Self-managed Abortion as a Medico-legal Intervention in Ghana: a Systematic Review

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Abstract

Background

We examined the potential of improving self-managed abortion as a medico-legal intervention of safely and effectively resolving unwanted pregnancies in Ghana.

Methods

We undertook a systematic literature review on self-managed or self-induced abortion within the context of Ghanaian laws. We searched for studies from Advanced PubMed Central and Google Scholar and repositories of Public Universities in Ghana. With search words of self-managed or self-induced abortion and Ghanaian law, we found 13,100 papers. The search was then narrowed to studies conducted between 2015-2020 of which 22 most related papers were selected with Six (6) from the Advanced Google Scholar search, 18 from PubMed and 1 unpublished postgraduate thesis from a public university library.

Results

Despite a liberal law that supported positive and quite well-decentralized service delivery policy, standards, and protocols development on abortion in Ghana, self-induced abortion remains criminalized. Nonetheless, the longstanding practice persists with no evidence of prosecution of the person(s) found violating the law within the period under review. The use of abortifacients procured from pharmacies and chemists that are not recognized abortion care providers has become the leading method of self-induced.

Conclusion

Despite criminalizing self-induced abortion, Ghana's law on abortion is fairly liberal enough to permit the development of comprehensive abortion care policy, standards, and protocols that have a good potential of supporting improved self-managed abortion to reduce maternal morbidity and mortality in the country. Further studies are required for the exploration of ways of filling implementation gaps to harness the potentials of improving self-managed abortions in Ghana.

Background

Every day, many women including adolescents within varied jurisdictions of the world are saddled with taking the right decision in safely resolving unwanted pregnancies that often result from the violations of their reproductive rights.[1] Although, abortion choice is a very personal decision of a woman, it often influenced by her socio-legal setting and locally available resources for optimizing reproductive health and rights.[2] Considering widespread negative undercurrents of induced abortion with little purposeful concern about enhancing the health of women, access to quality abortion care remains inadequate in many countries.

Globally, abortion laws have been liberalized since the 1950s, with a resultant decrease in abortion-related illnesses and deaths among women.[2] Currently, about three-quarters of the world's population, is governed by laws that permit abortion on medical or broader social and economic grounds. Yet still, over 25 million unsafe abortions with about 31,000 deaths, occur annually.[3, 4] The situation is worse in countries that have resisted liberalization of their abortion laws and women have limited access to abortion care.[5]

Even in countries where abortion is technically legal, for reasons including a lack of government or public commitment to provide or fund services,[6] lack of trained specialists[7], administrative/logistical challenges,[8] a woman's ability to pay for abortion care,[9] a lack of adequate information about legal rights to services, [10] and abortion-related stigma, abortion services are rarely accessible.[11] To circumvent these and other challenges, many abortion seekers resort to self-managed abortion (SMA) also termed self-induced, self-sourced, or self-administered abortion.[12,13]

Self-managed abortion is a well-known approach to terminating pregnancy using various abortifacients including herbal concoctions some of which are injurious to the health of users. In recent times, SMA is self-sourcing of abortion pills, followed by self-use and management of the abortion process outside of a clinical environment.[14] With appropriate use of improved medications, self-managed abortion (SMA) has become safe and effective in resolving unwanted pregnancy even in developing countries.[15] Nonetheless, successful SMA intervention would depend on a good flow of accurate information on the medications and reliable sources of supply, which in turn would depend on the perceived state of the law and policy environment.

Ghana's law on abortion is enshrined in the Criminal Offences Act, Act 29 of 1960 as amended by the 1985 PNDCL 102, which made the hitherto restrictive law liberal enough to support the development of comprehensive abortion care policy.[16] With the development of service delivery standards and protocols that were implemented in 2006 and revised in 2015, access to various forms of abortion care is expected in most settings of the country.[17] However, a recent publication still highlighted high rates of 'criminal' abortion in the country.[18] For instance, from the 2017 maternal health survey about 71% of the most recent abortions were said to be 'criminal abortions'; the majority were self-induced abortions.[19] Within the current context of improving self-managed abortion as a measure to reduce abortion-related maternal death and complications, this unexpected observation calls for an interrogation of the legal status of self-induced abortion and other prevailing service delivery practices that contravene the law and any documented consequences of the legal breaches.

We contend, that there are unduly high criminal connotations related to self-managed abortion in Ghana. This could promote stigmatization and drive the practice underground and remain unsafe to women. In this study, we examined the legal status of self-induced abortion in Ghana with a focus on the law, policy, standards, and protocols as well as the extent, methods used, sources of assistance, and the connotation given of self-induced abortion in recent literature in Ghana. The purpose was to explore the potentials of

improving self-managed abortion as a medico-legal intervention to increase access to a safe, and effective way of resolving unwanted pregnancies in Ghana. By identifying gaps in the literature, the paper would also guide the conduct of abortion care research for the advancement of sexual reproductive health and rights in Ghana.

Methods

Study design

This was a desk review of recently published literature and relevant documents on self-induced abortion in Ghana. This review is neither registered as a systematic review nor associated with any pre-existing protocol.

Search strategy

We performed electronically and hand searches of documents and research articles on the law and self-induced or self-managed abortion in Ghana from 2015 to 2020. We limited our search to published works in English peer-review journals and relevant legal and health policy documents in Ghana. Databases searched were Advanced PubMed Central and Google Scholar, repositories of public universities in Ghana, and the Digital Attorney, an electronic legal database of Ghana Law Reports.

Two Standardized systematic search strategies were used in identifying relevant studies for this review. We used the principles of the PICO (Population, Intervention, Comparison, and Outcome), Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA), and SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, and Research type) search strategy tools. PICO tools were used for defining the key elements of the review questions during the search for qualitative and mixed methods research studies whilst the SPIDER tool was used to compliment the PICO tool due to its perceived relevance for the mixed-method research questions.[20] PRISMA was also useful for critical appraisal of published systematic reviews, although it was not used as a quality assessment instrument to gauge the quality of the systematic reviews observed.

Search words used

The search words used were “Ghana” and, “self-induced abortion”, self-managed abortion “location or place of induced abortion”, “illegal induced abortion”, criminal induced abortion” “illegal termination of pregnancy”.

Eligibility criteria

Studies selected for this paper were those directly related to self-managed or self-induced abortion and those that discussed the abortion law of Ghana or aspects of the law. Publications arising from either qualitative or quantitative studies on abortion methods, place of care, and providers from 2015 to 2020 were eligible to be included in the review. Publications before 2015 were excluded.

Data extraction

A standardized form was developed by the authors for data extraction from studies that met the inclusion criteria. We focused attention on study title, author(s), aim/objectives, design, and characteristics of respondents, key findings, and authors' conclusion. Although critical appraisal of extracted studies was not done for the peer-reviewed papers used, the unpublished postgraduate theses were all thoroughly reviewed for scientific rigor, data credibility, technical accuracy of findings, and plagiarism. Data extraction, analysis, and interpretations were done by all authors.

Sources of evidence are appropriately cited and listed under references in Appendix 1.

Results

We found 13,100 papers in our initial search. The search was then narrowed to those studies conducted between 2015-2020 of which six (6) results were obtained from the Advanced Google Scholar search, 18 from PubMed, and one postgraduate thesis from a library in a public university in Ghana. We further focused the search looking at the legal implications of self-managed induced abortion in Ghana and found 22 related studies that were reviewed in this study. We found no study conducted in Ghana on self-induced or self-managed abortion within the period under review. However, self-induced abortion was reported in a number of studies elsewhere [13, 14] including systematic reviews conducted in 2020.[21,22]

Legal status of self-induced abortion in Ghana

The legal status of self-induced abortion concerns the current law and policy on the practice in the country of self-induced abortion found in recent literature in Ghana. The Criminal Offences Act (Act 29) section 58, sub-section 1 criminalizes self-induced abortion. It states that (a) "a woman who, with intent to cause abortion or miscarriage, administers to herself or consents to be administered to her a poison, drug or any other noxious thing or uses an instrument or any other means, or (b) a person who:(i) administers to a woman a poison, drug or any other noxious thing or uses an instrument or any other means with the intent to cause abortion or miscarriage of that woman, whether or not that woman is pregnant or has given her consent, (ii) induces a woman to cause or consent to causing abortion or miscarriage, (iii) aids and abets a woman to cause abortion or miscarriage, (iv) attempts to cause abortion of miscarriage, or (v) supplies or procures a poison, drug, an instrument or any other thing knowing that it is intended to be used or employed to cause abortion or miscarriage; commits a criminal offense and is liable on conviction to a term of imprisonment not exceeding five years". [16]

Sub-section 2 of the law that indicated circumstances under which abortion is legal is silent on self-induced abortion. It is emphatic in allowing registered medical practitioners to provide in registered health facilities abortion when the pregnancy is the result of rape, defilement, or incest; when a continuation of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health; or where there is a substantial risk that if the pregnancy were carried to term the child would suffer from or later develop a serious physical abnormality or disease."[16, 17]

Self-induced abortion has not been mentioned in the Act. Based on the permissive provisions in sub-section 2 of the law the national Comprehensive Abortion Care (CAC) policy, standards and protocols were developed with the broad operational interpretation of the law to minimize maternal morbidity and mortality associated with complications of induced abortion in the country.[17] CAC was made an integral part of the national reproductive health policy and program. Despite the seemingly favourable legal and policy environment, accessing safe abortion care remains a challenge to most service seekers in Ghana".[18] There is no mention of self-managed abortion in the Ghana Health Service reproductive health policy, standards, and protocols. In line with the law, the CAC policy, standards and protocols clearly indicated health care professionals can provide various forms of abortion including medication abortion, under which medical practitioners allow self-managed abortion. For gestations up to 9 weeks, services are extended to a community level by allowing community health officers, nurses, midwives, medical (physician) assistants, and physicians to carry out procedures in health centres, clinics, and hospitals. For gestations more than 9 weeks, only physicians are permitted to perform the procedure in hospitals in addition to manual surgical evaluation which is permitted under similar conditions as medication abortion.[23]

Methods and extent of self-induced abortion in Ghana

Notwithstanding the guidelines in the revised national CAC policy, standards, and protocols that allow the provision of medication abortion via task sharing,[23] the services with the low-level cadres of healthcare providers in the country, self-induced abortion using less safe approaches than expected, continues to be a convenient option to many women in need.[24] Although various publications have reported self-induced abortion as criminal or illegal abortion, medication abortion has become a leading approach to resolving unwanted pregnancy in the country.[22, 25]

Many women in Ghana have previously used over-the-counter medications, herbal concoctions, and other locally known chemical abortifacients, which have been widely reported to be associated with severe maternal complications over the years.[26] In line with current evidence there is an increasing shift to the use of misoprostol based medications that may be cheaper alternatives to hospital procured abortion methods.[27,28] The evidence was clear in the 2017 maternal health survey that nearly indicated that about 3 in 4 (73%) of the most recent induced abortions were by Misoprostol/+Mifepristone preparations.[19] Currently misoprostol only or misoprostol-mifepristone combination is the commonest method of self-induced abortion among educated and other well-informed women in Ghana.[28]

Forms of self-induced abortion

Both provider-led and in-person self-managed medication abortions are practiced in Ghana and both trained and untrained providers aid the process in varied settings in the country.[29,30] Though trained abortion services may be available especially in urban communities, the cost of care is often beyond most women, particularly the youth and other socially disadvantaged ones.[18,31] Thus, many women relied on pharmacies and chemists for supply and guidance on how to use the abortion pill, although they

are not permitted by the law, policy, standards, and protocols to perform pregnancy terminations. There are also reported disparities between misoprostol provision and demand at pharmacies and chemists.

Despite the wide distribution of the community pharmacies and chemists, and reported high demand for the pill, stocking, and willingness to sell the medication decrease from urban to rural settings. There was little evidence found on the use of telemedicine and digital means of increasing access to self-managed abortion services. Organized national services are non-existent although individual private abortion care providers operate limited mobile services as part of increasing access to underprivileged or vulnerable women at their clinics.

Location of abortion and promoters of self-induced abortion

The publications reviewed reported locations of medication abortions as public or private health facilities, homes, pharmacies, or chemists. The perception that abortion is illegal, negative attitudes of healthcare providers, social stigma, and the need to keep the unwanted pregnancy and the abortion process secret as well as cost, are the main reasons for recourse to self-induced abortion at locations and use of the services of personnel that is not indicated in the national standards and protocols as providers.[32,33] Second-trimester abortions for instance are relatively very expensive and are mostly available only in a few private health facilities in urban centres.[34]

Most providers are aware of the fact that if women had no access to safe abortion services, they would resort to unsafe methods of terminating unwanted pregnancies.[35] Yet, many providers have serious dilemmas about care provision. Highly trained providers use the reproductive rights approach to arrive at a decision to provide the procedure whilst less trained providers frequently relied on religious and moral judgment to arrive at a less favourable decision and decline the service provision. Thus provider attitude greatly influences access to safe abortion care in Ghana. The state law criminalizes abortion, society frowns on it and social stigma has been high resulting in inadequate access to provider-based safe services and women still resort to using unsafe self-induced methods or use of the services of the untrained personnel operating in unregistered facilities.

Consequences

The health facility reports and surveys indicated medical complications and social stigma as the most widely reported consequences of induced abortion. Most of the reports were unable to classify and identify those emanating from self-managed abortions partly attributed to poor documentation, the unwillingness of clients to disclose their real experiences for fear of societal stigmatization, shame, and embarrassment as well as criminalization.[36,37,38] Consequently, a study has shown that much more is yet to be unearthed about self-managed induced abortion, methods used, safety, effectiveness, client experiences, and reasons for this method of abortion in Ghana.[28]

Legal Consequences of self-managed abortions in Ghana

There was no evidence of prosecutions of the person(s) found violating the abortion law of Ghana in the literature, although anecdotal shreds of evidence have shown that self-managed abortions using medications have increased and continue to increase particularly during the recent pandemic of Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) also known as Coronavirus Disease, 2019 (COVID-19) and its associated restrictions on health care delivery as well as the selective lockdowns of some Ghanaian communities.

Discussions

Although self-induced abortion is common, access to safe and quality care in the current context of self-managed abortion is yet to be fully explored in Ghana and other less-developed nations of sub-Saharan Africa. Thus, the Covid-19 pandemic and attendant limitations on access to health care have brought to fore the importance of self-managed abortion as an essential service in reducing related maternal morbidity and mortality, particularly in nations such as Ghana with less developed health delivery service. The literature review shows that self-induced abortion is not new in Ghana and that the practice has been reported in publications on induced abortion in the country over the years.

Unsafe abortion with serious complications has also been well documented and self-induced had been captured in the opening clause of the law on abortion suggesting the nation has taken a serious of the practice. Even, with the liberalization of law and development of current liberal policy, standards, and protocols, due cognizance was given medication abortion by allowing a low cadre of healthcare providers such as community health officers to administer care. Yet, there is a paucity of related research in the country while publications continue to document the existent of the practice. There is little work on the outcome and the impact of the intervention such as the provision of medication abortion aided by the low cadre of legitimate providers such as community health officers and nurses and illegitimate providers such as pharmacists and chemists. Making it difficult to determine the challenges and effectiveness of the intervention. Such a research gap is difficult to explain but maybe pose a change to the development of self-induced abortion in the country. Further task-sharing would be needed. In view of the fact that the current concept of self-managed abortion focuses on the use of evidence-based safe and effective methods in resolving unwanted pregnancies, there is a yawning need to evaluate the implementation of the intervention to attract the needed resources for the improvement of the services.

Although a global review of abortion laws and policies by country provides quite comprehensive information on the legal status of abortion in Ghana [39] not much has been discussed regarding how to address the challenges in local policy implementation. The perception that abortion is illegal, negative provider attitudes, social stigma, and the need to keep the pregnancy and the termination secret are the leading reasons for recourse to self-induced abortion by women that have featured prominently in the literature and therefore need to be addressed in using more innovative approaches to the implementation of the comprehensive abortion care program. There is also the need for public health education on the prevention of complications of unsafe abortion and reproductive rights as well as reintroducing

comprehensive sexuality education in a culturally appropriate form to impart to young people accurate information.

The Ghanaian law, in sub-Sect. 2 clearly indicates the kind of persons allowed to perform induced abortion and the location where legal induced abortion could be performed. Although self-induced abortion is criminalized as in sub-Sect. 1 of the law, it is not mentioned in the sub-Sect. 2 of the law that specifies the circumstances under which abortion is legally permissible. Further clarity has been provided in the policy, standards, and protocols, which outline the levels of care that are allowed to be provided by various cadres of health care professionals. Clearly, the law and national comprehensive policy, do not give women the freedom to end unwanted pregnancies themselves. Awareness of this legal status of self-induced abortion has the potential of women engaging in the procedure undercover which could be associated with the use of unsafe methods with attendant preventable complications.

Besides legal status challenges as in other nations, induced abortion method choice decision-making in Ghana has been influenced by various factors including circumstances surrounding the onset of pregnancy,[40] the influence of the male partner and other role players [41] and other situations that arise during pregnancy and ultimately the woman's socio-economic status and self-efficacy.[42,43,44] Indeed, within the reproductive rights the abortion care seeker in Ghana, some claim, would have a justification to end unwanted pregnancy at any gestation.[16,17,23] Although there are various dimensions to this claim, one thing that is clear is the fact that the pregnancy is unwanted and the woman seeks to end it with its associated mental disturbance at the time of decision-making, where her immediate concern is often how to end it safely.[40]

As in any self-care health intervention, the legalization of all methods, the flow of accurate information, accessibility of medical care to the woman when needed are essential to the successful practice of self-managed abortion resolving unwanted pregnancy.[45] This underscores the importance of comprehensive sexuality education particularly in schools as a reliable way of ensuring that young people are given accurate information on reproductive health. Indeed, most people including some providers are not aware of the details of the legal status of induced abortion in Ghana and often exhibit attitudes that negatively affect access to safe abortion care in the country.[46,47] Similar observations have been made in India and Zambia where abortion is legal yet unsafe abortions still prevail due to misinformation about the law.[48] By policy, Ghana has gone far by ensuring that in giving consent for an induced abortion in Ghana the decision is predominantly a prerogative of the pregnant woman. For, the protocols clearly indicate that for marital harmony spousal involvement is encouraged but not mandatory.[23]

Medical abortion can be safely and effectively provided by midlevel health care providers as well as women themselves through telemedicine up to 9 weeks gestation. As indicated by other researchers there is the need to expand task-sharing of abortion care to include physician assistants, pharmacists, and dispensary assistants, and technologists to provide or facilitative accurate information flow for enhancement of the use of self-managed abortion in Ghana.[49] Additionally, acceptability and outcome

are similar if the medical abortion is offered by doctors, nurse midwives, or administered by women themselves or via telemedicine.[50, 51]

As in other jurisdictions, despite the availability of health facility cantered services in Ghana, some women face a number of challenges accessing abortion care and therefore resort to or prefer self-managed abortion care in their homes.[52] Their reproductive rights have to be respected particularly when there is growing evidence that self-managed abortion is as safe as health facility care. Considering the fact that self-induced abortion is not a new practice in Ghana, making improved approaches available would not only save the lives of women but reduce the rate of unwanted pregnancy and the need for induced abortion.

The continued criminalization of self-induced abortion with no exception is not in line with the current quality improvement drive of improving self-managed abortion. It has the tendency to drive the practice underground making it difficult to identify service providers and users for the purposes of education to improve the quality of care. Indeed, criminalization of the abortion over the years has failed to reduce the rate of induced abortion. The consequential high social stigma and inadequate access to provider-based safe and improved induced abortion methods result in the frequent recourse of women to using unsafe self-induced methods or patronage of the services of untrained personnel.[53]

With the availability of improved and safer methods, it is prudent for local and national stakeholders to consider a review of the law for the creation socio-cultural enabling environment where reproductive rights are respected. This would help women in need access and use self-managed abortion care without fear of prosecution, which hardly occurs anyway. Abortion care as an essential public health service can be effectively provided via the development of telemedicine-based medication abortion services which largely depends on access to accurate information particularly the gestational age at which the termination is intended.[54]

Stakeholder surveys on the promotion of improved self-managed abortion methods are paramount to the improvement of abortion care. Other approaches could be further task-sharing to improve the flow of accurate information. Some commentators are of the view that by definition, the practice of self-sourcing and use of medicines in self-management of abortion process outside of clinical environment is inconsistent with the concept of unsafe abortion. Nonetheless, self-managed abortion could save cost as a major barrier to accessing abortion care among the poor and socially deprived populations.[14, 54]

LIMITATIONS

The study was limited by the search engines used (i.e Advanced Google Scholar search, PubMed, the library of a public university in Ghana.). Because the search was based predominantly on published papers in peer reviewed journals, and the library of a public university in Ghana, the authors believed that, there could be other papers relevant to the study objectives that were omitted because they were either

not published at the time of the study or published in journals that were not indexed in the search engines that were used in this study.

Conclusions

There is a paucity of research on self-managed abortion in Ghana. However, this review has identified a positive legal environment with the existence of national, policy, standards, and protocols for the provision of medication abortion as motivations for improving self-managed abortion. The financial cost, access to accurate information, and perception of induced abortion being a criminal act are key potential barriers to improving self-managed abortion care in Ghana. Ways of improving access to self-managed abortion including decriminalization of the practice, integrating induced abortion costs into the national health insurance scheme, and developing basic telemedicine, which may include establishing community call centres and service delivery referral networks would go a long way to improve access and safety to improved self-managed abortion services in the country.

Abbreviations

CAC : Comprehensive Abortion Care

COVID-19 : Coronavirus Disease, 2019

PICO : Population, Intervention, Comparison, and Outcome

PNDCL : Provisional National Defense Council Law

PRISMA : Preferred Reporting Items for Systematic Reviews and Meta-Analyses

SARS-CoV-2 : Acute Respiratory Syndrome Coronavirus 2

SMA : Self-managed Abortion

SPIDER : Sample, Phenomenon of Interest, Design, Evaluation, and Research type

Declarations

- **Ethics approval and consent to participate**

Not applicable

- **Consent for publication**

Not applicable

- **Availability of data and material**

The raw data and any material related to the study are available upon reasonable request from the corresponding author.

- **Competing interests**

The authors declare that they have no competing interests in this study.

- **Funding**

Not applicable

- **Authors' contributions**

E.K.S.M conceptualized the study from a medical perspective, F.Y.G developed the outline of the study and drafted the manuscript, R.A.S.M reviewed the medico-legal implications of the concepts within the Ghanaian context. Data extraction, analysis, and interpretations were done by all authors. E.K.S.M and R.A.S.M respectively reviewed the manuscript critically for medical and legal accuracies. F.Y.G developed the final draft, did the editing and correspondence with the publishers. All authors have read the final manuscript and have consented to its publication.

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