



Table 33: Motivational factors that encourage health workers to participate in provision of SAC as permitted by law (n=393)⁶⁸

	%
Desire to help reduce maternal death and disabilities in Ghana	75.6
Desire to help women avoid the injuries from self-induced or badly performed abortions	73.5
Desire to help restore women's physical and mental health when they have been the victims of forced sex, rape or incest	65.4
Desire to provide comprehensive care for my patients	59.8
Belief in the rights and responsibilities of my patients to make their own moral choices	49.6
Desire to bring safe abortion (as permitted by the law) into the public domain and under the jurisdiction of the GHS in order to improve the quality, transparency and lower costs	48.1
Desire to be competent in as many aspects of clinical reproductive health care as possible and thus expand my marketability and my career opportunities in this field	43.8
Desire to prevent suffering of families having more children than they can adequately support	43.3
Desire to help pregnant school girls who otherwise will forfeit their education and their economic future	39.4
Desire to foster a supportive environment for abortion access and abortion providers within the medical community	36.9
Desire to see only wanted children brought into the world	32.6
Desire to provide the same opportunity to obtain safe abortion services as I/my partner had when I/she needed an abortion	23.4

⁶⁸ As many as 20% of respondents chose not to answer the questions regarding hopes and hesitations. This high degree of nonresponse is indicative of the highly sensitive nature of the topic.



Table 34: Comparison of motivations between those willing and those unwilling to offer MVA up to 12 weeks (n=393)

	Total (%)	Not willing (%)	Willing (%)	Odds ratio (95% confidence interval)
Desire to help women avoid the injuries from self-induced or badly performed abortions	73.5	56	80	3.1 (CI 1.8-5.4)
Desire to help reduce maternal death and disabilities in Ghana	75.6	65	80	2.3 (CI 1.4-4.1)
Desire to help restore women's physical and mental health when they have been the victims of forced sex, rape or incest	65.4	56	74	2.2 (CI 1.7-3.8)
Desire to provide comprehensive care for my patients	59.8	55	70	1.8 (CI 1.1-3.1)
Desire to see only wanted children brought into the world	32.6	30	63	4.9 (CI 2.3-6.7)
Desire to foster a supportive environment for abortion access and abortion providers within the medical community	36.9	22	49	3.4 (CI 2.0-6.0)
Desire to help pregnant school girls who otherwise will forfeit their education and their economic future	39.4	32	46	1.9 (CI 1.1-3.2)
Desire to provide the same opportunity to obtain safe abortion services as I/my partner had when I/she needed an abortion	23.4	11	32	3.7 (CI 1.8-7.9)

Health workers who report willingness to offer MVA up to 12 weeks were significantly more likely to report commitment to overarching societal goals and values. Potential providers were more likely to express a desire to reduce maternal death and disability in Ghana (80% versus 56%) and a desire to address the health consequences of sexual violence (74% versus 56%) than those who would not provide CAC. Health workers interested in offering early abortion care were more likely to report an interest in providing comprehensive care for patients (70% versus 55%), a desire to see only wanted pregnancies brought to term (63% versus 30%), a desire to foster a supportive climate for abortion access (49% versus 22%), and a desire to assist pregnant youth (46% versus 32%). On a personal level, those willing to offer CAC were slightly more likely to report that they were motivated by need for termination that they or their partner had experienced in the past (32% versus 11%).



Concerns regarding participation in SAC as permitted by law

Whether or not staff are interested in participating in SAC, they expressed a number of concerns. The most frequent concern expressed by health workers was a perceived religious conflict (50.2%). This hesitation was followed by uncertainties about circumstances when Ghana's law permits abortion (47.8%) and uncertainties of the policies and procedures for providing safe abortion (37.9%). Legal liability (36%) and administration opposition (33.3%) were identified by one-third of those surveyed. Health workers were infrequently concerned with their reputation with medical colleagues (16.3%), clinical competence if safe abortion is offered only occasionally (20.4%) and reactions of friends and relatives who oppose abortion (21.4%).

Table 35: Concerns that might preclude health-worker participation in SAC as permitted by law (n=406)

	%
Perception that safe abortion is contrary to health workers' religious beliefs	50.2
Uncertainty of the circumstances when Ghana's law permits abortion	47.8
Uncertainty of the process for providing safe abortion	37.9
Concern about legal problems	36
Perception of lack of support from hospital administration	33.3
Perception that safe abortion is contrary to health workers' oath to do no harm	31.5
Concern for health workers' reputation in the community	25.4
Perception that it is personally objectionable	24.4
Concern for reaction by friends and relatives who oppose abortion	21.4
Concern about clinical competence if safe abortions are offered only on an occasional basis	20.4
Concern for health workers' reputation with medical colleagues	16.3

On average, those who are willing and those who are not willing to offer MVA for procedures less than 12 weeks reported three hesitations from a list of potential concerns. However, their specific hesitations tended to be different. Those who were not willing were significantly more likely to report feeling hindered by a perceived religious conflict (66% versus 42%). Those who were willing to provide legal abortion were more likely to be concerned with practical considerations such as perceived administrative opposition (46% versus 22%), legal uncertainty (55% versus 45%) and potential liability issues (44% versus 30%).



Table 36: Comparison of hesitations between those willing and those unwilling to offer MVA up to 12 weeks (n=393)

	Total (%)	Not willing to offer MVA up to 12 weeks (%)	Willing to offer MVA up to 12 weeks (%)	Odds ratio (Confidence Interval)
I would be concerned about lack of support from hospital administration.	33.3	22	46	3.0 (CI 1.8-5.1)
I lack a clear understanding of the circumstances when Ghana's law permits abortion.	47.8	45	55	2.1 (CI 1.3-3.3)
I would be concerned about legal problems.	36.0	30	44	1.7 (CI 1.1-2.9)
Abortion as permitted by the law is contrary to my religious beliefs.	50.2	66	42	.37 (CI .23-.61)

Cost of comprehensive abortion services

Staff were asked about the current fees for PAC and CAC services as well as their attitudes toward user fees in general. The median fee for MVA was significantly lower than the fee for D&C in most service models except ambulatory legal abortion in which the same median fee was charged. Due to nonresponse, the fee information was based on reports from a very small number of facilities (five) and should be interpreted with caution.

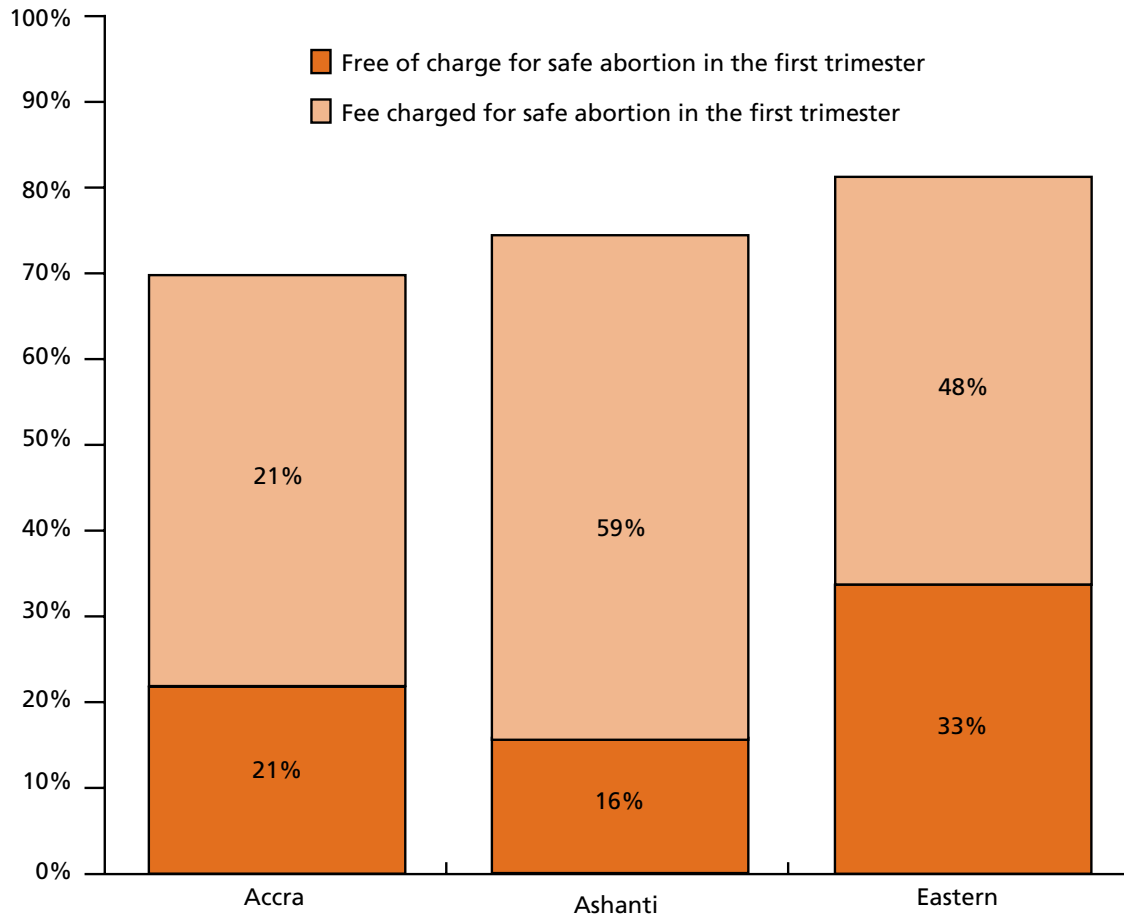
Table 37: Fees for uterine evacuation by technique and service (n=5)

Diagnosis	Service	Evacuation technique	Median fees charged (in cedis)	Fee range (in cedis)
PAC	in-patient	D&C	300,000	66,000-500,000
		MVA	200,000	0-500,000
	ambulatory	D&C	300,000	80,000-300,000
		MVA	200,000	0-300,000
Legal abortion	in-patient	D&C	450,000	300,000-500,000
		MVA	350,000	300,000-500,000
	ambulatory	D&C	300,000	250,000-300,000
		MVA	300,000	150,000-300,000



In addition to information about current fees, health-worker and manager attitudes toward fees were also surveyed. Slightly more than half of respondents surveyed (51.8%) indicated that safe-abortion services should be fee-based, whereas 23% favour the provision of services free of charge.

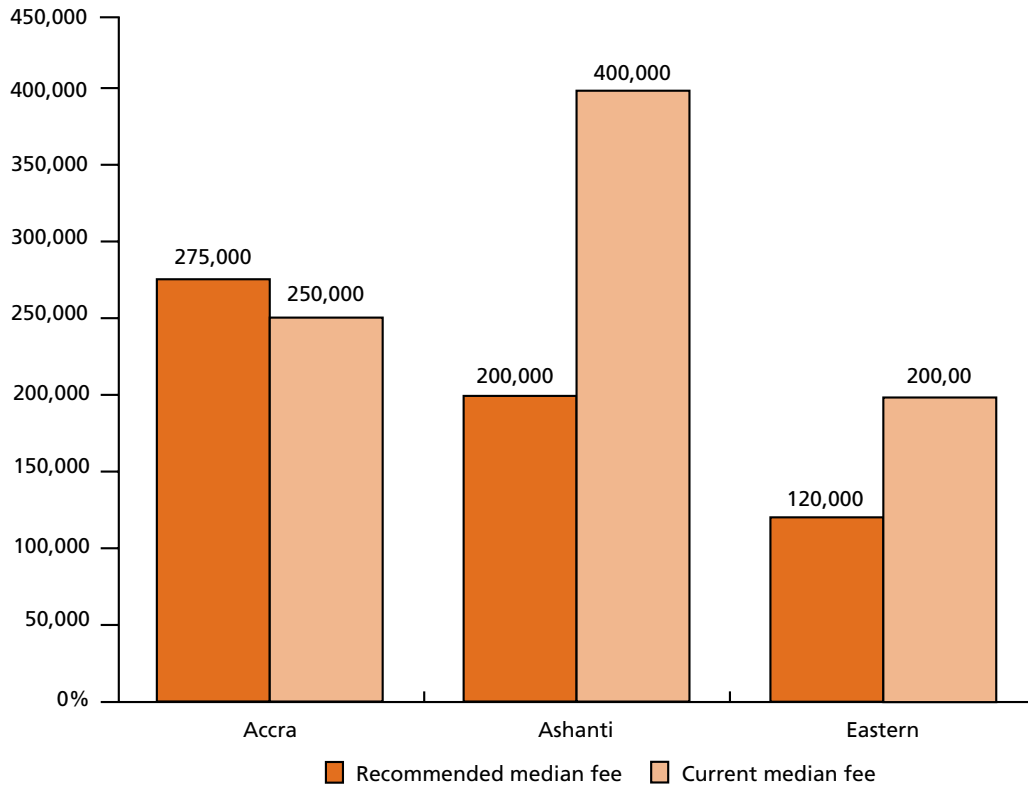
Figure 14: Health-worker attitudes toward the charging of fees for provision of SAC in the first trimester in accordance with the law (n=513)⁶⁹



⁶⁹ Individuals who oppose providing legal abortion in public facilities could decline to answer this question, so totals do not always add up to 100%.



Figure 15. Current versus recommended charges for legal abortion by region



The current median fee for legal abortion in the first trimester was highest in Ashanti Region (400,000 cedis), with the Eastern Region having the lowest median fee of 200,000 cedis. Among those who believe that fees are warranted, Ashanti and Eastern Regions recommended lower fees for early abortion care, ranging from 120,000 to 200,000, while Greater Accra Region recommended a higher fee than the reported median (250,000 to 275,000 cedis). The recommended mean fee was 200,000 cedis.

In terms of the distribution of fees, 41.5% of health workers felt that abortion providers should receive a portion of fees collected in the public sector. A slightly larger proportion (45.8%) was against compensating clinicians extra for abortion care, and 12.9% were undecided.



Financial burden for families

If the annual out-of-pocket cost of incomplete abortion for women and families based on the median fee of 250,000 cedis (US\$27.78) reported in this study is applied to the national estimate of 105,720 PAC cases per year, the total direct cost to households is estimated at US\$2,936,901. If one includes the additional financial burden of the estimated 20% of cases that require more comprehensive care (for example, surgical intervention) estimated to cost as much as 2.5 million cedis (\$289) per case,⁷⁰ the total cost burden on families of treating incomplete abortion is estimated to be US\$8,460,137 annually.⁷¹

If half of these women were to qualify for early induced abortion under Ghanaian law and receive a safe, high-quality service for the fee recommended by the health workers surveyed (200,000 cedis), the overall financial savings for families would be estimated at as much as US\$3,030,194.

Staff priority strategies for reducing abortion-related maternal mortality

The rank-ordered strategies recommended by health workers for reducing abortion related mortality in Ghana:

1. Prevent unwanted pregnancies through a combination of education and expanded access to contraception (particularly for young people) [63.6% (n=276)].
2. Implement the abortion law and increase the accessibility and affordability of safe abortion [17.4% (n=76)].
3. Provide moral education, abstinence education, and faith-based approaches to prevent sex, pregnancy, and abortion [8.9% (n=39)].
4. Discourage unsafe abortion through education about its dangers [7.8% (n=34)].
5. Treat complications of unsafe abortion in a timely, expert manner [2.3% (n=10)].

Community outreach and referral

Most facilities (84.4%) surveyed reported having an outreach programme where facility staff go into local communities on a regular basis to deliver services. When asked what types of community-health workers refer women to public facilities for abortion care, 14.6% reported community-health nurses (CHNs), 14.6% identified traditional-birth attendants (TBAs), 6.1% reported referrals by community-health officers (CHOs), and 2.4% mentioned community-based distributors (CBD) as referring women for care.

⁷⁰ Abbey, Mercy. 2004. *Report on Pre-Testing of Instruments for Data Collection and "Savings" Cost Model in Accra, Ghana*. Unpublished Ipas report uses the 2004 exchange rate of \$1 US to 8,650 cedis.

⁷¹ Gebreselassie et al. (2005) found 28% of Kenyan women need additional services, whereas Jewkes et al. (2002) found 10% of South African women needed additional interventions for treatment of incomplete abortion.



Study limitations

Studies on sensitive subjects often experience underreporting and high rates of nonresponse. In this study, we identified some intentional underestimates of service provision. There was a lack of log books to verify provider estimates. Clinical records for the assessment of quality of care were similarly absent. Cost data were seldom provided. Therefore, national caseload and cost projections are based on a small sample that is not generalizable. These projections should be regarded as very preliminary estimates of the true morbidity and financial burden. The cost estimates do not take into account the new insurance programme being implemented in Ghana.

Study-respondent recruitment logs were misplaced and therefore the refusal rate and reasons for refusal for the health worker and managers surveys are unknown. This limits the generalizability and reliability of the attitudinal data presented. If nonparticipation was related to attitudes about CAC or LTPM, then the results may not be a valid reflection of current beliefs on these topics. However, given the diversity of opinions expressed and the procedures used to guarantee anonymity, it is unlikely that nonresponse significantly impacted the results.

Recommendations

1. It is vital to engage all stakeholders in the dissemination and enforcement of Ghana's national reproductive health policies and protocols to improve access to life-saving emergency care as well as preventive care, including legal abortion. This includes the dissemination of the abortion law; LTPM and 2006 CAC Standards and Guidelines; and related policies on sexual and gender-based violence to service providers, managers and facility leadership.
2. The R3M partners should cooperate intensely to integrate CAC and LTPM as part of the unified plan to reduce maternal mortality and morbidity, because health workers perceive the two services as part of a broader initiative.
3. It is critical for the R3M to work with medical associations, the Ghana Registered Nurses and Midwives Council and other midlevel-provider associations to educate and change attitudes regarding the role of midlevel providers in comprehensive reproductive health services.
4. A referral strategy is needed for the public-health centres that lack the staffing and infrastructure to offer LTPM and CAC in the immediate term.
5. The study highlights the need for effective values clarification and education to help health workers understand the root causes of and relationships between unwanted pregnancy, abortion, sexual violence, mental health and maternal morbidity and mortality.
6. An equipment-sustainability plan is needed to address gaps and shortages in essential equipment and commodities for LTPM and CAC in the public sector, including MVA.
7. Clinical training in PAC, MR, nonjudgmental counseling and long-acting or permanent contraception and early legal abortion may need to precede training in second-trimester legal services, due to the greater acceptance of these skills and services.



8. The language of the R3M programme should be sensitive and reflective of health workers' preferences for "menstrual regulation" and other nonstigmatizing terms for uterine evacuation.
9. An outreach strategy is essential to educate women, policymakers and the general public (including adolescents) on pregnancy and unsafe abortion prevention and to increase awareness of services.
10. Government authorities must register and include misoprostol and mifepristone on the essential-drugs list to increase women's access to important technologies for the prevention of maternal morbidity and mortality.
11. The GHS should strengthen services at the primary levels (health centres and maternity homes) through capacity building, equipment provision and training.
12. The GHS should support supervisors and managers to ensure compliance with the GHS Code of Ethics, GHS Patients Rights, GHS Code of Conduct, CAC Standards and Guidelines and conscientious-objection policies.
13. The GHS should support physicians and midwives in offering services despite societal stigma and hesitations regarding legal LTPM and CAC services and provision by midlevel cadres in particular.
14. The GHS should support research on CAC costs and ability to pay, which is needed to inform the development of a uniform pricing policy for services.
15. Community-based research on care-seeking behaviour for abortion services and how best to address societal-attitudinal barriers to CAC and FP services is needed.
16. Public/private sector collaboration should be promoted by actively strengthening collaboration with bodies such as the Ghana Registered Midwives Association (GRMA) and the Society for Private Medical and Dental Practitioners (SPMDP).
17. Given the underreporting of existing services, it is vital to develop and support simple management information systems for CAC and contraception to assure documentation and quality of services.
18. Incorporating LTPM and CAC into existing quality-improvement (QI) programmes is important to guarantee quality and coherence with GHS standards of care.

Conclusions

The assessment provides baseline information on the readiness to provide CAC services in public facilities in the selected districts of the three regions in the following areas: infrastructure availability, knowledge, attitudes and available skills, as well as willingness and comfort in RH-service provision with emphasis on CAC. Generally there is a favourable disposition toward the prevention of unwanted pregnancy through the promotion of FP and the provision of CAC services to reduce maternal mortality and morbidity. Key challenges and recommended action steps have been identified. The full implementation of the policy mandate now becomes the shared task of all who value Ghana's women and families.



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Appendix I

The current law on abortion in Ghana

In Ghana abortion is a criminal offence regulated by Act 29, section 58 of the Criminal code of 1960, amended by PNDCL 102 of 1985. It states that:

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.
3. 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.(9)

