Choosing Unsafe Abortion Services: Influences on Decision-Making in Accra, Ghana

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Introduction

Induced abortion is illegal in Ghana but there are a number of exceptions within the law that make it more accessible than in many other developing countries (United Nations Department of Economic and Social Affairs & Population Division, 2001). In recent years, the problem of unsafe abortion has gained increasing attention in both the academic literature and the popular press and it is clear that large numbers of women have unsafe abortions despite the availability of safe services to some (Ahiadeke, 2001; Srofenyoh & Lassey, 2003; Turpin, Danso, & Odoi, 2002). Little research has been done on what determines women's use of safe or unsafe abortion services in Ghana. This paper uses the results of focus group discussions to explore the factors that may affect women's choice of abortion services.

In particular, this paper shows that the focus group participants were aware of the risks of unsafe abortion, knew that some services were safer than others, and could identify features of unsafe abortion providers. At the same time, they discussed the social and economic costs of seeking abortion services from hospitals and health clinics as well as social norms that may influence their choices. Together, these various factors may lead to choices that are seemingly irrational—choosing to use abortion services that are known to be unsafe. The choice is, however, only irrational if the lens through which is seen focuses on maximizing health and ignores such influences as the socio-cultural context and power relations (Vahabi & Gastaldo, 2003).

Methods

The research, which used focus group discussions, was conducted in the Nima and Mamobi community of Accra, a low income area of the city with a high population density, large Muslim (41% vs. 10% for the rest of Accra) and migrant populations (15% vs. 9%), and high rates of illiteracy (30% vs. 20%). Other qualitative work on abortion in Accra has excluded this population, perhaps because abortion is assumed to be less common here. While this may be true, when Muslim women use abortion they may be more likely to use unsafe services because of the greater stigma surrounding abortion; they are therefore a population of interest. In addition, the high level of poverty in this community may limit access to safe abortion services.

Prior to the focus group discussions, I visited Nima and Maamobi on multiple trips to Ghana over a one year period. I talked with English-speaking women in the community informally at home and in their workplaces and attended community meetings in an attempt to become more familiar with the physical, social and economic setting of the study. With the help of the Legal Resource Centre (LRC), a non-

governmental, not-for-profit human rights organization engaged in activities designed to increase democratic participation among the residents of the Nima and Maamobi community, a community advisory board was formed. The five women who served on the advisory board provided guidance on how best to recruit women in the community, reviewed the informed consent materials and gave feedback on the discussion guide. Prior to recruitment they talked with women in the community about the study so that people were aware of the project.

Focus group discussions were the main method used because of the paucity of information on modern norms, knowledge and beliefs about abortion in urban Ghana. Focus groups provide an ideal venue for collecting this type of information (Morgan, 1997). A group technique may provide different insight into sensitive issues than do other means of data collection (Wellings, Branigan, & Mitchell, 2000), so it was used in order to understand the community norms.

In order to include a range of views, the discussions included women and girls from 15 to 60 years old. Although girls and younger women appear to be highest at risk of unsafe abortion, the views of older women were also solicited, because they may influence the views of younger women, which are formed in response to their social context; in a society with a large degree of separation between male and female domains, women are likely to have the most influence on one another.

Eight focus group discussions were held in October to November of 2003. Each group comprised 6 to 11 women with a total of 67 women participating. Each group was designed to include women in a particular age range (i.e., under 18, 18-24, and over 25) in order to encourage discussion. Although the goal was to separate groups according to parity and work or educational status as well as age, this was not possible. The facilitator asked each woman confidentially about her age, parity and martial status.

The participants ranged in age from 15 to 55 (median of 23). Four women were under 18, 30 were aged 19 to 24, and 25 were over the age of 25. Eight participants did not report their age. The majority of women over age 24 had children (60%) but among the younger women, 23% had children and 40% did not. The maximum number of children per woman was eight.

All discussions were facilitated by a woman from Nima who had prior experience facilitating groups discussions, was knowledgeable about reproductive heath, and who spoke Hausa, the most common language in the community. She was 23 years old and had just started at the University of Ghana, which is rare for women in the community. She had worked for the LRC in the past and, in that role, was familiar to many community members. Another young woman (also a student at the University and from Maamobi) took notes on the proceedings in English so that the principal investigator could review the discussion after each session. The lead researcher attended all of the discussions and took notes on the characteristics of the participants, their interactions and level of comfort during the discussion.

Each discussion lasted approximately one hour and followed a structured discussion guide. The topics covered included: 1) community norms about fertility, 2) knowledge and beliefs about contraceptive methods, 3) knowledge and beliefs about post-coital contraception, 4) knowledge and beliefs about regulating menstruation and 5) knowledge and beliefs about abortion. The facilitator allowed the discussion to follow a natural course and probed for greater detail when necessary, but the specified topics were

covered by all groups. With the exception of one group, which was conducted in English, the groups were conducted in Hausa. All discussions were tape recorded and the tapes were transcribed and translated into English. A selection of these transcripts was reviewed against the recording by a qualified third party to ensure the accuracy of the translations.

The study protocol was approved by the Human Subjects Committee of the Harvard School of Public Health and the Noguchi Memorial Institute Ethical Review Board at the University of Ghana at Legon. Informed consent and permission to audiotape the discussion were obtained from each participant, and group norms were reviewed just prior to the discussion. Women were asked to discuss use of abortion and contraception in the third person to maintain confidentiality.

Member checks provide an important means of establishing the validity of the results in qualitative research (Merriam, 2002). Therefore, four follow-up discussions were also conducted with some of the original participants. These took place four months after the initial discussions and provided a means to ask the women if the interpretation of their responses was accurate, to ask some follow-up questions, and to probe for more detail on topics raised earlier.

Discussion

This paper will apply the rational choice model to women's choices between safe and unsafe abortion providers and show that such a model does not adequately capture the many factors that may influence a woman's decision. In turn, it will show that the decision to use unsafe providers is neither uninformed nor irrational. It will highlight the importance of an in-depth understanding of such factors to the development of effective policies to reduce reliance on unsafe abortion.

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