

Prince Oppong-Darko

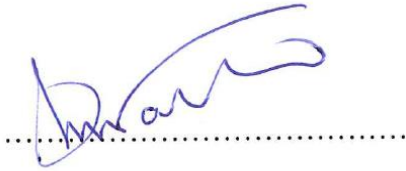
“It is against my religion”
The attitude of the midwife in
increasing access to safe
abortion care in Ghana: A
qualitative study design

Trondheim, June, 2017



Declaration

I, Prince Oppong-Darko the author of this work, do hereby declare that, apart from references to literature and works of other researchers which have been duly cited, this thesis is my own work and it has not been submitted anywhere.



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Dedication

I dedicate this piece of work to my wife, Sabina and my three wonderful girls; Adwoa Agyeiwaa, Abena Acheampomaa and Esi Mbra.

Acknowledgement

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List of abbreviations

PNDCL	-Provisional National Defense Council Law
WHO	-World Health Organization
CHPS	-Community-based Health Planning and Services
WIFA	-Women in Fertility Age
GHS	-Ghana Health Service
SDGs	-Sustainable Development Goals

Abstract

Background: Unsafe abortion remains a major public health problem in spite of international convention calling for the prevention of unwanted pregnancies and the provision of safe abortion services. Standards and protocols developed by the Ghana Health Service in 2006 authorized midwives to provide early induced abortion services under the law.

Objective: The purpose of the study was to understand midwives' readiness to be involved in increasing access to legal safe induced abortion care in primary health facilities in Ghana.

Methods: A qualitative research approach using semi-structured topic guide for individual in-depth interviews on purposefully selected participants was adopted. The interviews were recorded on tape and analysed using content analysis approach.

Results: Participants revealed various reasons behind their choice of midwifery as a profession. They emphasised on reasons such as their past experiences on maternal deaths in their community, passion for the health of pregnant women and their willingness to help reduce maternal mortalities in Ghana. Knowledge on Ghana's abortion law was found to be generally low among the participants. They expressed different views on the provision of safe abortion services in their facility. Some felt it was against their religious belief and that it is sinful to provide abortion services, whilst others felt it was good to save the lives of women. Religion was highlighted as one of the main reasons why some participants would not provide abortion services in their facility.

Conclusion: There was a realization that maternal mortality is a problem in Ghana and participants were enthuse to help reduce it. The main motivator for midwives to provide abortion services in their facility was to help reduce maternal mortality. A pronounced hindrance for midwives to provide abortion services was religion.

1.0 Introduction

1.1 Background

Unsafe abortion remains a major public health challenge in spite of international convention calling for prevention of unintended pregnancies and the provision of safe abortion care services (1). It is estimated that, around 22 million unsafe abortions occur worldwide each year, almost all in developing countries (2). Recent data shows an estimated 44,000 deaths due to unsafe abortion and Africa is disproportionately affected, with nearly two-thirds of all abortion-related deaths (3).

Ghana has ratified to various international charters and conventions including the universal declaration of human rights. The right to health is a fundamental human right. The United Nations Sustainable Development Goals 3 and 5 seeks to achieve good health and wellbeing for all at all ages and gender equity respectively. All countries are responsible for achieving the SDGs, including reducing the global maternal mortality ratio to 70 per 100,000 live births by 2030 according to one of the targets of SDG 3. Unsafe abortion is a common cause of maternal morbidity and mortality. The main problem is that; many countries have laws that are generally against induced abortion but permitted to be performed under certain circumstances.

Abortion in Ghana is regulated by section 58 of Act 29 of 1960, amended by PNDCL 102 of 1985. The Act states that, “Abortion is unlawful and both the woman and anyone who abets the offence by facilitating the abortion by whatever means, are guilty of an offense of causing abortion” (1). However, abortion is permitted under some circumstances, such as when pregnancy is the result of rape, defilement, or incest; its continuation would involve risk to the

life of the pregnant woman or injury to her physical or mental health; and if there is a substantial risk that, when the child is born, it may suffer from or later develop a serious physical abnormality or disease. In these circumstances, abortion is permitted when performed by a gynecologist or any other registered medical practitioner.

The Ministry of Health and Ghana Health Service developed standards and protocols in the provision of comprehensive abortion care in 2006. In this protocol, midwives and medical assistants with midwifery training are authorized to provide early legal abortion in accordance with the law. The main idea behind the authorization of midwives and medical assistants is to shift the task of physicians to these calibre of health workers to provide the service in primary health facilities due to the shortage of physicians in the country. The World Health Organisation (WHO) established a minimum threshold of doctors, nurses and midwives necessary to deliver essential maternal and child health services as 23 per 10,000 population but in Ghana, it is 11 per 10,000 population (4).

Although unsafe abortions are preventable, policy makers, legislators, health professionals and society has not given it the necessary attention and thus continue to pose an undue treat to the health and lives of women (5). The stigma and silence amongst others are known to be major causes of unsafe abortions in the country (5), which accounts for 11% of all maternal deaths in Ghana (6). Available evidence associates that, health professionals who do not support safe abortion often lack sufficient knowledge of current legislative of their countries (7).

1.2 Literature review

WHO defines unsafe abortion as a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform

to minimal medical standards, or both. This definition is linked to the process involved in unsafe abortion, but the characteristics of an unsafe abortion touch on inappropriate circumstances *before, during or after* an abortion (8). The following conditions typically characterize an unsafe abortion, sometimes only a few conditions prevail, and sometimes all or most of them (8):

- no pre-abortion counselling and advice;
- abortion is induced by an unskilled provider, frequently in unhygienic conditions, or by a health practitioner outside official/adequate health facilities;
- abortion is provoked by insertion of an object into the uterus by the woman herself or by a traditional practitioner, or by a violent abdominal massage;
- a medical abortion is prescribed incorrectly or medication is issued by a pharmacist with no or inadequate instructions and no follow-up;
- abortion is self-induced by ingestion of traditional medication or hazardous substances.

Further hazardous features of unsafe abortion are:

- the lack of immediate intervention if severe bleeding or other emergency develops during the procedure;
- failure to provide post-abortion check-up and care, including no contraceptive counselling to prevent repeat abortion;
- the reluctance of a woman to seek timely medical care in case of complications because of legal restrictions and social and cultural beliefs linked to induced abortion.

1.3 Global Situation of Unsafe Abortion

The numbers of unsafe abortions have increased from 19.7 million in 2003 to an estimated 21.6 million in 2008 although the overall unsafe abortion rate remains unchanged at about 14 unsafe abortions per 1000 women aged 15–44 years. This increase in the number of unsafe abortions

without a corresponding increase in the rate is mainly due to the growing population of women of reproductive age (3).

The proportion of abortions that are performed under unsafe conditions are not currently known. However, complications from unsafe abortions are common in developing regions, where the procedure is often highly restricted. Estimates from 2012 indicate that 6.9 million women in these regions were treated for complications from unsafe abortions. Furthermore, most recent estimates suggest that some 40% of women who experience complications never receive treatment (3).

The treatment of medical complications from unsafe abortion places a considerable financial burden on public health care systems and on women and families in developing regions. According to estimates from 2014, the annual cost of providing post-abortion care in developing countries was US\$232 million. If all those who needed treatment received it, the cost would be US\$562 million (3)

Almost all abortion-related deaths occur in developing countries, with the highest number occurring in Africa. Recent studies estimate a variation between 8–18% of maternal deaths worldwide are due to unsafe abortion, and the number of abortion-related deaths in 2014 ranged from 22,500 to 44,000 (3).

1.4 The Midwife and Abortion Care

By definition, midwives are educated professionals who are dedicated to providing reproductive health care to women and to helping them maintain healthy reproductive lives. Midwives are often the front-line providers of care, not only for women with normal pregnancy

and childbirth, but for those who experience complications related to pregnancy and childbirth, including abortion (9). However, there are few programmes that provide education for or authorise midwives to provide treatment for the life-threatening obstetric complications that are major causes of maternal mortality, including abortion. Women in an abortion-related crisis - whether they are experiencing a miscarriage, an unwanted pregnancy or suffering from complications of an unsafely induced procedure are particularly not likely to get accessible care due to the controversial nature of abortion (9).

Evidence shows that access to safe abortion-related services can almost eliminate maternal deaths due to unsafe abortion (9). Realizing that authorized and well-trained midwives can provide competent and safe abortion-related services, many governments have modified their laws and policies to empower midwives to provide induced and post abortion services (9). In Ghana, midwives are trained as part of their curricular on the use of manual vacuum aspiration (MVA) for post abortion care in case of complications after miscarriage.

The American College of Nurse-Midwives' nation-wide survey conducted to study their membership's attitudes to abortion practices showed that, 79% supported unlimited access to abortion and 52% supported abortion practice by nurse midwives (10), however in some hospitals, abortion procedures have been hindered due to a lack of nurses willing to assist physicians with the procedure (11).

1.5 Liberal Abortion Laws and their Effect

Induced abortion is generally seen as a taboo in almost all cultures in Ghana hence, society frowns on individuals and health facilities who provide safe abortion services (1). However, it

is an undeniable fact that unsafe abortion is one of the four main causes of maternal mortality and morbidity in the country (4).

Unplanned and unwanted pregnancies and unsafe abortions are serious public health problems in the developing world. One of the reasons for unsafe abortion is because safe abortion services are frequently not available, even when they are legal for a variety of indications in almost all countries (4). Legalization of safe abortion care service is a human rights imperative. Even in countries where abortion is allowed by law, safe public sector services are often not available for eligible women for various reasons, such as providers bias, lack of medical equipment or lack of trained personnel, and bureaucratic problems (5).

Whether abortion is legally restricted or not, the likelihood that a woman will have an abortion for an unintended pregnancy is about the same. Legal restrictions on abortion do not result in fewer abortions, nor do they result in significant increases in birth rates (2). The lack of legal access to abortion services is likely to increase the number of women seeking illegal and unsafe abortions, leading to increased morbidity and mortality (2). Legal restrictions lead many women to seek services from unskilled providers or under unhygienic conditions, exposing them to a significant risk of death or disability (12).

Less restrictive abortion laws also do not guarantee safe abortions for those in need; better education and access to health care are also required. In India, unsafe illegal abortions persist despite India's passage of the Medical Termination of Pregnancy Act in the early 1970s. The act appeared to remove legal hindrances to terminating pregnancies in the underfunded national health care system, but women still turn to unqualified local providers for abortion (13).

Evidence however shows a remarkable decline in the abortion rate in developed countries where abortion is available on request and contraception readily accessible (14).

Access to safe abortion services remains limited for a majority of the world's women by either legal, cultural, health policy, or religious restrictions. Because of limited access, many women turn to unskilled providers to terminate their pregnancies and may suffer complications requiring medical intervention and this action can have grave health consequences (9). It is possible that the numbers of unsafe abortions will continue to increase unless women's access to safe abortion and contraception; and support to empower women, including their freedom to decide whether and when to have a child are put in place and further strengthened (15).

Evidence demonstrates that liberalizing abortion laws to allow services to be provided openly by skilled practitioners can reduce the rate of abortion-related morbidity and mortality (16). When abortions are performed by skilled providers using correct medical techniques and drugs, and under hygienic conditions, induced abortion is a very safe medical procedure. Unsafe abortion and associated morbidity and mortality in women are avoidable. Safe abortion services should be readily available and affordable to all women to the full extent of the law. This means services should be available at primary care level, with referral systems in place for all who require higher-level care (2). Policy makers should not only make abortion legal, but simultaneously making family planning methods accessible are important to reduce the amount of unsafe abortions.

There is little risk involved when the procedure is performed by educated and skilled providers under sanitary conditions - less risk, in fact, than childbirth (8). Ghana has an abortion law that allows women the legal option to terminate unwanted pregnancy when it is as a result of rape,

incest, when pregnancy threatens the life of the woman or when there is foetal malformation. The 2006 standards and protocols on the provision of comprehensive abortion care can only be implemented in primary health facilities with motivated midwives who are ready and willing to provide abortion services. However, much is not known about midwives' readiness and willingness to offer abortion services in Ghana.

1.6 Description of Ghana

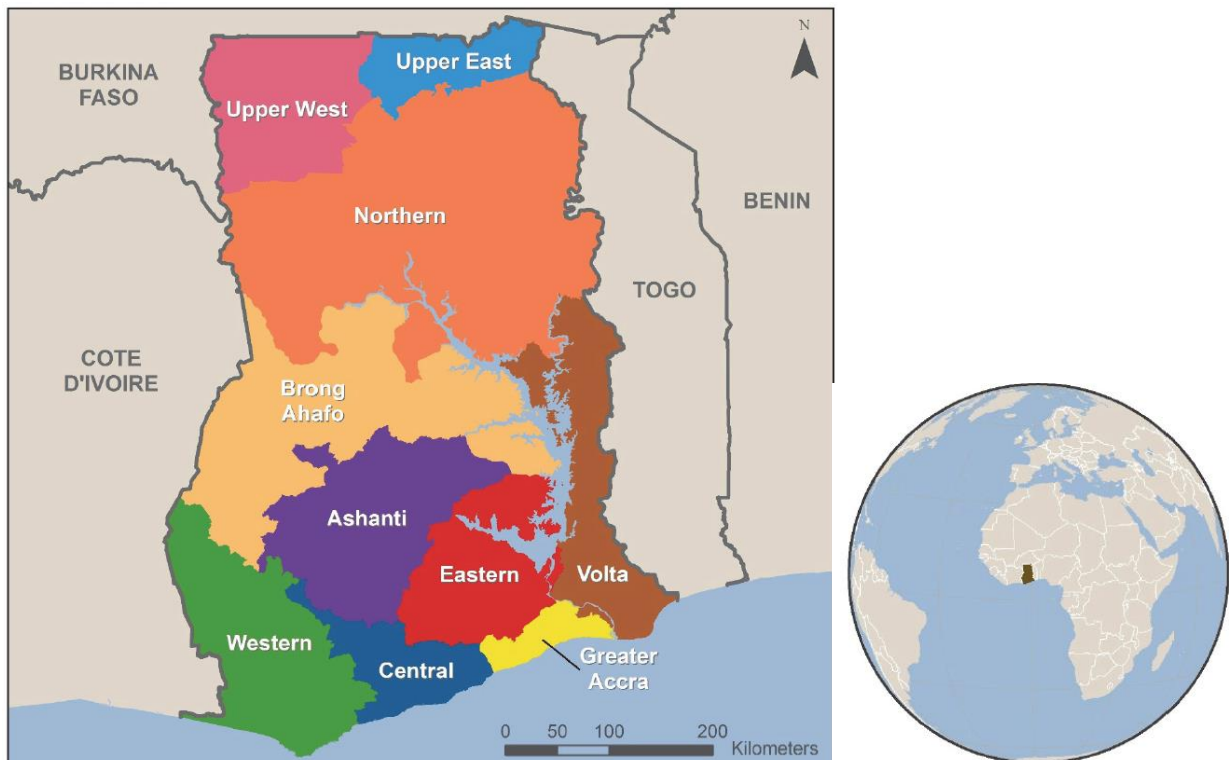
The Republic of Ghana with a population of 28 million is centrally located on the West African coast. It has a total land area of 238,537 square kilometres, and it is bordered by three French-speaking countries: Togo on the east, Burkina Faso on the north and northwest, and Côte d'Ivoire on the west. The Gulf of Guinea lies to the south and stretches across the 560-kilometre coastline.

Ghana has a tropical climate with temperatures and rainfall patterns that vary according to distance from the coast and elevation. The eastern coastal area is comparatively dry, the southwestern corner is hot and humid, and the north of the country is hot and dry. The average annual temperature is about 26°C (79°F). There are two distinct rainy seasons in the southern and middle parts of the country, from April to June and September to November. The North is, however, characterised by one rainfall season that begins in May, peaks in August, and lasts until September.

There are 10 administrative regions in Ghana: Western, Central, Greater Accra, Volta, Eastern, Ashanti, Brong Ahafo, Northern, Upper East, and Upper West. The Ashanti, Eastern, and Greater Accra regions together constitute about 50 percent of the country's population. Upper East is the least populated region, accounting for 2 percent of the total population of Ghana.

The regions are subdivided into 216 districts to ensure equitable resource allocation and efficient, effective administration at the local level. More than 30% of the population live in rural areas of the country.

Figure 1: Map of Ghana showing the 10 administrative regions



Source: Ghana Demographic and Health Survey 2014

1.7 Overview of the Healthcare System in Ghana

The health delivery system in Ghana is faced with the responsibility of improving and ensuring the health and well-being of the people of Ghanaian. The healthcare system has five levels of providers: health posts, health centres and clinics, district hospitals, regional hospitals and teaching hospitals.

1.7.1 Health posts

The health posts are the first level primary care for rural areas. This level of care is usually managed by a midwife or a trained community health nurse.

1.7.2 Health Centres/Clinics

The health centre has traditionally been the first point of contact between the formal health delivery system and the client. It is headed by a medical assistant and is staffed with programme heads in the areas of midwifery, laboratory services, public health, environment, and nutrition. Each health centre serves a population of approximately 20,000. They provide basic curative and preventive services for adults and children, as well as reproductive health services. They provide minor surgical services such as incision and drainage. They augment their service coverage with outreach services, and refer severe and complicated conditions to appropriate levels. The polyclinic is the urban version of the rural health centre. Polyclinics are usually larger, offer a more comprehensive array of services, manned by physicians, and can offer complicated surgical services. They are mainly in metropolitan areas such as Accra and Kumasi.

1.7.3 District Hospitals

District hospitals are the facilities for clinical care at the district level. District hospitals serve an average population of 100,000 to 200,000 people in a clearly defined geographical area. The number of beds in a district hospital is usually between 50 and 60. It is the first referral hospital and forms an integral part of the district health system. The cadre of staff include physicians, midwives, nurses, auxiliary nurses and other public health workers.

1.7.4 Regional Hospitals

Regional hospitals form a secondary level of health care for their locations. They provide services to a geographically well-defined area of a population of about 1.2 million. Regional hospitals are an integral part of the regional health system, functioning to support it. They provide specialized care, involving skills and competence not available at district hospitals, which makes them the next level of referral from district hospitals. The personnel usually include medical professionals, such as general surgeons, general medical physicians, obstetricians, paediatricians, general and specialized nurses, and midwives.

1.7.5 Teaching Hospitals

Teaching hospitals are centres of excellence and complex health care. Governance of teaching hospitals is unusual interdisciplinary because it involves many players, such as the Ministry of Health, the Ministry of Education, and university and political influences in the community; teaching hospitals have a high social and political profile. The care at these facilities requires more complex technology and highly skilled personnel. They have a high concentration of resources and are relatively expensive to run. They also support the training of health workers both preservice and in-service.

1.8 The Current Law on Abortion in Ghana

Abortion is a criminal offence in Ghana and is regulated by Act 29, section 58 of the Criminal code of 1960, amended by PNDCL 102 of 1985 [Criminal Code of Ghana, 1960]. It states that (17):

1. Subject to the provisions of subsection [2] of this section

- a. Any woman who with intent to cause abortion or miscarriage administers to herself or consent to be administered to her any poison, drug or other noxious thing or uses any instrument or other means whatsoever; or
 - b. Any person who
 - i. Administers to a woman any poison, drug or other noxious thing or uses any instrument or other means whatsoever with intent to cause abortion or miscarriage, whether or not the woman is pregnant or has given her consent;
 - ii. Induces a woman to cause or consent to causing abortion or miscarriage;
 - iii. Aids and abets a woman to cause abortion or miscarriage;
 - iv. Attempts to cause abortion or miscarriage; or
 - v. Supplies or procures any poison, drug, instrument or other thing knowing that it is intended to be used or employed to cause abortion or miscarriage; shall be guilty of an offence and liable on conviction to imprisonment for a term not exceeding five years.
2. It is not an offence under section [1] if an abortion or miscarriage is caused in any of the following circumstances by a registered medical practitioner specializing in gynaecology or any other registered medical practitioner in a government hospital or a private hospital or clinic registered under the Private Hospital and Maternity Home Act, 1958 (No. 9) or in a place approved for the purpose by legislative instrument made by the Secretary:
- a. Where pregnancy is the result of rape or defilement of a female idiot or incest and the abortion or miscarriage is requested by the victim or her next of kin or the person in loco parentis, if she lacks the capacity to make such request;
 - b. Where the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health and such a woman consents to it or if

she lacks the capacity to give such consent it is given on her behalf by her next of kin or the person in loco parentis;

- c. Where there is substantial risk that if the child were born, it may suffer from or later develop a serious physical abnormality or disease.

For the purposes of this section Abortion or miscarriage means premature expulsion or removal of conception from the uterus or womb before the period of gestation is completed.

1.9 Rationale for the study

The high levels of maternal morbidity and mortality in Ghana are partly attributed to the high number of unwanted pregnancies, unsafe abortion and the relatively low use of modern contraceptives (18). Three out of every ten women of reproductive age in Ghana, had an unmet need for contraception in 2014 (19). The situation is even worse in rural areas where access to reproductive health services remains poor, and particularly so for the majority of the population who live in impoverished and isolated communities (18).

Currently in Ghana, the limited health infrastructure allows for the provision of safe abortion services mostly in government hospitals even though the service could as well be provided in government health centres and clinics as allowed by the law. Ipas, Marie Stopes International and some other NGOs in reproductive health are committed to providing financial and technical resources that enable the government to significantly expand women's access to modern contraception and Comprehensive Abortion Care (CAC) to reduce unwanted pregnancies and the severe complications and deaths caused by unsafe abortion within the remit of the law.

A successful expansion of safe abortion services to primary health care facilities would largely depend on midwives who are the frontline service providers in reproductive health care in

Ghana. Such midwives should be well motivated, knowledgeable of Ghana's abortion laws and ready to provide abortion service. To our knowledge, no study has been performed in Ghana, in order to explore the potential safe abortion services providers' perception, if the law was changed with less restrictions, with the aim to reduce the amount of unsafe abortions and with the ultimate goal to reduce maternal mortalities due to this cause. The aim of this study was to explore midwives' readiness in the provision of safe abortion services in primary health care facilities in Ghana.

1.10 Research questions

1. What are midwives' perception and attitudes to Ghana's abortion laws?
2. Are they ready to offer safe abortion services within the confines of the law?
3. What in their view could influence their decision whether or not to provide the service if it was made legal?

1.11 Objectives of the Study

1.11.1 Main objective

To understand midwives' readiness to be involved in increasing access to safe induced abortion care

1.11.2 Specific objectives

1. To explore the attitudes of midwives on the current laws on abortion
2. To get a deeper understanding of midwives' readiness to provide safe abortion services
3. To explore the factors that influence midwives' decision in the provision of safe abortion services

2.0 Methods

2.1 Study design

A qualitative study design was used to explore readiness of midwives in the provision of safe induced abortion services in primary health care facilities if abortion was made legal in Ghana. Individual in-depth interviews were preferred, due to the sensitive nature of the topic. We anticipated that discussing potential illegal matters in a group, could be a hindrance to get open and in depth information of their perceptions, which was the aim to explore. A qualitative study design was chosen, due to its ability to understand attitudes and perceptions of midwives on abortion services, which a quantitative survey would not be able to bring out.

2.2 Study setting

The study was conducted in the Mpohor district of the western region. The district has a population of 48,629 and it is part of the 46 new districts created in 2012. The Mpohor district was carved out from the Mpohor Wassa East district. The district is located at the south-eastern end of the Western Region. It is bounded on the west by Ahanta West District, east by Wassa East, north west by Tarkwa Nsuaem Municipal and Shama District Assemblies. The District capital is Mpohor, which is 19 km off the Takoradi-Agona Nkwanta main road. Majority of the inhabitants in the Mpohor district are in rural areas. The district has a government health centre, three clinics, five community-based health planning and services clinics and one company-owned clinic. The table on page 16 shows the projected population of Mpohor district.

Table 1: Mpohor district 2016 population

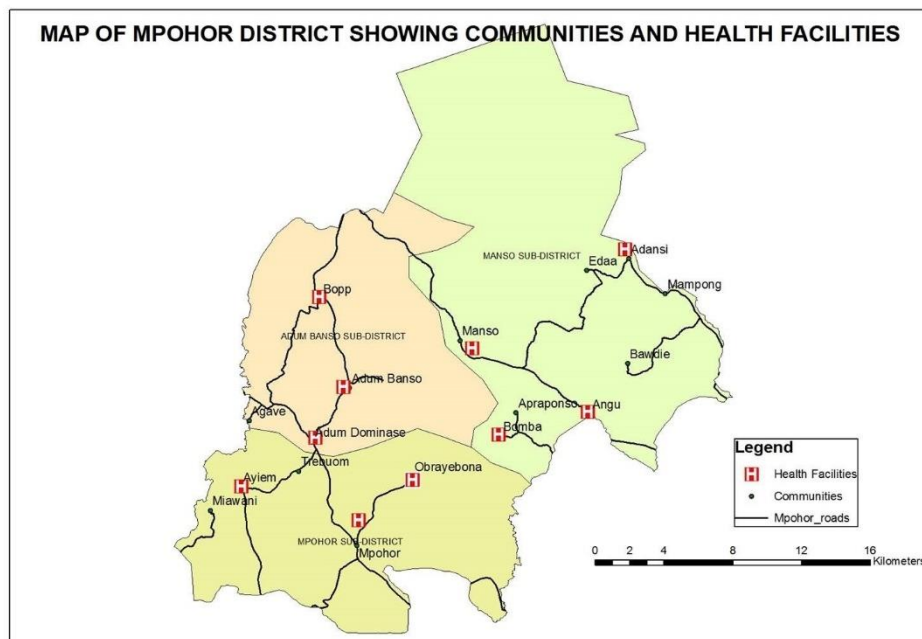
	Estimated Population	Total expected Pregnancies (4%)	Estimated WIFA population (24%)
Mpohor District	48,629	1,944	11,671

Source: District Health Sector Report, 2016

WIFA -Women in Fertility Age

There are no reliable national figures on induced abortions in Ghana recently and WHO estimates 28 procedures per 1,000 women (aged 14-44 years) in western Africa and same can be estimated in Ghana (6). An estimated 327 miscarriages and induced abortion were supposed occur in the Mpohor district in 2016 which the nine midwives were supposed to step in and provide safe abortion care within the law.

Figure 2: Map of Mpohor District showing major communities and health facilities



Source: District Health Sector Report, 2014

2.3 Study population

The population included practicing midwives in the Mpohor district of the Western region of Ghana. They were purposefully invited in order to get a broad variation of views. Inclusion

criteria was practicing midwives. No specific exclusion criteria were set due to age, gender, time of work experience, however no retired midwives were invited. All the practicing midwives in Mpohor district were approached for voluntary participation in this study.

2.4 Recruiting process

A nominal roll and phone numbers of midwives was received from the Human Resource Office of the District Health Directorate which showed a total nine midwives in the Mpohor District. Text messages were sent to all the nine midwives to inform them about the study. This was followed by sending printed copies of the consent forms to them. A second text message was sent to seek consent for voluntary participation. Seven of the midwives responded to take part in the study. A convenient date and time was agreed on with each of them for the interviews. All written material was available in both English and the local language Twi.

2.5 Data collection

The data for this study was collected using a semi-structured topic guide for individual in-depth interviews, covering areas such motivation to become a midwife, their individual attitudes to participate in abortions services and their knowledge of practices of unsafe abortion and the Ghana's laws on abortions. The interviews were conducted in Twi language, which participants were comfortable with and spoken by the interviewer, the author of this Master thesis. The interviews were recorded using a voice recorder after permission of the respondents. The recorded audios were transcribed verbatim and translated to English for analysis, in order to include the non-Twi speaking supervisor.

2.6 Data analysis

Content analysis, described by Graneheim and Lundman was used to analyse the data, in order to get the manifest meaning of the discussions (20). The analysis was made together with the supervisor in Norway. Transcripts were read several times by the researcher and supervisor to get familiar and be conversant with the text. Using Nvivo 11, the meaning units were condensed and coded. The coded groups were created into sub-categories, which were merged to categories, depending upon their adhering findings. The categories and subcategories were discussed between the researcher and supervisor until consensus was reached.

2.7 Ethical reflection

Ethical clearance was received from the Regional Committee for Medical and Health Research Ethics (REK) at NTNU, Norway and the Ghana Health Service Ethical Review Committee. Consent was also sought from the District Directors of Health Services and the study participants. Copies of ethical clearance are attached as appendices on page 39 and 41. Participants were informed that when the transcription from the recording were made the voice recording would be deleted. It will not be possible to trace back who said what during the individual interviews and results will only be provided on group level. If they had given consent, they could contact the researcher afterwards, if they would like to withdraw their consent. No monetary reimbursement was given to the participants.

3.0 Findings

Seven practicing midwives aged ranging from 31 to 58 years with an average age of 39 years participated in the study. Their years of working experience ranges from 2 to 20 years. The individual midwives are called in the quotes MW, with the numbers 1-7, and their age.

During the analysis, three main categories were identified from the individual in-depth interviews.

Table 2: Categories and subcategories from participants' responses

Categories	Subcategories
Motivation to be a midwife	Passion for maternal health
	Previous experiences
	Lack of professional opportunities
Unsafe abortions common and hidden	Stigmatization
	Unsafe abortion practices
The law and abortion	Knowledge
	Views on abortion law
	Willingness to provide safe abortion care

3.1 Motivation to be a midwife

3.1.1 Passion for maternal health

The participants expressed different motivations for choosing midwifery as a profession. A strong desire for improving the health of pregnant women was generally the motivation for choosing midwifery as a profession by the participants.

“My main motivation is to help improve the health of pregnant women and to help save their lives”. (MW2, 37)

“I wanted to provide care for pregnant women. I have a passion for the health of pregnant women”. (MW3, 32)

They were highly aware of the high mortality occurring among young pregnant women in Ghana and wished to improve the situation. The knowledge of mortality was a motivating factor for becoming a midwife and a fact that they desired to help reducing.

“I want to help reduce maternal mortalities”. (MW4, 32)

“I studied nursing before midwifery, so during my training as a nurse, I made up my mind that I needed to study midwifery so that I could help to reduce maternal mortalities”. (MW1, 58)

Midwives expressed worries that maternal mortality is high in deprived areas of the country due to the apparent low access to antenatal services. They emphasized that pregnant women in rural communities without health facilities are highly at risk of maternal death, and they showed motivation and readiness to work in rural areas to help improve access to safe motherhood.

“Woman in rural areas who are usually poor, do not have access to quality maternal health services during pregnancy. I did midwifery so that I could add to the few numbers of midwives so that maternal health will be accessible to pregnant women irrespective of where they live” (MW5, 31)

3.1.2 Previous experiences

The study revealed that participants became midwives due to previous experiences. They were influenced by what they and learnt and witnessed in the area they lived during their youthful years. These respondents witnessed they had heard a lot of stories of maternal deaths in their

community due to lack of access to maternal health care. This motivated them to become midwives so that they would help to save the lives of pregnant women in their community.

“When I was growing up I used to hear about women going into labour and dying especially in the community I was living and my mother also told me some history about issues and I also saw some myself, that a woman went into labour and died. I also heard stories like; a woman delivered at home and was bleeding, or...falling into unconsciousness and on rushing her to the hospital, the woman died. All this stories and what I heard encouraged me to study nursing and for that matter went ahead to study midwifery” (MW1, 58)

3.1.3 Lack of professional opportunities

Participants also disclosed that nothing special motivated them to become midwives. Becoming a midwife was the only available opportunity and not necessarily the desired profession. They admitted they became midwives only because they did not get opportunity to pursue their desired career.

“For me, nothing motivated me, I was interested in becoming a disease control officer. I opted for midwifery when I did not get the opportunity to study disease control. I needed to develop my career and midwifery was the only available opportunity” (MW7, 38)

3.2 Unsafe abortions are common and hidden

3.2.1 Stigmatization

Midwives admitted that unsafe abortion practices are common in the communities, but it is a hidden procedure, as abortion is perceived to be a taboo. They explained that, the society frowns on abortions and stigmatize those who seek abortion services and those providing the service alike.

“It is something that goes on in the communities and because of the stigma attached to abortion, women who do abortions always do it under the cover of darkness” (MW7, 38)

“... relating to unsafe abortion is unknown because of the way society perceive abortion. People hide to do it.” (MW3, 32)

Another opinion that came forward was that, the extent of unsafe abortion as a problem is still unknown because victims only sought their help when there are complications.

“People do it at the blindside of society, so it is something that goes on, but because of how society perceive it, we do not get to hear about it. It only comes to us when the victim suffers complications. When unsafe abortion is done and the victim does not suffer any complication, we do not hear about it”. (MW5, 31)

3.2.2 Unsafe abortion practices

The participants expressed worries about how pregnancies are terminated outside the health facility settings. They emphasized that, the methods used were very dangerous and were the cause of complications of unsafe abortions. Some of the crude ways women use to terminate pregnancies as mentioned by the midwives include; the use of herbal concoctions, administering un-prescribed drugs, grinded bottle mixed with Guinness (beer), insertion of cassava sticks. They meant that the use of misoprostol (Cytotec®), normally used in postpartum haemorrhages, was known and used illegally for termination a pregnancy.

“Some prepare herbal concoction and get it into the body through enema. The herbal concoction then forces the fetus to fall out. Some also use grinded bottle mixed with Guinness for enema. This is very dangerous!” (MW5, 31)

“Some use enema or drink all kinds of herbal concoctions, some insert cytotec into the vagina; yes, they know about cytotec! Some also drink un-prescribed drugs which they buy from the local drug stores”. (MW7, 38)

“Some insert herbs in the vagina. Some also use sticks; cassava stick, they insert it into the vagina”. (MW6, 51)

3.3 The law and abortion

3.3.1 Knowledge

Abortion is a crime under the laws of Ghana, but permitted under certain circumstance, example when the pregnancy is as a result of rape or incest, affects the psychology of the woman, when pregnancy is life-threatening, or there is foetal malformation. A common misunderstanding in the interviews was concerning the legality of performing an induced abortion. Midwives could not demonstrate a good understanding of the abortion laws and misinterpreted the nature of Ghana’s abortion laws and meant that abortions are legal in Ghana. This interpretation was apparent in both old and young midwives.

“I know that abortion is legal under the law so if someone walks in and you are trained, you can do it for the fellow. Also, if a pregnant woman attempts an unsafe abortion, you can complete it for her”. (MW5, 31)

“Abortion is legal in Ghana. If you get pregnant and you feel you do not want it, the law allows you to terminate the pregnancy”. (MW1, 58)

3.3.2 Views on the current abortion law

There was a general perception that, legalizing abortion and making it accessible would increase the number of abortions that occur in the country. The participants who had the correct knowledge and view on the Ghana's abortion law, thought that the law is good in its current state. They meant that abortions should not be wholly legalized.

“I do not support the termination of any pregnancy outside what the law allows. I feel that the law is good” (MW7, 38)

“Providing safe abortion services should be done within the remit of the law. It should not like abortions to be allow for every unwanted pregnancy. But if it affects the health of the pregnant women, then why not! Such a pregnancy can be terminated and that is what the law allows” (MW4, 32)

3.3.3 Willingness to provide safe abortion care

The participants expressed mixed views as to whether or not to provide safe abortion care in their facility if it was legalized and could be provided on maternal request. In spite of their concerns on maternal mortalities and the habit of unsafe, hidden abortion, they felt it was against their religious belief and it is sinful and would not want to be involved. Those who shared this view were however ready to help in situations of incomplete abortions, miscarriages.

“I am not ready and I am not willing to provide comprehensive abortion services where a woman can just walk to me and ask for an unwanted pregnancy to be terminated. The best I may offer is when the woman comes with an incomplete abortion, in that case, I will help complete the abortion for her. I would rather refer a woman who need comprehensive abortion care to the nearest health facility where the service is provided”. (MW1, 58)

“Seriously for me, it is against my religious belief and that does not allow me to provide abortion services. I can provide clients with pre-abortion counselling, but not to do the actual abortion”. (MW4, 32)

Others felt that even though abortion was against their religious belief, they are ready to provide abortion care, within the remit of the law in order to save lives. They were of the opinion that; it is always better to save lives than to allow them perish from preventable causes.

“Providing safe abortion services and making it readily available and accessible is one way of preventing maternal deaths. For me, I am ready and willing to provide the service.... though my religion frowns on abortion, but I see this profession as a duty call devoid of religious and moral judgement. It’s more important that our women do not die from these kinds of avoidable deaths”. (MW2, 37)

4.0 Discussion

There is an urgent need to address the setbacks that hinder the progress in maternal health in the developing world. Unsafe abortion is undoubtedly a public health problem in Ghana and much attention is needed in addressing the menace. The Government of Ghana has made a commitment to the SDGs. Ghana is committed to reducing maternal mortality ratio to 70 per 100,000 live births by 2030 (21). Legalizing abortion and making it accessible and affordable will be a giant step to reducing the high maternal mortality ratio in Ghana.

In the Ghanaian culture, women are seen to be humble, caring and passionate when things go wrong around them. In Ghana, midwifery is apparently a reserved profession for women. The study reveals the same passionate attitude among midwives towards maternal health care in Ghana. Majority of the midwives in this study decided to become midwives because they wanted to care for pregnant women in their communities. They have so much concern for reducing maternal deaths. As a result, they share their frustrations on the seeming increase of unsafe abortions in their communities which contribute more to maternal deaths. This is similar to a study in Papua New Guinea in which students studying midwifery expressed similar motivation for choosing their profession (22).

Another finding of the study is the low level of understanding among midwives on the abortion law in Ghana. Most of the midwives could not clearly state the position of the law regarding safe abortion care. Abortion is illegal in Ghana since the Ghana constitutions referendum and independence 1960 (Criminal Code of Ghana, 1960). This makes it a criminal offence except under conditions such as medical, incest, rape and must be done by registered qualified person at a medical facility registered by the law. Contrary to this law, most midwives in this study believe abortion is legalised in Ghana and hence any person who does not want a pregnancy

can freely walk into any health facility for safe service. This finding contradicts the high level of knowledge found among doctors in a similar study in Ghana (1).

Although some participants showed strong feelings about unsafe abortions and its consequences, any modification of the abortion law to make it legal was not appreciated. This would mean that health professional and midwives would play a key role. Moreover, a successful implementation of any health sector reform is dependent on its acceptance and also the willingness of health professionals to implement the desired change.

Participants expressed mixed views on the provision of abortion services if it was legalized. Religious belief appeared as a major reason why some midwives would not want to offer abortion services in their facility, but would only assist in cases of incomplete abortion. This attitude is likely to hinder midwives from providing safe abortion services in primary health facilities in Ghana as found in other studies (11). They were however ready to help those who need the service by referring them to the nearest health facility where the service is available. Religious belief did not prevent some midwives from providing abortion care because they perceived their profession as a duty call and need to help prevent deaths from unsafe abortions.

4.1 Trustworthiness

Measures were taken to ensure credibility of this study (23). This was achieved through collaborative effort from the Ghanaian researcher (Master student) and the supervisor in Norway and co-supervisor in Ghana. The researcher is a fluent Twi speaker and familiar with the study settings. The main supervisor is an obstetrician/gynaecologist, with experiences of reproductive health research in Africa and other developing regions. Furthermore, she is knowledgeable in using qualitative research methods. The co-supervisor is also a public health physician who has a publication on unsafe abortion to his credit. A semi-structured interview

guide, audio recording of interviews, verbatim transcription and a systematic process of data analysis were done to enhance confirmability of the results from this study. Transferability is achieved with a detailed description of the methodology used in this study. In addition to the detailed description of the methods, the same researcher conducted all seven individual in-depth interviews within a period of one month to increase consistency of data and to achieve dependability.

4.2 Strengths and limitations of the study

The researcher conducted the interviews in the local language (Twi) which the participants the researcher could speaker fluently and understand. The background of researcher in public health the supervisor's in reproductive health, was a strength and facilitated this study. A strength was to make this interviews individually. A limitation could be that only nine midwives were available in the chosen district. However, the researcher felt that the midwives spoke freely and openly about their feeling and perceptions regarding abortions, and no more information came up after five-sixth interviews, and the material was considered saturated. More information could have surfaced if doctors and community members had been included in this study, however this was not the aim for this first study.

5.0 Conclusion

Based on the above findings, this study can conclude that, there is a challenge to increasing access to safe abortion care in Ghana. In this case, there are legal indications in order to avoid unsafe abortions. Midwives were motivated by their passion for improving maternal health, but their religious belief was a major hindrance for them to provide legal induced abortion services.

Recommendation from this study adopted the framework of the Social Ecological Model (SEM). This model contrary to most health behaviour theories argues that individual behaviour is shaped by factors at multiple levels, including individual, community, and policy levels in addition to intrapersonal and interpersonal levels (24).

Individual level

The midwife needs training and the necessary equipment to enhance service provision. Supervision, support and orientation on behaviour are necessary to boost confidence in providing safe abortion care.

Community level

The community must be made aware that the high maternal deaths in Ghana are partly because of unsafe abortions. Awareness of the possibility to save lives if abortion was legal and discussion with religious leaders are necessary steps in making a change. Also, contraceptives should be made readily accessible, affordable and accepted for use at the community level.

Policy level

A change in the current law on abortion to make abortion legal and making the service accessible and affordable are also necessary.

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APPENDIX

Participants Information Sheet

Request for participation in a research project

“The midwife at the forefront of increasing access to safe abortion care in primary health care facilities in Ghana: A qualitative study”

My name is Prince Oppong-Darko and I am a Master student in Global Health at the Norwegian University of Science and Technology (NTNU). I am now conducting data collection for my thesis. This is a request for your voluntary participation in a research study, which intends to explore midwives’ perception of safe abortion services. You have been selected, as you are a midwife in Ghana.

Brief Background

The high levels of maternal morbidity and mortality in Ghana are partly attributed to the high unwanted pregnancy and unsafe abortion and the relatively low use of modern contraceptives. The situation is even worse in rural areas where access to reproductive health services remains poor, and particularly so for the majority of the population who live in impoverished and isolated communities.

The Ministry of Health and Ghana Health Service developed standards and protocols in the provision of comprehensive abortion care in 2006. In this protocol, midwives and medical assistants with midwifery training are authorized to provide early legal abortion in accordance with the law.

Any quest to extend a functional safe abortion services in primary healthcare facilities would depend on a motivated midwife who has a good knowledge of Ghana’s abortion laws and ready

to offer the service. Hence, this study seeks to explore midwives' readiness in the provision of safe abortion services in primary health care facilities in Ghana.

The study will be an interview on topics regarding abortions. No examinations, samples or filming will be performed. However, if you agree, I will record our discussion and transcribe it. Afterwards the recording shall be deleted. My supervisor, who is Norway and myself will discuss the results.

Benefits

I anticipate that the participants in this study will not gain any direct advantages nor any disadvantages or discomforts. The results will nevertheless be important to decision-makers or stakeholders in the health sector of Ghana.

Confidentiality

The interview material I collect will only be used in accordance with the purpose of the study as described above. I will only register your first name and age. All the data will be processed without name, ID number or other directly recognizable type of information. It will not be possible to identify you as one of the participants. Only I and my supervisor will have access to the data collected. No list of names will be kept. Transcripts of the interviews will be kept on my computer using a password to get access to it. It will be deleted after the study is finished. The result will be published in an international journal without any possibility to identify you.

Voluntary Participation

Participation in the study is voluntary. You can withdraw your consent to participate in the study at any time and without stating any particular reason. This will not have any consequences.

If you wish to participate, sign the declaration of consent on the final page. If you agree to participate at this time, you may later on withdraw your consent without being affected in any way. If you later on wish to withdraw your consent or have questions concerning the study, you may contact my supervisor, myself or any of the contacts below.

Prince Oppong-Darko

Master student, NTNU

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Elisabeth Darj

Professor at Norwegian University of
Science and Technology (NTNU)

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Hannah Frimpong

Administrator, Ghana Health Service Ethics Committee

Research and Development Division, GHS, Accra

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Consent for participation in the study

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any question I have asked have been answered to my satisfaction. I consent voluntarily to participate as a subject in this study and understand that I have the right to withdraw from the study at any time without in any way affecting my further medical care.

I am willing to participate in the study

(Signed by the study participant, date)

I confirm that I have given information about the study

(Signed, role in the study, date)

Guide for interview with Practicing Midwives, 2016

- 1. What motivated you to become a midwife?**
- 2. What do you know about unsafe abortion?**
- 3. To what extent is unsafe abortions a problem in your catchment area?**
- 4. How do women terminate unwanted pregnancies outside the health facility settings?**
- 5. What does Ghana's law on abortion says? (In summary)**
- 6. What is your position on the law on abortion?**
- 7. What is/will be your attitude towards the provision of safe abortion services in your facility?**
- 8. What factors may influence your decision whether or not to offer abortion services?**

Ethical clearance from the Regional Committee for Medical and Health Research Ethics (REK) at NTNU



Region:	Adviser:	Telephone:	Our Date:	Our Ref.:
REC South East	Hege Holde Andersson	22845514	01.07.2016	2016/874
			Your Date:	
			03.05.2016	

Elisabeth Darj
NTNU

2016/874 Jordemor i fremkant for økande bruk av sikker aborter i primær helsetjenesten i Ghana: en kvalitativ studie

We are writing in reference to your Application for Preliminary Approval for the above-mentioned Research Project. The Regional Committee for Medical and Health Research Ethics, Section B, South East Norway, reviewed your Application during its meeting on the 1th of June 2016. The Project was assessed in accordance to the Norwegian Research Ethics Act § 4 2006, and the Health Research Act § 10 2008, for Regional Committees for Medical and Health Research Ethics

Institution responsible for research: NTNU
Project Manager: Elisabeth Darj

Project description

The high levels of maternal morbidity and mortality in Ghana are partly attributed to the high unwanted fertility and unsafe abortion. The situation is even worse in rural areas where access to reproductive health services remains poor. This study seeks to explore midwives readiness in the provision of safe abortion care in primary health facilities. The objectives of this study include; i)To explore the knowledge of midwives on the current laws on abortion ii)To examine midwives' readiness to provide safe abortion services iii)To explore the factors that could influence midwives decision in the provision of safe abortion services. Study design: Qualitative study design Study population:Practicing midwives in primary health care facilities. Sampling method:Convenient sampling Data collection:Recording of in-depth interview using a semi-structured interview guide Data analysis:Materud's systematic text condensation Benefits:To policy-maker for future extension of abortion services.

Review

The research project aims to: *understand midwives readiness to be involved in increasing access to safe abortion care.*

Research questions:

- *Are midwives knowledgeable about Ghana's abortion laws?*
- *Are they ready to offer safe abortion services within the confines of the law?*
- *What factors could influence their decision whether or not to provide the service?*

Paragraph 4 of the Health Research Act defines Medical and Health Research as “*activity conducted using scientific methods to generate new knowledge about health and disease,*”

In reference to paragraph 4, the Committee finds that the remit of the project falls outside of the scope of the Health Research Act.

Besøksadresse:
Gullhaugveien 1-3, 0484 Oslo

Telefon: 22845511
E-post: post@helseforskning.etikkom.no
Web: <http://helseforskning.etikkom.no/>

All post og e-post som inngår i saksbehandlingen, bes adressert til REK sør-øst og ikke til enkelte personer

Kindly address all mail and e-mails to the Regional Ethics Committee, REK sør-øst, not to individual staff

Approval is therefore not required by REC in order for the research project to be implemented.

The Committee's Decision

The Regional Committee for Medical & Health Research Ethics, Section B, South East Norway, find the Research Project to be outside the remit of the Health Research Act 2008 and therefore can be implemented without its approval.

Appeals process

The decision of the Committee may be appealed to the National Committee for Research Ethics in Norway. The appeal will need to be sent to the Regional Committee for Research Ethics, Section B, South East Norway. The deadline for appeal is three weeks from the date on which you receive this letter.

With kind regards,

Grete Dyb
Chair of the Regional Committee for Medical &
Health Research Ethics of South East Norway, Section B

Hege Holde Andersson
Committee Secretary

CC:
- *Management of Administration, NTNU*

Ethical clearance from Ghana Health Service Ethics Review Committee

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

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



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My Ref. GHS/RDD/ERC/Admin/App/16/183
Your Ref. No.

Prince Opong-Darko
P. O. Box 1632
Sunyani

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

GHS-ERC Number	GHS-ERC 12/09/16
Project Title	“The Midwife at the Forefront of Increasing Access to Safe Abortion Care in Primary Health Care Facilities in Ghana: A Qualitative Study”
Approval Date	27 th October, 2016
Expiry Date	26 th October, 2017
GHS-ERC Decision	Approved

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report **after completion** of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....
DR. CYNTHIA BANNERMAN
(GHS-ERC CHAIRPERSON)

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