

Research Article

Thinking Quality in Safe Abortion Care: Results of a Mystery Client Survey of ‘Abortion Clinics’ in Ghana

Fred Yao Gbagbo*

Department of Health Administration and Education, University of Education Winneba, Ghana

Abstract

Background: Despite legalization of abortion in Ghana, little is known about services quality in hospitals.

Objectives: The study assessed quality of care being provided abortion seekers in hospitals in Ghana.

Methods: A mystery client survey was conducted in public, NGO and private abortion providing facilities in six regions of Ghana between September and November 2018. Ten females from tertiary institutions in Ghana were recruited and trained for data collection.

Results: A total of 118 facility visits were made. About 63% of these visits were in private facilities due to their wide availability in the regions. Counseling services were rated best in public facilities compared to private and NGO facilities. Discussions on options available for abortion, pain relief, side effects and complications were rated far below excellent in NGO and private facilities. Professional knowledge of care, friendliness, provider biases, waiting time, operating hours, directional signs, infection prevention, discrepancies between displayed prices and actually bills for services were key quality concerns.

Conclusions: The quality of induced abortion services being provided in health facilities in Ghana as per clients' perspectives is generally unsatisfactory. A nationwide quality assessment of all facilities providing abortion and related services is recommended to guide policy decisions.

Keywords: Abortion; Ghana; Mystery-client-survey; Quality-of-care

Abbreviations

ERC: Ethics Review Committee; FP: Family Planning; GHS: Ghana Health Service; ICPD: International Conference on Population and Development; MSI: Marie Stopes International; MC: Mystery Client; MCS: Mystery Client Survey; NGO: Non-Governmental Organization; OPD: Out Patients' Department; SPSS: Scientific Package for Social Science; SRH: Sexual Reproductive Health

Introduction

Ghana has a comprehensive law enacted in 1985 to guide the provision of induced abortion services in a legal and safe manner [1]. This law is being operationalized by guidelines (clinical standards and protocols) developed by the Ghana Health Service and Ministry of Health for the provision of safe abortions [2]. Adopted in 2006, the guidelines outline the components of comprehensive abortion care, including counseling; define mental health conditions that could qualify a patient for an abortion; provision of post abortion contraceptives and advocate the expansion of the cadre of first-trimester abortion providers to include nurses and midwives [3]. Although Ghana is well positioned to remedy the problem of unsafe abortion and its consequences [4], maternal deaths are the second most common cause of deaths among women in Ghana of which more

than 11% are due to unsafe induced abortions [5]. These observations call for an objective assessment of the quality of induced abortion services being provided in health facilities in Ghana using a mystery client survey.

Objectives

The study examined the quality of induced abortion services provided by private, public and NGO facilities from the provider perspective. The study assessed six aspects of quality (i.e. Counseling, pricing, visibility of abortion providers, customer care, waiting time for services and infection prevention).

Methods

Study design

The study design is a Mystery Client Survey (MCS). The use of mystery client evaluation methods ('mystery client', 'simulated patient', or 'mystery shopper' surveys) in assessing quality of service provision in developed countries has proven to be reliable, valid, feasible and acceptable [6-8]. The method involves a trained observer posing as a patient who records their experiences of provider encounters. This has been found to be an appropriate method in capturing 'real life' accounts of provider performance and environments in which Sexual and Reproductive Health (SRH) services are provided in low-middle income settings [9]. Since the providers do not know they are being observed, in most cases the information gathered through mystery client encounters reflects providers' normal performance [10]. In this study, ten females aged 20-25 years from tertiary institutions in Ghana who were based in the communities of study were recruited and trained for the field work. The field assistants visited identified health facilities, acting as clients without the facilities staff or service providers knowing that they are involved in a monitoring activity. This was intended to capture the actual practice of abortion providers, given that prior knowledge of an evaluation may lead providers to alter their usual practice. This design allowed the researcher to gauge the quality of induced abortion services being offered to clients

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***Corresponding author:** Fred Yao Gbagbo, Department of Health Administration and Education, University of Education Winneba, Ghana, Tel: +233243335708; E-mail: gbagbofredyao2002@yahoo.co.uk; fyg-bagbo@uew.edu.gh

when service providers are not being supervised or unknowingly observed. Following their visit, the mystery clients reported their observations and experiences of the service received in the form of participant observation and an interview using author developed questionnaires and scripted scenarios relating to customer care, quality of environments, visibility of facilities, available services, price and payment procedures were used.

Study setting

The study was conducted in private, public and NGO health facilities that were purposively selected from six regions of Ghana (Ashanti, Greater Accra, Northern, Eastern, Western and Brong Ahafo). These regions were selected because of wide availability of public, private and NGO facilities that are well known for providing induced abortion services following an initiative of the Ghana Health Service and its development partners to build provider capacities and equip health facilities to increase access to safe abortion services as permitted by law.

Study population and Sampling

The study targeted health workers who provide direct abortion services in the identified facilities. Nine public facilities, eight NGO clinics and thirty-five private facilities were selected using a combination of purposive and random techniques for selecting Public, Private and NGO facilities providing abortion services respectively. The selection of a facility was based on the type of abortion services provided at each facility. For instance NGO and public facilities provided first-trimester abortion services whilst the private provided abortion services at all gestations.

Data collection

Data was collected between September and November 2018 using questionnaires and the scripted scenarios as a guide. All the field assistants were trained in basic service components of safe abortion care (client centered care, counseling, history taking, informed consent, post abortion care, options) to gain some understanding of the key quality indicators expected in abortion care.

Data analysis

Data collected was entered twice and validated by the Epi-data software. However, analysis was conducted using Scientific Package for Social Science version 16 (SPSS). The data was presented using tables, charts, graphs and mean.

Results

A total of 118 facility visits were recorded during the field work with varying number of visits per regions of respondents. A greater proportion of the Mystery clients (62.7%) visited the private providers. However, the least of them (15.0%) resorted to public providers (14.4%) while (22.9%) visited the NGO clinics due to availability of providers in their respective communities Table 1. Various main themes and sub-themes related to quality of abortion services were identified from the field survey (Table 2).

Counseling

Counseling was a key area of concern in this study as it forms the basis for history taking and quality of abortion care. Clients' age, time of last menstruation period, medical & obstetrics history as well as gestational age and parity were key quality indicators investigated. The majority of mystery clients (70%) were of the view that service providers in public facilities adequately requested for information regarding their age, last menstruation period, medical

Table 1: Regional Distributions of number of visits.

Regions of study	Number of facility visits	Percent
Greater Accra Region	26	22.0
Eastern Region	26	22.0
Ashanti Region	36	30.5
Western Region	11	9.3
Brong Ahafo	4	3.4
Central Region	2	1.7
Northern Region	13	11.0
Total	118	100.0

Source: Field data 2018.

Table 2: main themes and sub-themes related to quality of abortion services.

Main Themes	Sub-themes
• Counseling	History taking, knowledge of services, consenting for services, available options, pain relief options, Cross selling Services, Service delivery procedures available, consequences and questioning
• Customer care	Professional knowledge of care, friendliness of providers and staff, empathy and respect shown to clients, waiting times, operating hours and religious biases to abortion service delivery
• Pricing and payment procedures	Display cost of services, Point at which services are charged at the facilities and Issuance of receipts.
• Infection prevention	Appearance of facility, sitting arrangements at waiting areas, cleanliness of environments, refuse disposal and availability of toilets and hand washing facilities for clients.
• Visibility of facility & service providers' identity	Directional signage, sign posts, staff uniforms and name tags.
• Waiting time for services	Time spent at reception area, at consultation room and other client care areas.

Source: Field data 2018.

and Obstetrics histories, whereas service providers at NGO and private facilities did not but were more concern about gestational age and parity (Table 3). Table 4 presents results of provider-client instructions during counseling on abortion services in facilities. Whereas the quality indicators reviewed were rated high in public facilities, those identified in the private and NGO facilities requires significant improvement. Likewise, a high number of mystery clients (60.0%) from public facilities had clearly discussed options available for termination. At the NGO and private facilities, clients observed that discussions on options available for termination were far below excellent. Nevertheless, quite a high number of mystery clients (60.0%) from Public and NGO facilities had adequate discussions on how each method of termination works compared with the private facilities that were rated as far below good or excellent. About 60.0% of clients from public and NGO facilities reported to have had adequate discussions on consequences of having induced abortion whereas very few of such discussions occurred in the private facilities hence reported as far below good or excellent. It is evident that Safe Abortion discussion was moderate in the three facilities of service delivery. Specifically, mystery clients revealed that providers highly gave them opportunity to ask questions on the service ($m = 2.8$). Clients' perceptions about service providers level of knowledge relating to induced abortion during counseling was critical in decision making for an abortion service at the various facilities. Though to a large extent, knowledge level was reported as good across the facilities, some abortion service providers at the public and private facilities were reported to have had some challenges with clearly explaining the concept of post abortion contraception to clients. For instance, there was a report that:

“.....The service provider who attended to me is not well abreast with current information on family planning methods suitable for

Table 3: Key areas of Counseling the abortion client in facilities.

Type of facility	Age of client		Total
	No	Yes	
NGO	3(21.4%)	11(78.6%)	14(100.0%)
Public	1(20.0%)	4(80.0%)	5(100.0%)
Private	4(19.0%)	17(81.0%)	21(100.0%)
Total	8(20.0%)	32(80.0%)	40(100.0%)
Type of facility	Time of last menstruation period		Total
	No	Yes	
NGO	1(7.1%)	13(92.9%)	14(100.0%)
Public	0(.0%)	5(100.0%)	5(100.0%)
Private	6(28.6%)	15(71.4%)	21(100.0%)
Total	7(17.5%)	33(82.5%)	40(100.0%)
Type of facility	Medical & Obstetrics History taken		Total
	No	Yes	
NGO	5(35.7%)	9(64.3%)	14(100.0%)
Public	1(20.0%)	4(80.0%)	5(100.0%)
Private	12(57.1%)	9(42.9%)	21(100.0%)
Total	18(45.0%)	22(55.0%)	40(100.0%)
Type of facility	Gestational age and parity taken		Total
	No	Yes	
NGO	5(35.7%)	9(64.3%)	14(100.0%)
Public	1(20.0%)	4(80.0%)	5(100.0%)
Private	7(33.3%)	13(65.7%)	21(100.0%)
Total	13(32.5%)	26(67.5%)	40(100.0%)

Source: Field data 2018.
women after having an induced abortion.....”(Public facility).

Another reporter indicated that:

I was told the IUD is not a suitable immediate family planning method for women opting for surgical abortion because the wound in the womb must be healed before it can be safely done(Private facility).

Summary reports of clients' observations during counseling shows that although opportunities were given clients to ask questions,

Table 4: Provider-client instructions in facilities during counseling.

Type of facility	Had opportunity to ask questions					Total
	Poor	Needs improvement	Satisfactory	Good	Excellent	
NGO	0(0.0%)	3(21.4%)	0(0.0%)	8(57.1%)	3(21.4%)	14(100.0%)
Public	0(0.0%)	0(0.0%)	0(0.0%)	1(20.0%)	4(80.0%)	5(100.0%)
Private	1(4.8%)	3(14.3%)	5(23.8%)	7(33.3%)	5(23.8%)	21(100.0%)
Total	1(2.5%)	6(15.0%)	5(12.5%)	16(40.0%)	12(30.0%)	40(100.0%)
Type of facility	Discussed options available for termination					Total
	Poor	Needs improvement	Satisfactory	Good	Excellent	
NGO	0(0.0%)	2(14.3%)	1(7.1%)	6(42.9%)	5(35.7%)	14(100.0%)
Public	0(0.0%)	1(20.0%)	0(0%)	1(20.0%)	3(60.0%)	5(100.0%)
Private	2(9.5%)	8(38.1%)	1(4.8%)	10(47.6%)	0(0%)	21(100.0%)
Total	2(5.0%)	11(27.5%)	2(5.0%)	17(42.5%)	8(20.0%)	40(100.0%)
Type of facility	Discussed how each method of termination works					Total
	Poor	Needs improvement	Satisfactory	Good	Excellent	
NGO	0(0%)	2(14.3%)	1(7.1%)	5(35.7%)	6(42.9%)	14(100.0%)
Public	1(20.0%)	0(.0%)	1(20.0%)	0(0.0%)	3(60.0%)	5(100.0%)
Private	4(19.0%)	6(28.6%)	4(19.0%)	6(28.6%)	1(4.8%)	21(100.0%)
Total	5(12.5%)	8(20.0%)	6(15.0%)	11(27.5%)	10(25.0%)	40(100.0%)
Type of facility	Discussed consequences of abortion					Total
	poor	needs improvement	satisfactory	good	excellent	
NGO	0(0.0%)	4(28.6%)	3(21.4%)	3(21.4%)	4(28.6%)	14(100.0%)
Public	0(0%)	1(20.0%)	1(20.0%)	0(0.0%)	3(60.0%)	5(100.0%)
Private	3(14.3%)	5(23.8%)	8(38.1%)	4(19.0%)	1(4.8%)	21(100.0%)
Total	3(7.5%)	10(25%)	12(15%)	7(27.5%)	8(29.2%)	40(100)

Source: Field data 2018.

pain relief options for induced abortions were however not adequately discussed compared to other quality indicators. Cross selling of Marie Stopes International (MSI) products/services was observed to have been well discussed in all the 3 facilities types visited (Figure 1). It was reported that:

'... although I wanted an immediate abortion, the nurse told me there is a medication sold by Marie stopes which is very effective and affordable.....' (Private facility).

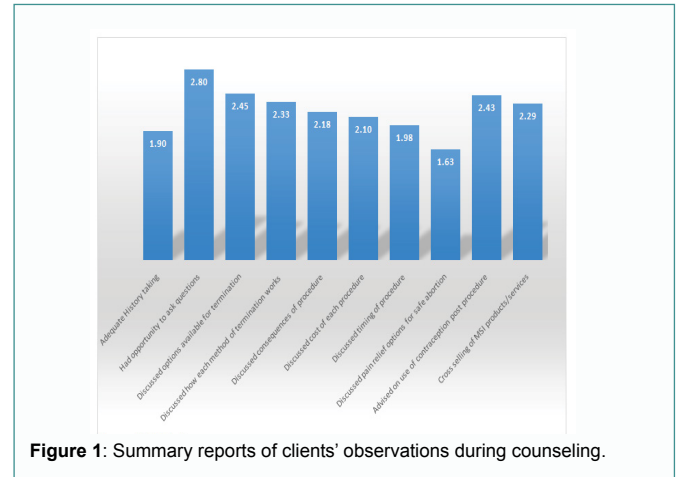


Figure 1: Summary reports of clients' observations during counseling.

Another reported that:

'...there methods of abortion were discussed with me at the consultation room, but I was told to choose Medabon which is a Marie stopes product....' (Public facility).

Another report which suggests a deliberate promotion of medication abortion to client using Marie stopes branded product is as follows:

'...because you have not done an abortion before, it's best we give you this Marie stopes drug so that you will not have problems with childbirth in future....' (NGO Facility)

Customer care

Professional knowledge of care, friendliness of providers/staff, religious biases to abortion, empathy and respect shown to clients, waiting times and operating hours, were some quality concerns raised under this theme. Religious faith and biases towards induced abortion influenced the quality of customer care received from some providers' hence the impact on decisions on induced abortion. A client narrated that:

".....after narrating my story and how badly and readily I need an abortion at this facility, the person in-charge of the clinic, told me blatantly that her faith doesn't allow her to provide abortion services at her clinic. I further asked her if she knew of another facility which I could go for this service but she told me she didn't know of any such place so I should better start preparing for a baby" (Public facility).

Another client was of the view that:

‘.The health worker I met was not too receptive. She didn't ask me why I needed an abortion nor was educated on options to abortion. She was just interested in my money and ready to provide me an abortion as soon as I'm ready to pay....’ (Private facility).

Some service providers across the private facilities in particular were reported for not ruling out pregnancy to confirm clients' status of pregnancy, yet starts preparations for abortion. It was reported that:

‘... he didn't ask me to go for any test or a scan when I told him I had missed my period for the past two months; but started discussing the methods and cost of abortion with me after which I was told to pay GHS400.00 for the abortion if I'm ready ..’(Private facility).

Another client reported that:

‘...we don't provide abortion services for big pregnancies here but I can direct you to a private clinic where it is done, you will have to budget for about GHS 2,000 for the procedure’ (from NGO Clinic).

Visibility of facility

There were various complaints with the location and visibility of the facilities visited. It was reported that, directional signs were inadequate and/or very poor across all the facility types studied. Where there were good directional signs and sign boards, they did not bear anything that clearly indicates that abortion services are provided. Additionally, some services providers were not in uniform/ name tags for proper identification, thereby making it difficult to be sure of who a service provider is and his/her designation in the facility visited. A client was of the view that:

‘....I spent about 2hours in this vicinity trying to locate this clinic. I am very worried about absence of a sign post and directional signs. There should be directional signs to really show that, there are abortion clinics in this community’. (Private Facility)

Another respondent noticed that:

---‘the lady who counselled me was not in uniform and was having no identification tag as well. This was challenging for me to identify who is a trained health professional and who is not’ (Private facility).

There were other concerns about labelling the client care areas in some facilities. A respondent reported that:

‘...in this big facility, there were no other labelling's apart from the reception and the cashier labels’ (Private facility).

Price and payment procedures

All the NGO and few private facilities had a price list of services displayed on a notice board at the reception area. There were however some discrepancies between what is on the notice boards and actual bills given to be paid for services. For instance, though the notice board indicated standard prices, some service providers at the NGO clinic over-billed clients for services. A client indicated that:

“At this clinic, the service provider was calling prices like Ghc 400.00 for medication abortion and other huge prices for fast track abortion services when the opposite was on the price list” (NGO Clinic).

Most of the Private and Public facilities had not displayed the cost of services for comparing and decision making. This makes prices differ significantly among the private clinics compared to the Public facilities. A client reported that:

‘Some private facilities even call abortion and family planning services as ‘Special services’, whereas in the NGO clinics both services are integrated at one cost’ (Private facility).

Infection prevention

Concerns raised regarding infection prevention were appearance of facility, sitting arrangements at waiting areas, cleanliness of environments, refuse disposal, availability of toilets and hand washing facilities for clients. With respect to the cleanliness of facilities in which abortion services were provided. A client reported that:

‘The filth and stench that welcomed me at the entrance of this facility just pissed me off so I didn't even enter the clinic to ask which services are provided there’ (Private facility).

Another client commented:

‘The front view was nicely painted in blue and white colors but the consulting room was very stinking with blood stained gauze swabs and over full used syringes spilling to the floor’(NGO Facility).

Concerning availability of toilet facilities, some clients recounted that:

‘-----there was only one toilet available to all clients in most of the facilities visited. This was very dirty, smelling and half full’ (Private facility).

Another report was that:

‘----the facility we visited had a clean toilet but lack hand washing facilities after using the place hence it was not possible to wash hands (NGO Facility)’.

Likewise, another report indicated that:

‘-----the washroom is clean but there was no water to flush nor wash hands after using the place’ (Public facility).

Waiting time for services

The time spent at reception area, consultation room and other client care areas were described as either ‘just right’, ‘too long’ or ‘too short’. Although the time spent varied from one client care area to the other as well as across facilities, time spent at the reception prior to being attended to, during history taking and in the consultation rooms were some key areas of concerns (Table 5). Although time spent on actual abortion services were not captured because service uptake was not part of the methodology of the mystery shopper survey, the field assistants whilst sitting at the facilities reception/OPDs indirectly

Table 5: Approximate waiting time for services.

Client care areas	Approximate waiting time for services			Service provided
	NGO	Private	Public	
Reception/OPD	too long	just right	too long	<ul style="list-style-type: none"> • Waiting for attention • History taking
Consultation/counseling room	just right	too short	too long	Counseling

Source: Field data 2018.

estimated the time other clients who actually came for abortion services spent before being discharged home. The following reports were presented in this regard:

‘..... One of the ladies I observed and later spoke with on her experiences said she was given an injection in her veins before the abortion started and did not see what happened thereafter.....’ (Private facility).

Another reported that:

‘.....they set a drip on me in the theater and whilst we were conversing I felt asleep only to wake and found that the abortion has been completed.....’ (Public facility).

Whilst still groaning in pains my ‘friend’ reported that:

‘.....this people lied to me that the abortion will not be painful so they didn’t give me any drugs. But I swear to God that it was very painful although they kept talking to me and playing loud music to confuse me.....’ (NGO Facility).

Discussion

This study used a mystery shopper method in assessing quality of induced abortion service delivery in Ghana. In general, the results indicate that the overall quality of abortion services in the health facilities reviewed (Private, Public and NGO) were poor, with specific concerns on counseling, client-provider-communication, visibility and cleanliness of facilities among others. Following the International Conference on Population and Development (ICPD) in 1994, the Program of Action developed had a positive step towards legitimizing abortion as a component of basic reproductive health services [11]. Consequently, governments of nations agreed to support comprehensive reproductive health services including women’s choice of fertility regulation, with the provision that access should be available for abortion care as permitted by law [12]. However, since abortion is heavily stigmatized in Ghana, actual incidence of the procedure is underreported in face-to-face interviews [13]. While recent, reliable national abortion figures for Ghana are not available, the World Health Organization estimates that there are 28 procedures per 1,000 women each year in Western Africa which is alleged that the true incidence in Ghana is likely to reach this rate [14]. Non adherence to clinical quality standards whilst providing induced abortion services could also be linked to the WHO definition of unsafe abortion [15] and not only the focus on environment where the service is provided and the cadre of service providers as enshrined in the abortion law of Ghana [16]. Various issues emanating from the current study are of public health policy and program importance as they affect the quality of care being provider to abortion seekers in the health facilities in Ghana. The importance of thinking quality ahead of scaling abortion services cannot be overemphasized since clinical quality is key in all efforts geared at increasing access to safe abortion care in Ghana. Clinical quality is also central to the ICPD

program of action for that matter the implementations of Ghana’s abortion standards and protocols which provides the required guidelines for service delivery. Whiles findings of this study are very worrying because they undermine national efforts in ensuring access to high quality abortion services, the findings also suggest that a onetime licensing of a facility to provide an abortion service does not guarantee sustainable quality of care if sustainable systems are not put in place for effective monitoring, continuous supportive supervision of providers in facilities and reaccreditation of facilities for renewal of operating licenses based on meeting required quality standards for setting up a facility that provides induced abortion and related services in Ghana. The observation that majority of mystery clients were at private facilities implies that more abortions are available in private facilities than the public and NGO facilities. This observation reflects dichotomy of four concepts that has to be considered in ensuring high clinical standards for providing quality abortion services in health facilities in Ghana (i.e. High abortion client vs. High Quality Standards; High abortion client vs. Low Quality Standards; Low abortion client vs. High Quality Standards; Low abortion client vs. Low Quality Standards). With the increasing demands for induced abortion services in Ghana, the temptation of providing abortion services on demand in health facilities without proper counseling of abortion seekers to make the best informed decisions and choices is an emerging issue [17]. Whilst the increasing demand for abortion services particularly in urban settings looks lucrative for providers, little attention is being paid to the quality of services. The observation that abortion providers in some private facilities do not confirm pregnancies before discussing the costs of termination confirms the perception that abortion providers within private facilities in Ghana are ‘using the female pelvis as a goldmine’ [18]. This observation could probably imply that, some women who missed their periods and visits some private facilities for an induced abortion thinking they are pregnant might not have been pregnant after all but had to undergo the process of pregnancy termination probably because the facility is dishonest and just interested in taking their money. The absences of price list for abortion services, advertising abortion services on facility sign boards and lack of directional signs to many abortion clinics in the study areas could be deliberate to avoid the consequences of associated stigma and cultural sensitivities surrounding abortion services in Ghana. Although time spent on actually abortion services were not captured in this study because service uptake was not part of the methodology of the mystery shopper survey, the field assistants could estimate from observations whilst waiting at the reception/OPD area that time spent on abortion services were longer in private and public facilities compared to NGO facilities. This estimation was done by the field assistants’ ability to conceal their identities, intentions and probe into the experiences of clients’ who had actually visited the various facilities for an induced abortion. The variation in time spent for an abortion procedure could be due partially to time spent on sedating clients and recovery before discharged. Client sedation for an induced abortion was reported as not being practiced in the NGO facilities visited since the investigations relating to pain management confirmed that clients who had abortion services in NGO facilities were not sedated. Whatever be the situation, the importance of quality in abortion care and standardization of practice within the confines of national standards and protocol should be an integral part of facility set up, staff orientation and facility routines. Concerns about client provider interruption during counselling shows some knowledge deficit regarding updates on safe abortion care in all facilities. It is thus very essential for a standard knowledge to be given to all sectors

providing abortion services in Ghana. In this regard, there is the need for continuous professional education on emerging issues and updates on safe abortion care as permitted by the laws of Ghana with focus on quality inputs and outputs for safe services. Such updates can be included in discussions with service providers by supervisors to allow for clarity on the part of clients and also improve communication on history taking, options counseling and pain relief options for safe abortion. Moving forward, Ghana could introduce a moderate pricing policy across all facilities or perhaps provide more subsidized products to reduce the price differences at all facilities providing abortion services, especially those in the private sector. This when done could prevent clients from patronising cheaper abortion services from unsafe places so as to further reduce incidence of unsafe abortions and related complications in Ghana. Through effective continuous professional development training programs, knowledge and skills relevant for high quality safe induced abortion service delivery could be enhanced. Where facilities are not adhering to quality standards despite efforts to ensure quality, appropriate national sanctions could be applied to such facilities and/or individuals' abortion service providers to save lives and prevent injuries.

Conclusion

The quality of induced abortion services being provided in health facilities in Ghana as per clients' perspectives is generally unsatisfactory despite policies and laws to guide quality of care. Improvement of services standards through continuous supportive supervision and standardisation of all aspects of abortion care will enhance the expected standards of care in Ghana. A nationwide quality assessment of all abortion facilities is highly recommended to evaluate service quality for appropriate interventions.

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