Journal of Asian Midwives (JAM)

Volume 5 | Issue 1 Article

6-2018

Determinants of Inadequate Provision and Utilization of Post Abortion Care Services in Pakistan

Marina Baig
Aga Khan University, marina.baig@aku.edu

Kiran Mubeen
Aga Khan University, kiran.mubeen@aku.edu

Determinants of Inadequate Provision and Utilization of Post Abortion Care services in Pakistan

[1*]Marina Baig, [2]Kiran Mubeen

1. Senior Instructor, The Aga khan University School of Nursing and Midwifery, Email: marina.baig@aku.edu
2. Senior Instructor, The Aga khan University School of Nursing and Midwifery, Email: kiran.mubeen@aku.edu

***Corresponding Author:** Marina Baig

Abstract

Access to safe abortion services remain a challenge in many low and middle income countries like Pakistan. Evidence suggests that Pakistan shares a huge burden of abortion related morbidities and mortalities. Timely provision of Post Abortion Care (PAC) services could assist in preventing maternal deaths associated with unsafe abortions. However, there are certain socio-cultural, financial and political factors that restricts the provision and utilization of effective PAC services. This paper explores these determinants and suggest recommendations for policy and practice to promote PAC services in Pakistan.

Introduction

Maternal mortality remains a great challenge throughout the developing world. Worldwide around 830 maternal deaths occur every day, and 99% of these deaths take place in developing countries. Sub-Saharan Africa accounts for more than half of these deaths and almost one third occur in the South Asian region.[1] According to a Systematic Analysis of World Health Organization (WHO) [2], abortion is the fourth leading cause of maternal deaths (7.9%), preceded by hemorrhage (27%), hypertension (14.0%), and sepsis (10.7%).

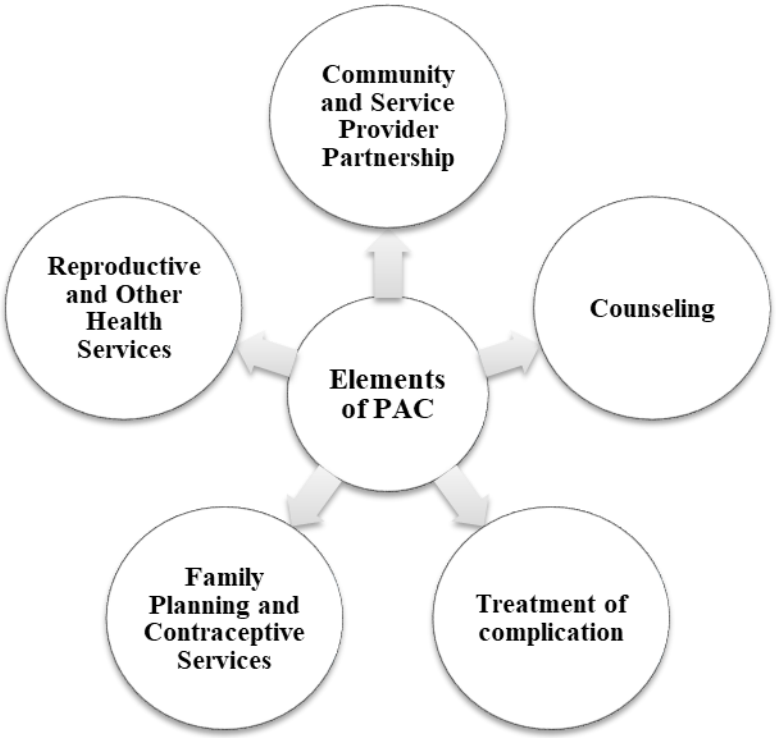
Each year almost 25% of pregnancies end in abortions; it is estimated that annually 35 abortions occur per 1000 women between 15–44 years of age.[3] The incidence of abortion is higher in developing countries with 37 per 1000 women compared to 27 per 1000 women in developed countries.[3] Abortion can be a very safe procedure when performed according to the

recommended guidelines; however, in developing countries abortions are often unsafe leading to complications. WHO [4] defines unsafe abortion as "a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both". Evidence suggests that there are not fewer abortions associated with legal restrictions.[5] In settings in which abortions are legally prohibited women tend to use the services of untrained providers who may perform the procedure in unhygienic conditions.[6] In such circumstances if abortion related complications occur, women rarely turn to medical facilities for treatment because of the fear of legal repercussions and stigma.[7] This poses a major challenge for accurate reporting of abortions and is a major limitation in understanding the extent of abortion-related issues and how to address them.

According to Pakistani law, induced abortion is legally acceptable only in circumstances where to save the woman's life or in order to provide 'necessary treatment' until 120 days of gestation. After 120 days (4 months) abortion is only legal when it is done to save the life of mother.[8] In Pakistan, nearly half of all the pregnancies (46%) are unintended, and more than half of these end in induced abortion.[9] According to a National Post Abortion Care study, 2.2 million abortions took place in Pakistan in 2012 yielding an estimated annual abortion rate of 50 per 1000 women. In the same year almost 700,000 women sought medical treatment for post abortion complications at health care facilities. Despite the large sample size of this study, the reported figures can be inaccurate because of under-reporting of this sensitive issue.[10] Secondly, the common complications associated with abortions are hemorrhage and sepsis and thus may be categorized as obstetric complications rather than abortion related.[7]

In the countries like Pakistan where safe abortion is legally restricted the best hope for preventing deaths related to abortion is timely provision of Post Abortion Care (PAC). PAC refers to the services that should be provided to women who experience spontaneous or induced abortion to prevent complications and reduce abortion related maternal mortality and morbidity. The PAC Consortium introduced an updated model of essential elements of PAC (Figure 1**).**[11]

Figure 1: Elements of Post Abortion Care



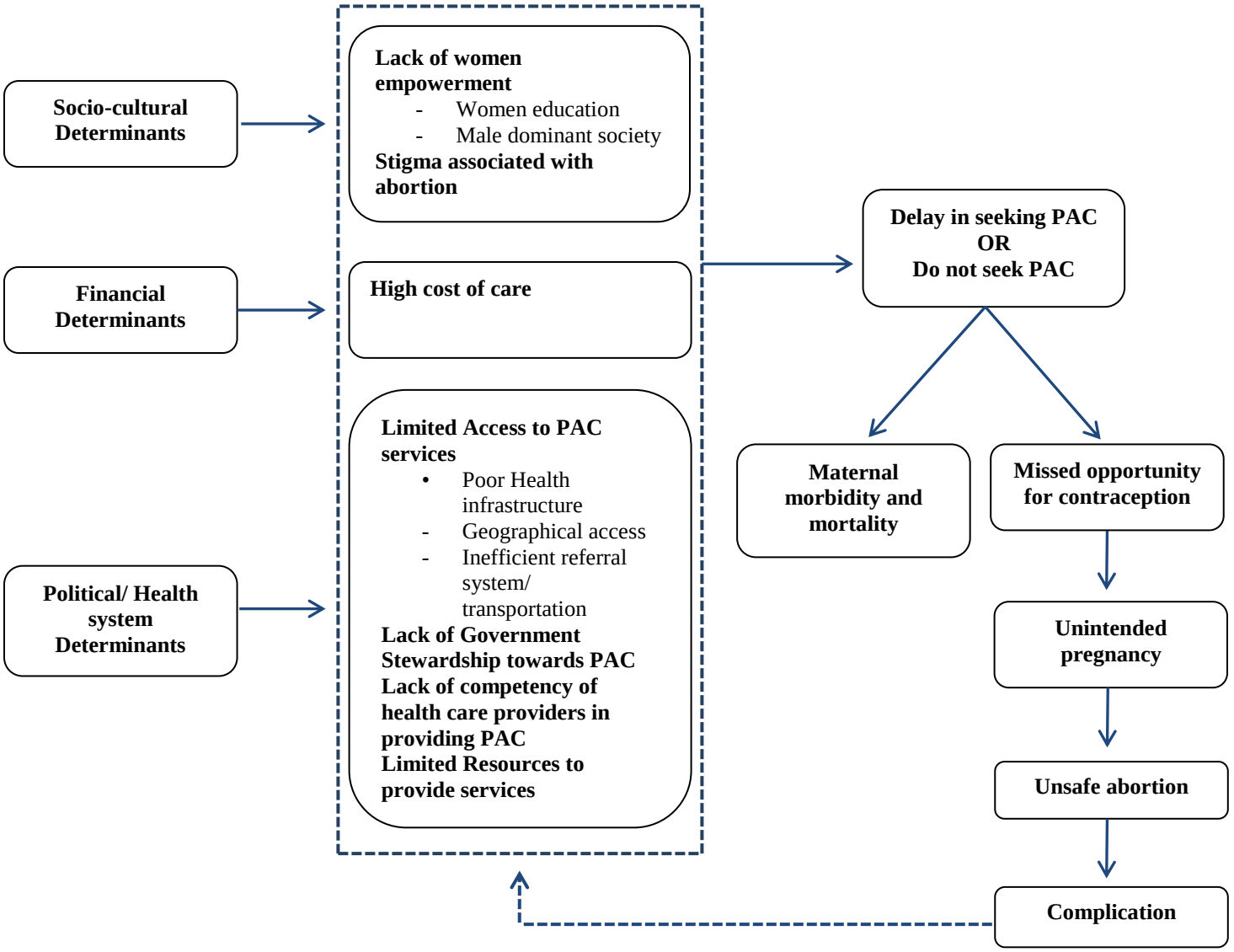
According to the WHO, PAC services can be safely provided by any trained health provider, including mid-level cadres of skilled birth attendants i.e. Lady Health Visitors (LHVs) and community midwives.[12] However, despite many efforts, provision of PAC services remains a challenge in Pakistan. There are social, cultural, and political determinants that hinder provision of PAC services. This paper explores these determinants and suggest recommendations for policy and practice to promote PAC services in Pakistan. A literature search was conducted to identify determinants associated with provision of PAC, however, very few studies were available from Pakistan. Therefore, studies from other developing countries with a similar context to Pakistan were included in this analysis.

Determinants of Inadequate Post Abortion Care in Pakistan

Figure 2 shows the determinants of inadequate provision and utilization of PAC that affect the health of Pakistani women. The framework was developed after analysis of an extensive literature search. This framework helps to understand the main factors that influence

the coverage of quality PAC services. The following sections discusses the elements of the framework.

Figure 2: Framework of Determinants for Inadequate Provision of PAC in Pakistan



Socio-cultural Determinants

1. Lack of women's empowerment

Women's Education

Women in Pakistan have a low level of educational attainment; only 51% of girls are enrolled in primary education, and two-third drops out before completing primary education.[9] Many studies have shown that the educational level of women is directly associated with utilization of PAC services. According to Al Riyami and colleagues[13], less educated and illiterate women delayed seeking PAC when faced with any complication when compared to educated women. Similarly, a study in Malawi on 2,028 clients who received PAC services, showed that a majority (87.8%) were educated to at least the primary level whereas the proportion of uneducated clients was 12.2%.[14] This suggests that education empowers women to make autonomous decisions to seek care when faced with health risks.[15] This is also supported by a systematic review based on 67 studies from the developing world (including Pakistan) that found a significant association between women's empowerment and utilization of maternal health services.[16] A qualitative study[17] conducted in six districts of Pakistan identified challenges that Reproductive Health Volunteers (RHVs) face concerning PAC services. The 15 sampled RHVs reported that educated women were open minded and positive regarding PAC services. However, those women who observe seclusion are restricted by their in-laws and husbands in making their own decisions regarding health care including PAC services.[17] Hence, in this context where the majority of women is devoid of basic education, their lack of empowerment can lead to poor maternal outcomes when women have unintended pregnancies.

Male Dominated Society

In Pakistani culture women are supposed to be (a) submissive; and (b) silent recipients of their father's/ husband's decisions. Male dominance is a custom of this society, often justified as a traditional Islamic and cultural belief, but it greatly affects women's autonomy and power to make decisions.[18] After marriage when it comes to the decisions regarding health seeking behaviour and using a facility for skilled care, the most women depend on their husbands'

decisions. Misinterpretation of the Muslim culture and women's economic dependency on their partner gives men the power to control the relationship. In a study of 168 women who presented for PAC, 77% relied on their partners' approval for post abortion contraception and the partners' approval was 20 times the odds of intending to use contraception by the women.[19] A qualitative study in Pakistan exploring the perceptions of rural couples about PAC services indicated the women were reluctant to discuss fertility intentions with their husbands until they faced undesired pregnancy outcomes.[20] When a woman suffers any post abortion complication, she might not decide independently to seek treatment. There are many people who play a part in the decision-making process including her husband, mother in law, other family and even community members.[10] However, some women who are not economically dependent on their husbands and can pay for services are more empowered and can independently seek care.

2. Stigma associated with abortion

Abortion is prohibited in Islam which is why Pakistan severely restricts legal abortions. According to the 1990's revision in abortion law, the condition for legal abortion depends on whether the fetus's organs are formed or not. As per the consensus of the Islamic scholars the fetus's organs are developed by the fourth month of gestation.[21] Considering this, abortions are permitted till 4 months, to save the woman's life or in order to provide "necessary treatment." Any induced abortion which is not caused in good faith for the purpose of providing necessary treatment or saving the life of the woman will be considered as criminal offence and would be liable to punishment.[21]

Due to religious and legal restrictions, there is a stigma concerning abortion; it is thought to be highly shameful. For this reason, if a woman has an induced abortion due to any circumstance she must keep it secret. She only discloses it to someone who can be trusted, usually to obtain advice about cheap and effective services. Consequently, if complications arise, a woman does not attend for PAC, but rather prefers to manage a problem at home. Even if a woman goes to a health facility she may not disclose the abortion, which further delays the effective and timely management of complications.[22] A study in Kenya also reported legal restrictions and stigma associated with abortions as the major factor leading to delayed care-seeking at the time of severe complications.[23] In addition, the stigma also leads to poor attitudes

from health care providers towards women who come for PAC. Health care providers become judgmental and are disrespectful of the women.[24] The two main reasons for which women tend to delay PAC after induced abortion are fear of people in the community in which they live and the blaming attitude of health care providers.[25] Some studies have also identified that community members stigmatize the provider of PAC services. In a study from Pakistan a provider expressed: "they say it's a sin against God and we are facilitating it unnecessarily, but I don't care as my priority is (my) client and her life. The clerics consider us murderers and hound us".[17]

Financial Determinants

1. High Cost of Care

Evidence shows that the income status of women is directly related to obtaining an abortion and receiving PAC.[26] Cost of quality PAC may serve as a barrier to the utilization of services especially for marginalized women. In Pakistan about 70% of the population depend on the private sector for their health care because the public sector though comparatively cheaper, has sub-optimal quality of care.[27] In a qualitative study from Istanbul, women stated that in public facilities the care provided was often not humane, privacy was violated, no one bothered to ask how clients felt, and neither did they provide appropriate pain management.[28] Because the PAC services available at private facilities are unaffordable to most women, many do not use any services at all. When RHVs were asked about barriers to PAC in Pakistan, the lack of affordable, good quality treatment was a major problem. Women often could not be referred to private health centers because they are relatively expensive.[17]

Because abortion is considered illegal, some private providers earn income from providing clandestine abortions. Some may not counsel women about post-abortion contraception because repeat abortions provide greater income.[29] This can further restrict marginalized women from seeking care. The National PAC study[10] also explored the women's barriers in decision making and accessing post-abortion care services through in-depth interviews with women who developed complications due to induced abortion. The findings revealed that six out of 33 women did not seek any health care for their problems, mostly due to poverty. One of the women expressed that she was so poor that either she could provide food to her children or pay the fees of the doctor.[10]

Political/ Health System Related Determinants

1. Poor Access to PAC Services

Poor Health Infrastructure

Another important factor that leads to delay in obtaining PAC is poor health infrastructure in Pakistan. A Basic Health Unit caters to a large population that is located far from small villages. It can take hours to reach the facility. These distances inhibit PAC service utilization. The distances are even more daunting since there is no efficient transfer system. Delay in reaching the facility can mean complications become worse by the time women arrive at a facility equipped to provide appropriate care. Village health workers in Pakistan identified a strong need to provide transport services for women seeking treatment for complications.[17] In communities where there is no transport service, family members struggle to get women to hospital. Some rely on the ambulance from a health facility while others use private taxis which are not only expensive, but sometimes refuse to transfer bleeding women to avoid spoiling their vehicles.[24] A study from Kenya reported that women who receives PAC treatment at facilities of their first contact have low risk of severe complications, as compared to women referred for PAC from lower level facilities. The latter were more likely to present at the final treatment facility much later, hence needing a higher level of treatment.[30]

Lack of Government Stewardship towards PAC

The Ministries of Health and Population Welfare of Pakistan promised to institutionalize PAC at a national level in 2009. To achieve the WHO Millennium Development Goals, this commitment was part of the Karachi Declaration, which aimed to scale up best practices for maternal, newborn and child health, and family planning. PAC was also included in a 2010 draft of National Health and Population Policies. However, the Ministries of Health and Population Welfare were devolved to the provinces in 2011, each to develop its own population and health policies. The decentralization process delayed the development and implementation of provincial PAC policies.[8] Therefore, NGOs (Non-Governmental Organizations) primarily promote PAC and provide quality PAC services to their clients.[17] However, these private services do not reach

poorer women, especially those in more distant locations who are left with no choice but staying at home.

Lack of Competency of Health Care Providers in Providing PAC

Health care providers often lack competency in providing PAC, which is a further barrier to accessing quality services. According to the WHO safe abortion guideline[12], misoprostol and Manual Vacuum Aspiration (MVA) are considered safer methods for uterine evacuation. However, there is evidence from many countries including Pakistan that health care providers are not well trained to use modern and safe methods, resulting in a continued high prevalence of procedures like dilatation and curettage.[31, 10, 32] Azmat[17] identified that women preferred medical over surgical treatment for incomplete abortions because of its convenience, limited complications, no requirement for anesthesia, and less pain.[17]

Knowledge about PAC was found to be limited in a study that evaluated the knowledge, attitude and practices of providers regarding PAC in Pakistan. Only 30 out of 100 providers were aware of the recommended oral dose of misoprostol for the treatment of first trimester incomplete abortion[33] , thus putting women at higher risk of complications from inadequate treatment. A limited knowledge base was also reported in Afghanistan, India and Sudan.[34, 35, 32]

In addition, providers' competency depends on the quality of their education and clinical exposure. Since abortion related services are not offered openly, facilities may not allow students/trainees to be involved in PAC which clearly limits the development of competency. This has implications for educators who teach students about PAC. This was highlighted in a Ghanaian study of 74 midwifery tutors whose capacity to teach comprehensive abortion care to pre-service students was limited because of inadequate educational preparation and the imposition of negative personal beliefs.[36]

2) Limited Resources to Provide Services

The unavailability of quality PAC services at the basic health units within smaller villages is a major challenge. These facilities are the first level of contact for women with an emergency. However, these often lack resources to provide treatment. A situational analysis conducted in Ghana revealed that despite consensus about the serious need for MVA, the country

lacked sustainable access to MVA because of government restriction on procurement due to high costs. Generally procurement and maintenance of MVA is a challenge in many low-resource settings.[37] Similarly, the National PAC study in Pakistan found that of 266 sampled health care facilities MVA kits were available in less than one-fifth of them.[10]

Conclusion

The inadequate provision and utilization of PAC services in Pakistan requires serious attention from all key stakeholders, especially those who hold public office. Strong alliances with the private sector and NGOs must be developed with an aim to eradicate barriers by promoting education, formulating policies that support PAC, improving health infrastructure, building capacity of mid-level providers, and procuring necessary equipment and medicines. Only with concerted action will there be improvement in the present situation which sees too many women experience serious complications including death from inadequate post abortion services.

Recommendations

This analysis of the determinants of inadequate provision of PAC services in Pakistan identified gaps that need to be addressed so that women have the access to PAC and family planning services. Some important recommendations that need to be considered are:.

- The educational sector of government must ensure the provision of education at least at the primary level for girls and boys, especially in the remote areas. Within the national curriculum at the secondary level, a focus is required on sexual and reproductive health topics. This would help improve the status of women and raise their awareness of reproductive rights and the elements of basic care.

- Advocacy campaigns should be initiated at community level to engage key stakeholders such as community leaders, male guardians of families and religious scholars for values clarification and attitude transformation pertaining to PAC and family planning services. Awareness sessions that include key leaders who provide visible support should then be arranged for community members. This will help increase the acceptance and utilization of PAC and family planning services.

- Considering the sensitivity of the issue and the fear of being stigmatized, an emergency helpline for women should be introduced by government or the NGO sector. This would provide a confidential channel for those in need of appropriate guidance regarding their post abortion complications and also provide information about how to access PAC services. Trained health care staff can provide advice and direct care for the presenting symptoms/problems and send women to referral facilities as needed.

- The government should reorganize the infrastructure of health services to provide more primary health facilities and link them to secondary and tertiary care hospitals. PAC services can serve more women by increasing the numbers of primary health facilities operated by mid-level providers.

- Government should increase the number of community midwives and provide them with resources to offer a range of services to women at the community level. This would overcome the shortage of doctors in low resource settings.

- Government should also promote more effective referral mechanisms to link facilities from primary to tertiary level. This would improve PAC services, especially if transportation is organized as part of the linkage. Timely access to specialized services can help save lives. To achieve this, a good road network across whole country is a prerequisite; therefore, the government officials must consider this and act accordingly.

- Government should take the lead in making national policies that promote the provision of PAC in all public and private facilities. The policies and the needed resources to implement them should reinforce the use of the safest methods of uterine evacuation for incomplete abortion, such as misoprostol and MVA.

- The Midwifery Association of Pakistan (MAP) in conjunction with government should undertake to build the capacity of mid-level providers' competency in providing PAC. Continuing professional education is required for Community Midwives (CMWs) and Lady Health Visitors (LHVs).

– The quality of government facilities should be improved by using strong and transparent monitoring and evaluation mechanisms. The staff of public facilities should participate in training about human rights, the seven rights of child bearing women, and the skills of providing sensitive supportive care.[38]

References

1. World Health Organization, (2014). Maternal mortality: to improve maternal health, barriers that limit access to quality maternal health services must be identified and addressed at all levels of the health system: Fact sheet.
2. Say, L., Chou, D., Gemmill, A., Tunçalp, Ö., Moller, A.B., Daniels, J., Gülmezoglu, A.M., Temmerman, M. and Alkema, L, (2014) Global causes of maternal death: a WHO systematic analysis. *The Lancet Global Health*, 2(6), pp.e323-e333.
3. Sedgh, G., Bearak, J., Singh, S., Bankole, A., Popinchalk, A., Ganatra, B., Rossier, C., Gerdts, C., Tunçalp, Ö., Johnson, B.R. and Johnston, H.B, (2016) Abortion incidence between 1990 and 2014: global, regional, and sub-regional levels and trends. *The Lancet*, 388(10041), pp.258-267.
4. World Health Organization, (2011) Unsafe abortion: global and regional estimates of incidence of unsafe abortion and associated mortality in 2008. Available at: http://apps.who.int/iris/bitstream/10665/44529/1/9789241501118_eng.pdf
5. Foster, D.G. (2016) Unmet need for abortion and woman-centered contraceptive care. Available at: http://dx.doi.org/10.1016/ S0140-6736(16)30452-4 (Accessed: 07.02.2017).
6. Boland, R. and Katzive, L. (2008) Developments in laws on induced abortion: 1998-2007. *International Family Planning Perspectives*, pp.110-120.
7. Gerdts, C., Tunçalp, O., Johnston, H. and Ganatra, B. (2015) Measuring abortion-related mortality: challenges and opportunities. *Reproductive Health, 12*(1), p.87.
8. Guttmacher Institute and NCMNH, (2009) Abortion in Pakistan [online] Available at: https://www.guttmacher.org/sites/default/files/pdfs/pubs/IB_Abortion-in-Pakistan.pdf
9. National Institute of Population Studies: NIPS, (2013). Pakistan Demographic and Health Survey 2012–13. Islamabad, Pakistan and Calverton, USA: NIPS & ICF International. Available at:

http://www.nips.org.pk/abstract_files/PDHS%20Final%20Report%20as%20of%20Jan%2022-2014.pdf

10. Sathar, ZA, Singh, S., Shah, ZH., Gul., R., Kamran, I., and Eshai, K, (2013) 'Post-abortion care in Pakistan: A national study'. Available at: http://www.popcouncil.org/uploads/pdfs/2013RH_PakistanPAC.pdf
11. Post-abortion Care Consortium, (2002) 'Essential elements of post abortion care: an expanded and updated model. Post abortion Care Consortium, PAC in Action'. Jul(2). Available at: http://pac-consortium.org/downloads/Essential%20Elements%20of%20Postabortion%20Care.pdf
12. World Health Organization, (2012) 'Safe abortion: Technical and policy guidance for health systems', (Second Edition). Geneva: World Health Organization.
13. Al Riyami, A., Afifi, M. and Mabry, R.M., (2004) 'Women's autonomy, education and employment in Oman and their influence on contraceptive use'. *Reproductive Health matters*, 12(23), pp.144-154
14. Levandowski, B.A., Pearson, E., Lunguzi, J. and Katengeza, H.R., (2012) Reproductive health characteristics of young Malawian women seeking post-abortion care. *African Journal of Reproductive Health*, 16(2), pp.253-262.
15. Eide, E.R. and Showalter, M.H., (2011) Estimating the relation between health and education: What do we know and what do we need to know? *Economics of Education Review*, 30(5), pp.778-791.
16. Pratley, P., (2016) Associations between quantitative measures of women's empowerment and access to care and health status for mothers and their children: A systematic review of evidence from the developing world. *Social Science & Medicine*, 169, pp.119-131.
17. Azmat, S.K., T Shaikh, B.A.B.A.R., Mustafa, G., Hameed, W. and Bilgrami, M., (2012). 'Delivering post-abortion care through a community-based reproductive health volunteer programme in Pakistan'. *Journal of BiosocialSscience*, 44(06), pp.719-731.
18. Hou, X. and Ma, N. (2011) Empowering women: the effect of women's decision-making power on reproductive health services uptake--Evidence from Pakistan. Available at: https://openknowledge.worldbank.org/bitstream/handle/10986/3314/WPS5543.pdf?sequence%20%3C2009%3E%20%20%3CE035%3E%20%20%3C2009%3E%201

19. Esber, A., Foraker, R.E., Hemed, M. and Norris, A., (2014) Partner approval and intention to use contraception among Zanzibari women presenting for post-abortion care. *Contraception*, 90(1), pp.23-28.
20. Kamran, I., Arif, M.S. and Vassos, K. (2011) Concordance and discordance of couples living in a rural Pakistani village: perspectives on contraception and abortion-a qualitative study. *Global Public Health*, 6(sup1), pp.S38-S51.
21. Sraw K. Abortion Law of Pakistan: Reform Needed? [Internet]. Human Rights Review. 2018. Available from: https://uclhumanrightsreview.wordpress.com/volume-ii-students/abortion-law-of-pakistan-reform-needed/
22. Hill, Z.E., Tawiah-Agyemang, C. and Kirkwood, B., (2009) The context of informal abortions in rural Ghana. *Journal of Women's Health*, 18(12), pp.2017-2022.
23. Lithur, N.O. (2004) Destigmatising abortion: expanding community awareness of abortion as a reproductive health issue in Ghana. *African Journal of Reproductive Health*, 8(1),pp.70-74.
24. RamaRao, S., Ottolenghi, E., Faye, Y., Diop, N.J. and Dieng, T. (2007) Assessment of the extension of post abortion care services in Senegal. FRONTIERS Final Report.
25. Htay, T.T., Sauvarin, J. and Khan, S. (2003) Integration of post-abortion care: the role of township medical officers and midwives in Myanmar. *Reproductive Health Matters*, 11(21), pp.27-36.
26. Awoyemi, B.O. and Novignon, J., (2014) 'Demand for abortion and post abortion care in Ibadan, Nigeria'. *Health economics review*, 4(1), p.3.
27. Nishtar, S., (2006) The Gateway Paper: Health Systems in Pakistan - A way forward. Retrieved from Pakistan Health Policy Forum. Available at: http://www.heartfile.org/pdf/phpf-GWP.pdf
28. MacFarlane, K.A., O'Neil, M.L., Tekdemir, D. and Foster, A.M. (2017) It was as if society didn't want a woman to get an abortion: A qualitative study in Istanbul, Turkey. *Contraception*, 95(2), pp.154-160.
29. Bandewar, S. (2003) Abortion Services and Providers' Perceptions: Gender Dimensions. *Economic and Political Weekly*, pp.2075-2081.

30. Mutua, M.M., Maina, B.W., Achia, T.O. and Izugbara, C.O. (2015) Factors associated with delays in seeking post abortion care among women in Kenya. *BMC Pregnancy & Childbirth*, 15(1), p.241.
31. Darney, B.G., Simancas-Mendoza, W., Edelman, A.B., Guerra-Palacio, C., Tolosa, J.E. and Rodriguez, M.I. (2014) Post-abortion and induced abortion services in two public hospitals in Colombia. *Contraception*, 90(1), pp.36-41.
32. Kinaro, J., Ali, T.E.M., Schlangen, R. and Mack, J. (2009) Unsafe abortion and abortion care in Khartoum, Sudan. *Reproductive Health Matters*, 17(34), pp.71-77.
33. Baig, M, Jan, R, Lakhani, A, Ali, S A, Mubeen, K, Ali, S S, and Adnan, F. (2017) Knowledge, Attitude, and Practices of Mid-Level Providers regarding Post Abortion Care in Sindh, Pakistan. Journal of Asian Midwives. 4(1):21–34.
34. Ansari, N., Zainullah, P., Kim, Y.M., Tappis, H., Kols, A., Currie, S., Haver, J., van Roosmalen, J., Broerse, J.E. and Stekelenburg, J., (2015) 'Assessing post-abortion care in health facilities in Afghanistan: a cross-sectional study'. *BMC Pregnancy & Childbirth*, 15(1), p.6.
35. Sridhar, K., (2013) November. Evaluation of a behavior change communication (BCC) intervention on abortion knowledge, attitudes and practices (KAP) in Bihar and Jharkhand, India. In 141st APHA Annual Meeting & Exposition (Nov. 2-6). APHA.
36. Voetagbe, G., Yellu, N., Mills, J., Mitchell, E., Adu-Amankwah, A., Jehu-Appiah, K. and Nyante, F. (2010) Midwifery tutors' capacity and willingness to teach contraception, post-abortion care, and legal pregnancy termination in Ghana. *Human Resources for Health*, 8(1), p.2.
37. Graff, M. and Amoyaw, D.A. (2009) Barriers to sustainable MVA supply in Ghana: challenges for the low-volume, low-income providers: original research article. *African Journal of Reproductive Health*, 13(4), pp.73-80).
38. White Ribbon Alliance, (2011) 'Respectful maternity care: the universal rights of childbearing women'. *White Ribbon Alliance*. Available from: https://www.whiteribbonalliance.org/wp-content/uploads/2017/11/Final_RMC_Charter.pdf