Abortion-Possible and Impossible: Stigma and the Narratives of Ghanaian Doctors Who Provide Abortions

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The following narrative describes the legal, financial, and social barriers that make access to abortion difficult in Ghana, where abortion is illegal, but accessible. Stigma is attached not only to the women seeking an abortion, but to the physicians who perform them.

According to World Health Organization (WHO) estimates, approximately 80 women around the world have an abortion each minute. Of these, nearly 39 per minute occur in unsafe conditions. Between 2003 and 2008, unsafe abortion rates remained unchanged, with 14 out of every 1,000 women between the ages of 15 and 44 experiencing an unsafe abortion (World Health Organization 2007). Though legal and financial barriers to safe abortion exist throughout the world, stigma is a fundamental cause of unsafe abortion and maternal mortality (Kumar, Hessini, and Mitchell, 2009).

As Kumar and colleagues describe, abortion stigma operates at multiple levels within society, from the socio-cultural to the individual. Abortion stigma exists across the globe, but its character and particularities can be "profoundly local," manifesting in varying degrees of intensity and consequence to the women who seek abortions and the providers who perform them (Kumar et al., 2009, p.3). In Ghana, we witnessed stigma operating at the intersection of law, policy, clinical abortion care, and the lives of women seeking abortions. We also came to understand the impact such stigma had on maternal mortality.

We began our work in Ghana as a group of researchers who, through our work with U.S. abortion providers, have documented the intensity and importance of abortion stigma in the lives and work of abortion-care providers. We have argued that U.S. abortion stigma is so pervasive and powerful that it creates dangerous situations, both for women seeking abortions and for the healthcare providers serving these women. Our work in Ghana began in the context of a long-standing institutional partnership between the University of Michigan and the medical schools at University of Ghana and Kwame Nkrumah University of Science and Technology. In 2009, one member of our team, a University of Michigan Obstetrics and Gynecology faculty member, engaged four Ghanaian physicians known for their commitment to safe abortion services in open-ended, semi-structured interviews.[1] The following year, our team participated in additional conversations in Accra and Kumasi with doctors, midwives, and administrators from nongovernmental organizations (NGOs) and university hospitals. Among other topics, we explored the culturally specific ways in which these professionals observe the effects of abortion stigma.

In Ghana, abortion is illegal, but accessible. Maternal mortality is high: a Ghanaian woman's lifetime risk of maternal death is 1 in 45, compared to 1 in 5,000 in the U.S. (UNICEF 2009). Unsafe abortion accounts for as much as 30% of maternal deaths (Lithur 2004). Few studies exist on Ghanaian women who seek

or have sought abortion services, and fewer describe providers' experiences (Morhe and Morhe, 2006). Therefore, stories from medical providers are vital in helping us understand the experiences of the high numbers of women who either attempt to self-abort, or seek the abortion services of nonprofessionals or poorly trained professionals.

Outside of the hospitals and clinics where abortion services are offered, talking about abortion seems almost impermissible. Frequently, when asked to comment on the status of abortion in Ghana, people winced, looked away, and said only, "It happens." When we asked a social-science colleague at the University of Ghana about abortion, she reflected on the meaning of maternity and its connection to the identities of Ghanaian women. She told us that the idea of a Ghanaian woman who would willingly forgo the chance to bear a child is unfathomable.

In contrast to our experience in the U.S., where abortion stigma is strongly tied to the idea of fetal personhood, in Ghana abortion is stigmatized because it challenges the idea of a woman's personhood. In Ghanaian culture, the very identity of "woman" is linked to "mother." Without children, her life is wasted and shameful (Oduyoye, 1995). Women attend religious ceremonies or healing camps in an attempt to "[secure] 'fruits of the womb'" (Asamoah-Gyadu, 2007, p. 439). According to one social scientist we spoke with, even in death in the cemetery childless women are buried in separate places. Well-known Akan proverbs capture the worthlessness of women who do not bear children: "A barren woman is like a leaking pot"; and the deep sorrow and social shame that attend childlessness: "A woman whose sons have died is richer than a barren woman" (Mbiti, 1988).

Our conversations in Ghana illuminated the complex intersections of gender, maternity, and abortion stigma, as well as creative ways in which Ghanaian medical practitioners, pharmacists, and women navigate fast-changing Ghanaian cultural, technological, and legal waters. This paper is an effort to give voice to the narratives of Ghanaian physicians on the front lines of abortion provision, and their colleagues in NGOs and universities, through the lens of abortion stigma. Their stories illustrate—in broad brushstrokes—the ways in which stigma operates in law, policy, clinical care provision, and in women's lives, as well as the impact of these manifestations of stigma on the incidence of unsafe abortion and maternal death.

Ghanaian Abortion Law

Ghanaian law states that abortion is illegal: "Abortion is unlawful and both the woman and anyone who abets the offence by facilitating the abortion by whatever means are guilty of an offense of causing an abortion" (Anon., 1999). However, the Ghanaian legal code then elaborates the many circumstances under which physicians may determine whether an abortion is permissible, including rape, fetal anomaly, or in cases where "the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health" (Morhe and Morhe, 2006; Dailard 1999).

Consequently, Ghana has what amounts to a relatively liberal abortion law. Women can obtain a legal abortion in a licensed and regulated facility such as a hospital or clinic, or with a trained, entrepreneurial private provider. Women also obtain abortions illegally with nonphysician providers of various sorts (including indigenous healers and spiritualists, community leaders, family members), and through self-induction via ingestion/insertion of toxic/caustic substances. Those with whom we spoke indicated that these illegal access routes are associated with nearly 90% of abortion complications in Ghana.

The ambiguity of the law is both a manifestation of abortion stigma, and a method by which such stigma is perpetuated. The legal code begins with a clear prohibition; it is only after that prohibition is crisply demarcated that the "extenuating circumstances" under which abortion is permitted can be listed. Several of the physicians we interviewed discussed that both physicians and women suffer the consequences of such ambiguity. According to their stories, neither medical professionals nor women often get beyond the first sentence of the law, and there is pervasive belief that

abortion is strictly illegal in Ghana. One physician stated:

> *"Right now, I think what we have to do is to create the awareness that there's safe abortion services in the country and make practitioners understand that safe abortion services can actually be provided within the confines of the law."*

Another physician, illustrating the intersection of stigma and the law, added:

> *"...healthcare professionals generally don't want to be associated with abortion. In my own view, I think that one of the ways which we can overcome that kind of social stigma is to liberalize the law, so that if it clearly stated that abortion could be provided without breaking the law, provided it is done within the hospital setting, then providers can go out and do it. For now, a lot of people in private practice in particular, engage in abortion services without keeping any records because it is a general notion among practitioners that abortion is illegal."*

Another physician described the way in which legal ambiguity can push abortion into shadowy corners of medical practice, where training and safety might be questionable:

> *"...Because most of the doctors think that abortion is illegal they don't record, and they don't undergo any formal training. It allows people to do it under [any] conditions, so people who haven't done training go directly to this clinic and do it off record. And that is why complications arise out of it."*

He went on to further describe how liberalization might improve safety and reporting:

> *"But if it is open...all of the health administrations can provide it...We make people walk to the hospital and it is done for them as one of the services. But as it stands, the practitioners will continue to hide."*

The ambiguous status of Ghanaian abortion law has both positive and negative aspects for providers. On one hand, this ambiguity creates anxiety about the possibilities for prosecution for all potentially culpable participants (providers, women, parents of adolescents seeking abortion); on the other hand, it allows physicians great latitude in providing care. In addition, the abortion statute empowers doctors to certify the necessity of the procedure. Some of the doctors we spoke to felt this placed doctors in an appropriate position of power, but others expressed that physicians worry over the amount of legal risk involved, should their judgment ever be called into question.

Reflecting on the risks of prosecution, one physician suggested that doctors are protected by the widespread belief that they are generally trying to do the right thing when they provide abortion services, particularly after complications have occurred with self-induced procedures and/or abortions started in clandestine settings. However, while current practices suggest that physicians are unlikely to experience legal challenges, the language of the law instills fear in some physicians who may otherwise be inclined to provide abortion services. Even physicians who understand that abortion may be performed legally continue to "hide" as a result of the wording of the law, taking protective measures such as not keeping any records related to abortion services.

The Tainted Economics of Abortion in Practice and Policy

Beyond these legal concerns, physicians also talked about the professional risks associated with providing abortion. Although Ghanaians typically have high regard for medical professionals, those who provide abortion services often experience both

professional and social marginalization. Abortion stigma perpetuates a climate in which capable, well-trained physicians are suspected of having base motivations for choosing to provide abortions. The physicians described how the association of money with abortion work could taint doctors' reputations. One administrator mentioned a common stereotype that the cost of abortions increased at later gestational stages not because of the increased difficulty of the procedure, but solely to elevate the abortion provider's income. Several providers referred to the snide comments and sidelong glances associated with "abortion money." Neighbors or colleagues often suspect that new cars or homes have been purchased with money earned from providing abortions. Similarly, doctors' wealth and possessions are sometimes assumed to be gifts offered from grateful parents whose daughters' "predicaments" were adeptly managed by accommodating doctors. "That Mercedes—they call that the abortion car." Abortion is ostensibly big business.

In reality, doctors can lose money as a consequence of providing abortions. One pointed out how providers' fears over the ambiguities in the law can be exploited by family members who demand money in return for not reporting the provider to the police. One physician told a story of a time when a young woman's parents tried to extort him by threatening to report him to the police. While he knew the law well and ultimately did not pay, he noted that because of the ambiguity of the law, many other providers would rather pay a fee to the parent than risk being reported to the police.

While physicians deal with navigating the stigma associated with financial transactions for abortion procedures, the physicians we spoke with also acknowledged that regulatory constraints imposed significant financial hardships on the women who seek abortion. In particular, Ghana's recently implemented National Health Insurance plan does not explicitly cover abortions. The physicians we interviewed decried the implicit contradiction in government regulations which would permit national health insurance coverage for managing complications from self-induced or "botched" abortions, but would not permit coverage for safe abortions. One doctor spoke about the ways in which the widespread availability of Cytotec, an ulcer medication with abortifacient properties, has altered women's behavior in the face of regulations restricting insurance coverage for abortion. Women, especially those with limited means, will commonly use (or misuse) Cytotec to ensure that they present at the hospital with vaginal bleeding that appears to be a miscarriage, which *is* covered by insurance.

> *"...now we have Cytotec...this over-the-counter drug...they take it, they start to bleed, they come in. When they come in to be treated as [a miscarriage]...[then the abortion] would be covered. Once she is bleeding it [becomes] an emergency. But if she came in with an intact [pregnancy], not bleeding and so on, it would not be covered [by insurance.] So [women] are using that a lot now...[The pharmacists] that give [Cytotec] to them tell them, 'When you start to bleed, go [to the hospital.]'"*

The regulatory choice to exclude abortion from public health insurance funding is once again a manifestation of widespread social stigma against abortion, and reduces access to abortion care. Just as importantly, the separation of payment for abortion services from other services also *perpetuates* stigma, making abortion seem outside of the sphere of acceptable or legitmate medical needs. A vicious cycle is in motion here: abortion stigma leads to a national policy of not funding abortion, which further delegitimizes abortion, increasing the stigma. Furthermore, restricting access to funds to pay for abortion induces an illegal market for abortion services that are more affordable, but may be unsafe. Women often find themselves attempting to circumvent the system to access the services they need. Unfortunately, as the physicians we interviewed described, the avenues they use to bypass the system often lead them to engage

with clandestine, ill-trained, and unsafe providers.

Women's Experiences through the Lens of Physicians

Conventional wisdom suggests that a lack of economic resources and a lack of knowledge on how to access safe abortion services are the primary barriers leading many women to terminate their pregnancies through self-induction or in clandestine settings. While the physicians we spoke with felt that these barriers are present in Ghanaian society, social stigma is the true barrier influencing women's decision-making. One physician stated, "The local people know [which clinics are registered and safe]. The major problem with abortion in Ghana has to do with the social stigma."

The physicians hypothesized that some women may choose not to have their procedures performed in the safety of the registered clinics or hospitals as a way to shield themselves from the public eye. Protecting their anonymity is of the utmost concern to women seeking abortion services. However, as a result of limited hospital and clinic resources, patient volume in these settings is high, waiting rooms are small and crowded, and women wait for long periods of time alongside other people from their communities. Physicians reported that women have good reason to fear that they will lose privacy and confidentiality if they present for abortion at a public hospital. As one physician explained:

> *"The problem with that service [abortion] is that the people are labeled, anyone who goes to sit on [one particular] bench outside in a very busy part of the hospital. So once they see you sitting on the bench, you're female, they say, 'Ah, she's going for abortion.'"*

Social consequences to a woman who has an abortion may include loss of resources, public shunning, or divorce. Thus, if a woman is unable to protect her identity in the public hospitals and clinics, she has a strong incentive to seek out an abortion in more remote locations. Another doctor observed:

> *"Some doctors do it in very obscure areas and quite a number of people go there for abortions because they feel they have more privacy there than in the hospital."*

Ghanaian society's views on the unacceptability of premarital sex and importance of motherhood place extreme pressure on women to keep their unwanted pregnancies secret, often resulting in these women making unsafe decisions:

> *"They know that [abortion] is morally unacceptable. When they get pregnant, pregnancy outside marriage, they don't want people to know, and when they are very young they also hide it from their parents. So that leads a lot of people to hide, to have [their abortion] done in such a way that is, I don't know. They go to these quacks and some of them take all kinds of concoctions, they mix all kinds of things to take thinking they will cause an abortion. And those are the ones that lead to complications. We've had situations where people take naphthalene [moth] balls."*

Unsafe procedures have high rates of complications, ranging from incomplete abortion to perforations, potentially resulting in major blood loss or organ damage:

> *"Most of the complications, very bad complications [involve]...uterine perforations, cervical lacerations, and abdominal viscera [damage to abdominal organs]."*

Unfortunately, by the time many women arrive at the hospital from a clandestine abortion setting, it may be too late to preserve the woman's fertility, or even her life.

Stigma and Maternal Mortality

Abortion stigma drives women to unsafe procedures, and thus directly contributes to maternal mortality. Each of the doctors we spoke to could give an account of at least one harrowing tale of maternal death as a result of unsafe abortion. In one particularly disturbing story, a physician recounted how a teenaged school-girl had ingested an unidentfied toxic substance to end an 18-week pregnancy. She arrived at the hospital in a coma and died shortly thereafter.

Perhaps because of the high rates of complications with self-induced and later-stage abortions, abortion is commonly associated with infertility and death in women's minds. One doctor observed:

> *"Current work that I've done, [shows that] over 80% [of women] associate abortion with death, and the other 20%...think that abortion is associated with infertility...[but] they do it anyway [pursue unsafe, clandestine abortion]...so it means that people have been dying for abortion, and therefore they associate abortion with death. So...there is a lot that we need to do."*

Widespread perception of abortion as an incredibly risky undertaking (regardless of whether it is provided legally or illegally) disincentivizes women to seek safe abortion services, and increases risk of injury and death from clandestine abortion.

Furthermore, fear of social stigma causes delays in accessing care, leading to presentation at later gestational ages, which impacts the safety of procedures. The physicians we interviewed noted that for adolescents in particular, fear of the stigma and shame of admitting sexual activity to their parents leads to delays in care. These later procedures are more difficult, resulting in higher rates of complications, regardless of setting (though clearly worse in unsafe settings). One physician stated:

> *"With the first trimester terminations, they are not a big problem. Because even those who go for unsafe abortion in the first trimester, they come with sepsis and incomplete abortion, which you could easily work with. But in the second trimester, that is when the mistakes [occur], and [they use] sharp instruments to try to [remove the fetus]...so most of the time [the women] come to the hospital and the baby is already dead and there is damage to the uterus already, sometimes there is perforation, and then you see a real challenge of trying to bring out the dead baby when the uterus is perforated."*

Together, these two scenarios illustrate a second vicious cycle of stigma: abortion is stigmatized in part because of the perception that it is associated with infertility and death, but this stigma increases the likelihood that women will not seek safe care or will delay care, which increases the chance that women will die from abortion procedures. The perception of abortion as dangerous ultimately contributes to deepening abortion stigma.

Concluding Thoughts

The experiences of Ghanaian physicians with whom we spoke suggest that neither legality nor availability of safe abortion care is sufficient to prevent the tragedy of maternal mortality from unsafe procedures. Clarifications in the law, and increased awareness of the availability of abortion services in safe, public facilities are likely necessary. Regardless, these efforts may fall short of significantly reducing the burden of morbidity and mortality from unsafe abortion without a recognition that stigma is both reflected in *and sustained by* the current legal, political, and social climate.

Furthermore, the social sanctions imposed upon women who seek abortion must be understood and addressed through a lens that appreciates the misogynistic roots of cultural stigma against abortion. Efforts to address abortion stigma and its consequent maternal mortality and morbidity may require challenging traditional patriarchal culture, in which abortion

is often viewed as an affront to gendered power hierarchies and related practices (Braam & Hessini, 2004). A woman's choice to abort a pregnancy may be experienced as a rejection of familial and social roles as well as a dangerous expression of resistance to authority. Stigma serves to preserve and reproduce male/female power hierarchies by restricting women's freedom to determine the timing and place of their decision to parent. As we heard through the voices of the Ghanaian physicians, women bear the burden of intense social stigma against abortion, which stems from patriarchal, religious, and gendered social norms, and ultimately forces them to engage in secretive practices that often prove unsafe.

Importantly, we also heard that providers experience the weight of abortion stigma. They face a dangerously ambiguous legal situation and are marginalized in both professional and personal situations when their motivations and skills are called into question. Through the avenues of legal ambiguity and the moral outrage of the communities in which they practice, abortion stigma translates directly into stigma against abortion providers. The legal, professional, social, and economic consequences of working in a heavily stigmatized field may ultimately discourage providers from undergoing training in the procedures, or drive them to give up abortion work.

Abortion stigma ultimately acts as a double-edged sword to reduce access to safe abortion: it reduces women's ability and willingness to seek timely, safe abortion care, and reduces providers' ability and willingness to undergo training and offer abortion services in their communities. Furthermore, the prevalence of abortion stigma in law and policy acts in direct opposition to building women's health care services with an eye toward reproductive justice. Speaking about the separation of abortion services from the national health insurance law, one physician expressed his fear that the most vulnerable women in Ghanaian society will suffer most heavily from restrictive laws:

> *"Well, I've always said that health insurance should cover reproductive health as a whole from contraception to abortion care and all other (related services). I've always advocated for that...[The government] says that [reproductive health services] have been so much subsidized...that they think people should also pay for [contraception] themselves...[and] make reproduction really their own...In fact, we know that people in low-income groups don't contracept, they get pregnant, and they can't afford prenatal care. So they go to seek unsafe procedures..."*

This physician describes a belief by Ghanaian insurance authorities that requiring Ghanaians to put "skin in the game" (to paraphrase U.S. health economists) when it comes to contraception services might increase individuals' ownership and agency around pregnancy prevention and childbearing. As the physician points out, such ideas rarely work so well in practice. Requiring payment for contraception and abortion leaves poor women vulnerable to the consequences of unsafe abortion procedures. In his statement, the physician advocates for a more just application of reproductive health services across the spectrum; he calls for the re-integration of all reproductive health services under one umbrella, rather than separating abortion. Though not explicit, this physician's comments speak to the barriers abortion stigma erects to realizing reproductive justice.

Understanding the burden stigma places on women and on doctors is largely understudied around the world. The voices of Ghanaian doctors illuminate this issue, and have important implications for anyone who hopes to alleviate the burden of maternal mortality in Ghana or elsewhere. Their stories clearly delineate a role for eradicating abortion stigma in the pursuit of reproductive justice. Unless future efforts attend to legal, policy, and cultural manifestations of abortion stigma we fear that

efforts to significantly reduce maternal mortality from unsafe abortion will fall short.

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Footnotes

1 Each physician was independently interviewed for approximately 25 minutes, and a final 40-minute conversation was conducted with the entire group. The four physicians were asked to share their thoughts and observations on the following matters: stories about and managing abortion-related complications; reasons why women seek care in unsafe settings when safe care is legally available; barriers women face in accessing safe abortion and physicians face in providing abortion; and how to reduce serious consequences and death from unsafe abortion in Ghana. We did not ask specifically about abortion stigma. All interviews were digitally recorded, transcribed, and analyzed with the assistance of NVivo 8.0 (QSR International, 2008). Institutional Review Board approval for this study was obtained from the University of Michigan Health and Behavioral Sciences Committee, and all participants provided written consent.

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