



Three Delays Model applied to prevention of unsafe abortion in Ghana: a qualitative study

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ABSTRACT

Background Unsafe abortion is an important public health problem in Ghana, making significant contributions to the morbidity and mortality of reproductive-aged women. Although mostly used in explaining mortality associated with perinatal care, recent calls for research on induced abortion in Africa suggest that the Three Delays Model could be used to enhance understanding of women's experiences and access to induced abortion care.

Methods We conducted 47 face-to-face interviews with women who had experienced unsafe abortions, with formal abortion providers (abortion providers in hospitals) and with informal and non-legal abortion providers (pharmacy workers and herb sellers). Study participants were recruited from selected hospitals, community pharmacies and markets within the Ashanti region of Ghana. We drew on phenomenology to analyse the data.

Findings The first delay (in seeking care) occurred because of women's poor knowledge of pregnancy, the influence of religion, and as a result of women underestimating the seriousness of abortion complications. Factors including cost, provider attitudes, stigma, and the proximity of pharmacies to women's homes delayed their access to safe abortion and resulted in their experience of the second delay (in reaching a healthcare facility). The third delay (in receiving appropriate care) was a result of hospitals' non-prioritisation of abortion complications and a shortage of equipment, resulting in long hospital waiting times before treatment.

Conclusion This study has shown the value of the Three Delays Model in illustrating women's experiences of unsafe abortions and ways of preventing the first, second and third delays in their access to care.

INTRODUCTION

In Africa, 8.3 million abortions occur annually, with African women

Key messages

- Despite abortions being legally permissible, Ghanaian women mainly obtain abortions outside the formal health delivery system using unsafe methods.
- Various individual, community and societal factors act as barriers, delaying Ghanaian women's access to safe abortion care within the formal health delivery system.
- The Three Delays Model can be used as a framework for understanding these delays experienced by women in accessing abortion care.

experiencing the highest risk of induced abortion-related mortality than women anywhere in the world.^{1–3} Based on current estimates, some 16 000 African women die each year from unsafe abortion-related complications, and an estimated 1.6 million women experience morbidities as a consequence of unsafe abortions.⁴ In Ghana, legal abortions are allowed in cases of rape, incest, fetal anomalies, and to protect the physical or mental health of the pregnant woman; this notwithstanding, unsafe abortion is a significant public health problem.^{5–7}

Formal Ghanaian healthcare is mainly provided by the Ghana Health Service and healthcare delivery is structured into primary, secondary and tertiary care.⁸ However, access to safe abortion care in these facilities is not readily available.⁹ In a national study on maternal health including induced abortions, the majority of women were reported to have ended their pregnancies outside the formal health system with medical

abortifacients containing either misoprostol alone or a combination of misoprostol and mifepristone.⁷

While Ghanaian research has presented women's abortion experiences,^{7 10} there is limited evidence from Ghanaian abortion providers, including pharmacy workers and herb sellers. Given the role providers play (formal and informal) in abortion safety, and women's experience of delays, an exploration of their perspectives is important.

The Three Delays Model has been used to explain maternal mortality related to perinatal care, but not with induced abortions.¹¹ The model proposes that delays experienced in deciding to seek healthcare, reaching a healthcare facility, and receiving appropriate care are important contributory factors to maternal mortality.¹¹ Recent calls for a research agenda on induced abortion have suggested that using the Three Delays Model and exploring specific populations, such as healthcare providers, could enhance our understanding of women's unsafe abortions.¹²

This article, from a wider study exploring providers' and women's unsafe abortion experiences, aims to provide evidence for the utility of the Three Delays Model as a framework for understanding women's experiences of unsafe abortion in Ghana.

METHODS

We conducted the study in the Ashanti region of Ghana, the most populous region, with significant prevalence of induced abortions.^{7 13} Women and formal abortion providers were recruited from three hospitals. Informal abortion providers (pharmacy workers and herb sellers) were recruited from eight pharmacies and three markets within the wider community between June 2017 and March 2018.

Women were eligible for the study if aged between 18 and 49 years and reporting to participating hospitals after complications from unsafe abortions. The single inclusion criterion for abortion providers was abortion provision.

We utilised purposive sampling in recruiting women and formal abortion providers from the hospitals. In recruiting the women, advertising materials were placed on notice boards and at vantage locations within hospitals. Study materials were also left with healthcare workers, who advised women meeting the inclusion criteria about the study. Women who expressed interest in participating were approached by the lead researcher (MNAO). Only women treated and ready for discharge were enrolled in the study to avoid situations in which women felt their participation could influence care. The lead researcher explained the purpose of the study and sought both verbal and written consent. Participants were made aware of the voluntary nature of participation and all underwent a confidential interview in Twi (the local language) using an interview guide (online supplemental file 1).

Formal abortion providers were recruited through one-on-one promotion of the study. Following explanation of the voluntary nature of participation and consent, confidential interviews with providers were conducted after their hospital shift (online supplemental file 2).

With informal abortion providers, due to the sensitivities surrounding illegal activities, initial attempts at recruitment failed. MNAO therefore recruited a respected community leader who facilitated the process to reach these individuals.¹⁴ After initial informal abortion provider interviews, we used a 'snowballing' technique to recruit the remainder of the sample (online supplemental files 3 and 4).

We used thematic semi-structured interview guides. Interviews were a one-off encounter and interviewees were assured that data were stored confidentially and in an anonymous form. Participants were further assured that their location would not be identified. Each interview lasted between 30 and 75 min and was conducted and audio-recorded by the lead researcher in Twi, the local language. Both verbal and written informed consent were obtained.

This qualitative study drew on phenomenology, which studies patterns of peoples' lived experience and how they have explained it, to enable detailed analysis of participants' abortion experiences.¹⁵ Data analysis commenced with cleaning and transcribing of interviews into English. Coding was an inductive process during which the research team read and re-read the interview transcripts to generate and finalise codes for onward categorisation.¹⁵⁻¹⁷ To validate and enhance a more comprehensive understanding of unsafe abortion, we triangulated the data of women with providers (formal and informal).¹⁷ During data analysis, the research team identified women experiencing delays in their decision to seek, reach and receive care after unsafe abortions, for which we found the Three Delays Model a good fit to explain what was occurring. All names used in this article are pseudonyms.

RESULTS

Participant characteristics

We interviewed 47 participants: 24 women mostly from low-income households and employed in their own small businesses, 10 formal abortion providers who were mainly midwives and 13 informal abortion providers, comprising eight pharmacy workers and five herb sellers (tables 1 and 2).

We present the results of the study highlighting the first, second and third delays women experienced in their unsafe abortion journey. All delays represented in figure 1 emerged from the experiences of the women in this study.

First delay

In this study, women experienced the first delay when they delayed their decision to seek abortion or

Table 1 Characteristics of women seeking care following informal abortions (n=24)

Characteristic	Women n (%)
Age (years)	
<20	5 (21)
20–29	11 (46)
30–39	5 (21)
≥40	3 (12)
Marital status	
Single	15 (63)
Married	8 (33)
Separated/divorced/widowed	1 (4)
Educational level	
No formal education	3 (12)
Primary/junior high school	9 (38)
Senior high	9 (38)
University	3 (12)
Employment status	
Formal sector	3 (12.5)
Informal sector	16 (67)
Student	2 (8)
Unemployed	3 (12.5)
Children (n)	
0	14 (58)
1–3	6 (25)
≥4	4 (17)
Method of inducing abortion	
Herbal abortifacient	6 (25)
Medical abortifacient	18 (75)

post-abortion care due to late recognition of pregnancy, underestimating the seriousness of an abortion complication, and concerns about suffering stigma from breaching religious norms. Women's poor knowledge about reproductive health led to delayed testing and late recognition of pregnancy signs, resulting in abortions at higher gestations, with greater risks to the lives and health of women. Patricia delayed her decision to seek abortion care because she did not recognise she was pregnant until her pregnancy was well advanced:

... I used to get tired easily, but I thought it was because of the kind of work I did ... I also noticed that the number of days I menstruated had reduced from 7 days to 3 days, but I did not think it was pregnancy... [Patricia, aged 44 years]

Similarly, other women spoke of delays in their decision to seek care due to poor education around pregnancy:

Table 2 Characteristics of abortion providers (n=23)

Interview participants	n	Age (years)	Sex (n)	
			Male	Female
Formal abortion providers (n=10)				
Midwives	5	30–50	–	5
General practitioners	2	39–42	2	–
Gynaecologists	1	55	1	–
Physician assistants	1	31	–	1
Public health nurses	1	59	–	1
Informal abortion providers (n=13)				
Pharmacy workers (n=8)				
Pharmacists	2	30–40	2	–
Dispensing technicians	3	26–30	2	1
Pharmacy assistants	3	20–24	2	1
Herb sellers (n=5)	5	20–70	1	4

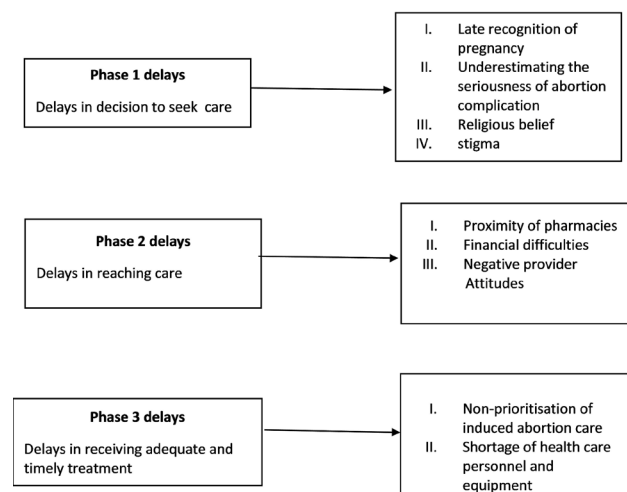
... the pregnancy resulted from my first sexual intercourse; I did not know I could get pregnant the first time. [Leticia, aged 19 years]

After undergoing an unsafe abortion using a herbal abortifacient, Juliana thought the bleeding she was experiencing would resolve on its own and hence delayed seeking care till her situation worsened:

... abortion occurred after using herbs. ... the blood was still coming. I thought it was normal and would resolve on its own. ... fainted and was brought here. ... they told me I was anaemic and there were still some products of conception. ... they evacuated it at the theatre. [Juliana, aged 24 years]

The strong influence of religion also caused delays in women's decision to access care:

... Most of our women know that they can come to the hospital for safe abortion, but they would not, with our Christian life. We think we are so Christian that the thing is wrong. ['Auntie' Vida, midwife]

**Figure 1** The Three Delays Model applied to unsafe abortion prevention.

Second delay

The second delay in this study is defined by difficulties in reaching care. Financial difficulties, stigma, prejudice, power imbalance, local pharmacy access and patriarchal attitudes contributed to women's experience of the second delay. Women's financial resources played an important role in their experience of this delay: the inability to pay for safe abortion was a barrier to care, resulting in abortions at higher gestations and reliance on inexpensive unsafe methods:

... he gave me fifty cedis ... it was not enough ... I bought an abortifacient from the market. [Beatrice, aged 28 years]

... the herbs are not expensive but very efficacious ... many buy. ['Sister' Gifty, herb seller]

... she will sit at home and save till she gets the two hundred cedis or use an unsafe means which is cheaper. ['Aunty' Mary, midwife]

Because pharmacy provision is illegal and unregulated, pharmacy workers could adjust the costs as they please:

... usually, I look at the person coming to buy if they appear rich... I increase the price a bit. [Bra George, pharmacy shop assistant]

Women denied access to care due to poverty may not only experience delays but could also die:

It was after she died that the sonographer working with us mentioned that the girl came to enquire from him the cost of an abortion. ... she had only thirty cedis ... he told her to go and raise the additional money and then come. Since the girl could not raise the extra money, she opted for the cheaper option which led to her death. ['Aunty' Charlotte, midwife]

Women also delayed reaching the formal health system due to the ease of local pharmacy access:

... they go to the pharmacy to buy medicines rather than ... the hospital. ... pharmacy it is fast you buy, and you are off unlike the hospital where you have to be registered and wait your turn to see the doctor. [Dr John, general practitioner]

... I told the person ... at the pharmacy I wanted medabon and he brought it. I paid and left; he did not ask any questions. [Sarah, aged 21 years]

Though without training, some pharmacy workers took it upon themselves to treat women with complications, an act which delayed women from accessing hospital care:

... I tell them that if the bleeding is usually long ... they should come back so I give them something to stop the flow. ['Bra' Josh, pharmacy shop assistant]

Third delay

The third delay occurred when women arrived at the hospital with post-abortion complications. Women sometimes reported waiting for very long periods because of negative provider attitudes, stigma or

abortion being treated as the lowest priority in obstetric care. This sometimes led to situations whereby women with life-threatening complications were not treated as an emergency and were made to undergo cumbersome administrative processes:

... I was bleeding all this while ... but was not attended to until my husband did the paperwork ... when he finished a nurse sent me to the ward and administered IV fluids. I was very weak I bleed so much. ... you see how white my palms have become it is now even better. [Patricia, aged 44 years]

There are also instances where women experienced delays after reporting to hospitals for treatment due to limited supply of equipment:

... the doctor wanted me admitted at the ward but there were no beds... [Matilda, aged 31 years]

DISCUSSION

As far as we are aware, this is the first study to use the Three Delays Model in relation to induced abortion care.¹¹ The model proposes that abortion-related maternal morbidity and mortality can be classified in terms of delays in seeking, reaching and receiving appropriate treatment at health facilities.¹¹ Our study, conducted in the Ashanti region of Ghana, illustrated that interwoven factors within women's individual level of education, together with their communities and wider structural environment, contributed to the first, second and third delays. As this research involved only women who sought hospital care after experiencing abortion complications, it may not be representative of all women seeking abortion. Community-based studies could further enhance an understanding of the delays experienced by women and explore differences in abortion provision by herb sellers and pharmacy workers.

Many women who participated in this study did not recognise the signs of pregnancy until their pregnancies were more advanced, at which point terminating the pregnancy not only carried greater health risks but was also more expensive. Though available evidence suggests that adolescents are more likely to delay abortions due to late recognition of pregnancy,¹⁸ in this study women who had experienced a number of pregnancies and births also delayed accessing care due to late recognition of pregnancy.

Despite pharmacy provision of medical abortion being illegal in Ghana, a significant number of women in the study used it. Like other low-resourced settings, women who accessed pharmacy abortions were either given no or limited information on the safe use of the abortifacients.^{19 20} Though available evidence highlights the contribution of pharmacy provision of medical abortion to maternal mortality reduction,^{21 22} inadequate information about the safe use of these abortifacients could result in incorrect dosages and

unsafe abortions.²³ Additionally, pharmacy workers in this study described providing on- and off-label treatment to women with complications. This is not only inimical to women's lives as pharmacy workers are not trained in this management, but could delay sick women from accessing appropriate care promptly. This indicates a need for legalisation around pharmacy supply; in this way pharmacy workers can be given the necessary training to safeguard the lives of women and be monitored for safe and effective practice.

Despite prompt treatment being a major determinant of the health outcomes after unsafe abortion,²⁴ medical care for women with abortion complications in hospitals was not deemed urgent. Their delayed care may reflect healthcare provider and wider societal attitudes towards women who abort their pregnancies. Evidence of obstetric violence²⁵ and the mistreatment of women seeking treatment for abortion complications has been reported in Ghana and elsewhere.^{24 26} Delayed access to treatment may have also been influenced by limited healthcare equipment and personnel.²⁷

CONCLUSION AND RECOMMENDATIONS

This study explored the applicability of the Three Delays Model in studies on unsafe induced abortions and enhanced understanding of ways in which women's abortion experiences impacts their access to care. This study was conducted in Ghana and may therefore not reflect the pattern of delays experienced by women in other settings. Negotiating access to discussions on abortions among women and providers within the Ghanaian context where abortion is stigmatised is a major strength of this study. To help prevent unsafe abortion, there is a need for more sexual and reproductive health school-based education together with public health campaigns to equip women to make informed decisions. Campaigns targeted at reducing abortion-related stigma are also important. Pharmacy provision of medical abortions should be legalised, and its role monitored. In addition, there is a need for regular training of pharmacy workers on safe dispensing of medical abortifacients, as well as signs of abortion complications, in order to safeguard the lives and health of the women they serve. The Three Delays Model is an important framework that can be used to identify where delays occur for women seeking induced abortion care.

Contributors MNAO designed and collected data for the study. Data were analysed by MNAO with input from all authors regarding interpretation of the results. MNAO prepared the first draft of the manuscript. All authors contributed to revising the manuscript and approved the final version.

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Competing interests None declared.

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Patient consent for publication Not required.

Ethics approval This study was approved by the La Trobe University Human Ethics Committee (HEC17-009) in Australia and Komfo Anokye Teaching and the School of Medical Sciences, Committee on Human Ethics Research and Publication (CHRPE/AP/547/17) in Ghana.

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**Topic: A Mixed Methods Study of Post Abortion Women and Service Providers in the Ashanti
Region of Ghana**

Introduction:

Issues about abortion is sensitive and some of the questions I will be asking may make you feel uncomfortable, but as you have read/have had explained to you from the participant information statement and the consent forms your responses will be kept confidential, anonymous and you have the right to withdraw from the study at any time. If you are uncomfortable with a question just let me know and I will move to the next one.

We can use local language if they are more comfortable with it.

I want to thank you for you agreeing to participate in the study

I will start by asking a few general questions about you

Background Information

1. Please how old are you?
2. Can you read and write?
3. What is the highest level of school you have attended?
4. To which religious group do you belong?
5. Are you currently married?
6. Please what you do for a living?
7. What about your partner, what work does he do?
8. Where do you live?
9. How far is it from this health facility?

Reproduction

Now I will want us to talk a bit about the number of pregnancies and births that you have experienced so far

10. Please how many times have you been pregnant in your life?
11. Sometimes women become pregnant a number of times but not all will result in live births, please tell me the number of children you have?
12. Let us come back to the just ended pregnancy, at the time you became pregnant did you want to become pregnant then?

Probe

- Whether participant wanted to wait until later or
- Did not want to have any more children?

13. What was the reaction of your partner to the pregnancy?

Probe

- If partner unaware of pregnancy?

Family planning and contraceptive use

Were you using contraception when any of these pregnancies and births occurred?

Probe

- If no, reason for non-use

14. What about the current pregnancy which ended, were you using contraception?

Induced abortions

15. Apart from the just ended pregnancy, have you ever been in a situation where you had to intervene in ending a pregnancy?

16. Now let us come back to the just ended pregnancy, please remember that this interview is confidential and everything you say will not be divulged to anyone unrelated to the research team. Women who happen to be pregnant when they do not want to sometimes take several actions in trying to end it, what are some of the things you did in trying to end this pregnancy before finally deciding to access care at this health facility?

Probe:

- Source of knowledge on ways of self-inducing abortion.
- Duration of pregnancy when termination occurred
- If participant sort provider, ask:
 - ◆ Type of provider
 - ◆ Method provided
 - ◆ Instruments used
 - ◆ Facility where the procedure took place
 - ◆ Reason for choice of provider
 - ◆ How provider was identified
 - ◆ Cost of service
 - ◆ Distance between provider and residence
 - ◆ How the provider related to her
 - ◆ Satisfaction with the services
 - ◆ Whether they will opt for services again or recommend to a friend if need be?

- ◆ Ask why they did not first come to the hospital after deciding on abortion

- Ask for a comparison between the earlier provider and current provider in relation to the initial probes

17. What were some of the health challenges you encountered in your initial attempts at ending the pregnancy before finally reporting at this health facility?

Probe:

- What attempts were made at treating the complications before report at health facility?
- I will want us now to focus briefly on your partner, what were his views about ending the pregnancy?

Probe

- If partner unaware of pregnancy and abortion?

18. Going back to when you were pregnant, what was the main reason for not wanting to keep it?

19. With whom did you decide on ending the pregnancy?

Probe

- Reasons for choice of person?

20. What about your community, how do they see abortion?

Probe:

- Ways in which community perceptions affected abortion decisions?

21. I want us to now come back to the health facility, how far is this facility from where you live?

22. What made you decide to come here to seek for treatment after experiencing the complication?

23. After the treatment were you given advice about ways of preventing future pregnancies?

Probe

- Whether participant accepted a method and the type of method?
- If did not find out why?

24. Finally, please tell me what you know about the law concerning abortion in Ghana

Closure

We have come to the end of the interview thank you very much for your time. Is there anything else you would like to tell me? Anything you would have liked me to ask but I didn't or anything you need further clarification on?

I wish to thank you once again

Topic: A Mixed Methods Study of Post Abortion Women and Service Providers in Ghana**Introduction:**

I am Mercy Otsin, a PhD student at Latrobe University. I am undertaking a Doctoral study at the Judith Lumley Centre for Mother, Infant and Family Health Research, in the school of Nursing and Midwifery. This study is about women who have experienced abortion related complications as well as persons involved in the provision of services to them. As a clinician your views are extremely important in helping shape the provision of safe abortion services for women. I really do appreciate you taking time off your busy schedule to grant me this interview. I will start by first asking some general questions about you

Background information/warming up

1. If I say that tell me something about how a typical day in your working life is what will you say?
2. Please how old are you?
3. Are you married?
4. Please what is your area of specialisation?
5. How long have you been practicing in that field?

Main issues

6. What training have you received in the provision of safe abortions?
7. Please can you tell how long you have been involved in the provision of services?
8. Now I will want to pick your thoughts about the different methods?

Probe:

- Method often provided?
 - Reasons for its frequent use?
 - The least favourite method?
 - Why it is least preferred?
 - Instruments used in provision of services?
 - How the instruments are procured?
9. Do you always provide the terminations in this facility or there are instances where you arrange with patients to provide the terminations elsewhere?
 10. There are various reasons women give for seeking terminations, please I will like to know some of the factors that might influence you in either providing or not providing services?
 11. What are some of the characteristics of the women who seek for services?

12. Do you think health facility based terminations is the first option for the clients seeking services or it is often the last resort?
13. If not what do you think could be the cause?
14. On the average how many clients do you see in a week?
15. What do you know about the laws governing abortions in Ghana?
16. How do you see the legislation?
17. In your view do you think it provides sufficient grounds for women to seek for safe abortion services?
18. Now let us look at the providers, in your view does the law allow them to do operate without fear of legal reprisals?
19. As a practitioner who provides safe services for women, do you think the law in anyway influences decisions women take about where to seek for services?
20. As you know unsafe abortion contributes significantly to the maternal mortality rate, do women in need of services know where to get it safely done but still seek for services from the quacks, I will like to pick your thoughts on it?
21. What is the cost of services?
22. Do you counsel the women before the procedure about what to expect?
Probe:
 - Whether provider explains the various methods to them and
 - allows them to choose their method of choice
23. What has been some of your experiences with the attitude of colleagues who know you provide services?
24. There are some instances where some of the health facilities will not be supportive of personnel providing services, what has been the attitude of the administration here?
25. What are some other challenges faced in your work?
26. Please share with me your thoughts about the current way services are provided?
27. What do you think can be done to make it better?

Closure

We have come to the end of the interview I want to thank you very much for your time. Is there anything else you would like to tell me? Anything you would have liked me to ask but I didn't or anything you need further clarification on

Thank you once again.

Topic: A Mixed Methods Study of Post Abortion Women and Service Providers in the Ashanti region of Ghana

Introduction

I am Mercy Otsin, a PhD student at Latrobe University. I am undertaking a Doctoral study at the Judith Lumley Centre for Mother, Infant and Family Health Research, in the school of Nursing and Midwifery. This study is about women who have experienced induced abortion related complications as well as persons involved in the provision of services. As a pharmacy worker who helps women needing abortions your views are extremely important in helping shape the provision of safe abortion services for women. I really do appreciate you taking time off your busy schedule to grant me this interview. I will want us to get to know each other a little bit before delving into the main issues.

Background information/warming up

1. Please how old you are?
2. Are you married?
3. Please what is the highest level of education you have attained?
4. Please tell me the number of years you have been practicing as a pharmacy worker?

Main issues

5. Please do women in the community who are pregnant but do not want to keep it often come here to seek for help in ending it?
6. In what ways do you assist them?
7. Please, what types of abortifacients do you have in stock?

Probe:

- The most popular?
- Why do you think those brands are preferred over the others?

8. Please tell me where you get your supplies from?
9. On the average, how much do they cost?
10. On the average how many abortifacients do you sell in a week?
11. Please how long have you been involved in selling abortifacients?
12. Do you just sell the abortifacients or you give them advice on the dosage as well?

Probe:

- Advice about how the abortifacient works
- Advice on what to do in the event of a complication
- Whether they dispense the medication on site or the women buy and administer it at home

13. There are various reasons women give for seeking terminations, please I will like to know some of the factors that might influence you in either providing or not providing services?
14. What are some of the characteristics of the women who seek for services?
15. Do you think this is the first point of call for women desiring to end their pregnancies?
Probe:
 - If yes, why do you think so
 - If no, why
16. Do you interact with them to ascertain how they found out about your services?
17. Have you received any training in medical abortion?
Probe:
 - If yes, ask source
 - If no, ask source of knowledge in the current work he/she is involved in
18. What do you know about the laws governing abortions in Ghana?
Probe:
 - How do you see the legislation
 - Does your knowledge about the law in anyway influence the kind of services you provide
 - Do you think it provides sufficient grounds for women to seek for safe abortion services
 - providers to do their work without fear of legal reprisals
19. Do you give advice about ways of preventing future pregnancies?
20. What are some of the challenges you face in your work?
21. How do you think they can be solved?

Closure

We have come to the end of the interview I want to thank you very much for your time. Is there anything else you would like to tell me? Anything you would have liked me to ask but I didn't or anything you need further clarification on

Thank you once again

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Introduction

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Background information/warming up

1. Can you please tell your age?
2. Please are you married?
3. Please what is the highest level of education you have attained?
4. Please tell me the number of years you have been practicing as a herb seller?
5. Please tell me what you do in a typical working day?

Main issues

6. Women who are pregnant but do not want to keep it go to various places to seek help in ending it, in your view do they often call on you first for help before going anywhere else?

Probe:

- If yes, why do you think so
- If no, why
- Do you interact with them to ascertain how they find out about your services?

7. Please tell me the types of methods you provide?

Probe:

- Types of herbs used?
- Source of supply of the herbs?
- Mode of administration?
- How it works?

8. Please share with me how efficacious the different methods are?

9. There are various reasons women often give for seeking terminations, please I will like to know some of the reasons that might influence you in either providing or not providing services for them?
10. What are some of the characteristics of the women who seek for services?
11. Do you always provide the services in this facility or there are instances where you arrange with patients and provide services elsewhere?
12. Apart from the herbs do you use any instrument in providing services?
13. Please tell me what you do if something goes wrong during service provision?
14. Please how much do you charge for your services?
15. Do you give advice about ways of preventing future pregnancies?
16. What do you know about the laws governing abortions in Ghana?
Probe:
 - How do you see the legislation?
 - Does your knowledge about the law in anyway influence the kind of services you provide?
 - Do you think it provides sufficient grounds for women to seek for safe abortion services without fear of legal reprisals?
17. What about the providers, in your view does their knowledge of the law in any way influence the kind of services provided?
18. There are other places like hospitals where women seeking terminations can go, why do you think they prefer your services over the others?
19. What are some challenges you face in your work?

Closure

We have come to the end of the interview I want to thank you very much for your time. Is there anything else you would like to tell me? Anything you would have liked me to ask but I didn't or anything you need further clarification on

I wish to thank you once again