Healthcare professionals’ experiences of working with abortion care in Ghana
A qualitative study about saving lives

Hälso- sjukvårdspersonalens erfarenheter av att arbeta med abortvård i Ghana
En kvalitativ studie om att rädda liv

Author: Linn Bruno
        Cecilia Lindh
Tutor: Mia Kraft
       Stephanie Paillard-Borg
Examinator: Lars Strömberg
ABSTRACT

Background: Abortion continues to be stigmatized in Ghana even though Ghana has one of the most liberal abortion laws in West Africa. This stigmatization discourages women from having safe abortion and discourages the health care professionals to provide services for abortion. The recruitment of healthcare providers is therefore marginalized, isolated and difficult. Aim: The aim of the study is to describe the healthcare professionals’ experiences of working with the abortion care in Ghana. Method: Five qualitative, semi-structured interviews were conducted with healthcare professionals working at two different governmentally owned hospitals in Ghana. The findings were analysed with qualitative content analysis. Results: Four main themes emerged in this study describing healthcare professionals’ experiences of working with abortion care in Ghana; Context, Nursing care, Challenges and Saving lives. The healthcare professionals work is stigmatized and challenging but the best part of their profession was helping adolescents, families and saving lives. Conclusion: To save lives, enhance the working situation for the healthcare professionals and to reduce stigma, education and better working environment is necessary.

Key words: abortion, adolescents, Ghana, healthcare professionals, saving life, stigma
SAMMANFATTNING


Nyckelord: abort, Ghana, hälso-sjukvårdspersonal, rädda liv, stigma, ungdomar.
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INTRODUCTION

Maternal mortality is the second most common cause of death among women in Ghana and one of ten maternal deaths are caused by unsafe abortions and abortion related complications. To decrease the maternal mortality rate (MMR) skilled healthcare professionals and accessible healthcare facilities is needed. With a special interest in sexual and reproductive health and rights (SRHR) and empowerment of women, the authors wanted to find out how the healthcare professionals experienced working with issues as branded by stigmatization as abortion care. In a country where two out of three abortions are conducted under unsafe conditions a foundation of trust for the healthcare profession is vital. Through discussions with exchange students from Ghana, the curiosity about the healthcare professionals experiences of their work increased, which resulted in this study.
BACKGROUND

Sexual and reproductive health and rights

Human rights include the right to sexual and reproductive healthcare and the right to decide if and when you want to have children, so called family planning (Hulter, 2015). In large parts of the world these rights are not respected (ibid). Sexual and reproductive health and rights (SRHR) is a difficult and controversial issue internationally (http://www.manskligarattigheter.se). Sexual and reproductive ill health is one of the most common health problems among women in the ages of 14 to 44 in low and middle-income countries (LMICs). Early pregnancies, delivery with complications and/or unsafe abortions are some of the dangers that can affect maternal health. SRHR is essential because of the correlation with equity in health and the empowerment of women (ibid). According to a report conducted by UNICEF (2008), the Millennium Development Goal (MDG) 5 was to reduce the maternal mortality ratio (MMR) by three quarters between 1990 and 2015. The progress on reducing the MMR has been slow and neglected in some parts of the world (ibid.) However, Mocheraud et al. (2016) indicates a significant progress was accomplished during the MDG era, in the countries with highest burden. To address the new Global Strategy for women, children and adolescents’ health the global community needs to invest in strengthening actions in the health system (Mocheraud et al. 2016).

According to Yao Gbagbo, Amo-Adjei, & Laar (2015) prevailing socio-demographic, cultural norms, economic situations and values concerning pregnancy and childbirth is some of the factors for deciding to terminate a pregnancy. However, the major push factor for choosing abortion is noted as the strict enforcement of religious standards. Action needs to increase the accessibility of high quality care (ibid). However, the underlying political and social determinants of health need to be addressed and knowledge of how to improve the outcomes for vulnerable groups, such as adolescents, needs to be prioritized (Mocheraud et al. 2016). Ganle, Obeng, Yeboah, Tagoe-Darko & Mensah (2016) implies that the Reproductive Health Strategic Plan in Ghana acknowledge unsafe abortion as a hindering factor for the country’s goal at achieving MDG 5 target.
Abortion condition globally

Globally, more than 500,000 women die every year due to sepsis, hemorrhage, hypertensive disorders and unsafe abortion (UNICEF, 2008). There are 22 million unsafe abortions conducted every year around the world according to The World Health Organization (WHO) (http://www.who.int). WHO defines unsafe abortion as a procedure for terminating a pregnancy performed by persons lacking the necessary skills or in an environment not in conformity with minimal medical standards, or both (ibid). According to WHO (2015) safe, effective and evidence-based interventions exist but there is a lack of skilled health care professionals. Furthermore, barriers that limit the access to safe abortion care are certain regulations and policies, but also an unwillingness and stigmatization by some health care professionals to provide care (ibid). This exposes subpopulations of women such as less educated, poor, rural, adolescents and unmarried women to the risk of unsafe abortion (ibid.) UNICEF (2008) emphasizes that family planning and access to effective contraception contributes to maternal health. In countries with a high birthrate, promotion of family planning could prevent one third of the maternal deaths. In addition, contraception can avert women from resort to unsafe abortion (ibid). Every year, two to four million adolescents is estimated to conduct unsafe abortions globally. These millions add significantly to the number of deaths and permanent injuries (UNICEF, 2008). The underlying causes of the choice to conduct unsafe abortion are social factors such as poverty, socio-economic inequity, women’s low status and attitudes towards women and their needs (ibid).

Abortion condition in Ghana

Ghana is located in West Africa in the Sub-Saharan region (Dalton et al. 2013). The country has a population of twenty-five million and most of the population lives in rural areas. The total fertility rate reach from 3.1 in urban areas to 4.9 in rural areas (ibid). There are also large differences across the nation in access to health service, modern contraceptive use and MMR (Dalton et al. 2013). Despite differences in MMR across the nation, the rate is considered poor at its 319 per 100,000 live births (Anitiye, O’Brien & Meyhew, 2016). Guttmacher institute (2010) describes maternal mortality as the second most common cause of death among women in Ghana. Furthermore, the Guttmacher institute (2010) also reveals that more than one in ten maternal deaths is caused by unsafe abortion. According to Dalton et al. (2013) two out of three abortions in Ghana are still conducted under unsafe and illegal
conditions. It is estimated that fifteen to thirty percent of the maternal deaths in Ghana is caused by abortion-related complications (ibid). The Maternal Mortality Re-View Committee in Ghana has determined that causes of maternal deaths are hemorrhage, ectopic pregnancy, hypertensive disease of pregnancy, eclampsia and preeclampsia, infections and abortion complications (Adomoko et al. 2016).

The Ghanaian law from 1985 allows abortions to be performed by medical practitioners if the pregnancy is the result of rape or incest (Dalton et al. 2013). It also allows abortion if it is a risk for the life of the mother, if it is threatening the woman’s health or if it is a significant risk that the child would suffer from a disease or physical abnormality (ibid). The law did not specify gestational age limits or methods for the procedure (Aniteye et al. 2016). Medical practitioners are permitted to conduct surgical abortions in designated healthcare facilities but a clear definition of medical practitioner was not emphasized in the law. The Ghana Health Service produced an operational protocol year 2006, where unsafe abortion management and post-abortion care procedures were included (ibid). This document explicated that doctors, nurse/midwives, community health officers, obstetricians and medical assistants with training are permitted to provide medical or surgical abortions. If the pregnancy has been less than nine weeks, a medical abortion is allowed to be performed by a nurse/midwife or a community health officer (ibid). After nine weeks of pregnancy the medical abortion has to be supervised by a doctor. The content of this protocol was not known by many of the healthcare professionals working with obstetric and gynecological care (Aniteye et al. 2016). Guttmacher institute (2010) illuminates the fact that many women most likely turn to unsafe providers because of unawareness of the Ghanaian abortion law. Many women probably do not obtain adequate post-abortion care because of their unawareness of that abortion is legal in Ghana (ibid). Unsafe abortion among adolescents contributes to the maternal morbidity and mortality in Ghana (Aniteye et al. 2016). The incidence of abortion is highest among women in their early twenties and among educated, wealthy women (Guttmacher institute, 2010). Asare, Blemano, Darteh & Esia-Donkoh (2015) confirms that the highest amount of abortions is among young women, sixteen percent is less than twenty years old in Ghana.

The abortion rate is twice as high in urban areas than in rural areas (Guttmacher institute, 2010). In the Greater Accra and Eastern Regions there are almost 50 percent of the young
unmarried women, who had been pregnant, chose to end their pregnancy. The main reasons for young people to abort are fear of education discontinuity, poverty, shame and stigma (Asare et al. 2016). Dalton et al. (2013) describes that abortion continues to be stigmatized in Ghana even though Ghana has one of the most liberal law about abortion in the region of Sub-Saharan Africa. This stigmatization discourages women from having safe abortion and discourages the health care professionals to provide services for abortion. The recruitment for health care professionals is therefore marginalized, isolated and difficult (ibid).

**PROBLEM STATEMENT**

Although many studies have been conducted concerning abortion and its risk-factors, a limited number has been focused on the experiences of healthcare professionals concerning these issues in Ghana. Due to the stigmatization in the community, there is lack of skilled personnel and the accessibility of the service is therefore limited. This leads to a challenging situation for the healthcare professionals. It also increases the risk of premature death among adolescent women who are particular vulnerable. By understanding the work situation of the healthcare professionals, knowledge can be disseminated to enhancing the work conditions of abortion care.

**AIM**

The aim of the study is to describe the healthcare professionals’ experiences of working with the abortion care in Ghana.
METHOD

Design
This is an empirical qualitative study conducted with semi-structured interviews. According to Henricson & Billhult (2012) a qualitative study is based in the holistic tradition and it pertains to investigate the person’s experiences of a phenomenon. The intension of the qualitative study design is that the research is located in the natural place of the phenomenon (ibid). Experiences of the phenomenon can only be properly described in a context of the abortion care. Therefore, this method was chosen for this particular study.

Sample
The research demanded two gate-keepers to convey connection with hospitals and suitable informants for the study. The first contact with Gate-keeper 1 was established in Sweden, nine months before the research was taking place. Gate-keeper 1 was the principal of a nursing training school in rural Ghana and was introduced to the aim of the study by an information letter. Gate-keeper 1 disseminated the aim and proceedings to a colleague, who became Gate-keeper 2. When at site Gate-keeper 2 handed the information about the study to the current hospitals and applicable informants were introduced to the study.

Visits were made to Akim-Oda Government Hospital and La General Hospital in Accra during the first week to establish contacts. Before arriving, an information letter (appendix 3) was sent to the facilities and at site the study was presented to the manager of the hospital and the head nurse who gave their permission to conduct the interviews. With assistance from the head nurse, contacts with the health care professionals in the family planning department were established and informants were selected. A total of five informants were selected. The inclusion criterion for the participating informants was a minimum of six months experience of working with abortion care. They also had to be able to communicate and express themselves in English. Healthcare professionals’ who were not nurses or midwives educated in Manual Vacuum Aspiration (MVA) was excluded during the research. The healthcare professionals were strategically selected to get a variation and insight among the informants on the phenomenon of this study. However, the informants had different experiences of the abortion care. Their age, education, work experiences and lineage gave a variation in the study. The healthcare professionals, who voluntarily participated in the study and whom were
compatible with the inclusion criterion, were handed a letter that contained information about the study and the main topics of the interviews were presented. Two health care professionals were describing their aspects of working with abortion care of adolescents in a rural area of Ghana. Three health care professionals described their experiences of the same phenomenon in a city with a cosmopolitan nature, in the Greater Accra region. Both facilities were governmentally owned. The conducted interviews took 15-30 minutes each.

**Data collection**

In this study, data was collected through semi-structured interviews. An interview guide (appendix 1) designed with questions to fit the aim. The first draft was created in Sweden but at site the interview guide was rewritten several times. The interview guide was tested a week before the first interview which resulted in a few changes. The changes made were modification of the written language and adding of one more question. The questions were organized in different themes; work environment, safe/unsafe abortion, knowledge of abortion laws and effects on the maternal mortality rate (MMR).

Before each interview, a presentation was given to the informants about the authors LB and CL and information about the study was explained. The informants were asked to sign a consent form (appendix 2), which explained the informants’ right and chance to withdraw from the study at any time, for any reason. The consent form also stressed that participating in the study was voluntary and that the informants were kept anonymous during the whole process.

During the interviews, LB was conducting the interview and CL was observing and taking notes. A dictaphone was used to record the interviews, making the transcription easier. The roles/positions were switched after each interview and the interviewer got response from the observer. The recordings were deleted after transcribing to follow the demands of confidentiality.

**Data analysis**

A qualitative content analysis with an inductive approach was chosen to analyze the collected data. This method was chosen to be able to interpret and find meanings in a deep context in the interviews (Danielsson, 2012a). After each conducted interview the recorded data was
transcribed by one of the authors. To make sure that the transcription was correct, the recorded interview was listened to again by the other author and corrected if needed. Then the text was read four times to make sure that the content were correct and understandable. Afterwards, the text was divided into smaller units in correlation with the aim of the study. The units were highlighted individually and then discussed between the authors. These highlighted parts became the units of meaning. The units of meaning were inserted in a chart and then shortened to condensed units of meaning. To gain an understanding how one unit of meaning could link to another, subcategories were made. The subcategories were then discussed and different main categories were created. A total of 136 units of meaning led to twenty-eight categories. The categories were then organized under four themes and seven sub themes, which become the headlines of the study; Context, Challenges, Nursing Care and Saving life (Table 1.).

Table 1. Example of the analyzing method used in this study.

<table>
<thead>
<tr>
<th>units of meaning</th>
<th>condensed units of meaning</th>
<th>subcategory</th>
<th>category</th>
<th>sub-theme</th>
<th>theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>the person will come here, we explain the procedure to the person, we assists her, we position the patient, reassure the relatives that comes with them.</td>
<td>preparing the patient and the relatives for the procedure</td>
<td>caring and information</td>
<td>nursing</td>
<td>caring</td>
<td>Nursing Care</td>
</tr>
<tr>
<td>They know, some of them know, and some of them thinks that when she comes they will insult her or whatever or money problem</td>
<td>despite education they won’t come cause of money and insults</td>
<td>miscommunication</td>
<td>stigma in the community</td>
<td>stigma in the community</td>
<td>challenges</td>
</tr>
<tr>
<td>I don’t know it supposed to be low so that everybody can access easily. (the costs of abortion)</td>
<td>low costs for everybody</td>
<td>access for abortion</td>
<td>access for everybody</td>
<td>situation</td>
<td>context</td>
</tr>
</tbody>
</table>

Ethical considerations

The International Council of Nurses (ICN) (2012) describes ethical codes to be met concerning nursing research. The first code refers to nurses and people which show the importance of including references of human rights, equity, justice and solidarity as basic
needs to the investigation. The code explains the importance to acknowledge the ethical issues in decision making and to provide informed consent, integrity and confidentiality in the research (ibid). By using an ethical review and conducting an information/consent form, the authors acknowledged the ethical issues. The informants were also informed by the consent form that they would be kept anonymous during the whole research. ICN (2012) describes the second code which refers to conducting and disseminating research which links to continual learning and competence in the profession (ibid). This code shows the importance of developing the profession which this research is a part of by providing knowledge to the reader. Moreover, ICN (2012) emphasizes the third code, nurses and the profession, and it describes the importance to conduct, utilize and disseminate research to benefit and to advance the nursing profession. It also enlightens developing position statements, guidelines and standards related to research (ibid). This code was met during background research, the discussion and the publishing of the study. Further ICN (2012) enlightens the fourth and final code, nurses and co-workers, and it describes the importance of developing understanding between different professions in the health care area and to protect the individual, family and/or community when conducting a research (ibid). By interviewing an assortment of professions, an understanding for the other profession emerged. This code was also applied during the whole process due to respect for the individual and the profession.

According to Brüllde & Persson (2011) The Principal of Human Dignity describes that treatment and other arrangements cannot be based on age, gender or sexual orientation. Neither should cultural belongings, social orientation or ethnic attribute interfere with the research (ibid). Brüllde and Persson (2011) emphasize the importance to acknowledge the underlying cultural, ethnical, individual and social contexts when conducting research. It is also of significance to have an open-minded and non-judgmental view to avoid sociocultural bias in the study. Therefore, before arriving in Ghana an ethical review was discussed and presented with possible ethical risks and its measures at the Swedish Red Cross University College. This was taken under consideration when preparing for the research.
RESULTS

Four main themes and eight sub-themes emerged in this study describing healthcare professionals’ experiences of working with abortion care in Ghana; Context, Challenges, Nursing care and Saving Lives (Table 2).

Table 2. Categories analyzed and converted to sub- and main themes

<table>
<thead>
<tr>
<th>category</th>
<th>sub-theme</th>
<th>theme</th>
</tr>
</thead>
</table>
| Knowledge, Clientele, reasons to do abortion, Unsafe abortion | * Clientele  
* Situation | Context |
| Not being trusted, Work motivation, Work environment, Lack of personnel, Stigma in community | * stigma in the community  
* Working condition | Challenges |
| Information, Caring, Helping, Education, Counselling, Preventing pregnancies, Access for everybody | * Health promotion  
* Health prevention  
* Caring | Nursing Care |
| Prevent maternal deaths, abortion law, hope | * saving Life | Saving Life |

Context

The working environment and the clients who are visiting the hospital were mentioned as one aspect that affected the healthcare professionals’ experiences of their work. Therefore the main theme Context was chosen.

Clientele

The healthcare professionals illuminate the fact that everyone who is sexually active and interested in reproductive health is welcome to the facility. Family planning, comprehensive abortion care (CAC) and post abortion care (PAC) are the services offered at the clinic. A wide spread of ages is using the services, mainly female adolescents and every socioeconomic category is represented.

Everybody! Who is interested in reproductive health. So those who are active sexually they come. Teens, adults… they come the males I think they also coming. (Personal communication, 2016)
Adolescents were welcome to participate in family planning at the clinic in a room called *adolescents corner*. The cases dealt with at the clinic are miscarriages, abortion, and complications after unsafe abortions.

**Situation**

The healthcare professionals referred to several reasons for choosing abortion; mental disorders, rape, defilement and incest were some of them. Among adolescents, there was also a feeling of insecurity of whether or not they were ready for the pregnancy, which tinged the decision. According to the healthcare professionals, not being ready could be related to adolescents’ physical and psychological state. Therefore the healthcare professionals felt the need to help adolescents when they had entered the hospital. Other reasons for terminating a pregnancy was economical, family issues or if the client already had many children.

Mentioned by the informants, one of the reasons to choose an unsafe abortion is economic issues. The price of MVA is approximately 100 GHC (226 SEK, 27 november 2016). If the client is an adolescent, the price is adjustable to what she can afford. The family planning price is also adjustable between 50 pesewa (1,2 SEK, 27 november 2016) and 1 GHC (2,27 SEK, 27 november 2016). Even though the price is flexible, some girls do not want to spend their money on abortion. Unsafe abortion, for example through herbal concoction is therefore chosen as procedure instead. The informants spoke about several reasons to go through an unsafe abortion. Accessibility, fear and nobody to talk to were some of the reasons mentioned.

The most common methods to perform an unsafe abortion described by the health care professionals were the use of herbal concoction or by shoving a stick into the uterus. Persons who have conducted an unsafe abortion are often ending up in the maternity ward with complications, which can lead to removing of the uterus or death. The health care professionals stressed the awfulness in dying because of an unsafe abortion and the feelings described were frustration, anxiety and distress:

…She vomits black with green particles inside. Then she said, she went to a certain women in the community and the women proceed the.. she used herbal medicine(…)she became heavy and when we gave the infusion and no output.. they transferred her to gynecology and they lost her! And what!! Everybody was weeping in this room. That if is girl had come early to us we should have saved her life. And she just died…. and it’s not nice at all (Personal communication, 2016).
This quoted case clearly describes the situations the healthcare professionals have to work with on a regular basis. It also gives a perspective of the procedure of an unsafe abortion and its complications.

**Challenges**

The healthcare professionals considered several aspects of their work as challenging. Lack of personnel, lack of resources, stress and stigma affected their working condition.

**Stigma in the community**

Talking to colleagues about abortion was described as OK but several of the health care professionals emphasized that the stigma in the community and the religion made it problematic to discuss outside of work. But if someone asked questions about unwanted pregnancies, the health care professionals felt responsible to help them by referring them to clinic. The informants working in the rural area described feelings of being tagged as an abortionist and sometimes even branded as a devil as of the work they were doing.

…but when you move out in the community they look at you, therefore something like the abortionist . . . they are encouraging human to have sex. They encouraging what’s what so it like they branding you as devil by..by the work you are doing (Personal communication, 2016).

Not being trusted was a great issue created by stigma in the community. The clients did not rely on the health care professionals, which in worst case, sometimes led to septic abortion. The health care professionals described a desire of being trusted in their profession and wished that the clients felt that they were in safe hands at the hospital. The healthcare professionals illuminated that the people of community did not believe that people were dying from unsafe abortion in Ghana; they believed that it was a foreign issue.

**Working condition**

The stigma around the focus area affects the hiring situation and this result in lack of skilled personnel. The healthcare professionals described feelings of despair when they often were undermanned at the clinic and the work could be tiring, exhausting and stressing. Working at the family planning unit was described as not a calling and the health care professionals emphasized that no one chooses to work at the unit voluntarily in the beginning. They all did it because they were trained for it. Though all of the health care professionals described this phenomenon, several of them were happy with working with family planning and abortions.
In the urban area the health care professionals were working in two shifts, morning and night. A twenty-four/seven service was necessary for the cases of great emergency such as miscarriages and complications from unsafe abortions. Other challenges mentioned were lack of resources. Sometimes there was not enough blood at the hospital to do a blood transfusion and this was really stressful for the healthcare professionals. Moreover, to not be able to save a persons’ life because of lack of hospital beds was also described as demanding.

The working environment and the work motivation were crucial according to the informants. The theatre and the MVA-room were small, hot and the ventilation was packed. According to the health care professionals the current situation was not sustainable.

… and the condition here, the room is very hot, it can be all night, we’ll be here like this… saving lives, sweating at the same time (personal communication, 2016).

To be able to offer a safe and qualitative care the healthcare professionals implied that the environment has to be conducive and comfortable. To gain motivation the health care professionals required a salary that could be accountable to the necessary work they are doing.

**Nursing Care**

Health promotion and health prevention such as family planning, education about SRHR and contraceptives has nursing care as a common theme. To care about the client and educate them is the core of nursing.

**Health promotion**

In the urban area, the knowledge of safe abortion and family planning was disseminated by school nurses and committed community health nurses. Conducting outreach programs was another way of informing the region. During the outreach programs the healthcare professionals explained that their main focus lay on the family planning and not on the abortion. They merely touch the subject of abortion without any details.

The best thing is, we educate them and a good family planning care, so that if you do good family care there would be no abortion, no pregnancies, so no abortion (Personal communication, 2016).

Counseling were the main part of working with CAC and family planning according to the healthcare professionals. In the first stage the health care professionals counseled the client to
keep the pregnancy. If the women chose to go through the abortion instead, a meeting for counseling was scheduled immediately after the abortion.

One informant explained that the education about maternal mortality was poor in the society and this resulted in a high MMR. The healthcare professionals explained that health education was taught in school and in the community but they felt that the information was ignored. They felt like the people in the community did not understand the meaning of a health education.

Health prevention
Knowledge among the health care professionals about the Ghanaian abortion law was mostly focused on preventing maternal deaths. All the healthcare professionals knew that abortion was legalized. An upcoming subject during all interviews was a consent form. The consent form was used to make sure that the client had truly understood the abortion procedure and its risk factors. The health care professionals stressed the importance of presenting this consent form for the client undergoing CAC and/or PAC.

According to the healthcare professionals, the parents to adolescents often argued about their children being too young for sexual education. The health care professionals emphasized that all children should get education about this matters and that parents should teach their adolescents about abstinence, faithfulness and contraception use. The health care professionals recommended condom, both male and female condoms, as of the best contraceptive for adolescents who wanted to be sexually active. Using a condom is a cheap way of preventing unwanted pregnancies and sexually transmitted infections (STI), but they were facing challenges:

…at least they should… at least they should rid their minds of that contraceptives is false, it is for some people, some obruni (white) people. it’s not for us. that’s sometimes what they think (personal communication, 2016).

This and the misunderstanding among adolescents that using contraceptives would cause infertility for life, was some reasons to choose to not adapt the family planning services, according to the health care professionals.

Caring
Caring about the client and helping them in their situation was a core theme through all the interviews. Giving proper information, counseling and including the womens’ relatives in the
abortion procedure was mandatory in all the procedures being conducted at the units. The health care professionals tried to individualize the care of the client and adjusting the care after condition and maturity of the pregnancy. They were also observing side effects or complication after each procedure according to the healthcare professionals in the urban hospital.

Some of the informants were proud of themselves when they helped counsel an adolescent to keep her pregnancy. In their opinion, keeping the baby was always the right decision. Even if abortion was described as bad, the healthcare professionals always helped if needed:

I give my number to them and tell them to give it to another student.. so when they have a friend, I say, if they have a friend and she miss a period and she don’t want to take, um, she don’t want to keep the pregnancy, give my number to her or let the person come and see us here so that we save life (Personal communication, 2016).

The healthcare professionals described that they were personally engaged in helping the clients. Caring and worrying about the adolescents and their private life often led to counseling and education about relationships and family planning.

**Saving life**

The overall view about the informants work was illustrated as the possibility to save lives. This phenomenon was reoccurring in all the interviews and was described as the best thing about their work. The informants stress the importance of choosing a contraceptive method after terminating a pregnancy. If a method was not chosen, the health care professionals experienced that the women would return to terminate another unwanted pregnancy. Two weeks after the abortion the client were rescheduled to make sure of the clients well-being. According to the healthcare professionals the best way to reduce the high MMR is by safe abortions and health education. One informant described that even though everyone knew that abortion was bad, they had to be trained to match the rate of the maternal deaths.

Stopping bleedings related to miscarriages or unsafe abortions, helping adolescents to be able to go back to school and helping desperate parents were the most appreciated parts of the work according to the healthcare professionals. All informants described joy and fulfillment when they were able to help a woman in need and they all did everything they could to save a women's life.
I’m saving life, not I’m killing anybody but I’m saving life, if the person started at home and she comes, and she’s bleeding and I say I will not do it for her because I will be a sinner and all those things, NO I’m saving life (Personal communication, 2016)

By performing safe abortion at the hospitals, the MMR is reduced which leads to the possibility to save lives, despite the stigma in the society. Wishes and hopes for a decrease of unsafe abortions and preventions of pregnancy were stated by several of the healthcare professionals. In the urban area, one of the informants gave a hopeful expression saying that nowadays people in Ghana come to the hospital for abortion and post abortion care.

DISCUSSION

Discussion of methods
The aim of the study was to describe the healthcare professionals’ experiences of working with the abortion care in Ghana. The main part of this study was to describe experiences, therefore a qualitative design was chosen since it illuminates the participant's experiences of a phenomenon (Henricsson & Billhult, 2012). While using a qualitative method, the researchers are a part of the study, as of the fundamental interactions with the informants and earlier experiences of the focus area. Biases such as subjectiveness of this phenomenon can therefore not be disregarded, as of different relations between informants and the authors and the researchers’ previous knowledge about abortion care (ibid). Therefore, the roles/positions between interviewer and observer were switched during the interview, to avoid one-sided thinking and decrease the subjectiveness.

As for the interview a semi-structured method was chosen because of the possibility to adapt the questions to the informants and the surroundings. The method also gives the opportunity to adjust the order of questions and it does not have to be in the same order for each interview (Danielsson, 2012a). However, the use of this method demands a deep understanding about the focus area to be able to find suitable questions to the aim. Information about the human sexuality is sometimes difficult to discuss, even more in societies surrounded by stigmatizations. Adjustments had to be made related to the authors’ upbringing in a high income country (HIC) versus the informants’ upbringing in a low income country (LMIC). Therefore, some of the questions had to be rewritten to address the issues in diverse ways.
Graneheim & Lundman (2004) describes the process of finding suitable informants. To receive a high credibility the informants should represent different views to get various perspectives of the phenomenon (ibid). In this study, informants were selected according to their age, work experience and area of the hospital they were working at. According to Danielsson (2012b) it is preferable to use the same accommodation for every interview. There was no possibility to conduct all interviews in the same room because of different facilities and different levels of hierarchy among the informants. The interviews were held during working hours which resulted in several disturbances which led to loss of focus during the interviews and irregularity in the answers. This may have affected the result.

Full disclosure means, according to Polit & Beck (2012) to completely describe the nature of the research, the researchers’ responsibilities towards the informants in the study and the informants’ right to deny participation. Two persons chose to withdraw from the study. The healthcare professionals were asked to contribute by the head of nurses; therefore a feeling of being forced to assist in the research could have been affecting their decisions. They chose not participate after reading the consent form, which informed about that participation was voluntary. The consent form can be considered as clear and understandable since two of the persons, who were asked to contribute in the study, chose to exercise their rights. The persons stated that they were not qualified to answer the questions, even though they did not know exactly what the research was about. This can be a result of the strict hierarchy in the hospital and fear of the risk to answer incorrect in the interview. If these persons had contributed in the study the result may had differ. The number of informants in this study affects the generalizability. The lack of skilled personnel in this limited area resulted in only a few interviews. Despite the few interviews the transferability of this study can be applicable in other areas or countries where there is a similar culture. Graneheim and Lundman (2004) describe another way of evaluate the findings to access credibility; to carefully illustrate how the analysis procedure was processed. In this study the analysis is carefully narrated and every part of the process was evaluated by the authors which strengthened the credibility. During the analysis and the result representation, the study has been peer-reviewed which contributes to high trustworthiness. Due to the quantity of the interviews, it may have been possible to identify the informants by the quotations. To be able to keep the anonymity of the informants, the authors chose not to reveal date and interview number in the quotation references.
Discussion of results

The findings of this study showed that the overall aim of the nurses’ work with abortion care in rural and urban areas, was to support adolescents and families to be able to save lives and decrease the MMR. Counselling, education and personal engagement was the key to good nursing care. However, because of the context the healthcare professionals was facing challenges such as stigma, lack of resources and lack of skilled personnel.

Situation regarding the abortion issue

As the Guttmacher institute (2010) is explaining, the incidence of abortion is highest among women in their early twenties and among educated, wealthy women. The findings of this study showed that women in a wide spread of ages and socio-economic status were using the family planning and CAC services but the most frequent clients were female adolescents. Wealthy and educated women could be more represented than the poor and uneducated part of the population related to several factors. For example the high price of conducting a safe abortion is one of the prior reasons why wealthy women are more represented at the clinics. With education, knowledge about human rights and laws, as well as knowledge about the anatomy of the female body would occur. This could be the reason contributing to the high level of educated women seeking for safe abortion. The rate of safe abortions is twice as high urban areas than in rural areas (Guttmacher institute, 2012). This shows that access to the services are another factor which affect the incidence of safe abortions.

Guttmacher institute (2010) implies that knowledge of the Ghanaian abortion law is not widespread among the healthcare professionals. Only fifty-four percent of the providers were aware that abortion was legal if the womens’ life were in danger (ibid). The five informants that were interviewed for this study knew about the laws due to the consent form used in the clinics. However, the law is more complex than the consent form reveals. Therefore it is important to educate the healthcare professionals about the laws of abortion and SRHR to prevent abortion being conducted in unsafe environments. This is confirmed by Aniteye et al. (2016) who explains that the resistance of abortion care is correlated to fear of stigmatization and juridical threats. It is increased by the ambiguity of the abortion law and the lack of institutional endorsement Asare et al. (2015) describes that the main reasons for young people to abort are fear of education discontinuity, poverty, shame and stigma. The healthcare professionals in this study referred to these reasons as well, but they also mentioned other
reasons for choosing abortion, such as; mental disorders, rape, defilement and incest. If rape, incest or defilement resulted in a pregnancy, there could be feelings of desperation and distress by the mother which may end in an abortion. Kumi-Kyereme, Yao Gbagbo and Amo-Adjei, (2014) confirms that misinformation and desperation among women can result in women conducting unsafe abortions performed by male-partners, parents, friends or unlicensed providers.

Ganle et al. (2016) implies that maternal education is associated with reproductive health services, including abortion. Maternal education could influence empowerment of women, being able to decide regarding reproductive choices and access to abortion services (ibid). The health care professionals stressed that knowledge about reproductive health and education could save lives. With awareness of SRHR, a decrease of unwanted pregnancies could occur, leading to a reduction of unsafe abortion. Empowerment of women and education about SRHR could lead to equity and decreased MMR. Ganle et al (2016) also emphasizes that the need for abortion could never be fully eliminated, despite availability and modern contraception use. Yet, improved access to family planning and effective contraception use has been demonstrated as a significant pathway to reduce the incidence of unsafe abortions and unwanted pregnancies (ibid.)

Experiences of healthcare professionals working with abortion care
Dalton et al. (2013) describes that abortion continues to be stigmatized in Ghana even though Ghana has one of the most liberal abortion law in the region of Sub-Saharan Africa. As a result of the stigmatized community, the healthcare professionals in this study described feelings of not being trusted by the clients as a great challenge. According to Aniteye et al. (2016) abortion and providers of abortion care are stigmatized by the community but also by the healthcare professionals themselves. The stigma affects the abortion care providers to being reluctant to provide safe and legal services. The informants in this study described feelings of being tagged as an abortionist and sometimes even branded as a devil as of the work they were doing. Working with sexual and reproductive health in a stigmatized community is not easy. The fact that sexuality is personal, versatile and tinged by society and religion contributes to make abortion a hard topic to discuss in the community. It is important that the healthcare professionals who face the clients have an open mind and a positive,
respectful approach. The situation in the community can then be altered and the stigmatization reduced.

Stigmatization discourages women from having safe abortion and discourages the healthcare professionals to provide services for abortion. The recruitment for healthcare professionals is therefore marginalized, isolated and difficult (Dalton et al. 2013). Aniteye et al. (2016) Negative attitudes among healthcare professionals, because of religious and socio-cultural norms, can develop a stigmatized environment for the clients in abortion care (ibid).

McLemore, Kools & Levi (2015) defined that the nurses described a clutter of personal attitudes, feelings, beliefs and professional responsibilities as healthcare professionals. To handle the involvement in all these issues, the healthcare professionals describe fighting with the own self, which included to separate self from the patients and becoming self-aware (ibid). The informants in this study claimed that abortion is "bad" which can be interpreted as a negative view of abortion, which could reflect on the client. The care should be offered regardless of personal views and attributes of the healthcare professionals. SRHR should be respected and protected, free from oppression, stigmatization and discrimination from the client as well as of the healthcare professional. SRHR represents the rights to sexual and reproductive health care and nobody has the right to violate another humans rights.

According to WHO (2015) most countries, including many high-income ones, have a disparity in the accessibility of an advanced health workforce. This is highly represented among rural communities (ibid). Lack of trained healthcare professionals affects not only the clients and the accessibility but also the working environment, causing stress and impairing of the professions. A need of more trained healthcare professionals is also of importance to extend the services and expand the accessibility. Deficits among healthcare professionals are especially critical in regions where a high burden of unsafe abortion and related mortality is represented. Focus has to be on providing abortion care services in rural areas where the MMR is highest and the women are most vulnerable. Giving proper information, counseling and including the women’s relatives in the abortion procedure was mandatory in all the procedures being conducted at the unit. UNICEF (2008) emphasizes that family planning and access to effective contraception contributes to maternal health (ibid). Healthcare professionals caring about their patient by giving them counseling and information could enable sexual and reproductive health, including maternal health. SRHR includes the rights to
search and receive information in relation to sexuality and sexual education. Through counseling and support the healthcare professionals can increase the patients’ possibilities to sexual health and well-being.

The findings of this study show a great will to help women in need. Even though the healthcare professionals work was stigmatized and challenging, the best part of their profession was helping adolescents, families and saving lives. The wish and hope for a decrease of the MMR and the desire to save life is mutual for the healthcare professionals in this study. Guttmacher institute (2010) described the two most important aspects of achieving the fifth MDG of improving maternal health and saving lives. The aspects were to identify and overcoming the barriers to develop the abortion law and to prevent women from unwanted pregnancies (ibid). If the working conditions, the laws and the stigma in the community where altered and improved; more lives could be saved and the healthcare professionals would be even more proud over the work they are doing.

**Conclusion**

The findings of this study indicate that healthcare professionals’ experiences of abortion care are variating. Feelings of not being trusted, being branded as an abortionist and a devil were affecting the healthcare professionals working situation. The stigma in the society is affecting both the recruitment of more providers and the situation for the young pregnant women seeking for abortion. To decrease the stigma in the society, education is necessary. Because of lack of providers the healthcare professionals described feelings of despair, tiredness, exhaustion and stress The income is not enough and the working environment is not conducive according to the healthcare professionals. The salary should be higher and the working environment could be changed by simple measures such as air condition and ventilation. These measures would improve the hiring situation of skilled personnel. Health systems that provide skilled healthcare professionals in abortion care can make a difference between life and death related to abortion and complications from abortion. Lack of resources, lack of skilled trained healthcare professionals and stigma challenged the healthcare professionals to give out the best possible care. Despite this, the healthcare professionals expressed motivation to save life with the aim of reducing the MMR in Ghana.
Clinical significance

The challenges illustrated in the result are common in the rest of the world and not only specific to Ghana. Therefore, by illuminating the working situations in the abortion care, the knowledge can be disseminated to enhance the working condition of the healthcare professionals. The method to train midwifes and nurses to conduct an MVA are shown as an effective way of increasing the accessibility to abortion care. With this procedure and better working conditions there would be more healthcare professionals providing care which is necessary in order to fight maternal mortality.

Suggestion for further research

In this study, the experiences of health care professionals were in focus. It would be interesting to do the same research from the clients’ perspective; are they affected by the healthcare professionals working situation? Another interesting perspective would be the male populations (non-health professionals) view of the abortion situation in Ghana. Studies with combined informants such as nurses, midwifes and client should strengthen and deepen the subject and more informants would also increase the credibility of the study.

Authors contribution

Both authors were equally engaged during the whole process. However, during transcribing and analyzing the execution were kept separate and then rewritten by the other to make sure that the result were correct. When writing, the different parts were divided between the authors and then proofread by the other. Both authors discussed the problems that occurred and found usable conclusion to each issue. The authors’ contribution was equally divided from start to end.

Acknowledgement

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REFERENCES


International Council of Nurses. (2012)


APPENDIX 1.

Interview guide

Work environment

- Can you describe one day at your work?

- What kind of patients do you treat here., (age, socioeconomic status, reason to go through an abortion)

- Can you reflect on the best thing about your job?

- Can you reflect on the worst thing about your job?

Safe/unsafe abortion

- What is your point of view of unsafe abortions?

- What is your experience of the abortion care in this hospital?

- Can you tell me about a situation you have experienced related to unsafe/septic abortions? How did you feel when it happened?

Knowledge of the abortion laws and stigmatization in the community

- Can you tell me about your view when it comes to the abortion situation in Ghana?

- What is your knowledge about the laws of abortion in Ghana?

- Can you tell me how it is to talk about abortion with your family, friends, at school?

Effects on the maternal mortality rate

- What do you think will be needed to decrease the maternal mortality rate when it comes to abortions in Ghana?
APPENDIX 2.

Consent form

We are two nursing students from the Swedish Red Cross University College in Stockholm, Sweden. We are writing our bachelor thesis in the South of Ghana this semester. The aim of the thesis is about healthcare professionals working in the family planning department.

You will be asked to participate in an interview which will take about 20 minutes. During the interviews we will take field notes and we will also record the interview.

If you choose to participate in this study we would like to inform you that participation is voluntary and you can withdraw from the study at any point, for any reasons. We would also like to inform that you will contribute anonymous in the study.

Please sign the attached consent form if choosing to participate.

_____________________________  _______________________
Date, Place  Date, Place

Linn Bruno  Cecilia Lindh
Nurse student at the Nurse student at the
Swedish Red Cross University Collage Swedish Red Cross University Collage
I, hereby consent to participate in the study.

____________________________________
Date, Place

______________________________
Signature

______________________________
Clarification of signature
APPENDIX 3.

Information letter

We are two nursing students from the Swedish Red Cross University College in Stockholm, Sweden. We are writing our bachelor thesis whose aim is about healthcare professionals having experience working within family planning in the Southern part of Ghana.

The informants will be asked to participate in an interview which will take about 20 minutes. During the interviews we will take field notes and record the interview. The interviews will be performed during working hours but according to your most suitable availability.

Participation is voluntary and withdrawal from the study can be done at any point and without explanation. The participation to the study is anonymous and the data concerning this study will be destroyed after the completion of the study.

If you have any question, you can contact us and send us an email.
xxxxx@gmail.com

Best regards
Linn Bruno and Cecilia Lindh.