ABSTRACT

Introduction: Despite abortion being legal, complications from induced abortion are the leading cause of maternal mortality in Ghana.

Objective: The objective of this study was to understand the decision-making process associated with induced abortion.

Methods: We collected data from female postabortion care patients, male partners, family planning nurses, and obstetricians/gynecologists at the two teaching hospitals in Ghana using in-depth interviews and focus group discussions.

Results: While experiences differ for married and single women, men are involved in abortion decision-making directly, through "orders" to abort, or indirectly, through denying responsibility for the pregnancy, women may or may not disclose the pregnancy to their male partners, and health providers may actually be barriers to healthcare in this setting.

Conclusion: While results suggest that targeting men may be important, there are substantial gender norms to overcome in order to prevent unsafe induced abortions in Ghana. Women who choose to terminate without their male partners' knowledge should have the means to do so safely. Interventions with nurses should discourage judgmental attitudes and emphasize individually focused patient care.

INTRODUCTION

The leading cause of maternal death in Ghana is complications from unsafe abortion (Baiden et al. 2006). The maternal mortality ratio in Ghana has been estimated at 540 maternal deaths per 100,000 live births (UNFPA 2003), and the rate of unsafe abortions is 31 per 1000 women (WHO 2003). According to a national needs assessment performed by the Ghana Health Service, abortion-related deaths are responsible for 22 to 30% of all maternal deaths (GHS 2005), in comparison to the worldwide estimate of 13% (WHO 2007). Given the minimal risk of an induced abortion procedure when performed by health professionals with the appropriate equipment and sanitary conditions, the loss of maternal life from abortion complications makes this public health topic particularly poignant (WHO 2007).

The contraceptive prevalence rate in Ghana is quite low, at 21%. Furthermore, the modern contraceptive prevalence rate is even lower at 15% (GSS, NMIMR, and ORC Macro 2004). At these levels of contraceptive protection in Ghana it would be reasonable to expect a significant number of unintended pregnancies and births. In fact, the total fertility rate is just 4.4 births per woman (GSS et al. 2004). The difference in the contraceptive prevalence rate and the total fertility rate is quite astonishing, and it is thought that the deficit in births may be compensated with induced abortion (Blanc and Grey 2002; Bongaarts and Westoff 2000). The induced abortion rate in Ghana has been estimated to be between 11 and 19 per 100 pregnancies (Oliveras et al. 2008).

In 1985, the law in Ghana regarding induced abortion was modified (Law No. 102 of 22 February, 1985). The law prior to 1985, governed by the Criminal Code of 1960 (Act 29, sections 58-59 and 67), stated that induced abortion was prohibited unless the pregnancy endangered the woman's life. Anyone providing or self inducing an abortion could be fined and/or imprisoned at a maximum of 10 years (PNDC 1985). After 1985 the law changed, and the induced abortion law now articulates that abortion is not an offense if it is "…caused by a medical practitioner specializing in gynecology or other registered practitioner in a government hospital or registered private hospital or clinic when the pregnancy is the result of rape, defilement of a female idiot, or incest; when continuation of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health; or where there is substantial risk that if the pregnancy were carried to term the child would suffer from or later develop a serious physical abnormality or disease…" (PNDC 1985).

The law now includes most physical and emotional reasons for seeking an abortion. However, the elevated rate of unsafe abortions and complications from unsafe abortions has been sustained in Ghana. Although abortion is legal in Ghana, most women, men, and health providers are not aware that this procedure is legal, creating a situation in which many abortions in Ghana are unsafe. This disparity between the law and reality in regards to abortion has been noted as a cause for unsafe abortion (WHO 2007) and has been observed in two other countries, India and Zambia for example, where abortion is legal

yet unsafe abortions still prevail due to misinformation about the legality of abortion and/or the lack of advertised, accessible, and nonjudgmental safe abortion services (Grimes 2003).

Research is needed in the area of pathways to induced abortion and its significant subset of unsafe abortions in Ghana in order to target interventions to those in the population at highest risk. In an effort to better understand the pathways in Ghana and the role male partners and health providers play in those pathways, qualitative methods were utilized to explore the decisions women and men take when faced with an unwanted pregnancy.

METHODS

Focus group discussions were chosen to obtain information on the socially sanctioned attitudes and beliefs. To engage study participants in a more intimate discussion, in-depth interviews were also utilized to obtain information on personal views and experiences. Using both data collection techniques allowed the researcher the ability to examine the topic from multiple perspectives drawn from group settings and one-on-one interviews. Focus group discussions and in-depth interviews with female postabortion patients, male partners, family planning nurses, and obstetricians/gynecologists were conducted with participants recruited from the two teaching hospitals in Ghana: Korle Bu in Accra and Komfo Anokye in Kumasi. The postabortion patients were recruited directly from the gynecology wards when they were feeling well and nearing discharge. The male partners were recruited before and after gynecology ward visiting hours. The postabortion patients and male partners were eligible for this study if they were 18 years of age and older. Family planning nurses were recruited from the family planning clinics associated with the teaching hospitals. Obstetricians/gynecologists were recruited on the hospital grounds. The nurses and doctors were eligible for this study if they had at least one year of experience working with postabortion patients. All persons included in this study were purposively sampled.

We conducted one focus group discussion with obstetrician/gynecologists at each teaching hospital. There was only one focus group with family planning nurses, which was held at the Komfo Anokye Teaching Hospital. There were too few family planning nurses at the Korle Bu Teaching Hospital to make up a reasonably sized focus group. We aimed to conduct two focus group discussions with both the postabortion patients and male partners at both study sites. We were able to conduct two focus group discussions with postabortion patients at both study sites.

In Kumasi, recruiting male partners was more of a challenge than in Accra; most likely due to the different location and attitude of security guards in relation to the gynecology wards at the two hospitals. Although no focus group discussions with male partners occurred in Kumasi, we were able to conduct two focus group discussions with male partners in Accra (see Table 3.1).

We conducted ten in-depth interviews with postabortion patients at each study site, and a total of 19 in-depth interviews with male partners-nine in Kumasi and ten in Accra. For the health provider in-depth interviews there were seven and four with the family planning nurses and five and three with the obstetricians/gynecologists at the Komfo Anokye and Korle Bu Teaching Hospitals, respectively (see Table 3.1).

The focus group discussions and in-depth interviews with the postabortion patients and male partners were carried out on the same day as recruitment. The family planning nurses and obstetricians/gynecologists were interviewed on the same day as recruitment if schedules allowed. If not, appointments were made for group discussions and interviews at a later date. All focus group discussions and in-depth interviews were conducted in private rooms at the hospital.

The interviewers were trained by the student investigator using the in-depth interview and focus group discussion guides. Flexibility during data collection was encouraged, following the guide sequentially was discouraged if topics came up in an order different from the order in the guides. Interviewers were encouraged to continue discussions even if the specific topic was not listed on the guide. The interviewers were also trained to be non-judgmental, verbally and nonverbally, in their approach and response to the study participants' stories, experiences, and emotions.

The focus group discussions and in-depth interviews were conducted by trained interviewers in either the local languages of Twi or Ga, or in English. Focus group discussions and in-depth interviews with obstetrician/gynecologists were conducted in English, and nearly half of the family planning nurse interviews were also conducted in English, the rest were in Twi. The postabortion and male partner focus group discussions and in-depth interviews were mainly conducted in Twi. All focus group discussions and interviews were recorded and translated into English during the transcription process.

Trained female interviewers interviewed the postabortion patients. Trained male interviewers interviewed the male partners. Family planning nurses were either interviewed by male or female trained interviewers or the student investigator because the family planning nurses did not indicate a sex or ethnic preference. Obstetricians/gynecologists focus group discussions and in-depth interviews were all conducted by the student investigator, with assistance during the focus group discussions by the trained male research assistants. The average duration of the focus group discussions and in-depth interviews was 38 and 23 minutes, respectively.

This study was approved by the Committee on Human Subjects Research at the Johns Hopkins School of Public Health and the Institutional Review Boards at the Korle Bu and Komfo Anokye Teaching Hospitals. After recruitment we obtained verbal informed consent from all study participants before proceeding. All study participants were asked whether they objected to the interview or focus group being recorded. No study participant in this study objected to any of the study procedures. Data collection took place in March and April 2008.

Data Management and Analysis

Every focus group discussion and interview was translated and transcribed immediately after the discussion/interview. As the transcripts were produced, the student investigator read through them to become familiar with the data. Once familiar with the data, the student investigator developed a list of code labels to create a series of categories for the main themes or concepts that emerged from the transcripts. In this study, 'coding up' as opposed to 'coding down' was utilized; meaning that the codes were developed based on the data and were not defined prior to data collection (Keenan, van Teijlingen, and Pitchforth 2005). In addition, when possible, 'in vivo' codes were used, meaning that the words used by the participants themselves to articulate the themes or concepts were used as the code label. Using the code label list, all of the focus group discussion and interview transcripts were coded based on the code list. Throughout the process of coding, the coding list was refined further to reflect the concepts that emerged from the data.

The data analysis was guided by the thematic content analysis approach (Green and Thorogood 2004). After all of the transcripts were coded the next step in analysis was creating matrices to help identify patterns in the data. The matrices were at the person-level, stratified by study population. Each row in each matrix represented one study participant and the relevant data from that study participant was placed in the cell under the column headed with the matching code. The matrices were useful in grouping the different nuances within each theme, discerning differences and similarities between study populations within themes, and making connections broadly between themes.

RESULTS

Sample characteristics

The social and demographic characteristics of the study participants are reported in Table 3.2. There were a total of 50 postabortion patients involved in the study, 30 focus group discussion participants and 20 in-depth interview interviewees. The postabortion study participants' ages ranged from 18 to 44. The in-depth interview postabortion patients were younger, on average, than the focus group discussion postabortion participants. The majority of the postabortion patients were married, at 54%, with a higher proportion of single women in the in-depth interviews (55% vs. 37%). In total, 32 male partners participated in the study – 19 via in-depth interviews and 13 in focus group discussions. Most male partners were in the 30 to 34 age group, but the ages ranged from 20 to 53, and most were married (75%). As mentioned previously, all of the male partner focus group discussions occurred in Accra. Nearly equal proportions of the male partner in-depth interviews were conducted at each study site.

There were a total of 17 family planning nurse participants; 11 in the in-depth interviews and 6 in the focus group discussions. The family planning nurses ranged in age from 39 to 58. There were no male family planning nurses interviewed as at the time of the study as there were no male family planning nurses on staff. A total of 23 obstetricians/gynecologists participated in the study. There were 8 in-depth interviewees and 15 focus group participants in a total of two focus group discussions, one at each study site. The doctors' ages ranged from 28 to 50, with most obstetricians/gynecologists in the 30 to 34 age range (35%). There were few females obstetricians/gynecologists at the hospitals and that is a reflection of the fact that more men go into obstetrics/gynecology than women in Ghana. The majority of doctors in this study were from Kumasi due to the larger focus group discussion and a greater number of in-depth interviews at that study site.

Although many themes emerged from the overall data, a number of major themes emerged during the analysis. The following is a discussion of three of the most important themes: *Men and Abortion Decision-Making*, *Pregnancy Disclosure*, and *Providers as Barriers*.

Men and Abortion Decision-Making

The postabortion patients, family planning nurses, and obstetricians/gynecologists all discussed the influence of men on decisions related to pregnancy and abortion. It was apparent through these comments that men are the decision-makers. Male partners did not discuss their role in decision-making as clearly as did the other study populations, but their role was insinuated by their comments.

Postabortion patients discussed the issue of the male partner either taking or denying responsibility for the pregnancy. Taking responsibility for a pregnancy is synonymous here with a male acknowledging paternity of a pregnancy, as well as financially supporting the woman and the child indefinitely. At times it was also seen as the first step toward an official marriage.

Whether or not a male partner accepted responsibility for a pregnancy had a significant influence on a woman's decision to keep or terminate a pregnancy.

> *In my situation, I was four months pregnant and told my boy friend about it [the pregnancy] but he rejected the pregnancy, so I went to the market place and got my self some drugs to terminate the pregnancy.*
>
> -Postabortion patient, single, 21 years old, 0 children

The comments were often centered upon the marital status of the couple. How a male partner responded to the pregnancy depended largely on whether he was married to the woman or not. It was felt that married men had to accept responsibility for the pregnancy while unmarried men were able to choose whether or not to acknowledge paternity.

In cases of unwanted pregnancies, usually the men are at comfort especially when he has not married the girl/woman. Some men in such instances behave as though they have never known the woman.

-Postabortion patient, single, 22 years old, 1 child

The male partner's ability to deny responsibility for a pregnancy generated fear among the postabortion patients. For unmarried women, having a child out of wedlock is stigmatized. Within marriage if the husband does not accept paternity for a child, then society will suspect the woman has been unfaithful to her husband.

The male partner was cited as the person who is often suggesting, or demanding, that the woman have an abortion. This reality was reiterated by all study populations except the male partners. Family planning nurses, obstetricians/gynecologists, and postabortion patients all said that the reason for the abortion is usually the male partner who demands that the woman go for an abortion when he does not want the child.

Even those who are in stable relationships you find it is the man who was like 'I don't want this baby; get rid of it, any how you do, just get rid of it'.

- Doctor, 34 years old

The postabortion patients note how the male partner's involvement may also be indirect, by denying responsibility for the pregnancy and leaving the woman with no support in raising the child, reducing her chances of marriage, and subjecting her to ridicule by her community. By denying the pregnancy is his, the male partner is letting the woman know that he does not want to take social and financial responsibility for the woman or the unborn child.

I got a miscarriage in my first pregnancy and my partner told me to abort the second one which I refused. He denied responsibility because of my decision…

-Postabortion patient, married, 43 years old, 2 children

Male partners and postabortion patients were asked whether they discuss induced abortion with their partners. As this postabortion patient explains, if the woman raises the issue of termination she is opening herself up for questions about her fidelity from her male partner:

Most of the time it is the men who raise the idea of abortion so if the lady raises it, it becomes very awkward and it becomes difficult for the men to believe in their women's faithfulness.

-Postabortion Patient, married, 35 years old, 2 children

Some male partners let the females know, upon hearing about the pregnancy, that they were in favor of the pregnancy and would allow her to keep the pregnancy. In other instances, the male partner let his female partner know that he 'doesn't like' the pregnancy.

Moderator: If he should tell you that he dislikes the pregnancy [doesn't want the pregnancy], what do you do?

Response: You would simply have to abort, because he will tell you that it is you who has gotten pregnant. But if he wants it, he would not comment.

Patient: …there are times he would like it and there are times he would not. There also times that he leaves everything unto your hands, expecting you to take a step to terminating it.

Notetaker: Are you saying that, there are those [men] who would like the termination but would not verbally announce it?

Patient: Yes

-Postabortion patient, married, 33 years old, 6 children

Postabortion patients did not always discuss the termination with their male partners. For them, discussing the pregnancy was difficult as aborting the pregnancy may have been something she desired.

Interviewer: Was he the one who brought the idea for the termination or you suggested it?

Response: Actually, I dropped a wrapper of a used abortion drug in his pocket one time that he left for a funeral and I told him purchase one for my use. For him, he did not know of my intentions at all.

-Postabortion patient, single, 19 years old, 0 children

As is evidenced by this quote below, male partners were not always clear about their role in pregnancy terminations. This male partner told the interviewer that his wife had terminated the pregnancy without his consent early on in the interview. Later in the interview he tells a different story:

Interviewer: Did your wife discuss the pregnancy termination with you?

Male Partner: She initially discussed this with me and I gave her money to go and see a doctor. But she did not but rather went to buy a drug from a pharmacist and these complications came about when she took the drug.

-Male Partner, married, 31 years old, 4 children

This doctor explains how the culture is patriarchal, which is the root of the problem for many of these women.

It is very important to note that we are in a society where the men dominate. They are in charge of all decisions wherever that you go. Maybe the only exception is

> *among the very highly educated ones. But generally most folks in Ghana it's the man, whatever he says is final. And even when it comes to relationships, the man tends to dominate. Even with sex. There are a few occasions I have sat in the consulting room a young lady walks in and says I want to find out whether everything is ok. Because my partner says I should get pregnant before he gets married to me. So she is under pressure to have unprotected sex, with the promise that when she gets pregnant with him, the man. So at that point you see that the man is virtually, is controlling her. I usually tell her that that kind of man is going to be quote 'testing a number of women' to see which one of them gets pregnant before he gets married to one of them. So at the end of the day, one of you will get married and the man will tell the rest I don't want the pregnancy. Or at the time you get pregnant he is not really ready to get married. So the girl gets pregnant, come on, I don't want it, I don't want the pregnancy now, so you terminate the pregnancy, so they put so much pressure. So it is important also to focus on the men – that is the main thing. If we can change the attitude of the men in Ghana, a lot of this will change.*
>
> - Doctor, 43 years old

There were some postabortion patients who spoke of understanding in their relationships and their male partners' willingness to consent to the woman's wishes; however, these women were the minority of our sample. As this postabortion patient explains, against the grain of her counterparts in the study, she would go ahead with the termination against his will if she felt if would be the best thing for her future:

> *Patient: I will tell him if I am not ready to give birth, then if he agrees, I will abort.*
>
> *Moderator: What if he doesn't?*
>
> *Patient: I will still do what is best for me.*
>
> -Postabortion Patient, married, 22 years old, 1 child

Pregnancy Disclosure

We asked postabortion patients whether they always disclose pregnancies to their male partners. While most women responded that they had, some responded that they did not, or do not tell their male partners when they are pregnant every time. Among the 14 postabortion patient who referenced their most recent personal experiences with pregnancy disclosure, 11 (79%) said they had revealed the pregnancy to their male partners while 3 (21%) said they had not.

> *I see it as appropriate to inform, so that he can be held responsible in case of any emergencies. If not, he might deny completely.*
>
> -Postabortion patient, single, 20 years old, 0 children

When the male partners were asked whether women disclose pregnancies to them or not, no male partner said that the women fail to disclose pregnancies. Despite the fact that male partners unanimously said that women always tell their male partners about pregnancies, some male partners, when reflecting on their current crises, revealed that they did not know of this current pregnancy nor termination. As an example, this male partner reveals:

> *Interviewer: Did your partner tell you about this current pregnancy?*
>
> *Male Partner: No, she did not.*
>
> *Interviewer: Really? How did you feel about that?*
>
> *Male Partner: I am highly annoyed with her, serious! How can you decide to hide this from me when I am your man?*
>
> -Male Partner, married, 30 years old, 2 children

The postabortion patients in the focus group discussions explained how disclosing a pregnancy is not a simple decision, even when the pregnancy occurred in a marital relationship. Postabortion patients felt that married individuals were required to tell their husbands about pregnancies, especially since the husbands would have to assume responsibility for the pregnancy – given the legal status of their union. Although women in marital relationships were expected to tell their husbands of the pregnancy, it was presented as a difficult task. Many participants discussed the fear involved in revealing pregnancies to their male partners – irrespective of the marital status of the couple.

> *If it is a real marriage then you have to get the courage to tell him.*
>
> - Postabortion patient, married, 42 years old, 5 children

Even though the postabortion patients focused on the responsibility of married women to tell their husbands when they were pregnant, there were cases of deviation from this scenario.

> *Sometimes, it is not that the women flirt around [infidelity] but the attitude of the men! The way the men behave towards the women during instances of pregnancy, ehhh, the men get angry and unwelcoming – as though you should not have gotten pregnant! It is enough to scare the women from disclosing. The best option would be to terminate secretly. The character of the men sometimes is scary.*
>
> - Postabortion patient, married, 25 years old, 3 children

For women who were not officially married, the timing of the pregnancy disclosure was especially vital - as the male partner is more likely to accept responsibility for the pregnancy if she discloses sooner than later:

> *As for me, my partner has not married me officially so if I don't tell him right away and I do so later, he might even say he is not responsible.*

- Postabortion patient, single, 20 years old, 1 child

Issues of fidelity were raised in conjunction with the question about pregnancy disclosure. Both postabortion patients and male partners made reference to this issue. The postabortion patients explained how disclosure of a pregnancy from an extramarital affair is inadvisable, and that most women who have a pregnancy as a result of an affair must 'secretly' abort. The male partners implied that whether the female discloses or doesn't disclose a pregnancy is not the main issue. The concern is that she may willfully withhold the information regarding the paternity of the pregnancy, even though she will definitely know who impregnated her.

Another instance where women may not disclose pregnancies to their male partners is when the woman is ready for a child and the male partner is not.

> *Sometimes when she sees that her friends have given birth and her husband is not ready for a child she can hide it. The time the man will see that the woman is pregnant then it is too late to terminate it.*
>
> - Male partner, single, 29 years old, 0 children

Postabortion patients echoed this concept discussed by the male partners. They also talked about the strategy of waiting to disclose the pregnancy until the pregnancy was too far along to abort:

> *Most of the ladies will hide it up to 5 months when it will be dangerous to abort and he will understand [he won't force her to abort].*
>
> - Postabortion patient, married, 35 years old, 2 children

Providers as Barriers

Issues related to the theme 'barriers to abortion' were mostly initiated by the health providers – the family planning nurses and the obstetricians/gynecologists. The doctors discussed the broad social and legal stigma associated with premarital sex and abortion in this setting.

Through working on the gynecology wards, the family planning nurses were familiar with patients who have had negative health outcomes as a result of complications from an unsafe abortion. The experiences of seeing these tragic cases in combination with their strong religious views and negative attitudes toward abortion, the family planning nurses themselves came across as barriers to abortion in this study.

> *Because she was very young, I began to advise her not to abort the pregnancy.*
>
> - Family Planning Nurse, 54 years old

> *Someone would not know anything about complications with abortion. They are only interested in terminating the baby, thus if you sit such one down, counsel her*

and she is willing to heed your advise, it helps. So another time, she might even tell a friend about what she learnt from us to scare the friend from abortion.

- Family Planning Nurse, 53 years old

Sometimes, because of some drugs you have taken, it starts threatening the fetus; after the threatening we can have an inevitable; that is you will get an abortion no matter what we do.

- Family Planning Nurse, 53 years old

This family planning nurse demonstrates how, if the opportunity arose, she would interfere with the termination of pregnancy despite the patient's intentions.

Young, unmarried, postabortion patients spoke about the fact that the nurses were 'on them' from their arrival on the gynecology ward by scolding them for having premarital sex/aborting an unwanted pregnancy.

I have not been counseled; rather I have been scolded by the nurses.

-Postabortion patient, single, 19 years old, 0 children

The tendency for nurses to treat the younger patients harshly may be due to the fact that they see themselves in a maternal role to these female patients and possibly, that their own fears about their own children or other family members may be realized. It is also possible that health providers feel that pregnancy is the punishment that young girls receive for engaging in premarital sex and their role as the health provider is to compliment the punishment with the aim of scaring the girl from engaging in premarital ever again. The nurses tell the younger patients to return to school after discharge so that they make something of themselves and build a future.

And normally if you are not married – we tell them if you are not married then abstain from sex!

-Family Planning Nurse, 54 years old

The family planning nurses assisting with the manual vacuum administration (MVA) discuss how treating the postabortion patients is a low priority at the hospital, something to be attended to after all other patients have been seen:

The doctor, sometimes they are busy over there – so any time they come. Sometimes we start early, other times too maybe 4 o'clock. Depending on the normal rotations, whenever the doctor finishes, that is when we start the day.

-Family Planning Nurse, 40 years old

The obstetricians/gynecologists discussed the judgmental attitudes of health providers towards induced abortion patients, and the negative effects of these attitudes on the patients.

Unfortunately, you see, because of the stigmatization of abortion, eh, health care professionals tend to be a bit; I don't know whether the word I should use is hostile or kind of judgmental.

- Doctor, 34 years old

We all have been guilty of it at one time or another. If you come to the theatre sometimes, and we are taking care of some of these patients. Some of the comments that come from the nurses. Hey, this small girl you will not stop having sex when your mother and your dad are away from home - this is what you have been doing. And you have been swallowing cytotec. How much do you put there? 3 or 4? I mean, the sort of comments that come from doctors and nurses when they are seeing these young girls. You can imagine that probably they feel that the ground would open up to swallow them. I am not saying ALL staff but sometimes you hear these comments, comments that make the people feel guilty, very very guilty. Now after we see them, maybe we have done the evacuation given them the antibiotics and they have been discharged, do you think that they will come back to the hospital where they are supposed to receive family planning products? They will not. So I think health providers, we have to educate them to change their attitudes. We are health providers. When someone comes and she has had an abortion, we are not supposed to be judgmental in our approach. We are supposed to provide service, deal with the complications that the patient has presented with and then inform them on their choices. ... During treatment, the comments that come out of our mouths. I think that is also one big issue. If you ask a number of patients who have been through this hospital about their treatment, the kinds of questions and comments that we made, a lot, I am telling you a lot of comments, horrible comments that come from nurses and doctors.

- Doctor, 37 years old

DISCUSSION

Men were seen as the decision-makers for most women coming in for postabortion care. Research in other settings has found that males are a main reason for terminating a pregnancy through their denial of responsibility (Bankole et al. 2008) or they were involved in the decision to terminate a pregnancy and navigating the services to implement their wishes (Bennett 2001; Gipson and Hindin 2008). One study in Nigeria found that nearly 20% of the women inducing abortions did so due to problems with the male partner. When the male partner was not involved or he had not consented to the abortion the women were less likely to terminate prior to eleven weeks gestation and go to a professional provider, both of which were associated with requiring fewer attempts to terminate a pregnancy. It was not reported whether the decisions made with the male partner involvement/approval, although safer abortions, were decisions shared by the female partner (Bankole et al. 2008).

Literature on induced abortion has highlighted the fact that abortion is a means for women to exert some control over their fertility (AGI 1999). This has been referenced in relation to societies where family planning use is low and males are dominant in fertility decision-making. As this study shows, induced abortion is not always a woman's choice to exert control over her own fertility, but may be her only option given the dominance of her male partner in fertility control decisions. While she may defy her partner and decide to carry the pregnancy to term, she does so with social implications. Alternatively, a woman may decide to hide the pregnancy from her male partner for a variety of reasons including fear of accusations of infidelity and discordant fertility preferences with her partner. Nondisclosure of the terminated pregnancy was 40% of the sample in Nigeria (Bankole et al. 2008).

It has been noted in other research that relationship problems are a main reason for induced abortions in Ghana (Bankole 1998, 2008). Research has shown that couples in Ghana adjust their coital frequency based on their fertility preferences (Blanc and Grey 2002). There are additionally traditional sustained periods of postpartum abstinence, and it has been reported that people look down on women who do not adequately space births by saying 'she reproduces like a chicken' (Addai 1997). If couples used effective contraception, they could engage in coitus more often, without fears of unintended pregnancies—potentially reducing the role of infidelity and its associated issues in Ghanaian partnerships.

The health providers' biases and negative attitudes can serve as a barrier to abortion services (Bennett 2001; Huntington, Nawar, and Abdel-Hady 1997; Lie, Robson, and May 2008). Nurses often are reported to be more judgmental toward induced abortion patients than other health care professionals (Lipp 2008; Marshall, Gould, and Roberts 1994). Individual attributes of health providers can have an affect on how they treat induced abortion patients, such as religiosity and length of experience working on gynecology wards (Lipp 2008; Marshall et al. 1994). This study shows that some family planning nurses view induced abortion negatively and address the needs of women with unwanted pregnancies in a judgmental fashion. It is important for interventions with family planning nurses in this setting to address the issue of barriers to care among this population.

Although this study has several strengths, it also has a few limitations. It is possible that the social differences between the study participants and the research team created a barrier to additional dialogue or disclosure into the pathways and barriers to unsafe abortion. As any type of induced abortion in Ghana is highly stigmatized, it is likely that some study participants were reluctant to share their thoughts or experiences on the subject. Another limitation is that only one of the researchers coded and analyzed the data. There is also the limited generalizability of the study findings. The study was conducted at two teaching hospitals in the two largest cities in Ghana. In addition, the only postabortion patients included in this study were those patients who had abortion complications and came to the hospital for treatment of those complications. Women who had safe abortions, unsafe abortions without complications, unsafe abortions with complications but did not come to the hospital either due to the severity of the

complications, cost, or death, were not included in the sample – therefore, our sample is limited to those women who survived the unsafe abortion procedure, had complications, and came to the hospital for treatment of those complications. Additionally, the male partners included in our study were the male partners who came to the hospital. Many male partners in this setting do not visit their female partners at the hospital. Finally, we interviewed many young obstetrician/gynecologists as the older doctors were reluctant to participate in the study.

This study has several strengths. First, qualitative methods were utilized to explore the pathways to unsafe abortion that provided a forum for study participants to share their experiences, stories, attitudes, and beliefs in regards to unsafe abortion in Ghana. The study participants were able to share their experiences without any preset limitations on their contribution. Second, this study uses perspectives from four different study populations – the patients and their male partners and the two sets of health providers. The congruity of discussions and comments, as well as the discordance in comments provided the study with additional depth that would not have been afforded if only one of the study populations had been included. Finally, little research has been done in this setting on this topic and the findings presented here may be a catalyst to future research and health promotion work in this area where is needed.

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Table 3.1. Number of in-depth interviews and focus group discussions at each study site and overall, by study population in a qualitative study at 2 teaching hospitals, Kumasi and Accra Ghana

	Komfo Anokye		**Korle Bu**		**Total**	
	IDI*	**FGD****	**IDI**	**FGD**	**IDI**	**FGD**
Study Group						
Postabortion Patients	10	2	10	2	20	4
Male Partners	9	0	10	2	19	2
Family Planning Nurses	7	1	4	0	11	1
OB/GYN	5	1	3	1	8	2
N	31	4	27	5	58	9

* IDI = in-depth interview

** FGD = focus group discussion

Table 3.2. Characteristics of each study population by in-depth interview, focus group discussion participation, and overall in a qualitative study at 2 teaching hospitals, Kumasi and Accra Ghana

	Postabortion Patients			Male Partners			Family Planning Nurses			OB/GYN		
	IDI (n=20)	FGD (n=30)	Total (n=50)	IDI (n=19)	FGD (n=13)	Total (n=32)	IDI (n=11)	FGD (n=6)	Total (n=17)	IDI (n=8)	FGD (n=15)	Total (n=23)
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Age												
18-19	6 (30)	3 (10)	9 (18)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
20-24	7 (35)	7 (23)	14 (28)	2 (11)	2 (15)	4 (13)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
25-29	3 (15)	10 (33)	13 (26)	2 (11)	2 (15)	4 (13)	0 (0)	0 (0)	0 (0)	2 (8)	2 (13)	4 (17)
30-34	2 (10)	4 (13)	6 (12)	9 (47)	4 (31)	13 (41)	0 (0)	0 (0)	0 (0)	4 (50)	4 (27)	8 (35)
35-39	0 (0)	4 (13)	4 (8)	1 (5)	2 (15)	3 (9)	1 (9)	0 (0)	1 (6)	1 (13)	4 (27)	5 (22)
40-44	2 (10)	2 (7)	4 (8)	2 (11)	2 (15)	4 (13)	2 (18)	1 (17)	3 (18)	1 (13)	3 (20)	4 (17)
45-49	0 (0)	0 (0)	0 (0)	0 (0)	1 (8)	1 (3)	1 (9)	1 (17)	2 (12)	0 (0)	0 (0)	0 (0)
50-54	0 (0)	0 (0)	0 (0)	3 (16)	0 (0)	3 (9)	6 (55)	3 (50)	9 (53)	0 (0)	2 (13)	2 (9)
55-59	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	1 (9)	1 (17)	2 (12)	0 (0)	0 (0)	0 (0)
Sex												
Female	20 (100)	30 (100)	50 (100)	0 (0)	0 (0)	0 (0)	11 (100)	6 (100)	17 (100)	1 (13)	3 (20)	4 (17)
Male	0 (0)	0 (0)	0 (0)	19 (100)	13 (100)	32 (100)	0 (0)	0 (0)	0 (0)	7 (88)	12 (80)	19 (83)
Site												
Kumasi	10 (50)	14 (47)	24 (48)	9 (47)	0 (0)	9 (28)	7 (64)	6 (100)	13 (76)	5 (63)	9 (60)	14 (61)
Accra	10 (50)	16 (53)	26 (52)	10 (53)	13 (100)	23 (72)	4 (36)	0 (0)	4 (24)	3 (38)	6 (40)	9 (39)