inherent dimension of politics regarding the use of power in policy making (Buse et al. 2005).

Thus policies span statements of intent, decisions, actions and inactions purposefully carried out or omitted by individuals, a group or government in response to problems in society. The definitions are subjective and depend largely on who is defining the concept. Policy connotes behaviour as well as intentions, goals and means of achieving them. A policy is more than just what is written or decided but is also embodied in action and what is done. Sometimes policies have unpredictable outcomes (Hill and Hupe 2009). They are formulated in a dynamic, complex, iterative and inherently political process that spans a considerable period of time. The policy process involves how problems are identified and defined, formulation of the policy and its implementation and evaluation. In my case study of Ghana, a health policy will be considered as actions or inactions of actors including government and implementers in response to a health problem (complications of unsafe abortion) with a focus on implementation. In the ensuing section, relevant frameworks and theories that describe and illuminate the policy process are discussed.

4.3 Frameworks and theories of the policy process

Given the extreme complexity of the policy process, frameworks and theories have been developed by scholars to help explain it. According to Ostrom (2007), a framework describes the relationships among a group of variables and how they may explain an observed phenomenon. Frameworks help with identification of elements associated with a given phenomenon and how these are connected. The elements in a framework and the way in which they are linked help to generate questions to analyze phenomena.

Theories go further than frameworks though sometimes the two concepts are used interchangeably and sometimes even confused. Theories offer deeper and more logical explanations of a set of relationships. Based on assumptions, theories offer explanations of the processes of a phenomenon and can predict outcomes (Ostrom 2007). Theories are more far reaching than frameworks. Whereas frameworks only identify variables and their links, theories may have values attached to some variables and the relationships could vary based on the values of the variables. Theories are able to make predictions of behaviour and outcomes and have the ability to explain observed phenomenon. Frameworks serve as templates or foundations that show the elements of a phenomenon. A theory then builds on the framework by making assumptions as well as predictions concerning the phenomenon.

Distinguishing between a framework and theory is useful as this sheds light on the inherent characteristics of these concepts and the usefulness of each. A model represents a specific situation, narrower in scope and more precise in its assumptions than the underlying theory. ‘Models make precise assumptions about a limited set of parameters and variables. Logic, mathematics, game theory, experimentation and simulation, and other means are used to explore systematically the consequences of these assumptions in a limited set of outcomes’ (Ostrom 2007).

John (1998) also highlights three types of explanation (frameworks, models and theories) of the interrelationships and actions of the many actors of public policy as well as causality. He considers a framework as a conceptual scheme or signpost which explains what is happening but which is descriptive rather than being analytical. A model is useful in exploring relationships and helpful for framing research problems but its explanatory power is limited. Of the three, theories provide better explanations, create models of behaviour and hypotheses that can be tested.

4.4 Summary of policy analysis field

There are a vast number of theories and frameworks that explain the policy process (or policy change) many of which focus on agenda setting or decision making. Discussion of the full range of these theories and frameworks is beyond the scope of this thesis. John (1998) identifies five broad categories of political science theories

that illuminate policy formulation and implementation; they explain why policies differ between sectors and why some policies change whilst others remain stable. All the theories shed light on the policy process. Given the vastness of theories of the policy process, for the purposes of this thesis, a summary of John's classification is provided showing the different groups into which the diverse theories of the policy process fall. These are:

- Institutional approaches: These theories hold that political organizations including parliaments, legal systems and bureaucracies structure policy decisions and outcomes. Institutional approaches consider the challenges of the actors of the policy process as well as the norms and practices of policy making in different political systems and policy sub-systems.
- Group and network approaches: Explain how associations and informal relationships within and outside political institutions, shape policy decisions and outcomes. Networks of relationships between multiple actors determine policy outputs and outcomes. Group and network approaches focus on how alliances are formed and how networks are mobilized in public decision making.
- Socio-economic approaches: Prevailing socio-economic factors influence what decisions public actors make as well as policy outputs and outcomes.
- Rational choice theory: Such theories show how the preferences and bargaining of actors illuminate policy decisions and outcomes. The bargains are in the form of interactions between participants and the choices that emerge are shaped by institutional and socio-economic constraints. This theory better explains the policy process than the others. The rational choice theory is able to link action to structure by explaining how actors respond to constraints and how they shape them. The theory best explains causation, human action and makes use of other theories for purposes of explanation. It can use institutions, groups, political and socio-economic factors as well as individual choices.
- Idea-based approaches: Idea-based approaches assess the beliefs actors have about policy and how they view the concept. Ideas about solutions to policy problems have a life of their own. Ideas circulate and gain influence independently or prior to interests in the policy process.

The theories provide useful insights for researchers in analysis of data and serve as tools for examining the policy process. The theories complement each other and when combined can offer better explanation of the complex policy process. From this wide body of theory, the discussion concentrates on implementation theories since policy implementation is the focus of this thesis. In the section that follows, there is an overview of the stages heuristic, which considers implementation as a stage in the policy process. Thus, its discussion serves as a good starting point to set the stage for discussion of the implementation theory within which this work is situated.

4. 5 Usefulness of ‘stages’ in policy research: The stages heuristic

The policy process is complex and inherently chaotic (John 1998). There is need for order if researchers are to understand this public decision-making process. This order is achieved by the stages heuristic developed by Lasswell (1956), Jones (1970), Anderson (1975), and Brewer and deLeon (1983). It is the best known public policy framework (Walt et al. 2008) and Sabatier (2007) considers it the most influential framework for understanding the policy process.

The stages heuristic is a useful framework for explaining the policy process. This framework divides the public policy process into four separate and sequential stages thus considering the complex process as a linear one. The stages are agenda setting, policy formulation and legitimization, implementation and evaluation (Sabatier 2007). Different authors divide the policy process into different number of stages (Hogwood and Gunn 1984; Rose 1973, Lasswell, 1956). Hogwood and Gunn (1984) for instance divide the policy process into nine stages. During agenda setting, a range of problems that confronts society reach the attention of decision-makers for action to be taken. At the stage of policy formulation, legislatures and other decision making bodies enact policies. The implementation stage is where policies are carried out. During the evaluation stage, the impact of policies is assessed (Walt et al. 2008).

The stages heuristic is the most enduring and common framework that breaks down the policy process into a series of stages to facilitate understanding. It also simplifies the complex policy process enabling researchers to organize their work within a framework (Walt et al. 2008). The stages framework simplified public decision

making by assuming that policy emerges in distinct stages (John 1998). The linear representation of the policy process increased understanding of the process and fostered research work in the proposed stages, for instance in agenda setting (Hall 1975, Kingdon 1984), policy formulation (Lindblom 1959, Simon 1961), policy implementation (Pressman and Wildavsky 1973, Lipsky 1980, Mazmanian and Sabatier 1983) and evaluation (Fischer 1995). An added advantage of the framework is that it shows the activities that take place in the proposed stages and the actors involved (Buse et al. 2005).

The stages heuristic faced a range of criticisms. The main criticisms (Sabatier 2007) include the fact that the staging of the policy process defies the cause-effect theory; the stages are presented as discrete or mutually exclusive but the framework does not offer explanations of how policy moves from one stage to another. Also, whilst the policy formulation stage in the stages heuristic is considered as preceding policy implementation, some writers (Anderson 1975) assert that policies emerge as they are implemented and are also implemented as they are formulated thus the two stages are iterative rather than linear; for instance in some cases, policies are formulated in the process of implementation where street-level bureaucrats use their discretionary powers to shape the policy that emerges. Also many policies can be formulated simultaneously in the real world so the framework does not in itself represent what really happens. The framework cannot be tested empirically. It presents policy-making as ‘top-down’, not considering street-level bureaucrats and other actors. Presenting policy-making in the form of cycles overlooks characteristics of policy-making in the real world which comprise multiple levels of government as well as interacting cycles (Parsons 1995). Saetren (2005) in his extensive survey of implementation research also highlighted the scepticism of policy scholars concerning the segmentation of the policy process into discrete sequential stages which was considered a misrepresentation of the complex public policy process. These criticisms, notwithstanding, the stages heuristic offers a useful and simple way of thinking about the policy process as well as a useful guide for researchers (Walt et al. 2008). The stages approach provides a rational structure that helps to analyse the complexities of the policy process to allow better understanding of what happens in reality (Parsons 1995).

From the above description of the policy process in discreet stages, and the limitations raised, the question that arises here is – is it acceptable to focus on implementation as a stage in the policy process? Yes, it is for researchers have conducted studies on the different stages of the policy process, for instance implementation and evaluation (Hill and Hupe 2009). Recent research also demonstrates that implementation forms a legitimate part of the policy process (Hill and Hupe 2009). Although the critiques of the stages heuristic are valid due to its identified limitations, considering policy process in stages is still useful for it helps design research to address questions pertaining to specific stages as in this study. The section that follows briefly looks at the top-down and bottom-up implementation theories and later focuses on Lipsky's street-level bureaucracy-the theory that informs this study.

4.6 Implementation theories: top-down and bottom-up theories

Implementation has been defined as ‘the carrying out of a basic policy decision, usually incorporated in a statute but which can also take the form of important executive orders or court decisions...’(Mazmanian and Sabatier 1983). Implementation is considered as a part of the policy process. It constitutes an important stage of the policy process and has spurred considerable research which spanned over several decades. Implementation literature dates back to the early 1970s. Matland (1995) notes how many authors (including O’Toole 1986; Sabatier 1986; Van Horn 1987; Goggin et al. 1990) have reviewed the policy implementation literature beyond the 1970s highlighting lessons learned and challenges to future research. A recent review of implementation research by Saetren (2005) found that studies on policy implementation have not stalled since the mid 1980s but instead have grown through the 1990s to the twenty-first century. Some of the key issues that arose in the study of implementation concern the relationship between policy formulation and its implementation. Also, there was the question of identification of the features of this complex process which occurs over time and involves many actors. This led to debates on the ‘top-down’ and ‘bottom-up’ perspectives or a synthesis of the two (Hill and Hupe 2009). Thus the most prominent implementation theories that emerged focussed on the top-down or bottom-up approaches or a synthesis of the two (Sabatier 1999).

4.6.1 ‘Top-down’ approaches to policy implementation: proponents and criticisms

Buse et al. (2005) describe proponents of the top-down approach as holding the view that policies often originate from central government (top) and are then communicated to lower levels (bottom) for implementation; that their perception of implementation is akin to the rational and linear model of the policy process. Proponents of the top-down approach to policy implementation view policy formulation and implementation as two distinct activities as in the stages heuristic and consider successful implementation of policy as a function of an array of factors including clear policy objectives, availability of resources and effective communication (Buse et al. 2005).

Similar ideas for studying and describing implementation were put forward by Matland (1995) who described the proponents of the top-down approach as those who view policy makers as central actors, focusing on factors that can be changed at the central level. The proponents of the bottom-up approach in contrast believe that policy is made at the local level and emphasize the active role of implementers in the policy process. Matland (1995) highlighted the need for a merger of these two perspectives.

Authors who were top-down in approach included Pressman and Wildavsky (1973). They were considered as the pioneers of implementation studies and known for the introduction of the idea of ‘implementation deficit’; considering implementation research as being concerned with what makes the achievement of policy goals difficult (Hill and Hupe 2009). Their original work followed a rational approach with a view to identifying measures to overcome the deficit.

Sabatier and Mazmanian (1979) identified a wide range of variables that influence the implementation process synthesizing them into six sufficient and necessary conditions for effective implementation of legal objectives. These included the need for clear and consistent objectives, adequate causal theory and an implementation process structured in a way to facilitate compliance on the part of implementing officials. To them, implementing officials should show commitment to policy

objectives and discretion in the use of resources. Hogwood and Gunn (1984) described more sophisticated but similar factors or preconditions for successful implementation including the need for a valid cause and effect theory, clarity of objectives, adequate resources, good communication and coordination and compliance on the part of implementers.

As with the stages heuristic, the top-down approach for effective policy implementation met with many criticisms. The major criticism of the top-down approach concerns its narrow focus on central decision makers and the neglect of other actors such as street-level bureaucrats (Buse et al. 2005). Top-down theorists consider policy formulation as the starting point thus failing to take into consideration actions that have been taken earlier in the policy process (Matland 1995). The political nature of implementation is ignored and implementation is viewed as an entirely administrative process. To the critics, this was a fallacy. Furthermore, top-down theorists were criticized for considering local implementers as impediments to successful implementation and felt that their behaviour needed to be controlled (Matland 1995).

4.6.2 Bottom-up approaches to policy implementation: proponents and criticisms

The criticisms of proponents of the top-down approach to policy implementation led to a new focus - the bottom-up approach which focussed on interactions at the local level. Matland (1995) reviewed work by a number of authors such as Hjern and Porter (1981), Hjern (1982), Hjern and Hull (1982), Hull and Hjern (1987), Barrett and Fudge (1981), Lipsky (1980, 1978), Berman (1978, 1980) and Elmore (1979) and argued that these works show problems with a top-down view. In the implementation literature, Hjern et al. (1985, 1987) are noted for their use of a networking methodology – the ‘implementation structure’ approach or idea (Sabatier 1986). They postulated that policy implementation depends on structures and that programmes succeed mainly because of the skills of individuals in local implementation structures who adapt policy to local conditions (Matland 1995). Barrett and Fudge who endorse this idea also see ‘action’ and ‘policy’ as related. In their view, the policy process is highly political and the political processes continue

throughout implementation and that policy formulation and implementation cannot be separated but are intertwined (Hill and Hupe 2009). Berman considers policy implementation as occurring on two levels, with actors who are located centrally designing government programmes at the macro implementation level and local organizations at the micro implementation level, developing their own programmes and implementing them. The influence of central actors on factors at the micro level is minimal with most implementation challenges coming from the interaction of policy with the micro institutional environment (Matland 1995). Elmore sees the policy process as an organizational one with reciprocity of authority relations; where formal authority goes from top to bottom, stressing that informal authority which is crucial for solving problems goes from bottom to top (Erasmus and Gilson 2008). He suggested the use of mixed methods or triangulation for the study of events that are complex in order to obtain better insights of events (Hill and Hupe 2009).

It can be seen that these authors focussed on different elements of implementation but they shared a concern for the ways that local implementing actors influence the final results for instance:

- That bottom-up perspective of the implementation process was that of active participation of implementers in the process.
- Bottom-up perspectives regarded implementers as powerful actors who may be able to redefine objectives of a policy and alter the way a policy is implemented.
- Local implementers have so much influence on the policy objectives.
- Also, that contextual factors were important determinants of policy implementation thus policy designers at the top have minimum control over the process. In circumstances where the local implementers were not allowed to adapt proposed programmes to local conditions, the programme may fail (Matland 1995).
- Local implementers' use of discretionary power to resist efforts to control their actions (Erasmus and Gilson 2008).

Hjern (1981) and Lipsky (1980) were two prominent proponents of the bottom-up approach. Hjern (1981) studied networks and how they influenced policy

implementation whilst Lipsky focussed on street-level bureaucrats. Hjern et al. (1985, 1987) viewed implementation as an integral part of the wider policy process that is negotiated through networks and that effective implementation is attainable via the development of collaborative networks (Hill and Hupe 2009). Policy networks are a stable pattern of social relations between interdependent actors which form round policy problems and/or policy programmes (Klijn and Koppenjan 2000). They are fluid in nature and constitute a context for actors to act; the actors are autonomous and have their own objectives and there is need for cooperation to achieve outcomes (Hill and Hupe 2009). Hjern et al. (1985, 1987) were noted for their extensive work within the bottom-up tradition. Their approach begins by identifying the network of actors involved in delivery of services in the local areas, finds out their goals, strategies, activities and contacts. They then used this networking technique to identify those who were involved in planning and executing the programmes. By using this strategy, Hjern et al. (1985, 1987) mapped out a network which identified the relevant implementation structure for a specific policy at local, regional and national levels. He developed the idea of ‘implementation structures’ whose origin is from a pool of organizations and noted that the success of a programme is influenced by the skills of individuals in the local implementation structure who can adapt policy to suit local conditions (Matland 1995, Sabatier 1986).

Lipsky’s approach will be discussed as a theory that informed this study. The choice of Lipsky’s approach over Hjern’s is because the available knowledge of the situation and stakeholders in Ghana indicated that there were no real networks to study in the abortion field therefore Lipsky’s theory seemed much more relevant. In the section that follows, an overview of Lipsky’s street-level bureaucracy is presented highlighting how it particularly informs this study’s conceptual framework. Looking at Lipsky’s work will be helpful to further explore the issues of implementation.

4.7 Lipsky’s street-level bureaucracy: an overview

Lipsky (1980) extensively discussed the role of ‘street-level bureaucrats’ in policy implementation. He described street-level bureaucracies as public services including

schools, legal services offices, lower courts, police and welfare departments and other agencies whose services require its workers to use their discretion largely in the execution of their duties. Lipsky's (1980) street-level bureaucrats are frontline workers or public service workers such as doctors, nurses, police officers, lawyers and teachers who interact directly with citizens in the course of their jobs and who have substantial discretion in the execution of their work.

He described how these workers experience the policies they are supposed to implement and what they make out of those policies. He also described the pressures and dilemmas the bureaucrats face in their work. In his view, public policies are best understood by the street-level bureaucrats who are confronted with their implementation and not by the top officials who made them. He also believes that the outcome of a policy in terms of its implementation is largely determined by street-level bureaucrats based on realities that confront them in their work and the mechanisms they develop to cope with them.

Lipsky thinks public policies by government are shaped by the bureaucrats. These low level workers in effect '*make*' the policies they are supposed to implement - in Lipsky's view, the decisions taken by street-level bureaucrats, the routines they establish and what they do to cope with the numerous pressures associated with their work turn out to be the public policies they carry out. Even though Lipsky describes bureaucrats as people with full commitment to their work, conditions in their organizations do not allow them to work efficiently. Undue pressure at work from heavy caseloads, paucity of resources, uncertainties regarding their jobs and client reactions make them behave contrary to the expectations of their organizations and even how the organization's policies are to be implemented.

Street-level bureaucrats may not treat all clients as individuals, but show favouritism and stereotyping and may create routines at their workplaces to suit them. In their interaction with clients, they demonstrate a lot of power; whilst clients seek services to meet their needs, street-level bureaucrats seek control over these services. They exercise a lot of discretion in allocating resources among clients, they control the clients as much as possible, and can withhold information, cause delay and even distinguish between clients classifying them as deserving and undeserving - an action

which may be contrary to organizational goals. Lipsky observes that street-level bureaucrats resort to categorizing when they cannot do their best for clients. They however show their clients that they are doing their best and give justifications for their actions. By virtue of their work experiences and associated pressures, street-level bureaucrats burn out and try to adjust using coping strategies. In Lipsky's (1980) view although public workers, are regarded as low level workers, they constitute an important group. They have a lot of impact on people's lives and determine what people get in terms of programmes and other benefits from the state. Lipsky (1980) describes them as 'de facto policy makers'. However, he notes that they have to adhere to certain demands and requirements of their organizations. Lipsky's theory best explains and distinctly describes who street-level bureaucrats are, the power they possess, how they use this power in circumstances surrounding their work and what they are capable of doing in terms of policy implementation. In the Ghanaian case study of this thesis, street-level bureaucrats are the obstetricians and midwives (especially) and pharmacists – health providers who are front-liners in abortion service provision. Studying street-level bureaucrats is important because of their major role in service provision and their ability to enhance or impede services. Whether or not services are provided largely depends on them. Studying street-level bureaucrats in abortion service provision would help to unravel the barriers. Lipsky's theory provides the road map or study guide that enables the researcher to look out for specific activities of bureaucrats and the underlying motivations; for instance Lipsky's description of bureaucrats' coping mechanisms helps to explain how Ghanaian midwives vent their anger on patients to ease their stress which is associated with work overload or lack of basic equipment. The bottom-up perspective of Lipsky et al. has been drawn on in a number of studies, for instance how some nurses experienced implementation of free care and other South African health policies introduced after 1996 (Walker and Gilson 2004). In the section that follows, the conceptual framework for this study is discussed using most of the ideas from this section.

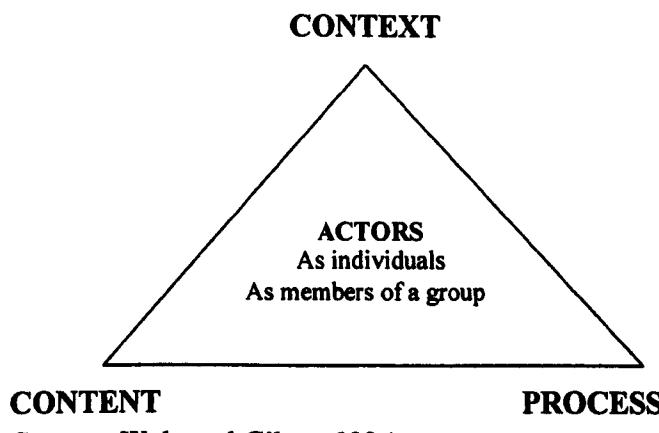
4.8 The Conceptual Framework

The theory that informed this study is Lipsky's street level bureaucracy as discussed in the previous section. It is the overarching theory that underpinned the study and

analysis of the data obtained from the interviews. In addition, insightful ideas from a framework and another theory were useful. Ideas from Walt and Gilson's (1994) policy analysis framework, a simple analytical framework which comprises the concepts of actors, content, context and process offer a better understanding of the interrelations of these concepts and how they influence policy choice and implementation. The four concepts (shown in figure 4.1 below) were drawn on to understand the circumstances surrounding implementation of the policy on abortion in Ghana.

Actors may be individuals or members of groups or organizations and are influenced by the context within which they live and work. Many factors impinge on context; these include cultural factors and the uncertainties associated with changes in political regimes. Actors, (with their power, values and expectations) in turn influence the process of policy making and the content of policy in turn is influenced by the other three concepts (Buse et al. 2005, Walt and Gilson 1994). Walt and Gilson (1994) underscore the usefulness of this framework for a better understanding of the process of health policy reform and for planning more effective policy implementation. They stressed the need to focus on all the components of the framework to shed light on the place of politics in health policy analysis and to provide a deeper understanding of the processes which explain why desired policy outcomes do not happen. Walt and Gilson's health policy framework is shown in figure 4.1 below:

Figure 4.1: Walt and Gilson's Health Policy Framework



Source: Walt and Gilson 1994

Ideas were also taken from the theory of *reasoned action (TRA) and planned behaviour (TPB)* (Ajzen and Fishbein 1980) to illuminate understanding of the determinants of behaviour. According to this theory the most important determinant of a person's behaviour is behavioural intention - this shows the extent to which people are willing to try and the efforts they plan to make in order to perform the behaviour. Behavioural intention is influenced by the person's attitudes towards performing the behaviour, the perceived social pressure known as subjective norm and perceived behavioural control. **Attitude** is the first determinant of behavioural intention. It is the extent to which the person has a favourable or unfavourable evaluation of the behaviour to be performed. **Subjective norm** is the second determinant of behavioural intention. It is the influence of social pressure that is perceived by the individual to perform or not to perform behaviour. An individual will intend to perform behaviour when he/she perceives that people who are important to him/her (such as spouse or close friend) think he/she should. The third antecedent of behavioural intention is **perceived behavioural control**. This is the degree to which an individual believes that performance or non-performance of behaviour is within his or her volitional control. People are less likely to intend to perform behaviour if they believe that they do not have any resources to do so even though they may have positive attitudes toward the behaviour and believe significant others would approve of the behaviour. This construct is the individual's belief concerning how easy or difficult performing the behaviour will be (Ajzen and Fishbein 1980).

Whether a policy is implemented or not and how it is implemented has been shown by Lipsky to depend largely on the actors as street level bureaucrats. It is therefore important to understand the factors that determine behaviour. The theory of reasoned action and theory of planned behaviour do not only help to predict behaviour but also help to understand behaviour (Ajzen and Fishbein 1980).

The conceptual framework for this study was developed based on information obtained from review of the theoretical and implementation literature and factors that influence the process of policy implementation. The framework was useful in the

development of the topic guide and also served as a guide for analysis of the data for this thesis.

Based on the implementation literature and other literature reviewed for this study, the factors that determine implementation may be conceptualized as including human personal factors, service-related factors, socio-cultural and factors related to the law/policy to be implemented.

4.8.1 Human Personal Factors

The literature has demonstrated how individuals as street-level bureaucrats have great influence over policy outcomes. The implementation of policies has also been shown to affect those implementing them. This has been demonstrated in studies in South Africa (Penn-Kekana 2004, Walker and Gilson 2004). Individual actors are therefore central to the conceptual framework for this study and it is important also to consider the human-personal factors (such as attitudes) that directly influence their behaviour. If the beliefs, attitudes and other factors that influence behaviour are borne in mind, these can be managed to facilitate effective implementation.

4.8.2 Service-Related Factors

Many factors at the health system's level determine whether policies are implemented at all or whether policy outcomes emerge as expected. In terms of implementation of abortion policies, barriers in the health system include paucity of designated facilities, inadequacy of trained providers who are willing to offer abortion services, lack of equipment and provider attitudes (Warriner et al. 2011; Kumar et al. 2009; Harries et al. 2009; Hill et al. 2009; Hessini et al. 2006; Jewkes et al. 2005 and Varkey 2000). Poor working conditions also influence the attitude of health providers (Walker and Gilson 2004). It is important to consider these factors for effective implementation because they affect the availability, access and quality of abortion services that actors are willing or able to provide.

4.8.3 Socio-cultural factors

Implementation of abortion policies has social, moral, religious and cultural implications (Lithur 2004). Most African countries place high value on children and

therefore abortion constitutes a taboo though it is practised in secret. Abortion is highly stigmatized and culturally abhorred in many African countries. The inclusion of socio-cultural dimensions in the conceptual framework draws attention to their important influence on abortion policy implementation through their influence on actors and their human-personal beliefs and on the nature of the laws and policies developed. In the literature, cultural values, social norms, religion and morality were shown as barriers to abortion services provision. Some health providers showed dilemmas and reluctance to provide abortion services based on religious and moral grounds. Focussing on these potential barriers to abortion policy implementation would help identify strategies to address them.

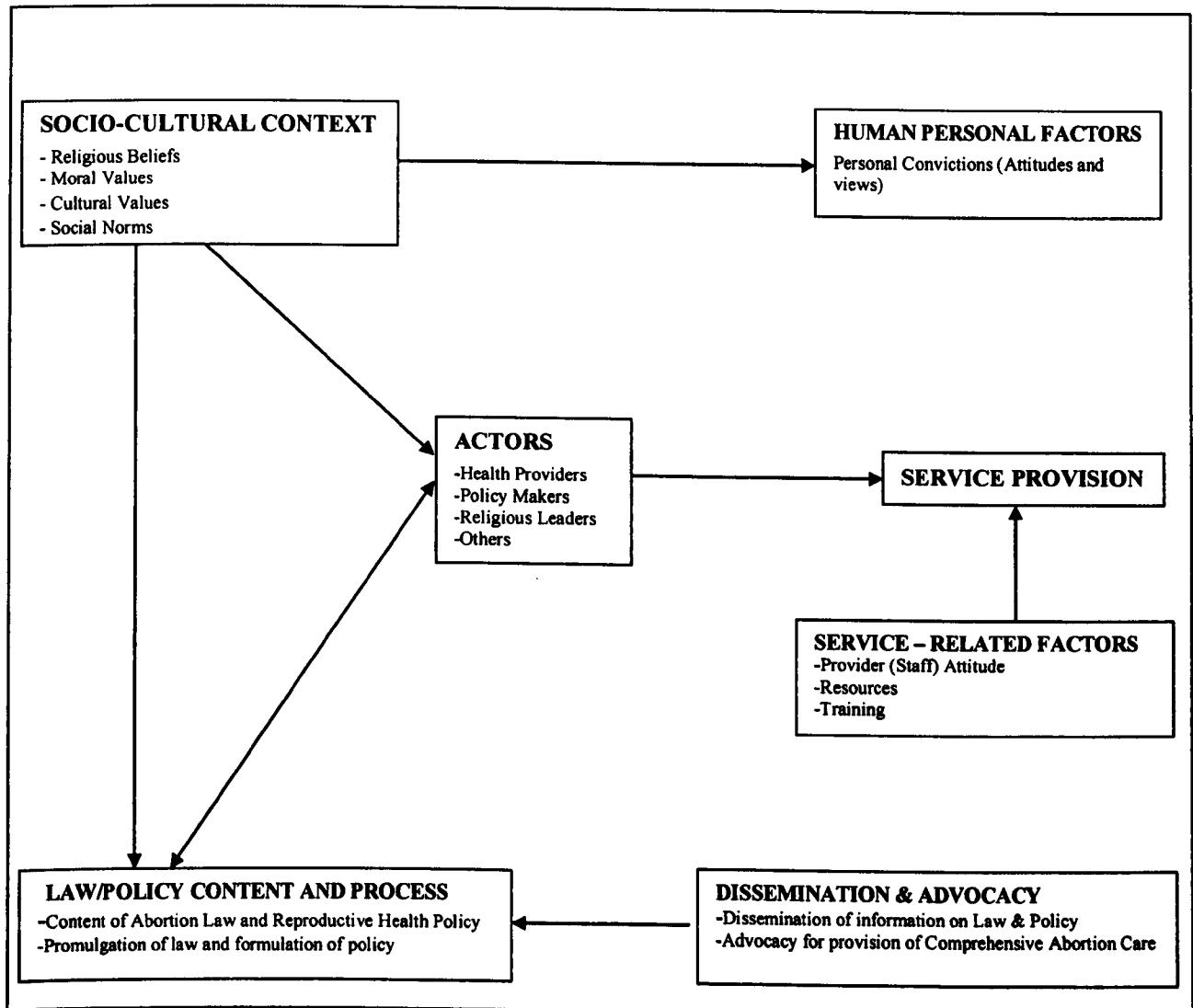
4.8.4 Legal/Policy-related factors

The availability of a policy is important to translate a law into services. Absence of policy to translate law into services limits availability of services (WHO 2003). The content of a policy is paramount, although there is caution not to focus exclusively on the element of policy for effective analysis of policy (Walt and Gilson 1994). Policy content must be clear; lack of clarity of policy content hampers implementation of policy on abortion because ambiguous laws make interpretation difficult (Morhee and Morhee 2006, Lithur 2004). Contentious issues inherent in some laws (e.g. whether mid-level providers are eligible to provide abortions) limits access to abortion services where doctors are not available. Lack of knowledge about abortion laws, multiple interpretations, non-availability of standards and protocols, poor dissemination of laws and policy documents and advocacy, all impinge on effective implementation of abortion policies (Berer 2009, Hessini 2005, Cook et al. 2003, Whitaker and Germain 1999). Also actors' knowledge and understanding of the contents of the abortion law and policy (which may depend on the extent to which dissemination and advocacy has occurred) influence their intention to apply them. This in turn is determined by the clarity of these documents as well as the extent to which these documents have been disseminated and discussed by the public

and custodians. A consideration of the law and policy in Ghana is therefore part of this framework, although the focus is primarily on implementation.

Below is a diagrammatic representation of the Conceptual Framework.

Figure 4.2: The Conceptual Framework



4.9 Summary

This chapter outlined the theoretical underpinnings of the study and described the conceptual framework on which analysis of the data obtained from the interviews was based. The need for the use of frameworks and theories to throw light on the complex policy process was highlighted and the importance of distinguishing between them was stressed. John's (1998) taxonomy of theories of the policy process showed one way of summarising the vast array of theories in the field of policy analysis. Although the stages heuristic had many criticisms it served as a starting point to explain this study's focus on implementation since the heuristic distinguishes implementation as a distinct stage in the policy process. Based on this link of thoughts on implementation and the policy process and ideas from the 'top-down and bottom-up' approaches to policy implementation, Lipsky's street-level bureaucracy was selected as the theory which best describes health providers' attitudes and behaviours in my study. To throw more light on analysis of my study findings and to guide the procedure, a detailed account of Lipsky's street-level bureaucracy was provided. Furthermore, elements from Walt and Gilson's policy analysis framework and ideas from the theory of reasoned action and planned behaviour were outlined to deepen understanding of the multiplicity of factors that inhibit provision of safe, legal abortion services in Ghana. The factors of relevance for analysing the data were discussed.

CHAPTER FIVE

RESEARCH DESIGN

5.1 Introduction

This chapter describes the type of study, research aim and objectives. The research questions are also outlined. The population from which the sample was drawn, the methods and data sources are described. Ethical issues and the limitations of the study are discussed.

5.2 Type of Research

The study is qualitative in nature. Qualitative inquiry is mostly carried out to describe phenomena about which little is known. It involves in-depth analysis of phenomena and is able to capture the meaning of phenomena as well as illuminate aspects of a problem which numbers may fail to unravel (Mayan, 2001).

5.3 Research Aim and Objectives

5.3.1 Aim of Research

The aim of this study is to understand the barriers to and opportunities for improving access to safe, legal abortion services in Ghana.

5.3.2 Specific Objectives

The specific objectives of the study are to:

1. Analyze the content of the abortion law and policy;
2. Examine the process of promulgation of the law and identify the actors involved and the roles they played;
3. Identify the service-related and socio-cultural factors including social norms, cultural values, religion and morality that act as barriers to provision of safe, legal abortion services;
4. Determine the differences in actors' knowledge, attitudes, and views concerning abortion in general, the abortion law in particular, its implementation and the underlying reasons for actors' attitude and views;

5. Consider implications of the research findings for policy and practice.

5.4 Research Questions

Formulation of research questions in qualitative inquiry is imperative as these constitute the backbone of the study design. According to Mason (1996) research questions are the expressions of the researcher's intellectual puzzle i.e. the issue or phenomenon in question that the researcher wishes to explain. The hallmark of research questions that are carefully and coherently formulated is that they express the essence of the inquiry. The objectives, research questions, data collection methods, data sources and analysis are shown in Table 5.1 below:

Table 5.1: Relevant objectives, research questions, methods, data sources and analysis

Relevant objectives	Research questions	Data collection methods, sources and analysis
1. Analyze the content of the abortion law and policy	<p>What are the contents of the abortion law?</p> <p>What are the policy guidelines to be followed for comprehensive abortion care?</p>	<p>Document analysis of the abortion law and the national reproductive health service policy and standards.</p> <p>In-depth interviews with politicians, policy makers, doctors, midwives, pharmacists, trainers in medical & midwifery institutions, lawyers, and representatives of development agencies /NGOs.</p> <p>Framework analysis of interviews</p>
2. Examine the process of promulgation of the law and identify the actors involved and the roles they played.	<p>When was the law developed?</p> <p>How was the law developed?</p> <p>What groups of actors were involved?</p> <p>What were the roles of the actors?</p>	<p>In-depth interviews with politicians, policy-makers, doctors and lawyers.</p> <p>Framework analysis of interviews</p>
3. Identify the service - related and socio-cultural factors including social norms, cultural values, religion and morality that act as barriers to provision of safe, legal abortion services.	<p>Are providers trained to offer abortion services?</p> <p>Are there designated facilities and equipment for provision of safe, legal abortion services?</p> <p>Are providers willing to offer safe abortion services?</p> <p>What is the attitude of providers towards safe abortion services?</p> <p>What are the social norms, cultural values, religious and moral factors that are barriers to provision abortion services?</p>	<p>In-depth interviews with policy-makers, obstetrician/ gynaecologists, midwives, pharmacists and representatives of development agencies /NGOs.</p> <p>Framework analysis of interviews</p>
4. Determine the differences in actors' knowledge, attitudes, and views concerning abortion in general, the abortion law in particular, its implementation and the underlying reasons for actors' attitude and views.	<p>What is the level of knowledge of the different categories of 'actors' (e.g. policy-makers & health providers) about the law on abortion in Ghana?</p> <p>What are the differences in attitudes and views concerning abortions?</p> <p>What factors influence these attitudes?</p> <p>What are the reasons for these viewpoints?</p>	<p>In- depth interviews with politicians, policy-makers, doctors, midwives, pharmacists, lawyers and representatives of development agencies / NGOs and the journalist.</p> <p>Framework analysis of interviews</p>

5.5 The study population

The population constituted Ghanaians living in the Accra Metropolitan Area. Accra is the capital city of Ghana. If those in the capital, closest to policy making are not fully implementing CAC then it is much less likely that others are. I was interested in understanding the perceived legal as well as non-legal barriers to provision of services therefore I needed to interview people who could reasonably have been expected to know something about the policy.

5.5.1 The Sample

The sample consisted of people drawn from the national, regional and district levels of the Accra Metropolis. Specifically, the sample was made up of key informants including politicians, policy-makers, medical and legal practitioners, heads of selected medical and midwifery training institutions and other health providers. The health providers were pharmacists as well as doctors and midwives working in the gynaecological, reproductive and child health and family planning (RCH/FP) units of the selected hospitals and health centres respectively.

5.5.2 Selection Criteria

The main aim of this study was to understand the barriers to provision of safe, legal abortion services in Ghana. Thus there was need for stakeholders who knew about these phenomena to be included in the study to help unravel the various barriers to service provision. Based on the research questions and guided by the literature, respondents who were recognized as knowledgeable about the topic were selected. Health providers, policy-makers, parliamentarians and lawyers were considered as people who were best suited to help identify the barriers to abortion service provision. Given the highly religious context of the research and the culture in Ghana of involving religious leaders in all important national programmes, I found it necessary to include them in my sample as stakeholders. Secondly, for a religious country such as Ghana, if the MOH/GHS is considering expanding access to safe, legal abortion services, due to the controversial nature of abortion, it is important to find out what religious leaders think about the idea. It is also worthy to note that the ethical review committee of the MOH/GHS has a Reverend Minister as a member of the committee. Thirdly, religious leaders are the most likely group to oppose provision of abortion services in the country therefore their involvement at the

planning stages is important to forestall any negative reactions from them. Lastly, Nunes (2000) underscores the importance and benefits of involving professional bodies including doctors, lawyers, journalists, care givers and religious leaders in legislative and policy reforms especially where such reforms border on deeply enshrined values and abortion is a typical example. Schuster (2005) also argues that religious leaders are key players in discussions bordering on society's attitude towards contraception and abortion laws and policies.

The journalist in the sample was selected for participation in the study because she has many publications on reproductive health issues (especially abortion) in one of the local newspapers. She is also a member of a team that conducted a 10-year operations research in maternal mortality in Ghana and periodically published most of the team's research activities. She has interest in reproductive health issues and showed keen interest in the study when contacted. Her participation in workshops organized by the Population Reference Bureau for media people has given her the opportunity to see and talk to women on admission in hospital with abortion complications. She is an experienced journalist. The respondents selected for participation in the study were all willing to talk about the sensitive topic being researched.

5.5.3 Sampling

Abortion is a multi-dimensional issue. It has health, legal, religious, social, ethical and policy implications. Thus implementation of the abortion policy (the focus of my study) is a multidisciplinary task that requires the inputs of many stakeholders. Furthermore, sampling in qualitative research should be such that the data obtained is rich (Fossey et al. 2002). It was therefore important that I identify the range of respondents who can provide adequate information (and triangulation) about the topic being researched. For these reasons, I selected a wide range of respondents comprising obstetricians, midwives and other health professionals who represent the 'street-level bureaucrats' at the front-line of service provision, as well as non-health professionals who are important in influencing public views on abortion, namely policy-makers, religious leaders, lawyers and a journalist.

The health providers were purposively chosen from the national, regional and one district hospital of the Greater Accra Region where the study was carried out as well as five urban health centres. The health centres were systematically selected from the MOH list of facilities in the region; every fifth health centre was selected. All the health centres had units (RCH/FP) that offer reproductive health services.

The obstetricians, midwives and pharmacists were selected from obstetrics and gynaecological units in hospitals or reproductive and child health units in health centres where women with abortion complications are treated. Other health professionals were chosen from medical/midwifery training and research institutions. Although the health professionals' sample was not a random sample, the systematic sampling of the facilities from which they were drawn helps to ensure some measure of representativeness of health providers in Accra.

The non-health respondents for this study were also selected by purposive sampling. My experience in working in service-delivery in Ghana, and my previous master's study on abortion, enabled me to purposively hand-pick respondents for the study based on their field of specialization, where they worked and who could provide the most information about the topic being researched or who was known to write/speak in the public sphere about the topic. Purposive sampling helps generate data for a detailed description of the phenomenon being investigated (Fossey et al. 2002). This was to ensure that the research objectives were adequately met.

The policy-makers (eight of whom were doctors and had practised in obstetric and gynaecological units in teaching hospitals) were from the MOH headquarters, an NGO and a development agency. The religious leaders were selected from their respective Church secretariats and Church offices. Two were chosen from the teaching hospital where they worked as Chaplain and pharmacy technologist. The two religious leaders were chosen because of their experiences with women who have had abortions. The lawyer(s) were selected due to the legal implications of induced abortion. Both lawyers showed keen interest in legal issues pertaining to women. One was a human rights activist and women's advocate with interest in reproductive health issues including access to safe abortion.

The study was based in Accra, the capital city of Ghana. This is because the focus of the study is on the implementation of the abortion law and policy and it was considered that the people who live in the capital city, (i.e. the seat of Government) are better placed to be knowledgeable about the research topic.

5.6 Data Collection Techniques and Tools

The data collection techniques and tool employed in the study were:

- i) Document analysis
- ii) In-depth interviews.

The tool for the interviews was a topic guide.

The interviews were carried out with all the key informants.

5.6.1 Document Analysis

Document analysis was one of the main techniques used for collecting data on the content of the law and policies. It can be used for qualitative as well as quantitative data. Documents reflect social reality and they also offer accounts of events. In addition qualitative inquiry requires adequate sampling of sources of data (Fossey 2002). To derive more from documents for research purposes, it is helpful to analyze related documents and compare them (Blaxter et al. 1996). Document analysis was used in this study to add to what respondents had said in the interviews. This was to ensure a full and deeper understanding of the challenges to provision of safe, legal abortion services being explored.

i. A detailed analysis of the following documents was carried out:

- The abortion law (Sections of Criminal Code 1960; 1985 law)

Policy documents of the Ministry of Health/Ghana Health Service including:

- National Reproductive Health Service Policy and Standards (1996)
- National Reproductive Health Service Policy and Standards (2003)

- Prevention and Management of Unsafe Abortion: Comprehensive Abortion Care Services Standards and Protocols 2006

I critically read the four documents listed and noted their contents and purpose, comparing my findings with data from the interviews. The analysis illuminated barriers to implementation inherent in the documents themselves. It also provided triangulation for respondents' comments on the law and RH policies, thus complementing the interview data. Findings from the document analysis are discussed together with the interview data at relevant points in the thesis, in particular in chapter 6 (on the law and policy). See appendix 3 for detail on the document analysis.

5.6.2 In-Depth Interviews

In-depth interviews were selected as the technique for this study because the objectives of the study necessitated the use of an in-depth approach. One of the objectives of this study sought to identify amongst other things, the attitudes of respondents concerning abortion. In-depth interviews as opposed to surveys are more likely to offer opportunities for more refined open-ended questions which allow for responses that reflect the complexities of the issue, giving rise to more nuanced data. Surveys have limitations in measuring attitudes. They are not the most suitable instrument for finding and disaggregating subtle differences especially in studies on issues as controversial as abortion when attitude measurements are particularly problematic (Everatt et al. 1999). In-depth interviews are very useful in qualitative research. According to Ritchie and Lewis (2003), unstructured interviews are very flexible and allow interaction between interviewer and interviewee. They also enable the interviewer to use probes to explore and get a deeper and more detailed understanding of what interviewees say and mean. Furthermore, they maintain that in-depth interviews offer interviewers the opportunity to explore deeply interviewee-based issues like reasons, feelings, opinions and beliefs that underlie the responses they give (Ritchie and Lewis 2003).

The interview was the most relevant approach because I was exploring complex issues around interpretation of law, socio-cultural barriers and a sensitive topic '*abortion*', all of which require a qualitative in-depth approach best achieved through

in-depth interviews. I expected that a critical and thorough analysis of the views and attitudes of the actors concerning the implementation of the abortion law will enable me to understand the status quo.

Finally, the theory that informed this study (Lipsky's street-level bureaucracy) highlights the important role of actors in policy implementation, thus using in-depth interviews to collect the research data from these actors affords me the opportunity to meet, interact, build trust and confidence in these actors and obtain the needed information from them. The research questions sought to identify the clarity of the abortion law and policy, determine the service-level and socio-cultural barriers to service provision and elicit the attitudes and views of respondents, key actors of abortion service provision. The in-depth interview best serves the purpose of eliciting such information from the most suitable informants. Analytical interpretation of the interview data will bring to the fore social realities associated with the topic under discussion. The topic guides used for this research are given in Appendix 4.

5.7 Data Collection

The in-depth interviews were held with selected respondents mostly in their offices. After ethical approval for the study was secured (see Section 5.9), written permission was sought from the heads of the various institutions where some respondents work. A few were interviewed in their homes at their request. Initial contacts were made with the respondents either on telephone or in person. Based on the convenient time for the respondent, interviews were scheduled and done or rescheduled where necessary. The initial contacts and appointments were facilitated by the use of link persons. These were friends working in the health facilities or organizations where the respondents were selected from. They were very influential in introducing me to the respondents and ensuring that appointments were fixed and usually kept. Having fixed the time with a respondent, I always made sure I was punctual at the venue and had all I needed for the interview.

I contacted 81 people for participation in the study. Two obstetricians could not be interviewed since they were always busy at the scheduled time; three refused to be interviewed (policy-maker, senior nurse and clergyman). The policy-maker told me she did not like the topic (abortion) but the other respondents continually gave

excuses and did not grant me the interview. For the interview, I usually met my respondents with a greeting. We normally sat facing each other usually behind a table on which I placed my recorder after asking permission from the respondent to record the interview. For most respondents, I gave them the information sheet to read. Others preferred that I told them about the study verbally. Having learnt about the study, they proceeded to sign the consent form. I usually established rapport with the respondent by briefly discussing any appropriate issue. Then in a conversational manner I started the interview and the recording process. I allowed the respondent to lead the conversation but I ensured it was on course by slotting in questions and issues where necessary. I maintained eye contact and used non-verbal cues to elicit more discussion where appropriate. I also kept an eye on the recorder intermittently to ensure it was working well. The topic guide was not strictly followed but all important issues were often explored. I observed and noted all mannerisms of the respondents, especially with each question. At the end of each interview, I thanked the respondent before leaving. In some cases respondents wanted to hear their voices on the recorder so I played the interviews to their hearing.

I wrote down field notes and transcribed recorded interviews as soon as possible after each interview. The data collection period lasted for nine months, from 2nd November 2006 – July, 2007. Altogether seventy six (76) interviews were done. For purposes of analysis, the respondents were categorized as follows:

Table 5.2 Distribution of Respondent by Groups

Obstetrician/ Gynaecologists	Midwives	Other Health Professionals	Non-Health Professionals	Policy Makers	Religious Leaders
Obstetricians -15	Midwives-14	Pharmacists-7 Trainers -5 Researcher -1 NGO Rep -1	Parliamentarians -6 Lawyers -2 Journalist -1	Policy Makers (MOH) -7 Dev. Ag. Rep. -2	Clergy - 13 Clerics - 2

5.8 Pretesting

Pretesting of the research tools was done with five doctors and three midwives (groups similar to the respondents of the study). The purpose of the pretest was to determine peoples' understanding of the issues in the topic guide. Following the pre-test, a few redundant questions were deleted and omitted ones were included in the guide. Questions that were not very clear were modified for the main study.

5.9 Ethical Considerations

Ethical considerations are of uttermost importance in any research undertaking. Ethical clearance was sought and granted from the Ethical Review Committee of the Ghana Health Service. In addition clearance was obtained from the Ethical Review Committee of the London School of Hygiene and Tropical Medicine. Written permission was sought from the various institutional heads where the sample was drawn from, that is the heads of the various health facilities. All the respondents were given information sheets with a detailed description of the nature of the study, its purpose and rationale. The researcher explained the study in detail to all respondents. When they had understood what the study was about and expressed interest in participation, they were asked to sign a consent form. No respondent was coerced to join the study. Participation in the study was voluntary. Confidentiality and anonymity were ensured. The recorded interviews will be discarded when the study is completed. Silverman (2000) underscores the need to obtain consent from one's respondents in studies where the researcher records what the respondents say and the need to tell respondents about how the data may be used. Copies of the information sheet and consent form are available in the appendix (Appendices 8 and 9).

5.10 Field Notes

Field notes were written during data collection. These notes were written immediately after the interviews. I described all that took place during each interview. These included a detailed description of the environment or venue used for the interview, the mannerisms, non-verbal behaviours and the general reaction of the interviewee with respect to questions posed. Everything that happened during each interview was recorded e.g. pauses/hesitation, laughter, giggles, grimaces and all

other expressions made by the interviewee as well as my own reflections, feelings, ideas about the data and interpretations. The field notes and interview transcripts were used to write summaries of each interview to provide an overview of descriptive accounts of the interviews. The field notes were useful in helping with the interpretation of the interview data.

For purposes of reflexivity and rigour, I thought through, unpacked and wrote down my own knowledge, beliefs, attitudes and views on the subject being studied prior to the commencement of the fieldwork. In addition, details of decisions taken during the course of the study with regard to analysis of data were all recorded in a field diary.

5.11 Data Management

The data was obtained from in-depth interviews with key informants. The interviews were digitally recorded and downloaded into a computer at the end of each day. The recorded interviews were played and transcribed verbatim. This was done shortly after each interview so as not to forget fine details. I transcribed about two thirds of the interviews. The other one third was transcribed by research assistants, one of whom was hired from a research unit (Health Research Unit, Accra). The research assistants were trained to record everything in great detail, leaving out nothing. I listened to the tapes and edited the transcriptions done by the research assistants where necessary. Folders were opened in the computer and the transcripts were kept in these folders according to types of respondents.

In addition, all transcripts were printed out and hard copies were filed and labelled according to types of respondents and kept in a cabinet in my office. For confidentiality, pseudonyms were put on transcripts. Each respondent had a code signifying the category to which he/she belonged. For instance all transcripts belonging to policy-makers were kept in one file and labelled. After transcription, the transcripts were shown to some (22) of the respondents to ensure that what had been transcribed was what they said. It was not possible to show transcripts to all respondents due to time and other constraints.

5.12 Data analysis

Analysis of data was initiated during fieldwork and was carried out concurrently with the data collection. The data obtained was voluminous and unwieldy and needed to be reduced and managed taking care not to lose the contexts within which issues from the data were captured. The approach employed for the data analysis was the '*framework*' method. It is a qualitative method for applied policy research developed by Ritchie and Spencer (1994) in the Social and Community Planning Institute in London. Framework analysis permits easy access to the original textual data. It is a flexible and dynamic data analysis tool, open to change at any time during the analytic process. It therefore facilitated the iterative nature of the analysis. The process is transparent or explicit and can be viewed and judged by others. It allows within and between case analyses. It is similar to grounded theory (generative and inductive), as it reflects respondents' own accounts and observations however, it is also considered deductive because it is informed by pre-set reasoning; it starts with pre-set research questions thus making the data collection more structured (Ritchie and Spencer 1994).

The framework approach was chosen as the method of analysis because of its inherent strengths and suitability. Given the voluminous nature of data to be analyzed, the systematic nature of the approach enabled each unit of analysis (each respondent) to be handled methodically. Also, because it is comprehensive, it permits a thorough review of the data. My study was driven by specific research questions (informed by the conceptual framework that was developed from a review of the theoretical and applied literature on policy implementation) and data collection was guided by topic guides; for these reasons the framework approach was suitable for the data analysis for this study. The framework approach involves five (5) steps namely: familiarization, identification of a thematic framework, indexing (coding), charting, mapping and interpretation (Ritchie and Spencer 1994).

5.12.1 Familiarization and identification of thematic code framework

Each interview was read several times to familiarize myself with the entire data set. Summaries were then written for each interview using the interview transcripts and field notes. This provided detailed descriptive accounts that showed each respondent's understanding of the issues being studied. As the transcripts were

reread, the recurring themes that were identified within each transcript were noted down as they emerged as well as any links identified amongst them. Based on the links identified, these themes were grouped into categories. An initial thematic framework (code frame) of the main themes was developed based on the research questions as well as the themes that emerged from familiarization with the data.

Each main theme was named to reflect what it included. Since the initial code frame was constructed at a time when not all the transcripts had been read, I had to add on new themes upon further reading and go back to check whether the transcripts already read contained those new concepts or ideas. As more themes were identified, they were re-grouped into categories comprising main themes and sub-themes based on the links amongst them. The initial thematic framework was thus revised to form a hierarchical structure which was used for indexing (coding) the data set in NUD*IST.

5.12.2 Indexing

Using the NUD*IST computer software and the thematic code frame (shown in Appendix 5), the entire data set was systematically indexed. This involved importing all transcripts into a named project and applying the code frame to the raw data. The entire text was read in portions systematically to determine what each portion was talking about. That portion of the text was then highlighted and placed under a node labelled with an appropriate sub-theme (code) that best described it. This was done for the entire text. The indexed segments of text were sorted and stored in the NUD*IST project as reports.

The indexing process gave clues to emerging relationships or patterns among themes within a single case and across cases. For instance, a particular segment of text was indexed under multiple themes. This indicated that there might be a relationship among the themes. Indexing enabled me to become deeply familiar with the raw data sorting them out into main themes and sub-themes. During the indexing and sorting out processes, memos were written down to draw attention to facts or some details worth noting later in the iterative process of analysis.

5.12.3 Charting

NUD*IST software is a data management tool and cannot conduct analysis for the researcher. Therefore, the next step in the analysis was the development of thematic charts or matrices that were constructed using the thematic code framework: coded text held at nodes in the software programme was exported to word and thence transferred to excel spreadsheets for clearer, easier, systematic comparison of themes and respondents. The purpose of these charts is to examine the data for patterns and connections because charting facilitates closer examination of themes and how they are related. Using the spread sheet, each theme was presented in a matrix of respondents arranged by types in rows and sub-themes in columns. Under each sub-theme, data from each respondent was summarised making sure not to lose the context within which the raw data were obtained. The language used by the respondents was maintained. (See appendix 6 for examples of sub-theme analysis tables).

5.12.4 Mapping and interpretation

Having summarized the raw data through the thematic charts, each theme was critically examined across cases noting the relationships identified amongst them. The range of issues making up the themes was unpacked to identify constituent elements. The dimensions of the elements were noted. This stage of analysis was facilitated by the use of new matrices of respondents and sub-themes for closer examination. For instance, further analysis of the sub-theme ‘access to safe abortion services’ showed a link between that and ‘health providers’ attitudes towards services’. Thus health providers’ attitudes towards abortion services seemed to influence access to services. Some dimensions of access e.g. social and economic were also identified in the process. At this stage, explanations or interpretation of the data were made based on themes that emerged from the data (i.e. what respondents themselves have said), the literature and drawing on the theoretical underpinnings of this study.

5.13. Reliability and Validity

Quality control in research is essential thus in my study a variety of measures were carefully taken throughout the study to ensure quality including systematic data collection, analysis and presentation. Reliability and validity are two concepts that help to define the strength or soundness of data from research. Reliability refers to the replicability of research findings; that is the extent to which the same research findings will be obtained if the study is repeated using the same or similar methods. This means that the original data and their interpretation or meanings attached should be obtained if the study is repeated. Terms such as confirmability, consistency or dependability, which are synonymous to reliability, are often preferred (Ritchie and Lewis 2003).

Measures I took to ensure reliability of my findings, some of which are discussed under the section on reflections, include unpacking and writing down all my assumptions, reflections, values and biases concerning the study before data collection and being aware of them throughout the research process. There was concurrent data collection and analysis. I was open and paid attention (*'listened'*) to the data rather than follow preconceived ideas.

All the interviews were carried out in venues chosen by the respondents and at their convenience to make them comfortable, relaxed and to rule out the effects of external influences on their responses. As a nurse and a former worker at one of the institutions where data was collected, I considered myself an 'insider' and was neutral in the way I posed my interview questions and solicited responses, carefully using probes for purposes of clarification and allowing respondents to express themselves fully without my interruptions. I tape-recorded all but two interviews with respondents' permission to make sure I had verbatim records of responses for others' review. In the case of respondents who did not want to be recorded, I wrote down their responses in my field journal. I also wrote down field notes which helped with interpretation of my findings. These notes included the nature of the environment at the time of the interview, the nature of the interruptions that occurred and respondents' reactions to specific questions and their actions. I transcribed verbatim most (two-thirds) of the interviews. Those that were transcribed by research

assistants were checked using the audio recording and corrected. All copies of the transcripts and audio recordings have been kept for review by others. Data analysis was systematically and comprehensively done and described in adequate detail ensuring that the original meanings of data were maintained. Coding checks and triangulation of data sources was a priority. Frequent discussions were held with my supervisor, advisory committee, and peers on the interpretation of my findings to obtain the views of others on the findings.

The validity of findings denotes the correctness or exactness of research findings. The terms credibility and plausibility are sometimes used to refer to the same concept. Validity has two dimensions namely internal and external validity. Internal validity ascertains whether a researcher actually investigates the phenomenon he/she sets out to research on. It shows the extent to which the phenomenon being studied accurately reflects how the study population perceives it. External validity concerns whether a study's findings are transferable or can be applied to the study population (Ritchie and Lewis 2003, Miles and Huberman 1994).

Validity can also refer to the type of understanding that emerges from a qualitative study. These are i) descriptive – what happened in specific situations; ii) interpretive – what it meant to the people involved; iii) theoretical - concepts and their relationships used to explain actions and meanings; and iv) evaluative; judgements of the worth or value of actions and meanings (Miles and Huberman 1994, p.278). Natural validity concerns the idea that the events and settings studied are uncontrived, unmodified by the researcher's presence and actions (Miles and Huberman 1994). My study, which looks at the contents of the abortion law and how it is interpreted as well as the context of provision of safe, legal abortion services and what that means to actors, portrays the descriptive, interpretive and theoretical understandings from my study. The analysis provided in Chapters 8 and 9 seeks to provide evaluative validity, assessing the implications of actors' views and actions.

Triangulation and respondent validation were other measures that were used for checking the validity of my study findings. Four kinds of triangulation are known. Methods triangulation involves comparison of data from different methods e.g.

qualitative and quantitative. Triangulation of sources involves comparing data from different qualitative methods such as observations, interviews and documents. In triangulation through multiple analyses, different researchers, interviewers compare and check data collection and interpretation. Theory triangulation analyzes data from different theoretical perspectives. Triangulation of sources and methods were used in this study. Data was collected using interviews as well as analysis of relevant documents. In the interviews, different categories of respondents were used. Among the health providers and other health workers, different cadres (e.g. obstetricians, pharmacists, midwives and policy-makers) were interviewed to illuminate the barriers to provision of safe abortion services which constitutes the thrust of the study.

5.14. Limitations of the Study

A number of limitations confronted this study, for all research work is fraught with varying degrees of limiting factors. The most important limitation of this study comprised the methodological challenges associated with studies on issues as sensitive as abortion. It has been observed that generally, data on unsafe abortion are scarce and inevitably unreliable due to an array of legal and ethical/moral constraints that hamper data collection.

In this study, a qualitative approach was employed to understand the barriers to provision of safe, legal abortion in public health facilities. Attitudes and views of different stakeholders towards safe abortion services were explored using in-depth interviews. This method is not perfect in itself. For instance, there is a gap between what people say and what they do. Interviews might not perfectly fill these gaps. I endeavoured to minimize this limitation by triangulation. This involved the use of different methods, sources and theories which served the dual purpose of ensuring validity and comprehensiveness.

Also, the in-depth questions allowed a rapport to build up and also allowed me to return to topics later if I felt the respondent had relaxed or opened up. Many respondents expressed forceful opinions which suggested they were prepared to tell me what they thought. There were many ambiguities/inconsistencies and sometimes it seemed as though people were working out what they thought during the interview.

Since the thrust of the study was to identify the barriers to access to safe, legal abortion services in Ghana, and women are those who need and seek these services, I had wanted to include focus group discussions of women's groups in my study sample however, my upgrading committee advised against that in order not to end up with too much data to be analyzed in the available time. I adhered to the advice. I had wanted to organize a dissemination seminar to share my initial study findings with respondents and to obtain feedback from them (respondent validation) but this was not feasible due to time constraints. I could only show transcripts to a few (22) respondents for feedback which was not adequate. The initial delays affected my time frame.

For a qualitative study to gain analytic integrity, the researcher ought to transcribe the data systematically and analyze them critically based on sound theory. These were also ensured in the current study.

5.15 Constraints

I was confronted with a number of constraints during the course of this study. Funds for the fieldwork were delayed and this delayed my progress to some extent. I was delayed by respondents on many occasions. I had to wait for some respondents for very long hours, sometimes only for the interview to be postponed. Most of the respondents were very busy people in key positions hence many of my interviews were rescheduled a number of times before finally getting the opportunity to interview them. Due to their busy schedules, some of them rushed through the interviews. Some of the interviews were also interrupted many times disrupting them from running smoothly.

The very nature of my topic even subjected me to derogatory comments from some colleagues and superiors; while some colleagues chose to reserve their comments, others wondered why I chose this topic of all topics and confronted me. Below are examples of comments and questions I got:

- “Mrs. Aniteye, I thought you were a Christian, why are you undertaking such a study? (From an MSc. Student of London School of Hygiene and Tropical Medicine.)

- “Patience, I don’t envy you one bit for the kind of study you are undertaking; good luck”. (From a superior, a Lecturer at London School of Hygiene and Tropical Medicine.)
- “What do you think of assisted death”? (From a Professor at the London School of Hygiene and Tropical Medicine. He must have asked this question simply because my research is on abortion, a subject just as controversial as assisted death.)
- “Pat, how come you chose this topic?” (From a Head of Department in my previous university in Ghana.)

A number of people who were working in positions where I knew they would be able to provide me with valuable information simply declined to be respondents after being briefed about the study. One such respondent said she did not like an aspect of my topic (i.e. CAC). During the course of the fieldwork, I felt I was being labelled myself since I went to a number of institutions several times and people got to know what I was doing and whispered among themselves to announce my arrival. There were times I felt isolated.

When I contacted one senior midwife working in a gynaecological unit where numerous cases of abortion complications are seen on daily basis for an interview, she kept postponing the interview date with the excuse that she was busy. Although I had worked in the same unit with her for over a decade and considered her a friend, she always had an unfriendly expression when she met me on the corridors of the hospital during my efforts at data collection. After about six to eight weeks of postponement, I met her one day at her unit sitting at the OPD with her colleagues, virtually idle since there was no patient to be seen then. When I asked if we could have the interview since she appeared to be free all she told me was: *“Abortion is not a subject I want to think about, let alone talk about it.”*

Meanwhile not less than ten cases of abortion complications are managed in her unit every day. I ruled out the possibility of an interview with her. In one of the interviews with a research assistant working in a health institution, she did not want me to record the interview though she agreed to be interviewed. Her responses were

curt and succinct. At the end of the interview, she told me that she had not exhausted her study of the Bible for her to focus attention on abortion and its related issues. Meanwhile, I was reliably informed by a colleague that she had been involved in much research work on abortions and thus was a very resourceful person for my research.

There was also one clergyman who agreed to be interviewed. We fixed an appointment and I was there on schedule for the interview only to be told he had to go out on a mission so we should re-schedule it. The interview was never conducted even though I met with him a few times. He never mentioned it again. I did not also mention it again since I strongly felt that he did not want to be interviewed but could not tell me.

The responses I obtained from these few examples did not in any way bias my sample (selection bias). My sample included people who were against CAC as well as some who appeared to be for CAC in certain circumstances and against it in other circumstances so these views might have been represented. Those who refused to be interviewed were three in number- two females and a male; a senior midwife, senior policy-maker/doctor (female) and a young Methodist Minister (male). Two obstetricians agreed to be interviewed but were called for emergency operations each time we scheduled an interview. They could therefore not be interviewed.

Finally, the sheer number of interviews meant a long time was spent in transcribing and analysis. Qualitative analysis is never quick, and the large number of interviews – needed in order to thoroughly explore the perceptions of a range of key stakeholders – was at times very slow.

5.16 Strengths and Weaknesses of the Research

This study sought to identify the barriers to and opportunities for improving access to safe abortion services in Ghana within the framework of the law on abortion. There are health systems (service-related) and socio-cultural barriers that confront service provision as well as utilization. Using women for this study would have been appropriate since information from them would have highlighted their perspectives on the barriers.

I had wanted to have FGDs with groups of university girls and market women but was advised against it by my upgrading committee for fear of generating too much data to be handled within the time frame at my disposal. Despite this shortfall, data from the respondents revealed a lot on what women face in their search for termination of unwanted pregnancies. The wide mix of respondents shed more light on the diverse challenges emanating from the law, RH policy, health system constraints and socio-cultural ones.

Time and other constraints did not permit me to disseminate my preliminary findings to all respondents for feedback. Doing this would have contributed to validity of my findings. I was able though to elicit feedback from a few respondents and also had an opportunity to present some of my findings at the Global Safe Abortion Conference in London in October, 2007. This gave me the chance to get some feedback from some key respondents who attended the conference.

My research topic is a sensitive one. Underreporting is an issue in such studies (Jones et al. 2007; Ahiadeke 2001). Having worked in the Department of Obstetrics and Gynaecology for 15 years, I knew most of the respondents and had worked with some of them or met them at conferences and/or workshops. The respondents felt free and relaxed with me and ensured they told me all I needed and wanted to know. They knew that I had some knowledge of issues already and so they had nothing to hide. This yielded valuable and rich data.

I clearly understood all scenarios/situations described and could picture them vividly and interpret them. My profession as a nurse/midwife and previous work experience in an obstetric and gynaecological unit was helpful. The technical terms used by some respondents were all very familiar and I could capture most if not all nuances. Being a Ghanaian and researching amongst Ghanaians was an added advantage. I thoroughly understood and appreciated the socio-cultural (contextual) issues and problems raised. Also my previous research on abortion gave me much insight into issues in this current study.

For a qualitative study, my sample size was big. This had both a positive and negative impact on the study. I lost time scheduling and conducting interviews but I

got the bigger picture. Knowing a lot about the area of study would have introduced some biases or prejudices however, I wrote these down before the study to make me aware of them.

5.17 My reflections and thoughts about abortion and abortion care, health providers and users.

5.17.1 Before the Study

But for my exposure to women who have had unsafe abortions at the Department of Obstetrics and Gynaecology where I worked as a research assistant for 15 years, abortion would have been an issue I may hear about in gossip or until recently in the print media. My work schedule at the department did not involve nursing women with unwanted pregnancies per se, but I had opportunity to observe these women as I collected and collated gynaecological data on the wards. Also my previous research (MPhil) gave me much insight into the problem of unsafe abortion.

As a person, I was not comfortable with the practice of induced abortion. I had been approached a number of times in the teaching hospital where I worked by women seeking abortion for direction to a place for the procedure. My spontaneous reaction then was to counsel them (though I am not a trained counsellor) against the procedure. I told them about the possible dangers of unsafe abortions and also made sure I always added my Christian perspectives. I wondered why women would let themselves get to the point of having unwanted pregnancies. My immediate reaction would be to advise a woman with an unwanted pregnancy against safe, legal abortion. I felt proud and very good about my action anytime I advised a woman against abortion, thinking I had done my Christian duty and God would be pleased with me. I would readily tell someone, especially a Christian colleague what I had done. I deemed it an achievement that would score me '*imaginary divine marks*'.

As a nursing student, I always refused to assist doctors to perform abortions in a private clinic where I once worked (on vacation) and did not even accept money offered me when I learnt it accrued from revenue from abortion cases. I remember being forced into theatre one day during an abortion, by my superior nurse at the clinic. She knew my attitude towards abortion and I believe she wanted to test me. Since I was not the only nurse in the theatre, I did practically nothing. I just stood

there bewildered and watched while various thoughts ran through me. The other nurses were cooperative with me. My attitude and behaviour were all due to my religious inclinations.

In the case of the women I saw on the wards undergoing treatment for unsafe abortions, I was judgmental with those who seemed well, who had no serious complications. These were all in my thoughts; I made no pronouncements since that would be professionally unacceptable. However for those who had serious complications, I had mixed feelings; '*anger*' and '*pity*'. Anger, because I asked myself why they had subjected themselves to such dangerous practices. I pitied them for the suffering they were undergoing. In my previous study, after my data collection, I cautioned them against unsafe abortions. In terms of research, I only had little knowledge about qualitative research and this was all theory not practical. I only had opportunity to analyze some open ended questions as part of a survey I carried out.

5.17.2 After the Study

This study has been an eye opener for me as an individual, a researcher, and a health provider. As a researcher, I have gained greater insight into qualitative methods and have gained more experience into qualitative research processes. I have gained deeper understanding of the qualitative terms and techniques which hitherto were mere words I had knowledge about. Now, I have had firsthand experience and when I use the terms, I really know what I am talking about. What I found intriguing and challenging was the process of analysis. Though daunting, iterative, time-consuming, laborious and seemingly a never-ending enterprise, looking back, I would say understanding the process and coming face to face with emerging themes and how they were interconnected was a wonderful experience. Sharing experiences with my supervisor and colleagues were moments I really enjoyed.

When I had not fully grasped the idea of the analysis process and was not sure of what I was doing, I felt frustrated and dejected (I even told one of my supervisors I wanted to cry and she asked me to go ahead and do it in order to feel freer) but when the '*eureka*' moment arrived, I was thrilled. I must say I have learnt a lot, though the hard way, for nobody will teach you qualitative analysis in a step by step fashion for

you to grasp the intricacies. It is a '*Do it yourself*' (DIY) endeavour but when you get it, it is a joyous moment. I have also learned that research findings need not be '*giant*' and '*spectacular*' to accentuate their credibility and acceptance. One needs to take cognisance of '*little*' findings since these may also be helpful to unravel the intellectual puzzle being resolved in the research.

As a nurse and health provider, familiarisation with the data taught me a lot. I have learnt not to be judgmental about patients. I have also learnt to put my personal convictions about issues aside and not bring them to bear on professional judgments and decisions. I now have a different attitude towards women with abortion complications and would do things differently if I need to be part of their care. Since I am not a trained counsellor, I would refer them to the experts for that purpose. I would be supportive and show understanding and empathy.

Before my study, I perceived induced abortion not as a crime, even though I knew the abortion law. I did not consider it as a crime. Personally, I thought any woman who had abortions was immoral, loose and bad. I also thought the providers of abortion were bad people in society - people to be shunned. This has been due to my Christian upbringing or socialization, beliefs and principles. This is also the norm in Ghana.

My thoughts and attitudes towards providers and especially users of abortion services have changed to some extent. With regard to the services, I am now a bit more comfortable with services being provided for women on medical grounds but I still have reservations concerning abortion on other grounds e.g. social grounds like academic pursuits. I would not however in anyway hinder a woman from obtaining the services if she says she needs them. I would not also object to making contraceptives available to all, even unmarried women. As a person, this study has influenced my threshold of patience in a positive direction. I have also learned what it takes to show '*compassion*' in a more meaningful way.

Lastly, having gone through this research and gained much insight into the plight of women with unwanted pregnancy and unsafe abortion, I have a dream. I wish to come up with a multi-disciplinary team which will include myself, another midwife,

two obstetricians, a lawyer, a clergyman and a cleric, (flexible group composed of people motivated to help) that would make a documentary on unsafe abortions and with the permission of heads of the institution, show this in secondary educational institutions, making room for question time and interaction with the students. This could constitute part of our work in the community as expected of those of us in the group who are university workers. It could also serve as a means of creating awareness among in-school youth. Little though this contribution may be, it will serve a valuable purpose.

5.18 My Role in the Research

I played a major role in this research undertaking. I designed the entire research with the guidance of my substantive supervisor. There were inputs from an advisory committee. During the fieldwork, I did all the interviews myself. I had wanted to transcribe all the interviews single-handedly, however, I could not for health reasons and thus sought the help of research assistants as a last resort. Analysis of the data and writing up was all undertaken by me with guidance from my supervisor and advisors.

CHAPTER SIX

THE LAW AND POLICY ON ABORTION IN GHANA AND RESPONSES TO THEM

6.1 Introduction

As noted in my literature review, the kind of abortion law and policy a country has, has been shown to influence access to safe abortion (Crane et al. 2006). According to AGI (1999), legality and safety of abortion usually coincide.

Drawing on document analysis and primary interviews, this chapter discusses first, the law which covers abortion in Ghana and then the policies through which the Ministry of Health has sought to operationalise the law.

As part of this study, my document analysis reviewed the law on abortion in Ghana and the national reproductive health service policy in order to illuminate the abortion situation in the country. The first (and main) part of this chapter presents the abortion law according to analysis of the relevant documents and describes its promulgation processes drawing both on document analysis and what respondents had to say about the law's development. It then describes respondents' knowledge, understanding and interpretation of the law, drawing on primary interviews but indicating the wide variation in understanding that underscores the ambiguity of certain parts of the law as it appears on paper.

The second part of the chapter discusses the national reproductive health service policy and standards. These are described with respect first to their contents and second to their knowledge and use among health providers.

The sources of data from which information was obtained for this chapter included '*The Criminal Code of Ghana*', '*The National Reproductive Health Service Policy and Standards*', '*The Prevention and Management of Unsafe Abortion: Comprehensive Abortion Care Services Standards and Protocols*' documents and primary interviews with respondents such as policy-makers, health providers (obstetrician/gynaecologists, pharmacists and midwives), parliamentarians, lawyers, journalist(s), clergymen and representatives of Development Agencies and NGOs.

6.2 The Law

6.2.1 The Law and its Promulgation

As indicated by some of the respondents who knew the law (e.g. obstetricians and lawyers) and confirmed by a review of the law document, the law on abortion in Ghana is not a stand-alone law. It is captured in sections 58 and 59 of the Criminal Code of 1960 (Act 29) as shown in box 1 below.

BOX 1 Act 29 Criminal Code, 1960

Suicide and Abortion

Abortion.

58. Whoever intentionally and unlawfully causes abortion or miscarriage shall be guilty of second degree felony.

Explanation as to causing abortion

59. (1) The offence of causing abortion or miscarriage of a woman can be committed either by that woman or by any other person ; and that woman or any other person can be guilty of using means with intent to commit that offence, although the woman is not in fact pregnant.

(2) The offence of causing abortion can be committed by causing a woman to be prematurely delivered of a child with intent unlawfully to cause or hasten the death of the child.

This was the law on abortion in Ghana until 1985 when it was amended by a military government, the Provisional National Defence Council (P.N.D.C.) led by Flight Lieutenant Jerry John Rawlings as chairman. The amended law was referred to as P.N.D.C. Law 102 which is shown in box 2.

The amended law of 1985 (Box 2) allows abortions in cases where the pregnancy is due to rape or incest and where the continuation of the pregnancy would be detrimental to the life of the pregnant woman or would be injurious to her physical or mental health. It also allows termination of pregnancies in cases of foetal abnormalities.

BOX 2 P.N.D.C.L. 102: CRIMINAL CODE (AMENDMENT) LAW, 1985

In pursuance of the Provisional National Defence Council (Establishment) Proclamation, 1981 this law is hereby made:

"The criminal code, 1960 (Act 29) as amended is hereby further amended by the substitution for section 58 and 59 thereof of the following new section -

"Abortion or miscarriage 58 (1): Subject to the provisions of subsection (2) of this section -

(a) any woman who, with intent to cause abortion or miscarriage and administers to herself or consents to be administered to her any poison, drug or other obnoxious thing or uses an instrument or other means whatsoever; or
(b) any person who-
i) Administers to a woman any poisonous drug or other obnoxious thing or uses any instrument or any means whatsoever with the intent to cause abortion or miscarriage of that woman whether or not the woman is pregnant or has given her consent ;
ii) Induces a woman to cause or consent to causing abortion or miscarriage,
iii) aids and abets a woman to cause abortion or miscarriage;
iv) attempts to cause abortion or miscarriage; or
v) Supplies or procures any poison, drug, instrument or other thing knowing that it is intended to be used or employed to cause abortion or miscarriage, shall be guilty of an offence and liable on conviction to imprisonment for a term not exceeding five years'

(2) It is not an offence under sub- section (1) of this section if an abortion or miscarriage is caused in any of the following circumstances by a registered medical practitioner specialising in Gynaecology or any other registered medical practitioner in a government hospital or private hospital or clinic registered under the Private Hospitals and Maternity Homes Act 1958 (No. 9) or in a place approved for the purpose by legislative instrument by the Secretary;

- a) where the pregnancy is the result of rape, defilement of a female idiot or incest and the abortion or miscarriage is requested by the victim or her next of kin or person in loco parentis if the victim lacks the capacity to make such a request ;
- b) where the continuance of the pregnancy would involve risk to the life of the pregnant mother or injury to her physical or mental health and such a woman consents to it or if she lacks the capacity to give consent, it can be given on her behalf by her next of kin or person in loco parentis; or
- c) where there is a substantial risk that if the child is born it may suffer from or later develop a serious physical abnormality or disease.

3) For the purpose of this section, abortion or miscarriage means premature expulsion or removal of conception from the uterus or womb before the period of conception is completed."

Made this 15th day of January, 1985.

FLT.-LT. JERRY JOHN RAWLINGS

Chairman of the Provisional National Defence Council

Source: PNDC. Law 102: The Criminal Code (Amendment) Law, 1985.

i. Promulgation of laws

According to interviews with politicians, lawyers and the researcher's reading of political documents, the process of law-making in Ghana can be identified.

Generally, laws are promulgated by the legislature. The request for a law can be initiated by the government, interest/pressure groups or private individuals. The process commences by experts or pressure groups lobbying the Minister about the need for a bill to address a problem at stake. The minister, when convinced, introduces the bill in parliament with an accompanying explanatory memorandum that outlines in detail the tenets of the bill and the need for its introduction.

The cabinet first reviews the bill and refers it to the ministry for more groundwork to be done. After this, the Minister officially writes to the Speaker of Parliament for permission to lay a paper in parliament on behalf of the government. The initial presentation of the bill is referred to as the first reading. The Speaker refers the bill to the appropriate parliamentary committee. The committee studies the paper in great detail, and as required by the Ghanaian Constitution, seeks wider public opinion on the issue and writes a report for members of parliament (MPs) to review.

The bill goes through the second reading during which its tenets are subjected to parliamentary debate alongside the committee reports. From parliament, it is sent to the Attorney General's Department for drafting purposes. Thereafter, amendments to the bill are proposed and it is further subjected to extensive parliamentary scrutiny and debate. This is known as the consideration stage. The bill is then read for the third time after which the Speaker signs and forwards it to the president for his assent. The bill only becomes a law when the president assents his signature.

The 1985 amendment of the abortion law in Ghana did not go through the above process because it was during a military era. The processes employed were not known to the public; they were not transparent, however future amendments would go through this.

The above description of the process of promulgation of laws was given by some respondents, mainly the parliamentarians and lawyers. This description is a very rational, linear process; however in reality it is not so linear. Although it is the

process eventually followed, there may be points at which it becomes more complex and may stall for a while as was the case of the Domestic Violence Bill.

6.2.2 The abortion laws of 1960 and 1985

According to the 1960 law, any woman or an accomplice who aids a woman to terminate a pregnancy is guilty of a second degree felony. Both parties are guilty of the offence once the intention is to evacuate the womb of its contents at such a time as to cause or hasten the death of the foetus. The law further states that even when the woman may not be pregnant, the offenders are still guilty if the intention is to get rid of the foetus prematurely in order to cause its death.

This implies that a woman who knowingly causes abortion or someone who assists a woman to cause abortion have both committed an indictable offence, higher in order than a minor offence or misdemeanour and render themselves liable to be charged with a crime that warrants trial by a jury.

According to the respondents who knew the law on abortion in Ghana, this law was derived from the British law. Although not explicitly stated in the law, the respondents mentioned that this law only allowed abortion in instances where the mother's life was at risk. They described the 1960 law as archaic and restrictive because it only allowed abortion when the mother's life was at risk, but noted that nevertheless the main purpose of the law was to protect women. One of these respondents, an old, senior policy maker and advisor who knew about the current law promulgated in 1985, the repealed law of 1960 and the history of abortion laws generally, explained:

"The 1985 law on abortion was a repeal of the one of the 60s which was patterned on the very old British law which at that time stated that abortion was only legal if it was done to save the life of the pregnant woman.

... Originally in 1861 or thereabouts when these laws were being made, they were made to save women. They were not made to punish them because surgery was in its infancy... anaesthesia was practically unknown, antiseptic was not there so infections and haemorrhage was killing women ...the only thing they could use to stop it was, enough - no abortion! True, the Christians were behind it like the sin complex I have talked about. But the major reason why governments passed the law was to save women".

Policy maker 1, age 84.

This indicates that in principle, the Ghana abortion law, like abortion laws of the mid 19th century, was made to protect women through prohibition. Ghana simply inherited the law and did not update it.

ii. The amended law of 1985

According to some of the respondents, the 1960 law needed amendment because it was restrictive. A senior clergyman indicated that efforts for the amendment were initiated in the early 70s; during the administration of a military government, the Supreme Military Council. He did not mention who initiated the efforts for the amendment. However, he said the leader of the then government refused to sign the abortion bill into law:

"The 1985 law in Ghana was presented to General I. K. Acheampong and these are the words he said ... I will quote it in 'twi': (a Ghanaian dialect)

"Bone, medi ninyinaabi da; na nkwaadaa mogya, nmotofrowa mogya a yen wuu woomu dei minfa nka me bone hu".

What he said amounted to the fact that, I have done all evil before but I will not sign the death of unborn children and have their blood upon me".

Clergyman 9, age 60

The words of the military leader above (quoted by the clergyman) explained how he regarded abortion. He regarded abortion as a sin that called for God's judgement upon the individual who commits it. His refusal to assent his signature was to avoid God's judgement. This view was shared by many of my respondents as discussed later in the chapter.

The amendment of the Ghana law of 1960 was effected in 1985 by another military government, the Provisional National Defence Council. Respondents who knew the law (See Table 6.1 in section 6.2.4 below) described how the 1985 amendment was finally achieved. In 1985, an obstetrician/gynaecologist who worked in one of the teaching hospitals in the country led a group of doctors to fight for the amendment. The respondents explained that probably this doctor's day-to-day clinical work in the hospital as well as studies he had conducted on abortion motivated him to lead a campaign for an amendment. The respondents did not have much information about

how the amendment was done or the processes the law went through perhaps because it was a military era and the processes were less transparent.

The amended law of 1985 renders a woman, an accomplice or an abortionist who attempts to cause or causes an abortion guilty of an offence and liable on conviction to at most five years prison sentence. The law however, further indicates that it is not an offence if the abortion is caused by a qualified medical practitioner in a properly registered facility (public or private if: i) the pregnancy resulted from rape, ii) the continuation of the pregnancy would be risky to the life of the pregnant woman or injurious to her physical and mental health and iii) the foetus is likely to be born with serious foetal abnormalities (PNDC Law 102). The respondents maintained that this law considerably expands the conditions under which abortion is legal and was passed to save women's health.

6.2.3 Dissemination and discussion of the law

According to some of the respondents, (obstetrician/gynaecologists, policy-makers, lawyers, journalist and midwife) the Ghana law on abortion of 1960 and the amendment of 1985 have all been inadequately discussed or disseminated. Both laws were described as '*'silent'*'. Some reasons were given for this. According to one respondent, a policy-maker, the government might have kept quiet about the law in order to avoid confrontation with religious groups:

"... when this law (PNDC Law 102) was passed by the military, whether it was because they were fearing the opposition of the Catholic Church I don't know; but they passed it and they didn't make any noise about it at all so it took some of us a while before we realised that this thing had been done."

Policy-maker 1, age 84

Other respondents (obstetrician/gynaecologist (1), trainer in medical institution (1), a lawyer (1) and a journalist (1) cited instances where the amended law had been discussed and disseminated in the recent past. According to the medical trainer, a symposium was held by the Ghana Medical Association (GMA) in collaboration with Ipas (an NGO) in Kumasi (a Ghanaian town) in 2005 where abortion and the law were discussed under the theme: '*Abortion in Ghana: The hard facts and the way forward*'. He also cited a publication of the abortion law in the Ghana Medical Journal (which I found to be in the September edition; 1987 volume 21 pages 47-48).

Efforts to obtain a copy of the workshop report from the office of the Ghana Medical Association were not successful. The fact that the report was not available shows that dissemination was not very good.

The journalist and lawyer spoke of a one-day sensitization workshop on '*Unsafe Abortion*' in Accra organized by the African Women Lawyers' Association (AWLA) in cooperation with the African Alliance for Women's Reproductive Health and Rights. The aim of the workshop was to equip health professionals, police officers, media practitioners, religious and traditional leaders with basic information on abortion and also lobby for gender equality through legislative reform, public education and advocacy. Details of this workshop were published in the 24/05/05 edition of '*The Mirror*', a local Ghanaian paper. The title of the publication was: '*Female lawyers' group demands safe abortion services for women*'.

At both the above events, presentations were said to be made by legal, medical and other experts on abortion and the law. There was a call on health providers to help dispel the notion that abortion is an illegal practice that would lead to prosecution. Communities were also called upon to be supportive of abortion victims and the GHS was urged to put in place structures to equip healthcare facilities in the country to provide safe, legal abortion services to reduce maternal mortality resulting from abortions in order to save women's lives.

The obstetrician/gynaecologist cited a recent publication on the abortion law authored by a female lawyer. This was a 20-page handbook entitled '*The legal and policy framework on abortion in Ghana, a handbook for practitioners*'. The book outlined the legal understanding of abortion and highlighted the requirements to be met for the performance of abortion in Ghana. It also discussed implementation of abortion laws and the problems with abortion laws. The book enhances understanding of the abortion law and facilitates its practical application by health providers.

These findings indicate a change of mood towards abortion by the GHS, medical practitioners, lawyers and even journalists, all concerned with detrimental effects of unsafe abortion on women's health. According to the journalist who was interviewed

for this study, many journalists hitherto had been reluctant to write on abortion for fear of public outrage. The seminars by the Population Reference Bureau which exposed them to the realities of unsafe abortion in hospital situations where they had opportunities to see and talk to women (on admission with abortion complications), served jointly as an impetus and eye opener that encouraged journalists to start publishing on abortion issues without as much inhibition as before. The increasing openness in public debate and advocacy initiatives explain the many articles on abortion in the local papers some of which are presented in chapter two.

6.2.4 Knowledge of the Abortion Law

Knowledge of the law on abortion varied among respondents (see Table 6.1). Those who knew all the sections of the law were categorized as having much knowledge. Those who did not know all the sections were described as having some knowledge. Some respondents only knew that abortion is illegal in Ghana. These were categorized as having little knowledge about the law. The fourth category comprised those who knew nothing about the law. This category did not know about the existence of a law.

It is encouraging to see not only policy makers and lawyers have quite good knowledge but also that obstetrician/gynaecologists are highly knowledgeable too. On the other hand, pharmacists and middle-level cadres of health providers (midwives & midwifery trainers) had poor knowledge as did most of the Clergy. This clearly shows there is more room for improvement of all practitioners' knowledge about the abortion law.

Table 6.1 Respondents' Knowledge about Abortion Law

Respondent Type/ Knowledge	Much Knowledge n (%)	Some Knowledge n (%)	Little Knowledge n (%)	No Knowledge n (%)	Total n (%)
Obstetrician/gynaecologists	14 (18.4)	-	1 (1.3)	-	15(19.7)
Midwives	2 (2.6)	1 (1.3)	4 (5.3)	7 (9.2)	14(18.4)
Pharmacists	-	3 (3.9)	4 (5.3)	-	7 (9.2)
Trainers in Med/Midwifery Inst.	-	2 (2.6)	2 (2.6)	1 (1.3)	5 (6.6)
Researcher	-	-	1 (1.3)	-	1 (1.3)
NGO Representative	1 (1.3)	-	-	-	1 (1.3)
Policy-Makers	4 (5.3)	3 (3.9)	-	-	7(9.2)
Representative of Dev. Agency	1 (1.3)	-	1 (1.3)	-	2 (2.6)
Lawyers	2 (2.6)	-	-	-	2 (2.6)
Parliamentarian	-	3 (3.9)	2 (2.6)	1 (1.3)	6 (7.9)
Journalist	1 (1.3)	-	-	-	1 (1.3)
Clergymen	-	2 (2.6)	6 (7.9)	5 (6.6)	13(17.1)
Muslim Clerics	-	-	-	2 (2.6)	2 (2.6)
Total	25 (32.8)	14 (18.4)	21 (27.6)	16 (21.0)	76 (100)

The respondents who knew the law in detail and those who had some knowledge about the law held various views and interpretations about it. These are discussed below.

6.2.5 Views and Interpretations of the law

The views and interpretations of the law appeared to be greatly influenced by the stance of the individual on abortion.

There was an array of views and interpretations of the abortion law based on the respondents' understanding of the law and individual stance on abortion. These views can be categorised into four main types: liberal-positive, liberal-negative, restrictive or ambiguous.

i. Law as liberal: Positive views

Some respondents described the abortion law as reasonable, clear, elastic, fair and excellent. Altogether, 14 respondents described the abortion law as liberal.

Some respondents think the law is liberal because it allows abortion in cases of rape, incest, foetal abnormality, physical and mental ill health of the mother. Some indicated that the physical and mental health clause in the law offers an opportunity for women to procure abortions within a wide scope. The respondents who knew the law also mentioned that the law requires only one doctor for the decision to terminate a pregnancy to be made. They indicated that the law does not require proof of rape or mental illness. These, in their view lessen the requirements for procurement of abortion, making it more accessible:

“.....very liberal... you can do a lot within the confines of the law. Those of us who are in favour of provision of safe abortion because of the problems of unsafe abortion we have seen, think we can use the mental health of the woman; like, the woman comes to say if I carry on this pregnancy, I will commit suicide... So we can capitalize on those aspects...physical or mental health of the woman... you need only one doctor; you don’t need several doctors like in other places; once the woman says; I want an abortion and you think that the physical or mental state is not conducive..... it is liberal; the only thing is that people don’t know the law”.

Obstetrician 4, age 42

The interview clearly showed that this respondent is pro choice. It was also apparent from the interview that he has been influenced by his experience at work with women with complications of unsafe abortion. He identified the mental health clause as a window of opportunity to offer safe abortion services to women and believed that the clause renders more women eligible for the procedure. He perceived lack of knowledge about the law by the general public as a drawback to access and provision of the service.

Another respondent said:

“The law is very liberal... any doctor can perform an abortion. It doesn’t restrict the time duration. You can perform an abortion at seven months if you think it will cause jeopardy of the mother. It puts all the power in the hands of the doctor. That is the law on abortion in Ghana. The law is very liberal and you wonder why we have unsafe abortions in Ghana”.

Obstetrician 3, age 38

This respondent also perceived the law as liberal because there are no restrictions in the law as to the category of medical officer who performs the procedure. It may be any medical officer, whether he has specialized in gynaecology or not. In his view, since the law does not put gestational limits as to when abortion can be done, one can terminate pregnancies to gestations as far as seven months. He might have used this gestational period (28 weeks) because by the code of practice of obstetrics and gynaecology in Ghana, a foetus is considered non-viable outside the womb until it is over 28 weeks or seven months old. The respondent also attributed the liberality of the law to the fact that only the attending medical officer is required to take the decision once a woman seeks abortion. He seemed frustrated that despite all this, unsafe abortions are still common.

Some respondents regarded even the provision of abortion for rape among other provisions as liberal whereas the mental health clause was only recognized by a few (e.g. obstetricians 4, 13 and policy-maker 2) as being the truly liberal provision. This is the liberal clause that more restrictive laws do not have.

ii. Law as liberal: Negative views

Liberality also has its detractors and two respondents (all Catholics) saw the law as '*pernicious*' and '*excessively liberal*' and opposed it:

"...It is sad that it was signed by another head of state in 1985; I am aware there is a law. We don't talk much about the fact that it has been signed into law. We try to help people avoid coming to the point where they may say they have a legal right because we believe that a legal right is only a legal right if it is not infringing divine law."

Clergy man 9, age 60

The quote reflects the clergyman's sentiments about the abortion bill that was signed into law by one of Ghana's military leaders (P.N.D.C.). He appeared to agree with the previous military leader of the Supreme Military Council (S.M.C.) who refused to sign it and registers his displeasure about the second military leader who signed the bill into law. He cited the quiet disposition about the church and the Ghanaian public about the law and efforts of the church to ensure that members of their congregation do not demand abortion based on its legality. He desired that church members would perceive abortion in the church's perspective as sin and not commit

it because it is legal. He was of the view that abortion could only be termed legal if it did not violate God's laws.

One of the obstetricians noted:

“... the law we have in this country is too wide. There are no safe guards to the clauses... there is no provision in the law that requires that the woman must have reported the rape before; where is my guarantee? The woman comes to me that she was raped, three months ago. Where is the proof? Do I just accept what the patient is saying? That is a flaw. The worst part of our law is the period of gestation. There is no limit. As far as the woman has not delivered, you can terminate the pregnancy. Where in the world do you get this type of law? The law needs a serious review. The law was never discussed and many of my legal friends did not know the law existed. How it was passed; many of us don't know. But it is there on the statute books. The Ghana Medical Association recently published it in its journal... There are serious flaws in that law that need to be looked at because one can bend any situation into the law”.

Obstetrician 15, age 66

Both respondents are Catholics. Their attitude to the abortion law is therefore not surprising. Discussions on attitudes about abortion by the various categories of respondents in one of the subsequent chapters (chapter eight) will describe the stance of the various denominations including Catholics. Obstetrician 15 is well known for his stance on abortion and some obstetricians I interviewed suggested that I interviewed him as well. He was also referred to in one of my interviews with a parliamentarian and although his name was not mentioned, I knew he was the one being referred to. This fore knowledge is because I have worked under him as a research assistant and had once before interviewed him on abortion. In the interview for this study, he stated that if proponents of safe abortion gear towards abortion on demand, they would mount platforms to oppose it if the need arises.

iii. Law as Restrictive

Two respondents described the law as restrictive. They attributed its restrictiveness primarily to its inclusion in the Criminal Code of Ghana:

“... It is the fact that the abortion law has been put in the Criminal Code... A lawyer said the fact that they have put it in a Criminal Code means it is a crime unless it is done under some provisions... a lawyer gave that interpretation”.

Obstetrician 13, age 40

Another fact that makes the law restrictive in their view is the requirement for the service to be provided only by medical practitioners.

In the case of the respondents who described the law as neither restrictive nor liberal, once abortion cannot be obtained on demand, they explained that it cannot be described as liberal. In their view, the law is not restrictive *per se*, because abortion is permitted under certain conditions:

"... It's not liberal in the sense that if you are pregnant it's not open that you'll go and knock on a doctor's door (knocks on his table twice) and say I am pregnant I don't like it, I want you to terminate it for me. I don't think the law allows that. And it's not too restrictive because the indications are not closed. If really you have a problem with the pregnancy and it is assessed that indeed there is a problem, by the law you should be offered the service ; as I said because people don't know they don't open up for the service. "

Obstetrician 10, age 40+

6.2.6 Ambiguities in law and its interpretation

Some of the obstetricians, policy-makers and one lawyer described the abortion law as one with many loopholes and grey areas thus making it ambiguous. In their opinion, the law did not define many things which ought to have been defined for purposes of clarity. These included the gestational limits for the procurement of abortion, the need for proof of rape, the nature of risk to mother's life for which abortion is allowed, what constitutes physical and mental health and who a medical practitioner refers to.

According to some of the respondents, (Obstetricians, policy-makers, lawyers and a journalist), the inclusion of abortion in the Criminal Code criminalizes the procedure and renders it an offence while in their view abortion should be regarded solely as a health or social issue and not a criminal one. Some obstetricians and a lawyer had observed that the ambiguities in the law made it difficult for medical practitioners to interpret and apply the law (discussed in Chapter 7). This is further exacerbated by the fact that, as a lawyer noted, only a few cases have been tried in the courts of law thus making implementation of the law largely untested. The fact that in over two decades of amendment of the 1960 law, only a few cases have been brought to court suggests a '*de jure*': '*de facto*' difference in the law and its interpretation. The main

problem is not criminal convictions but too few people accessing safe services partly because obstetricians are unclear of their legal ground as the quote below shows:

"There is some confusion within the profession. Because the law does state that only doctors may provide the service, many doctors are not sure; they don't know and are not certain whether they are covered or not. I have heard the opinion expressed that since I am a doctor, I can do it but supposing the police drag me to court; the MOH is not going to support me to say it is part of the policy of the MOH that abortion under the conditions specified in the law may be provided by a qualified medical doctor; so I am left out there and because I am not certain what will happen to me , I would rather not do it".

Obstetrician 6, age 70

The quote describes the nature of the issues that surround implementation of the abortion law. In the respondent's view, even though the law allows doctors to provide abortions, the doctors are not sure and do not know whether they have the support of the MOH in case they get into trouble with the law and have to face prosecution. Due to this uncertainty, some doctors choose not to offer the procedure.

One obstetrician/gynaecologist mentioned that he had had encounters with the police which made him believe that the police force do not know the law on when abortion is legal:

"The public are unaware of the law. Even the Police who have to implement the law are unaware of the law. There are instances where Police have come to the hospital looking for patients whose mothers have come to report that their children have gone to a clinic and had termination of pregnancy and you begin to realize that they are not aware of the law. Because it is done in a registered premise by a registered doctor and the patient develops a complication that does not warrant an arrest of the patient...the powers that be are not even aware of the law".

Obstetrician 3, age 38

Lack of knowledge about the law among Ghanaians was an issue that came up in most of his quotes. In another quote he noted:

".. they don't even know the law, let alone interpret it. I got to know the law when I was writing the post graduate exam last year when I have been practising for the past 7-8 years".

Obstetrician 3, age 38

The respondent did not see how people could interpret a law they did not know about, knowledge of the law being a pre-requisite to its interpretation, and his own experience indicates that people often do not read things that they think they do not need, particularly laws that they think do not affect them. Obstetrician 3 and a few of his colleagues mentioned the conditions under which safe abortion is obviously not covered in standard medical training, which is perhaps surprising. For instance they mentioned that lecturers against abortion will not teach it even though it is in the curriculum.

In the interview, obstetrician 3 also made an important observation. He maintained that in Ghana, laws do not work. In his view, Ghanaians live according to norms. This observation signifies that in Ghana laws are not strictly adhered to and that the Ghanaian society is run by norms. This may also explain why abortion cases are hardly prosecuted. During my fieldwork, I read an article (20/12/03 issue of '*The Mirror*'), I found in the archives of one of our press houses about a woman who was sentenced to 10 years imprisonment for having had an abortion. The woman was imprisoned following the Magistrate's ruling but the case was quashed and the woman was acquitted and discharged through the efforts of some law students and a practising female lawyer. The case was quashed because ironically, the Magistrate was presumably not very conversant with the law and gave the wrong sentence of 10 instead of 5 years. The lawyers thus used this loophole to get the woman freed. This incident shows that there are lawyers who are prepared to challenge prosecutions.

6.2.7 Perceptions of legality

The ambiguities observed in the law and its untested nature gave rise to a wide range of interpretations from illegal to legal. Respondents' attitude to the abortion law and the interpretation given to it depended to a large extent on their stance on abortion. This is taken up again in Chapter 8 and discussed in detail in Chapter 9. The respondents who held views against abortion also perceived abortion as largely illegal. They usually referred to section 58, sub-section 1 of the law which describes abortion as a criminal offence. Most of them were silent on the exemptions. The only exemption cited was risk to the mothers' life (i.e. the 1960, pre-amendment law). This, in their view, was the only reason for which abortion could be permitted as a

last resort. A few emphasized that even in cases of rape, incest or foetal abnormality, the pregnant woman could be counselled to deliver the baby.

On the other hand, the respondents who were for abortion described it as legal for the cases prescribed by the amended law. Emphasis was put on section 58; sub-section 2, which highlights the exemptions. The respondents who were in favour of the provision of safe abortion services perceived the law as one that offers them a wide range of options for provision of the service. The mental health clause was identified by some respondents as one that allows abortion within a wide scope. A few respondents, mainly obstetrician/gynaecologists, thought that they could work within the confines of the current law because it is relatively unspecific. They did not see the need to initiate debate for any change in the law now for fear that it might backfire and lead to the law being made more restrictive:

"the consensus is that we should leave the law alone now. We can do so much within the law so there is no point going to say that it should be done like the South African one; we can still work within the confines of the law. We don't want to touch it because if you rock the boat now, it's likely to backfire. We are likely to get it being more restrictive".

Obstetrician 4, age 42

In the interview, this respondent identified further avenues where the law could be employed to offer abortion and thought it was premature to ask for a change in the law. Another respondent, a representative of an international NGO perceived the law as excellent and clear enough to be used to offer safe abortion services to women who need it. According to him, ambiguities are seen by those who want to see them and who have particular reasons to present these as obstacles whereas they might not necessarily be obstacles. In other words, ambiguities are being used by some as excuses for non provision of the service when they are against abortion.

6.2.8 Perceptions of needed future changes in the law

Even though most of the obstetricians were content to work with the law for now, they expressed the need for further clarification in future. They called for a more detailed law in future since they thought the current law is not explicit enough and thus liable to multiple interpretations by those for and against abortion, making doctors and other medical staff nervous about providing abortion services.

There was some controversy surrounding the term '*medical practitioner*' in the law. Hitherto, the term had been solely interpreted as a medical doctor. Now, some of the obstetricians mentioned that the term now covers midwives. This may probably be due to the fact that the GHS protocol and guidelines published in 2006 allow midwives to offer comprehensive abortion care at various levels of healthcare delivery.

One respondent, a professor in law, however indicated that this definition of medical practitioner, viewed as including midwives, was a fallacy and could get midwives in trouble if they started providing abortions without a legal mandate or cover. According to her, the issue needs to be sent to court by the midwives for the court to decide whether midwives are covered. It appears the term '*medical practitioner*' has not been clearly defined by MOH or the government. In my analysis of the GHS standards and protocols for CAC, I did not find any definition of the term. The document only indicated the roles of midwives and the levels where they are to play those roles. The omission of clarification of the term has raised some questions. This issue will further be raised in the discussion chapter. A respondent, a representative of the Nurses and Midwives' Council expressed much concern and called for clarifications to be made before midwives were trained for providing CAC. This clarification would pave the way for providers who would want to offer the service to be able to do so legally under the protection of the law.

The need was expressed by some respondents for the law to indicate gestational limits for abortion. This omission was perceived by some respondents as inhumane as it could lead to abortions being done any time before delivery. It may allow late abortions which could be detrimental to women's health. One of the respondents, a lawyer however, clarified that another section of the Criminal Code, refers to termination of pregnancy above six months as a crime known as child destruction. Thus a gestational age of less than 6 months is implied in that part of the Criminal Code, hence its omission from the section on abortion. Such cross-referencing between legal codes is not helpful for medical professionals and, as noted earlier, led to a variety of interpretations about the gestational limits. Even the lawyers interviewed did not agree on the legal limits, indicating the level of ambiguity.

Another area of the law where some respondents expressed the need for a change is the requirement for only one doctor to verify the need for abortion. Even though most of the obstetricians who were in favour of abortion thought it was good, a few thought it provided an inadequate assessment of the situation and allowed abortions to be done too easily. Reference was made to the UK law's requirement that two doctors verify the need.

Although the amended law is largely an improvement on the earlier one, there are still many issues that need to be clarified or amended in the long term. The document analysis showed that the law allows abortion where there is defilement of a 'female idiot', but does not cover other vulnerable groups, such as minors (girls under 16 years). In addition, the term 'female idiot' could be replaced with a less derogatory term such as 'mentally challenged'. In the section that follows, the abortion policy is described and discussed.

6.3 The Policy

6.3.1 The evolution of the national reproductive health service policy and standards documents

The National Reproductive Health Service Policy and Standards was first published by the MOH in 1996. The purpose of the document was to offer direction and focus to organizations that provide reproductive health care throughout the country. It was to guide training in reproductive health as well as service provision; serving as a framework for future development (MOH 1996). Analysis of the policy document showed that it covered safe motherhood in great detail highlighting important components such as antenatal care, supervised delivery, postnatal care, family planning, post abortion care and health education. The strategies outlined included provision of essential obstetric care, ensuring skilled attendance at labour and delivery as well as equipping traditional birth attendants (TBAs) and other community health workers with skills and tools to render quality service to mothers and children. However, there was no comprehensive strategy for reducing maternal mortality. This represents a major omission given the high maternal mortality ratio in the country. The 1996 policy also did not have programmes on unsafe abortion, prevention and management of cancers of the reproductive tract, adolescent health

and prevention and management of harmful traditional practices. This narrowed the scope of reproductive health services available to the Ghanaian populace and compromised their reproductive rights, health and wellbeing.

In 2003 the need arose for a policy review to address these important omissions and to incorporate some changes in approach to care, such as the shift from the risk approach in safe motherhood, the newly introduced refocused antenatal and postnatal care services, adolescent and male friendly services. Some new sections on maternal mortality, sexual health and gender-based violence were added to the 2003 edition.

This document is in two parts – The first part (Part 1) covers the reproductive health service policy. It is divided into twelve sections under which the reproductive health service components, training, management information systems, quality assurance and other issues such as sexual health are discussed. A few of the sections relevant to comprehensive abortion care are now highlighted. In section one, reproductive health was defined as ‘a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity in all matters related to the reproductive system and its functions and processes’ (ICPD 1994). Nine service components of reproductive health care were outlined in section two. These were:

- Safe motherhood
- Family planning
- Prevention and management of unsafe abortion and post abortion care
- Prevention and management of reproductive tract infections (RTIs), including sexually transmitted infections (STIs) and HIV/AIDS
- Prevention and management of infertility
- Prevention and management of cancers of the female and male reproductive system, including the breast
- Responding to concerns about menopause and andropause (male climacteric)
- Discouragement of harmful traditional practices and gender-based violence that affect the reproductive health of women and men
- Information and counselling on human sexuality, responsible sexual behaviour, responsible parenthood, pre-conceptional care and sexual health.

These components undoubtedly covered a wider area compared to the policy of 1996. Each of the above components was exhaustively outlined; the objectives of care, the strategies, activities, target groups and beneficiaries, the providers at each level of care were highlighted. Under the component ‘family planning’, two important cautions emphasized were that emergency contraception should not be promoted as a regular family planning method and abortion should not be used as family planning. These cautions help put family planning in its correct perspectives, in line with ICPD principles.

Six objectives were outlined under the component, ‘prevention and management of unsafe abortion and post abortion care’. These included prevention of unwanted pregnancy through family planning counselling and services, providing abortion services in accordance with the law, managing and referring abortion complications, linking post abortion care to other related healthcare services, creating awareness on the dangers of unsafe abortion and educating clients on the complications of unsafe abortion. However, there was no objective on educating the public regarding where or how to obtain safe, legal abortion. Women who are ignorant of where to obtain safe services may resort to unsafe abortions putting their lives in jeopardy. This constitutes a violation of women’s constitutional rights to information.

Under Part 1, Section 6 of the 2003 policy document, training (pre-service and in-service) of reproductive health service providers was outlined. The scope of training was wide, ranging from safe motherhood, family planning, adolescents and their needs, gender issues, sexual health, management of unsafe abortion to post abortion care and counselling. Such training would better prepare providers to support their patients.

Section 9 highlighted ‘management information systems’. Under ‘abortion management’, information to be documented included the proportions of unsafe abortion cases seen, clients provided with manual vacuum aspiration, post abortion care clients accepting a family planning method and proportions of admissions for abortion-related complications. The correct documentation of such records and their

proper management will ease the difficulties that researchers face in obtaining data on abortion. It will also promote and facilitate abortion research.

Under Section 10 which covers ‘quality assurance’, special attention is to be paid to client-provider interaction, counselling for informed choice/decision, privacy and confidentiality and effective referral systems. Ensuring optimum quality in these areas in abortion care cannot be over-emphasized. Poor quality of care results in women seeking care from people and places that are not safe. This undermines their health and puts their lives in danger. Efforts to reduce maternal mortality and to realize MDG 5 are therefore compromised.

Part 2 of the document covered reproductive health service standards. It highlights various activities to be performed, the eligible health providers for each activity and the level of service delivery. Under prevention and management of unsafe abortion and post abortion care, the activities ranged from history taking, resuscitation, referral, MVA provision to family planning and counselling. The providers included TBAs, community health officers (CHOs), midwives, medical assistants, medical practitioners, and obstetricians. The reproductive health standards distinguished between midwives (MWs) and medical practitioners (MPs). The standards permitted medical practitioners to provide MVA at all levels where they worked, such as the district, regional and teaching hospital levels. Midwives were only permitted to provide MVAs at the sub-district and district levels but not at the regional and teaching hospital levels. However, when the comprehensive abortion care standards and protocols was developed in 2006 it permitted the midwife to provide MVAs at all levels. There is need for clarification of some inconsistencies. The law indicates that eligible providers of abortion are ‘medical practitioners’ and the term ‘medical practitioner’ in the law invariably refers to doctors. Since the CAC policy standards and protocols (GHS 2006) permits midwives to provide abortion, there is need for future amendment in the law about the eligible providers to safeguard midwives from legal issues when they provide abortions.

The interviews confirmed review of the first edition of the policy document in 2003 and highlighted some factors that motivated it. The review reportedly became

necessary due to changes in society as well as in strategy and approach in some of the components of reproductive health. Another impetus for the review according to some respondents, may have originated from the endorsement of the need for safe abortion in recent years by conferences and organizations including the International Conference on Population and Development (ICPD)-1994, the Fourth World Conference on Women in Beijing - 1995, the International Federation Of Obstetrics and Gynaecology (FIGO) and the Confederation of African Medical Associations and Societies (Hessini et al. 2006).

A call by the WHO on governments and health systems to provide safe abortion services where permitted by law and the provision of technical and policy guidelines by the organization for health systems could also have served as a driving force (WHO 2003). The final motivation cited for the policy review was a meeting organized by Ipas (an international NGO) for African Ministers of Health in Addis Ababa, Ethiopia in 2003 and attended by some Ghanaian health officials which urged all countries represented to come up with pragmatic ways of reducing high levels of unsafe abortion and maternal mortality.

The 2003 review of the policy was conducted by a group of stakeholders, including obstetrician/gynaecologists in the public and private sector, policy-makers, midwives and lawyers. According to policy-maker 2, the need for the change was identified by the MOH. A multi-disciplinary group of experts was then formed. The group met, deliberated on the first edition and sought a wider public opinion (via a survey with sections of the population) on what society needs with respect to reproductive health. The WHO technical and policy guidelines for provision of safe, legal abortion were employed. Even though the provision of abortion services was identified as necessary, its inclusion in the document was not welcomed by all stakeholders.

Two female respondents, an obstetrician/gynaecologist and a lawyer, active in the review process indicated that they had to insist on the inclusion of a clause allowing the provision of safe, legal abortion services in the new document since the previous document only focused on the provision of post abortion care. The quote below describes the political sensitivities of ensuring the inclusion of abortion and provision of safe, legal abortion services in the policy document:

"...It wasn't in the previous one... when we were writing the policy, the issue of termination of pregnancy was...a-c-t-u-a-l-l-y rejected!... when people were talking about safe motherhood, it was not one of those areas they wanted to talk about until it became a thing that it's a big topic which accounts for nearly a quarter of your deaths so if you don't do anything, you can't reduce your maternal deaths so everybody is beginning to realize that it's a subject... the first policy didn't talk about it ...but the latest review has included termination of pregnancy within the limits of the law. A protocol has recently been developed to facilitate the process of safe abortion".

Obstetrician7, age 40+

The omission of abortion in a national document on safe motherhood and a reproductive health policy document is significant. Why would such an important reproductive health issue be left out in two important documents? It may be an indication of a subject people would rather not discuss, at least publicly.

The obstetrician further described her behaviour at the meetings where she raised issues on abortion as '*naughty*' because of how the issue of abortion is perceived in the country, even amongst medical professionals. Nobody wants to talk about abortion. However, she said she insisted despite the rejection, that abortion had to be included in the documents and this was eventually done, though against the wish of some of the team members.

According to the female lawyer, some stakeholders were surprised when they saw an objective allowing safe abortion to be provided in the draft policy document. This clearly indicates how strong peoples' emotions are concerning abortion. They may agree in principle but not in practice. Even though the policy document was reviewed in 2003 to include an objective on abortion, there was no accompanying document to spell out the standards until 2006 and dissemination of the 2003 policy document has been poor. One policy-maker in the MOH partially admitted this and attributed the shortcoming to the problem of logistics and poor dissemination procedures. She mentioned that they were yet to identify the best and most effective mode of dissemination of the documents to the districts and health facilities in the periphery.

Most of the respondents working in obstetrics and gynaecology, who were expected to have copies, did not have copies within easy reach at the time they were interviewed. The majority of the midwives, in particular, did not have copies (mirroring their poor knowledge of the law).

The CAC standards and protocols document was developed by the Ghana Health Service in 2006 in collaboration with the WHO and Ipas. It is a 75-page document entitled '*Prevention and Management of Unsafe Abortion: Comprehensive Abortion Care Services. Standards and Protocols*'. The GHS, the author of the document recognize the high and unacceptable levels of maternal mortality and morbidity and the urgency of addressing these issues in order to meet national and international goals. In this regard, the GHS expressed the need for safe abortion services in response to the review of the National Reproductive Health Policy and Standards in 2003, which added an objective on safe abortion.

The purpose of the document was to facilitate the provision of CAC in order to reduce maternal morbidity and mortality from complications of unsafe abortion. It offers guidance and direction on interpreting the abortion law (GMHS 2007). The document provides step by step guidance and direction to health providers and service managers on the practicalities of providing CAC services, namely who should provide services, how the services are to be provided and in which facilities (GHS 2006).

It has twelve sections. The first section gives an overview of the services, stating the purpose and objectives of CAC in Ghana. The section also discusses the essence of CAC based on commitment by the international community at ICPD (1994) to address the problem of unsafe abortion. Furthermore, the principles that guide implementation of CAC services were highlighted including issues pertaining to rape, mental health and conscientious objection, some of which were not clear in the law. Women who require abortion services are to have access to these services and be assured of privacy and confidentiality. This is important because lack of privacy and confidentiality is one issue of concern in quality control in public hospitals in Ghana which makes clients who can afford services in private hospitals seek care there instead. Women who do not have the means may resort to unsafe services.

These were important issues identified in the literature as well as in the interviews for this study.

Another important feature of this section was an outline of the circumstances under which abortion is permitted in Ghana. Placing the indications for legal abortion at the beginning of the document is essential. This makes them prominent and affords health providers the opportunity to study and be knowledgeable about the conditions for which abortion is permitted in Ghana. When the standards and protocols are properly disseminated and available, trained health providers who have the necessary resources to provide abortion services can be held accountable if services are not available.

Contrary to the definition of abortion provided in the abortion law (which implicitly permits abortion until the end of gestation), the standards and protocols defined abortion as the loss of pregnancy before the foetus is viable; putting viability in Ghana at 28 weeks of gestation and not at the end of gestation as the law indicated. As mentioned in the discussion on the law, there is need for the definition of abortion in the law to be altered in line with that in the Standards and Protocol to ensure uniformity. The definition of abortion in the standards and protocol conforms to sound obstetric practice (GHS 2006).

The document outlined six objectives for comprehensive abortion care. These were:

- prevention of unwanted pregnancy through family planning services;
- ensuring the availability, accessibility and affordability of safe abortion services;
- helping women make free and informed decisions about their pregnancy;
- reducing deaths from abortion complications through effective management and referral;
- integrating abortion services into other sexual and reproductive health services was another objective cited. This objective is essential as it would help dispel the stigma that goes with stand-alone abortion services;
- reducing morbidity and mortality arising from unsafe abortion through public education on the availability of safe abortion services and dangers of unsafe abortion.

Assessments carried out by the GHS (2005) revealed problems with provider and public attitudes towards abortion. Another factor identified that militates against abortion service provision was the strong religious Ghanaian context. It would have been expedient therefore if the objectives had included efforts to improve provider and public attitudes towards abortion given the strong religious and moral stance against abortion in the country and its influence on provider attitudes. Dialogue, public discussions and values clarification were cited in the interviews as good measures for this purpose. An objective towards making services acceptable was also lacking. Given the social norms (e.g. the value of children) in the Ghanaian context and how these norms prohibit abortion, this measure is crucial and constitutes a major omission for, the norms may lead women to avoid using safe, legal abortion and instead use more ‘secret’ unsafe methods. This omission constitutes a violation of the ‘Right to Health’ (Lithur 2003). This is one of the rights contained within ‘the International Covenant on Economic, Social and Cultural Rights (CESCR). This right requires that healthcare services are available in sufficient quantities that services (including information) are physically and economically accessible to all without discrimination and that services are respectful of the cultures of communities, scientifically appropriate and of high quality (Teklehaimanot 2002). Ghana ratified the International Covenant on Economic, Social and Cultural Rights in September 2000; its provisions are thus binding upon the state. This means the state has an obligation to achieve full realization of the rights contained within CESCR. Ghana is therefore responsible for ensuring that every Ghanaian citizen enjoys the highest attainable standard of physical and mental health (Lithur 2003).

The remaining sections of the document focussed on specific services and procedures including assessment of clients and referral, pre and post procedure counselling, post abortion care, standards for infection prevention and documentation. Some of these are discussed below. The need to take proper history was mentioned and each client is to be treated as an individual based on her prevailing circumstances. Pre- and post-procedure counselling should form part of CAC as well as counselling on contraceptives, with a method acceptable to the client.

The protocol maintains that partner or spousal consent is encouraged but not mandatory. There are likely to be problems if women terminate pregnancies that their partners want. It may be best for couples to agree on the decision before the pregnancy is terminated. Where it is possible, partners or spouses should be involved in the counselling sessions. The document defines counselling as 'a structured interaction through which a person voluntarily receives emotional support and guidance from a trained person in an environment that is conducive to openly sharing thoughts, feelings and perceptions' (GHS Standards and Protocols 2006 p5).

During counselling, all options are to be shared with the client and providers are not to impose their own values and beliefs on the client. This is very important, since in the interviews it was mentioned that some health providers (especially midwives who were not trained counsellors) had the habit of counselling women based on their own personal convictions imposing their values and beliefs on the clients. Wide dissemination and use of the standards and protocols, as well as supervision of those who use it, may help to prevent this practice.

Among the issues that remained contentious and unclear in the law which were discussed in the Standards and Protocols, the issue of 'medical practitioner' was not explicitly discussed even though one would expect this to have been done given the confusion surrounding it when it comes to provision of safe, legal abortions.

Under the standards section, medical practitioners (MPs) as well as midwives (MWs) were listed as providers of CAC (MVA and medical abortion). This gives them the mandate to offer abortion services. However the law only cites medical practitioners as those eligible to provide abortions. There is need for clarification of this term.

According to the document, there is no need for legal evidence of rape, defilement or incest for a client to procure abortion. There is no need for a psychiatric assessment for one to obtain legal abortion. Children under 18 years are considered minors. Pregnancy in a minor less than 16 years constitutes statutory rape and is entitled to legal abortion. Minors are encouraged to seek parental consent or that of a guardian before having an abortion. Given the cultural context of Ghana, it will be very

difficult for a minor to obtain abortion without parental consent. Also many children would not be keen to tell their parents about being raped probably because of fear and stigma. These may affect their ability to access safe abortion.

With regard to conscientious objection, the document acknowledges and also accepts that health providers have a right to their own beliefs and personal convictions on abortion. However it states that their beliefs and moral perspectives should not hinder access to care for others. In this regard, facilities designated for the provision of services are to do so. Health facility managers are to ensure that services are provided in accordance with the abortion law. Only health providers directly providing abortion services are entitled to conscientious objection, however providers have no right to conscientious objection in an emergency situation or if the client is below 18 years. According to the constitution of Ghana, no child is to be deprived by another person of medical treatment, education or any social and economic benefit based on religious and other beliefs (Article 28, Constitution of Republic of Ghana, Clause 4). Any health provider who claims conscientious objection should provide needed information to the client about her right to services and refer her to another provider who is eligible and willing to provide abortion services.

The Standards and Protocols for CAC outlined a range of methods to be used for inducing abortion in health facilities in Ghana. For pregnancies up to 12 weeks old, medical abortion and vacuum aspiration (electric or manual) were mentioned. These two methods appeared to be relatively safe methods. Medical abortion, dilatation and evacuation (D & E), forceps/vacuum and dilatation and curettage (D & C) were also mentioned as applicable for pregnancies over 12 weeks old. D & E was cited as the most preferred method of termination of pregnancies from 13 weeks and above because of its safety and efficacy.

The Protocol and Standards described all the induced abortion methods in a step by step manner, which gives the provider adequate details of what to do and how to do it. This should enhance service delivery and ensure quality care. Manual vacuum aspiration was cited as the more common method in most Ghanaian health facilities.

The safety of the D & C method was discussed in relation to vacuum aspiration. D & C is less safe than vacuum aspiration and women experience more pain with its use (Cates et al. 2000). The standards and protocols discouraged its use. It can only be used where safer methods such as medical abortion and vacuum aspiration are not available. There is need to replace it with vacuum aspiration as in most industrialized countries (WHO 2003). The safety of D & C was an issue raised in the interviews by some obstetricians. They highlighted the dangers associated with its use. With widespread training of health providers in the use of MVA, procurement and wide distribution of MVA kits nationally, the use of D & C could be stopped altogether, given the dangers associated with it. However, procurement of MVA instruments in Ghana is a challenge and sustainable strategies are recommended (Graaf and Amoyaw 2009). The scarcity of MVA equipment was confirmed in the interviews.

Included in the Standards and Protocols was an outline on preparation of clients for safe induced abortion. This is to be carried out in all facilities equipped with trained health providers and infrastructure for CAC services. It described how to establish rapport with clients, history taking, and examination of clients, counselling on pregnancy options, abortion methods, pain management options, family planning and informed consent. The descriptions were clear, straight forward and detailed and would make it easy for providers to use.

Counselling forms a very important part of client preparation because it is during this session that the client (if pregnancy is established) is supported to make a free and informed choice based on accurate information given. The purpose of counselling for comprehensive abortion care includes helping to clarify feelings and decisions about pregnancy, to discuss options and to help determine the clients' physical and emotional needs. During counselling, the risks, benefits and alternatives of all the options are to be discussed with clients. Clients who decide to continue with the pregnancy are to be referred to antenatal services. Clients whose pregnancies are due to rape or incest are also to be referred to the clinical psychologists or the Department of Social Welfare.

There were three important considerations during counselling. Firstly, the counsellor should not impose his/her personal values and beliefs on clients. Secondly, counsellors are not to coerce clients to go with their own preferred options. Finally, they were to ascertain whether clients' circumstances fall within the conditions for legal terminations, as well as the guiding principles for the implementation of CAC services. These cautions are necessary. For instance, during the interviews an obstetrician and some policy-makers (all of whom were against the establishment of CAC services) raised concerns that if CAC services were scaled up, it would open the 'floodgates' for abortion to be performed 'en masse'. They believed many women may come seeking abortion using 'rape' as the reason for abortion when in reality they may be seeking abortion on demand for 'flimsy excuses' not covered in the law.

Under counselling for CAC on pregnancy options, three options were stated: the choice to continue the pregnancy and parent the child, continuing the pregnancy and giving away the child for parenting by others (including adoption) and lastly, terminating the pregnancy. A client who decides to continue the pregnancy but not parent the child is to be referred to appropriate services. Although structures exist within Social Services in Ghana for adoption, these are not well developed and procedures for such purposes are cumbersome and time consuming. There is need for inter-sectoral collaboration between Ghana Health Service and the Department of Social Welfare and further development of Social Services to make this option a reality.

Post abortion care formed a significant part of the Standards and Protocols. This portrays its importance in comprehensive abortion care. The kind of care to be provided was described according to the level of health care facility and whether the patient is stable (non-critical) and whether the patient has an infection or poisoning. In addition, the Standards and Protocols had two flow charts showing what should be done for patients with abortion complications at the health centre and hospital levels. As with the client who reports for safe abortion, the woman who reports with an abortion complication needing post abortion care is taken through a series of steps including establishment of rapport, psychosocial assessment, physical examination, counselling, MVA, counselling (including contraception) and referral where

necessary. The post procedure care, counselling and follow up sections were well described, making it easy and highly informative for the providers' use. Contraceptive counselling was reinforced, which is good practice as it could help prevent repeat abortions. Similarly referral to other needed sexual and reproductive health services was stressed, which is an indication of proper integration of services.

The concluding parts of the Standards and Protocols highlighted standards for infection prevention, the need for documentation and standards for prevention and management of unsafe abortion (comprehensive abortion care). These are all crucial elements of care and essential features worth incorporating in a standards and protocols document. With respect to infection prevention, the document had specific detailed instructions for processing and handling MVA and other surgical instruments.

It also highlighted the poor manner of record-keeping of abortion-related needs and services in Ghana and stressed their importance to enable health managers to address the needs of the population. Poor documentation of abortion-related information in Ghanaian health facilities was an important issue raised in the interviews and was also found in the literature (Jones and Kost 2007; Ahiadeke 2001). Periodic workshops to sensitize health providers, as well as regular monitoring and supervision may be useful to ensure accurate documentation of services.

There was a matrix of various activities included in CAC and a list of health providers who are eligible to carry out these activities at various levels of health care delivery system namely community, sub-district, district, regional and teaching hospital. For instance, it shows that midwives are eligible to offer medical abortion for pregnancies less than 9 weeks gestation at all levels however, if the period of gestation is more than 9 weeks they can offer services at all but the sub-district level. This may be because terminating pregnancies more than 9 weeks is not a simple procedure so this should be done where doctors are available to help where necessary; doctors are usually not available in sub-districts.

Two important components of the standards and protocols were a copy of the abortion law and a list of conditions which, when present in a woman seeking services, should call for extra caution in management. The addition of the law in the document gives providers who do not know the law the opportunity to study and apply it. Also the list of conditions which includes heart disease, anaemia, diabetes and asthma gives the provider an insight of the action to take in managing such patients.

The CAC Standards and Protocols document was based on WHO's 'Safe Abortion: Technical and Policy Guidance for Health Systems' WHO (2003). The WHO requires that standards and protocols cover types of abortion services and where they can be provided, the needed equipment and supplies, medications and facility capabilities, referral mechanisms, respect for women's informed decision-making, autonomy, confidentiality and privacy. Attention is also to be paid to the special needs of adolescents and special provisions for women who have been raped (WHO 2003).

The CAC Standards and Protocols (GHS 2006) adequately covered most of these areas but not all. The needs of adolescents in accessing and using reproductive health services such as safe abortion were not given the prominence they required. For example it did not specify the need for a supportive environment (e.g. an adolescent-friendly facility). How health providers should package and give information to adolescents was not highlighted and how providers should deal with their prejudices about adolescent sexuality was not discussed. However, these are important issues that should be dealt with if care is to be made accessible to adolescents. It was only mentioned that they are encouraged to seek parental consent or that of a trusted adult. Encouraging minors to tell their parents that they had been raped, when going for abortion services, might put minors off from accessing safe, legal abortion services. They therefore might be tempted to use unsafe illicit means to try to abort.

Under the purpose of pre-procedure counselling, addressing the special needs of adolescents could have been added, with emphasis on how to meet their special needs. Another weakness of the Standards and Protocols is its feasibility. For

example, it states that women who have been raped are to be referred to a psychologist for assistance. However there are few psychologists accessible in Ghana for such purposes. It is important that when provisions are made in legal and policy documents, it must be ensured that the enabling factors are available for the realization of set objectives.

Overall, the Standards and Protocols is a useful document, well structured and laid emphasis on important components of CAC such as counselling, referral, infection prevention and documentation. There are however a few weaknesses or areas that could be improved when it is next revised such as clarification of the term 'medical practitioner' and efforts to streamline the cost of abortion services.

The Standards and Protocols, published in 2006 have not yet been disseminated. Only a few senior policy-makers, obstetrician/gynaecologists and midwives have copies. I made efforts to procure a copy at the MOH/GHS headquarters but I could not obtain one from there. I got a copy from the Country Director of Ipas when I attended a training workshop they were organizing for some GHS health providers on CAC. I attended the training workshop to interview some of the health providers. In the ensuing section, I explore providers' knowledge and use of the policy documents in the light of their availability.

6.3.2 Knowledge and use of the policy documents

The vast majority of policy-makers (officials of MOH and GHS most of whom were doctors based at the MOH/GHS headquarters and had worked in the area of reproductive health) had some knowledge about the RH policy. The obstetrician/gynaecologists particularly were very knowledgeable about the policy. Even though they did not produce copies during the interview, they could mention most of the contents especially the section on the objectives of abortion care. Two (2) of the young obstetricians admitted that even though they had been practising obstetrics for close to a decade, they only read the policy thoroughly prior to their post graduate examinations.

Two groups of respondents who were health workers had very little or no knowledge about the policy. These were the midwives and pharmacists - the same groups that knew little about the law. There were some midwives working in an

obstetrics and gynaecology unit who knew nothing about the policy and appeared not to have seen copies before. Clearly, besides the obstetricians, most practitioners '*on the ground*' had very poor knowledge. The few (3-4) who did know the policy, were either directly involved in its formulation and review or had heard about it at workshops. A midwife who initially indicated she had not seen a copy of the policy, on a later date drew my attention to her possession of a copy. She had put it away in a drawer with old documents and had entirely forgotten about it. She requested that I change my recording of her initial response to my question.

A number of observations were outlined by some obstetricians in the interviews. According to them, Ghanaians are generally good at formulating policies. They mentioned that Ghanaians are good at paperwork but not groundwork. Ghana was said to be noted for excellent paperwork but work on the ground leaves much to be desired. They claimed that when it came to formulation of policies, some African countries were referred to Ghana to understudy our policies. One obstetrician added that Ghana has a renowned reproductive health guru, known worldwide for chairing United Nations functions and making remarkable inputs in international and national documents on reproductive health. However, the problem of Ghanaians is with implementation. Ghana, as a nation, is quick to ratify treaties and conventions but slow to implement them:

"... in our society, there is nothing wrong with the paperwork. The problem is always the implementation. There is a big gap between the policy maker and the person implementing".

Obstetrician 6, age 70

6.4 Summary

The initially restrictive law was amended in 1985 through the efforts of a group of doctors concerned about high deaths from unsafe abortions, and was approved without public discussion by the then military leader. As safe abortions have come back onto the international agenda over the past ten years as part of a comprehensive reproductive health service mix, interest in the law in Ghana has rekindled.

The law, as it appears in legal documents, can be interpreted as quite liberal since it is relatively un-specific. The interviews however, showed how this lack of specificity

results in considerable ambiguity which has led to a wide range of interpretations about what is legal or not and has allowed the law to be used by both pro-choice and anti-abortion lobbies.

While there are many moral values brought to bear on people's views and discussion of the abortion law, the chief problem that is likely to impede implementation of the law is a widespread lack of knowledge about the detail of the law and subsequent reluctance of practitioners to practise something for which they fear they may be prosecuted. Specific ambiguities that contribute to uncertainty include: a lack of clarity about who are the '*medical practitioners*' legally allowed to perform abortions; a lack of clarity about what constitutes a detriment to '*physical or mental health*'; a lack of clarity on what, if any, gestational age limit could be construed as criminal; and a dearth of court-cases that might have tested and therefore clarified the law, though maybe this de facto non prosecution is a good thing.

This situation was compounded by the lack of clear operational policy guidelines for practitioners that might have helped them interpret the law. Until 2006, no practice guidelines on safe abortion existed to aid practitioners. Currently, the Standards and Protocols are available and its analysis shows its usefulness but these have still not been widely disseminated, thus respondents still have very limited knowledge of what is legally allowed to be put into practice. In the next chapter, I examine the implications of the legal ambiguities described here and other obstacles to the implementation of abortion services.

CHAPTER SEVEN

BARRIERS TO PROVISION OF COMPREHENSIVE ABORTION CARE (CAC) WITHIN GHANA'S LEGAL FRAMEWORK

7.1 Introduction

Drawing on data from interviews and analysis of policy documents of the MOH/GHS, this chapter explores the extent to which CAC is provided. It begins with a description of the availability of PAC and CAC services in public health institutions (section 7.2). Next, building on the discussion of the Reproductive Health Policy in Chapter 6, it gives the historical background of how CAC services were initiated as an adjunct to PAC and discusses the CAC content in more detail (Section 7.3). The justifications that respondents cited for CAC are then discussed (Section 7.4). This is followed by a discussion of the major barriers (service-level and socio-cultural) that make CAC largely inaccessible in public health facilities in Ghana (section 7.5).

7.2 The extent to which PAC and CAC are available in public health institutions

Post abortion care (PAC) is captured in the 1996 and 2003 national reproductive health service policy and standards under the component '*prevention and management of unsafe abortion and post abortion care*'. The objectives of the service include: i) to manage and refer abortion complications, ii) to link PAC to other related health care services, iii) to create public awareness on the dangers of unsafe abortion and iv) to educate clients about abortion complications.

PAC is to be provided at all levels of healthcare delivery. The providers at each level should be: traditional birth attendants (TBAs) and community health officers (CHOs) at the community level; nurses, midwives and medical assistants at the sub-district level; midwives, medical practitioners and obstetricians (where available) at the district, regional and teaching hospital levels GHS (2003).

The MOH's reproductive and child health (RCH) annual reports do not include institutions that offer PAC or CAC. What the reports usually present are institutions that provide reproductive and child care as shown below:

Table 7.1 Institutions providing RCH services in Ghana, 2006

Organisation	Number of health institutions providing RCH services
Ghana Health Service	1,110
Quasi Government	48
CHAG	184
PPAG	42
GRMA	401
Private Practitioners	477
Teaching Hospitals	2
TOTAL	2,264

Adapted from Ministry of Health Human Resource Policies and Strategies for the Health Sector 2007-2011

The facilities offer the entire package of reproductive and child health services in Ghana and could be used as proxy for provision of PAC or CAC. In a recent assessment of the readiness of selected facilities in three regions in Ghana to offer contraceptives and CAC, the availability of PAC and CAC was described as low in the health centres and polyclinics in all three regions (Greater Accra, Eastern and Ashanti) used for the pilot study (Aboagye et al. 2007). Out of 74 polyclinics and health centres surveyed, 7(9.5%) offer PAC and only 1(1.4%) offer CAC. With respect to hospitals, 15 (93.7%) of the 16 hospitals surveyed offer PAC and 11(68.7%) offer CAC as shown below:

Table 7.2 The availability of PAC and CAC by type of facility (n=90), 2007

	Already offering PAC	Already offering CAC
Health centres/polyclinics/RCH (n = 74)	7	1
Hospitals(n=16)	15	11
Total facilities (n = 90)	22 (24.4%)	12 (13.3%)

Source: Adapted from GHS/Ipas 2007.

With respect to availability of services per unit population, Aboagye et al. (2007) noted that none of the three regions satisfied the minimum requirement of five basic sites per 500,000 population. Following this assessment, national estimates of health facilities that offer PAC were obtained as shown in table 7.3.

Table 7.3 National Estimates of facilities that offer PAC, Ghana 2003

	No of facilities in Ghana that would be expected to have the capacity to implement CAC	Estimate of the no of facilities offering PAC	Proportion of facilities that offer PAC (%)
HOSPITALS	259	140	54
HEALTH CENTRES	622	81	13
CLINICS	899	293	33
PRIVATE MATERNITY HOMES	401	132	33
TOTAL	2,181	646	30

Source: Adapted from *Ghana Health Service Provision Assessment Survey 2002*. *Ghana Statistical Service, Health Research Unit, Ministry of Health, ORC Macro 2003*

Based on information from the above sources, it is evident that both PAC and CAC services are not widely available nationally. However, the availability of CAC appears to be much lower than PAC. Further reflections on PAC, from the data, are given in Appendix 10.

Since 2003, the GHS started a dialogue with health providers in managerial positions about the abortion law and provision of abortion services to the full extent of the law (Aboagye et al. 2007). A range of barriers to CAC remain which are the subject of this chapter.

7.3 The Road Map to CAC

In March 2003, Ipas organized a meeting in Addis Ababa, Ethiopia on '*Action to reduce maternal mortality in Africa*'. At this meeting, the WHO publication, '*Safe abortion: technical and policy guidance for health systems*', which discussed how countries could ensure access to safe abortion services to the extent permitted by law, was discussed and adopted by countries represented. Ghana sent MOH representatives to this meeting. According to policy-maker 2, a communiqué was signed by all the countries that were represented at the meeting in Addis Ababa. Each

country decided to take action to reduce maternal mortality. After that, Ghana formed a group of people from various disciplines related to reproductive health to make sure the recommendations of the meeting were put in action.

The GHS, having been charged with the mandate of reducing the high levels of maternal mortality, formed a taskforce whose duty was to come up with a strategic plan to address the problem of unsafe abortion in Ghana. In December 2003, the plan was adopted by key stakeholders. In order to further reduce the toll of maternal deaths attributable to unsafe abortions, the GHS revised the National Reproductive Health Service Policy and Standards (discussed in Chapter 6) incorporating an additional objective under the section: '*Prevention of Unsafe Abortion and Post Abortion Care*'. This objective was to allow for provision of safe abortion services to the full extent of the law. In May/June 2005, a strategic assessment of abortion and abortion care services was carried out under the leadership of the GHS and an advisory committee of policy-makers. The purpose of the assessment was to enable key stakeholders to hold discussions with various communities in the country on issues of interest in reproductive health including unwanted pregnancy, contraception and abortion. Measures to reduce abortion-related deaths and how to improve access to and quality of care in abortion services to the full extent of the law were also to be explored.

The assessment was done by a team comprising 17 stakeholders some of whom were policy-makers, programme managers, service providers, reproductive rights activists and women's health advocates. It covered the Upper East, Northern, Brong Ahafo, Ashanti, Greater Accra and Central Regions of Ghana. The major findings included the poor knowledge of the abortion law among the public and even health providers and the dangerous methods used by women and girls for induced abortion. Other findings were the strong '*culture of silence*' that surrounded abortion and related issues and the current willingness of communities to openly discuss abortion issues. In addition, the high cost of abortion services and the clandestine nature in which these services are provided were also identified. It was also established that women and girls in the study area had a high unmet need for contraception.

The upsurge of medical abortion in urban areas was another significant finding during the assessment. These findings from the strategic assessment of the GHS (2005) corroborate the findings on the abortion law in my study discussed in the preceding chapter. However, my study did not only identify respondents' knowledge and willingness to provide services in terms of attitudes, it further explored in depth, attitudes (towards referral of women for services, counselling and the establishment of centres for abortion services) including beliefs of key stakeholders towards abortion and the underlying reasons for these beliefs/attitudes. I also explored whether there are any links among these constructs and the behaviour of stakeholders towards abortion care. The findings have policy and service implications.

Based on these important findings and in response to the expanded objectives in the GHS 2003 RH policy to provide abortion services to the extent permitted by law, the Standards and Protocols for the Prevention and Management of Unsafe Abortion were developed in 2006 to provide technical and managerial guidance for the provision of comprehensive abortion care services of desired quality.

The development of the standards and protocols was also in fulfilment of a commitment on the part of the international community to address the problem of unsafe abortion partially through the provision of safe abortion (UN, ICPD Report, 1994). It was also in response to a call by WHO on health systems to ensure the availability of safe abortion services in accordance with national laws and supported by policies, regulations and health systems infrastructure (WHO, 2003).

The purpose, contents and uses of the Standards and Protocols on Prevention and Management of Unsafe Abortion have been discussed in detail in Chapter 6. It should be noted that comprehensive abortion care services incorporate safe induced abortion as well as post abortion care all of which go with counselling and provision of contraceptives.

The chapter now shows how respondents view provision of CAC as government's responsibility and as necessary if the government is to be accountable for women's health, especially maternal morbidity and death in Ghana.

7.4 Reasons Advanced for Provision of CAC

As described in the previous section, policies and protocols are now in place to provide CAC. The plan to provide CAC is a major undertaking in a country like Ghana, a very religious nation where abortion is highly stigmatized (Lithur, 2004). The procedure is frowned upon culturally and providers must have extremely good reasons for wanting to offer the service in public health facilities on a national basis. This has not been the norm. This section explores stakeholders' views of CAC and the various reasons why some stakeholders think the provision of CAC should now be made open and formal in designated public health facilities throughout the country. While a few respondents were strongly against provision of abortion services, most respondents gave reasons why they thought abortion services could, even should, be provided. Two major groups of reasons emerged: the first concerns the magnitude of the problem and the responsibility of government to do something about it; the second regards women's rights.

7.4.1 Maternal deaths, safe abortion and government accountability and responsibility

The government of Ghana has a commitment to improve the health status of all Ghanaians and is also aware that improving reproductive health services is essential if the Millennium Development Goal (MDG) 5 is to be achieved (Birungi et al. 2006). The MOH has the mandate of the government to promote and maintain the health status of Ghanaians. Now, the WHO defines '*health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity*'.

The law permits abortions when women are not in good mental condition. The MOH itself has defined standards of care. Why is the MOH not providing CAC for women who need it? These were questions some respondents posed. A few respondents were of the view that health providers of the MOH should be held accountable for failing to provide the service as required by law as well as specified in the RH policy:

"... If I had to choose an issue to fight on now, it wouldn't be a change in the law. It would be to hold the MOH doctors accountable - here it says, this is the law of Ghana; this is the policy of the MOH/GHS; that abortion services be provided as specified under the law... it is there on paper! I want to ask the Director General of

Health Services: why aren't your clinics and your hospitals providing safe abortion services to women who qualify under the law? "

Obstetrician 6, age 70

This obstetrician went on to say that although it is the right of a provider to refuse to perform an abortion on moral grounds (referred to as conscientious objection), providers nevertheless have a professional obligation to refer the client to someone who will conduct the procedure:

"Why aren't women coming forward for the treatment? ... Partly because of the attitudes of many service providers who project their own feelings. I respect everybody's personal feelings. I would not wish to impose my view. Any doctor or provider is free to say "I personally, will not provide this service" but that is not the end of the story! You still have an ethical, a professional; a contractual responsibility to refer that client to another provider who you know will be more willing to do it. You can't say "I won't do it so get out". No, it is not right!"

Obstetrician 6, age 70

The principle of conscientious objection and the requirement to refer to a non-objector are clearly set out in the 2006 safe abortion protocols, but the lack of dissemination of these, coupled with providers' attitudes towards abortion (among other reasons) means that most staff are not likely to refer.

Having signed various international consensus documents on reproductive health (RH) and the Millennium Development Goals (MDGs), most respondents were of the view that Ghana as a country has to reduce maternal mortality. Since 22 to 30% of the country's maternal mortalities are due to complications of abortion, some respondents felt that the MOH should show leadership in the health sector to reduce these deaths. Obstetrician 6 noted that for purposes of accountability, in-charges of hospitals admitting a lot of cases of women with abortion complications should be asked what they are doing about it.

Although, there were a few dissenting voices, for example Clergyman 12, regarding the seriousness of deaths from unsafe abortion, many respondents (notably policy-makers, obstetricians, pharmacists and midwives) believed that the death toll is in itself enough justification for the service to be universally available:

"...It is the government's responsibility to provide safe abortion services. It is a matter of urgency... considering the fact that people are dying from unsafe abortion."

Obstetrician 9, age 40+

The overarching reason warranting the availability of the service is to save the lives of women. This was clearly depicted in the passionate quote of a senior public health practitioner and policy-maker that follows:

"... I consider it the government's responsibility to maintain the wellbeing of all people. I think it is the worst form of discrimination that a task that only women can perform, (reproducing the next generation) can be used to help kill them... the government should understand that this is not the type of situation that will invoke the sin complex. Let's look at health as health, we have a public health need. A class of people are the only class that do a certain act, that act should be permitted in the safest possible way. No matter what governments have done, people who don't want to carry a pregnancy will not carry a pregnancy. There is no reason why they should be punished for it".

Policy-maker 1, age 84

The respondent did not see why women alone should bear the brunt of an unwanted pregnancy and be coerced to carry and deliver pregnancies they do not want. This raises a gender dimension. A female parliamentarian also thought that the problem of unsafe abortion is not being given the attention it deserves because it is a problem that affects women. Obstetrician 2 noted that some health providers act as though women with unwanted pregnancy deserve to be punished either by a denial of safe, legal abortion services which might make them resort to unsafe abortion or by providing safe abortions and charging them heavily for the services.

Some respondents also believed that if government facilities openly offered CAC for a token fee, women might no longer risk their lives by going to untrained abortion providers at the expense of their lives. Some said that if providers improved upon their attitudes, and other quality assurance issues like confidentiality, privacy and costs are addressed, the public health facilities will become more user-friendly, and women might more likely seek termination of pregnancy in public hospitals rather than private ones where most respondents said high fees were being charged for induced abortion.

Some respondents also believed that if the MOH made CAC widely available, the untrained providers would be out of '*business*' and the use of crude methods and lethal agents for termination of pregnancy would all be things of the past. However, a few respondents believed that with the advent of provision of termination of pregnancy in public health facilities, the untrained providers would wittingly lower their fees to attract unsuspecting women.

7.4.2 Women's legal and reproductive health rights

The other group of reasons why some respondents deemed it necessary for government to ensure provision of safe, legal abortion services related to notions of the rights of women.

Abortion is permitted in Ghana in some specified cases but not '*on demand*'. In cases of rape, incest, foetal abnormality and physical and mental ill health of the mother, the procedure is allowed. The mental health clause, in particular, offers a large window of opportunity but Ghanaian women are largely not aware of this and hence do not demand the service.

Some respondents, who were in favour of CAC, argued that this clause gives women the right to demand safe services when the need arises. According to most of these respondents, a woman with an unwanted pregnancy, though not mad per se, is not mentally healthy. Such women were described as very desperate people who would do all in their power to terminate the pregnancy, safe or unsafe. Since the law allows termination of pregnancy (TOP) to maintain the mental well-being of the women in question, denying such women the service was equated to violation of their rights.

Some respondents (especially Lawyer 2) argued that the observed absence of the services in public health facilities also amounted to violation of the law and a great disservice to women who need the services. One of the young obstetrician/gynaecologists also had this to say:

"...I am all for it (CAC), because it is very sad to go and take a 16 year old girl's uterus out; 17 year old, 20 year old girl, comes because she has used some herbal preparation or enema or medication you don't know of and just comes to die; young, beautiful ladies just come and die. It is better for me to sort it out rather than

go and in the night they call me to come and clear up the mess...so I am strongly for it; the provision of safe abortion services. It is the right of the woman to have it."

Obstetrician 4, age 42

One of the representatives of a Development Agency noted:

"... instead of women submitting themselves to unsafe procedures; they should know where to go and to have a safe process... it is not a matter of we have our ethics, we have our beliefs... but it should be considered... when it has to be; it should be safe."

Development Agency Rep. 1, age 50 +

The main reasons that respondents gave for provision of safe abortion services have been outlined. The nature of these justifications and the impact they have on the willingness of providers to actually provide services is discussed in detail in chapter 8. The remainder of this chapter turns to service-related and socio-cultural barriers to the provision of safe abortion services.

7.5 Service-Related and Socio-Cultural Barriers to Implementation of Safe, Legal Abortion Services in Ghana

Two types of barriers emerged from my interview data: service-related and socio-cultural barriers. The service-related barriers include generic health system issues (like lack of resources) as well as more abortion-specific issues such as unclear legal and policy guidelines on what services are permitted. Provider attitudes to abortion also emerged which are related to the socio-cultural context in which providers work. While both groups of barriers will be discussed in this section; due to their complexity, the socio-cultural barriers will be further explored in the next chapter.

7.5.1 Service-Related Barriers

Multiple service-related barriers were discussed by the respondents. The main ones, which are discussed here, include:

- i) Legal and policy gaps, ambiguities and inconsistencies relating to service provision
- ii) Provider attitudes (human/personal factors)
- iii) Lack of resources and training
- iv) Quality assurance issues

i. Legal and policy gaps, ambiguities and inconsistencies

As discussed in the preceding chapter, abortion is found in the Criminal Code of Ghana. This makes it a criminal offence unless the service is provided under the specified conditions for which it is allowed (i.e. rape, incest, foetal abnormality, and risk to physical and mental well-being). Interviews with respondents showed that those who know the abortion law in Ghana seemed to interpret it based on their stance on abortion. Those who are in favour of abortion care interpret it as legal (e.g. obstetricians 3 and 4) whereas those who are against it say it is illegal (e.g. trainer 3). A detailed analysis of the stances of respondents, and reasons for them, is given in chapter 8.

The various positions of respondents also reflect the part of the law on which they placed their emphasis. The first section of the law describes what makes abortion illegal in terms of the provider, where it is done and the method used; whilst the second section outlines the indications for which abortion is permitted under the law. Policy-maker 1 argued that most people dwell on the first section of the law at the expense of the second part.

Some respondents have also argued that circumstances surrounding the promulgation of the law made it widely unknown. Obstetrician 15 (who is strongly against the abortion law) made this observation. Policy-maker 1 also noted that the law was not widely disseminated probably for fear of opposition from religious groups hence health providers and the public are largely unaware of the law.

In addition, those who know the law do not understand some of the clauses. Lawyer 2 strongly argued that there is lack of clarity about gestational age and the definition of risk. Lawyer 1 however, noted that another section of the Criminal Code implicitly shows gestational age. For two professionals in law to differ on certain provisions of the law is an indication of the discrepancies in the law. As noted in the preceding chapter, the abortion law has a number of ambiguities. These result in misunderstanding of the law and difficulty in interpreting it. The pitfalls in the law make its application a problem. According to the law, abortions can be performed by registered medical practitioners. Currently, there is controversy over who a '*medical practitioner*' is. The term refers to doctors. Now, some advocates for abortion were

saying it could be stretched to cover midwives and indeed the MOH Policy Standards and Protocols also suggests this. Lawyer 1 cautioned the protagonists of the legal implications of this action and suggested that the nurses should take the matter to court for the court to decide who a medical practitioner is. These problems reportedly generate confusion and perceived legal fear making some obstetricians who are willing to provide abortion services apprehensive about getting into trouble with the law and not getting support from the MOH:

"There's some confusion ... because the law does state that only doctors may provide the service... many doctors are not certain whether they're covered... "since I am a doctor, I can do it; but supposing the police drag me to court, the MOH is not going to support me so I'm left out there and because I'm not certain what will happen to me , I would rather not do it".

Obstetrician 6, age 70

One respondent further elaborated the problems in applying the abortion law:

"...It is very difficult; it is a very complex thing... every country is governed by law and if our law says this I don't think any leader should go against it. If the law provides for anything, I don't think religion should stand in the way of the law. After all, the laws are made to protect us. People could express their opinion but I think the law should be allowed to work. The laws are there and they are simply not working. People will not allow the law to work because of vested personal interest. In this country, the interests of people supersede national interest that is why we find ourselves in this problem".

Pharmacist 1, age 38

This respondent was very emotional and expressive during the interview. He explained that if the law was properly applied, TOP would be available in public hospitals and be affordable hence the doctors who now do abortions clandestinely in these hospitals, charging exorbitant fees and putting the money in their private pockets might not be able to do so any more. They therefore do all they can to prevent the law from working. This includes those who thwart the law by misinterpreting it as well as those who skew its interpretation in accordance with their moral convictions on abortion. This pharmacist and obstetrician 3 share similar sentiments that laws in Ghana do not work. In their view the laws are not applied as they should.

The abortion law permits TOP in both public and private hospitals, clinics and maternity homes provided these are registered under the maternity homes' act. Thus by law, private hospitals and clinics could offer abortions, once these are safe. Some health providers reported of CAC as being more readily offered in private health institutions than public institutions:

"... it is being implemented in the private and maternity institutions; perhaps not being implemented in the public medical institutions. They don't want to do it in public institutions because if you are seen to be doing it, you are labelled...if people declare that they are offering this service and are backed by the law, probably lawyers and lawmakers would come out and say they are breaking the law so it is the social environment and the history of the institution that is why public institutions do not offer abortions... it is not as if this has always been the law. But the MOH has existed for so long. There was probably a time when this (abortion) could not even be done in institutions. Now that the law has become more liberal, that history (of no abortion) continues to follow the public medical practice".

Obstetrician2, age 40+

This quote shows how the fact that the MOH for years had forbidden abortions in these hospitals adds to the ambiguity; now that the law has been liberalized, the tradition of '*no abortion*' in these hospitals appears to persist. The quote illustrates both the confusion surrounding the use of the law and the legal fear providers have.

Pharmacist 5 talked of one obstetrician who fearlessly provides abortion services in a public facility because he said he could defend himself if he had to face prosecution. One obstetrician told me during the interview that she knows the law and is thus not afraid of prosecution. Thus fear of the law may be a real reason why some providers do not offer abortion services. It could also be their excuse to cover moral objection.

When the health providers were asked to describe the level of implementation of the law in terms of service provision, a number of terms were used to describe access to CAC in public health facilities. Some of the health providers and policy-makers mentioned that the abortion law is either '*partially being implemented*' or it is '*not being implemented to its full extent*'. This implies that though the law permits abortion in some instances, the services are not being offered as expected. Others, mainly obstetricians, observed that CAC services were being '*underutilized*'.

“... We are not providing the services. You can't just walk into a clinic and say I want TOP. You have to look for a friend who will send you to somebody before you can get this ‘thing’ (abortion) done so these are the problems ...”

Obstetrician 3, age 38

There were also problems with the policy on abortion. The first edition of the RH policy (MOH1996) did not have an objective on abortion. This omission meant provision of abortion services was not feasible. When the objective on abortion was put in the second edition in 2003, there were no standards and protocols until 2006. Also, all the policy documents have not been widely disseminated thus many health providers including those who work in obstetrics and gynaecological units have not seen or read the policies. If they are not conversant with the principles of the policies, how can they use them? This also inhibited service provision. For instance, conscientious objectors are to refer women with unwanted pregnancies to colleagues who are willing to offer the services; and they are to refrain from offering judgemental counselling to such women. However, some midwives do counsel women based on their inclinations and fail to refer them as the policy states. Again, this may be, at least in part, because they are not aware of the Protocols and there is no supervision to enforce them.

ii. Provider Attitudes

The attitude of health providers was identified as a major deterrent to provision of abortion services in public health hospitals. Nurses were described as the greatest ‘*offenders*’. These nurses were like gate keepers and would either refer you to obtain the service if available, scare you away harshly or take interest in you to ‘*lecture*’ you against procurement of abortion services and/or support you until delivery. These actions were often underpinned by the nurses’ conviction on abortion.

The midwives interviewed were all asked about their attitude towards women who reported to hospital with abortion complications. In some cases, this discussion led to their reaction towards women seeking abortion services. Most of the midwives mentioned that they sympathized with women with abortion complications and treated them with empathy. However, some midwives disclosed that they got angry with those women, especially when they came lying, wasting their time and making

their work difficult. Some of the women, especially the adolescents, sometimes reportedly continued to lie even until the verge of death.

The anger of some of the midwives may be due to the fact that the gynaecological emergency room in the teaching hospital in Accra, where these cases are treated, is often crowded with patients and the midwives are inundated with work, probably due to shortage of staff. Patient/nurse ratios are high and the nurse/midwives are probably overworked. Besides getting angry and sometimes harassing their patients, some health providers were reported as projecting their personal convictions into decision-making processes on abortion, '*playing God*' and often being judgemental. The attitudes of nurses remain a problem and were described by some respondents:

"The attitudes (of nurses/providers) are different. Some are sympathetic, others are not sympathetic. They are judgmental; they pronounce people sinners ahead of time".

Q: "They pronounce people sinners ahead of time. Could you please explain"?

A: "Well, as soon as they hear that a lady is pregnant and wants abortion, she is a sinner. They don't want to have anything to do with her. I thought that it is only God who can pronounce somebody a sinner, not human..."

Obstetrician 14, age 60+

This was the kind of attitude some respondents referred to as '*playing God*'. Some health providers show such attitudes which reportedly deter women from seeking care for unwanted pregnancies in public health facilities.

Lawyer 1 spoke of terrible personal experiences she had in two different public hospitals where she reported for delivery. She wondered how women who do not want their pregnancies would be treated if those who report to deliver their babies are treated so badly. Knowing that I am a Nurse, she narrated her experiences with such vehemence:

"The bigger barriers are personal attitudes of doctors and nurses who give people hell when they come to them for counselling or any such procedure... There is a lot of hostility with the nurses... their treatment of pregnant women who are not asking for abortion is the same. Very hostile, very unfriendly, very unkind..., I understand why people who want abortions would not even go there. Nurses are very hostile, very unkind so I can understand why people would not go there at all. If this is how they treat pregnant women who are going to have their babies, why should somebody who

does not want to have her baby appear there at all and be abused on top of all the unkind treatment. It is a bigger problem of attitudes than the law."

Lawyer 1 (Professor of law), age 50

Lawyer 1 vividly and with strong emotions narrated two instances where nurse/midwives had treated her poorly when she reported at two different hospitals for delivery. Although both incidents had happened over two decades ago they reflect attitudes held today, revealed by some of the respondents I interviewed. She continues to be angry with the providers for the way she was treated and to date she thinks some nurses and doctors are very hostile to patients. The level of her anger could be attributed to the midwife's pronouncements.

She spoke of being prepared to be taken to the theatre for a procedure after delivery and probably, due to the '*cash and carry*' system in operation, the midwife asked her to pay upfront for '*pentothal*', (a drug for anaesthesia) which was needed. She said when she told the midwife that her relatives would pay for it later; the midwife said "*what if you die during the procedure, who will pay?*" The mention of '*death*' to a patient, who had just delivered and was being taken to theatre due to a complication, was probably the cause and intensity of her anger to date. She must have been apprehensive about the outcome of the complication and expected the midwife to be supportive.

Lawyer 1 described this behaviour as unacceptable. Thinking of the biggest barrier to provision of safe, legal abortions as attitudes of doctors and nurses and not the law is understandable. She is a lawyer and may not easily identify and/or discuss problems in her own field.

In the interviews, apart from two midwives who reported of getting angry with lying patients, most of the midwives did not say anything derogatory about their behaviour towards their patients, though this is not surprising. Further analysis of their attitudes, discussed in Chapter 8, did reveal judgemental attitudes however.

One issue that came up among the midwives during the interviews was the differences in their attitudes towards PAC and CAC. The midwives were prepared to provide PAC but not CAC. Their fundamentalist Christian beliefs forbid them (in

their interpretation) to do CAC but not PAC, but PAC means the abortion has already been initiated so they would not be '*blamed*' for the abortion itself.

Some obstetricians and midwives reported of dilemmas they face regarding their religious beliefs vis-a vis their professional ethics and their reactions. Some of the midwives said they were trained to save and not destroy lives. This makes them refrain from getting involved in abortion care. Some midwives would not show women where to go for care or refer them for care. According to some of the doctors, they had to adhere to the Hippocratic Oath they have sworn, however they reported of occasions in the management of cases where they were confronted with dire situations warranting one life to be saved out of two:

"...I go through conflict situations. The way you resolve conflict situations is, look at the greater good when I experience a conflict, the church doctrine says no abortion; but as a gynaecologist, somebody carries a baby with no brain... the church still does not agree; my training teaches me that such pregnancy must be aborted, but the religious training tells you that you must not touch life , these are two conflicts; you look at the greater good... the greater good is to perform what professionally you have been taught to do. The (Hippocratic) Oath said you should do good to all patients. ... "

Obstetrician 13, age 40

The obstetrician tried to justify why they can sometimes perform abortions using examples of biblical laws being sometimes violated in the interest of people. He also argued that even though the Hippocratic Oath forbids abortion, the countries that made the laws have laws permitting abortion. By this, he implied that the Oath should not be a hindrance if abortion needs to be done in the interest of women in low-income countries.

Another attitudinal problem that prevents provision of abortion services was lack of commitment on the part of superiors in health institutions. Two junior obstetricians (3 and 4) reported that it is not feasible to provide CAC in public health institution due to lack of commitment and support from superiors/heads of institutions. Most people do not want to be associated with abortion and therefore would have nothing to do with it. A senior obstetrician, (obstetrician 6) described this attitude as ambivalence on the part of superiors. They would not discuss issues on abortion and would not attend meetings to discuss the subject. Superiors were also reported as

objecting to the provision of CAC in facilities they head. They are also not prepared to support any subordinate who '*meddled*' in termination of pregnancies. Some health providers and superiors declared their stand as conscientious objectors and stayed away from all abortion issues even though the policy guidelines expects these conscientious objectors to refer woman in need of expert care.

Obstetrician 3 said that policy-makers have a poor relationship with implementers and this he noted would not enhance service provision. According to obstetrician 6, there is no sense of accountability on the part of superiors at the MOH/GHS with regard to the lack of CAC in MOH facilities and the loss of lives of women in fertile age (WIFA). Policy-maker 2 talked of a form of low profile or covert '*politics*' *going* on at the MOH/GHS headquarters resulting in victimization of some subordinates by their bosses who are against abortion.

iii. Lack of Resources and Training

Generally, health resources have always been scarce; human, material and financial. In terms of human resource, the health sector in Ghana experiences serious manpower challenges (Aboagye 2008, Hable et al. 2004). Specific challenges confronting the national health system include inequitable distribution of workers at various levels of service delivery; inadequate staff numbers, low morale and motivation of health workforce and high attrition of health workers. In 2006, there were 2,026 medical officers, the doctor/population ratio being 1: 10,762. There were 10,260 general nurses and 2,810 midwives. The nurse/population, midwife/population ratios were 1: 2,125 and 1: 7, 759 respectively (MOH 2007-2011). Typically, there has been shortage of nurses/midwives in most public health facilities due to international migration (Appiah-Denkyira 2008). Nurses are unavailable to run certain clinics so these clinics have had to close down:

"... our medical and nursing profession, especially the nursing profession is in crisis as far as numbers are concerned. Here is a medical profession that is overburdened by ordinary medical problems... in this department we have two operating rooms for gynaecological emergencies, when are we going to use that place for abortions? It is not practical. We can't run some services because of lack of staff. We can't use two more theatres here because we don't have nurses. Shall we have nurses to terminate pregnancies?"

Obstetrician 15, age 66

Obstetrician 15 clearly indicated in the interview that he opposes abortion but in the above quote he uses the general lack of resources as a reason (or excuse) for not offering CAC. Furthermore, because of his attitude to abortion he did not think resources should go for CAC:

"For instance, I am against the law, I think the law is totally wrong... To me, it will be a travesty of justice to divert resources to look after peoples' irresponsibility"

Obstetrician 15, age 66

Obstetrician 15 put forward a strong argument that if others argue that abortion is a woman's right then they must also remember that rights go with responsibilities. In his view most of the reasons women give for abortion are social and therefore flimsy. He mentioned some of these reasons in the interview (e.g. a married woman who has become pregnant in her husband's absence or a married man who has made a girl/woman pregnant from an extra-marital relationship). He thinks unwanted pregnancies are due to people's irresponsible behaviour. It appeared he would be prepared to speak publicly against abortion if the need arises. He also added a gender dimension to his arguments. He noted that men are often left out of the '*equation*'. He said men are sometimes in favour of having the children and yet women go ahead and have abortions.

On the question of resources, doctor/patient ratios have remained low (Appiah-Denkyira 2008). Although midwives are widely distributed throughout the country, the law does not permit them to offer abortions. The policy and standards document however, indicates that midwives can perform MVAs for abortions at sub-district, district, regional and teaching hospital levels of healthcare delivery. They are also eligible to offer medical abortions for pregnancies below nine completed weeks, at all the above levels. There are reportedly no facilities purposely designated for CAC. MVA kits were also reported as not being widely available and in some cases these have been monopolised by some doctors who use it privately for CAC and put the money they obtain in their private pockets. According to Policy-maker 7, the budget for the MOH is 10% of the national budget. This was described as grossly inadequate thus calling for careful prioritization.

Some obstetricians, policy-makers and parliamentarians observed that geographically, the distribution of health providers is more concentrated in urban than rural areas. Also, midwives are more widely distributed in remote areas than doctors. The implication of this distribution is that rural women will have less access to safe, legal abortion services close to where they live due to limited resources (MVA kits and eligible providers of services by law). Such women might also have a missed opportunity of having information and education (if any) on where to go for services. Due to the scarcity of public health facilities that offer abortion, cost and legal implications, as well as the plurality of alternate health providers like herbalists, rural dwellers reportedly have increased tendency to resort to unorthodox means of terminating unwanted pregnancies:

“... our health practitioners are located mainly in the regional capitals and the two big cities and the expertise that would be required may not be there. In very deprived communities, we don't have these skilled medical practitioners therefore pregnancy and pregnancy-related problems are left to the people who perhaps know little about obstetrics... we should try to have our medical practitioners serving in deprived areas so they can also assist these people who will need their services.”

Trainer 1, age 40+

In terms of training, all doctors are trained to offer PAC but only a few nurses have undergone PAC training. There has not been any formal training for both cadres of health staff in CAC. The Nurses and Midwives Council have recently incorporated CAC in their curriculum; however it is still not clear whether the medical schools have CAC in their curriculum. I made this enquiry during the interview for this study but no straight forward answers were obtained from the trainers (1 and 3). Other respondents mainly obstetricians and some policy-makers who were doctors indicated that medical students are taught theoretically about CAC but there is no hands-on skill training in CAC.

Lack of knowledge of the contents of the policy also results in some of its objectives not being carried out. One of the objectives under the RH component '*prevention of unwanted pregnancy and post abortion care*' calls for education on the complications of unsafe abortion. To what extent is this being done and if so, are women told where to go for care? Some of the respondents who were in favour of

abortion care reiterated that due to the lack of designated facilities for comprehensive abortion care women who need such services do not know where to go.

Obstetrician 3 and midwife 6 among others presented this scenario; a woman seeking care for unwanted pregnancy may visit the hospital; she identifies who to ask for the venue for TOP; she meets someone who is against the procedure who may take her to a solitary place and counsel her against the procedure or harshly tells her not to come to the hospital in search for abortion because the service is not available in the hospital. She discards the idea of termination or she continues to seek help until she meets someone who is in favour and directs her to see someone; who may also direct her to see another until she gets to the doctor for an appointment. One of the pharmacists also described how a woman may obtain abortion services in a named public health facility:

"... They review you and you explain to them why you are there. Then they talk to you (counselling). If you insist (on having an abortion), they call a specialist who will talk to you to find your reasons for wanting a termination. If they think the reason is good enough they charge you 600,000 Cedis(\$40)...there is a little bit of 'whom you know'. If a person working in the hospital refers you, they will do it. But if you just walk in there and they are not sure where you are coming from..."

Pharmacist 5, age 47

This pharmacist described the screening processes women seeking terminations in one public facility are subjected to. Like other respondents have said, you need to know someone at the facility to make it easy for you to obtain care. If the abortion provider is not sure who you are and where you are coming from, you may be denied the service. This is partly in an attempt to avert the perceived legal consequences, as discussed in section i) on legal and policy gaps.

There are no existing formal structures in public health facilities for women with unwanted pregnancies. Even though clergyman 1, a representative of a council of Pentecostal churches, declared that the churches they represent have a stance against abortion, he noted the lack of pregnancy crises centres in Ghana, as found in other countries:

"We don't have pregnancy crisis centres. We don't have these centres which definitely governments (MOH/GHS) should champion so that people can be provided with adequate counselling... the medical services are not providing adequate counselling centres to address this issue."

Clergyman1, age 40+

The clergyman did mention the lack of pregnancy crises centres manned by the MOH or even religious organizations which could offer teenagers especially, avenues for counselling and options such as adoption. He cited these centres, not for the purpose of providing abortion services but for counselling and helping women with unwanted pregnancies to have access to other options and social support services. Lastly, it must be noted that lack of resources is a perennial and major constraint in the health sector. It may not be the sole reason or major constraint to provision of safe abortion services but it may be used as an excuse not to increase (or 'divert') resources for CAC. Abortion services can, according to some obstetricians, be provided with minimum resources however. Overall, the lack of trained health providers who are willing to offer the service, provider attitudes towards patients as well as the lack of MVA kits are the main problems.

iv. Quality Issues

A number of observations were made by respondents with respect to quality issues in health facilities. As with the resource and training issues, some of the quality issues are generic to the health system in Ghana, but others were specific to abortion care. Quality issues in both public and private health institutions are discussed in the ensuing section.

a. Quality issues in public health institutions

In the respondents' view, public health institutions, by default were not designed to ensure privacy and the large numbers of patients who use these facilities do not also help ensure privacy. Patient B would easily hear information being sought and received from patient A. They also noted that some health providers sometimes acted unprofessionally by not ensuring privacy. Obstetrician 6 said nurses especially do not keep personal details and experiences of their patients confidential as required by professional ethics but sometimes discuss them with patients' relatives. In some cases, patients were said to be unduly delayed in public health institutions for lack of

theatre space. Waiting areas offer no privacy and are not user-friendly. The emergency room in the teaching hospital is small thus always crowded. The cost of care can be high. Policy-maker 2 and obstetrician 2 said some providers charge high fees and behave as though they are doing the women a favour. Policy-maker 2 said such providers make the women believe that abortion is supposed to be illegal and so they face prosecution if caught.

Documentation of abortion cases carried out is reportedly not done at all or the procedure is usually misclassified as evacuation of the uterus (EOU) or MVA supposedly for incomplete abortion. This was said to be the status quo or modus operandi because the heads of some institutions or administrators strongly object to the provision of these services in institutions they sometimes refer to as '*my hospital*'. However, these heads and some providers were said to be comfortable with PAC, hence the misclassification. In public health institutions where the heads are against abortion, there were said to be no structures in place for the procedure and a '*defiant*' provider does not have the support of the boss in case of a legal problem.

According to some of the young obstetricians (3, 4, 5 & 7), when it comes to issues of abortion, there is always a gulf between the '*for and against*' and access to the service in the institution depends on the stance of the one in charge of the institution. If there are providers who would like to offer the service but are not able to do so due to the stance of the bosses, they are forced to find private clinics that offer the service and practise there on part-time basis. One of the obstetricians said when he contacted his boss about provision of the service in the facility; he was told that '*he did so at his own risk*'. These doctors therefore do '*locum*' (or private practice on part-time basis) in private hospitals and clinics and offer abortion services there.

This is the case of obstetrician 3. Doctors who provide CAC in public health facilities were reported to be often labelled as '*abortion doctors*', stigmatized and believed to be extorting women by behaving as though they were doing the women a favour at the risk of their jobs, (i.e. in case of prosecution) thus charging exorbitant amounts for the procedure. They argue that if they are caught, they might face the

law. Due to these quality issues, women who can afford the fees in private hospitals and clinics go there for CAC.

b. Quality issues in private health institutions

Some health providers (e.g. obstetrician 3) in public health institutions were sceptical about the quality of care in private health institutions. Pre and post abortion counselling, family planning counselling and aseptic technique were said to be compromised. The quote below portrays the scepticism shown by obstetrician 3 (who works in a public health institution) concerning certain quality issues in private clinics and hospitals:

"...you don't need much to carry out that kind of service but in our environment, the few people who would want to provide the service might not get access to the equipment that may be necessary... that is why private hospitals are springing up to offer the service. Do they have the right service? Do they have the right anaesthesia? Do they have the right aseptic techniques? ... do they have the technical knowledge? If they have perforations, if they have septic abortions, can they take care of the patient? ... that is why we are getting a lot of problems."

Obstetrician 3, age 38

There was said to be no documentation of cases. The vast majority of respondents cited that the cost of abortion in private health facilities was exceptionally high and thus prohibitive. Poor and marginalized women as well as needy adolescents cannot access these services. Many respondents described abortion as a lucrative venture especially in the private health facilities. These private clinics were said by some to thrive or survive mainly on abortion. Some respondents described abortion as a business and the pelvis was described by obstetrician 14 as equivalent to a 'gold mine':

"... The woman's pelvis is more of a gold mine. People make a livelihood out of that. Oh yes! Yes, they make a livelihood out of that."

Obstetrician 14, age 60+

Another respondent observed:

"... Their interest is to make money. We know the abortion business; people call it a business, when you investigate well, you'll realize that people who carry out abortion charge their unsuspecting victims very well... those people sitting there, they have no knowledge of the drug they are giving; their primary aim is to make money so they sell anything that could even be dangerous to human life."

Cleric 1, age 40

As a pharmacy technologist, Cleric 1 appears to be aware of what goes on in some private pharmacy and chemical shops and draws attention to the dangers involved. Other respondents also spoke of how some pharmacies indiscriminately sell medicines that are able to cause abortions to women without prescriptions. This has been a matter of concern among some respondents who made calls for control.

Still on the issue of quality assurance, obstetrician 12 notes that in the event of complications arising from abortions done in private clinics, prompt referral is not ensured. Women might be forced to resort to self referral or when referred by the private practitioner, the process is usually delayed with no referral notes as the policy and standards demand. This might result in deterioration of cases. Some obstetricians and midwives mentioned that the women are sometimes cautioned by abortion providers not to disclose the name of the clinics where they had the pregnancy terminated. This constitutes a drawback in management of abortion complications. However, privacy and confidentiality were said to be better in private health institutions. In the section that follows, the socio-cultural barriers are explored.

7.5.2 Socio-Cultural Barriers

A range of socio-cultural barriers to provision of abortion services were identified in this study. This comprised of complex and inter-related factors such as social norms, cultural values, religion and morality. Most respondents described abortion as an emotive and highly controversial issue. The vast majority described the procedure as highly stigmatized throughout the country. They noted that those who provide abortions as well as women who seek abortions are labelled as bad people and treated with ostracism.

Ghanaian society as a whole was described by most respondents as one that frowns on abortion and equates it to murder. According to a senior midwife (Midwife 6), no public hospital has a designated place well labelled for abortions or for the management of women with unwanted pregnancies, as we have places designated and labelled as '*labour ward*', '*dispensary*', '*emergency room*' or '*pharmacy*' etc. in public hospitals. Hence women who go to public hospitals to seek TOP are forced to keep on asking people they meet where they could obtain the service within the

hospital. Since abortion is reportedly shrouded in secrecy, such women even find it difficult asking and sometimes they meet health personnel who are against the procedure who then scare them away from the hospital:

"... I think people do not know they can go to the hospital for safe abortion. They think they will not have it done and they don't know how to approach people with their problems. This is why they go to have unsafe abortions. If they walk into a hospital and they are lucky and they find a nurse who will direct them; because it is not clearly written where they should go, they keep asking ... she is shy, she does not want anybody to know her intentions so she probably asked one person and maybe the person does not want to hear about abortion and then she gets insults that will make her problem worse so she goes to a quack for an abortion".

Midwife 6, age 60 +

Due to the intensity of the stigma associated with abortion in Ghana, obstetrician 2 suggested that the word '*abortion*' be removed completely from the name of a place designated to help women with unwanted pregnancy. He suggested the name '*Comprehensive Reproductive Healthcare Centre*'. He also suggested that '*comprehensive abortion care*' be reframed, without the term '*abortion*'. In his view if the name '*abortion*' is taken out, the stigma associated with it will also go.

A discussion of socio-cultural barriers to provision of safe, legal abortion services will be incomplete without the mention of culture. Culture has been simply described as the way of life of a people. Culture includes art, law, custom, beliefs, values, norms and morals of a people; all that go into their everyday life (Assimeng 2006). Religion is also embodied in culture and plays a large part in shaping social attitudes to abortion. Ghanaian culture by all intents and purposes denounces abortion and considers it reprehensible (Bleek 1976, Lassey 1995). Some respondents described how Ghanaian society considers abortion as a '*taboo*', an '*abominable act*', '*socially unacceptable*' and '*abhorred*'. My own experience has shown a strong negative view of abortion in Ghana. According to Muslim Cleric 1, Clergyman 3 and Obstetrician 6, women have had to relocate, moving from rural communities where there is much social cohesion to urban areas in order to hide under the cover of anonymity in cities after abortion. Due to the general attitude towards abortion, there is reportedly a culture of silence surrounding the issue and no public discussions are usually held on it. Those who have abortions and those who offer abortion services are considered immoral people and murderers:

"... I feel it's butchering human beings into pieces...there's a silent cry inside the womb... the voiceless are being murdered silently without anybody hearing and I fear the procedure... abortion... an interruption of life! It's against the rule of the creator. ..the creator said it and the creator knows how important we are for Him. He knows us before we were born and he has reasons for us before we were born..."

Midwife 12, age 50 +

Midwife 12 insisted on getting her bible before her interview. She willingly agreed to be interviewed and explained with passion why abortions should be forbidden. By her religious beliefs and standards, she strongly believes abortion is completely unacceptable and must be preached against. Midwife 8 said all those who offer abortions are answerable to God on the day of judgement. She talked of God demanding the '*blood*' and '*life*' of all the foetuses killed from the providers. Of all those against abortion it was mainly the midwives – women, who talked of eternal punishment for the providers from God. The senior Catholic Clergyman also implicitly said so. The reason for this may be religious.

Unlike Midwife 12, another midwife who was contacted for an interview declined. The reluctant midwife initially agreed to be interviewed but kept saying she was busy each time she was contacted for the interview. When she was contacted on a day she was not busy, she finally explained that she did not want to think and/or talk about the subject (abortion). Meanwhile, she is one of the principal nursing officers (PNO) in charge of a gynaecological clinic that treats women with abortion complications on a daily basis. Even though she was part of the team that cared for abortion cases, she would not grant an interview on abortion. Also, one of the respondents, a member of a research team that carries out research on abortion and who had attended several conferences and meetings on the topic, said she did not have any information to share on abortion when contacted for the interview. Although, she granted the interview, she was very succinct and guarded. This was the kind of attitude most respondents referred to as hypocrisy or the '*ostrich behaviour*'- a denial of a problem they confront daily at the workplace.

In this study, I found out from the headquarters/secretariats of two Protestant Churches, the Catholic Church, the Christian Council and the Ghana Pentecostal Council, what the stances of these churches were regarding abortion. Even though, I

requested to see any document which had the stance of the churches on abortion, none of the officials met produced a document showing the stance of the church. There was no written document, however, all the churches visited talked of a stance against abortion. However, on medical grounds, abortions are considered based on doctors' decisions. The Catholics did not talk about abortion on medical grounds. The senior Clergyman interviewed noted that the church does not countenance abortion under any circumstances. The Clerics also spoke of Islam being against abortion but allowing it in some circumstances. Thus, among the two major religions in Ghana namely Christianity and Islam abortion is forbidden, though some allow it in early pregnancy or for medical reasons.

The religious stance appeared to be a strong influence on health providers' decision to offer abortion services themselves or support the provision of the services in health facilities:

"...some people, just the mention of abortion would frown because they are religious. Medically, I think it will be stupid on my part - with my training to say no, go ahead (with a pregnancy) when the woman's life is at risk. Religion believes that when a woman is going to lose her life, God could come in and save her life; God would intervene. We call that a miracle. In medicine, we don't wait for miracles. We can't see patients dying and say let's hope for a miracle."

Pharmacist 4/Law Student, age, 28

Although the respondent is a Christian and described himself as highly religious, he observed that there could be situations where the continuation of a pregnancy would be medically unwise. He suggested the need for the two social institutions - religion and health to find a common ground to act in the interest of women dying or having complications of unsafe abortion.

Respondents presented the common view that Ghanaians are highly pro-natalistic. The vast majority also mentioned the general belief that all pregnancies achieved should be delivered thus socially, abortion is not a welcomed option:

"... in Eastern countries and in Europe, I know they have such facilities. Even single women who get pregnant from casual relationships can go for the service because over there they are so careful about their population and individuals choose to have children when they want. But here when one gets pregnant, we have a simple understanding that it is God who has given the child. So even if you are not ready

you should have the child because may be that will be the only child you may have in your life time. So based on our moral ground, we tend to encourage most women who get unplanned pregnancies to have the children”.

Pharmacist 5, age, 47

This is the norm. Respondents presented a common view that Ghanaians believe that children are blessings from God and thus abortion is viewed as destroying God's gift. Moral values held in Ghana consider children as valuable gifts to families and society. Children, including those yet to be born are thus held in high esteem. Abortion is thus highly reprehensible in Ghanaian society thus making social access to abortion services in Ghanaian health facilities a problem.

7.6 Summary

While both post abortion care and comprehensive abortion care constitute part of the MOH Reproductive Health Care Package (since 1990 and 2003 respectively), PAC is relatively more widely accessible and openly offered in major hospitals in the country with little or no stigmatization and condemnation. Access to CAC however, is limited in public health facilities and where offered it is usually done '*clandestinely*', and characterised by heavy charges at the expense of women's ignorance of the abortion law.

Despite an absolute lack of officially provided, public sector safe abortion services, the interviews revealed the use of two prominent arguments in favour of more widespread safe abortion services: that the government had a responsibility to reduce the high maternal morbidity and mortality rates, seen as linked to unsafe abortion; and that safe services were a matter of women's rights. Midwives, though, while accepting the need to provide post-abortion care, were much more reluctant to provide comprehensive abortion care.

Although some evidence of sympathy for safe abortion services, in some instances, was identified a range of barriers still operate. Service-related and socio-cultural barriers to CAC were identified. The service level barriers were legal ambiguities, gaps and inconsistencies, provider attitudes, lack of resources and training, and quality issues. Legal ambiguities impede service provision by making providers unsure and unwilling to provide safe, legal services. A range of resource and training

issues also limited availability of services. Quality of care issues, including lack of confidentiality and inflated costs which increase financial barriers increase women's reluctance to seek care. While some of these issues are generic to the health system, the sensitivity of abortion means that attitudes of providers can exacerbate them.

The most prominent of the barriers identified in this chapter was provider attitudes which cross-cut service level barriers and socio-cultural ones and appeared to be a critical influence on provision of care. Provider attitudes: a) prevent providers from providing abortions at all for moral and religious reasons, b) make them reluctant to provide the service because they are unsure of the legality of it and c) encourage them to use clients' ignorance of the law to charge high fees (usually in the private sector). The next chapter therefore explores in detail the wider beliefs and attitudes of respondents concerning abortion services identified in this chapter, and their wider social context.

CHAPTER EIGHT

FRONTLINE ACTORS' ATTITUDES AND BELIEFS TOWARDS PROVISION OF ABORTION CARE

8.1 Introduction

In the previous chapter, I explored the barriers to the provision of comprehensive abortion care; those experienced at the service-delivery level and socio-cultural factors. One key barrier that was identified was the attitudes held by individual providers that influenced (or had potential to influence) their professional practice. This chapter considers this issue in depth, exploring the complexity of arguments used by key informants for and against comprehensive abortion care and how these positions affect providers' service-delivery behaviour.

The issues in this chapter are discussed under six main sections. Section 8.1 provides a brief introduction to the chapter. Section 8.2 outlines the arguments given by the entire range of respondents to support positions in favour of comprehensive abortion care and against it. Section 8.3 describes the respondents' display of ambiguous or contradictory opinions and how multiple arguments interplay within individuals. Section 8.4 then discusses a group of respondents who held a markedly different view from the others in their respondent group – in other words, '*positive deviants*'. A few case studies of individuals are presented in order to understand why some people hold views so different from those of their peers and consider what lessons can be learned. In section 8.5, health providers' dilemma between their religious beliefs and professional obligations are highlighted. I describe the dilemmas faced by providers from personal confusions (e.g. balancing religious and professional beliefs) and social perceptions of them. Section 8.6 then narrows down to consider the 'street-level bureaucrats', i.e. the health providers who are crucial to the actual implementation of the policy and discusses how health providers' beliefs and attitudes affect implementation of abortion policy in Ghana drawing on Lipsky's street level bureaucracy theory. The final section, 8.7 discusses how the attitudes of some heads of institutions or facility managers influence abortion service provision.

Throughout the chapter, I attempt to differentiate between norms regarding '*abortion*' and those that refer to '*comprehensive abortion care*'. This distinction is important because people can hold negative views about abortion per se but be in support of comprehensive abortion care. To understand what the opportunities are for implementing the CAC policy, one needs to know what people really think about CAC and not just abortion.

8.2 Arguments used for and against Comprehensive Abortion Care

The main arguments put forward in favour of abortion care were on grounds of public health upheld in legal and professional codes. These basically constitute arguments showing the existence of a clear medical problem which the professionals saw as warranting their intervention based on ethics of their profession, and the legal and human rights mandates accorded to their profession. The arguments advanced against the provision of comprehensive abortion care were mainly based on religion and morality as well as human rights (i.e. the rights of the unborn child). In the ensuing section, each of the arguments will be discussed in turn.

8.2.1 Arguments to support comprehensive abortion care

Three main categories emerged: public health, professional ethics and human rights.

i. Abortion on grounds of public health

Arguments for comprehensive abortion care were largely based on public health grounds and were put forward by the vast majority of respondents. One of the younger obstetricians noted:

"... about 30% of maternal deaths is due to unsafe abortion... provision of safe abortion services is one of the easiest ways of reducing maternal mortality... Women are dying from unsafe abortion; young, beautiful, poor women are losing their lives needlessly through unsafe abortion. Safe abortion services are the easiest and safest procedures... provision of safe abortion services is a must! Ghana Health service should implement it. It will help to reduce maternal mortality."

Obstetrician 4, age 42

Obstetrician 4 considers provision of comprehensive abortion care an obligation of the government to address a serious need; saving women in their fertile age from unnecessary and preventable deaths. One of the older obstetricians also vented his frustration about lack of abortion services in public hospitals and described it as a

professional obligation to avoid a public health risk that is contrary to international goals. He noted that knowledge of the extent of the problem and availability of the technology for resolving the problem exists. He urged that action be taken in order to reduce maternal deaths:

"... There're too many women dying from unsafe abortion in our hospitals. We have signed on to the MDGs; we have to reduce maternal mortality. If X, (a pathologist who studied maternal deaths) says 30% of our women are dying as a result of complications of pregnancy and unsafe abortion then we (MOH/GHS) have the responsibility to take the lead.... Young women are dying because of abortion. Today, no woman should die as a result of abortion! It is not as if we don't know what to do. We know perfectly well what to do! So why are they still dying? It's not a plague; it's not Tsunami that we can do nothing about (Laughs). It's not "hurricane Katrina". We know how the problem arises; we know the magnitude of the problem we have the answers to deal with the problem; we have the technology to save women's lives and say no more! (Claps).

Obstetrician 6, age 70

Obstetrician 6, in the interview told me he had taught for many years in the Ghana Medical School. He further mentioned his work and experience in many countries. He is a member of the think tanks spearheading the scaling up of CAC in Ghana. His wealth of experience thus explains his frustration over the observed poor reproductive health outcomes (maternal morbidity and mortality) and attributed the situation to ambivalence of superior powers at the MOH/GHS.

Three obstetricians (4, 5 and 8) noted that if safe abortion services are not available and accessible in public health facilities, they inevitably have to focus on managing incomplete abortions (post abortion care) which were referred to as "*sitting back and cleaning up the mess*" or doing "*post abortion maintenance*". In their view, if women have no access to safe abortion services, they would resort to dangerous means of terminating unwanted pregnancies, for example through the use of untrained providers and end up in hospital seeking post abortion care.

Some midwives (11) believed abortion care could be provided on public health grounds by providers who are willing to do so. They deemed it professionally right to save women whose lives were at 'risk' due to their pregnancies:

"...these girls are getting pregnant at a tender age and they know they cannot afford to look after the children so they go to the backstreet abortionist and they abort for them and they end up dead, pelvic infections... I think what can be done is to make

safe abortion available... that is very controversial... once you mention...safe abortion, people think everybody can have abortion. If safe abortion is made available and people are told where they can get it, it may help...because they're dying; maternal deaths from abortion is over 30-35% and these are young girls...I don't have anything against it so long as that person needs it the person should be referred to the right place. I wouldn't like to have an abortion myself but I think that instead of people dying it will be better to save them; once you save them you educate them properly ... "

Midwife 14, age 60+

One of the pharmacists noted:

"...when I see the life of a woman at risk, it makes medical sense to consider termination...the women who are dying from unsafe abortions and having medical complications; if the continuation of the pregnancy could harm the woman's life medically, I think there should be abortion ...".

Pharmacist 4, age 28

Besides the medical reasons this young pharmacist gave for the need for abortion, he seemed to show compassion for women with complications following unsafe abortion whose lives were at risk and those who were dying as a result. He described himself as a very religious person and one who is also '*realistic*' based on the prevailing circumstances.

Several obstetricians argued that women with unwanted pregnancies are not healthy but desperate people with mental unrest who would go to all lengths to terminate pregnancy. Obstetrician 13 noted that for a very long time the focus of consideration for abortion on medical grounds, had solely been physical ailments at the expense of mental health:

"Another example is the emotional aspect. Formerly we did not put much emphasis there. The emphasis was all on physical. It had to be severe hypertension; something that you can physically see on the woman. Now we are giving more meaning to the emotional(mental) aspect. When the woman comes to say that this pregnancy I am carrying was by accident and it is disturbing me mentally and if I don't get rid of it, it will worry me emotionally..."

Obstetrician 13, age 40

It appears there have been newer insights or a reawakening of providers to the mental health needs of women when it comes to abortion care which was not highlighted by other types of respondents. Given that the mental health requirements of women with

unwanted pregnancies have been a neglected area over time, it seemed some providers are now prepared to use it in the interest of women in need of comprehensive abortion care. This has implications on access to abortion care; it has potential to increase access to care by widening the scope of application of the law.

ii. Professional ethics

The second motivation expressed in favour of comprehensive abortion care was based on issues of professional ethics. Arguments based on professional ethics were mainly raised by the health professionals. Professional ethics refer to the guiding principles health professionals are expected to follow in their work. Doctors, midwives, nurses, pharmacists and other health professionals have a set of ethics which they are introduced to both pre-service and during in-service training to guide their work and conduct. These are laid down in oaths or prayers or in a code of ethics (e.g. Code for Nurses, Ghana Registered Nurses Association; N&MC Ethics for Nursing and Midwifery).

For example, the Hippocratic Oath and the Midwives' Prayer (both given in Appendix 12) enjoin doctors and midwives respectively to save lives. In the interviews, the obstetricians described the execution of the duty of saving lives as spanning across a continuum of saving women's lives in emergency medical situations, responding to immediate physical health as well as protecting them from causing harm to themselves, curbing suicidal tendencies and other forms of mental ill health. Some obstetricians shared experiences in their practice where the principles of their profession warranted the provision of abortion based on having to choose the mother's life over that of the baby:

"....As a practising obstetrician, I sometimes have to make the choice about whether I save this child's life or the mother's. There are circumstances in which I cannot save both so I have to take one life in order to allow the other one to live. It's not a happy choice but I have to do it! My upbringing (training) is that I must sacrifice the child to save the mother. That's the principle..."

Obstetrician 6, age 70

Obstetrician 13, a younger professional also acknowledged that obstetric practice demands that they save the mother rather than the foetus in such situations. He described that measure as resorting to the '*greater good*' and argued that saving the mother would be more beneficial to other members of the family. He added that the

survival of the woman's other children depended on her. The use of the term '*greater good*' by the obstetrician implies that if a pregnancy is terminated to save a mother, it is only the loss of one life (that of the foetus) whereas the continuation of a pregnancy fraught with medical problems may result in the loss of the woman's life which will affect her other children. Keeping the woman alive thus yields more dividends.

As indicated by analysis of the Standards and Protocols on comprehensive abortion care and confirmed by some obstetricians, the Ghana Health Service's mandate to ensure availability and accessibility of comprehensive abortion care does not only require its workers to provide abortion care but also to refer for care as explained earlier. The Standards and Protocols of the Ghana Health Service indicates that health providers who claim conscientious objection are duty bound to refer women in need of abortion service to an accessible qualified provider. Midwife 2 reported referring women with unwanted pregnancies to see gynaecologists. She felt professionally obliged to do so in order to save the women's lives:

"Unsafe abortion kills and maims women... my profession demands that I save lives so I refer. I think I have done the best by referring her".

Midwife 2, age 50+

Another midwife (midwife 9) also reported that she refers women with unwanted pregnancy to the family planning unit² of the hospital where she worked. She also felt professionally obliged to refer them there for assistance, rather than leaving them to resort to unsafe abortion with all its complications and risks. Both midwives appeared to perceive abortion care as a professional obligation to save lives. Although the midwives did not explicitly refer to the prayer, their action may be in response to the midwives' prayer, a professional code of ethics that guides midwifery practice, enjoining them to save lives and not to destroy.

Even though a clause in the Hippocratic Oath (sworn by newly qualified doctors to guide their practice) forbids abortion, sometimes when faced with dire medical

² Some respondents informed me that termination of pregnancies was done at the unit and I was also aware of that.

conditions, this prohibition conflicts with the Oath's call to save lives and therefore some doctors perform abortions to save women's lives. They regard their action as a sound medical practice consistent with the Oath, as a public health practitioner/doctor explained:

"... as a doctor, what you do is to save lives. That is your calling. That is what you swore to do under the Hippocratic Oath so for us, we are doing our medical job and now we are doing it under the law... I think that we are doing the right thing".

NGO Representative, age 40+

This respondent argued that irrespective of the kinds of beliefs people have, doctors are duty-bound to save lives. He believes doctors can justifiably provide abortion services based on ethics of their vocation as well as the law on abortion in Ghana. He also implied that international conventions such as the ICPD platform of action permit abortion services. He thinks that one cannot judge clients' decisions to have an abortion; that health professionals do not have the right to question the beliefs of their clients but must respond to a medical situation according to their professional ethical codes. These on-going arguments appear to be pointers of the potential for dilemmas among respondents who are health professionals. This will be explored in section 8.5 on page 218.

iii. Human rights

Human rights was the third category of arguments that were put forward to support comprehensive abortion care. When ascertaining whether respondents supported the provision of abortion care, human rights reasons were frequently mentioned as justification for care. Lawyer 2 noted:

"I raised some concerns with respect to abortion... our laws allow abortion in certain circumstances so you can't have a policy, which is inconsistent with the law. When you have that you're violating human rights of people (women) in Ghana...now, in 2006... the equipment is not there, the personnel have not been trained..."

Lawyer 2, age 40

The Ghanaian female lawyer and human rights activist was very frustrated about the non-implementation of the abortion law despite over 20 years of its liberalization. In an earlier quote, she described how the absence of an objective on abortion in the 1996 RH policy document and the lack of abortion services in the public health

facilities amounted to violation of women's rights. She expressed surprise at the attitude of doctors who even though they are aware of the lingering high rates of maternal deaths in the country, appear not to be doing much about it. This is the same reason for obstetrician 6's frustration that was mentioned earlier.

Besides the lawyer, a number of respondents across the categories, cited human rights as one of the reasons why women should have access to comprehensive abortion care. They argued that based on Ghana's 1992 Constitution as well as International Conventions such as ICPD which Ghana has adopted, the health system is mandated to ensure that reproductive health care, including comprehensive abortion care within the law are available and accessible to women who need them. They believe it is the statutory rights of women to have abortion services if they need them. Lawyer 2 emphatically mentioned in the interview that hitherto, the health system's emphasis on post abortion care in the RH policy document and lack of safe abortion care in the public health facilities show the level of disservice to women in need of safe abortion.

On the question of abortion and human rights, one of the obstetricians noted:

"It is the right of every woman who wants abortion services, that it should be provided. I want to see a day that women will go to the Ministry of Women and Children's Affairs holding placards saying that it is their right to have abortion services. Those who talk about the rights of the foetus are bringing religion in. Which comes first the chicken or the egg? If they continue like this, they won't find any headway".

Obstetrician 8, age 50

In terms of human rights, obstetrician 8 believes that it is the right of the woman that is paramount. He highlights the need for advocacy and demand from women themselves - something usually associated with calls from the legal profession and campaign groups.

Still arguing on human rights, another obstetrician also highlighted the obstetricians' position regarding the paramount right of women over the foetus, echoing those obstetricians cited earlier who justified this in relation to professional ethics:

"When you look at the Cairo Conference, (ICPD), it was stated categorically that it is the right of the woman to decide... Also, it said where abortion is not against the

law, it is the right of the woman to access safe abortion service so; it is a human right... those of us in obstetrics put the right of the woman above that of the foetus if the life of the mother conflicts with the life of the foetus..."

Obstetrician 13, age 40

Only a few midwives used arguments for abortion based on human rights probably due to their conservative attitude about abortion care:

"...everybody has a right ... so if somebody comes and the person qualifies to have an abortion, it is a right. We should not deny them their right...most of them do not even know their rights that is why they go to the quacks..."

Midwife 6, age 60+

The respondents in favour of abortion services based on human rights clearly articulated their arguments on the rights of women. Some of these respondents also acknowledged the rights of the foetus but the arguments were not clear-cut and indicate the uncertainties about the personhood of the foetus. This exemplifies the complexities that confront health providers and abortion care provision. The discussion now considers some of the arguments respondents used against abortion.

8.2.2 Arguments against comprehensive abortion care

This section describes the arguments forwarded by respondents to justify their position against the provision of abortion care. These were mainly developed on the grounds of religion and morality and human rights (i.e. the rights of the unborn child).

i. Religious Arguments

Many midwives were against abortion and showed scepticism about abortion care. A midwife who had worked in the gynaecological out patients' department of the teaching hospital for over a decade said:

"... I am against abortion because God says keep your bodies as a holy temple for me to come and dwell in you...To have sex, to get unwanted pregnancies? The Bible tells us that we should keep our bodies holy because our body is the temple of God..."

During the interview, her main concern was about adolescents having premarital sex, getting pregnant and aborting these pregnancies at the expense of their lives. She highlighted the health outcomes of unsafe abortions these youngsters encounter and

also stressed that eternal condemnation awaits them. On the question of designation of facilities for comprehensive abortion care she noted:

“...W-e-l-l, (took her time and spoke slowly) I feel we are giving license for women to have sex before marriage... they should not go into sex when they are not ready to have children... I don’t believe in setting centres for abortion... with the fear of God in me, I will not say they should open centres. When I say that, I sin before God. I am challenging God... if I don’t answer today in future; I know I will answer for it so I won’t support those who say centres should be opened for legalized abortion.

Midwife 8, age 50+

On the question of delegation of midwives for provision of safe, legal abortions she said:

“...I will object to it. I will never do it... I wouldn’t want to offend my God. Because he says don’t do it. So I don’t want to do it. When you do it, your hands become bloody. The bible tells us that when you do it you are killing. When you destroy that person you have blood on your hands.”.

Midwife 8, age 50+

Midwife 8 did not think provision of safe, legal abortions is a solution for unwanted pregnancy. In the interview, she said alternatives like social support services and adoption were the best options for women with unwanted pregnancies. To her abortion is killing and bloodshed that will attract punishment from God. She believed that supporting abortion care meant going against God’s commands. Two other midwives (Midwives 1 and 5) talked of having “*bloody hands*” when they get involved in abortion. One of them said her hands are “*healing hands*” and not ones for “*killing*”. The midwives did not explicitly refer to the midwives’ prayer as one that forbids abortion but implied in their arguments that their duty is to save lives. From the above descriptions, it appears midwives 1 and 5 were referring to saving the lives of foetuses. They believe that all those who carry out abortions and those who aid and abet will be punished by God. The most popular Bible quotation cited against abortion was Jeremiah 1:4-5. Midwife 12 noted:

“... they (abortion providers) are destroying human life. As the Bible says in Jeremiah 1:4-5- “The word of God came to me saying before I formed you in the womb, I knew you; before you were born I set you apart; I appointed you as a Prophet to the nation”...the word of God is so clear about us human beings before we were even formed in our mother’s womb. God knew us before we were formed so- to- destroy... we’re violating the rules of the creator”.

Midwife 12, age 50+

This midwife read and explained this passage to me during the interview and thought it was clear-cut that abortion is forbidden in the Bible. She also believed judgment awaits those who practise abortion and expressed the need for religious leaders to teach against it. This midwife works in a gynaecological out patients' department in a teaching hospital where women with complications of unsafe abortions are seen on a daily basis. She underscored the need for abortions to be curbed, whether they are safe or unsafe. In her own words she said "*abortion is abortion whether it is safe or unsafe*". One clergyman also pointed out:

"do not kill"; the Bible says we should not kill so from my perspective as a Reverend Minister, once the person is pregnant and it's not on medical grounds that termination must be done, the person must give birth because the life of that person is from God... Whether it is unwanted or wanted there shouldn't be any abortion except on genuine medical grounds..."

Clergyman 4, age 52

The clergyman called for adherence to the biblical commandment that forbids killing and spoke against abortion except those carried out on grounds of health. He was thus equating abortion to the act of killing.

Although most religious-based arguments were forwarded against abortion, a few respondents (e.g. obstetricians 2, 9 and 13, clergyman 5, cleric 2 and pharmacist 4) argued for abortion care based on the religious elements of '*compassion*' and '*forgiveness*'. They argued that health professionals who are charged with provision of abortion services should not '*play God*'. They are not to be judgemental but to show compassion and forgive women if they think the women have '*sinned*' by having an unwanted pregnancy. They argued that such women should be given a second chance and not allowed to resort to unsafe abortion at the risk of their lives.

ii. Arguments on Morality

Morality was another element that was mentioned as an issue against the provision of abortion care. I observed that sometimes the issue of morality was cited in conjunction with religion and it was not always easy or possible to disentangle the two. In this section, I discuss what constitutes '*morality*' from the interviews. This includes '*western*' '*decadent*' '*sexually liberal*' behaviour which is seen as

'immoral'. Also, morality was perceived in terms of arguments about '*good*' or '*evil*' more akin to religious beliefs but not given as explicitly religious.

Together with religion, ideas about morality were among the major deterrents to the provision of safe abortion. A policy maker at the MOH headquarters observes:

"... Having pregnancies aborted is not the best solution as most people think. Other options should be explored. We have cultural and religious values we cannot do away with. Society has its values and we should maintain them. Abortion brings immorality in the society. Safe abortion services should not be provided. "Safe abortion services"? If it is safe, it is "safe" in quotes. It cannot be 100% safe! Errors can occur ... It should not be abortion, abortion all the time. The debate on the solution is one-sided".

Policy-maker 3, age 50+

This policy-maker while claiming she was sceptical about the '*safety*' of the safe legal abortions being proposed to help curb the consequences of unsafe abortion was completely against abortion and abortion care and mentioned other plausible alternatives like social support services and adoption during the interview. She informed me about the adoption policy of the Department of Social Welfare and another policy at the Ministry of Education that enables girls who become pregnant in school to give birth and return to school. She appeared to imply that the introduction of safe abortion services means doing away with Ghanaian cultural and religious values and giving way to moral decadence in society. She occupies an influential position at the MOH Headquarters and is also a medical practitioner. Her position on abortion has implications for decisions on abortion care. Clergyman 9 does not also agree with the term '*safe abortion*' and considered it a misnomer that resulted in an immoral act (abortion):

"It is very sad to talk about safe abortion. What does it mean? Safe, for whom? The word "safe" and the word "abortion" are two anomalies. I don't think morally it should be accepted; I would not subscribe to any form of safe abortion. Abortion should not be allowed and should not be even called safe... It is like killing somebody and saying, I am killing you safely".

Clergyman 9, age 60

The Clergyman's choice of words clearly depicts his sentiments about abortion and abortion care. In the interview he indicated that criminalizing abortion is not an important measure to stop unsafe abortions, in keeping with the view of other

respondents (e.g. Lawyer 2). In his view the best measure is to educate society adequately and to sharpen the conscience of people to see the need to protect the foetus by standing up, for moral reasons, against abortion.

It is worth noting that a minority of respondents (e.g. Midwife 6, Policy-makers 1, 2 and 7, Obstetricians 2 and 13 and Parliamentarian 4) argued for provision of abortion services on moral grounds. They believe that withholding safe abortion services from women with unwanted pregnancies is immoral since some women are forced to seek unsafe abortions.

The final arguments advanced against abortion were in relation to protection of the rights of the foetus.

iii. Arguments on human rights of the foetus

Some respondents argued strongly against the provision of abortion on the basis of the rights of the foetus:

“.... Abortion is an inhuman right because it is against the rights of very defenceless human beings. This for me is the bottom line... I am sad that some people claim it is the woman’s right to have abortion. Any woman who subscribes to the fact that she has the right to abortion is submitting to an inhuman right against herself ... because one of the strongest gifts that women have is the gift of giving life. If a woman should get to the point where she thinks that her rights should help her trample upon the rights of that which she can give birth to then it is a totally inhuman right”.

Clergyman 9 age, 60

Another clergyman noted:

... The woman thinks it’s her reproductive right but I always ask the question; on what basis do you (mother) claim a right when you are violating the right of another (foetus) because in every abortion, there is a violation of the right of the foetus; on what basis is your right more important than that of the unborn child; that is the problem I have...when we talk of rights, the mother has a right as well as the foetus; that of the mother alone is selfishness

Clergyman 1 age, 40

All the Catholic Clergy interviewed as well as a few of the non-clergy Catholics (e.g. obstetrician 15) argued against abortion on grounds of the rights of the foetus. Clergy

9 and 10 emphasized that Catholic doctrine considers foetuses as weak and defenceless persons with rights that should be protected.

One of the trainers interviewed spoke vehemently against abortion and refused to refer his own sister (when she said she needed an abortion) to an obstetrician in the teaching hospital where he works:

... I am not in favour of it (abortion) now and I will never be in favour of it, and wherever I am given the opportunity I will speak against it... Yes, the foetus also has got rights to live so they (protagonists) should also think about that. Yes, the foetus also has got rights; the right to live.

Trainer 3 age, 54

The next section discusses the complexity of factors that influence providers' decisions regarding provision of abortion services.

8.3 Ambiguity and Complexity revealed in Arguments for and against Safe Abortion

In analyzing the data, I looked for patterns among the various arguments used for or against the provision of abortion care. This was because of the way some respondents apparently used a combination of some issues and not others for their arguments. Based on the data, I can say that with respect to arguments for abortion care the primary arguments used namely: public health, professional ethics and human rights, are all mandates from international treaties, conventions, declarations or Oaths and are considered universal or global. These arguments were used primarily by the more highly educated cadres of respondents (e.g. obstetricians, pharmacists, lawyers, policy makers). The primary arguments used against abortion and abortion care, namely: religion and morality were more traditional and less influenced by knowledge from outside Ghana and were used primarily by the lower cadres of respondents, especially mid-wives who were generally less exposed to knowledge from outside their own socio-cultural context. Nevertheless, while some arguments may be considered more universal (professional ethics, human rights) their interpretation and use by respondents was highly complex. The table below shows the arguments used by different respondent types for or against comprehensive abortion care. It indicates how multiple arguments are used by each

type of respondent and how the same type of argument (e.g. human rights) is used both for and against abortion. Not all respondents forwarded arguments on each issue. A minority of respondents were silent on some of the issues. For instance, nine (9) respondents did not comment on public health, eight (8) made no comments on human rights, 13 were silent on religion and 10 on morality.

Furthermore, with respect to religious and moral arguments against abortion, some respondents did not only advance their own arguments but in addition mentioned how other Ghanaians and the society as a whole perceive abortion. Out of the 12 obstetricians who advanced arguments against abortion on the basis of religion, two explicitly argued in their own right but as many as 10 projected ‘religion’ as a factor that many Ghanaians would use against the practice of abortion. Three out of 11 respondents belonging to the category ‘other health professionals’ also argued that Ghanaians are generally against abortion on grounds of religion; however the remaining eight made their own arguments against abortion on religious grounds.

Table 8.1 Distribution of respondents by arguments for or against abortion care

ARGUMENTS/ RESPONDENTS	FOR					AGAINST				
	PUBLIC HEALTH	HUMAN RIGHTS OF WOMEN	PROFESSIONAL ETHICS	RELIGION	MORALITY	RELIGION	MORALITY	HUMAN RIGHTS OF FOETUS	PROFESSIONAL ETHICS	
OBSTETRICIANS N=15	14(93%)	13(86%)	12(80%)	3(20%)	2(13%)	12 (80%)	11(73%)	6(40%)	-	
MIDWIVES N=14	11(79%)	2(14%)	8(57%)	-	1(7%)	13(93%)	9(64%)	1(7%)	2(14%)	
*OTHER HEALTH PROFESSIONALS N=14	14(100%)	9(64%)	5(36%)	1(7%)	-	11(79%)	10(71%)	6(43%)	-	
NON-HEALTH PROFESSIONALS N=9	9(100%)	7(78%)	-	-	1(11%)	8(89%)	7(78%)	2(22%)	-	
POLICY MAKERS N=9	7(78%)	5(56%)	6(67%)	-	3(33%)	8(89%)	8(89%)	3(33%)	2(22%)	
RELIGIOUS LEADERS N=15	12(80%)	4(27%)	3(20%)	2(13%)	-	15(100%)	14(93%)	10(67%)	-	
TOTAL	67 (9)	40 (8)	33	6	7	57 (13)	59 (10)	28	4	

*The respondents were re-grouped to facilitate presentation and analysis. As shown in the methods chapter, other health professionals comprised pharmacists, trainers, researcher and NGO representative; non-health professionals were parliamentarians, lawyers and journalist whilst the policy makers were policy makers and representatives of development agencies.

Although religious arguments were primarily used by opponents of safe abortion, some respondents who were mainly ‘pro’ abortion also discussed religious beliefs and dilemmas. These respondents are aware of the strong religious/moral context within which comprehensive abortion care needs to be practised and the challenges practitioners (who are themselves inherently religious) encounter:

“... Abortion, sex, Adam and Eve... we are going back to the Bible... people are very uncomfortable about it (abortion). It doesn’t however diminish the danger to women’s health and lives... I accept that people have a moral problem about abortion. Nobody likes it! Nobody likes it! I’m not talking because I l-i-k-e abortion, No! My first this thing (option) is to prevent it...”

“...in Ghana we don’t have organized religion against abortion but they (religious bodies) have this pervasive influence! Pastors shout ... preaching dooms day; if you sin God will strike you dead, abortion is bad Ghanaians are very religious so the churches have a pervasive influence in which they think that abortion is bad”.

Obstetrician 6, age 70

The obstetrician was passionate in the interviews about the GHS assuming leadership in ensuring that safe, legal abortion services are available and accessible for women with unwanted pregnancies. He however acknowledges the religious/moral dimensions of abortion and considers himself like most Ghanaians as ‘religious’ and with the mindset that abortion is bad. Another obstetrician, a protagonist shared similar sentiments about how religious beliefs of people in Ghana impinge on provision of abortion services:

“... It is because of the notion people have about abortion. If you do abortion, you are evil...it’s been with us all the years, we have all been brought up that way; thinking negatively about abortion...the faith-based organizations think about the religious aspect that it is a sin... . The religious organizations are against it. Pastors and Imams go on air to condemn it...”

Obstetrician 4, age 42

Both obstetricians noted how Ghanaians (including themselves) have been socialized to be religious and how this influences attitudes towards abortion services. Laying much emphasis on the religiosity of Ghanaians points to the fact that the influence of

religion is an element that needs to be surmounted if scaling up of abortion service provision is being considered in Ghana.

In my observation, from analysis of the data, a '*thin line*' demarcates religion and morality in the data. Religion was used to depict abortion as '*sin*' or '*evil*' with references to Biblical passages or precepts from the Koran supposedly against it. Reference was also made by some respondents to repercussions following abortion like eternal condemnation from a divine source (God). However, morality was employed to portray abortion as socially '*evil*' or '*wrong*' with repercussions from the society being stigma, rejection or ostracism.

Human rights arguments were also used (with different emphases) by both proponents and opponents of safe abortion services. Some proponents of abortion argued using the rights of both mother and foetus but focused largely on the human rights of the mother:

When talking about abortion and human rights; there are those who will tell you that, that child, depending on when you terminate it also has rights and I remember one of our professors saying that; it is difficult for you to talk of a 'parasite' having rights over the 'host' ... (Laughs). People talk about the foetus having rights to life but invariably, a foetus is a parasite on the mother so the foetus' rights cannot override that of the host, the mother.

Obstetrician 9, age 40

Of the pharmacists who argued using human rights as justification for abortion the youngest noted:

"... I believe that giving life is God's prerogative; taking life is God's prerogative. So when you take life... all these are crimes, very serious crimes... when we attempt to take it (life) at whatever stage, I think we are playing God. We should leave it for God to decide. I am highly religious... I have been a pharmacist for five years and I am going to the law school. I will think in a more open manner (gets up, holds the arms of his chair and re-positions himself on it) ...think about the rights of the woman, look at the health of the woman... if only the health of the woman is at risk; medically³ when I see the life of a woman at risk, it makes medical sense to consider termination..."

Pharmacist 4, age 28

³ Part of this quotation has also been used on page 194

This pharmacist was noted in the interviews as a very religious respondent who was against abortion but favourable towards comprehensive abortion care based on his compassion for women with unwanted pregnancies whose circumstances warrant abortion on medical grounds. He also argued for abortion on grounds of human rights probably due to his legal background. His background in law may be the reason why he considers abortion a crime, though he showed compassion in the interviews for women to have abortion when medically indicated. His strong religious faith may have been tempered by his studies in law:

... "Traditionally abortion has been like murder. It is not always so. You should look at some of the issues. You should read some of the US cases on abortion - arguments on abortion. You realise that there are very potent arguments for abortion. There are very strong cases for abortion. We have to soften some of the religious positions and look for a grey area (common ground) where we can meet - the women who are dying from unsafe abortions and medical complications resulting ...and also preserve the traditional and religious positions".

Pharmacist 4, age 28

An obstetrician who argued for safe abortion on other grounds (e.g. compassion) made the following observation on abortion and human rights:

"... Many are arguing on the rights of the female... agreed the woman's rights. Every right goes with a responsibility. If they have rights; they must also take the responsibilities... ". One could argue and say that a person has a right to decide whether they want to carry a pregnancy to term or not. But then rights also carry responsibilities..."If you are going to use rights in support of safe abortion services, then another person would say that responsible living is that if you do not want a pregnancy, you abstain or use contraception!

Obstetrician 2, age 40.

Some respondents who were anti-abortion focused on the rights of the foetus and ignored the rights of the mother:

... "The baby is left out! That baby is an individual and has rights! We all know from physiology that the baby is only using the uterus as a temporary abode. Science is trying very hard to keep babies out of the womb... the mother offers the baby temporary shelter and nutrition. That baby is a complete individual with its own rights and that one is left out of the equation all the time. The people who are

pushing so hard for abortion on demand focussing only on the lives of the mother, what about the life of the baby?

Obstetrician 15, age 66

However, some respondents who were generally ‘anti’ abortion also acknowledged the human rights of the mother to apparently make an exception to their anti-abortion view, indicating the ambiguity that many respondents showed when discussing abortion as a rights issue:

“Human rights! Everybody has a right; ... I believe the women have a right to good health. If having access to safe abortion is what will help her lead a normal life, then fine”...

Pharmacist 6, age 49

Similar to arguments on human rights, the respondents who cited the Hippocratic Oath in their arguments used different emphases. The Hippocratic Oath used in Ghana (The Geneva Declaration 1968) speaks against the practice of abortion. Four out of the five respondents who cited the Oath were proponents of abortion care. They focussed on the mandate of the Oath to save lives, referring to saving the lives of women who would otherwise die from complications of unsafe abortion. The only respondent amongst them who opposed abortion highlighted the part of the Oath that forbids abortion:

“... You see, morality is at the base of this whole discussion. That is why Hippocrates said; ‘I will not give potion to a woman to abort a pregnancy’. That was thousands of years ago without all the scientific proof that what had been conceived was human. In the Catholic Church in the earlier days a baby was not human until it was born. Then it was 28 weeks when they preached that the foetus was ensouled. Technically if you terminated the pregnancy before a certain state it was not human. Now a baby is a baby from the time of conception! So morality comes in...”

Obstetrician 15, age 66

Based on their beliefs, views and position on abortion, respondents seemed to highlight aspects of treaties or Oaths they want to use for the arguments ignoring other parts that go against their arguments.

Some respondents appeared to be torn between the two sets of arguments (i.e. arguments for and against abortion) and appeared to be evasive about their stance on abortion but in reality they were ambivalent and taking both sides. In some situations, they would argue in favour of abortions whilst in other situations they would argue against it:

... "The girl is pregnant; she is not married so psychologically she is not stable. She comes to you and says I want an abortion; the thing to do is to let her go through counselling; family planning people are well trained to do the counselling. If counselling is not done, and anybody does the abortion, then we are not doing the right thing ... If she can be made to continue the pregnancy that is very good... Some people come and they are pastors and choristers; they have positions in church and they are not married. You tell them during counselling that, look here you have committed a crime (pre-marital sex) already. If you go ahead and do this thing (abortion) you are using one sin (abortion) to cover another sin (pre-marital sex)... Those people must have the abortion done for them because they are resolved to do it".

Obstetrician 5, age 38 years

Although this obstetrician acknowledges the importance of counselling and the need for trained counsellors to do so, he portrayed a judgemental attitude referring to pregnancy out of wedlock as sin and abortion as an additional sin. His attitude was contrary to the principles of the GHS (2006) standards and protocols, which forbid health providers to be judgemental. He was one of the few obstetricians who were ambivalent in their responses. As a Catholic, his faith might have influenced his counselling.

The above section discussed the range of arguments used for and against abortion care. In the section that follows, I describe the characteristics of three groups of respondents, obstetricians, midwives and religious leaders to show how some deviants were identified. I then describe these deviants and their respective arguments.

8.4 Norms and Deviants

During the interviews, it was my aim to ascertain the stance of all respondents with respect to abortion care. These respondents were all important stakeholders. Understanding their views, perceptions, attitudes and behaviours about

comprehensive abortion care is a very important determinant of whether comprehensive abortion care could be made easily accessible or not.

I attempted to determine the respondents' stance through direct questions to them as well as analysis of all they said and did (including non-verbal cues) in the course of the interview. Some respondents were overt about their stance. Others did not spell out whether they were in favour of abortion care or not; it was up to me to determine their general stance from the interview. This was difficult to do. Those who declared their stance as for or against comprehensive abortion care were noted as such. Those who were not explicit about their stance, whose quotes and comments reflected that they were neither here nor there and who expressed contradictory views on abortion care throughout the interview were initially classified as '*evasive*' but further during analysis found to be *ambivalent* rather than evasive. It should be noted that even those against abortion and abortion care would often concede that on narrow medical grounds, as a last resort, abortion might be possible though they did not indicate how to make abortion under these circumstances accessible (See Appendix 11 for an attempt at distribution of respondents by stance/position on abortion care. Although respondents have been categorized as such, it must be noted that for some respondents their stance on abortion is rather fluid and depends on the situation). In the ensuing discussion, I focus on the three respondent groups from where the deviants emerged, namely obstetricians, midwives and religious leaders. Based on the interviews and an attempt at categorizing respondents by stance on abortion care as previously discussed, a few respondents were identified as having extremely different views from respondents in their own category. The positions of these respondents seemed rather atypical and were referred to as deviants.

Obstetricians

There were 15 obstetricians, 14 males and one female. Fourteen obstetricians have worked or are currently working in government hospitals and one is in private practice. Twelve obstetricians had their basic medical training in Ghana; two of whom had further training in UK. One obstetrician each trained in Russia, Ukraine and Nigeria. The ages ranged from 38-70. Fourteen of them were married with children and one was divorced. All but two were Christians mainly of the Orthodox

category. A few were Catholics or of the Charismatic category. Two were Muslims. All the obstetricians have had between 8-25 years working experience or more. Five of them have had opportunity to head units and departments of obstetrics and gynaecology in district and regional hospitals respectively. Almost all the obstetricians were either lecturers in the medical school or specialists of the GHS.

As a group, most obstetricians were in favour of provision of comprehensive abortion care. Many of them would provide abortion services where necessary, would offer counselling on all available options for women with unwanted pregnancies and would also refer women where they are not comfortable to provide services. They are faced daily with women with unsafe abortions and the dire consequences. Many of them cited their reasons for being in favour of abortion care as being because of their mandate from international conventions and in loyalty to professional oaths, they are to save lives.

The obstetrician who put his Catholicism first

The first deviant was an obstetrician ('obstetrician 15'). He was the only one among 15 who was completely against abortion care. Given his professional position, one would normally expect him to be in favour of abortion care on medical grounds but was in fact strongly against it under any circumstance. Obstetrician 15 was the only Catholic amongst the obstetricians who spoke vehemently against the abortion law. He was against the abortion law and would speak against abortion if the proponents of abortion call for that. In his view, all that the proponents are fighting for is '*abortion on demand*' which he considered unacceptable and unnecessary. Whilst obstetricians 8 and 14 (who were also Catholics) were working to see safe abortion services scaled up with the stated aim of reducing maternal mortality, obstetrician 15 was prepared to challenge proponents since he believed they were lobbying the '*powers that be*' for '*abortion on demand*':

"... ... their major drive is abortion on demand. The protagonists... all they are saying is that when a woman walks into your consulting room and says she wants an abortion; you must oblige irrespective of the circumstances... is that what society wants to support"?

Obstetrician 15, age 66

Obstetrician 15 had a high position in the Catholic Church. This perhaps helps to explain his uncompromising Catholicism. It appears he does not want to be seen to have anything to do with abortion in case it is seen as compromising his religious standing.

Midwives

There were 14 midwives. They were all females. Their ages ranged from 40 to about 60+. Eleven were married, two were single, and one was widowed. All but one had children. Thirteen of the midwives were Christians mainly of the Charismatic category. One midwife was a Muslim. All the midwives trained in Ghana. Only one had further training in the UK. Their working experience ranged from 10 to over 30 years. They were more likely to be against abortion care. Based on the interviews, it appeared their stance was largely influenced by religion. Most midwives would not undergo training for CAC but would willingly train for PAC. Although they would counsel women on abortion, they do not offer counselling on all available options. They usually counsel women against abortion and their counselling is mainly based on their religious beliefs. They are usually judgemental in their interaction with women seeking abortions. Some midwives refer women after counselling to ante natal clinics. Others refer them without guiding them where to go. Some also refer women to clinics where they know abortions are provided but do so with reservations. Only two midwives appeared to be highly knowledgeable about international declarations and human rights issues.

The midwives with exposure to international debate

The second group of deviants comprised two midwives. They were among the few midwives who were in favour of comprehensive abortion care. They have had further training in reproductive health including PAC and were both consultants and trainers of the GHS. They were both among the reviewers of the RH policy (1996) and have had international exposure and experience - they have attended several international workshops and seminars. One of the midwives described the nature of her work as a trainer/counsellor in reproductive health:

"... this is my profession, I have been in it for over 15 years...I am a trainer and I go to train – international consultant. Recently, I was in Sierra Leone to train service providers... I was part of the people who reviewed the reproductive health policy. I am a clinical trainer – for reproductive health and family planning...they pick people from the various regions and then they come together, the Directors from the Ministries and all the specialists, the gynaecologists; those who are into reproductive health. We come together and review – we look at the previous protocols and see what can be changed. The recent one we went to do was the reproductive health protocol. We looked at it to see whether the previous one can still be maintained... WHO has to come out with new update, when there is a new update, that one can be used to review the old one... recently the one we did, 2006 December just came...That was the reproductive health Protocol and FP. There was a new update from WHO so, that was what we used to review the protocol".

Midwife 4 age, 45

On the question of knowledge about the RH policy and any involvement in its review midwife 14 noted:

"...Oh yes, I was involved. I was there as a training coordinator for FP. There were midwifery tutors, obstetricians, a lawyer and some NGOs...The lawyer made inputs based on what is acceptable internationally. We discussed FP ... With each component, the objectives were outlined; who should provide the services and where the services should be provided were also outlined. The standards were discussed after the policy. The standards outline which category of people should do what and at what level; you may find that a midwife cannot offer a certain service in a tertiary institution but can offer the same service at the periphery... We worked on the policy topic by topic and the necessary corrections were made. We came out with the first draft and later the final draft..."

Midwife 14 age, 60+

The two midwives shared experiences of various trainings they have had and workshops they had attended and how these have informed their attitudes and decisions concerning abortion care. Midwife 4 described herself as a counsellor and highlighted the qualities of a good counsellor. The need to be empathic and non-judgemental was underscored. Both midwives considered comprehensive abortion care necessary for women who have unwanted pregnancies. They described their roles in the review of the RH policy documents which now include comprehensive abortion care as a component. It appears their international exposure and broader intellectual experiences with policy debates have influenced their more liberal views.

Religious leaders

There were 15 religious leaders belonging to the Orthodox (6), Catholic (3) and Charismatic (4) categories of Christians and two (2) were Muslim Clerics. Their ages ranged between 40 and 63. Eleven of the religious leaders were married, three were single and one was widowed. They were actively involved in pastoral duties or were based at the headquarters of their respective churches, one was teaching in a Theological College. One of the Christian (Orthodox) leaders was a Chaplain for the teaching hospital; another taught at one of the Collegiate Schools of the University of Ghana, a laboratory-based institution without frontline experience. One of the Muslim Clerics also works in the same teaching hospital as a pharmacy technologist.

Understandably, the vast majority of the religious leaders (10/15) appeared to be against abortion care; a few (3/15) were ambivalent. Even though a few religious leaders would consent to safe abortion under medical grounds, they would rather leave doctors to take that decision; clearly leaving the responsibility to doctors. One of the leaders (Catholic) opposed abortion services for any reason.

The 'realistic' clergyman and cleric who show compassion

The third group of deviants were two religious leaders. By virtue of their social position as religious leaders, they would normally be expected to be against abortion care but in fact were in favour of it under certain circumstances; they were '*Clergyman 5*' (Christian) and '*Cleric 1*' (Muslim).

Clergyman 5, the hospital chaplain and Cleric 1, the pharmacy technologist were in favour of safe abortion services on medical grounds, including the expanded cases of physical and mental health. They do not object to the establishment of units in hospitals for provision of services on a national basis. The hospital Chaplain noted:

" ...as a medical personnel and a religious person, when the baby or the mother's life becomes life threatening, I'll go for the abortion, I don't have any problem because people are going for unsafe abortion and they're dying ...we can't leave them like that. People don't want to accept realities and situations... People are going underground...the doctors themselves, they're doing it at their private clinics; Why don't we promote it? I don't have any problem?"

Clergyman 5, age 40+

Clergyman 5 is the Chaplain of a teaching hospital and he shared his experiences of women he had been called to see with serious complications of abortion. He clearly had compassion on them. This probably accounts for his stance on provision of abortion services. One commonality about these religious leaders is the fact that they both work in a teaching hospital and their interviews showed experience they have had with women on admission with abortion complications. Both leaders have seen real life cases and deemed it necessary that safe abortion services are provided to save lives. The leaders did not allow religion, the law, social norms or any other factor to cloud their judgement about abortion. The religious leaders further noted:

People are not in health facilities like I am so they don't know what's happening; they're only in the church shouting "Praise the Lord, praise the Lord" but don't come to see what's happening so I invite them to the health facilities to see things for themselves... "

Clergyman 5, age 40+

The Cleric noted:

Let's face facts; the reality in Ghana is the society is so complex; human character is very complex. A human being does what suits him or her whether Christianity, Islam shun abortion or not. People will have pregnancies, planned or unplanned. They need to be helped. They will do it whether we make laws or not. Do we say that because the law or religion says abortion is illegal, we should abandon them to their fate? As a religious cleric and as a health personnel, I like being realistic... if her life is in danger, I'd recommend termination of the pregnancy. As Muslim cleric or health worker, I would recommend the best that will serve her interest..."

Muslim Cleric 1, age 40

The clergyman and cleric, who were a hospital chaplain and pharmacy technologist respectively, based their judgements concerning safe abortion on their experiences with cases they had seen at work. Their day-to-day contact with real cases of women with complications of unsafe abortion seemed to have influenced their overall attitude in favour of CAC. It appears they give more weight to '*reality*' rather than religious ideals. A few respondents across all categories (e.g. Clergyman 6, Parliamentarian 5 and Policy-maker 5) talked of considering the realities on the ground to make decisions concerning abortion. This indicates that sometimes one's experiences are paramount in one's judgement although, this was not the case of Obstetrician 15.

Are there any lessons?

Exposure to international ideas and training (experienced by the majority of obstetricians and the deviant midwives) and the experience of the realities of women dying from unsafe abortions (most obstetricians and the deviant clergyman and cleric) seem to influence attitudes of people, including those in groups usually unsympathetic to safe abortion care (midwives and clergy). However, the deviant obstetrician shows that dogmatic religious views may remain, despite exposure to international debate and front-line experiences, although his position is at least in part explained by his high position in the Catholic Church which he would not want compromised.

Since health providers are those who offer abortion services, they are the group of respondents directly affected by the complex arguments and the effects of the perception of others concerning abortion care. The final sections of this chapter therefore focus on the experiences of health professionals and other issues concerning abortion service provision.

8.5 Providers' dilemmas between personal religious beliefs and professional ethics.

This section focuses on health providers (principally, midwives and obstetricians) since they are those that are almost always faced directly with offering abortion care. Some healthcare providers who have to provide abortion care are faced with complex factors that influence their decisions to provide care. The factors include conflicts, and agitations that the individual experiences and the influence of the views and moral judgements of others (colleagues or significant others).

The conflicts that health providers most commonly alluded to were those where personal religious beliefs were in conflict with the providers' interpretation of their professional ethics. As previous sections have suggested, religion appears to be a strong and overarching factor that influences providers' decision and willingness to offer abortion services. It is a pervasive factor, with its influence transcending providers' attitudes to making an impact on their behaviours as well. Its direct influence sometimes occurs as conflicts between professional ethics and the

faith/religious beliefs of the provider in question. During the interview with one of the midwives, I asked what her reaction would be if she is approached in the hospital by a woman who wants an abortion done.

"Hm! (gives a big sigh) ... in the Christian way, we are not to do abortion, this is a very difficult situation but my work is to prevent death, especially maternal death. So, when someone approaches me with such a situation, I will refer the client to see the doctor ...after referring her, I reflect; if it is done for her, it means I have taken part... maybe the doctor will counsel her and will not do it for her".

Midwife 2, age 50+

The midwife seems to abdicate responsibility for the practice of abortion. She refers for someone else to make a decision. The midwife was religious and for her, referral to someone else to take the final responsibility to counsel the woman to accept seems to be a way for her to clear her conscience that she is not aiding and abetting a 'sin'. (See Appendix 12 for the Midwives' Prayer).

This is the kind of situation that confronts some health professionals working in obstetrics and gynaecology, specifically abortion care. The midwife who was a Christian described the dilemma associated with dealing with a woman in need of abortion. Irrespective of her faith and reservations, she refers her patients to qualified doctors. It was implied in her quote and from the interview that her motive for the referral was to prevent maternal deaths from complications of unsafe abortions. This action is in agreement with the principles of the standards and protocols (shown by the document analysis) of the GHS which calls on providers to refer patients to qualified providers even if they are conscientious objectors. Her reflections of the possible outcomes of the referral appear to be a strategy to help her cope with her action (referral). As a Christian, she seemed to be concerned about referral for induced abortion so she considers several outcomes one of which is that the doctor may not perform the abortion but may counsel the woman to keep the pregnancy. This notion appears to put her mind at rest.

The difficulty surrounding decisions on abortion is exemplified in this quote from a policy maker (doctor) who has had some experience in obstetrics and gynaecology:

"It's kind of h-a-r-d ethically. I am really in a dilemma. My values and (religious) beliefs conflict with what I know as a provider. The conflict is in the fact that I know

the reality. I know the number of people who are losing their lives as a result of abortion. But on religious grounds it is hard to approve of it (abortion) because you are taking the life of another human being. I am really in a dilemma ... I refer them to a proper clinic but most of the time you don't want to be part of this whole thing(abortion) ... It is difficult for those who are in a position to take decisions; they know they cannot ignore it. It is a real issue, a problem that we have to address... the solutions are against your beliefs and values. How do you reconcile the two?

Policy maker 5, age 40

The realities of the jobs of some health providers lead them to take decisions that are not congruent with their faith and this poses a real conflict within them.

Two respondents (Obstetrician 2 and 13) one of whom described himself as fundamentally religious used analogies from the Bible to inform their clinical judgements and decisions regarding abortion. These respondents described the difficulty surrounding such decisions; Obstetrician 2 thought the answers to questions that confronted them were elusive:

"... Although the Koran talks about abortion, the Bible doesn't. People infer... there is a limit to which people can infer. Going back to the bible; adultery is wrong. God had rules about adultery in the Old Testament. A person caught in adultery had to be stoned. But a woman caught in adultery was brought before Jesus Christ and he didn't have her stoned. This tells me there is more to what you do in a situation. By law that woman should have been stoned! I don't think any of us has the answers... I think a Christian can terminate pregnancy under certain situations."

Obstetrician 2, age 40+

The Biblical analogy made here draws attention to the element of compassion. He appeared to argue that if in some cases rules are put aside and compassion is shown, then even though the Christian religion (according to some people's interpretation or inference) forbids abortion, the procedure can be allowed out of compassion. He disclosed having performed an abortion for a patient before, because in his view, the procedure was necessary. He added that even though he considered himself fundamentally religious, he would provide the service if the situation demands it.

Obstetrician 13 talked of how he resolves the conflicts he faces regarding his religious beliefs and professional obligations:

“... conflict situations ... I go through such situations. The way you resolve conflict situations are that you look at the greater good you want to achieve. Jesus Christ also experienced conflict when he had to heal somebody on a Sunday, but he looked at the greater good and went ahead and healed the person. When the Pharisees took him on, he explained to them. When I experience a conflict, the church doctrine says no abortion but as a gynaecologist, somebody carries a baby with no brain my training as a gynaecologist teaches me that such pregnancy must be aborted but the religious training tells you that you must not touch life...two conflicts;...the greater good is to perform what professionally you have been taught to do. !

Obstetrician 13, age 40

The Obstetrician considered the overall benefits his patients would derive from his clinical judgement and based his decision on the principles guiding his discipline. As previously cited on page 194 under discussion of professional ethics, Obstetrician 6 spoke of the dilemma of saving a mother rather than a foetus in dire situations and tended to save the mother based on principles of obstetric practice also cited by Obstetrician 13. In discussing the dilemmas health providers face, it seems many have had to take difficult decisions. Some reflected and others rationalized about their actions sometimes using biblical inferences. Many respondents talked about considering the '*reality of the abortion situation*' which influenced them more than religious ideals. Having described the dilemmas health providers encounter from conflicts between their religious beliefs and professional obligations, I now describe how implementation of Ghana's abortion policy is influenced by providers' beliefs and attitudes.

8.6 How Health Providers act as Street-Level Bureaucrats to shape implementation of abortion policy in Ghana.

In this study, the health providers constitute the front line abortion providers and are the actors Lipsky calls the street level bureaucrats. My previous analysis has shown the complex interplay of factors that have an impact on what services they are willing to provide. Their modification of what is supposed to be provided (as per the standards and protocols of GHS 2006), in an attempt to balance the many pressures they face, can be seen as an illustration of Lipsky's street level bureaucracy.

In the ensuing discussion, I describe the different ways in which providers' provision of services is affected by their beliefs and attitudes. I discuss their modifications of the care components of the standards and protocols (counselling, referral, provision

of abortion services) that enable them to meet the demands of the profession as well as their entrenched religious beliefs incorporating insights drawn from Lipsky's street-level bureaucracy - the use of *discretion and coping mechanisms*.

8.6.1 Counselling, referral and provision of abortion services

The dilemmas that providers experience as a result of the conflicts between their religious beliefs and professional demands influence their attitudes towards women seeking care for unwanted pregnancies. Thus, providers exhibit an array of attitudes in relation to the care they render to women. The analysis of the standards and protocols for comprehensive abortion care (GHS 2006) outlined various care components providers are required to offer for CAC. This includes counselling, referral and provision of services (manual aspiration). Even though the standards and protocols spell out the activities of different cadres of health providers at various levels of health care delivery and how these should be carried out (discussed in Chapter 6 under analysis and review of documents), providers appeared to have their own way of shaping what happens on the ground. My data showed that providers have developed their own ways of dealing with the dilemmas they experience in their work.

i. Counselling

The document analysis showed that when a woman reports to a facility for service, the attending health provider should carry out an initial assessment and refer to appropriate services. The assessment involves establishment of rapport, determination of patient's needs and her reason for the visit. Pregnancy should be established and the woman asked about what she wants to do. The woman is to be given information on the risks, benefits and the alternatives of all the options which are:

- She can continue the pregnancy and parent the child
- She can continue the pregnancy and offer the child for parenting by others (e.g. adoption)
- She can terminate the pregnancy where legally permitted

The woman is to be given complete and accurate information and be supported to make an informed choice. Health providers are cautioned not to impose their beliefs and moral values on clients but to focus solely on client's needs. These are the requirements of the standards and protocols (GHS 2006) on CAC. My data from the interviews showed that with respect to counselling women who seek abortion services, most obstetricians (11 out of 15) would offer counselling on all options available to women with unwanted pregnancy to enable them make an informed choice as required by the standards and protocols. Counselling on all options available for women seeking abortion services appeared to be a *routine* most obstetricians followed. Two obstetricians use their *discretionary* powers during counselling to decide or 'label' women with unwanted pregnancies, classifying them as those who '*genuinely*' need termination of pregnancy and those with '*flimsy*' excuses for abortion who should carry their pregnancies to term: (see discussion of this in the next section).

I will take your history; examine you, if the pregnancy is truly going to be problematic to you, I'll refer you. If not and your reasons are just flimsy, I may counsel you to maintain the pregnancy...

Obstetrician 10 age, 40+

Two other obstetricians would counsel women to deliver their babies; one of them was judgemental in his counselling:

"... You tell them during counselling that, look here you have committed a crime already. If you go ahead and do this thing (abortion) you are using one sin to cover another sin...."

Obstetrician 5, age 38

Of the 15 obstetricians interviewed, this was the only one (other than the deviant Obstetrician 15) who was openly judgemental about women having abortions as previously noted, his religious background (Catholic) appeared to be a contributing factor. In the interview, he referred to young women who got pregnant out of wedlock as committing a sin and having an abortion as a second sin. In his view if during counselling women insist on having abortions, they should have their way.

Thirteen out of fourteen midwives said they would counsel women with unwanted pregnancies seeking abortion services. Four of the thirteen midwives offer options counselling; two of whom are trained counsellors in reproductive health. The remaining midwife who does not counsel ascertains the women's reason for abortion and refers them to see qualified doctors.

Seven out of the thirteen counsel women to deliver their babies. When such women change their minds and decide to have their babies, the midwives would find them obstetricians to care for them until they deliver. This was one practice of Midwife 8. She boasted of a number of children who have been born through her counselling of women who wanted termination of pregnancies not to do it:

"...I have met such people...I advise them to keep the pregnancy...I have about 3 or 4 children I call my adopted children. I did help them (the mothers who wanted to abort) and they delivered.... At maternity OPD, a woman approached me. She told me she has 6 children and is pregnant again so the husband said she should come to hospital and have an abortion. I spoke to her and invited the husband. I told them, I will help the woman to deliver the baby. After that I will give them to the family planning people to do sterilization..."

Midwife 8 age 60+

She was completely against abortion for religious reasons and sometimes appeared to scare women in search of abortion care:

"...if you abide by the laws of our God, I don't think you will be tempted to have sex and get pregnant. Me, I am against abortion... God says if you do this you pollute your body.... then the devil will come in to use you, kill you and destroy you. Wait until you are married and when you are pregnant you wouldn't want to abort it because the man married you to have children for him. But when you have sex before marriage and get pregnant, you are afraid... to avoid disgrace you are compelled to have an abortion and that will end your life. The man will go Scot free, but you will die..."

Midwife 8 age 60+

Midwife 14 also noted with pride that some of the babies born (through her counselling of mothers not to abort) have been named after her, an honour in Ghanaian society.

Two midwives would also counsel women about the dangers of abortion. They would counsel women against abortion and would over-emphasise the negative outcomes telling women of all the medical, psychological and religious consequences of abortion.

These actions may be ways of *coping* with the professional need to counsel which conflicts with their religious beliefs that abortion is a sin. One midwife suggested that women seeking abortion services need to be counselled based on Biblical principles. This reflects the entrenched religious beliefs of some providers, especially midwives. This was the same midwife who read quotations from the Bible to me during the interview. She appeared to bring her beliefs to bear on her professional duties. This also reflects her lack of knowledge of the guidelines on counselling provided in the standards and protocol and points to training needs.

Judgemental attitudes of providers especially midwives during counselling was projected strongly during the interviews as barriers to women seeking abortion services in public health facilities:

"... the health personnel – the way they l-o-o-k at abortion...it is a problem. It is part of the cause of unsafe abortion. They see you as a criminal if you go in for abortion...the service providers'; they are very hostile, not friendly towards people due to their religious backgrounds - 'abortion, who told you that this place you can do abortion'? So, they scare the clients away.

Midwife 4 age, 45

A midwife who described herself as an ‘international consultant’ and a ‘trainer of trainers’ in reproductive health (for the GHS) made this observation with some reservations. She considered the attitudes of health providers as unprofessional and stressed the need for training for providers with these attitudes.

One of the obstetricians, also a trainer in reproductive health care including post abortion care made a similar observation:

“... they are judgmental; they pronounce people sinners ahead of time...as soon as they hear that a lady is pregnant and wants abortion, she is a sinner. They don’t want to have anything to do with her...”

Obstetrician 14, age 60

It appears that being judgemental is one way health providers can stay away from getting involved in induced abortion. It may help them to distance themselves from induced abortion, especially for those who are conscientious objectors. It may also be one way health providers can get women to change their minds about having abortions and in so doing providers are able to clear their consciences of aiding and abetting a ‘sinful’ act.

ii. Referral to Services

Following counselling, women are referred based on the decision taken. The woman seeking abortion services is either referred to antenatal services if she decides to keep the pregnancy or she is referred for safe induced abortion services when she chooses to terminate the pregnancy. Like counselling, referral is the duty of all service providers at all health service delivery levels. According to the standards and protocols, referral is mandatory even if providers object to service delivery on grounds of conscience. While many obstetricians would perform abortion, others preferred to refer. As noted in the previous discussion on counselling on page 220, some obstetricians also use their discretion to classify patients during counselling:

“...Well, as obstetrician/gynaecologist, I don’t induce abortion but if you come, I will refer you to the family planning clinic... I don’t know the outcome because they don’t report back to me...I will examine you... I’ll refer you ... the Family Planning (Clinic) offers abortion ... if you have a genuine problem, I will send you there; if you go and you satisfy the doctors there, okay”.

Obstetrician 10, age 40+

Even though this obstetrician would refer a woman in need of abortion it appeared he did not want to know the outcome and was content no one told him. He did not want to take the responsibility for the procedure. It seemed he referred women to the clinic and left the decision for other doctors at the clinic to take. His use of the terms ‘genuine problem’ and ‘satisfy the doctors’ indicates his view that only some women really deserve an abortion, and he thus acts as a gatekeeper, preventing women who

do not have a ‘genuine problem’ (in his view) from being referred. Similarly, Obstetrician 15 made note of this issue:

“...The bulk of requests for terminations are social and flimsy... If we are honest that forms the bulk of the requests for termination, flimsy social excuses; is that what society wants to support”?

Obstetrician 15, age 66

As discussed in section 8.4 obstetrician 15 was open about his stance against abortion and would not refer under any circumstances.

Midwives exhibited a range of attitudes towards referral of women for services mainly based on their religious beliefs. Although they generally showed conservative attitudes towards abortion care, many (10 out of 14) midwives would refer women seeking abortion services. Most referrals were to a unit in the teaching hospital where abortions were reportedly done, though not openly. Before referral, they usually ascertained the reason for the abortion. Based on the reasons women give for wanting abortions, some midwives use their discretion to determine where to refer them. Midwives 2, 5 and 9 for instance did not feel comfortable referring women for abortion services. They think they are aiding and abetting a sin. Thus, Midwife 2 reflects and convinces herself that the women may be counselled by the doctor not to have the abortion in the end. Midwife 5 would not tell women specifically where to go but would only tell them to go see a qualified doctor. Her Catholic faith influences her professional mandate to refer women. Midwife 9 prays for forgiveness after referral. Contrary to requirements of the standards and protocols, three midwives would not refer women for abortion and one midwife would engage the woman in a conversation concerning her circumstances and leave her to decide what she wants to do. These actions may be seen as examples of *coping mechanisms* midwives use to withstand the conflicts they experience between their religious beliefs and professional obligations.

iii. Provision of Services

Twelve out of 15 obstetricians said they would provide safe, legal abortion services however two of these would only do so as a last resort. They were both Christians and would provide abortions services only if they are forced by prevailing

circumstances. Obstetrician 2's example of such a situation is when there is no other obstetrician to provide abortion when a woman needs to have one; such as a physical condition in the mother with signs of imminent death.

There were few obstetricians (e.g. 10 and 12) who would not provide abortion services themselves but were willing to refer to colleagues (or clinics) who would. These obstetricians did not explicitly give reasons for their choice but their interviews in their entirety showed that the reasons could be due to religion and social stigma. Only one obstetrician (obstetrician 15) would neither refer women for services nor provide the service himself.

The interviews revealed a number of strategies used by health providers directly involved in abortion service provision to help them deal with the difficulties they encounter. To avoid stigmatization, for fear of prosecution and other elements of social disapproval concerning abortion service provision, abortions are reportedly provided clandestinely. One obstetrician who openly provides services said she is knowledgeable about the law, works within the framework of the law, documents her cases and could defend herself.

That there is stigma of association and pressure on doctors who perform abortion was confirmed by some obstetricians. In the interview, Obstetrician 3 spoke of "pressure" from society on doctors who provide abortions and the benefits that women would derive health wise if the doctors withheld the pressures and went ahead and offered the services to women who need it. Obstetrician 2 talked of social labelling:

"If you are seen to be doing abortions, you are labelled. It will take someone who is strong willed and immune to what people say to offer abortions in a public health facility. Doctors cannot come out openly to speak for provision of safe abortion for fear of being labelled abortionists. "

Obstetrician 2, age 40+

The interviews showed that it was mainly obstetricians rather than midwives or pharmacists who cited stigma (some used the word "stigma" whilst others used synonyms) associated with abortion. This is significant. Of the cadres of providers that were interviewed, obstetricians constituted the group that directly provided

abortion care and thus were the prime objects of stigma. One way of dealing with stigmatization and social pressures was to conceal the fact that a provider offers abortion services:

"I have talked to many people I know who do abortions... put them a direct question, whether because he believes that women have a right to abortion he will terminate pregnancy, he will say no. Why is it that people don't want to be known that they are doing abortions? Why? If you perform abortions why don't you let people know? They don't want to be known as abortionists."

Obstetrician 15, age 66

In the same vein, some doctors who do not want others to know that they provide abortions in public hospitals either do so but do not record them or record but misclassify them as other operations such as '*diagnostic D&C*':

"... sometimes doctors hide behind the fact that for medical reasons they can perform abortions and do it en masse.... They will say 'diagnostic D and C' but, you and I know that there is nothing diagnostic about it... in actual fact it's just an abortion, TOP ..."

Trainer 3, age 54

The abortion standards and protocols demand that there is proper documentation of procedures performed but doctors who perform abortions do not add '*abortions*' to their operation lists. Some doctors declare themselves as '*conscientious objectors*'; people who would not provide abortion services on grounds of conscience.

A few health providers thought that some of their colleagues showed vindictive attitudes towards women seeking abortion:

" ... In this part of the world where people oppose abortion, safe abortion services are very expensive. It's like a major income generating thing.... 'for something that I am doing that people don't like and since I am doing it, you have to pay so much'... that service provider is just as bad as the person who opposes abortion. Because he says: 'I will punish you by letting you pay with your life, and another says I will punish you by letting you pay so much'... we are in a society which feels that a person with an unwanted pregnancy deserves some punishment. That is how I see it".

Obstetrician 2, age 40+

This obstetrician distinguishes between two groups – i) those who withhold services from women with unwanted pregnancies thus leaving them to seek unsafe abortions with their attendant complications including death and ii) those who provide abortion

services but charge high fees – primarily as a money-making exercise. Both actions contravene the service protocols. The obstetrician believes both attitudes are morally wrong in that the women seeking abortion are being punished for choosing to end their pregnancies.

Thus many service providers fail to implement the standards and protocols, choosing to offer services, if they are provided at all, clandestinely and sometimes at high prices, impeding access for women and making them very dependent on the highly variable counselling and referral strategies discussed earlier. The general unwillingness to provide services openly could be described as *coping mechanisms* of providers to avoid open association with the provision of socially stigmatised services, or to avoid service provision altogether and deter women from seeking abortion services.

8.7 Attitudes of facility managers

In this final section, I briefly describe the attitude of senior health workers who were described by some respondents in the interviews as individuals who used their positions to block provision of safe abortion services. This group of health workers were not frontline workers who directly provided abortion services. They were heads of institutions and in charge of the day-to-day administration of health facilities. They were influential people whose attitudes towards abortion affect service provision in the facilities they head. The interviews showed that some facility managers showed negative attitudes towards abortion. Some obstetricians, most of whom were young and worked under these managers spoke of their non-supportive attitudes:

“...the equipment is under certain ‘authorities’. If the authorities do not believe in making the services available... we are far from the provision... the few people who want to provide the service might not get access to the medical equipment that may be necessary... If my head of department is a Catholic and does not believe in abortions, is he going to provide the right set-up for me to carry out abortions? If I get a complication of abortion I need a senior colleague to take care of the complication. If I am in a set-up where my senior colleague does not believe in carrying out an abortion, where do I go? ”

Obstetrician 3, age 38

Obstetricians 3, 4 and 9 all of whom were young appeared frustrated during the interviews for lack of support from the head of the facility where they worked. Obstetrician 4 said he once approached the head and told him of his plans to provide abortion services in the facility but was told that he did so at his own risk. This meant that he did not have the support of the head of the facility. This attitude of the head reportedly makes the young obstetricians offer the services in private facilities on part-time basis as previously discussed in chapter 7.

The managers would not ensure that places in their facilities are designated for provision of abortion services. MVA equipment are not procured, midwives and doctors who have training needs for CAC and who may be willing to undergo training are not sent for training:

“...there were challenges with abortion; it’s a moral issue so if you have leaders who morally are against abortion, then it becomes difficult. I recollect being told that, ‘I will not allow that nonsense to be performed in my health facility’. This is an administrator of a government hospital so if he says I can’t allow this in my facility’ and this was said to prevent people from being trained”.

Obstetrician 7, age 40

The administrator was described in the interview as one who was against provision of abortion services in the institution he was heading and thus would not send health providers who were willing to be trained for the necessary training. This attitude influenced availability of services as well as the morale of some health providers in the facility he heads. One of the old obstetricians described the attitudes of these managers as ambivalent. They reportedly show no accountability for the cases of unsafe abortions they see in their facilities and they do not also question the lingering high rates of maternal mortality attributable to abortion. The obstetrician notes that some of the managers avoid attending meetings where abortion issues are discussed or attend the meetings but leave before decisions are taken:

“... there is no accountability! ... Key people in the Ministry of Health are very ambivalent when it comes to implementation; they will not attend any meeting that

deals with abortion... ' we were discussing with X General Hospital about providing comprehensive abortion services but we had to have the consent of the administrator of the hospital. She initially agreed but when I called she said 'I have changed my mind because I don't think I am going to permit this thing to be done in my hospital... she is wrong. Her personal view should not deny women access to the services in a government hospital! ...'

Obstetrician 6, age 70

I learnt from Obstetrician 6 during the interview that two such heads of facilities refused to allow a pilot test on medical abortion to be carried out in their facilities. The aim of choosing to conduct the studies in those facilities was for purposes of credibility and acceptability. The studies were later carried out in two district hospitals instead of the initial facilities chosen.

8.8 Summary

This chapter set out to explore the attitudes and beliefs of frontline actors and how they affect provision of comprehensive abortion care. It explored the range of arguments for and against abortion and abortion care including the complex stakeholder views on abortion. The key arguments forwarded to justify provision of safe abortion services were on grounds of public health, professional ethics and human rights.

The proponents for abortion argued that key stakeholders/society should perceive the worth of saving the lives of women from the needless suffering and deaths that result from complications of unsafe abortion. Those who were against abortion based their arguments on religious and moral grounds; however there were some respondents who even though were against abortion on religious grounds thought it could be done when medically necessary. Indeed public health arguments were the ones most widely used to justify the provision of safe abortion services.

Some critical issues emerged. Perhaps the most important finding is that, contrary to popular perception, many highly and openly religious people were not completely against provision of safe abortion services and that it is the way the arguments are framed that is critically important. The obstetricians' favourable attitudes and behaviour towards comprehensive abortion care may be attributable to higher education, further professional training, knowledge of international treaties and

conventions and exposure to Western settings. These experiences seem to come with more lenient attitudes. Another important finding was that midwives displayed the most fundamentalist religious-based views against abortion and many were against provision of abortion services. The conservative attitudes of midwives may be explained by their lower education and international exposure and highlights potential training needs.

Five respondents could be characterised as '*deviants*' because they differed from people in their groups. Two of the deviants were religious leaders and were in favour of abortion services for medical reasons. Both leaders work in a teaching hospital and have had experience with women admitted to hospital with abortion complications. The third deviant, an obstetrician, was against abortion services. Even though experience with cases of unsafe abortion was an important factor that influenced the decisions of some key stakeholders on provision of abortion services, his views indicate that in the face of extreme religious views not all stakeholders were influenced by their experience. The same was true for most midwives, though the two deviant midwives have had further training in reproductive health - they were both trained counsellors and trainers of the GHS for safe motherhood and post abortion care. They were actively involved in the policy review in 2003. Their experiences and wider exposure to a range of arguments may have influenced their more liberal attitudes.

The determinants of health providers' stance on provision of abortion services are complex. They comprised religious/moral conflicts that confront providers in the execution of their professional duties (e.g. religious beliefs about the sanctity of life conflicting with duties such as providing abortion care). In addition to these '*personal dilemmas*' that providers experience, the perceived view of others concerning abortion (which they often projected onto health providers) constituted '*social pressures*' which affected their decision to provide abortion services. The individual dilemmas seemed to stem from conflicts between an individual's religious/moral beliefs and professional ethics, while the social pressures appeared to be primarily due to social norms which add a further level of conflict to providers. The heads of some health institutions showed ambivalent and non-supportive attitudes that frustrated some subordinates (obstetricians) and impeded provision of

abortion services. Their behaviours may have been in response to social pressures against abortion.

Finally, drawing on the elements of '*discretion*' and '*coping mechanisms*' of Lipsky's theory, I explored how health providers' beliefs and attitudes affect implementation of abortion policy with particular reference to counselling, referral and provision of services. It is possible to conclude that what providers do and how they do it is indeed underpinned by their beliefs and attitudes and facilitated or driven by the use of discretion and coping mechanisms: elements of Lipsky's street-level bureaucracy. The relevance of these findings will be discussed in the next chapter in relation to the literature and to Lipsky's theory showing how these findings confirm and extend it.

CHAPTER NINE

DISCUSSION AND CONCLUSIONS

9.1 Introduction

The study was designed to understand the barriers that confront provision of safe, legal abortion services in Ghana and consider implications for improving access to such services. Specifically, the study sought to:

1. Analyze the content of the abortion law and policy ;
2. Examine the process of promulgation of the law and identify the actors involved and the roles they played;
3. Identify the service-related and socio-cultural factors including social norms, cultural values, religion and morality that act as barriers to provision of safe, legal abortion services;
4. Determine the differences in actors' knowledge, attitudes, and views concerning abortion in general, the abortion law in particular, its implementation and the underlying reasons for actors' attitudes and views;
5. Consider implications of the research findings for policy and practice.

This chapter first provides an overview of the key findings, their significance and implications for service delivery and discusses these in the light of the literature (Sections 9.2-9.4). The discussion focuses on the abortion law and its interpretation, barriers to implementation of the law and specific barriers such as provider attitudes along with reflections on these barriers. Complex ethical/moral issues that confront health service providers and the impact on abortion service provision are discussed. A range of arguments forwarded for and against abortion are also highlighted with a view to identifying what factors best favour provision of abortion services in Ghana. Second, these key findings are then discussed in relation to the theories that underpinned the study and additional relevant theories for a deeper understanding and insight of the issues under investigation; that is barriers to abortion service provision within the context of a liberal abortion law (section 9.5).

Third, I consider what my findings show for taking forward the abortion debate in Ghana, specifically whether ‘medicalising’ the issue could make safe abortion services more acceptable. The chapter ends with some reflections, conclusions and recommendations based on key findings.

9.2 The abortion law and policy: interpretation and implementation

This section covers findings generated from all the respondents under objectives 1 and 2. As previously noted the current law on abortion in Ghana (PNDC Law 102) is an amendment of Act 29 of 1960. The circumstances and processes that led to the amendment and the motive behind the revision of the law by the PNDC government in 1985 remain covert. The amended law was not also publicized by the military government which is not surprising. It follows that most of the Ghanaian public and even health providers are not aware of the law. The obstetricians were the most knowledgeable. Among the non health professionals, the lawyers, a few parliamentarians and the journalist were aware of the law; describing it as liberal but ambiguous. The few respondents who knew anything about the development of the law believed that the law was not publicized for fear of religious opposition. Lack of knowledge of national abortion laws is a common finding in the literature on Ghana (Morhee et al. 2006, Lithur 2004, Lassey 1995) and elsewhere in sub-Saharan Africa (Cooper et al. 2005, Jewkes et al. 2005, Hessini 2005, Sibiyi 2004). Poor dissemination of the law in Ghana may partly explain the situation; it has serious implications for implementation of services, including service availability and accessibility and women’s reproductive health.

In addition to lack of dissemination and knowledge, the abortion law is given multiple interpretations by different actors who influence society’s views on abortion (e.g. religious leaders, journalists) and those who provide services (doctors, midwives and heads of clinical units permitted to provide abortion). That the law was grossly misunderstood and fraught with multiple interpretations partly explains the observed partial implementation making safe, legal abortion services largely inaccessible to women who need the services. There are a number of explanations for the multiple interpretations given. First, the location of the Ghana abortion law in the Criminal Code and its presentation therein (Section 1 of the law says abortion is

illegal; Section 2 cites the conditions under which it is permitted) gives a false perception that abortion in Ghana is illegal – confirming the finding by Lithur (2004). Second, the wording of the law is ambiguous in a number of key issues, including the ‘mental health clause’ and the definition of who is an eligible provider. The interpretation of the ‘mental health clause’ may have an impact on access to services based on whether this is narrowly interpreted or interpreted in a relatively wider scope which increases potential for its use. Similarly, if the term ‘medical practitioner’ is interpreted to cover mid-level providers (e.g. midwives) there is potential for increasing access to safe, legal abortion services in rural areas where doctors are few. Given the definition of ‘abortion’ in the Ghana law, which implicitly allows termination of pregnancy to the end of the gestational period, late abortions, which endanger women’s lives may be carried out. Ambiguities over the level of evidence needed for ‘proof of rape’ may also lead to late and dangerous abortions since such evidence may require assessment by a doctor, police reports and court verdict and such activities in Ghana span several months by which time the pregnancy may be far advanced.

Problems identified in this study regarding interpretation, implementation of abortion laws, availability and access to abortion services including the contention surrounding whether mid-level cadres should be permitted to provide abortion services are in line with existing literature. (Berer 2009, WHO 2003, Rahman et al. 1998). The standards and protocols document (GHS 2006) which was developed 18 years after the current abortion law addresses some of the discrepancies in the law such as those concerning ‘rape’ but the protocol needs to be widely disseminated for it to be useful. Given the many ambiguities in the Ghana abortion law and the problems of interpretation that result, abortion law reform in the long term may be necessary to iron out the discrepancies. Morhee et al. (2006) however call for immediate reform in Ghana’s law but it can be argued that it would be better to ensure services are made available now – which is possible within the current framework - rather than risk a backlash to legal reform which could result in the return of a more repressive law if public opinion and key decision-makers turn against reform. Efforts towards legal reform can be mustered later when services are established and evaluated.

Finally, two other, non-policy documents that were considered important by health facility staff were the Hippocratic Oath, sworn by doctors, and the midwives' prayer used by midwives. The content of these seemed contradictory to the provision of safe abortion services and their use may consequently affect providers' interpretation of the law and policy documents and subsequent provision of services.

The Hippocratic Oath is a medical pledge of allegiance. It is a code of ethics sworn by newly qualified doctors to guide their practice. The Oath calls on doctors to treat the sick to the best of their ability with the health of their patients being their first consideration. The version being used by the Ghana Medical and Dental Council is that adopted by the World Medical Association in 1948 and amended by the World Medical Assembly in 1968. It also speaks of respect for human life from the time of conception; the implication is that doctors should not carry out abortions. In my study, the Hippocratic Oath was cited by five doctors of whom four were in favour of provision of abortion services to women in need. Their main focus was on the call on doctors to save lives. They thought 'looking on' for women to die from lack of safe abortion services defeats the purpose of the Oath which is in the utmost interest and wellbeing of the patient. Since the Ghana law on abortion permits abortion services in certain instances whilst the Oath sworn implicitly forbids abortion there is bound to be confusion especially among medical practitioners regarding provision of abortion services. It may be imperative for debates to be initiated by the Ghana Medical and Dental Council, Ghana Medical Association and other stakeholders to consider modification of the Oath to cover abortions in line with the law as has been done, for example, in the UK (See Appendix 12 for further discussion of the Hippocratic Oath and its interpretations and amendment in UK).

Among the midwives, although none of them specifically mentioned the midwives' prayer, I formed the impression that what they said during the interviews were with reference to the prayer. The findings from my interviews with midwives suggest that the emphasis they place on their practice when confronted by women requesting abortion is indeed that they should not get involved with 'destroying' life of the foetus, rather than consideration for the consequences to the mother's life.

I would argue that an additional determinant of midwives' conservative attitudes towards abortion service provision stem from the 'Code for Nurses' in Ghana. Most midwives in Ghana are registered nurses. Nursing practice is guided by ethical principles in the above Code. The most prominent principle in the 'Code for Nurses' is respect for life. The code holds that 'respect for life', dignity and rights of man constitute an integral part of nursing; my experience shows that nurses appear to have been socialized via training to show optimum respect for life. Abortion which destroys the lives of foetuses is thus perceived as contrary to the ethics of professional nursing. The fact that withholding abortion services could result in destroying a woman's life was an issue that most of my mid-wife respondents were reluctant to engage in.

9.3 Barriers to safe, legal abortion services

This section constitutes the main bulk of findings from this study, generated from objectives 3 and 4. I cover first the service-related barriers and then the socio-cultural barriers for provision of safe abortion services. The views and attitudes of key stakeholders, and the explanatory reasons for these are discussed.

9.3.1 Service-related barriers to provision of safe abortion services

Four sets of service-related barriers emerged from my data. These are lack of designated facilities, lack of equipment and other resources, lack of trained providers, and attitudes of health facility staff towards abortion service delivery.

i. Lack of designated facilities

In my interviews some respondents especially obstetricians noted that in Ghana facilities have not been officially designated for provision of abortion services. Services are largely provided in private health facilities at high costs often not accessible to women who need abortions. Although some public health facilities provide abortion services, many of my respondents reported how these services are mainly provided in a clandestine way, are expensive and available only to a few women who are 'linked' to the providers. This results in many women resorting to clandestine unsafe abortion. An MOH/GHS facility assessment in the three most populous regions in Ghana has confirmed that only 13% of public health facilities

officially provide abortion care (Aboagye et al. 2007). This is likely to be a direct result of lack of knowledge of abortion law and ambiguities regarding who can legally provide abortions services. Provider attitudes are another barrier to open provision of services in public facilities – this is discussed in later sections.

By contrast, post abortion care is widely available in most hospitals but not in health centres (Aboagye 2007, Aniteye 2002). The dearth of facilities designated in Ghana for abortion services is in keeping with findings in India (Duggal and Ramachandran 2004; Berer 2002) and South Africa (Harries et al. 2009, Dickens et al. 2003, Varkey 2000). The reasons given for the paucity of designated facilities for abortion in these studies are also consistent with my study findings. For instance, in South Africa, Harries et al. (2009) reported of fragmented levels of service provision due to attitude of staff to service provision and Varkey (2000) also observed that staff members' unwillingness to be involved in abortion provision was a major problem. The lack of official facilities means that women may have difficulty locating where to go for services. Moreover in Ghana, the silence on issues of abortion reported by many respondents means that women are not openly educated about where to seek services for safe abortion. This makes them vulnerable and open to the dangers of unsafe abortion.

ii. Lack of equipment and other resources

Lack of resources like the MVA instrument was another service-level challenge found in my study. The interviews, document analysis (Standards and Protocols for CAC P7) and the literature showed that of the surgical methods used for induced abortion, vacuum aspiration is relatively safe and simple but still not sufficiently available. Other research in Ghana similarly found the availability of the MVA equipment a challenge (Aboagye et al. 2007) and barriers exist to a sustainable MVA supply in Ghana (Graff and Amoyaw 2009). Consistent with my study findings, acquisition of this instrument for use following the enactment of the South African CTOP Act was challenging (Mhlanga 2003). Recent research on the role of advanced nurse practitioners in the availability of abortion shows that inadequate and poor infrastructure was the main influence on availability of care (Kishen and Stedman 2010). Even though my findings showed strong indications of the emerging use of

medical abortion ('cytotec') in Ghana by both lay people and health professionals, the drug had not yet been registered by the Food and Drugs Board for obstetric purposes (personal communication with Director, Food & Drugs Board). In the absence of these relatively safe means of procuring abortions, health providers and women are more likely to turn to unsafe means.

Finally, as noted earlier, post-abortion care was commonly available, however some studies have shown that health centres are poorly equipped for providing PAC (Aboagye et al. 2007, Aniteye 2002).

iii. Lack of trained providers and staff attitudes towards provision of safe abortion services

In addition to paucity of designated facilities for abortion services, there are also inadequate numbers of trained providers who are also willing to provide abortion services. My findings are in keeping with observations of Kishen and Stedman (2010). They noted that lack of trained and willing physicians is one of the factors that contribute to poor access to abortion for many women in countries with legalised abortion. Lack of providers willing to offer abortion services was also identified in South Africa following the enactment of the Choice on Termination of Pregnancy Act (Mhlanga 2003, Harries et al. 2009). In Ghana this may partly be a result of confusion over who a 'medical practitioner' is, legally (discussed in Section 9.2). This was an issue raised in many interviews, especially with the obstetricians and one of the lawyers. The issue of suitably trained mid-level providers offering abortion services to enhance access, raised by some obstetricians, was considered contentious since the Ghana law permits only 'medical practitioners' (usually interpreted as doctors) to provide abortions.

While there is a wealth of evidence from studies indicating the competence of mid-level providers and abortion service provision (Berer 2009), many obstetricians in my study were silent over this issue of midwives providing abortion services. This may have been to protect their professional turf as shown in a study in one of the teaching hospitals in Ghana where as many as 97% of doctors said that only doctors should be trained to perform pregnancy terminations whereas 3% said that doctors,

midwives and medical assistants should be trained for abortion service provision. (Morhee et al. 2007).

Additionally, my interviews found that doctors were more supportive of abortion care and most were willing to offer services, counsel and refer women for services; only a few were conscientious objectors. However, the vast majority of midwives were not willing to train for CAC and would not offer services, though most showed favourable attitudes towards provision of PAC which they perceived as a service to prevent women dying from complications of an unsafe abortion already committed. Most midwives were conscientious objectors thus one wonders why the Standards and Protocols of GHS (2006) includes midwives as providers of abortion care when in reality most midwives are strongly against provision of abortion services. My findings therefore call into question the assumption of some authors (e.g. Hessini 2005, Berer 2009) that allowing mid-level providers to offer abortion services would expand access. Given the negative attitudes shown by the mid-level providers (midwives) in my study, the MOH/GHS would need to collaborate with the N&MC to work towards changing attitudes if the potential of mid-level health providers to enhance access and availability of abortion services in Ghana is to be tapped.

In Ghana, judgemental attitudes of health providers in general have been identified as a persistent problem by other studies (Witter et al. 2007; Armar-Klemesu et al. 2006). Not many studies in Ghana have focused on attitudes of health professionals towards abortion however the few studies done confirm negative attitudes of health facility staff (Jehu-Appiah et al. 2009, GHS 2005). The literature from elsewhere also confirms that provider attitudes constitute one of the major barriers to access to abortion services (Harries et al. 2009, 2007, Mokgethi 2006, Jewkes et al. 2005 Sibuyi 2004; Dickson et al. 2003, Mhlanga 2003, Varkey 2001, Whitaker and Germain 1999).

A further finding of my study is the poor attitudes of heads of health institutions who do not feature prominently in other studies of health professionals. In the interviews some obstetricians cited how some heads of health institutions opposed provision of services in their institutions and failed to support providers who wanted to offer

services. My study highlighted overt and covert activities of these heads that pose as barriers to abortion service provision. They do not attend meetings where issues on abortion are discussed and do not allow obstetricians in their institutions to provide abortion. Some heads of tertiary institutions objected to the use of their facilities for pilot research on medical abortion. Staff are not sent for training in abortion and equipment for abortions are not procured. The peculiar covert behaviour of those in senior positions to obstruct abortion service provision is a unique finding. Clearly the attitudes of frontline workers and management can create serious problems for implementing safe abortion services, and a greater understanding of what influences these attitudes among different cadres is necessary and was an integral part of my study.

a. Some explanations for attitudes observed

In my study, nurses/midwives were described by other respondents as judgemental, and in interviews with the midwives themselves it was clear that they often projected their religious/moral views on patients. In the wider literature, many studies portrayed nurses/midwives as gatekeepers who largely exhibit negative attitudes towards patients. That nurses/midwives are judgemental is supported by most literature on provider attitudes which tend to focus on nurses (Walker and Gilson 2004, Gilson 2003, Jewkes 1998, Gilson et al. 1994), though these studies tend not to highlight religious and moral issues. Gilson's work reveals a range of explanations for the judgemental behaviour of nurses related to their training, working conditions and lack of accountability (Walker and Gilson 2004, Gilson 2003, Gilson et al. 1994). In South Africa, the apartheid system had its toll on nurses' approach to their work. Other pressures on nurses such as being inundated with work (Penn-Kekana 2004) resulted in low morale and poor behaviour. Jewkes (1998) also described a complex mix of factors including organizational issues, professional insecurities, nurses' exhibition of power by creating social distance between them and their patients and their perceived superiority as contributory to the observed patterns of nurses' behaviour. These studies were not specific to abortion, however, and it is important to note that abortion literature in general does highlight the predominance of religious and moral issues, which supports my study's findings (Lazarus 1997, Garel et al. 2002, GHS 2005, Mokgethi et al. 2006, Hill et al. 2009, Onah et al.

2009). My study is one of few that provides an explicit account of the reasons for staff attitudes to abortion services, and finds that for lower cadres of staff, religious and moral issues are often paramount in their decisions about abortion service-provision contrast. Similar to my study findings, Harries et al. (2009) who studied health providers' attitudes towards termination of pregnancy in South Africa found that providers had some aversion towards abortion care on a mix of religious and moral grounds. Religious beliefs constituted part of the reasons why some providers decide not to be involved in abortion services. Whilst some providers were vehement about their dislike of abortion care, others would not provide direct abortion services i.e. performing abortions but would offer pre and post abortion counselling or basic nursing duties. Aboagye et al. (2007) in an assessment on CAC in Ghana also found that the main reasons why some health providers hesitate to provide abortions include perceived religious conflicts, uncertainty of the legality of abortion, doubts about the standards and protocol for CAC and perceived lack of administrative support. These findings corroborate my study findings.

Not many studies have reported judgemental attitudes of doctors though some have pointed to religious beliefs and personal morality as having influence on their attitudes towards abortion (Lazarus 1997, Adams 2003, Gleeson et al. 2008). My study, however, showed that in contrast to the lower staff cadres, doctors were less judgemental and were more influenced by their professional judgements than religious or moral arguments. This seemed to be, in large part, because they were more highly educated and had much more exposure to Western settings (often training in western countries for many years). The result seemed to be that my obstetrician respondents were less likely to hold entrenched religious views and were more likely to temper their religious beliefs. The impact of training and higher education on promoting favourable provider attitudes towards reproductive and sexual health in general has been exemplified in the literature (Warenius et al. 2006). My study also found that exposure of staff to the problem of unsafe abortions and associated complications (typically obstetricians, though some midwives had also seen these) positively influenced providers' attitudes towards provision of services, making them more willing to intervene; similar findings were reported in a study in Brazil (Faundes et al. 2004).

Lupton's (1994) expose of the medical encounter also sheds some light on health professionals' attitudes towards patients. In her description of the power differentials among doctors, nurses and patients, she describes doctors as the group that wields more power based on their knowledge, skills, expertise and competence; patients on the other hand have little or no control whilst nurses occupy a middle position. To ensure control and compliance from patients, the doctors and nurses classify the patients by some 'unwritten moral code' which influences the way they are treated. Patients are either labelled 'good' or 'bad' based on characteristics they exhibit in the encounter; for instance patients who are compliant are 'good' and those who are non-compliant and sometimes resistant are the reverse. My study found that some health providers label women seeking abortion as irresponsible women with unwanted pregnancies who seek abortions using flimsy excuses. Women requesting abortions are classified as those who genuinely need abortion services and 'those with flimsy excuses for abortion'. Health providers pass judgement on the action of requesting abortion – and so by extension on the women seeking it. While obstetricians tended to employ their clinical judgement (with minimal element of value judgement) to counsel women on available options of care, midwives appeared to employ little or no clinical judgement plus some unwritten religious/moral code, often counselling women against termination of pregnancy.

Finally, with regard to training, a few obstetricians and a senior midwife, all protagonists of abortion service provision, expressed the need for 'values clarification' to help alter nurses' attitude and enable them to conceptualize abortion in a different perspective. They cited examples of how such workshops in Ghana have 'converted' some health professionals who once opposed abortion services to view it differently. Mitchell et al. (2005) describe values clarification as an intervention that transforms attitudes and behaviours of health professional to be less judgemental and more positive towards abortion services. According to Chapman et al. (2006), during values clarification, individuals get involved in a time of self-reflection and problem confrontation, identifying their values in the process and making sure these are consistent with what they believe. Many studies (e.g. Turner et al. 2008; Dickson et al. 2003; Marais 1996) have demonstrated the usefulness of values clarification in making an impact on the attitude of stakeholders (e.g. health

providers) towards abortion services. Although values clarification workshops do not change all negative opinions, there are observed positive shifts in attitudes (Turner et al. 2008; Mitchell et al. 2005). Values clarification could be a useful strategy the MOH/GHS could further explore in collaboration with N &MC for use in training midwives especially and other health professionals to build and expand capacity for abortion service provision.

9.3.2 Socio-cultural factors as barriers to provision of abortion services

The main socio-cultural factors that influenced abortion service provision in Ghana identified in this study were cultural values and social norms, and (particularly prominent) religion and morality.

i. Cultural values and social norms

Ghana was presented by respondents in my study as a profoundly pronatalist country. Thus children are greatly valued in Ghana and perceived as gifts from God. Ideally all pregnancies should be carried to term and babies delivered; abortion is perceived by the Ghanaian society as killing (murder) and a violation of God's commandment, though there is evidence of the practice of abortion and infanticide in ancient Ghana (Bleek 1981). My study showed that the value placed on children in Ghana is one factor that impinges on abortion service provision. This distinguished value accorded to children and its impact on the practice of abortion is confirmed by Kenyah (2000) in his study of abortion in a mining town in Ghana. Abortion is incompatible with the social norms that prevail in Ghana. The social stigma associated with abortion and disrespect for providers and women alike sometimes resulting in ostracism of women from their local communities and name calling of providers were revealed in my study. Other authors (Hessini et al. 2006, Lithur 2004, Brookman-Amissah and Moyo 2004) confirm these study findings which appear to account for the clandestine nature of the practice of abortion besides the fear of prosecution where abortion laws are restrictive or even where they are liberal but vague. The clandestine practice of abortion accentuates the dangers involved since this undermines the quality of the procedure.

It was also revealed that despite the practice of abortion and infanticide in Ghana for a long time, abortion is still considered reprehensible and a socially disapproved phenomenon (Bleek 1981)⁴. This finding is corroborated by more recent findings of Ghanaian studies on abortion (GHS 2005, Senah 2003, Henry and Fayorsey 2002, Lassey, 1995) as well as others in sub-Saharan Africa (Schuster 2005, Makinwa-Adebusoye et al. 1997). Some studies in Ghana have showed that even though abortion in Ghana is culturally abhorred when exposed, when secrecy is achieved and the outcome of abortion is successful the procedure is accepted (Hill et al. 2009, Henry and Fayorsey 2002).

Religion and moral values are recognized as integral parts of a country's socio-cultural fabric (Assimeng 2006, Gyekye 1996). In my study, while cultural values and social norms were mentioned, they were not nearly as commonly mentioned as religious and moral values which were identified as major barriers to abortion service provision and therefore form the focus of the rest of this section.

ii. Religion and Morality: influence on professional obligations (provision of abortion services)

The impact of religious and moral attitudes on providers' willingness to provide abortion services was shown to be significant, though different among different types of providers. Religion especially was portrayed as a major underlying reason why health professionals especially midwives were reluctant to offer abortion services. Midwives demonstrated more conservative and fundamentalist religious beliefs on abortion than obstetricians. Many midwives considered abortion as destruction of lives, bloodshed and murder. The vast majority of midwives considered abortion an immoral act which is against their religious beliefs but which may only be warranted on medical grounds; they believed that medical indications are the only justifiable grounds for abortion and some of them referred to this phenomenon as 'therapeutic abortion'. Most of the midwives were therefore not willing to provide abortions services except for counselling and referral. Meanwhile, in addition to provision of

⁴ This reference, though an old one is widely cited in Ghanaian studies on abortion that highlight Ghanaian culture because there is paucity of studies in Ghana that focus on its socio-cultural aspects.

abortion on medical grounds, a minority of obstetricians believed abortion could be provided for women who need it on grounds of compassion. These few obstetricians argued that it is equally immoral to deny women services they need and to which they are also entitled. These differences in beliefs, attitudes and behaviours may reflect differences in education and exposure to international debates (as discussed in 9.3.1). Nevertheless, in both cadres, conflicts between religious and professional obligations were observed. These can compromise service delivery and cause emotional problems (stress) for the providers.

For instance, my findings showed that some midwives were not comfortable with referring women for abortion services for religious reasons. To them, this meant aiding and abetting a sinful act which would attract condemnation. However, these midwives believed they were professionally obliged to ensure women with unwanted pregnancies do not resort to unsafe abortions. To resolve such conflicts some midwives referred women for abortion services and prayed for forgiveness for their actions, some reflected that the women they referred may be counselled to change their minds about termination, thus abdicating responsibility by shifting the decision to terminate pregnancy onto obstetricians; whilst some obstetricians usually resorted to what in their view was professionally best for women who needed abortion care, sometimes compromising their religious views.

In this study, a complex interplay and balancing of religious and moral convictions and professional practice occurred which often prevented health professionals from providing abortion services for fear of social or professional repercussions. Nevertheless, there were exceptions and many obstetricians were in favour of provision of safe abortion services. Such religious or moral conflict and dilemma that confront some Ghanaian health professionals in their daily encounter with their patients were similarly found in studies among French midwives (Garel et al. 2002), South African nurses (Mokgethi et al. 2006) and among US resident doctors (Lazarus 1997). Research has showed that direct involvement in abortion care places heavy emotional demands on nurses which may result in increased stress levels (Lipp and Fothergill 2009). Stress, burnout and the need to cope are deemed important issues of concern in abortion care (Lipp and Fothergill 2009).

Whilst some of the professionals in these studies experienced ‘physician burn outs’, some professional nurses experienced depression, anxiety and religious conflicts as a result of providing abortion services. The result was that they were reluctant to provide services and did not also want to be associated with the services. These findings reveal the level of the impact such conflicts could have on health professionals. Support and help for these professionals is paramount. The need for organizations and managers to address these challenges with abortion services cannot be overemphasized. There is need for dialogue, open debates, discussion, destigmatisation and workshops to help professionals re-examine and clarify their values. In the absence of these support systems, nurses are likely to seek to avoid involvement in abortion service provision or even abortion counselling, with ramifications for service availability.

Whether or not abortion services should be made open and available in public health facilities and the attitude of respondents to this was an issue that evoked much discussion in my study. This question led to arguments for or against abortion and abortion services in Ghana. The next section summarises the arguments forwarded for abortion care in an attempt to explore strategies that are likely to advance open abortion service provision in Ghanaian public health facilities.

9.4 Arguments for promoting abortion care in Ghana

The findings from my study give some pointers to how safe abortion care could be successfully promoted in Ghana. The arguments in favour of abortion given across the range of respondents were based on public health, professional ethics and women’s human rights whilst those against abortion were mainly based on religion and morality and - to a lesser extent – the human rights of the foetus. Respondents tended to use multiple arguments for justifying abortion services, though public health arguments were the most prominent, seemingly meaningful and acceptable to most respondents including those who were religious and those who were not medical personnel (including religious leaders and journalists). This suggests that '*medicalisation*' of the issue might prove acceptable to most people and help remove the issue from the domain of religious condemnation – this is discussed in detail later on. The fact that professional ethics and human rights arguments were also brought

suggests that these could be combined or used to gain the approval of certain groups, together with the public health arguments. However, as some respondents suggested, some may oppose '*rights*' as a Western concept so on balance perhaps the focus for Ghana should primarily be the public health one. Coalition building with '*rights activists*' especially women's rights activists for purposes of advocacy could be beneficial though some may argue that this may polarise opinion, nevertheless it would help to get the issues debated in public. Exposure to different arguments and ideas appeared to be an important factor influencing the two 'deviant' midwives who showed more liberal attitudes to the need for safe abortion care.

The fact that two '*deviants*' in the religious respondent group (i.e. religious leaders not explicitly against safe abortion services) and some religious health providers had been exposed to the human realities of women dying or being permanently injured from unsafe abortions, also suggests that pursuing a '*human face*' to a '*medical problem*' could have an influence on public perceptions of the need for abortion services.

The entrenched religious views of the deviant obstetrician (i.e. an obstetrician who explicitly held his religious views above the professional need to provide abortion services) on the other hand indicates that for religious hard-liners, such arguments would make no difference, however my study as a whole suggests that such views are in the minority, though they may be vocal and powerful. In addition to '*medicalising*' the issue of abortion services, as discussed above, it will be important to encourage open debate with more liberal religious leaders and thinkers who can put forward a more compassionate position and acknowledge that abortion services may sometimes be necessary. My findings suggest that the elements of compassion and realism are significant in shaping how people react to abortion care. The ensuing section discusses the key findings of this study in the light of relevant theories.

9.5 Study Findings and their theoretical significance

Analysis of the behaviour of front-line health workers, as well as other actors who influence the abortion debate in Ghana, was the central aim of this thesis.

The findings, summarised above, raise a number of questions: What explains the actions of front-line staff and other actors involved in implementing the abortion

law? Why are obstetricians more favourable to providing abortion services than midwives? Can Lipsky's theory help in explaining their views and actions? Are there particular ideological arguments that could help promote safe abortion services in Ghana?

This section seeks to address these questions through the following sub-sections:

- Validation and extension of Lipsky's 'Street-Level Bureaucrats' theory:
 - The law on abortion in Ghana and its interpretation
 - Differential behaviour by cadre; conflicts between religious beliefs and professional obligations
 - What explains the differences? Is theory useful?
- Rights and Medicalisation of abortion: what arguments could make abortion services more acceptable in the Ghanaian context?

9.5.1 Validation of Lipsky's Theory

i. The abortion law and its interpretation

As noted in the findings summary above, the law was said by most respondents who knew of it (obstetricians, the lawyers, some parliamentarians and the journalist) to be vaguely framed. It had gaps and inconsistencies, namely: a maximum gestational age was not specified, 'risk' was not defined, extent of foetal abnormalities was not defined and the issue of 'mental health' was not defined. The 'mental health clause' is widely used in Britain to offer services to women but its use in Ghana is almost nonexistent because of the lack of interpretation given to it. Mental health is not defined in law, leaving it open to individual practitioners to decide how they will interpret it - which many are reluctant to do. This lack of clarity in the law has resulted in its gross misunderstanding and multiple interpretations from the view that, because it is part of the Criminal Code, abortion is illegal, to those who think that the law allows it to be provided on most grounds, including to protect mental health. These multiple interpretations hamper abortion service provision, as discussed in previous sections.

Why would the abortion law which was actually intended to make safe services available to women in order to prevent unsafe abortions be framed so vaguely? Why would the law be permitted to create confusion rather than paving the way for abortion service provision? The formulation of the law was not the focus of this thesis and little is known about it since it was the result of a dictator's decree. Nevertheless, it could be hypothesised that the vague wording of the law was itself a compromise – the result of multiple pressures affecting policy decisions in a way similar to that hypothesised by Lipsky as influencing street level bureaucrats, though Lipsky's theory does not shed any direct light on policy formulation. The main question for this thesis, however, was how the existing law is interpreted – and then applied – by actors who influence public debate on abortion (especially religious leaders) and by the front line staff who are charged with implementing it. It is to this question that I now turn. The interpretation and application of the law is the duty of 'medical practitioners' who the law in Ghana specifies as eligible to provide abortion services. In the light of Lipsky's theory, these are the street level-bureaucrats who use their discretion to tackle the conditions that confront them. The theory can help explain the differences between the attitudes of obstetricians on the one hand and midwives and managers on the other. The next section briefly contrasts the different behaviour.

ii. Differential behaviour by cadre: conflicts between religious and professional obligations

My study showed that obstetricians have more favourable attitudes towards abortion services. Many showed willingness to provide services where necessary even though some would only perform abortion as a last resort. They would offer counselling on various options for unwanted pregnancies including safe abortion as per the Standards and Protocols and also refer women who needed services to colleagues where they themselves are not able to perform abortion. They were willing to teach medical students on the subject and hold discussions on it; many obstetricians were generally highly supportive of safe, legal abortion services as an important measure for reducing maternal mortality and only a few were conscientious objectors.

Many obstetricians were, nevertheless, religious and some obstetricians mentioned their religious beliefs quite openly, but their attitudes suggested that they were of a less fundamentalist nature than those beliefs the midwives usually displayed, and were more tempered by their experiences of working in Western countries or being exposed to Western (European) thinking on abortion, and were consequently more willing to provide services, justifying it primarily on medical grounds. Some also made reference to the Hippocratic Oath either implicitly or explicitly as something that enjoined them to save lives which many interpreted as lives of women not of unborn foetuses.

There were notable exceptions to the generally positive view of doctors towards providing abortion services. Some doctors who were heads of health institutions or medical administrators in charge of health facilities tended to oppose the open provision of abortion services in institutions they head and failed to support providers who want to offer services. They would not send eligible health workers in their institutions for training on abortion neither would they attend any meetings where they know the issue of abortion would be discussed. If they do attend such meetings at all, they make no contributions.

At the lower level of service provision, most midwives exhibited negative attitudes towards abortion services – except post-abortion care. They were more opposed to comprehensive abortion care provision than doctors; the midwives were far more conservative and reluctant to provide CAC than obstetricians were. To them CAC meant destroying lives which was morally unacceptable; however they perceived PAC as service to save women from dying from the complications of unsafe abortion once already undertaken. Most midwives would not train to provide abortion services but would undergo training for PAC. They were eager to counsel women seeking abortion to keep their pregnancies and to deliver their babies. They took pride in getting women to change their minds about abortion and some added that some of such women named their babies after them (the nurses). In Ghana, one feels highly respected and honoured if a child is named after him or her. A few midwives would refer women to the right places for abortion care but some choose not to refer for fear

of getting involved in a ‘sinful act’. Most of them were conscientious objectors and religion was the main reason for their objection.

Furthermore, a common finding among the midwives (and a few doctors) was a challenge or conflict between their personal (religious) beliefs and professional obligations. This resulted in dilemmas in their work which could be stress-provoking. They described how their religious beliefs on the sanctity of life were confronted by women needing abortions. One midwife spoke of referring such women to see ‘a doctor’ without specifically telling women where to go. This was a way of ensuring that she did not lead or direct women to terminate pregnancies. Other midwives referred women to ‘the FP Clinic’ where they know terminations are done but hoped that the women they referred would be counselled against termination. There were two examples of midwives referring clients to providers for help and then feeling guilty, one of whom prays for forgiveness. Like the doctors, most of the midwives were adamant that they were ‘called’ to save lives and not to ‘destroy’ and would never go against their vocation. Unlike doctors, though, in cases of abortion they interpreted this clause as saving the life of the foetus rather than the life of the mother.

iii. What explains the differences? Is theory useful?

Questions that arise from the attitudes of the different cadres of health staff, and staff in managerial as opposed to service-provision positions are: why do obstetricians have more favourable views towards providing abortion services than midwives? Why do heads of departments sometimes prevent obstetricians from openly providing abortion services in their facilities? A two-pronged explanation could be given to this; an empirical or practical one and a theoretical explanation.

Practical explanatory issues include: workload pressures, exposure to Western settings and the type of religious affiliation, knowledge of the law and international treaties covering abortion.

a. Workload Pressures

Medical practitioners and in this instance obstetrician/gynaecologists come under a lot of work-related pressure. Having worked in the department of obstetrics and gynaecology at the National Teaching Hospital for over a decade, my experience shows that these doctors are overwhelmed with work; their caseloads are heavy. They have long clinic sessions, long operating and waiting lists that run into several months, in-patients waiting to be seen on ward rounds and various groups of medical students, residents and interns to teach, supervise and mentor. There are also multiple meetings to attend and administrative duties to be performed. Those in academia have the added task of undertaking research and publishing papers to earn promotion and also to keep their jobs. The doctors also have the responsibility of taking major and sometimes difficult decisions concerning patient care and the work environment. To cope with these arduous tasks, the controversies surrounding abortion and the difficult decisions that sometimes need to be taken, some health providers appear to use the vagueness of the law as an excuse for some of their actions (for instance staying away from provision of abortion services). If the law is unambiguous and is interpreted in a much more liberal manner than it currently is, then some respondents felt that the demand for abortion may be so overwhelming that doctors may not be able to cope. In the interviews some providers referred to such a situation as ‘opening the floodgates for abortion’ which in their view is unacceptable. It appears that the doctors interpret the abortion law in ways that would enable them cope with the many pressures they are subjected to. The vagueness of the law offers them room to interpret the law to suit their circumstances. Each doctor’s interpretation may be subject to his circumstances or ideologies about abortion. This reflects the ‘coping mechanisms’ street level bureaucrats adopt to help them manage their peculiar situations. My findings with respect to how doctors interpret and apply the abortion law thus appear to mirror elements of Lipsky’s street level bureaucracy explaining why doctors interpret the law the way they do.

b. Exposure to Western settings, knowledge of international law and consequences of unsafe abortion

Empirically, the interviews showed that some obstetricians had further training in Europe (mainly Britain) after their basic medical training in Ghana. Others had all

their training in Eastern Europe. Thus obstetricians have had more exposure than midwives to Western settings and have often worked in facilities overseas where abortion services were openly provided. They are also more aware of international conventions and treaties to which Ghana has ratified. Thirdly they are more knowledgeable of the law on abortion. All these things act to temper their religious beliefs.

By contrast, midwives held more fundamentalist beliefs, interpreting their medical calling to ‘save lives’ as being about not destroying foetal life rather than preserving the life of women in need of abortion. Why? Perhaps because they do not well understand the implications of refusing abortions to desperate women. Their lower education and lower exposure to Western views of abortion and international debates on provision of safe services also help to account for this more fundamentalist religious interpretation.

Again, this is in line with Lipsky’s theory that street-level bureaucrats shape their actions (and thus policy implementation) according to dilemmas they face in the context of their professional lives.

c. Influence of religion, social and ethical considerations

To some extent, although doctors and midwives are from the same communities, there are class differences and midwives tended to frequent Charismatic Churches whilst obstetricians were more likely to belong to more mainstream Protestant Churches. The influence of religion tended to be profound amongst the midwives and they were explicit about this in the interviews. It must also be noted that in practice, the doctors are guided by an Oath which is secular in nature whilst the midwives follow a Prayer. This further underlines the extent of religious influence on the two groups of health providers. Nevertheless, some heads of institutions who opposed abortion service delivery displayed more rigid religious beliefs vis-a-vis abortion. This may partly be explained by their views of their role in society. For example, heads of institutions are arguably more ‘visible’ in society than the obstetricians; it also emerged during the interviews that some heads of institutions hold important positions in Church and would not want to be seen to be involved in abortion. Their

positions in Church and society conflict with their professional obligations and possible willingness to allow provision of services in their institutions. Some of the obstetricians referred to a head who obviously avoided all meetings on abortion. It also emerged in the interviews that two heads of tertiary hospitals refused to allow a pilot study on the feasibility and acceptability of medical abortion in low resource settings to be carried out in the hospitals they head. The study was thus carried out in two district hospitals.

Similar conflicts between ethical/moral or religious and professional obligations have been found in the literature. In her study of a residency programme in the USA Lazarus (1997) described how politicizing abortion exacerbated challenges faced by practising doctors (residents) and in turn accentuated ethical conflicts between doctors' personal morality and professional responsibility. Some doctors would provide abortion services whilst others would not for various ethical and moral reasons. These diverse moral perspectives of doctors did sometimes result in unprofessional treatment of women seeking abortion services. Furthermore, studies among French doctors and midwives have also demonstrated important ethical dilemmas concerning decisions by doctors and midwives on abortion; the latter experiencing intense moral conflicts and emotional distress.

iv. Does Lipsky's theory hold against these explanations?

My empirical findings validate Lipsky's theory. They explain the attitudes of doctors, nurses as well as the heads of institutions towards provision of abortion services. As street-level bureaucrats, these frontline health workers have the power to interpret and implement policy in their own way depending on their perceptions of their prevailing circumstances and what they think is feasible given their working conditions.

While the respondents in my study did not use theoretical language, they talked about the 'dilemmas', even 'conflicts' which they faced trying to balance their religious beliefs, social expectations and professional good practice. Both the doctors and midwives appeared to have mental scenarios of how they would handle certain cases. These ideas are reflections of 'routines' developed by health providers to help

ease the pressure of work. For instance, the reasons certain women give when seeking abortions are classified by some providers as ‘flimsy’ and they are counselled against termination of pregnancy or sometimes sent away.

In the case of pressures faced by nurses in Ghana, they are not generally accorded much respect for various reasons. From experience, I know that they are perceived as subordinates to doctors, having to obey doctors’ instructions, doing undesirable jobs like serving bed pans and receiving low pay; similar to Lupton’s (1994) description of nurses’ position in the medical encounter. She observed that nurses are far lower in the medical hierarchy than doctors and have the added strain of being treated almost like servants by both doctors and patients; that the duties that nurses perform which are regarded as ‘dirty work’ or ‘women’s work’, contribute to their low social status and the power differential between nurses and doctors. My experience as a Ghanaian nurse also shows that nurses in Ghana complain that they are always forced to improvise because they do not always get the necessary equipment to work with. A few respondents stated during the interviews that the shortage of nurses in Ghana due to the ‘brain drain’ is an added strain since nurses are inundated with work. Voetagbe et al. (2010) in their recent study showed that even though about 500-600 midwives graduate from various midwifery programmes in Ghana each year, only a few midwives are available to provide reproductive health services in the public sector as a result of the brain drain (Mensah et al. 2005, Nyonator and Dovlo 2004). The perceptions of the Ghanaian public about nurses, their heavy workload, poor working conditions and low pay make them frustrated and patients bear the brunt of their anger. Patients and sometimes their relatives are the nearest people nurses can vent their anger and frustrations on. Nurses also tend to get angrier with patients who they think have caused their own health problems especially those with sexual and reproductive health problems such as adolescents with complications of unsafe abortion, STIs as well as those who are pregnant. Confirming what Lipsky’s theory describes, they control their prevailing circumstances in pragmatic ways to help them cope with their working conditions which are usually poor and demanding.

The doctors, by contrast, mostly showed that their greater exposure to Western training and higher education tempered their religious views to a greater extent than

midwives. Moreover because of the greater social and professional position they hold, compared to midwives, they could perhaps be more confident in their decisions to provide abortion services. Nevertheless, even though most doctors showed theoretical willingness to provide abortion services, deeper insights obtained during the interviews meant that when confronted with real cases, some would counsel on various options, refer women to colleagues, while others would provide the services, though often not openly.

Indeed, while people often interpret Lipsky's theory as applying primarily to 'frontline health providers' its principles can be applied to actors at many different levels. My study indicates that Lipsky's theory can equally be applied to the case of heads of institutions and how they prevent abortion services from being provided in their facilities. Given the multiple competing demands these heads have, they also adapt policy to cope with their particular circumstances (social or professional).

In my study, it appeared that, as heads of institutions, they felt more socially exposed (e.g. prominent positions in church) and therefore it was more important to them not to be seen to be openly allowing controversial abortion services in facilities that were their responsibility. This stands in contrast to the obstetricians beneath them who more openly expressed favourable views towards provision of safe abortion services – possibly because they felt more shielded from potential criticism since they were not ultimately responsible for abortion practices at their facilities. In the ensuing discussion, I focus on a phenomenon which may make provision of abortion services more acceptable in the Ghanaian context. The next section briefly describes the concept of medicalisation of abortion drawing on information on how abortion became a medical rather than moral concern from literature in Britain and the US.

9.5.2 Would Medicalisation of abortion make it more acceptable in Ghana?

Abortion is a much contested and thorny issue (Lee 2003). The literature indicates debates and arguments about abortion that have been raging globally for years. The debates and arguments border on issues relating to abortion and morality, religion, ethics, and human rights among others. My data showed strong arguments against abortion (see chapter 8) based on religious and moral ideologies. However, the data also showed an overarching argument in favour of provision of abortion services on

medical grounds. The latter arguments were widespread - cutting across all respondent types including those against provision of abortion services in public health facilities as previously discussed. Based on this finding, it is believed that when the need for abortion is framed on medical grounds, many opponents are likely to accept abortion services where medically indicated. Thus medicalisation of abortion may enhance on-going efforts of the GHS to scale up abortion service provision in public health facilities in Ghana.

'Medicalisation has been described as the process by which non-medical problems become defined and treated as medical problems, usually in terms of illnesses and disorders' (Lee 2003). With respect to abortion, Luker (1984) considers medicalisation as the process by which abortion is construed as a medical rather than a moral issue and highlights how abortion became a medical rather than moral concern in the US. She described how through medicalisation, physicians claimed maximum control over decision-making on abortion based on professional and technical expertise with the claim that only trained doctors could tell when there is a need for abortion.

The literature indicates that medicalisation is not a new phenomenon. It dates back to the 1960s with studies at the time showing how through medicalisation, Western societies moved from defining problems in religious and legal terms to define them in medical terms (Lee 2003). A wide range of social problems have been medicalised. For instance, social problems such as child abuse, alcoholism, drug addiction, compulsive overeating, gambling and homosexuality were all perceived and defined in medical terms (Lee 2003). It appeared that the vast majority of social problems could be explained in medical terms or that they had medical underpinnings. Furthermore, hallucinations and delusion which were once understood and explained in religious terms as indications of demon possession became medicalised by giving them medical explanations (Fox 1997). Also, certain behaviours in children which could be termed as bad behaviour were medically explained as hyperactivity.

Medicalisation therefore offered other explanations of human behaviour with a shift from the perception of certain behaviours as immoral and wrong (based on religion or law) to less punitive ideas. Based on the aforementioned descriptions of the term ‘medicalisation’, my understanding of the concept is viewing social problems via a medical lens or a way of explaining social problems solely from medical perspectives and downplaying other dimensions of the problem.

Abortion is one of the social problems that has also been – or has potential to be – medicalised. Medicalisation of abortion is also not new. In the US, by the end of the 20th Century, via efforts of the ‘right to life’ movement, abortion became a medical rather than a moral issue. Lee (2003) described how the medicalisation of abortion, specifically the linking of both abortion and motherhood to potential mental illness, arose in the US, and how this has helped those in favour of and against abortion shift away from moral arguments for or against, and towards the alleged neutrality of more scientific/medical questions of mental illness. Medicalisation of abortion was highly contested and fraught with many problems. It appears that medicalisation of abortion was initiated by opponents of abortion who framed their opposition in medical perspectives. Their claim was that abortion is risky and results in ‘post abortion syndrome’ - a collection of psychological symptoms believed to be evoked by abortion. This claim led to debates because it lacked empirical evidence. With time abortion was considered as a low risk health problem that confronts women and became situated within the overall medicalisation of pregnancy. Unlike abortion, the link between motherhood and mental illness was evidence based and thus more acceptable.

The process of medicalisation was so wide ranging (as previously discussed) hence it appeared society had moved away from perceiving social problems in other perspectives ; constructing social problems mainly in medical terms even though they were formerly construed and managed in other terms such as moral, religious or criminal. This led to many criticisms against the process. The criticisms were that the medical profession had dominated society and were exerting some form of social control by their construction of many social problems in medical terms. There was said to be over medicalisation of life’s experiences; that medical definition of

problems overshadowed that of others. In addition, there was ‘colonization’ of the human experience by medical professionals (Luker 1984). What this meant was that the medical profession had power and control over many social problems which they explained and managed using medical terms. It appeared the medical professionals were being criticized as misconstruing many social problems or monopolizing them.

Feminism or the women’s movement was one of the critics of medicalisation particularly of women’s bodies and reproduction. They criticized the domination of doctors and questioned the neutrality of the medical knowledge they apply. Joffe et al. (2004) discussed how uneasy physicians in the US have felt over political/moral arguments in favour of abortion put forth by feminists and how, as a result, they have pushed for a more medicalised view of abortion as a way of relieving their anxieties. Though the moral/medicalisation tension here is not that between religion and medicine, as in my study (but rather feminists and medicine), the underlying principle of how medicalisation can make an issue more “neutral” and less politically and morally charged, and thus more acceptable may be useful and applicable in Ghana.

Meanwhile it has been argued that there are actors besides medical professionals who have employed medical ideology and have been engaged in medicalisation. Medicalisation of alcoholism is an example showing that not only medical professionals construct problems in medical terms (Lee 2003).

Despite the criticisms of medicalisation, its characteristic neutral feature could make it useful in abortion care in Ghana. Given the nature of arguments forwarded for and against abortion and abortion care, my data suggests that if abortion is constructed as a medical issue rather than a religious, moral and legal issue, it stands a better chance of being accepted in the deeply religious Ghanaian context. Since many respondents in my study beside medical professionals were in favour of abortion on medical grounds, it is possible for different groups of Ghanaians such as lawyers, feminists, the legislature, the clergy, policy makers and other stake holders to work jointly towards medicalising abortion to enhance acceptance of abortion service provision in Ghana. When a wide range of stakeholders work together to medicalise abortion, no

single group would face criticisms for their action. Doctors would not be seen as having too much control over abortion. It appears that ‘actors’ of the medicalisation process as well as the ‘context’ in which the social problem is constructed are important determinants of responses to the process. There is need for careful deliberations and planning of the medicalisation process by stakeholders for success. The section that follows outlines the summary of the entire thesis, makes some recommendations for policy and practice and presents some final conclusions of the study.

9. 6. Summary, Recommendations and Conclusion

This study set out to understand the barriers to and opportunities for improving access to safe, legal abortion services in Ghana. The overall purpose was to help unravel the policy, service level and other barriers that confront women with unwanted pregnancies in their bid to access services that should be available to help meet their needs. This would help reduce unsafe abortion and the toll it exacts (maternal morbidity and mortality) on women, families, communities and the nation as a whole. MDG 5 would then be realized.

9.6.1 Summary

The main objective of this study was to understand the barriers to and opportunities for improving access to safe, legal abortion services.

The objectives of the study were to:

1. Analyze the content of the abortion law and policy
2. Examine the process of promulgation of the law and identify the actors involved and the roles they played.
3. Identify the service-related and socio-cultural factors including social norms, cultural values, religion and morality that act as barriers to provision of safe, legal abortion services.

4. Determine the differences in actors' knowledge, attitudes, and views concerning abortion in general, the abortion law in particular, its implementation and the underlying reasons for actors' attitude and views.
5. Consider implications of the research findings for policy and practice.

In line with the specific objectives, I summarize the key findings.

i. The abortion law and policy

The study reviewed the abortion law and policy to understand whether and how the contents of these documents influenced provision of safe, legal abortion services. The abortion law was described as liberal but with several ambiguities in relation to 'risk', gestational age, and the mental health clause thus liable to multiple interpretations. This has implications for service delivery. Lack of clarity in the law and the range of interpretations influence availability of services. The abortion law is partially implemented and there is paucity of services in public health facilities. Where available abortion services are provided clandestinely for fear of prosecution. Location of the law in the Criminal Code gives the false impression that abortion is illegal. There is need for law reform and clarification of some of the provisions of the law in the long term.

ii. Promulgation of the abortion law

Laws are enacted by the legislature in a well structured iterative process. It goes through a series of stages including the first, second readings and the consideration stage and the public are actively involved. The president finally assents his signature for the bill to become a law. The current abortion law did not go through such recognized stages. It was enacted by a military ruler and not much is known about the processes. The law was not disseminated after promulgation thus many Ghanaians were not aware of its existence.

iii. Barriers to abortion service provision

The range of barriers to abortion service provision were service-related including lack of designated facilities, lack of trained staff and other resources such as needed

equipment and provider attitudes. The socio-cultural determinants of abortion service provision were religious beliefs, moral values, cultural values and social norms.

iv. Actors' knowledge, attitudes and views toward abortion and underlying reasons

Many respondents including health providers did not know about the abortion law. Attitudes towards abortion varied among respondents and were demonstrated through a complex combination of arguments for and against. The arguments focused on public health grounds, professional ethics and human rights on one hand and religion and morality on the other however, some arguments cut across a multiplicity of factors, an indication of the complex issues concerning abortion service provision. Notably, obstetricians showed generally favourable attitudes whilst midwives showed fundamentalist conservative attitudes towards abortion and abortion service provision. Many respondents argued for abortion on medical grounds.

v. Theoretical reflection

My findings appear to uphold Lipsky's theory that front-line actors do indeed use their discretion to interpret and implement policy depending on their views of the situation confronting them and a balancing of their professional and religious concerns. Further, my findings suggest that Lipsky's theory can also be applied to the level of managers and heads of institutions.

9.6.2 Recommendations

There are four over-arching areas for immediate action that arise from this thesis:

i. Public debate and advocacy to refocus the abortion debate

There is need for open public debates on abortion to break the long-standing silence. Open forums for dialogue, discussions and debates among student and practising midwives through organizations such as Nursing/Midwifery Students' Associations, the Ghana Registered Nurses' Association, and Ghana Registered Midwives' Association may promote more compassionate and professional responses to women

seeking abortion care from midwives. On-going advocacy is paramount, however the message needs to be packaged carefully to make it acceptable as this study suggests – using a public health framework to ‘medicalise’ the issue may be most generally acceptable since it downplays controversial religious and moral dimensions. Key stakeholders such as Government Officials in sectors like Education, Health, Social Welfare, Women and Children’s Affairs and Information, the legislature, judiciary, the media and religious leaders must all be engaged in the reshaping of the abortion debate. The GHS must be seen to be in the forefront of such initiatives, so that provision of abortion services is seen as a health issue.

It is imperative to employ the principles of risk communication to ensure effective two-way communication. There is already advocacy by some female lawyers; more advocacy could be done by professional bodies and policy makers on the need for CAC. The debate should address when abortion is legal, attempt to change public opinion about abortion services (to address a medical problem) and gain the support of communities, though this may be a difficult and lengthy undertaking; well noted by (Mitchell et al. 2005) who observed that “*opening minds and hearts to the abortion issue is a complex process*”. Nevertheless, encouragement can be taken from other countries in sub-Saharan Africa which have opened public debate, sometimes in the face of fierce social opposition – most recently in Kenya which legalised abortion in 2010.

ii. Improving access to CAC

a. Clarifying the law

The ambiguities identified in the abortion law need clarification. For instance, the gestational age for which abortions are allowed by law should be clearly specified and the mental health clause should be well explained. These changes could be effected in future law reform since agitating for immediate law reform may result in a backlash that could compromise existing liberalities in the law. There is need for the regulatory body i.e. the Nurses and Midwives Council to clarify whether midwives are legally permitted to provide abortions. This may need to be done

through the courts due to the discrepancy about this issue in the law and the GHS (2006) Policy and Standards document.

Since Ghana's abortion law allows the procedure under certain conditions, and demand for the service is inevitable in all societies, there is need for the Ghana Medical and Dental Council to consider reviewing the Hippocratic Oath which implicitly forbids abortion, to expand its interpretation. To initiate this, debates, dialogue, and open discussion among all stakeholders – health professionals, lawyers, the legislature, NGOs such as the Ghana Medical Association, civil society organizations and religious leaders may be beneficial.

The N&MC should also widen the scope of interpretation of the midwives' prayer. Clarification and explanation of interpretation of the midwives' prayer is needed; that 'saving lives' includes that of pregnant women who will go for unsafe abortions if not referred and permitted to have safe ones.

b. Dissemination of law and policy

The study showed that many midwives are not aware of the law on abortion, or the RH policy and the Standards and Protocol. Given that knowledge about the policy was low even among health providers in reproductive health units and copies of the policy were reportedly unavailable where they should be, the Reproductive and Child Health Unit of the Public Health Division, MOH must ensure that copies of the policy reach delivery points of all levels of health care delivery and their utilization must also be ensured by those in charge, through effective supervision of abortion service provision and referrals.

c. Extend Training and Resourcing

Health providers should be properly trained in the use of vacuum aspiration. MVA kits should be made widely available by the MOH. Future curriculum review in nursing, midwifery and medical training institutions should consider inputs on pragmatic ethical issues such as personal morality and professional obligations that confront providers in their work. Referrals by conscientious objectors must be encouraged and seen as standard practice. Periodic refresher courses may be helpful. Training in values clarification and on-going training is essential. There is need for

continuing education to be encouraged especially amongst midwives and other mid-level health providers. In-service training and refresher courses run for these cadres should incorporate sessions on '*provider attitudes*' and how to improve these. In Ghana, the use of drama or role plays would be effective.

d. Addressing Provider Attitudes

There is need for caution to be exercised in delegating provision of abortion services to midwives in Ghana since midwives were far more opposed to CAC than obstetricians. Medicalising abortion is likely to make it more acceptable and to reduce stigma, but not without other more in-depth training efforts.

Values clarification workshops could have a valuable role to play here. Values clarification has potential to help transform the attitudes of stakeholders to abortion and abortion care. The GHS/MOH must institute mechanisms for ensuring these workshops for relevant stakeholders. Values clarification exercises could be incorporated in in-service education programmes; provider attitudes should not be ignored. Nurses who exhibit unprofessional attitudes towards patients needing any reproductive health service should be sanctioned.

Structures that support provision of CAC must be put in place to allay the fears of practitioners who are unsure of the law. Regular supervision, support and mentoring of student midwives, practising midwives and all health providers (in relation to abortion care) by superiors is essential and performance appraisal is also beneficial.

9.6.3 Future Research

There is scope for future research on abortion care into complex determinants of health professionals' behaviour using a qualitative approach to expand the evidence base begun by this research. Studies could also be carried out to determine pragmatic methods that can best promote favourable provider attitudes to abortion care provision; focussing on how and under what circumstances attitudes to abortion services can be changed. My discussion of the 'deviant' cases was a start but more comprehensive studies of factors determining attitude transformation are necessary.

This study took a number of measures to facilitate replicability of its findings by others. A thick description of the methods was provided. In addition, the data

analysis was described in detail to enable future researchers to follow. I explicitly described my biases and assumptions in relation to the research topic and indicated how these were dealt with. To further enhance validity and reliability, it is important that future studies should bear the limitations of this study in mind. Involving respondents in the interpretation of the data (respondent validation) would enhance the validity of findings. Including women (in reproductive age) in future studies on barriers to safe, legal abortion services would illuminate the peculiar barriers faced by direct users of abortion services.

9.6.4 Final Conclusions

This study has generated a range of new findings as a contribution to knowledge on the barriers to implementing the abortion law regarding provision of safe abortion services in Ghana. This study, though a complex and Herculean task has been overall beneficial and fruitful. The policy approach (consideration of policy content and the context, process and actors involved in policy implementation) employed was necessary and expedient but not entirely sufficient to understand the context/climate in Ghana regarding implementation of the abortion law to make safe abortion services accessible to women in need within the context of our cultural setting. There was need to further explore and critically analyze all factors impinging on implementation thus, the policy approach was expanded to incorporate additional elements such as '*socio-cultural factors*' (cultural values, social norms, religious beliefs and moral values) all of which are formidable influences identified in this study as strongly influencing behaviour (implementation). Placing actors central in the framework indicated their pivotal role and therefore Lipsky's street-level bureaucracy theory was selected as the core underlying theory.

Ghanaian traditional society considers abortion a '*taboo*' and hence reprehensible. Ghanaians, like other African nations are characteristically pronatalist. Ghana is also a religious nation and predominantly Christian. It is thus no surprise that a liberal abortion law is not fully implemented in the interest of women who need safe abortion services. Operating in this context, my study confirmed the importance of front-line actors in affecting provision of and access to comprehensive abortion care

in Ghana. However, it also showed that there is scope for improving access. Implementation, which in this study referred to provision of safe, legal services, can happen for those who need it, if the service-related barriers and attitudes of front-line health workers and their managers are pragmatically dealt with. Culture is hard to change and attitude change is a daunting undertaking. Nevertheless, I found that among respondents who were against abortion per se, there were situations where they would make way for abortion care, though some did not say so explicitly. “Medicalising” abortion could therefore help to remove the social stigma and make it more culturally acceptable. This will not be easy and requires a careful and multi-pronged approach, as discussed above, but it is a necessary step remembering that the ultimate goal is to reduce maternal mortality in Ghana and to achieve MDG 5.

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APPENDICES

APPENDIX 1: Countries and various grounds on which abortions are allowed

Country	Usual grounds	Rape	Incest	Foetal Impairment
SUB-SAHARAN AFRICA				
Botswana	Life, Mental, Phys. Health	X	x	x
Burkina Faso	Life, Phys. Health	X		
Cameroon	Life, Phys. Health	X		
Congo, D.R.	Life			x
Ghana	Life, Mental, Phys. Health	X	x	x
Liberia	Life, Mental, Phys. Health	X	x	x
Namibia	Life, Mental, Phys. Health	X	x	x
Zimbabwe	Life, Phys. Health	X	x	x
MIDDLE EAST				
Israel	Life, Mental, Phys. Health	X	x	x
Kuwait	Life, Phys. Health			x
Sudan	Life	X		
ASIA				
Hong Kong	Life, Mental, Phys. Health	X	x	x
Iraq	Life, Mental, Phys. Health	X	x	x
South Korea	Life, Phys. Health	X	x	x
Thailand	Life, Phys. Health	X		
LATIN AMERICA				
Argentina	Life, Phys. Health	X		
Brazil	Life	X		
Bolivia	Life, Phys. Health	X	x	
Ecuador	Life, Phys. Health	X	x	
Mexico	Life	X		
Panama	Life	X		x
Uruguay	Life, Phys. Health		x	
DEVELOPED COUNTRIES				
New Zealand	Life, Mental, Phys. Health		x	x
Poland	Life, Phys. Health	X	x	x
Portugal	Life, Mental, Phys. Health	X		x
Spain	Life, Mental, Phys. Health	X		x

Note: Table includes only countries with population of one million or more.

Source: AGI 1999 p23.

APPENDIX 2: Selected Abortion Laws

A) The Abortion Act 1967(Britain)

"The abortion Act came into effect on 27 April 1986 and permits termination of pregnancy subject to certain conditions. Regulations under the act mean that abortions must be performed by a registered practitioner in a National Health Service hospital or in a location that has been specially approved by the Department of Health- such as a bpas clinic.

An abortion may be approved providing two doctors agree in good faith that one or more of the following criteria apply:

1. the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated;
2. the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman;
3. the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman;
4. the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of any existing child(ren) of the family of the pregnant woman;
5. there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped; or in an emergency, certified by the operating practitioner, as immediately necessary;
6. to save the life of the pregnant woman; or
7. to prevent grave permanent injury to the physical or mental health of the pregnant woman.

In relation to grounds 3 and 4 the doctor may take account of the pregnant woman's actual or reasonably foreseeable environment, including her social and economic circumstances.

Most abortions of unwanted pregnancies are carried out under grounds 3 and 4 because the doctor confirms that it would be damaging to the woman's mental health to force her to continue the pregnancy.

Doctors and other medical staff have the legal right to ‘conscientiously object’ to taking part in abortions unless this is necessary to save the life or prevent grave permanent injury to the woman.

Source: *bpas 2006. The Abortion Act of 1967. <http://www.bpas.org/abortions/legal.html>*

B) South Africa’s Abortion Law

South Africa’s 1996 abortion law includes the following:

“2. (1) A pregnancy may be terminated

(a) upon request of a woman during the first 12 weeks of the gestation period
of

pregnancy

(b) from the 13th week up to and including the 20th week of the gestation period if a medical practitioner, after consultation with the pregnant women, is of the opinion that-

(i) the continued pregnancy would pose a risk of injury to the woman’s physical or mental health; or

(ii) there exists a substantial risk that the foetus would suffer from a severe physical or mental disability; or

(iii) the pregnancy resulted from rape or incest; or

(iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman.

(2) The termination of a pregnancy may only be carried out by a medical practitioner, except for a pregnancy referred to in subsection (1) (a), which may also be carried out by a registered midwife who has completed the prescribed training course.

“3. (1) The surgical termination of a pregnancy may take place only at a facility designated by the Ministry [of Health] by notice in the Gazette for the purpose under subsection (2).

(2) The Minister may designate any facility for the purpose contemplated in subsection (1) subject to such conditions and requirements as he or she may consider necessary or expedient for achieving the objects of this act”.

Source: *AGI 1999 p24*

C) Zambia's abortion law

Zambia has one of the most liberal abortion laws in sub-Saharan Africa, allowing abortions to be carried out on broad health, as well as socioeconomic grounds. The Termination of Pregnancy Act of 1972 permits an abortion to be performed if three registered medical practitioners are of the opinion formed in good faith that (a) continuation of the pregnancy would involve risk to the life or of injury to the physical or mental health of the pregnant woman, or of injury to the physical or mental health of any existing children of the pregnant woman, greater than if the pregnancy were terminated; or (b) that there is substantial risk that if the child should be born, it would suffer from such physical or mental abnormalities as to be severely handicapped. In determining whether (a) above exists, account may be taken of the pregnant woman's actual or reasonably foreseeable environment or age.

A person who performs an abortion in violation of the provisions of the Act is subject to the punishments prescribed in the Penal Code of 1 November 1931 for the performance of an illegal abortion. The penalty is fourteen years' imprisonment for a person who, with intent to procure a miscarriage, unlawfully administers a noxious thing or uses any means. A woman who undertakes the same act with respect to herself or consents to such an act is subject to seven years' imprisonment.

A legal abortion must be performed by a registered medical practitioner in a hospital. One of the three physicians consenting to an abortion must be a specialist in the branch of medicine in which the patient is specifically required to be examined. Thus, a woman seeking an abortion for mental health reasons must be examined by a psychiatrist, while one with a specific medical condition must be examined by a specialist in that area of medicine. In the case of an emergency, an abortion need not be performed in a hospital and only one physician needs consent to its performance.

Source:<http://www.un.org/esa/population/publications/abortion/doc/zambia.doc>
Accessed on 22/08/09

APPENDIX 3: Documentary analysis display table for research project on barriers to safe, legal abortion in Ghana. 2005-2007

Source: Author, date, place	Summary of document(purpose, key points, who wrote it and primary audience	Key points/meanings of relevance to research themes	Theme label(main or sub theme
Section 58. Consolidated Criminal Code, 1960, Act 29. Republic of Ghana. {Legal document}. Inherited from the British, our Colonial Masters. Accra	Legal legacy from British Colonial Rule. Similar to British law on abortion. • Allows induced abortion only if the continuation of pregnancy endangers the life of the woman. Enacted to protect women and girls.	<ul style="list-style-type: none"> Restrictive nature of law influenced access to safe, legal abortion. Resulted in health inequalities; well to do women could access safe abortion in private health institutions whilst those who could not afford resorted to backstreet abortions with complications. Clandestine abortions prevailed with compromise on quality Maternal morbidity and mortality remained high. Ironically, desired protection for women and girls was not being realized 	Access to safe, legal abortion Quality issues
PNDC Law 102; An amendment in 1985 of Section 58 of the Consolidated Criminal Code, 1960, Act 29. Republic of Ghana, Accra	An amendment of the British law of 1960 • Liberalization of old law to widen the scope for abortion to safeguard the health of women and girls. • Amended law permits abortion on	<ul style="list-style-type: none"> Qualified practitioners and women have a wider scope to provide or seek abortions respectively Qualified practitioners have a 	Interpretation and application of abortion law

<p>Law enacted by a Military Government. There was no Parliament. Processes that led to promulgation of the law remain largely unknown. {Legal document}</p>	<ul style="list-style-type: none"> • physical as well as mental health grounds. • Abortions are allowed for rape • Incest, foetal abnormality, for an idiot and on physical and mental health grounds 	<ul style="list-style-type: none"> • legal backing and can offer services within the context of the law without fear of prosecution. • Lack of clarification with respect to gestational age, mental clause? Proof of rape etc meant difficulty in interpretation and application of the liberalized law. <p>Lack of clarity in abortion law</p>
<p>National Reproductive Health Service Policy and Standards. First Edition. 1996. Ministry of Health. Republic of Ghana, Accra {Policy Document}</p>	<ul style="list-style-type: none"> • Policy document with guidelines that provide the focus for Reproductive Health Services. Also streamlines training and service provision. • Contains rules and regulations guiding provision of Reproductive Health Services and Training. • Components of Reproductive Health Services are listed as well as target groups • Spells out range of services and cadres of service providers • Service standards are outlined that indicate acceptable performance levels for each service component, functions of service providers and levels of service delivery amongst others 	<ul style="list-style-type: none"> • No objective on provision of safe abortion in document • What are the implications for access to services by rape victims and other women eligible for services within the confines of the law? • Lack of safe, legal abortion for eligible women implies recourse to unsafe abortions with its toll on the health and lives of women • What are the human right implications for the omission of services? What about ICPD programme of action and other international consensus documents to which Ghana is a signatory? <p>Access to safe, legal abortion in public health facilities</p> <p>Quality issues</p> <p>Abortion and human rights</p>

<p>National Reproductive Health Service Policy and Standards. Second Edition. 2003 Ghana Health Service. Republic of Ghana, Accra {Policy Document}</p> <ul style="list-style-type: none"> • Changes cover an inclusion of an objective on the provision of safe abortion under the prevention and management of unsafe abortion • Under standards, activities to be performed by various service providers at different levels of the health system are outlined for prevention and management of unsafe abortion and post abortion care. 	<p>A review of the premier edition to address changes in society.</p> <ul style="list-style-type: none"> • Provides the way for the translation of the abortion law to services • Opens an avenue for improved access to safe, legal abortion • Permits qualified practitioners to provide services within the policy framework • Gives Ghana Health Service the mandate to provide services in designated facilities <p>The inclusion of the objective: "To provide abortion care services as permitted by law"</p> <ul style="list-style-type: none"> • Paves the way for the translation of the abortion law to services • Provides the way for the translation of the abortion law to services • Provides the way for the translation of the abortion law to services • Provides the way for the translation of the abortion law to services <p>Lack of access to safe, legal abortions in designated public health facilities</p>
<p>Prevention and Management of Unsafe Abortions: Comprehensive Abortion Care Standards and Services. Protocols 2006. Ghana Health Service. Republic of Ghana, Accra.</p>	<p>Document compiled by a team of experts in Ghana with technical support from WHO and IPAS in response to the expanded objectives in abortion care.</p> <ul style="list-style-type: none"> • Provides technical and managerial guidelines for provision of services • Facilitates provision of Comprehensive Abortion Care • Outlines who, where and how comprehensive abortion care should be provided <p>Guiding principles underscore the rights of clients to access to comprehensive abortion care</p> <ul style="list-style-type: none"> • Highlights the rights of clients to privacy and confidentiality • Clarifies ambiguities in law on rape and mental health • Expounds on the issue of conscientious objection to ensure access to services within the law • Specific guidelines on counselling to rule out biases on the part of providers <p>Abortion and human rights</p> <p>Barriers to access</p> <p>Ambiguities in abortion law</p> <p>Barriers to access</p> <p>Attitudes of providers</p>

APPENDIX 4: Topic Guides

These topic guides are only guides, so they were not used as semi-structured questions. As my familiarity with the topics and the respondents grew I did not need to take such detailed guides to the interviews. Therefore the guides I used with later respondent groups are much shorter than the early ones.

1. Interview Guide – National Key Informants (Policy-makers, Politicians, Representative of Donor Agencies & NGOs)

Participants' Particulars

Code Number:.....No of years in current position

Sex..... Place of Work..... Job Title.....

1. The Abortion Law

A. Knowledge

- Do you know about the law on abortion in Ghana? If you do, could you please explain its content?

Probe: -Views: What and Why? -Amendment: When, Why and Who?

B. Processes and Actors

- Are you aware of how the law and its amendment were promulgated?

Probe: -Processes, -Actors: Who (? General public), roles and positions, (that of respondent), and support/ how?

C. Interpretation and implementation

- How would you describe the abortion law; liberal or restrictive and why?

Probe: -Interpretation: By other policy-makers, health providers and the general public? -Scope for liberal interpretation? Views?

- How is the law being implemented?

Probe: Extent of implementation of current law and reasons, Contents (Clauses) of law and ease of implementation, Views on factors hampering implementation, description of factors, actors for or against implementation.

2. The policy

- Are you aware of the reproductive health service policy on abortion? Please tell me what it covers.

Probe: - Formulation processes? - Actors involved. Health providers? -Revision in 2003? Contextual factors/ circumstances leading to revision. -Key policy-makers (actors) and support of the tenets of the 2003 policy? -Clarity of policy to actors

3. Feasibility of implementation of safe abortion services

- To what extent do you think the law and policy have been implemented? Please explain your answer.

Probe: - Challenges

- How able do you think current health services are to implement the abortion law and policy?

Probe: - resources, training, provider knowledge/attitudes

4. Medical and Nursing training implications of implementing safe abortion services

- Do the curricula of the medical and nursing schools have the abortion law/policy and management of abortions?
- Are all medical students taught how to manage incomplete abortions/perform safe abortions? If not, why, since they are bound to see cases of incomplete abortions?

Probe: -In-service training programmes on the provision of safe abortion services?

-Quality control measures. Regularity.

5. Legitimacy and support for safe abortion services

- How would you describe the abortion situation in Ghana? Do you consider abortion as a problem in Ghana? Please explain.
- Do you deem it as government's responsibility to ensure that safe abortion services are provided for women who need it or request for it?

Probe: -Content of abortion law and policy, and government's responsibility to women who request abortion services.

- How would you describe the support of key actors (especially politicians, policy-makers, health providers and the general public) for safe abortion services and influence on implementation?

- Personal support for implementation of safe abortion services in Ghana and reasons.
- Opinion of factors that influence actors' support for safe abortion services in Ghana and reasons.

6. Advocacy and diffusion of safe abortion services

- What are your views concerning advocacy for safe abortion services in Ghana? Why?

Probe: - Views on population education on safe abortion services and reasons.

- Views on public education about the health consequences of unsafe abortions? -

Any on-going public education on abortion in Ghana? Why/ Why not?

- Opinion about dissemination of information in the media about the merits (and demerits) of safe abortion services? Will it influence different people (providers, educated public uneducated public) in different ways?

- Key actors who may influence education of the public about safe abortion.

7. Views and Other issues

- What are your personal views about and attitudes towards expanding legalization of abortion in Ghana?

Probe: - Implications of current law; observations and ideas?

- What can you say about the abortion situation in Ghana with respect to human and reproductive rights?

Probe: - Morality, religion, African Tradition and abortion situation in Ghana.

- Provision of safe abortion services in Ghana and politics. Actors?

- Would you like to make any other comments?

2. Interview Guide: Health Providers, Heads of Medical/Nursing Training Institutions

Participants' Particulars

Code Number:..... No of years in current position

Sex..... Place of Work: Job Title.....

1. The Abortion Law

A. Knowledge

- Do you know about the law on abortion in Ghana? If you do, could you please explain its content?

Probe: - Views: What and Why? - Amendment: When, Why and Who?

- Were you involved in any way with making or influencing the law or its amendment?

B. Interpretation and implementation

- How would you describe the abortion law; liberal or restrictive and why?

Probe: Interpretation: By policy-makers, other health providers and general public?

- Scope for liberal interpretation? Views?

- How is the law being implemented?

Probe: Extent of implementation of current law and reasons, - Contents (Clauses) of law and ease of implementation, views on factors hampering implementation. - description of factors. Actors for or against implementation.

2. The policy

- Are you aware of the reproductive health service policy on abortion? Please tell me what it covers.

Probe: - circumstances under which abortion can be performed, - treatment of abortion complications, - post-abortion care, - clarity of the policy

- Were you involved in the development of the policy in any way (e.g. attended consultation meetings)?

Probe: - Formulation processes? - Actors involved. Health providers? - Revision in 2003? Contextual factors/ circumstances leading to revision. - Key policy-makers (actors) and support of the tenets of 2003 policy?

3. Feasibility of implementation of safe abortion services

- To what extent do you think the law and policy have been implemented? Please explain.

Probe: - Challenges?

- How able do you think current health services are to implement the abortion law and policy?

Probe: - Preparedness of hospitals and clinics in Ghana in terms of resources such as modern technology (MVA Kits) and logistics for performing safe/legal abortions?

- MVA kits, -Theatre facilities (Tables, instruments, lights etc), -Blood transfusion services, -Anaesthetic agents, - Antibiotics, -Family Planning services on site, -Counselling services, -Referral systems, -Available?
- Adequate quantities of resources in their right mix, at the right time and in the right places for the timely provision of safe abortion services when necessary?
- Adequate numbers and calibre of trained medical personnel where they are needed most to carry out safe/legal abortions?
- Clear and straight forward policy guidelines for easy implementation?
- Recording/ documentation of legal abortions if any?
- Practicality of providing safe abortion services in Ghana with respect to the healthcare system.

- Attitude of key actors towards safe abortion services and influence on implementation?
- Reactions of health providers towards safe abortion and influence on practice.
- Providers' willingness to provide safe abortions.

4. Medical and Nursing training implications of implementing safe abortion services

- Do the curricula of the medical and nursing schools have the abortion law/policy and management of abortions?
- Are all medical students taught how to manage incomplete abortions/perform safe abortions? If not, why, since they are bound to see cases of incomplete abortions?

Probe: -In-service training programmes on the provision of safe abortion services?

- Quality control measures. Regularity. Last supervisory visit.

5. Legitimacy and support for safe abortion services

- How would you describe the abortion situation in Ghana? Do you consider abortion as a problem? Please explain.
- Do you deem it as government's responsibility to ensure that safe abortion services are provided for women who need it or request for it?

Probe: -Content of abortion law and policy, and government's responsibility to women who request abortion services.

- Support of key actors (especially politicians, policy-makers, health providers and the general public) for safe abortion services and influence on implementation?
- Personal support for implementation of safe abortion services in Ghana and reasons.
- Opinion of factors that influence actors' support for the provision of safe abortion services in Ghana and reasons.

6. Advocacy and diffusion of safe abortion services

- What are your views concerning advocacy for safe abortion services in Ghana? Why?
- Would you advocate for the provision of safe abortion services in Ghana? Please give reasons for your answer.

Probe: - Evidence of on-going advocacy.

-Contents of abortion law and policy and how they enhance advocacy for safe abortion services in Ghana.

-Factors that influence advocacy for safe abortion services in Ghana?

- Views on public education on safe abortion services and reasons.
- Views on public education about the health consequences of unsafe abortions?
- Any on-going public education on abortion in Ghana? Why/ Why not?
- Opinion about dissemination of information in the media about the merits (and demerits) of safe abortion services. Its influence on different people (providers, educated public uneducated public).
- Factors likely to influence dissemination of information on safe abortion services in Ghana?
- Key actors who may influence education of the public about safe abortion?
- Support of key actors and influence on implementation?

7. Other issues

- What are your personal views about and attitudes towards expanding legalization of abortion in Ghana?

Probe: - Implications of current law; observations and ideas?

- What can you say about the abortion situation in Ghana with respect to human and reproductive rights?
- Morality, Religion, African Tradition and abortion situation in Ghana.
- Politics and provision of safe abortion services in Ghana. Actors?
- Would you like to make any other comments?

3. Interview Guide- Pharmacists

Code Number.....Place of work.....Job title.....

Sex.....Date.....

How would you describe the abortion situation in Ghana?

-Probe about role of pharmacists

- Probe about attitudes and behaviours towards women seeking care for abortion and why

- What do you think of the establishment of centres for abortion in health facilities in Ghana?

-Probe about views concerning abortion and religion, morality, African traditional values/beliefs and human rights.

-Probe about knowledge and interpretation of abortion law

-Probe about knowledge of RH policy

- Any other comments

4. Interview Guide- Midwives

Code Number.....Place of work.....Job title.....

Date.....

How would you describe the abortion situation in Ghana?

-Probe about role of midwives

What do you have to say about women who come on admission with abortion complications?

What are your reactions towards such women; how do you feel nursing them?

- Probe about attitudes and behaviours towards women seeking care for abortion and why

What do you think of the establishment of centres for abortion in health facilities in Ghana?

-Probe about any opportunities and problems

-Probe about views concerning abortion and religion, morality, African traditional values/beliefs and human rights.

-Probe about knowledge and interpretation of abortion law

-Probe about knowledge of RH policy

- Any other comments

5. Interview Guide- Clergy

Code Number.....Place of work.....Job title.....

Sex..... Date.....

How would you describe the abortion situation in Ghana?

-Probe about reactions towards discussions on abortion among congregation

-Probe about attitudes and behaviours towards women seeking care for abortion and why

-Probe about attitudes towards abortion for rape, incest etc.

What do you think of the establishment of centres for abortion in health facilities in Ghana?

-Probe about any opportunities and problems

-Probe about views concerning abortion and religion, morality, African traditional values/beliefs and human rights.

-Probe about knowledge and interpretation of abortion law

- Any other comments

APPENDIX 5: Code Frame for Ghana Abortion Study

Main	Description of what it covers
LAW	Content
Positive attributes <i>L+</i>	Liberal, good , elastic
Negative attributes <i>L-</i>	Ambiguous ,loopholes, restrictive, ineffective, grey areas ,flaws, no safeguards, closed law, too wide
Other attributes(Knowledge & application of law) <i>Lo</i>	Knowledge or lack of knowledge about law, its interpretation, implementation, legalization, review of law, understanding of law, discussions on law
POLICY	Content; PAC
Positive attributes <i>P+</i>	Clear policy, Good policy
Negative attributes <i>P-</i>	Absence of issue of unsafe abortion in policy until 2003 Absence of standards & Protocols until 2006; Lack of clarity with parts of document
Other attributes <i>Po</i>	Dissemination, knowledge and use of policy
CURRENT PRACTICE OF INDUCED ABORTION (SAFE&UNSAFE)	
Practice justification <i>CPS-Pj</i>	Reasons why safe abortion services need to be provided e.g. issues of accountability
Access	Access to CAC; abortion on demand
Role of Public & Private Sector(Including pharmacists) <i>CPS-Pp</i>	What is currently going on in Public & Private sector with regard to abortion: Recent CAC Movement; Abortion for money; No documentation on abortions done in both sectors
Quality Assurance in current practice <i>CPS-Qa</i>	Cost & inequalities, privacy, skill of providers i.e. the issue of untrained providers; confidentiality, staff attitude, waiting time, availability of drugs ?(cytotec); non-user friendly environments for abortion
Motivations for safe and unsafe abortions <i>CPS-Mv+/- CPU-Mv +/-</i>	The various reasons why women opt for unsafe abortion e.g. cost issues; issues of access for safe abortion in Public health facilities e.g. lack of privacy & confidentiality and staff attitude and reasons for safe abortion e.g. socio-economic
Epidemiology of safe and unsafe abortion <i>CPS/CPU-Epd</i>	The calibre of people having abortions and the methods, when and where they are having the abortions, and the health outcomes or complications
IMPLEMENTATION OF ABORTION LAW	
Challenges or barriers to implementation <i>IMP-brr</i>	Ignorance of populace & health providers about abortion law; Poor understanding of law, Lack of resources; funds,

	conscientious objection; personal convictions; religious & moral beliefs; attitude of providers; no designated facilities, stigmatization, personal misgivings and professional ethics, no accountability
CAC: Merits & demerits <i>IMP- cac +/-</i>	CAC will reduce mortalities; CAC will prevent complications; Is safe abortion 100% safe? Women perpetually living with guilt feelings after abortion ; CAC means opening of floodgates for abortion or abortion on demand, medical abortion is safe
Delegation <i>IMP-mw</i>	The interpretation of medical practitioner in law; delegation of midwives to perform CAC
PERCEPTION OF THE PROBLEM OF UNSAFE ABORTION	
Perception of the problem <i>Pp</i>	Pervasive nature of unsafe abortion; Unsafe abortion as a public health problem; Unsafe abortion occurring because the world is an imperfect place and its people are non-infallible; Unsafe abortion attributable to loss of moral and cultural values due to Westernization; something has gone wrong with society, dynamism of society, poverty, failure of duty by society, church, family and health system
BELIEFS, ATTITUDES AND VIEWS ON ABORTION	
Beliefs <i>BAV-b</i>	Deep rooted and internalized constructs held about abortion e.g. religious/cultural/moral beliefs (abortion/sin complex); the sanctity of life; children as gifts from God; beliefs on ensoulment
Attitudes <i>BAV - a+</i>	Positive attitudes held about CAC e.g. Positive comments about procedure; Supportive attitude towards women in search of procedure; Readiness to refer women for procedure; Readiness to offer service
Attitudes <i>BAV-a -</i>	Negative attitude of populace and providers about CAC e.g. Criminalization; Stigmatization; Culture of silence; Ostrich behaviour; Ambivalent behaviours; Judgemental behaviour; Hypocritical behaviour; "Hands off" attitude; Non-supportive attitude; Reluctance to refer women who need service; lack of will power, easy way out.
Views <i>BAV-v+/-</i>	More rational and less emotional constructs held about abortion: views with respect to abortion and human rights;

	abortion and politics, foetus as human or not, abortion is not a priority.
RESOURCES, TRAINING & SYSTEM ISSUES	
Resources <i>RTS -r</i>	Human, material and financial requirements for CAC
Training <i>RTS -t</i>	Training needs of health providers with respect to CAC; Inclusion of CAC in curricula of trainees in medical & midwifery institutions
Service Issues <i>RTS -s</i>	Designated facilities for CAC; Issue of workload; Policy documents, standards and protocols; Documentation; Support from superiors or lack of it, mechanisms in place for CAC or non-existence; access to CAC or lack of access; no guidelines to streamline implementation
SUGGESTIONS FOR SOLUTIONS (Prevention, Education & Advocacy)	
Prevention <i>PEA-p</i>	Primary prevention:-Abstinence; Use of FP (Requires repositioning of FP, improving access) + Education on FP and counselling Secondary prevention:- Extensive counselling on Options e.g. social services, social support systems like adoption and new education policy + Provision of CAC Tertiary prevention:- Offer PAC + FP
Education <i>PEA-e</i>	Civic, moral & religious education; education on law; education on human sexuality and on abortion; dissemination of statistics on abortion to stakeholders
Advocacy <i>PEA -a</i>	Open debates on abortion to demystify it; Values clarification workshops for stakeholders

APPENDIX 6: Examples of thematic charts used during analysis of data

A) EXAMPLE OF THEMATIC CHART SHOWING SOME GENERAL VIEWS OF OBSTETRICIAN/GYNAECOLOGISTS ON ABORTION AND UNDERLYING REASONS FOR VIEWS

Views	Underlying reasons or Cultural underpinnings
<ul style="list-style-type: none"> • It's govt's responsibility to ensure provision of CAC. People in communities need service so it must be provided. Abortion services should be provided irrespective of prevailing religious or moral inclinations. • A lot of noise is made about Ghana being a religious country & thus no abortion; this contributes to religious bodies frowning on abortion. People cannot therefore come out openly to provide service • Some obstetricians who know better are not providing service so women resort to quacks with its attendant problems • Use of scarce govt's resources to sort out women with abortion complications • Policy makers and implementers are all careful not to be seen as doing something immoral • There's a lot of fanaticism; the few outspoken ones overshadow the views of the majority • Catholic President will not endorse CAC and will even dampen enthusiasm for FP • Political leaders should not let their personal beliefs thwart the efforts of others who want to promote their health; they're not there to drive country into Christianity. • Unsafe abortion contributes a huge percentage of maternal mortality so it is not a small issue; no adverts on FP anymore; no adverts about restricting family size anymore • Politicians should not interfere with efforts of experts to promote and maintain health. • Drs are not willing to offer CAC in public inst because socially Ghanaians do not approve of termination. They would rather go and do it in private institutions • Some obstetricians shy away from abortion 	<ul style="list-style-type: none"> • Unsafe abortion is a major contributor to deaths so safe abortions must be provided to curb deaths and promote health • People shy away from provision of abortions due to the religious atmosphere in Ghana (Context) • These are all on religious grounds • From the point of view as an obstetrician, he thinks the % of deaths due to unsafe abortion is a big issue • People's religious beliefs definitely play a part • Ghanaians are a life-loving people, we love large families • The society looks at abortion in a certain way; the society doesn't understand the problems of abortion • They don't understand that abortion from the pathologist's point of view is the number 1 cause of death in Ghana • People tend to stick to certain aspects of religion and they hold strong views on those aspects and then close their eyes

<p>because culturally it is frowned upon</p> <ul style="list-style-type: none"> • All local terms used for abortion in Ghana do not have nice connotations • Abortion is a big issue; people seem to have concluded that it is wrong and make inferences to support their conclusion because Koran talks about it but Bible does not; thinks there's a limit to which people can infer • Thinks that no one should impose his/her views on anybody; one can infer, yes but what is done depends on the circumstances or the situation. (Obstetrician 2, pg 4). • Some women may have no option but to terminate pregnancies for lack of compassionate community; due to a judgemental community • No policy maker will come on air and explain the abortion law because of the religious nature of our society • Laws are ineffective in Ghana. People refer to laws only when cases go to court. This is because our society is ruled by norms • In Ghana when solutions cannot be found to problems, the problems are referred to as "spiritual ones" as with a mal-functioning theatre in a teaching hospital • Not all people want to do abortion for religious purposes • Heads of institutions will not willingly release equipment for CAC but will do so for PAC due to their beliefs • European countries have different attitude to abortion. It is legal, women are supported & counselled. Ghana is far from provision of CAC • Private hosp springing up cos services are not being provided by public ones • Ghanaians generally believe abortion is illegal • It is a crime when you talk about abortion • Religion is different and medical practice is also different 	<p>on other aspects of religion but religion is supposed to cover everything</p> <ul style="list-style-type: none"> • People have their views; even medical practitioners have their ideas on abortion and these ideas are causing a lot of problems
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B): EXAMPLE OF THEMATIC CHART SHOWING ELEMENTS AND DIMENSIONS OF SUB-THEMES

Serial no, Sex & Age	Theme:-Implementation of abortion law. Sub-theme:- Access to CAC	Elements/dimensions	Categories/Classes	Comments
Obst 2 Male 40+	<p>It is being implemented in private and maternity institutions, not in public medical institutions.</p> <p>Socially Ghanaians do not approve of TOP so doctors in public facilities do not want to be seen as offering this service. Same doctor will go and do it in private institutions.</p> <p>Abortion was restrictive, now law is liberal but history of non provision continues. Thinks contents of law allow terminations; one can do TOP and be covered by law.</p> <p>It comes from the social environment. Peoples' conscience should be respected but they should also not impose their opinions on others who want to offer abortion services.</p> <p>Three groups of doctors; those who are happy to offer service, those who're not happy but do not find anything wrong if others offer services; those who will not offer service and think those who do it are wrong. With time those offering service are labelled. Only strong-willed people will offer services in public institutions. Those who are immune to what people say ; so it is the social environment. Factors that reduce</p>	<p>Abortion services available in private and not public institutions.</p> <p>Ghanaians' disapproval of abortion hampers the provision of services in public institutions.</p> <p>Culture of restrictive abortion goes on despite liberalization.</p>	<p>Access in private/public institutions.</p> <p>Reasons for limited access in public institutions.</p> <p>Public opposition to abortion services</p>	<p>The social environment influences provision of services.</p> <p>Provision of abortion services divides doctors in three segments with labelling of those who provide services.</p> <p>Barriers to service include costs and human resource.</p> <p><u>Barriers to access:</u> -Costs implications, -Human resource</p>

	<p>access include high charges. These act as access barrier to users. Largest challenge is human resource.</p> <p>CAC to be factored into people regular work or else be seen as extra work. It should be free so other aspects would be taken seriously.</p>	<p>Structures to be laid in place so CAC not regarded as extra duty.</p> <p>Strong opposition eminent</p>	<p>Structures for ensuring access</p>	
Obst 3 Male 38	<p>A segment of society will oppose it</p> <p>People, including medical practitioners have their views on abortion. These ideas are causing a lot of problems.</p> <p>We are not providing services; you cannot just walk into a clinic and say you want TOP; you have to look for a friend who will send you to somebody, who will also send you to somebody. It has allowed paramedics who are in to make money quickly see it as an area to make money.</p> <p>Our biggest problem is the use of 'cytotec' . The question is, which laws are implemented in Ghana? Our society is ruled by norms; you can make all laws and they would not be effective *Quote. Policy guidelines are clear, there is no problem with paperwork; the problem is always the implementation. There is a big gap between the policy maker and the person implementing* quote Ln173-190.</p> <p>There is lack of amenities in hospitals. In terms of trained staff we have a problem. In terms of equipment- equipment is under certain authorities who do not believe in making services available. The few who want to provide services might not get access to</p>	<p>People's ideas on abortion causing problems. Problems with access.</p> <p>Qualified people shun provision of abortion services; the unqualified are doing it for money.</p> <p>Big problem with 'cytotec' .</p> <p>Non implementation of laws</p>	<p>Views on abortion causing problems.</p> <p>Non implementation of laws</p> <p>Big problem with medical abortion drug- 'cytotec'</p>	<p>Views on abortion access.</p> <p>Access problems.</p> <p>Access to medical abortion</p>

	<p>the medical equipment i.e. MVA kits</p> <p>Private hospitals spring up to provide services.</p> <p>Can they offer the right service?</p> <p>Political element of lack of will to implement the policy to the letter. Lack of will of powers that be.</p> <p>If policy makers create the environment like the rooms, instruments and back up or support from superiors, safe abortion would be practised everywhere.</p>	<p>Proliferation of private providers</p> <p>Quality issues in private hospital</p> <p>No political will to implement policy</p> <p>Lack of support from superiors</p> <p>Non conducive environment for CAC</p>	<p>Quality issues</p>
<p>Obstetrician 4</p> <p>Male 42</p>	<p>You may be aware that the GHS is trying to introduce SAS in the government institutions. There are protocols and everything. We are waiting for DG to sign. Before then, no formal protocol for GHS in provision of SAS, it was only for PAC. Now we are calling it comprehensive abortion care to include termination and PAC.</p> <p>Private hospitals are doing abortions; but for private hospitals, the problem of unsafe abortion would have been enormous. Private clinics survive on abortion. But problem is because of financial aspects, how many of our people can have access.</p> <p>We think if government institutions start providing SAS then a lot more people will have access.</p> <p>We have conscientious objectors; unfortunately, significant proportions of policy makers themselves object to provision of SAS. There are a lot of</p>	<p>GHS initiating access in government institution</p> <p>No protocol for CAC, only for PAC</p> <p>CAC=SAS+PAC</p> <p>Access in private hospital</p> <p>Problem of financial access in private hospital</p> <p>Government hospitals will ensure more access to SAS</p> <p>Significant number of Policy makers are conscientious objectors</p>	<p>CAC in government institution</p> <p><u>Barriers to CAC</u></p> <ul style="list-style-type: none"> -No protocol - Financial access, a problem in private hospitals <p>Conscientious objection</p>
			<p>-External factors e.g. GAG RULE</p>

conscientious objectors.	<p>We have to be very cautious; now that George Bush is 'breathing on everybody's neck', the Global Gag Rule where, once they know that you have anything to do with abortion, USAID funds will be cut off.</p> <p>The President is a Catholic, so these are all issues that one has to be cautious about.</p> <p>There are so many religious faith-based organizations making so much noise...anti abortion, you know. When it comes to implementation, you see people going back; implementation is the problem. They know that unsafe abortion is a major problem and we need to provide the service, but when we come to implementation, then people start dragging their feet* Quote Line 243 of access report.</p> <p>You can't go to a government institution now and procure abortion; if done, it is done underground.</p>	<p>Effect of GAG RULE/External factors</p> <ul style="list-style-type: none"> - Catholic President - Anti abortion religious groups <p>Catholic Ghanaian President</p> <p>Anti-abortion religious groups</p> <p>Problem of unsafe abortion appreciated However, implementation is a problem People agree in principle but not practice.</p> <p>CAC largely inaccessible in govt inst. Only done under cover</p> <p>Policy makers in influential positions in GHS as anti-abortion</p>	<p>Implementation is a problem</p> <p>PAC as component of CAC Easier access in government hospital probably at a lower cost.</p> <p>Anti-abortion people in influential policy positions</p> <p><u>Barriers to CAC</u></p> <p>Stigmatization/labelling of providers No insight into problem. No community awareness about magnitude of problem</p> <p>The Deputy Director; She is not for it; the Director for PH is also against abortion; we know them. When we go for meetings their statements. The DG is leaving so we want him to sign the thing before he leaves; the one to replace him is anti-choice. They have made their feelings known so that is a major factor.</p> <p>If asked, very few doctors in this hospital will be willing to add TOP to their list. The worry is that somebody will say this man is an abortionist; the stigmatization makes people afraid. The community must know about the extent of the problem.*Quote Ln. 964-1027.</p>
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APPENDIX 7:

An example of analysis of main themes.

RESP. LABEL	STANCE ON ABORTION	ATTITUDE TOWARD ABORTION	RELIGIOUS/OTHER ATTITUDES	CONSTRAINTS IN PROVIDING CAC	REPORTS OF ATTITUDES OF HEALTH PROVIDERS AND OTHER STAKEHOLDERS
DVAG 1	M For	Favourable attitude, no WHO's mandate to help countries establish correct standards and strategies to solve different problems abortion is one.	People are against it for ethical and religious reasons. " Respondent did not himself disclose his religious sentiments about abortion.	Religious bodies in Ghana will definitely oppose CAC. Policy makers not certain of the magnitude of the problem. Ignorance of community about the nature of the abortion problem. Manpower to provide the service is another constraint. Policy initially did not cover abortion explicitly. Regulating policy, good paper work but education of implementers poor.	"I know our culture doesn't view abortion in a positive light because we are a patriarchal society and we believe in procreation and so anything that is affecting procreation is frowned on but then I think we may have to revisit it, knowing that yes, procreation has a lot of norm when they are pregnant, they are not ready or they don't want to have children and they are dying so we should sit down and talk about it".
DVAG 2	M Agreed	Spends as a match prince for his Org. USAID. The org. is not in favour of abortion and will not give funding for abortion related activities.		"No comments."	
OBGNY 1	M For	Favourable attitude towards abortion. Does not believe women should just wait in line and have abortions done but should be counseled and given options and have termination under the law. Believes in use of WHO's definition to health to offer abortions. Abortion should not be carried out as a lucrative venture but as a life saving measure. "I worked in UK and offered terminations as part of my services for no special pay. The law is there, but what is the law of the land if you don't implement it? Think abortion should be the last of all options provided during counselling.	Believes abortion services should be provided where necessary with no religious hindrance because health should be promoted." all these should be done without any religious or moral connotations. There is so much noise about Ghana being a religious country so people are not willing to provide abortion services." Failure to provide abortion services leads to more problems as people do it clandestinely. Not only people say it is wrong to provide abortion services in christian country. "Respondent did not clearly mention his own stance with regard to abortion and religion. "Quote. LIn 33-34.	Opposition by religious families. Lack of funds are not well resourced because the facilities are not just there...to implement the RH policy." No designated facilities. Ignorance of abortion law, misunderstanding and misinterpretation of law by those who know. People projecting their personal belief in efforts of others to promote health, inertia on the part of the medical community.	Socially, Ghanaians do not approve of TOP so the doctors in public hospitals do not want to be seen as people who provide abortions. The same people who go to private clinics and do it there. The attitude of providers towards women who have stampeded abortions is bad. Derogatory statements are made about them. We are in a society which feels the person with an unwanted pregnancy deserves some punishment. Comes up with a strong argument. Ln 390-393.
OBGNY 2	M Last report	No. Within there are instances when one could offer to seek abortion. There are also should be abortion for pro-choice and pro-life but not to extremes where he described extreme pro-choice as irresponsible behaviour and extreme pro-life as some instances, abortion could be offered. Think extreme pro-choice instances, abortion could lead to death. He believes that to avoid death of women in some instances, abortion is the best choice. I am a Christian and have strong fundamental views however, I think a Christian can perform abortion under certain circumstances. People are forced to do other programmes because they don't have supportive communities around them; they have judgemental ones. If faced with women seeking abortion, I counsel on various options, if that fails I refer to a safe place. I have had to terminate a pregnancy before because I was the only one available to do it safely. Run. ...Ln 602-616.	Issues in Islam, abortion is permitted for certain gestations and the Koran discusses abortion. The Bible does not. People only infer and sometimes they stretch things too far. They make primitive conclusions that abortion is wrong and look for quotations to support their claim. I am a Christian and have strong fundamental views however, I think a Christian can perform abortion under certain circumstances. People are forced to do other programmes because they don't have supportive communities around them; they have judgemental ones. If faced with women seeking abortion, I counsel on various options, if that fails I refer to a safe place. I have had to terminate a pregnancy before because I was the only one available to do it safely. Run.	Our social environment does not allow for abortion. History of the institutions is another constraint i.e. The law used to be restrictive so no abortions were done openly. Now that the law is liberal the tradition follows. Inhibitions from the social environment stronger than people's conscience issues. People's religious beliefs also constitute a constraint. Cost of services. Poor practice - its wrong. Ghanaians focus on abortion as you can't do it. Human resource is a challenge, abortion services would be seen as extra day.	Socially, Ghanaians do not approve of TOP so the doctors in public hospitals do not want to be seen as people who provide abortions. The same people who go to private clinics and do it there. The attitude of providers towards women who have stampeded abortions is bad. Derogatory statements are made about them. We are in a society which feels the person with an unwanted pregnancy deserves some punishment. Comes up with a strong argument. Ln 390-393.

Category	Question	Response
CATEGORY 3	Q10 "Other health-care workers, consulting and HPC and colleagues have a bit closer to me. Ln 400-411... I do it in a private setting I can't do it in a government set up."	<p>Names who are not listed</p> <p>Names who are not listed women who approach them in search of safe abortion based solely on their religious inclination. They do not refer such women to the FP clinic to see trained counsellors. I don't think the patients need the religious health-care providers. They are not willing to offer service. They think it is wrong. There is a religious problem.</p>
CATEGORY 4	Q11 "Very Russell Institutes. Some of us who are in the formulation of safe abortion because of the mistakes of unsafe abortion. Safe abortion now means that we can use the aspect where the medical needs of the woman..."	<p>He did not cite any religious institutions of his/her own. He described the attitude of most "non-other" religious people as hypocritical. They all say against it but they are the same people who come and see them with what, preference as to terminate. Ln 400-402 When he does not reflect them it is not an issue. People think negatively about abortion. If like you've committed a sin. People who are known to provide abortion services are disgruntled. Patients and trauma go on air to condemn abortion.</p>
CATEGORY 5	Q12 "I will not mention about the permitted other continuing when services are needed to have abortion as to prevent unsafe abortion. If they want to have it, they should go to it. You have no other option. If you don't let them have it, they are going to come back to you in a second state."	<p>No mentioning people's attitude towards provision of abortion care to their religious community. There are from different religious backgrounds. Some do not say no. You can't force them and they are right. But I always try to convince them to have the belief. Religion and medical practice are two different things. People should be educated to know that religion is quite different from safety of people's lives. They think their religion is at par with medical practice. When you talk about safe abortion, religion is one way and safe education, in their church.</p>
CATEGORY 5	Q13 "I will not mention about the permitted other continuing when services are needed to have abortion as to prevent unsafe abortion. If they want to have it, they should go to it. You have no other option. If you don't let them have it, they are going to come back to you in a second state."	<p>When people are informed about the burden of unsafe abortion, they actively support providers of safe abortion because but when it comes to implementation, they don't. --- Ln 172-173 ... People don't change their act. "We have been taught that..."</p> <p>People are changing their attitude about abortion as changing LN 160-162 "... she is not a doctor or a nurse? Yes, we know them because when we go for training, their statements. These are leaving at the end of this year that is why we want him to sign the thing before he leaves. No one who is supposed to replace him is an option. We have made that available known". Generally, Christians train on abortion. They think negatively about it. In the long term.</p>
CATEGORY 5	Q14 "I will not mention about the permitted other continuing when services are needed to have abortion as to prevent unsafe abortion. If they want to have it, they should go to it. You have no other option. If you don't let them have it, they are going to come back to you in a second state."	<p>If you believe safe abortion is no illegal and that it shouldn't be done, then we will sit back and manage incomplete abortion. We have informed religious people about it. Some say no and no. if the government is responsible to remove the safe abortion services are provided. You cannot just sit back in the socio and class and what have. They talk about national ID card at the first. They talk about NREGS, why isn't they talk about safe abortion? The policies are beautiful but they remain on paper. Our law, our policy and our problem still exist. The policies are organized for poor claim if our policies are being implemented at all, we don't see the effect. --- Note Ln 272-273</p>

OBSTET	M	For	<p>"...we are very religious people. Christians are very religious people. Everybody is at church on Sundays except myself so the churches do have a pervasive influence. They are all based on the Catholic; New the Pentecostal churches etc; the Catholic framework in which they think that abortion is 'bad'. God. He never said people who have sex should pay with their lives. That's just human interpretation. It's a derogatory thing, the Catholic Church's disposition about sex, FP, abortion etc. It derives from the religious doctrine. We are all religious people so we will continue to wrestle with our conscience about abortion and other issues like for instance with physicians, whether to save mother or child. He would save the mother because that's what his upbringing says.</p>	<p>The problem in Ghana is our inability to use the provisions of the law to make CAC available to women who qualify under the law.' That is the issue that confronts us in the MoH, key people who are very ambivalent about this...they will not stand any investigating at all, with abortion because they themselves are ambivalent. They do not ask the doctors in the facilities: why are you seeing so many criminal abortions, what is going on? They don't do that. Nobody wants to talk about it...the nurses and midwives, they are part of the community. They all go to the same churches and they all have very negative views about abortion." "Pastors shout this and that, preaching doom, day if you sin, God will strike you dead abortion is bad and yet the same Pastors are making 13 year olds pregnant. I have sat with some of our top gynaecologists, and said, 'hey guys, what are you going to do about this... they are in powerful positions of influence and they have all decided not because they are against it because happen to know that they both do it in their private clinic'. This gynaecologist together with a team of doctors and midwives had funds to undertake a study on medical abortion and had wanted to do the study in the two teaching hospitals to boost the credibility of the study but he was not granted permission to do so by the heads of the two institutions and wondered why since he knew the heads offered abortions in their private clinics. There are people in very important influential positions whose attitudes are really not in support of CAC. They may not expand on this in public but we know that behind the scenes, they are doing everything not to make the services available." "Quote. Ln 170-172. Certain key people in health institutions e.g. administrators object to provision of abortion services due to positions they hold in some churches.</p> <p>"The question is how many clients actually approach on those grounds?...very few clients know the law. They don't even know they have the right so they don't come to you...at my end, I see very few people who really walk in because they want abortion because of rape or incest". Liberating abortion law and not providing services is of no use. Apart from doctors, no other cadres of staff have been trained to provide the services. Some of the doctors had to learn it on the job. They have not had any formal training." "Quote. Refer to transcript. People not well educated about policy. They think its wrong to offer abortion. Not sure of law's decision. Not bold enough to provide services.</p> <p>"Nobody wants to talk about abortion, we still leave in a society that has all the religious inhibitions. People don't want to talk about it but they still do it. It's a very hypocritical situation when it comes to abortion; the very people who say no, they are the same people who practice it! Let them be faced with the same situation, they will change their minds...if raped and pregnant, they will not say because I am a Christian I'll have the baby, it will be rare. So is it religion? I think it is more..." "Quote</p> <p>"I can make the decisions and take action. I've had to terminate pregnancies because of rape, on request, for various reasons and I put it down. I have no use of the system I am with those advocating for provision of safe abortion services. I am the pole behind them; in fact front and side by side, I presume."</p>
OBSTET	F	For	<p>"If you were raped and you came to me then the decision would be made based on my own conviction of actually abortion...those were the lapses. Very few people actually know the law and so most people's practices are driven by their own personal convictions. They don't use the law. They base it on their moral convictions to implement the law. "People don't realize that the law gives them room and so most people still work under the belief system that abortion is criminal abortion is illegal to even if they will do it, they would not want to leave any trails behind to say they are doing abortion. We all know terminations are being done in public hospitals but where would you find that record? At best, you would find it, they would include it as an evacuation of the user." (Laughing) Even getting the policy accepted, there were challenges...abortion is a moral issue, if you have leaders who morally are against abortion, it becomes difficult. I can recollect being told by somebody that's will not allow that nonsense to be performed in my health facility". He said that to prevent people from being trained. This tells you the inhibitions and challenges we face. It's all hypocrisy". IPAS survey of facilities and attitudes indicates that people would provide safe abortion if given the opportunity." "We can't continue to behave like ostriches".</p>	

APPENDIX 8: Participant Information Sheet

London School of Hygiene & Tropical Medicine
(University of London)
Department of Epidemiology and Population Health
Centre for Population Studies
49-50 Bedford Square
London WC 1B 3DP

Tel: (Direct) +44 (0) 20 72 Fax: + 44 (0) 20 7299 4637
E-mail: patience.aniteye@lshtm.ac.uk

Date: _____

PARTICIPANT INFORMATION SHEET

INTRODUCTION TO THE STUDY

PROJECT TITLE: Understanding the barriers and opportunities for improving access to safe abortion services in Ghana: A policy analysis.

Unsafe abortion constitutes a major public health problem the world over. Many women lose their lives from complications arising from unsafe abortions while others become maimed either for life or for considerable periods of their lives. The numbers of women who die in Ghana from pregnancy-related conditions are high and unacceptable by WHO standards. Some medical experts believe that the provision of safe abortion services among other strategies could help save the lives of women. Ghana has an abortion law and policy but these are not implemented.

We are interested in exploring people's views and attitudes on abortion and the current situation in Ghana.

Data will be collected through in-depth interviews which will be held with key informants such as politicians, policy makers, medical and legal experts, clergymen, and journalists, representatives of donors and NGOs and health providers.

All interviews will be audio-taped. Each interview will last between an hour and an hour and a half. A field diary will also be used to record some observations. All data collected will be treated confidentially. All participants will be anonymized in such a

way that no one will know what they have said. Your ‘quotes’ will be used only if you so wish and also give me your consent. The tapes and transcripts will be accessible to me and my supervisor(s) only. They will be destroyed at the end of the study.

Data collection for the study will span over a period of 9 months to 1 year. Your participation in the study is voluntary and you are free to join or not. If you decide to join you are equally free to opt out at any time during the study.

This study has a dual purpose. First, it is an academic exercise being undertaken as a research degree supervised at the London School of Hygiene and Tropical Medicine with ethical clearance from the ethical review committee of the Ethical Review Committee of the Ghana Health Service and the Ethics Committee of The London School of Hygiene & Tropical Medicine. Secondly, it is hoped that the study will identify the difficulties around the issue of abortion and make recommendations to help improve the lives of women, to improve services as well as set the stage for public debate that could influence policy.

Thank you for the time you spared to read this information. If you have any other questions before signing the consent form, please ask me now. Please do not hesitate to contact me via the above e-mail address and phone number in case you have any queries during the study.

Thank you.

Patience Aniteye (Research student)

APPENDIX 9: Consent form

London School of Hygiene & Tropical Medicine
(University of London)

Department of Epidemiology and population Health
Centre for Population studies
49-50 Bedford Square
London WC 1B 3DP

Tel: (Direct) + 44 (0) 20 7299 4762 Fax: + 44 (0) 20 7299 4637
E- mail: patience.aniteye@lshtm.ac.uk

DATE

Study Level:

Interview Number:

CONSENT FORM- KEY INFORMANT INTERVIEWS

Project Title: Understanding the barriers and opportunities for improving access to safe abortion services in Ghana: A policy analysis.

Researcher: Patience Aniteye. Research Degree Student, LSHTM.

Please tick in boxes provided.

1. I have read the information sheet provided for the above study / I have been thoroughly informed about the study and have had all issues clarified to my satisfaction.
2. I am well informed that my participation is voluntary and that I am free to opt out of the study at any time without any explanation.
3. I am aware that this interview will be audio-taped and that my comments will also be written.
4. I agree that my quotations be used in the study where necessary.
5. I agree to take part in the proposed study.

Name of Interviewee:

Date:

Signature/ Thumbprint:

Researcher:

Date:

Signature:

Appendix 10: Further Information and Reflections on Post Abortion Care (PAC)

Post abortion care is a strategy to reduce maternal morbidity and mortality due to abortion GHS (2003). A previous study on abortions I carried out in Accra indicated that health centres (sub-district level) are the first point of call for women experiencing complications of induced abortion however; the health centres always referred cases of abortion complications to the hospital (Aniteye, 2002). I then formed the impression that probably, in terms of training and/or equipment, health centres in Ghana might not be well equipped to provide PAC.

This impression was confirmed in the current study. According to the obstetricians and midwives, PAC is largely provided in hospitals. However, some private clinics and maternity homes also offer PAC but this is not on a large scale. Midwife 6 (trained in life saving skills, LSS) indicated that she provides PAC in her private maternity home and gives trainee midwives on rotation at her home the opportunity to observe. Midwife 1 has had training in LSS and feels comfortable to offer PAC. Due to her religious beliefs, she would not undergo training for CAC and will not offer the service. Other midwives had the same stance (Midwives 5, 8, 9 & 10).

A few obstetricians mentioned that some health providers are comfortable providing PAC but not CAC. The reason given was that in PAC, they are helping women who need help for abortion complications who may die if not helped. The pregnancies have already been tampered with and they are helping with the aftermath whereas with CAC, they would have to initiate the process of induction. Two clergymen (9 and 10) disclosed their awareness of provision of PAC in some Mission health facilities and had no negative attitudes towards that. According to clergy 9, even though PAC is offered in their hospitals the leadership of the Catholic Church would not countenance CAC or subscribe to it under any circumstances.

Having worked in the Department of Obstetrics and Gynaecology of the Korle-Bu Teaching Hospital (KBTH) for a period of 15 years, I know what goes into PAC in the teaching hospital. Some of the midwives and obstetricians interviewed in this study described the flow of care:

The women with complications of abortion are first seen by doctors on call at the gynaecological emergency room of the premiere teaching hospital. It must be noted that this room is small, always busy with very little or no privacy. Patients are usually seen by interns, known in Ghana as '*house officers*'. The patients they see are later reviewed by their bosses if need be.

Patients are usually brought in by relatives and/or friends as '*referred*' cases from health centres or private clinics. The patients who come in shock or with serious complications like severe bleeding or perforated womb are resuscitated with infusions and sometimes with blood transfusion where there is need. Registration, history taking, general, physical and pelvic examinations are done. Patients are then admitted in the gynaecological ward for further management. This includes the nursing management of observation; measurement and recording of the patient's temperature, pulse and respiration rates. Medicines prescribed by the doctor are served and the womb is emptied (where indicated) using a surgical procedure called manual vacuum aspiration (MVA) carried out by the interns.

According to some obstetricians, some hospitals still use '*dilators*' and '*curettes*' for emptying the womb of any retained products of conception which to them are dangerous and outdated. The obstetricians thought that in this modern age of advance technology, no provider should use these outmoded instruments. Before and/or after the surgical procedure, the patients are treated with pain-killers, antibiotics and other medicines when there is need. They are briefly counselled on FP and general care on the day of discharge. The patients are then advised to come for follow up after two weeks. I have had several opportunities to observe PAC in the Teaching and the Regional Hospitals in the city where the study was carried out.

The impact of the FP counselling given to women who have had PAC is debatable. It is a one-off succinct talk with the client on her way home on the day of discharge. She is given this talk amidst several discharge formalities and paperwork. Possibly due to shortage of nurses and the resulting work overload, the nurse often hurries through this and advises her on follow-up visits to the hospital to see the doctor for review of her condition. How well does this message go down? Is this enough to

prevent repeat abortions? Clients may even not be given the opportunity to ask questions since there may be many other patients awaiting such formalities.

Even though PAC is a measure to reduce morbidity and mortality, it has been identified as one of the least commonly provided reproductive health services in Ghana. According to one of the representatives of a Development Agency interviewed, it is a major neglected area of reproductive health care. There are no reliable data on access to PAC services and the services are not equitably distributed throughout the country. It is also not clear how accessible PAC services are to adolescents.

Meanwhile, the MOH and PRIME⁵ integrated PAC into Safe Motherhood clinical skills training in three regions in Ghana (Eastern, Ashanti and Brong Ahafo) back in 1997. In the same year, PAC was incorporated in the first edition of the National RH Policy and Standards document under the section on '*Prevention of Unsafe Abortion and Post Abortion Care*'. In 1998, PRIME, in collaboration with MOH, GRMA, and Planned Parenthood Association of Ghana (PPAG) also decentralized and integrated PAC and Life Saving Skills (LSS) training and services to the primary levels in three designated regions in Ghana.

Training

In terms of training, pre-service training in post abortion care forms part of the curriculum for doctors in Ghana. Even though pre-service training for nurse/midwives includes post abortion Family Planning (FP) as well as recognition of signs and symptoms of incomplete abortion, there is no formal Manual Vacuum Aspiration (MVA) training. There is however, an in-service training programme on Safe Motherhood clinical skills which has training in post abortion care as a component as indicated above. Since these trainings were done in selected regions in Ghana, not all midwives received training.

⁵ PRIME I and II are projects carried out in low resource settings like Ghana. PRIME focuses on outputs. Project staff work with host country ministries of health and other organizations to identify and develop interventions to close performance gaps. The project includes two associate organizations: the American College of Nurse-Midwives (ACNM) and Save the Children. PRIME II was preceded by PRIME I, which was a five-year contract.

The key institutions and organizations involved in the provision of PAC are:

- i) Ministry of Health (MOH)
- ii) Ghana Registered midwives Association (GRMA)
- iii) Planned Parenthood Association of Ghana (PPAG)
- iv) iv) Ghana Social Marketing Foundation (GSMF) and

USAID is the principal Development Agency that supports PAC in Ghana.
Other agencies include UNICEF, IPPF, Packard Foundation, the Carnegie Foundation and JICA (GHS 2004-2008).

APPENDIX 11: Distribution of respondents by stance/position on abortion care

Respondents/Stance	Number n	For	Against	Ambivalent/Evasive
Obstetricians	15	11/15	1/15	3/15
Midwives	14	3/14	5/14	6/14
Other health professionals	14	2/14	3/14	9/14
Non-health professionals	9	4/9	1/9	4/9
Policy makers	9	4/9	3/9	2/9
Religious leaders	15	2/15	10/15	3/15
Total	76	26/76	23/76	27/76

*The above represents an attempt to categorise the respondents by their stance on abortion care.

APPENDIX 12: The Hippocratic Oath and Midwives' Prayer

The Hippocratic Oath is a medical pledge of allegiance. It is a code of ethics sworn by newly qualified doctors to guide their practice. There appear to be different versions of the Hippocratic Oath. These include the original, the classic and modern versions. The versions may differ based on cultures of the institution or country. However certain ethical principles are common to all the Oaths. The most basic and common principle of the Hippocratic Oath requires that doctors must always work towards healing their patients. The Oath calls on doctors to treat the sick to the best of their ability with the health of their patients being their first consideration. In ethics, this principle is referred to as the principle of beneficence. Doctors are not to harm their patients; this is the principle of 'non-maleficence'. They are to show fairness in the treatment of all patients which covers the 'principle of justice'. Showing optimum respect for patients' privacy amongst others encompasses the 'principle of autonomy' (George and Gillies 2006). It is also incumbent on doctors to show maximum respect for human lives from the moment of conception. This clause appears to be one that pertains to the practice of abortion.

The original Hippocratic Oath appears to have been altered and modernized. The version being used by the Ghana Medical and Dental Council is that adopted by the World Medical Association in 1948 and amended by the World Medical Assembly in 1968 (See Appendix 12). Newly qualified Ghanaian doctors swear this Oath during their graduation ceremony and before they commence their internship. This version of the Oath ('Declaration of Geneva - Physicians' Oath Declaration, 1968) has similar principles with the original, classic and modern versions. It also speaks of respect for human life from the time of conception; the implication is that doctors should not carry out abortions.

In my search for the British version of the Hippocratic Oath, I found that the British Medical Association (BMA) revised the version of the Hippocratic Oath known as the Geneva Declaration in March 1997 for consideration by the World Medical Association. The Geneva Declaration, which is the version of the Oath that is used in Ghana, is concise and relatively simple compared to the revised British version which is much more elaborate. Like the Geneva Declaration, the

version revised by the British Medical Association calls on doctors to observe the core values of the medical profession which border on helping the sick and avoiding causing harm to them. Unlike the Geneva Declaration (1968) which in my view implicitly forbids abortion, the British revised Oath was explicit about abortion. It maintains that ‘where abortion is permitted it should be carried out within ethical and legal framework’....

‘I recognise the special value of human life but I also know that the prolongation of human life is not the only aim of healthcare. Where abortion is permitted, I agree that it should take place only within an ethical and legal framework’.

(See the entire Oath on page...)

What the British Oath says regarding abortion is in line with the WHO’s guidance concerning provision of comprehensive abortion care; that safe services be made available and accessible to women with unwanted pregnancies so that they do not have recourse to unsafe abortion.

Since the Ghana law on abortion permits abortion services in certain instances whilst the Oath sworn implicitly forbids abortion there is bound to be confusion especially among medical practitioners regarding provision of abortion services. It may be imperative for debates to be initiated by the Ghana Medical Council, Ghana Medical Association and other stakeholders to consider modification of the Oath to cover abortions in line with the law. Reviewing the Oath and amending the parts that forbid abortion may ameliorate the confusion in the medical community especially among those who are not conscientious objectors.

The Geneva Declaration and its recent editorial revision are presented below as well as the British Medical Association’s Version of the Oath in 1997.

Hippocratic Oath (Geneva Declaration)

I solemnly pledge myself to consecrate my life to the service of humanity;
I will give to my teachers the respect and gratitude which is their due;
I will practice my profession with conscience and dignity;

The health of my patient will be my first consideration;
I will respect the secrets which are confided in me, even after the patient has died;
I will maintain by all means in my power, the honour and the noble traditions of the medical profession;
My colleagues will be my brothers;
I will not permit considerations of religion, nationality, race, party politics or social standing to interfere between my duty and my patient;
I will maintain the utmost respect for human life from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.
I make these promises solemnly, freely and upon my honour.

Declaration of Geneva(Physician's Oath Declaration), adopted by the General assembly of the World Medical Association at Geneva, Switzerland, September, 1948 and amended by the 22nd World Medical assembly, Sydney, Australia, August, 1968.

Source: Ghana Medical and Dental Council (2006) Newline Vol. 7 no 1

Declaration of Geneva - 2006

At the time of being admitted as a member of the medical profession:

I solemnly pledge to consecrate my life to the service of humanity;
I will give to my teachers the respect and gratitude that is their due;
I will practise my profession with conscience and dignity;
The health of my patient will be my first consideration;
I will respect the secrets that are confided in me, even after the patient has died;
I will maintain, by all the means in my power, the honour and the noble traditions of the medical profession;
My colleagues will be my sisters and brothers;
I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;
I will maintain the utmost respect for human life;
I will not use my medical knowledge to violate human rights and civil liberties, even under threat;

I make these promises solemnly, freely and upon my honour.

*Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948
and amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968
and the 35th World Medical Assembly, Venice, Italy, October 1983
and the 46th WMA General Assembly, Stockholm, Sweden, September 1994
and editorially revised at the 170th Council Session, Divonne-les-Bains, France, May 2005 and the 173rd Council Session, Divonne-les-Bains, France, May 2006*

Revised Hippocratic Oath (British Medical Association in 1997)

“The practice of medicine is a privilege which carries important responsibilities. All doctors should observe the core values of the profession which centre on the duty to help sick people and to avoid harm. I promise that my medical knowledge will be used to benefit people’s health. They are my first concern. I will listen to them and provide the best care I can. I will be honest, respectful and compassionate towards patients. In emergencies, I will do my best to help anyone in medical need.”

“I will make every effort to ensure that the rights of all patients are respected, including vulnerable groups who lack means of making their needs known, be it through immaturity, mental incapacity, imprisonment or detention or other circumstance.”

“My professional judgment will be exercised as independently as possible and not be influenced by political pressures nor by factors such as the social standing of the patient. I will not put personal profit or advancement above my duty to patients.”

“I recognize the special value of human life but I also know that the prolongation of human life is not the only aim of health care. Where abortion is permitted, I agree that it should take place only within an ethical and legal framework. I will not provide treatments which are pointless or harmful or which an informed and competent patient refuses.”

“I will ensure patients receive the information and support they want to make decisions about disease prevention and improvement of their health. I will answer as truthfully as I can and respect patients’ decisions unless that puts others at risk of harm. If I cannot agree with their requests, I will explain why.”

“If my patients have limited mental awareness, I will still encourage them to participate in decisions as much as they feel able and willing to do so.”

“I will do my best to maintain confidentiality about all patients. If there are overriding reasons which prevent my keeping a patient’s confidentiality I will explain them.”

“I will recognize the limits of my knowledge and seek advice from colleagues when necessary. I will acknowledge my mistakes. I will do my best to keep myself and colleagues informed of new developments and ensure that poor standards or bad practices are exposed to those who can improve them.”

“I will show respect for all those with whom I work and be ready to share my knowledge by teaching others what I know.”

“I will use my training and professional standing to improve the community in which I work. I will treat patients equitably and support a fair and humane distribution of health resources. I will try to influence positively authorities whose policies harm public health. I will oppose policies which breach internationally accepted standards of human rights. I will strive to change laws which are contrary to patients’ interests or to my professional ethics.”

Nursing & Midwifery: Midwives' Prayer

H ave mercy on me, oh lord
And in all my actions
Let me have thy fear before my eyes
That I may be careful for both rich and poor
To do good and not hurt
To save lives and not to destroy
Help my infirmities and imperfections
And grant me skill and judgement
Happily to finish every work
Through Jesus Christ our Lord

Amen

Our apologies for any biases or insensitivities reflected in the above

Source:-www.nmcg.org/midwives_prayer.html

Appendix 13: Example of coded text retrieved from N*UDIST

REPORT ON NODE (4 1) '~/Challenges to implementation'
Restriction to document: NONE

(4 1) /Implementation of abortion Law/Challenges to implementation

*** Description:

All barriers to implementation of law

+++++-----

+++ ON-LINE DOCUMENT: Dev. Agency 1

+++ Retrieval for this document: 55 units out of 229, = 24%

++ Text units 39-50:

39

15 Well, the first reality is that it is not enough to have the policy 40

16 That means it has to be put in action and in particular what concern 41
the abortion 42

17 I think it is a very sensitive issue, you know that Ghana is fortunate 43
in that sense it is very religious 44

18 And then when you talk about abortion, you see even when you talk 45
about the 19 Preventive aspect like the use of condom some churches are 46
fully against it 47

20 When you come to abortion it is a relatively difficult matter 48

21 Very very sensitive. I can tell you may be jumping a bit ahead. Last 49
year we tried to do something 50

++ Text units 161-165:

77 If it affects our work here? Not in the sense of blocking our work per 161
se 162

78 But it contributes to restrain the flow of resources that could help 163
the government 164

79 To do their job so it would be in that sense 165

++ Text units 169-187:

80 Yes it is linked to some resource limitation, that's true 169

81 But the important thing is to see this problem in the context of 170

82 All the determinants that contribute to the maternal mortality 171

83 Otherwise one of the MDG you see so if you want to approach 172

84 We cannot ignore unsafe abortion as one of the important contributors 173

85 Now, GAG RULE as you're saying, maybe they would rather 174

86 Promote the preventive side rather than to come to the abortion 175

87 But all these is a process of community education 176

88 Community mobilization so that people will be aware 177

89 And above all what I believe, once people come to know that this is a 178
public 179

90 Health problem, that people are dying due to that 180

91 I think one of the problem is that it is not common knowledge 181

92 That this problem is there; it is happening but the public does not 182

93 Perceive so; that is why research is needed 183

94 That we have, we can demonstrate, we can showcase 184

95 That it's a problem, people are dying we have to do something 185

96 To have the right approach 186

187

++ Text units 190-193:

97 It is not a matter of we have our ethics, we have our believes 190

98 It's not a matter of just promoting abortion but it should be 191
considered 192

99 When it has to be, it should be safe 193

++ Text units 200-214:

101 I think there was some effort to update it. What I know is that 200

102 There is a list of the issue that would illegalize it	201
103 Then they give few parameters where abortion could be acceptable to be legal	202
104 And now apparently even that window of opportunity is not being used	204
105 So what was intended by partners in this issue with WHO	205
106 Is under that window given by the law; like case of rape, case of idiot women	206
107 And other case where the future of the child is at stake	208
108 So if that window of opportunity given by the law could be used	209
109 At least it could be already; but if it could be used and done in a safe way	210
110 So what I mean the law gives already window of opportunity	212
111 That to my understanding is not being fully used	213
112 Due to all those barriers we have already spoken about	214
+++++ +++ ON-LINE DOCUMENT: Dev. Agency 2	
+++ Retrieval for this document: 18 units out of 62, = 29%	
++ Text units 26-39:	
19 USAID does not believe that provision of SAS is a solution to the problem	26
20 Of unsafe abortion. They therefore do not support or offer funds for SAS	28
21 They are not into that; it is not their mandate	30
22 Their funds are not supposed to be used for	31
23 Abortion related activities; there's monitoring to ensure this	32
24 And for this reason, a lady from the US will visit Ghana	33
25 For monitoring purposes; they are only into PAC	34
26 They are comfortable with that and offer funds to organizations	35
27 Who are into PAC. Because IPPF did not sign an undertaking	36
28 That they will not use USAID fund for abortions	37
29 They do not get funds from USAID	38
30 Therefore PPAG, an affiliate of IPPF does not get USAID funds	39
++ Text units 56-59:	
37 The GAG RULE is a policy binding on them so they abide by it	56
38 They comply with the GAG RULE	57
39 There is monitoring and funds will stop going where there is no compliance	59
+++++ +++ ON-LINE DOCUMENT: Obstetrician 1	
+++ Retrieval for this document: 269 units out of 884, = 30%	
++ Text units 137-138:	
78 No. Really it is not being implemented at all, minimally.	137
79 And the consequences of that are obvious	138
++ Text units 140-149:	
80 The law is not being implemented because we will come back to the fact that	140
81 You would or the state, the arm of government, the arm of the MOH	142
82 That should promote these has to provide the facilities for	143
83 Those who want to use the facility to be aware that	144
84 There are those facilities and has to educate the service providers	145
85 As to what, under what terms the law supports them	146
86 If they carry it out and then after that we'll then have to decide	147
87 It is a question of you know, interpretation	148
88 I think there is a big gap there and then	149
++ Text units 152-184:	
89 Well the factors I see are lack of the provision of facilities where these could be done	152
153	
90 Lack of the education of doctors and finally lack of education, I think it's just money	154
155	

91 You know, lack of education of the people who, the adolescents	156
92 And the unmarried and the married women	157
93 Who find themselves in a state like that and I don't actually	158
94 See the reason why people think that abortion is illegal if	159
95 If you're providing facilities to your community to prevent pregnancies	160
96 And you know that there's no 100% reliable contraceptives	161
97 All of them have failure rates then why wouldn't you have the provision	162
98 So that if these fail, you counsel the woman and see which way she's going to go	163
99 Some of those will carry on the pregnancy but others will say well	165
100 I didn't want this because of this and this and this	166
101 And in fact in some cases you may tie onto that, sterilization	167
102 You know, I've worked with people who if you genuinely do not want this	168
103 Pregnancy; you don't want any more at your age then yes we will do a termination for	170
104 you but as well we might as well do a permanent means of preventing pregnancy so	172
105 I don't think there is any hard and fast rule, it is a question of people not being	174
106 educated well. Medical students before they become doctors, you talk to them and	176
107 and thy tell you abortion is illegal because nobody has educated them on that and	178
108 maybe it is also the teachers to blame because if they understand the law then they	180
109 should educate, you know, the health providers even before they qualify so that they	182
110 have this basic information.	184
++ Text units 296-324:	
162 I do not know the reason for that. One thing I thought about as well, the factors that	296
163 would or that are in the way of implementing the abortion law, part of that on my	298
164 personal grounds I think is also a reluctance by those who provide us with the	300
165 facilities and money to implement things, not being too interested in other words	302
167 even though money that is coming from elsewhere for family planning is you know	304
168 pro-life so to speak you know, they will not be happy, you using their money and	306
169 resources for termination which would be more on the side of pro-choice	308
170 of the woman who is pregnant so family planning services are heavily subsidized by	310
171 certain international NGOs who are not necessarily pro-choice and that reduces funds	312
172 a lot and this present American government that is the head of international choice,	314
173 he is pro-life so money from there for family planning services is not going to go	316
174 anywhere into pro-choice activities so international organizations, if you are being	318
175 supported or funded by an organization that is not pro-choice, you may not have the	320
176 funds from outside to be able to move things in the direction that, you know is best	322
177 for your country.	324

++ Text units 327-347:

- 179 The reproductive and child health policy is being implemented by and 327
large with the 328
180 limited resources we have there is the effort to look at the 329
reproductive health 330
181 indicators and see how best we can try to improve upon those 331
indicators and err, I 332
182 think a lot of effort is going into it as to whether it is going in 333
the right direction is 334
183 difficult but it is also a problem of staff on the ground, you don't 335
even have the staff 336
184 to manage your acute services so cases that are not an emergency seem 337
to be sort of 338
185 moved into the background you know, you can't get the staff to run 339
wards where 340
186 acute health care is required so somebody who is just pregnant and 341
wants a removal 342
187 may not even find the staff to do that at all, so staff especially 343
not from the point of 344
188 view of doctors, but nursing staff is so acutely short that you may 345
not be thinking in 346
189 that direction to actually look for the nurses to provide that 347

++ Text units 351-355:

- 190 No, not well resourced because the funds are just not there much as 351
the government 352
191 may talk it out; the funds are not there to implement this 353
reproductive and child 354
192 health policy. 355

++ Text units 357-385:

- 193 There is the lack of resources, both human resource as you mentioned 357
but even 358
194 money for you know, the structures or equipment you need in place is 359
just not there 360
195 and once it isn't acute it is not an immediate problem for the 361
government because they 362
196 don't even have the money so that is how, a very important issue, the 363
commonest 364
197 cause of gynaecological and cervical cancer, cancer of the cervix 365
demonstrated 366
198 elsewhere that these, provided you implement good screening will be 367
reduced. 368
199 if the money is not there for you to do the screening much as policy 369
makers may 370
200 think it is important and I think they know it is important, the 371
money is just not there 372
201 you know but not to blame the policy makers as well because we also 373
know that 374
202 much as they will draw the budget for example this year where they've 375
drawn the 376
203 budget, you take it to government, they will slash it by 2/3 because 377
the money is just 378
204 not there full stop so you end up having money enough to pay salaries 379
and buy a few 380
205 reusables and nothing else, I mean, even if you look at our budget 381
you know, 50% or 382
206 more of that is you know, is funded by so called development partners 383
who borrow 384
207 money to live on. 385

++ Text units 470-504:

247 this service, it shouldn't determine whether you will get a job in that unit, it	470 471
248 shouldn't determine your promotion and what have you and that is the good thing	472 473
249 we should pick up from the whites because when you go for an interview in the west	474 475
250 they don't even ask you. When you get the job and you arrive at work then	476 477
251 somebody may ask by the way, is it okay we put this on your operation list then you	478 479
252 say yes or no that's all so you know it has to be properly organized by the medical	480 481
253 services themselves and make sure that those who feel that if they offer these, the	482 483
254 50% of maternal mortalities estimated due to complications of unsafe abortion would	484 485
255 be reduced so that we reduce maternal mortality. If you believe in that and want to go	486 487
256 ahead and do it. If you think morally its not right and you are pro-life it shouldn't	488 489
257 affect your chances of getting a job or your progress you know, things have to be more	490 491
258 open than I in that direction so it is a matter of discussions bringing in the experts to	492 493
259 interpret the law for us, being experts as far as health is concerned, you know being	494 495
260 clear right from medical association and so on that health is as defined by WHO,	496 497
261 if you make the government accept this one, if you make the MOH accept that then if	498 499
262 you think that you are promoting somebody's health and you are taken to court, the	500 501
263 law will free you because this person was unhealthy and fit in as a candidate by using	502 503
264 the abortion law	504
++ Text units 609-631:	
315 Definitely, it is the responsibility f government because they have to provide the facilities	609 610
316 that will promote heath in our community and problems with unsafe abortion contribute	611 612
317 immensely to morbidity so it is their responsibility whether they believe in it or not, if	613 614
318 there are some people in the community who want to use it then they have to provide the	615 616
319 facilities because all these should be sort of done without any religious or moral	617 618
320 connotations because the facilities have been provided, if that will promote health	619 620
321 as often shown worldwide and those who want use those facilities can then have it but	621 622
322 with religious backgrounds and connotations there may not be the will to provide these	623 624
323 services but I have the feeling by and large probably religious grounds as well as lack of	625 626
324 facilities that is making them not to be provided because if that were there then there should	627 628
325 be the possibility to now train doctors in that regard to provide these services even for	629 630
326 a nominal figure.	631

++ Text units 633-643:

- 327 What I am saying is that we think this is a Christian country and I 633
think if we were so 634
328 fanatical about the religion, we are Christians in church and when we 635
are outside we do 636
329 many other things, which are not very, Christian but there is so much 637
shout about being 638
330 a Christian country we should not providing and so on so the 639
religious bodies seem to not 640
331 be in favour of these because they think it is unchristian and that 641
maybe what is influencing 642
332 several people not to come out openly and provide these services. 643

++ Text units 649-669:

- 333 Well, there are factions but I think its based on looking at abortion 649
from the moral point 650
334 of view because morally several people would say this is wrong and 651
should not be allowed 652
335 in such a Christian country but we will have to tolerate each other 653
and we have more 654
336 knowledge as far as health is concerned so that if by not providing 655
these it drives those 656
337 those who want these facilities underground and create a good market 657
for back street 658
338 terminations by people who do not know what to do then it leads to 659
more problems 660
339 because you then have to use the same government facilities and funds 661
to help out those 662
340 who finally get maimed from these so in a way there is the creation 663
of more problems by 664
341 trying to avoid or get away from what should be provided but I think 665
it is more of the moral 666
342 aspect which is becoming a problem because the country seems to 667
highly Christian and on 668
343 Sundays they shout a lot and then the next day do different things. 669

++ Text units 703-720:

- 358 I think those are the main factors which probably even makes the 703
policy makers and 704
359 implementers very careful in order not to be seen to be doing what 705
needs to be done and I 706
360 suppose if we can go out of that a bit more then we will probably 707
move forward because 708
361 because there is so much fanaticism and I do not think that it is right 709
for the few who are 710
362 outspoken to deny the greater majority you know, what needs to be 711
done. In addition, 712
363 they on religious grounds also think that by educating adolescents on 713
the two views to 714
364 prevent pregnancy it will make them rather promiscuous but I don't 715
think this has been 716
365 proven in the literature and the fact that they know they can use 717
this therefore they go on and 718
366 use this. It is just logical thinking but it is not shown in practice 719
but if that happens there 720

++ Text units 799-830: