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Abortion in rural Ghana: Cultural norms, knowledge and attitudes

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Abstract

Using qualitative methodology, semi-structured questionnaires were administered to participants in the Barakese subdistrict of Ghana in order to understand the extent to which men and women have knowledge of family planning services and in what ways cultural norms, practices, and attitudes toward abortion affect the decision to abort. Women in the community pursue abortion using unsafe methods, despite fear of shame, bleeding, infection, or death, as the perceived cost of maintaining the pregnancy is greater. Protective factors that were reported to dissuade women from pursuing unsafe abortion include fear of social disgrace, divine retribution, and death. Women reported the inability to control the timing of their pregnancies, despite harboring knowledge of family planning. Concerned about perceived side effects of modern family planning methods, respondents chose to use fertility awareness methods or to use no contraception. There remains a gap between knowledge of the benefits of and the actual use of family planning methods, leading to unwanted pregnancy and seeking unsafe abortion. Intensified health promotion and education regarding side effects to combat misconceptions related to contraception, as well as expanding alternative contraceptive options to all regions of Ghana, are critical to improve uptake. *(Afr J Reprod Health 2020; 24[3]: 51-58).*

Keywords: Reproductive control, maternal health, family planning, contraception

Résumé

En utilisant une méthodologie qualitative, des questionnaires semi-structurés ont été administrés aux participants du sous-district de Barakese au Ghana afin de comprendre dans quelle mesure les hommes et les femmes connaissent les services de planification familiale et de quelle manière les normes culturelles, les pratiques et les attitudes à l'égard de l'avortement affectent le décision d'abandonner. Les femmes de la communauté poursuivent l'avortement en utilisant des méthodes dangereuses, malgré la peur de la honte, des saignements, des infections ou de la mort, car le coût perçu du maintien de la grossesse est plus élevé. Les facteurs de protection qui auraient dissuadé les femmes de recourir à un avortement non médicalisé comprennent la peur de la disgrâce sociale, des châtiments divins et la mort. Les femmes ont signalé l'incapacité de contrôler le moment de leur grossesse, bien qu'elles aient des connaissances en matière de planification familiale. Préoccupées par les effets secondaires perçus des méthodes modernes de planification familiale, les répondants ont choisi d'utiliser des méthodes de sensibilisation à la fécondité ou de ne pas utiliser de contraception. Il subsiste un fossé entre la connaissance des avantages et l'utilisation réelle des méthodes de planification familiale, conduisant à une grossesse non désirée et à la recherche d'un avortement à risque. Une promotion de la santé et une éducation intensifiées concernant les effets secondaires pour lutter contre les idées fausses liées à la contraception, ainsi que l'extension des options de contraception alternatives à toutes les régions du Ghana, sont essentielles pour améliorer l'utilisation. *(Afr J Reprod Health 2020; 24[3]: 51-58).*

Mots-clés: Contrôle de la reproduction, santé maternelle, planification familiale, contraception

Introduction

As modern family planning methods and comprehensive sex education become more available worldwide, pregnancy-related risks are prevented, infant mortality is reduced, and the demand for unsafe, induced abortions decreases[1,2]. When couples are able to plan the size of their families and the spacing of their children, the community benefits socially, economically, and environmentally[3]. Worldwide, families are increasingly utilizing family planning resources to

time pregnancies and to decrease the size of their families as evidenced by the contraceptive prevalence increase from 54.8% in 1990 to 63.3% in 2010 with a correlative reduction in fertility by one-half since the mid 20th century[4,5]. However, a large proportion of women still have an unmet need for family planning and that number was expected to grow to nearly 1 billion by 2015[4]. In Ghana, thirty percent of currently married women have an unmet need for family planning with 23.6% reporting they desired the birth of their most recent child to have been delayed and 7.3% wanting no more children before the birth of their last child[6].

The uptake of modern family planning methods, defined as oral contraceptives, intrauterine devices, injectables, implants, male or female condoms, female and male sterilization, emergency contraception, or lactational amenorrhea, still remains low in Ghana, despite the recognized benefits of improved timing and spacing of childbearing, with only 18.2% of currently sexually active women using a modern method of family planning[6]. This has resulted in high rates of unwanted pregnancies, unplanned deliveries, unsafe abortions and unacceptably high maternal mortality ratios in sub-Saharan Africa, including Ghana[7]. Irrespective of legal conditions, women all over the world are highly likely to have an induced abortion when faced with an unplanned pregnancy, often seeking unsafe abortion when legal restrictions preclude a safe procedure[8]. In Ghana, 15% of women report that they have had at least one induced abortion, while one third of these women have had more than one[7]. Ghanaian law, as of 1985, permits abortion fairly liberally in cases of rape, incest, or for maternal/fetal indications; however, only 3% of pregnant women and 6% of women seeking an abortion were aware of the instances when abortion is legal, with 45% of abortions performed in Ghana remaining unsafe[9].

In Ghana, maternal mortality is the second largest cause of female death, with induced abortion accounting for more than 1 in 10 maternal deaths, and even more women suffering short- and long-term morbidities that are largely underreported[10]. Despite the government subsidization of modern contraceptive methods to prevent unwanted pregnancy[6] and the broad grounds that abortion is legal in Ghana, pregnant women participating in a study previously conducted by the co-authors of this study were found to have aborted their pregnancies for unknown reasons. There is a need to further investigate the various factors contributing to these outcomes. This study aimed to understand the extent to which men and women in the Barakese subdistrict have knowledge of family planning services and how cultural norms, practices, and attitudes impact abortion in this region.

Methods

The study was conducted in 6 villages (Barekuma, Barekese, Fufuo, Maban, Abira, and Essaso) in the Barakese subdistrict in rural Ghana. The villages selected varied in both size of population and in distance from the city-center, Kumasi, reflecting differences in access to health clinics. This area is of particular interest as it is the geographic area covered by the Barekuma Collaborative Community Development Programme (BCCDP), a collaborative effort between Kwame Nkrumah University of Science and Technology (KNUST), Komfo Anokye Teaching Hospital (KATH), and the University of Utah School of Medicine. A prior study conducted by the BCCDP yielded unanticipated data suggesting that early identification of pregnancy led some participants to abort the pregnancy for unknown reasons. The BCCDP Advisory Panel recommended that this qualitative study be conducted to better understand this issue and to identify unmet family planning needs in the area.

A community-based, cross-sectional qualitative study design was used to survey men and women throughout the six rural villages of the Barakese subdistrict in Ghana. A convenience sample of women, ages 19-78 and of men, ages 18-72 in the subdistrict were selected for interview, yielding a total sample size of 56 women and 46 men. Participants were recruited within their communities and targeted for interview at that time using an 8-page semi-structured questionnaire. If a participant provided informed consent to participate, he or she was interviewed face-to-face using the questionnaire that was read from a digital tablet device in English and was then translated from English to

Twi for non-English-speaking participants. The interviewer began by asking respondents structured, close-ended questions concerning their demographic, social, educational, and economic characteristics. Then the interviewer led into open-ended questions regarding respondents' reproductive histories, contraceptive histories, and experiences with unwanted pregnancy and induced abortion. Probing questions were asked to clarify a respondent's answer or to get more information about a specific response. Because many women were reluctant to share personal experiences regarding unwanted pregnancy or abortion, a second set of questions was asked of each respondent concerning his or her knowledge of any unnamed community member's experience with unwanted pregnancy and abortion, permitting the respondent to maintain anonymity for the woman whose experiences were shared. Responses were recorded and saved on the tablet. Notes from each interview were transcribed by 2-3 research assistants on paper copies of the questionnaire.

Additionally, a focus group discussion was conducted with community clinicians and health workers in the Barakese subdistrict in order to assess their experiences with abortion in the region and perceived barriers to contraceptive use. The focus group consisted of 20 participants including medical assistants, nurses, and physician assistants. A discussion leader moderated the discussion and 4 research assistants were present to record the discussion and to take extemporaneous notes.

Typed field notes were coded according to participants' responses to questions or by significant themes present in the responses. The focus group transcript was similarly coded according to responses to questions. Salient concepts were identified based on their frequency of use. Ethical approval for the study was obtained from both the University of Utah's Institutional Review Board (IRB_00074352) and Kwame Nkrumah University of Science and Technology, School of Medical Sciences & Komfo Anokye Teaching Hospital's Committee on Human Research, Publication and Ethics (CHRPE / AP /250 /14).

Results

A total of 102 interviews were conducted, including 56 women and 46 men between the ages of 18-78. Age and demographic characteristics are listed in Table 1. The majority of participants had a middle school education level, identified themselves as Christian and from the Akan ethnic group, with an average age of 42 for male respondents and 41 for female respondents.

Of women in the study, nearly every woman interviewed (n=55) had been pregnant with an average of 4.2 pregnancies and 3.9 live births. Twenty-three of the women reported a miscarriage or stillbirth. A majority of women (n=32) felt they were able to control the timing of their pregnancies. Reasons reported for not being able to control the timing of their pregnancies included unawareness of family planning/contraception, mistiming oral contraceptives, pressure from a family member to conceive/ to have unprotected sex, and menstrual cycle irregularities (Table 2). One woman explained the inability to plan or time her pregnancies by saying,

"Once you start menstruating, you get pregnant and give birth. When you reach menopause, that is when you stop. That is just the way life is".

Seventeen women reported using an identified family planning method when they became pregnant, with oral contraceptive pills and fertility awareness methods being the most common forms. Women were overwhelmingly concerned about perceived side effects of oral, implantable, and other hormonal forms of contraception, citing infertility, weakness/dizziness, heart problems, nonspecific diseases, irregular menses, and death as reasons to avoid contraception (Table 2).

"The family planning drugs can change your menses, mine became darker. The drugs made me have rapid heart rates, chest pains, and it was difficult to get pregnant. I was afraid that I wouldn't be able to have children again".

"The woman can be barren or infertile if she takes family planning drugs. Also, if the family planning

Table 1: Demographic characteristics of respondents (n=102)

Variable	Number
Age group (years)	
≤20	3
21-30	27
31-40	26
41-50	18
>50	28
Sex	
Female	56
Male	46
Marital Status	
Married	66
Not married	27
Other	9
Ethnicity	
Akan	86
Other	16
Education	
None	12
Some education	14
Completed primary school	55
Completed secondary school	14
Beyond secondary school	7
Religion	
Catholic	20
Methodist	19
Other Christian	52
Other	7
No religion	4

Table 2: Reasons for being unable to control timing of pregnancies (n=27)

Main Reason	Number (%)
Unaware of contraception options	13 (48)
Feared complications of contraception	6 (22)
Pressure from family member	5 (19)
Menstrual cycle difficulties	3 (11)
Perceived Risks of Contraception	**Number (%) ***
Infertility	19 (60)
Weakness/dizziness	19 (60)
Heart problems	17 (53)
Nonspecific diseases	17 (53)
Irregular menses	11 (34)
Death	5 (16)

*Participants cited more than one variable

Table 3: Female-cited reasons for abortion (n=12)

Variable	Number (%)
Financial concerns	5 (42)
Young children at home	3 (25)
Wanting to continue education	2 (16.5)
Paternal issues	2 (16.5)

drugs don't match with her blood type, she could get a disease and die, even though the doctor might have warned her that the drugs did not match her".

Focus group participants reiterated these concerns by saying:

"If the client doesn't really understand the side effects, then she will go about telling others false information and then those women wouldn't come back to find out [about their contraceptive options] and they will trust what their friend tells them".

"Others believe that they are allergic to the method that they are using. We tell them that if they experience this, that we can change their method for them. We will counsel them that they could experience these symptoms. But if they do, for most women, they cannot take it".

"Some are afraid others will know that they are using contraception. If she is married and her husband is away and others see her using contraception, they will think she is going around".

Fertility awareness was the preferred method of contraception, despite 13 women reporting a mistimed pregnancy while using the method. One woman, however, qualified this preference for the fertility awareness method by saying,

"If you want to prevent a pregnancy, the best way is to abstain from sex for periods of time based on an agreement between the husband and wife. This can be hard on the husband, so the wife may use a pill to prevent the man from having an affair and bringing back diseases to the woman".

Of the 56 women in the study, 21% (n=12) reported having an abortion, but it was unclear from the respondents where and from whom they had the procedure performed. The most common reasons for seeking and obtaining an abortion were financial concerns, young children at home, interruptions in education, and paternal or other familial pressures (Table 3). Three women articulate these concerns by saying,

"When you don't have money to care for the children, you end up destroying the life of the child. I have to borrow loans to take care of the children I have".

"It is best to only have enough children that you can give your best to. When you have so many children, you can't financially take care of them all".

"I was afraid of my mother. Some are in school and they are afraid their parents will waste their money if they do not complete school. So, they end up aborting. Some of them, they didn't plan to have a baby. Then they realize that if they have the baby, they will be unable to take care of their child. Some of them, the men refuse to take responsibility for the pregnancy so they abort the baby".

The majority of women who reported having an abortion had an abortion at an estimated gestational age of 8-12 weeks with the latest gestational age of an abortion being 26 weeks. Four women reported health problems from their abortion, with 2 reporting abdominal pain, 1 reporting bleeding, and 1 reporting fetal damage. One woman said,

"Some women consider the month and duration of the pregnancy when deciding to abort, but once I made up my mind and decided to abort the baby, I did it no matter what month I was in".

"The concoction is made of glass shards that are strained and inserted in the vagina to destroy the baby in the uterus. I know 5 women that have bled by trying to abort the baby so late this way, but it was necessary for me to be able to go to the hospital to finish it".

A majority of women who had an abortion also reported being unable to time that pregnancy, however, this was not one of the cited motivations for obtaining the abortion. Reasons cited for being unable to time the pregnancy followed the same distribution as the total number of women reporting the inability to time their pregnancies (Table 2). Women who had an abortion also felt the best form of family planning was fertility awareness.

"Having sex during the safe period of the menstrual cycle is the best method of preventing pregnancy because it does not make one susceptible to sickness or diseases from the pills".

Of the respondents, 86% (n=88) reported knowing someone who had an abortion. The reasons cited for having the abortion were also financial and paternity concerns. The most commonly reported methods of abortion were herbal drugs, mechanical methods such as a dilation and curettage, and non-specific drugs purchased at a local pharmacy. A majority of men and women interviewed felt the safest method was to go to the hospital for a dilation and curettage, however, it was necessary to induce an illness by various methods and then go to the hospital where a dilation and curettage would be performed for maternal indications. The majority of community members felt that most women who underwent an abortion (whether in-hospital or at home) had experienced health complications as a result, with the most commonly reported complications including infertility, death, and unspecified diseases.

"The women know amongst themselves of special herbs that they pass in to their vaginas, but do not drink it. The herbs enter the uterus and destroy the baby and it comes out".

"Some take local wine or gin with a lot of salt. It is a quick method of aborting the baby".

"The safest way to stop a pregnancy is seeing a doctor in a hospital for a D & C. The local doctors cannot be trusted to keep it a secret".

Members of the focus group echoed what respondents said and added,

"They hear from somebody what drugs they should take. Most of them take misoprostol from the chemical shops or some sort of herbal drug they find. Others will go to the hospital to abort the pregnancy after failing to abort at home, those women don't come here. Some will drink a lot of molten sugar. Others will chew tree leaves from a tree with flowers. They boil it and drink it".

"When they [the male partners] are not expecting such pregnancies because they are married to another woman, they will put pressure on their girlfriend to abort the pregnancy; he may provide the money or drug to perform the abortion".

Table 4: Reasons for choosing not to abort (n=77)

Variable	Number (%)
Death/complications	23 (12)
Spiritual/fear of Godly punishment	12 (15)
Social stigma/avoiding disgrace	32 (41)
Late gestation	7 (10)
Law/arrest	3 (5)

Respondents also described reasons women cite for ultimately not obtaining an abortion, including fear of community disgrace and social stigma, fear of death or health complications, fear of divine punishment and spiritual motivations, and fear of arrest after violating the law (Table 4).

Overall, interviewees felt that abortion was *"wicked"* and would *"cause a woman to suffer a lifetime of guilt"*, some recognized that it was occurring in their community and that they would not treat a woman differently for having had an abortion but others acknowledged that women would suffer social stigma or spiritual harm, especially if she chose to abort after it was known throughout the community that she was pregnant.

"After 6 months you should not abort for fear of God and death. They would have disgust and hatred of that woman".

"If a woman stops a pregnancy and has a near-death experience the people will come and comfort her, but if she is healthy and aborts the baby, they many not have the confidence to tell her to her face, but they will gossip about her with others".

"Because she has sinned against God, the community will shun her and hate her".

"It is dangerous when it [the pregnancy] is known to others because someone can attack you spiritually to cause your death when you attempt to stop it".

"We can likely reduce it, but we won't be able to eliminate it. Once they have in their mind that it is unwanted, they will do anything to stop it".

Discussion

The results of this study suggest that women in the Barakese subdistrict recognize that abortion is occurring in their community, as 86% reported knowledge of a woman who had an abortion. However, few women that were interviewed reported having an abortion themselves, underscoring the likelihood that abortion incidence is underestimated in Ghana, as previous studies have suggested[9]. The reasons for underreporting are likely due to unfamiliarity with abortion law, as well as stigma from family and community members[9,11,12]. In this study, key themes related to the perception that abortion is common and, often necessary conflicted with the same attitudes, often held by the same respondents, that abortion is illegal, sinful, dangerous, shameful, and guilt-inducing. These conflicting positions were also noted by Hill and colleagues, in 2009, adding that none of their respondents knew the legal status of abortion, but most reported abortion to be illegal[12]. Interestingly, relatively few respondents cited illegality of abortion as a motivating factor to continue a pregnancy rather than pursue abortion.

Aware of the physical consequences of unsafe abortion, including severe bleeding, infection, and death, women still choose to abort their pregnancies unsafely, having greater fear of the personal costs of having a mistimed, unwanted pregnancy—mainly financial stress and paternal pressures—which for many women outweigh the perceived social, religious, and community costs of aborting. Due to the qualitative nature of this study, we were not able to determine which factors make a woman more at risk for undergoing unsafe abortion, such as education level, age, religious affiliation, etcetera, which would be imperative in future studies. Payne et al. describe that despite trained abortion providers in Ghana, safe abortion services are underutilized, suggesting that increasing accessibility, as well as cultural acceptability of abortion, need to be established to reduce unsafe abortion by increasing utilization of already established safe abortion services[13].

The healthcare workers interviewed for this study are aware of unsafe abortions in the community as well as the pressures that women face to abort. Women are familiar with contraceptive options, but that knowledge does not seem to translate into increased uptake of modern methods, fewer unwanted pregnancies, or decreased unsafe abortion[14-17].

Comparable to the findings in this study, Aniteye and Mayhew found that women admitted to the hospital with abortion complications in Ghana were likely to have knowledge of family

planning, but a lesser understanding of specific modern methods, including oral contraceptives, injections, and implants. Most notably, this group lacks knowledge of how modern methods work and what side effects to expect, with 41% avoiding use due to fear of side effects, a common theme among the respondents from this study[18]. Only 17% of the women surveyed report having ever used any method, compared to 39% of the national population reporting ever using any family planning method[18]. Their findings similarly underscore the gap between knowledge of family planning and uptake, reinforcing the narratives repeatedly heard while in the field during this study.

Women, in this study, prefer to use the fertility awareness method for family planning due to the aforementioned wariness of other modern methods, however, in an analysis of DHS data between 2008-2014, the prevalence of traditional method use was less than 5% and modern method use approached 18%[19]. Community health workers confirmed this reversed trend in the subdistrict, recognizing that their patients often misuse or discontinue hormonal methods when patients experience amenorrhea, and revert to intermittent abstinence, the withdrawal method, or other fertility awareness methods. A recent qualitative follow-up of a DHS survey in Ghana also showed that a number of women reporting an unmet need for contraception were using traditional methods[20].

Given the unmet need for family planning services and the lack of uptake of modern contraceptive methods, there is a need to improve patient education regarding contraceptives, including expected side effects. However, there is a correlation between lack of formal education and lack of uptake of modern family planning, suggesting that improving basic education, especially among females, is a key step in increasing use of modern family planning[15].
Barriers to accessing family planning resources still exist in Ghana[15]. In addition to improving basic education, family planning services need to be expanded in each district to reach rural areas, health education needs to involve community peers to help dispel rumors and misinformation regarding side effects, and the benefits of family planning services need to be stressed to male partners. Complete reproductive health care involves comprehensive sex education, access to all methods of family planning, and counseling and access to safe, legal abortion. Health workers and the public need to be educated concerning local law and the availability of services in rural and peri-urban Ghana, but further work needs to be done to understand the best ways to provide and disseminate that knowledge.

Conclusion

There is a significant knowledge gap between benefits and risks of contraception, as well as known and expected side effects, prompting most women to avoid using it. This can lead to increased unwanted or mistimed pregnancy and ultimately unsafe abortion. Despite the anticipated physical, cultural, legal, and religious consequences of unsafe abortion, women still choose to abort their pregnancies unsafely, having greater fear of the financial and familial burden of a mistimed, unwanted pregnancy. In order to reduce unsafe abortion by improving uptake of modern family planning methods, barriers to access to and the appropriate use of safe, legal family planning services need to be recognized and addressed.

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Contribution of Authors

Study was conceived by Ty T. Dickerson, Daniel Ansong, and Scott Benson. The study was designed by Tenley R. Klc and Stefanie Ames. Data collection and analysis performed by Tenley R. Klc, Stefanie Ames, Owusu O. Asibey, and Brooke Zollinger. Manuscript was prepared by Tenley R. Klc and Ty T. Dickerson. The authors were sent a copy and approve of the final manuscript.

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