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FACTORS RELATED TO INDUCED ABORTION AMONG WOMEN WITH ABORTION COMPLICATIONS AT THE KOMFO ANOKYE TEACHING HOSPITAL

BY

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CERTIFICATION

I hereby declare that this submission is my own work towards the MPH and that , to the best of my knowledge, it contains no material previously published by another person nor material which has been accepted for the award of another degree of the University, except where due acknowledgment has been made in the text.

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ABSTRACT

There are still high rates of death and injury as a result of unsafe abortion. It remains the second direct cause of maternal mortality in Ghana and the highest single cause of admissions to the Obstetrics and Gynaecology directorate of the KATH. However, there have not been many studies on decisions leading to induced abortion which ends with complications. The study was conducted to describe the factors that are related to decision-making on induced abortion with complications among women. Exit interviews, using questionnaires, were used to gather data from 160 women who had been admitted to the KATH due to complications from unsafe abortion.

Most respondents from the study were young, single, nulliparous and employed. Most also had not attained SHS level education but few had no formal education and majority were Christians. The results suggest a low level of knowledge on the abortion law, as well as low contraceptive usage among respondents. Also, pharmacists were the most sought providers while misoprostol (cytotec) was the most used method of abortion. Men were found to be principal decision makers in regard to abortion. The age of women, previous abortion experience, employment status and age of pregnancy were found to be associated with decision to have an abortion. However, education, marital status, religion and number of children were not associated with the decision to have an abortion.

Based on the findings, effective campaigns and education are recommended to raise the awareness on the legal status of abortion in Ghana and intensified programmes and policies intended to address unmet need for contraceptives and unsafe abortion. Medical abortion should be provided for under the National Health Insurance Scheme (NHIS) to the extent stipulated by the law.

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LIST OF FUGURES

LIST OF ABBREVIATIONS

AGI	Alan Guttmacher Institute
CAC	Comprehensive Abortion Care
CEDAW	Committee on the Elimination of Discrimination Against Women
DHS	Demographic and Health Survey
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
GMHS	Ghana Maternal Health Survey
GSS	Ghana Statistical Service
KATH	Komfo Anokye Teaching Hospital
KBTH	Korle-Bu Teaching Hospital
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MOH	Ministry if Health
MVA	Manual Vacuum Aspiration
NCCE	National Commission for Civic Education
NHIS	National Health Insurance Scheme
O&G	Obstetrics and Gynaecology
PNDC	Provisional National Defence Council
UNDP	United Nations Development Programme
UDHR	Universal Declaration of Human Rights
WHO	World Health Organisation

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DEDICATION

I dedicate this work to the Almighty God who made this possible and my beloved parents, Rev. and Mrs. Benjamin Nana Kuffour who nurtured and groomed me through parental upbringing to this height. Also, I bestow this work to my siblings for their immense support throughout this work.

CHAPTER ONE

INTRODUCTION

This chapter introduces the study with background information on abortion - especially in Ghana, the statement of the problem, the general and specific study objectives, research questions and the significance and justification for the study.

1.1 Background

Unsafe abortion is a major public health problem in many countries where abortion is restricted by law. The World Health Organisation (WHO) defines unsafe abortion as a procedure for terminating an unwanted pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both (WHO, 2007). It is estimated that globally, 14 of 1000 women aged 15–44 years had an unsafe abortion in 2008 (WHO, 2011). Unsafe abortions are both widespread and a significant cause of maternal deaths in developing countries (Ahman and Shah, 2011). It is estimated that 20 million illegal abortions occur every year (Grimes et al., 2006). Five million women are estimated to be hospitalized because of abortion related complications (WHO, 2007) and 67, 900 maternal deaths result from unsafe abortions annually, representing 13 percent of maternal mortality deaths, with 54 percent in Africa (Singh, 2006; WHO, 2007; Fawcus, 2008; Shah and Ahman, 2010). As recent as 2011, the WHO reported that there were 47 000 deaths globally due to unsafe abortion in 2008; the majority of unsafe-abortion-maternal deaths in 2008 took place in Africa and Asia, with much smaller numbers reported for Latin America (WHO, 2011). The risk of death caused

by unsafe abortion in 2008 was 30 per 100 000 live births globally and 40 per 100 000 live births in developing countries (WHO, 2011). Moreover, a woman dies every eight minutes in the developing world due to complications from unsafe abortion (WHO, 2007; Bhandari et al., 2008).

Women in countries with restrictive abortion laws are most likely to suffer or die from complications of unsafe abortion. Morbidity from unsafe abortion is even a greater problem with complications such as sepsis, haemorrhage, uterine perforations, cervical trauma and sometimes chronic conditions, for example infertility. AbouZahr and Ahman (1998) reported that between 20 and 30 percent of unsafe abortions cause reproductive tract infections; and between 20 and 40 percent of these develop into pelvic inflammatory disease or bilateral tubal occlusion and infertility. More recently, Grimes et al. (2006) reported that the toll of unsafe abortion is huge. The complications include infection, profuse bleeding, genital and abdominal trauma, perforated uterus, damage to internal organs and septicaemia. Death may also result from a range of serious complications including haemorrhage and sepsis.

Most of these deaths and complications can be prevented if unwanted pregnancies were decreased through widespread comprehensive sexual education, use of modern contraception, and if Comprehensive Abortion Care (CAC) services were provided and made easily accessible. Effective and safe comprehensive abortion care can save women's lives thereby reducing maternal mortality.

Data show that countries with easy access to safe and legal abortion and good contraceptive services have low rate of unsafe abortion whereas in other parts of the world where abortion remains prohibited or restricted, clandestine abortion remains a

serious health problem (Henshaw et al, 1999). It has been observed that the rate at which women seek abortion is similar for women living in developed and developing countries and that contrary to common belief, the legalization of abortion does not necessarily increase abortion rates (Henshaw et al, 1999). Also, the disparity between law and reality with regards to abortion has been observed in other countries like India and Zambia for example, where abortion is legal yet unsafe abortions still prevail due to misinformation about the legality of abortion and/or the lack of advertised, accessible, and nonjudgmental safe abortion services (Grimes, 2006).

In reality, when a woman becomes pregnant, she must make a decision as to whether she is ready and willing to bring a new life into the world or not. When faced with an unwanted pregnancy, and safe and legal abortion is unavailable or difficult to access, many women turn to unskilled providers or attempt to abort on their own. The decision making is a complex approach affected by many factors. It is typically motivated by multiple, diverse and interrelated reasons (Finer et al, 2005).

As per the definition of reproductive health which is a "state of complete physical, mental, and social well being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes" (WHO, 2007), health is a fundamental human right and hence, all people should have access to basic resources for health. This means that people must have a satisfying and safe sex life, the capability to reproduce and the freedom to decide if, when and how often to do so. Men and women must be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and

the right to access to appropriate health care services that will enable women to go through pregnancy and childbirth safely and also provide couples with the best choice of having a healthy baby (WHO, 2007).

The right to life of a woman is protected in many human rights instruments of which the Universal Declaration of Human Rights (UDHR) is supreme. Therefore, laws that force women to resort to unsafe abortion procedures are infringements upon women's right to life. Reproductive rights comprise certain human rights that are recognised in international human rights documents. Women have undeniable rights to life, to health, to non-discrimination and to reproductive self-determination. This includes women's ability to regulate their own fertility. They must have the right to make decisions concerning reproduction that is free of discrimination, coercion and violence.

The fifth Millennium Development Goal (MDG-5) which seeks to reduce maternal deaths across the globe calls for a reduction in the rate of maternal mortality by 75% by the year 2015. Intrinsic in this goal is the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have information and means to do so, and the right to obtain the highest standard of sexual and reproductive health. Other international human rights treaties such as the Protocol on the Rights of Women in Africa (Maputo Protocol) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) require governments to take steps to alleviate high rates of maternal mortality by working to address unsafe abortion. However, Ghana is not likely to meet its target of reducing maternal deaths from 740 in 1991 to 185 per 100,000 (UNDP, 2012) since the the

Maternal Mortality Ratio (MMR) in Ghana is estimated to be about 350 maternal deaths per 100,000 live births (WHO, 2012) with abortion related deaths being the number one cause of the high rates of maternal mortality in Ghana (GSS et al, 2009). According to the Ghana Millennium Development Goal (MDG) 2008 report issued by the National Development Planning Commission, improvements in reducing maternal mortality have been very slow (UNDP, 2010). Between 2003 and 2008, maternal mortality was reduced from 740 per 100,000 live births to 451 per 100,000 live births. The report further stated that if the current trend continues, maternal mortality would be reduced to only 340 per 100,000 live births by 2015 (UNDP, 2010).

Also, in the CEDAW's concluding observations to Ghana in 2006, the convention stated its alarm "at the high maternal mortality rate, particularly the number of deaths resulting from unsafe abortions" and further called upon the state to "improve the availability of sexual and reproductive health services" and recommended the adoption of measures to increase "access to safe abortion in accordance with the domestic legislation".

Although abortion is restricted in many countries leading to high rates of unsafe abortion, some research indicates a strong correlation between abortion legality and abortion safety and thus women in countries with restrictive abortion laws often resort to unsafe, clandestine abortions which jeopardises their lives and health (Alan Guttmacher Institute, 1999). Berer (2009) suggests that induced abortion has become one of the safest and most frequently used clinical procedures for women in areas where it is legal and publicly available (Schwandt, 2011). However, other studies suggest that inequity in access to safe abortion services is the major cause of unsafe

abortion (Baiden, 2009). The desperate measures taken by affected women demonstrate that in many cases, once a woman has arrived at the decision to terminate a pregnancy, she knows no bounds (Hill et al., 2009). Unlike other causes of maternal death, mortality attributable to unsafe abortion is entirely preventable. Unsafe abortions and the associated mortality could be largely avoided if unplanned pregnancies were prevented through effective family planning and if safe abortion services were available (Konney et al., 2009) to avert unwanted births from accidental pregnancies among contraceptive users and unintended pregnancies among nonusers of contraceptives and victims of rape or incest (Ahman and Shah, 2011)..

As part of government's effort to reduce unsafe abortion in Ghana, abortion has been made permissible under certain conditions by law (Criminal Code, 1960, Act 29), and safe through policy regulations like the National Reproductive Health Policy and Standards of 2003 and Comprehensive Abortion Care (CAC) services which aims to provide safe, affordable and accessible services, management of abortion complications and provision of family planning counselling and services. However, unsafe abortion remains a major public health problem in Ghana (Morhe et al, 2006). The level of abortion in Ghana, however, appears to be lower than West Africa as a whole, where the rate stands at 28 per 1,000 women (WHO, 2007).

In Ghana, estimates according to the Maternal Health Survey of 2007 show that 7% of all pregnancies end in abortion and 15% of women aged 15-49 have ever had an abortion with 13% experiencing a health problem after the procedure while 41% received no medical care (GSS et al, 2009). A study conducted in the late 1990s in Southern Ghana also revealed that 17 abortions were observed for every 1,000 women

of reproductive age (Ahiadeke, 2001). At the Komfo Anokye Teaching Hospital, admissions from abortion related complications increased from 525 in 2009 to 720 in 2010 while percentage of abortion related deaths in relation to maternal mortality also increased from 8% in 2009 to 11% in 2010 (KATH Biostatistics). Also, abortion and its related complications were the highest causes of admissions to the Obstetrics and Gynaecology unit in 2011 and 2012 (KATH Biostatistics) and among the leading causes of maternal mortality between 1998 and 2007 (Kwawununu et al., 2012). Moreover, unsafe abortion is the second largest direct cause of maternal mortality, second only to haemorrhage. With regard to family planning services, women currently using any family planning method is 24%, whiles women who use any modern family planning method is 17% and those with unmet need for family planning is 35% (GSS et al, 2009).

1.2 Problem statement

Despite the apparent liberal nature of the abortion law in Ghana, the right guaranteed by the abortion law is not yet a reality for all women in. Many abortions continue to be induced illegally and under unhygienic conditions by providers who are either untrained or inadequately trained to do so. Studies that relate abortion to socio-demographic variables have helped reveal the characteristics of women who undergo abortion as well as its extent (Hill et al., 2009). However, there have not been many studies on what influences decision making on induced abortion which ends with complications. Therefore, the full extent of abortion, the reasons behind it and what it means to women are poorly understood. There are still high rates of death and injury as a result of unsafe abortion. Most women still go through induced abortion with

some of them dying while most of those who survive end up with complications. There is therefore the need for research to expose the ways in which various factors may contribute to the decision to terminate a pregnancy.

The sociological dimensions of induced abortion are not well understood largely because there is limited research on the factors that relate to decision-making on induced abortion. Very little is known about how women and their partners steer the decision-making process from the state of it being unwanted to termination. Most abortion studies relate incidence to socio-demographic variables and help identify the characteristics of women involved as well as its extent. However, more research is needed to explain the diverse ways in which different factors may affect the decision to determine a pregnancy. It is imperative to better understand the processes by which women make decisions that relate to their fertility in other to be able to provide the needed services for women's reproductive health(Browner, 1979). Understanding women's reasons for having abortions can inform public debate and policy that relate to reproductive health in general. This is because social, economic, cultural and demographic characteristics may be associated with motivations for having an abortion.

Also, most women, men, and health providers are not aware that abortion is legal under certain circumstances in Ghana creating a situation in which many abortions in Ghana are unsafe (GMHS, 2008 and Morhe et al, 2007), The disparity between the law and reality in regards to abortion has been noted as a cause for unsafe abortion (WHO, 2007).

1.3 General objective

The primary objective of this study is to investigate the factors that are related to decision-making on induced abortion with complication among women in their reproductive ages who were admitted to the Komfo Anokye Teaching Hospital with the view of providing empirical evidence on abortion issues in the study area.

1.3.1 Specific objectives

The specific objectives of the study are;

- To assess the level of knowledge of women on abortion
- To examine the reasons why women choose to terminate a pregnancy
- To identify the various methods and providers of induced abortion
- To examine factors that influence women's induced abortion.

1.4 Research questions

The research questions that the study seeks to answer are:

- What is the level of knowledge of women on induced abortion?
- What are the reasons why women choose to terminate a pregnancy?
- What are the types of abortion methods used?
- Who are the providers of abortion?
- Who influences women's decision on abortion?

1.5 Justification

The aim of the study was to bring to the fore the different factors associated with induced abortion among women. It also sought to contribute to the expanding discourse on abortion with the view of understanding the role abortion plays in meeting childbearing intentions. Such data are critical for crafting effective policy and pragmatic options to improve reproductive outcomes and also help achieve MDG5.

1.6 Significance of the study

The fact that consequences of unsafe abortion still contribute highly to maternal mortality in Ghana calls for policies and interventions based on research evidence to address the problem. It is essential to have reliable data on abortion, not only for better estimation of the number of women who have abortions but also for adequately understanding the context in which women make abortion decisions. Accurate and comprehensive information about abortion is necessary for understanding women's reproductive options and the role abortion plays in meeting childbearing intentions, especially in countries where fertility preferences have been declining (Gill et al, 2007).

Ghana is one of the few countries in Sub-Saharan Africa where abortion is apparently liberal and therefore in a better position to remedy the problem of unsafe abortion and its consequences. Understanding women in this context and the role that the relationships with their partners play in women obtaining induced abortions, can assist policy makers and program managers in targeting those persons and relationship types at highest risk of opting for unsafe abortions. The result of targeted efforts will be a

reduction in the number of unsafe abortions in Ghana and the maternal mortality and morbidity that stem from such procedures. By identifying what influences women's decision making on induced abortion and overcoming them through responsive interventions, Ghana can make substantial progress toward saving women's lives and achieving the Millennium Development Goal of improving maternal health and reducing Maternal Mortality Ratio (MMR).

1.7 Limitations of the study

The constraint of easy access to study participants was perceived because of the vast nature of the metropolis and the sensitive nature of the issue (abortion) under study. For this reason, a hospital setting was chosen as the study site so women who have been admitted to the hospital due to complications related to induced abortion will be used in the study. This implies that it was difficult to have access to a sample to reflect the socio-demography of the total population of women who practice unsafe abortion. Also, the sample was drawn from a teaching hospital in an urban centre in Ghana and so it was likely that women's experiences with unsafe abortion would be different in rural settings. It is to be noted that information on this subject area was not readily available. Moreover, the constraint of time and money at the disposal of the researcher were not adequate for a population-based study.

1.8 Delimitation of the study

The study was limited to women who reported to the hospital due to unsafe abortion complications. The study, therefore, relied on the experiences of the study participants to depict a descriptive picture of the topic under study. Also, the Komfo Anokye

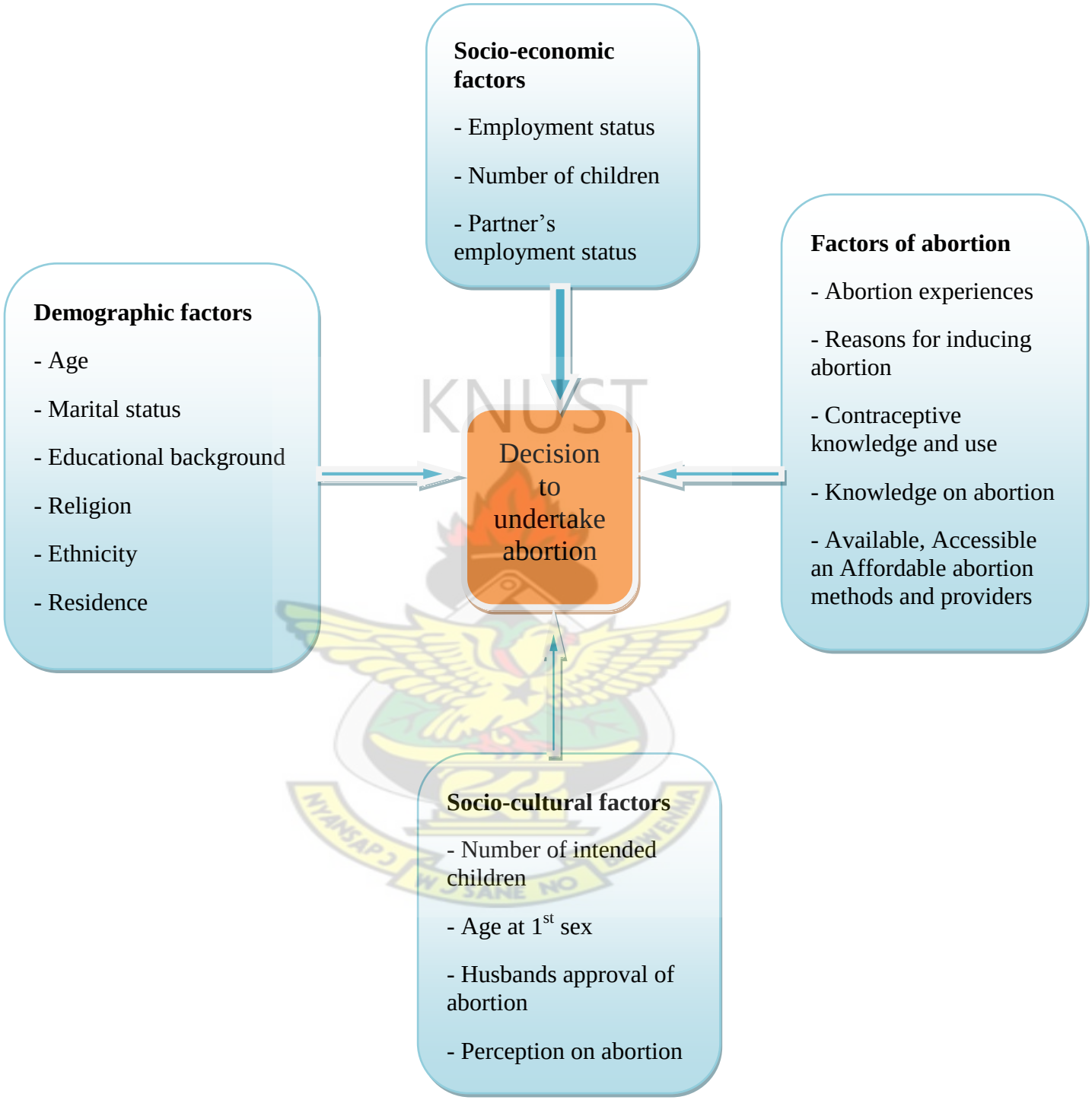
Teaching Hospital catchment area stretches beyond the Ashanti region to some parts of the Brong Ahafo, Western and the three Northern regions which reflected a wider catchment area.

1.9 Conceptual framework

The figure lays the conceptual framework for the study. Two groups of variables were identified for the study. These were dependent and independent variables. The dependent variable was considered as the decision to undertake induced abortion. For this study, the independent variables were assumed as; demographic factors, socio-economic factors, socio-cultural factors and factors of abortion.

Demographic factors included; age, marital status, educational background, religion, ethnicity and residence. Socio-economic factors included employment status, number of children and partner's employment status. Socio-cultural factors identified were; number of intended children, age at first sex, husband's approval of abortion and perception on abortion. Factors of abortion included abortion experiences, reasons for inducing abortion, knowledge on abortion, contraceptive knowledge and usage, availability of abortion methods and providers, accessibility of abortion methods and providers and affordability of abortion methods and providers. These were presumed to be the factors that influence women's decision to undertake induced abortion

Figure 1: Conceptual framework



CHAPTER TWO

LITERATURE REVIEW

This chapter contains a review of abortion related literature. The main themes under which literature was reviewed included the abortion framework in Ghana, knowledge on abortion, reasons why women have abortion and factors related to decision making on induced abortion.

2.1 Ghana's framework on abortion

As a country, Ghana has been represented at conferences and also appended its signature to various international legislation and frameworks on reproductive health which embraces the need to address unsafe abortion and provide safe abortion services where the law permits.

Abortion in Ghana is governed by PNDC Law 102. The law is an amendment in 1985 of the Criminal Code of 1960, Act 29, Sections 58-59 and 67. The original Criminal Code of 1960, Act 29 criminalized anyone causing or attempting to cause an abortion, regardless of whether the woman was pregnant and sanctioned a fine and/or imprisonment for up to 10 years. Also a woman inducing her own abortion or undergoing an illegal abortion was subject to the same punishment. An abortion was legal, however, if carried out in good faith without negligence for the purpose of providing medical or surgical treatment for the pregnant woman.

The code of 1960 was not sufficiently clear on several issues. It did not, for example, clarify who was qualified to perform an abortion, whether the consent of the woman (or guardian) was required, what the gestation limits were or where a legal abortion could be performed. Moreover, it did not define what constituted medical or surgical treatment. This called for the drafting of a clearer and a more liberal law in Ghana due to different interpretations of the law and its vagueness.

The amended abortion law (PNDC Law 102) criminalizes any person administering any poison or other noxious substance to a woman or using any instruments or other means with the intent to cause an abortion and sanctions an imprisonment term not exceeding five years, regardless of whether the woman is pregnant or has given her consent. Also, any person inducing a woman to cause or consent to an abortion, assisting a woman to cause an abortion or attempting to cause an abortion may also be imprisoned for a term not exceeding five years. A person who supplies or procures any poison, drug or instrument or any other thing knowing that it will be used to perform an abortion is also subject to the same punishment.

The new Law of 1985 also enlarges the circumstances under which abortion is permitted. According to the code, abortion is legal if the continuation of the pregnancy involves risk to the life or injury to the physical or mental health of the pregnant woman. Abortion is also legal if there is substantial risk that the child, if born, might suffer from or later develop a serious physical abnormality or disease and if the pregnancy results from rape, incest or the defilement of a mentally handicapped woman. Additionally, a legal abortion must be

performed by a registered medical practitioner with the consent of the pregnant woman. If the woman lacks the capacity to give her own consent, the consent of her next of kin or guardian is required. The abortion must be performed in a government hospital or a private hospital or clinic registered under the Private Hospitals and Maternity Homes Act of 1958 or in a place approved for that purpose by the law.

Other efforts by government on abortion include Post Abortion Care (PAC) which was integrated into the safe motherhood programme in 1996 and the training of Doctors and Midwives to provide PAC services including the use of Manual Vacuum Aspiration (MVA). The Ministry of Health and Ghana Health Service also revised the national reproductive health policy to include the provision of abortion care services to the extent permitted by law and also to provide Comprehensive Abortion Care (CAC). CAC services aims to provide safe, accessible and affordable abortion services, management of abortion complications and provision of family planning counselling and services.

2.2 Abortion in Ghana

In regions of the world where induced abortion services are not publicly available due to the law, misinformation exists about the legal status of abortion, or safe abortion services are either nonexistent or not publicized despite the legal status of the procedure (WHO, 2007; Alan Guttmacher Institute, 1991; Schwandt, 2011); women are admitted to hospitals at alarmingly high rates for treatment of complications of induced abortion

(Benson et al,. 1996; Berer, 2000; Mosaase et al., 1996; Sjostrand, 1995; Schwandt, 2011).

In addition to the limited service availability, many Ghanaians are unaware of their legal rights to abortion and where to access safe abortion services. Reliable data on induced abortions in Ghana is scarce. There are no national statistics on the prevalence of abortion in Ghana though statistics can be obtained from hospital based data and other research works on abortion. Since knowledge of the abortion law is low in communities and there is sensitivity around abortions (both miscarriages and induced abortions), it is difficult to derive reliable community level estimates. Data gathered from facilities have limitations of incompleteness or inaccuracy; they also reflect the experiences of only those women who have sought services and not others. Lack of complete understanding of the abortion law makes providers unwilling to accurately classify the type of abortion (induced or spontaneous) and for women seeking care to admit to having induced an abortion.

While data on induced abortion is limited, other data on reproductive behaviors support the conclusion that induced abortions are widespread. According to the 2003 Demographic and Health Survey (DHS) there is considerable unwanted pregnancy—Ghanaian women have on average 4.4 children but the wanted fertility rate is 3.7. There is also a wide gap between contraceptive knowledge and use. While there is near universal knowledge of at least one modern method of family planning, use is low at 19 percent. Further, nearly a third of women (34%) report an unmet need for contraception — (i.e.) where they wish to prevent a pregnancy but are not using contraception.

The level of abortion in Ghana appears to be lower than West Africa as a whole, where the rate stands at 28 per 1,000 women (WHO, 2007). According to the Ghana Maternal Health Survey (2007), 7% of all pregnancies end in abortion and 15% of women aged 15-49 have ever had an abortion while 43% of women who admitted having had an abortion went to a pharmacist, friend or traditional midwives to have induced abortion, with 13% experiencing a health problem after the procedure while 41% received no medical care (GSS et al, 2009). A study conducted in the late 1990s in Southern Ghana revealed that 17 abortions were observed for every 1,000 women of reproductive age (Ahiadeke, 2001). Also, a study on Contraception and Induced abortion in rural Ghana (Geelhoed et al., 2002) found that 22.6% reported having induced abortion.

Hospital based studies also indicates that abortion complications are a major cause of gynaecological admissions. According to Turpin et al (2002) abortions constituted 38.8% of admissions to the Obstetric and Gynaecology wards of the Komfo Anokye Teaching Hospital in 1994. Hospital based studies at the KorleBu Teaching Hospital and the Komfo Anokye Teaching Hospital indicated that 22% and 30% respectively of maternal deaths are due to unsafe abortion (Wilson and Lassey 1998). A case review of hospital admissions at the Korle Bu Teaching Hospital in 2000 disclosed that 41% of admissions were due to complications of abortion (Srofenyon and Lassey, 2003) and 18% of gynaecological admissions were related to complications of induced abortion (Srofenyon and Lassey, 2003; Schwandt, 2011). According to the study, 14 percent of maternal deaths that were recorded were as a result of complications from abortion. Baiden et al

(2006) also reports on a review of hospital records from the Kassena-Nankana district which confirms that complications of abortion are an important reason for hospital admissions and maternal deaths. Analysis of hospital records between 2000 and 2003 recorded 24 maternal deaths (7 of which were due to complications of abortion) representing a hospital maternal mortality ratio of 759 per 100,000 live births.

In urban Accra, 47% of women report having terminated one or more pregnancies. Abortion is common among all religious, ethnic and socioeconomic groups in Ghana (Oliveras, 2006). Fifty percent of women receiving maternity care at Korle-Bu hospital report a previous history of abortion (Klufio et al, 2002). Oliveras, (2006) reports that unsafe abortion is particularly common among Ghanaian adolescents and that in Accra, young women between the ages of 18 to 24 are six times more likely to report having an induced abortion than adult women. Experts find that up to 70% of Ghanaian urban adolescents aged 12 to 24 years self-report previous abortions (Glover et al, 2003; Agyei et al, 2000). Hospital-based studies also put abortion-related complications as the leading cause of maternal mortality in the country, reaching as high as 30% (Geelhoed et al, 2003; Baiden et al., 2006).

Data from a large survey covering 18,301 women aged 15-49 from four of the ten regions in Ghana provide some estimates of the extent of abortions in the country (Ahiadeke, 2001). The study reported 19 induced abortions per 100 pregnancies or 27 abortions for every 100 live births, and the researcher also indicates that these estimates may yet be lower than the reality. Sixty percent of the women who had the abortions were younger

than 30 and 36% were nulliparous. Very few had sought the service from a physician: 12% had received services from a physician and a large number of abortions were sought outside the medical system. Nearly half of the women had self-induced abortions or sought services from pharmacists. These data suggest that induced abortions are fairly common and women seek care from providers who may be untrained and conduct unsafe and unhygienic procedures.

According to a national needs assessment on abortion care conducted by the Ghana Health Service (GHS) in 2005, abortion-related deaths contributed between 22-30% maternal deaths, constituting the single largest contributor to maternal mortality (GHS, 2005). In the two Teaching hospitals in Ghana, the Korle-Bu and Komfo Anokye Teaching Hospitals, abortion complications make up to 50% of all gynaecological admissions (Turpin et al., 2000; Aniteye, 2002). Thirty per cent of maternal deaths are due to unsafe abortions according to data from studies at Korle-Bu Teaching Hospital (KBTH) in Accra, the capital city of Ghana (Aboagye and Akosa, 2000). A recent post abortion care project by Planned Parenthood Association of Ghana indicated that over 90 percent of women in Accra seeking care after abortion went to the gynaecological unit of Korle-Bu Teaching Hospital (PPAG, 2001). According to the gynaecological records unit at Korle-Bu abortion cases have constituted well over 50 percent of all cases admitted for over three decades (PPAG, 2001).

2.3 Knowledge on abortion

A survey of legal professionals and law enforcement officials was planned with a view of assessing their level of understanding and support for safe abortion as a women's right and public health issue in countries where abortion laws are restricted and where it is legal. The study aimed to obtain an understanding of the differences in knowledge, attitudes and understanding among legal professionals and law enforcement officials towards women's right to safe and legal abortion in order to inform strategies for advocacy and to liberalise abortion in those countries. The study revealed that all the (13) respondents were aware of the new abortion law in their respective countries but only two could recall the year it was enacted. It also reported that majority of the respondents said that abortions were permitted up to 12 weeks of pregnancy while six of them mentioned 18 weeks but only if the pregnancy was a s a result of rape or incest. Two of the respondents, according to the study, reported that abortion could be permitted if there was a foetal deformity or if the pregnancy affected the woman's health while one said it was allowed for sex selection of the child. Notwithstanding the awareness of respondents on abortion laws in their own countries, their awareness of abortion laws in other countries as well as other international agreements on abortion was virtually non-existent.

Most Ghanaian women, men, and health providers are not aware that this procedure is legal, creating a situation in which many abortions in Ghana are unsafe (GMHS, 2007 and Morhe, 2007). The GMHS (2007) found that only 4% of women thought that abortion was legal in Ghana. Even among women with at least a secondary school education, only 11% were aware of the legality of abortion in Ghana. The knowledge of

the country's liberal abortion law among medical professionals appears to be considerably higher but still not extensive. In 2007, a study in Ghana revealed that only 54% of physicians were aware that abortion is legal if indicated to preserve the health of the woman. (Morhe et al, 2007).

Although abortion is usually stigmatized in Ghana, it appears that many people consider it acceptable under certain conditions. In in-depth interviews with adolescent female in Accra, the majority of participants were strongly opposed to abortion, but nearly all described situations (such as being in an unstable relationship or not having enough money to raise a child) in which they considered abortion to be acceptable. (Henry and Fayorsey, 2002)

Due to illiteracy and social deprivation, many women and men in Ghana do not realise that abortion has been made legal under certain conditions for decades in Ghana. They, therefore, do not know their legal rights to safe abortion (Morhe and Morhe, 2006).

Traditional and cultural values, social perceptions and religious teachings have produced negative perceptions of abortion (Lithur, 2004). In addition, lack of knowledge and poor understanding of the accessibility of legal abortion contributes to the high degree of stigma attached to abortion in Ghana. A widespread misunderstanding of the law means that most women seeking abortion still seek clandestine abortions which are usually unsafe (Lithur, 2004; Lassey, 1995).

Grimes (2006) recognised that in addition to the negative views about abortion, the stigma associated with abortion in some third world nations resulted in the practice of clandestine, unsafe abortions even when legal services are available.

2.4 Reasons for abortion

The root cause of most induced abortions is unintended pregnancy which occurs when a woman is unable to time or limit her childbearing (Sundaram et al., 2012). The decision to have an abortion is usually influenced by diverse, multiple and interrelated reasons and factors (Finer et al, 2005). Age, religion, economic status, culture, relationship with others, reproductive history, resource limitations, interference with mother's education or work, unpreparedness for transition to motherhood and desire to have an abortion are among the reasons and factors that influence women to opt for abortion. The GDHS (2008) reports that 35% of married women and 20% of sexually active women have an unmet need for contraception; that is, they do not want a child soon or at all but are not using a contraceptive method. As a result, 37% of all pregnancies in Ghana are unintended: 23% are mistimed and 14% are unwanted.

Women's reasons for seeking abortion have been discussed in several studies (Archibong 1991; Bleek 1981; Huntington et al. 1993). These included inappropriate timing of the pregnancy, fear of expulsion from school, financial difficulties, and uncertainties about the partner. The 2007 Ghana Maternal Health Survey reports that one in five women who experienced an abortion in the last five years cited financial constraints as the main

reason for terminating the pregnancy for those residing in both rural and urban settings (GSS et al., 2009).

In a study on the profile of abortion seekers in Ghana and their decision-making processes, interviews on the reasons why they had arrived at the decision not to have the child, 39.7% of client indicated that the pregnancy was either mistimed or unwanted either by themselves and 19.8% by their partners or other family members while 16.4% of them indicated that they needed to get rid of the pregnancy so that they could continue with their work or education. The majority of the client (32%) indicated that they took the final decision themselves to come to the facility on that day while almost a quarter (24%) mentioned that it was a joint decision between themselves and their partners. Thus, 55% of the clients had a say in the decision to seek services at the current facility (Nyarko et al., 2008). In order to understand women's decision-making processes, the study sought to find out from respondents their reasons for deciding not to continue with pregnancy. Majority of the respondents indicated that the pregnancy was either mistimed (40%) or unwanted either by themselves, their partners or other family members (20%). Others were concerned that they could not take care of the baby due to financial constraints (21%), and a significant proportion felt that a pregnancy and a child would interrupt their work (16%) or education (16%). Other reasons given included relationship problems, not being psychologically prepared, not being old enough to be a mother, and not being married (Nyarko et al., 2008).

A study conducted to describe the prevalence, reasons for abortion and socio-demographic variables and also to describe the factors associated with induced abortion in women in Hohoe in the Volta region of Ghana revealed that the reasons why women go for abortion include: not to disrupt education or job (35.8%); too young to have children (28.4%); and cannot care for a baby (14.7%) (Mote et al, 2009). The study also interviewed women on knowledge and reasons why friends had abortion. 52.9% knew other friends who had had an abortion. On the reasons why friends has abortion, 31.1% reported not to disrupt education or job, 19.1% reported could not cater for a baby and 18.8% reported partner rejected pregnancy. Other reasons as given by respondents were; want to postpone childbearing (4.2%), last child was too young (3.2%) and don't want any more children (1.1%) (Mote et al, 2009). According to this study, majority of women who have abortion do so not to discontinue education or career.

In a study in the United States on the reasons why women have abortions using both structured survey and in-depth interviews, the research which used structured survey revealed that the two most common reasons were 'having a baby would dramatically change my life" and "I can't afford a baby now" - cited by 74% and 73%, respectively (Finer et al, 2005). A large proportion of women cited relationship problems or a desire to avoid single motherhood (48%). Nearly four in 10 indicated that they had completed their childbearing, and almost one-third said they were not ready to have a child. Women also cited possible problems affecting the health of the fetus or concerns about their own health (13% and 12%, respectively). Respondents wrote in a number of specific health

reasons, from chronic or debilitating conditions such as cancer and cystic fibrosis to pregnancy-specific concerns such as gestational diabetes and morning sickness. The most common sub-reason given was that the woman could not afford a baby now because she was unmarried (42%). Thirty-eight percent indicated that having a baby would interfere with their education, and the same proportion said it would interfere with their employment. In a related vein, 34% said they could not afford a child because they were students or were planning to study.

In the in-depth interviews, the three most frequently stated reasons were the same as in the structured survey: the dramatic impact a baby would have on the women's lives or the lives of their other children (32 of 38 respondents), financial concerns (28), and their current relationship or fear of single motherhood (21). Nine women cited health concerns for themselves, possible problems affecting the health of the fetus or both as a reason for terminating the pregnancy.

In an effort to understand the process by which some women seek to terminate a pregnancy, while others in apparently similar situations do not, Browner (1979) examined the relationships between a variety of social factors and the actions the women took to end unwanted pregnancies. The study revealed that there was a tendency for women with greater economic resources to take major or several minor steps to end the pregnancy. Women with fewer economic resources, on the other hand, were more likely to take no action or cease attempts to terminate the pregnancy after one minor intervention. Few women also cited economic reasons for not wanting to continue the

pregnancy while many women cited marital problems as their reason for terminating the pregnancy.

A study in Southern Ghana also reported the most common reason given by women for seeking an abortion as not having the financial means to take care of a child (GSS et al., 2009; Sedgh, 2010). Other common reasons include wanting to delay childbearing (13%), continue schooling (11%) and continue education (9%). Six percent of women said their partner did not want the child or denied responsibility for the pregnancy. Health reasons for terminating the pregnancy were cited by about 5% of women (GSS et al., 2009; Sedgh, 2010).

Sundaram et al. (2011), Baiden et al. (2006), Aboagye et al. (2007) and Blanc and Gray (2002) also suggest that abortion is used widely to space or limit childbearing although they also cited being financially unable to take care of a child and needing to delay childbearing in order to continue schooling or work as some of the reasons women opt for abortion.

2.5 Methods and Providers of abortion

There is limited data on the abortion methods and providers that women turn to for abortion services. However, the few studies available have produced conflicting evidence regarding the types of providers women turn to and the procedures they undergo to terminate a pregnancy. According to data from the GMHS (2008), many women who procure abortions do so with the help of a doctor and in a hospital setting, although

significant proportions do not undergo the safest procedures available (GSS et al., 2009; Sedgh, 2010). The GMHS (2008) reported most women (57%) sought a doctor to perform an abortion, 16% went to a pharmacist or chemical seller, and 19% turned to a friend or relative or induced the abortion themselves (GSS et al., 2009; Sedgh, 2010). The remaining women sought the help of a traditional practitioner (4%) or a nurse, midwife or auxiliary midwife (3%) but this study did not record traditional practitioners as a source or provider of abortion. Among women reporting on their most recent abortion in the five years before the survey, 40% underwent dilation and curettage (D&C) (GSS et al., 2009; Sedgh, 2010).

In contrast to the GMHS (2008), a 1997–1998 study in southern Ghana found that only about 12% of women who obtained an abortion did so with the help of a physician (Ahiadeke, 2001; Sedgh, 2010). According to Ahiadeke (2001), more than two-thirds of women who sought an abortion turned to an untrained provider or induced the abortion on their own (Sedgh, 2010).

Findings from other studies suggest that misoprostol (cytotec) is widely used in causing abortion including findings from a pilot study on medical abortion recently conducted in two hospitals in Ghana that found an overwhelming up-take of both Mifepristone and Misoprostol (Blum et al., 2007). Data from the GMHS (2008) showed only 16% of women said they terminated their pregnancy by taking tablets, and about 6% of women specified that they took misoprostol (cytotec) tablets (GSS et al., 2009; Sedgh, 2010). Less common methods included inserting an object, herbs or other substances in the

vagina; receiving an injection; and drinking an herbal concoction (GSS et al., 2009; Sedgh, 2010) which is similar to findings from this study.

It is possible that the reason for the discrepancy between the studies is that respondents in the GMHS underreported abortions obtained through dubious means, while reporting more fully on abortions performed by medical professionals.

2.6 Factors associated with abortion

Decision making is a broad term that applies to the process of making a choice between options as to a course of action (Thomas et al 1991). Research on abortion decision making has been limited in both quantity and scope. Most studies have been mainly conducted from epidemiological and/or demographic perspectives (Tamang et al., 1998; Thapa and Padhye, 2001). These studies that relate the incidence of abortion to socio-demographic variables have only increased the understanding of the characteristics of women who undergo abortion, as well as its extent. Abortion decision making may be complex and affected by many factors including; religion, age, culture, relationships and current life situations.

Finer et al (2005) examined the relationship between various social and demographic characteristics and reasons for having an abortion. Higher proportions of younger women, of women with no children and of never-married women identified interference with education or work and unreadiness for a child or another child as reasons for having an abortion. Compared with their respective counterparts even among older women and

women who had children, however, about one-third cited disruption of schooling or work. A higher proportion of more educated women than of less educated women gave this reason.

Nulliparity was the most important correlate of reporting interference with education or work as a reason for choosing abortion, after other variables were controlled for. Women who had children were less likely than women with no children to give these reasons. In addition, women aged 30 and older were much less likely than those aged 17 and younger to cite educational or career interference. Having no children was also the key predictor of reporting unreadiness for a child or another child. Fewer than half of the interview respondents said that having a baby now would keep them from fulfilling their goals or that they were not ready to have another child. The majority of these women were young and nulliparous; their aspirations were primarily educational. Many women who gave one of these reasons said they were too young to have children and felt they were "just starting out" in their lives. Most framed their decision in terms of the desire to have children later, when they could better provide for them.

In the same study, higher proportions of women who were unmarried or cohabiting, nonwhite, poorer and unemployed said they could not afford to have a child now, compared with their respective counterparts. This reason was also more commonly given by young teenagers and women aged 20–24. Some of these social and demographic characteristics likely have overlapping influence. For example, young women are likely

to be unmarried, and poor women are likely to be unemployed. In the multivariate analysis, marital status and both economic variables remained significant.

Abortion, safe and unsafe, is widely stigmatized in the Ghanaian society. Cultural, religious and traditional stigma against abortion is prevalent in Ghana (Lithur, 2004). The stigma attached to abortion raises serious concerns. It has for a long time been an unspoken and disregarded contributor to maternal mortality in Ghana. Traditional and cultural values, social perceptions and religious teachings have produced negative perceptions of abortion (Lithur, 2004).

Two Nigerian studies found that among those women presenting at hospital for treatment of induced abortion complications, 32% and 18% of them had had their abortion performed by a medical practitioner (Okonofua et al. 1992; Archibong 1991, respectively). In yet another Nigerian study, almost one-third of the illegal terminations were performed by physicians, with two-thirds of the deaths in the last year of the study occurring in women who had obtained an abortion from a physician (Adewole 1992). A 1998 community-based study in Ghana found that only 12% of the women obtaining induced abortions utilized physician services for the procedure (Ahiadeke, 2001).

As a result of abortion stigmatization, women are reluctant to seek abortion services at public health care facilities while many abortions are also not reported. In addition, lack of knowledge and poor understanding of the accessibility of legal abortion contributes to the high degree of stigma attached to abortion in Ghana. Grimes (2006) recognised that in addition to the negative views about abortion, the stigma associated with abortion in

some third world nations resulted in the practice of clandestine, unsafe abortions even when legal services are available.

Although abortion is usually stigmatized in Ghana, it appears that many people consider it acceptable under certain conditions. In in-depth interviews with adolescent female in Accra, the majority of participants were strongly opposed to abortion, but nearly all described situations (such as being in an unstable relationship or not having enough money to raise a child) in which they considered abortion to be acceptable. (Henry and Fayorsey, 2002)

The high cost of abortion is also a significant barrier to access to safe abortion. Due to the clandestine nature of abortion services and the lack of clarity about legality, many doctors charge additional fees, saying they are taking a professional risk in performing abortions. Even if a public facility offers abortion, the cost relative to the income of most Ghanaians means it is out of reach (GHS, 2005). The burden of unsafe abortion is very huge and the cost implications high. Moreover, abortion is not covered under the National Health Insurance Scheme, introduced in Ghana in 2004.

An in-depth study in Accra reported that women pay between GH¢ 3.00 and GH¢ 30.00 for a hospital or private clinic abortion (Henry and Fayorsey, 2002). As a result, poor women may be forced to seek risky abortions from untrained providers (Sedgh, 2010). More generally, it has been reported that a safe abortion is prohibitively expensive for

many women because few practitioners are available to perform the procedure, and they charge very high fees (Morhe and Morhe, 2006).

In sub-Saharan Africa, Ghana inclusive, males are recognized as heads of the households and principal decision makers in regard to fertility (DeRose et al., 2005; Dodoo et al., 2008; Schwant, 2011). Furthermore, past research has shown that, in Ghana, women's fertility intentions were affected by their partners' intentions (Ezeh, 1993; Schwant, 2011). Browner (1979), reported that it was the response of the man and not that of other kin that had direct bearing on their decision. They usually discussed their plans with their partners before any action and his response to the pregnancy was often the single most important factor influencing outcome. For many women, the man's denial of paternity or a suggestion of abortion indicated that he would not accept responsibility for the child. The understanding, then, was that if she wanted the child, the woman would have to manage without the man's material or emotional support. Also, men in Uganda are often highly involved in the decision to induce an abortion (Nyanzi et al., 2005; Schwandt, 2011).

Despite males' reported dominance in fertility-related decision making, the 2008 GDHS reported that some women identify themselves as having the “final say” on four general household decisions (GSS et al. 2009; Schwant, 2011) while in Nigeria, nearly half of all women studied made the decision to abort themselves (Oye-Adeniran, 2004; Schwandt, 2011). While data on why women choose not to disclose are not available in this study,

other research sheds some light on this topic. Also, in Schwandt (2011), significantly more women chose not to disclose their pregnancy to their male partners.

Research shows that there is a difference in views of abortion depending on the type of abortion. It seems that a person who identifies themselves as more associated with religious groups and being raised religiously come to be more opposing to abortion. On the other hand, people who don't identify with a religious background and identify within a religious group are more liberal with their views on abortion. Cochran et al (1996) also found proof of religious groups being influential on moral views, particularly regarding abortion, in relation to reference group theory. Leaders within these religious groups serve as significant others.

A study was conducted by Laurent Begue (2001) to determine how views of abortion differed depending on variations of why the abortion decision was being made. This study, using Catholics specifically, found that the individual attitudes were very much affected by the social identity of the person evaluating a person's decision to have an abortion. This study found that when the person having the elective abortion was constrained by financial or other obligations, it was found more permissible than an elective of the abortion just for the sake of aborting. The evaluators, when faced with a situation where the person having an abortion was also identified as a Catholic was judged much harsher than one who was not Catholic (Begue 2001).

Research also shows that parental socialization within religious groups affects a person's moral attitudes in a conservative way. The fact of belonging to the group is not a determining agent, but regular church attendance of a parent does have an effect. However, even stronger than the parent's socialization is the socialization habits of the person in question. If the person has close ties within regular church attendance, this is an even stronger force (Scheepers, Te Grotenhius, and Van Der Silk 2002). Also in moral attitudes, education is a large factor. There is a correlation between higher education and more liberal views, and in contrast there is a correlation between less education and more conservative moral views.

Evidence from other countries demonstrates that interpersonal relationships play a large role in abortion decisions. In India, husbands play a significant and dominant role in taking the final decision; older women who generally know how their husband will react to the suggestion of an abortion of an unintended pregnancy were found to be ready to take the authority in their own hands and decide to abort it without informing their husband (Sinha et al., 1998). Another study in India found that husbands and mothers-in law were more likely to decide for younger women when living in the same house. Young women felt they had been pressured into having an abortion when they had wanted to continue (Ganatra and Hirve, 2002). In Bangladesh, the husband is the final decision maker; however, neighbours, sisters-in-law, friends and, in some cases, health workers provided networks of informal support for those seeking abortion (Ahmed et al., 1997; Khan and D'costa, 2002). In Vietnam, except for the husband, no one else was

found to have had any major influence on the decision to terminate a pregnancy. In no cases were health workers or other people outside the family reported to have influenced the decisions. Parents and parents-in-law were sometime informed, but had not had any impact on the final decision (Johansson et al., 1998).

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This section covers the research design, study site, study population, sample size, sampling technique, data collection instrument, data collection procedure and analyses.

3.1 Study design

A research design is a planned structure and strategy of investigation, so as to obtain answers to research questions or problems (Kerlinger, 1986). For the purpose of this study, a descriptive cross-sectional design was employed to describe the factors that relate to decision-making in unsafe abortion. A subset of women within their reproductive ages of 15-44 years who had been admitted at the KATH due to complications from induced abortion were selected to answer questions of interest. The design was a method of choice and was most appropriate for this research because it fielded studies in natural setting and explained phenomena from the persons being studied and also produced descriptive data from the respondents (Streubert et al., 1999). Finally, organized data was presented systematically in order to arrive at valid and accurate conclusions.

3.2 Study site

The study was conducted at the Obstetrics and Gynaecology (O&G) Directorate of the Komfo Anokye Teaching Hospital (KATH). The hospital has twenty-eight directorates and units and provides services in all aspects of specialist healthcare. Although located in Kumasi, its catchment area stretches beyond the Ashanti region to some parts of the Western, Brong Ahafo and the three Northern regions.

The department of O&G is the second largest clinical directorate at the KATH and provides general and specialist women health care and also undertakes research into women's health among others. It has a bed capacity of 171 with 40 beds at ward A3 where abortion admissions are housed. From 2011 to date, abortion and its complications have been the highest causes of gynaecological admissions to the directorate with abortion related cases accounting for 35% of all gynaecological cases admitted to the directorate in 2012.

The directorate was selected because it provides specialized gynaecological care and serves as the referral point for various hospitals and health centres in Ghana which is in fulfilment of its mandate of providing advanced clinical care services to all people in Ghana.

3.3 Study population

This was a facility based study conducted among women within their reproductive ages (15-44years) who had been admitted at the Komfo Anokye Teaching Hospital due to complications of unsafe abortion. Women on admission were interviewed to reduce the

potential for recall bias and ensured that the desired sample size was attained within a relatively short period.

3.4 Sampling technique and sample size

The researcher did not use a sampling frame because the sample was purposively chosen to help to fulfill the predetermined purpose of the project. This was due to the clandestine nature of the issue under study and also to avoid recall bias. During the data collection period, participants were selected from among patients who were admitted to the KATH due to complications from unsafe abortion. All women admitted with abortion-related complications to the Department of Obstetrics and Gynaecology (O&G), KATH and consented to participate in the study were recruited. Women who consented were required to sign a consent form before they were allowed to answer the questionnaire.

The sample size was calculated using a 95% confidence level with a 5% margin of error and the general rate of abortion in Ghana at 15% (Sedgh, 2010; GMHS, 2007). Using $n=z^2pq/d^2$ where, z is the reliability co-efficient (1.96) at 95% confidence level, d is the error margin, p is the general rate of abortion in Ghana and q=1-p.

$N= (1.96)^2*(0.15)*(0.85)/0.05^2$

N= 195. A non response rate of 10% (corresponding to 19) was added to the initial number. Therefore, a total of two hundred and fourteen respondents were estimated for the study.

However, the study recorded a response rate of 75% during the data collection period. This was because some of the women had been discharged and left the ward by the time field officers went in to collect data every morning. Also, the period was met with a strike action by medical doctors in the hospital and the research time frame was not long enough to make up for the estimated number of participants. In all, a total of one hundred and sixty (160) consented and participated in the study.

3.5 Source of data

The main source of data for the study was obtained from the field using a questionnaire. Results from this source formed the basis of data analysis. Relevant literature on the subject area was also reviewed. Literature sources included books, handouts, newspapers, journals, magazines, the internet and periodicals. This information was used in discussing the results generated from primary data analysis. Also, hospital records were used to identify women who were potential respondents.

3.6 Data collection technique and tool

Data was collected through exit interviews by the principal investigator so as not to interfere with clinical management of patients' condition. Structured questionnaires developed to reflect the objectives and also answer the research questions were used in collecting data from the field. The questionnaire had both open and closed ended questions and was divided into 5 sections namely; socio-demographic characteristics of women, socio-demographic characteristics of partners, women's knowledge on abortion,

reasons for induced abortion and factors that relate to decision making. After it has been developed, it was pre-tested at the Kumasi South Hospital among 30 similar study participants. The research supervisor then assisted in reviewing and finalizing the questionnaire. Completed questionnaires were edited, numbered and coded.

3.7 Data analysis

Completed questionnaires were cleaned, coded and entered into the Statistical Package for the Social Sciences (SPSS) version 16. Analysis was undertaken to generate a descriptive picture of the data gathered on objectives of the study. The software was used to analyse the findings using frequency distributions. Simple percentages were used to analyze the quantitative data obtained from the questionnaire. Chi-square tests in the form of cross tabulations were used to estimate association between dependent and independent variables. The analysis was based on 95% confidence interval to determine the statistical significance of the associations between some of the key variables.

3.8 Ethical clearance

Ethical clearance was obtained from the Committee on Human Reasearch, Publications and Ethics (CHRPE) of the Kwamne Nkrumah University of Science and Technology, School of Medical Sciences and the Komfo Anokye Teaching Hospital. The study was also registered with the Research and Development Unit (RDU) of the hospital.

Informed consent and permission to participate were obtained from each participant. Participants also had the liberty to withdraw from the study anytime they deem necessary.

They could also choose not to answer a particular question they were uncomfortable with. Strict confidentiality of the identity of respondents was maintained using unique numeric codes which was available only to the principal investigator. Completed data collection tools were retained until the final work had been submitted and approved.

3.9 Assumptions

The assumptions underlying this study were that the data collection tools used for the study were appropriate and all respondents gave correct responses to the questions they were asked. It was also assumed that the sample selected was the true representation of the entire population of the women who are admitted due to unsafe abortion complications. A confidence level of 95% also assumed a true reflection of the situation under investigation at the Komfo Anokye Teaching Hospital.

CHAPTER FOUR

RESULTS

4.0 Introduction

This chapter presents the findings of the data collected from the study. The descriptive analysis of the data gathered from respondents from the Komfo Anokye Teaching Hospital is covered in this section of the study. The chapter describes the socio-demographic characteristics of the respondents and their partners, their knowledge on abortion, their reasons for abortion and the factors that relate to abortion. The presentations are in the form of tables, charts and graphs. There are also descriptive analyses in the form of cross tabulations.

4.1 Characteristics of study participants

This section explores the social and demographic characteristics of respondents and their partners. Variables that were captured include respondents': age, highest level of education attained, religious background, marital status and number of children of respondents and that of their partners (if different). .

A total of 160 respondents were used in the study. Their ages ranged from 15 to 39 years. The mean age was 19.6 (approximately 20 years) with a standard deviation 4. The study showed that majority of the respondents (about 54%) were aged between 15 and 19 years while 5% were aged 30 years and above.

Table 1: Socio-demographic characteristics

Variable	Frequency (n=160)	Percentage
Respondent's Age		
15-19	86	53.7
20-29	70	43.8
30+	4	5
Total	160	100
Partner's Age		
15-19	2	1.3
20-24	68	43.6
25-29	66	42.3
30+	20	12.7
Total	156	100
Respondent's level of education		
No formal education	8	5
Primary	38	23.8
JHS	66	41.3
SHS and above	48	30
Total	160	100
Partner's level of education		
No formal education	17	10.9
Primary	13	8.3
JHS	37	23.7
SHS and above	49	31.4
Tertiary	40	25.6
Total	156	100
Respondent's Religious background		
Christianity	98	61.3
Islam	54	33.8
Other	8	5
Total	160	100

Table 1: Socio-demographic characteristics cont.

Variable	Frequency (n=160)	Percentage
Respondent's Employment Status		
Unemployed	107	33.1
Employed	53	66.9
Total	160	100
Partner's Employment Status		
Unemployed	19	12.2
Employed	137	87.8
Total	156	100
Respondent's Marital Status		
Single	146	91.3
Married	6	3.8
Divorced/Separated	8	5.0
Total	160	100
Respondents number of children		
0	127	79.4
1-2	28	17.6
3+	5	3.1
Total	160	100
Partner's number of children		
0	116	75.8
1-2	26	17
3+	11	7.3
Total	153	100
Respondent' intended number of children		
1-2	74	49.3
3-4	71	47.3
5+	5	3.3
Total	150	100

Source: Field data, 2013.

On the age groups of the partners, it was realized that the response rate was 97.5 percent leaving out 4 respondents representing 2.5 percent who could not provide answers on the age of their partners. Of the 156 respondents who provided responses to the age of their

partners, majority (85.9 %) were between 20 and 29 years with the 20-24 and 25-29 age groups acquiring 43.6 and 42.3 percent respectively. Also, majority of respondents were aged between 15 and 24 years while majority of their partners were aged between 20 and 29 years. Moreover, as most respondents were within the 15-19 age group (53.1 percent) followed by the 20-24 age group (41.3 percent), majority of their partners were within the 20-24 age group (43.6 percent), followed by the 25-29 age group (42.3 percent).

Majority of the respondents (95%) had formal education although the percentages decrease as the level of education increase. As depicted by table 1, 5% of the respondents had no formal education while about 24% had attained education up to primary level. Forty one percent had attained Junior High School education with 30%t having Senior High School education.

The level of education of respondents' partners also recorded a 97.5% response rate. Of the 156 respondents who provided answers on their partner's level of education, the study showed that about a quarter (25.6%) had completed tertiary education. Majority (31.4%) had completed Senior High School, 23.7 had completed Junior High education and about 11% had no formal education. It was realized that more respondents (95%) had formal education than their partners (89%). However, their partners' education were higher than them since only 30% of respondents had completed Senior High and Tertiary education while 57% of their partners had completed Senior High and Tertiary education.

On their religious background, the study identified that Christianity was the major form of religion among the respondents accounting for 98 respondents thus 61.3%. Islam was the second form of religion accounting for 54 respondents representing 33.8%.

As depicted by table 1, about 67% of the respondents were unemployed and 33% were employed. On the employment status of partners, the study achieved a 97.5% response rate. The study, based on the 156 responses on partners' employment status, showed that unlike the respondents, majority of their partners were employed. About 12% of them were unemployed while 87.8% were employed.

The study showed that 146 respondents representing a majority of 91.3% of respondents were single, 6 respondents representing 3.8% and 8 respondents representing 5% were married and divorced/separated respectively.

Also, majority of the respondents (127 respondents representing79.4%) had no children while the highest number of children recorded was 5. About 18 respondents representing 11.3% had one child and one respondent had 5 children.

Out of the 160 respondents, 150 representing 93.8% provided responses on their intended number of children. All those who refused to provide responses for their intended number of children were respondents who had no children as at the time of the study. Of the 150 respondents who provided responses, majority thus 65 representing 43.3% wanted to have two children, 41 representing 27.3% wanted to have 3 children while 30 representing 20% wanted to have 4 children. Most of the respondents (90.6%) wanted to

have between two to four children while 9.3% wanted to have either one or five children. Moreover, all the 9 respondents who wanted to have one child had no children at the time of the study. From the table, majority of respondents with no children (43.6%) as well as majority of respondents with one child (66.7%) wanted to have two children. For respondents with two children, 20% had attained their intended number of 2 children, 30% wanted an additional child and majority (50 percent) wanted two more children. For respondents with three, four and five children, they had attained their intended number of children. To ascertain the association (if any) between respondents current number of children and their intended number of children, the chi-squared analysis (table 3) revealed a significant association between respondents current number of children and their intended number of children ($p<=0.001$) at 95% confidence level.

Table 2: Association between current and intended number of children

		Intended number of children		
		1-2 n (%)	3+ n (%)	P<=value
Number of Children	0	60 (51.3)	57 (48.7)	(0.001)
	1-2	14 (50)	14 (50)	
	3+	-	5 (100)	
Total		74 (49.3)	76 (50.6)	

Source: Field data, 2013.

The study showed that majority of the respondents' partners (75.8%) had no child and 10.5 percent had one child. It was also observed that, majority of respondents who had no child (84.4%) were with partners who also had no child while 14% of respondents with no child had partners with one or two children. About 44% of respondents with one child

had partners with no child while about 30% of respondents with one or two children also had partners with one or two children.

4.2 Knowledge on abortion

Table 3: Knowledge on abortion

Variable	Frequency, n=160	Percent
Knowledge on abortion law		
Yes	6	3.8
No	154	96.3
Awareness of safe abortion services		
Yes	2	1.3
No	158	98.8
Knowledge about abortion methods		
Yes	23	14.4
No	137	85.6
Method used	N=26	
"Misoprostol"	19	73
"coke/lime and sugar"	4	15.4
"Primolut-N tablet"	2	7.7
"U-pill"	1	3.9
Ever heard about contraceptives		
Yes	138	86.3
No	22	13.8
Circumstances for abortion		
Rape/defilement/incest	125	69.8
Teenage/unwanted pregnancy	10	5.6
Other	44	24.6
Total	179	100
Should not be permitted	41	25.6

Source: Field data, 2013.

One objective of the study was to find out respondents' knowledge on abortion in Ghana. On their understanding of induced abortion, all the respondents had a least a fair

understanding of what induced abortion meant. When respondents were asked about their understanding of induced abortion, every one of them was able to state in one or two sentences what was meant by induced abortion.

On whether or not respondents knew abortion was allowed under some circumstances in Ghana, almost all of them (96.3%) representing 154 respondents responded in the negative meaning most of them did not know abortion was allowed in any way in Ghana. Only 3.8% of respondents knew abortion in Ghana was allowed under some circumstances in Ghana. All those who knew abortion in Ghana was liberal mentioned the media as their source of knowledge. However, none of them were able to state anything about the law.

Respondents were also asked if they knew any methods or instruments used for safe abortion for which about 86% responded in the negative while 14% responded in the affirmative. Of the 14% representing 23 respondents who responded positively, there were 26 responses since some respondents gave multiple responses. Of the 26 responses, the most common method or instrument given was misoprostol (cytotec) representing 73%. “Coke or lime and sugar” accounted for 15.4%, “Primolut-N Tablet” accounted for 7.7% and “U-pill” accounted for 3.9% of the responses as depicted in table 3.

Respondents were further asked about the conditions or situations under which they thought an abortion should be allowed. As depicted in table 3, about 26% of respondents reported that abortion should not be permitted under any circumstance. However, 74% of

the respondents felt abortion should be permitted under certain circumstances for which they stated multiple responses. There were 236 responses that emanated as a result of multiple responses to the question. Of the responses, "rape/incest/defilement" accounted for the highest recording 69.8% (125 respondents).

As depicted by table 3, about 86% indicated that they had ever heard about contraceptives while about 14% had never heard about contraceptives. However, the study showed that only 49% out of the 138 had ever used a contraceptive while 51% had never used a contraceptive method. It was further realized that of the 138 respondents who had heard about contraceptives, only 78 representing 56.5% had ever used a contraceptive method. Moreover, about 14% of the respondents were using a contraceptive method as at the time they got pregnant while 86% were not using any contraceptive method at the time of conception. It was also evident from the information gathered that of those who had ever used a contraceptive, only 28% were still using a contraceptive at the time they got pregnant while 72% were no longer using a contraceptive at the time of conception. It was also ironic that the 28% though were using contraceptives, still became pregnant.

A test for association between level of education and knowledge on abortion (table 5) showed that level of education has an association with knowledge on the abortion law ($p=0.025$) at 95% confidence level. All the respondents who knew that abortion in Ghana was permitted under some circumstances had completed JHS education.

Table 4: Association between level of education and knowledge on abortion law

Level of education	Knowledge on abortion law		P=value
	Yes n (%)	No n (%)	
No formal education	-	8 (100)	0.025
Basic education	5 (4.8)	99 (95.2)	
Post basic	1 (2.1)	47 (97.9)	
Total	6 (3.8)	154 (96.2)	

Source: Field data, 2013.

That notwithstanding, when respondents were asked whether or not they were aware there was a place where a safe abortion could be sought, only 2 respondents representing 1.25% responded in the affirmative. The majority of 98.75% did not know any place that they thought they could seek for a legal or safe abortion.

Table 5: Association between level of education and ever heard about contraceptives

Level of education	Ever heard about contraceptives		P=value
	Yes n (%)	No n (%)	
No formal education	6 (75)	2 (25)	0.42
Primary	35 (92.1)	3 (7.9)	
JHS	54 (81.8)	12 (18.2)	
SHS+	43 89.6)	5 (10.4)	
Total	138	22	

Source: Field data, 2013.

Table 5 is a chi-squared test for association (if any) between level of education and ever heard about contraceptives. It was discovered from the study that level of education and respondents ever hearing about contraceptives were not in any way associated (p=0.42) at 95% confidence level. That is, contraceptive knowledge was high among all levels of education.

4.3 Reasons for induced abortion

Table 6: Number of abortions, ever had complications and reasons for induced abortion

Variable	Frequency, n=160	Percent
Number of induced abortions		
1	126	78.8
2	31	19.4
3	3	1.9
Total	160	100
Ever had abortion complications		
Yes	29	18.1
No	131	91.9
Total	160	100
Reason for abortion		
Not to disrupt work or education	26	16.3
Not old enough/married	39	24.4
Financial constraints	31	19.4
Partner's refusal/recommendation	39	24.4
Other	25	15.7
Total	160	100

Source: Field data, 2013.

The study also explored the reasons why respondents decided to terminate the pregnancy. For about 79% of the respondents, it was their first ever termination of a pregnancy and for 19%, it was their second abortion. Two percent of respondents reported that they had had abortion three times. The study revealed that all the respondents had been admitted to the hospital as a result of abortion complication. This means that 79% of the respondents for whom it was their first abortion had never experienced an abortion related complication.

However, most of those who reported that it was their second and third abortion had experienced abortion complications before. It was for only 13% of such respondents who were experiencing complications for the first time. Out of the 34 respondents who had had abortion before, only 5 respondents had never experienced abortion complication.

4.4 Methods and providers of abortion

As depicted by table 8, majority (87.5%) of the respondents induced abortion in their homes while for 6.3% abortion was done in a hospital/clinic or private maternity. Table 8 also shows the method or procedure used by respondents in inducing the abortion. As the table shows, about 67% of the respondents used only oral medication. Also, most of them (those who could recall) reported using misoprostol commonly known as "cytotec" as the oral medication they used in causing the abortion. Moreover, about 11% of the respondents reported using inserting medicines in inducing their abortion. Herbs and home-made concoctions recorded about 14%.

The study revealed that pharmacist and partner/friend were the most available providers of abortion methods to respondents. When respondents were asked about the source of the method they used in terminating the pregnancy, pharmacists and partner/friend together recorded 86% as shown in table 7.

Table 7: Methods and providers of abortion

Variable	Frequency, n=160	Percent
Place of abortion		
Home	140	87.5
Hospital/clinic/ Private maternity	10	6.3
Other	10	6.3
Total	160	100
Method used		
Oral medication	107	66.9
Herbs/Home-made concoctions	22	13.8
Inserting medicines	18	11.2
Other	13	8.1
Total	160	100
Source of abortion method		
Self	11	6.9
Friend/Partner	69	43.1
Pharmacist	69	43.1
Other	11	6.9
Total	160	100
Awareness of method complication		
Yes	12	7.5
No	148	92.5
Total	160	100

Source: Field data, 2013

When respondents were asked if they were aware that the method they used could cause complications, 92.5% reported that they didn't know that the method they used could cause complications and 7.5% were aware that the method they used could cause complication but still went ahead to used that method.

4.5 Factors related to abortion

On their reason for termination, 24.4% of the respondents each reported that they were either not old enough/married or their partners refused responsibility of the pregnancy or recommended they go in for an abortion, 19% related their reason to financial constraints in caring for a baby and 16.3% did not want to disrupt their work/education.

Although "not old enough/married" accounted for 24.4% of reasons for termination, age was found to have a significant association with number of induced abortions ($p<=0.001$) at 95% confidence level. It was realized that, generally, as age increased, number of abortions decreased as depicted by the related chi-squared test in table 9. Most respondents committed abortion in their young ages (15-24 years).

As stated earlier, education was cited as one of the reasons why respondents opt for abortion. The associated analysis shows that there are generally high values for respondents whose level of education ranges from primary to SHS. However, test of association disclosed that, there is no association between level of education and number of induced abortions ($p=0.344$) at 95% confidence level.

Table 8: Association between socio-demographic variables and number of abortions

Socio-demographic variables	Number of induced abortions		P value
	1 n (%)	More than 1 n (%)	
Age			
15-19	76 (88.4)	10 (11.6)	<=0.001
20-29	47 (67.1)	23 (32.9)	
30-39	3 (75)	1 (25)	
Level of education			
None	5 (62.5)	3 (17.5)	=0.344
Basic	80 ()	22 ()	
Post basic	41 ()	7 ()	
Employment status			
Employed	96 (89.7)	11 (10.2)	<=0.001
Unemployed	30 (56.6)	23 (43.4)	
Marital status			
Single	116 (79.5)	30 (20.6)	=0.064
Married	3 (50)	3 (50)	
Divorced/separated	7 (87.5)	1 (12.5)	
Number of children			
0	106 (83.5)	21 (16.5)	=0.030
1-2	17 (60.7)	11 (39.3)	
3+	3 (60)	2 (40)	
Intended number of children			
1-2	63 (85.1)	11 (14.9)	=0.298
3+	55 (72.4)	21 (27.6)	
Partner's consent			
Yes	60 (82.2)	13 (17.8)	=0.580
No	46 (76.7)	14 (23.4)	

Source: Field data, 2013.

When respondents employment status was compared with the number of times they had induced abortion, it was realized that majority of both employed and unemployed respondents (89.7% and 56.6% respectively) had induced abortion once. However, the

number of employed respondents who had induced abortion once was about three times the number of unemployed respondents who had induced abortion once. A chi-squared test to determine the relationship between the two variables revealed that there is a significant association between respondents' employment status and the number of times they had induced abortion ($p<=0.001$) at 95% confidence level as shown in table 10.

A comparison between marital status and number of induced abortions revealed that 146 respondents were single constituting the majority. Irrespective of the number of times of induced abortions, single women were of the majority in each category. Test of significance disclosed that marital status has no association with number of times respondents had induced abortion ($p=0.064$) at 95% confidence level.

When respondents were asked about their age at first sex, there was a response rate of 98.8 percent because two respondents refused to answer the question. Out of those who responded to the question, 80.4% pointed out that they had their first sex between 15 and 19 years and 16.5% reported having had their first sex within the ages of 10 and 14 years.

Table 9: Association between other reproductive variables and number of induced abortions

Variables	Number of induced abortions		P value
	1 n (%)	1+ n (%)	
Age @ first sex			
10-14	16 (61.5)	10 (38.5)	<=0.001
15-19	106 (83.5)	21 (16.6)	
20-24	4 (80)	1 (20)	
Weeks before termination			
< 5 weeks	48 (94.1)	3 (5.9)	
5-8 weeks	47 (70.1)	20 (29.9)	<=0.001
9-12 weeks	24 (70.6)	10 (29.4)	
13+ weeks	7 (87.5)	1 (12.5)	

Source: Field data, 2013.

The study further revealed that 74% of respondents aged 15 -19 years had first time sex within that same year group while 26% had first time sex within the 10-14 year group. Also, 89% of respondents aged 20-24 years had first time sex within the 15-19 year group. In sum, majority of the respondents had first time sexual activity within the ages of 15-19.

When respondents' age was analyzed with the number of times they had induced abortion, it was realized that the earlier respondents had sex, the more likely they were to get pregnant and induced abortion (p=0.001). Moreover, of those who were aged 15-19 years, majority (84 percent) had induced abortion once, while of those who were aged 10-14 years, majority (62 percent) had induced abortion once. In sum, majority (80%) of the respondents had induced abortion once accounting for 62% of respondents whose age at

first sex was 10-14 years, 84% of respondents whose age at first sex was 15-19 years and 80% of respondents whose age at first sex was 20-24 years.

The ages of pregnancy before termination varied from 4 weeks to 17 weeks. According to this study, most pregnancies were terminated within 5 to 8 weeks. Pregnancies less than 5 weeks recorded about 32% being the second highest range within which pregnancies were terminated. By the 8^{th} week, most of them had terminated their pregnancies but with 21 percent aborting within the 9^{th} and 12^{th} week as shown in table 10. The chi-squared test revealed that age of pregnancy was significantly associated with abortion ($p=0.001$) at 95% confidence level. This means that the younger the pregnancy, the less likely it would be terminated.

Respondents were also asked about how they got to know they were pregnant. The responses gathered revealed that 22.5% of the respondents got to know they were pregnant after they had done a pregnancy test compare with the majority (52.5%) who realized they were pregnant after they missed their menstrual period. Vomiting or nausea recorded the least with about 11% of the respondents indicating that they got to know they were pregnant after experiencing these symptoms over a period. About 14 percent of the respondents indicated that because they had been pregnant before, their previous experience was what prompted them about their pregnancy which.

Table 10: Pregnancy and abortion experiences

Variable	Frequency	Percent
Knowledge about pregnancy		
Delayed menses	84	52.5
Pregnancy test	36	22.5
Vomiting/Nausea	18	11.25
Previous experiences	22	13.75
Total	160	100
Partner's consent		
Yes	73	54.9
No	60	45.1
Total	133	100
Person informed		
No one	87	54.4
Friend/ Relative	69	43.1
Other	4	2.5
Total	160	100
Amount paid (GH¢)		
<25	47	32.6
25-49	82	56.9
50+	15	10.5
Total	144	100
Person who paid		
Self	77	53.5
Partner	49	34
Friend/Relative	18	12.5
Total	144	100

Source: Field data, 2013.

The study revealed that about 81% of respondents informed their partners about the pregnancy while about 19% did not, being responses from 159 out of the 160 respondents. On whether or not partners gave their consent to abortion upon being informed about the abortion, the study recorded a response rate of 83.1% out of which 55

percent reported “yes” and 45% reported “no” as depicted by table 11. Thus of the partners who were informed about the pregnancy, 56.6% gave their consent for abortion. A test for association at 95% confidence level revealed a significant association between partners who were informed about pregnancy and partners who gave their consent for abortion (p=0.001) at 95% confidence level.

The study further showed that apart from respondents’ partners, other significant others were informed about their pregnancy. Of these, the majority (30.6%) were friends while relatives recorded 12.5%. About 54% of respondents reported never sharing the knowledge of their pregnancy with anyone as shown in table 11.

The amount paid for abortion ranged from GH¢ 1.50 to GH¢ 300.00. With a response rate of 90% to the question of amount paid for abortion, majority of the respondents (about 57%) reported spending between GH¢ 25.00 to GH¢ 49.00 on their abortion with the modal amount recorded as GH¢ 25.00 which recorded 25.7% of all responses. About 33% also paid less that GH¢ 25.00 for their abortion as shown in table 11. Of the amounts paid in table 15, the study showed that majority of the respondents (about 54%) paid the money themselves while 34% indicated that their partners paid for them. Although most of the respondents informed their friends about the pregnancy, only 4.2% of respondents reported that their friends paid for them.

Respondents were further asked if they will induce abortion should they have an unwanted pregnancy in the future for which about 80% of the respondents said they

would not go in for abortion even if they have an unplanned pregnancy but 19% were still willing to go in for abortion notwithstanding the fact that they had experienced complications in their current abortion as shown in table 11. It was further revealed that majority (83%) of those who had induced abortion once as well as majority (70%) of those who had induced abortion twice were not going to induced abortion even if they had an unplanned pregnancy. Therefore, a test was done for an association between number of induced abortions and decision on future unplanned pregnancy. The test disclosed that there was no association between number of induced abortions and decision on future unplanned pregnancy at 95% confidence level ($p=0.076$).

CHAPTER FIVE

DISCUSSION

5.0 Introduction

This chapter discusses the findings of this study in relation to relevant literature in the field of study. The issues are discussed under the headings; characteristics of women having abortion, knowledge on abortion, reasons for abortion and factors that relate to abortion.

5.1 Characteristics of women having abortion

The great majority of respondents were young and single, presenting a typical pattern found in other studies of young women wanting to delay childbearing until they are married or have furthered their education (Aniteye, 2002; Ampofo, 1970; Bankole et al., 1998; Sundaram et al., 2012). This study showed a very young population of respondents with as much as 94% of respondents aged between 15 and 24 years with the 15-19 and 20-24 year groups accounting for 53% and 41% respectively and 91% of respondents being single. These findings support the results of a study to develop a profile of abortion seekers in Ghana and their decision-making processes which showed a mean age of 25 years with 59 percent of clients being young adults: 18 percent and 41 percent in the 14-19 and 20-24 age groups respectively (Nyarko et al., 2008). Also, a study on the factors associated with induced abortion among women in Hohoe, Ghana conveyed a mean age of 29.9 years (Mote. et al., 2009). Sedgh (2010) also reported that abortion incidence in

Ghana is high among 20-24 year olds. Another study at the Komfo Anokye Teaching Hospital also found that most of the abortion patients were aged between 20 to 24 years (26.5%) and 25 to 29 years (25.9%) (Turpin et al., 2002). Oliveras et al. (2008) also reported that among antenatal clinic attendees in Accra, women reporting past abortion experience were younger and more likely to be single (Schwandt, 2011). This study also reflects a population-based study in Ghana which reported that the majority of women who reported having induced abortion were younger than 30 years, nulliparous and more likely to be Christian than Muslim (Ahiadeke, 2001). This supports findings that suggest that clients seeking abortion care in Ghana are mostly between the ages of 15 and 29 years.

Many other researchers have shown that induced abortion complication patients tend to be younger and poorer (Bankole, 2008; Sundaram et al. 2012) and that adolescents and single women are at particularly high risk of unsafe abortion (WHO, 2007; Berer, 2000; Bankole et al., 1999; Munasinghe and van den Broek, 2005, Schwant, 2011). Findings from this study, however, showed that most respondents were employed although most were young. The findings that women in non-marital unions are more likely to choose induced abortion may support the fact that single women have fewer options when faced with unplanned pregnancies.

The GDHS (2008), however, reported that 59% of women in Ghana were married compared with 32% who had never married. A similar study in Hohoe, Ghana indicated that 58.8% of respondents were married. Turpin et al. (2002) also found that majority

(79.9%) of abortion patients were married. These variations can be explained by the fact that the median age at first marriage in Ghana has been consistently higher among women in urban areas and women with higher levels of education – as depicted by this study – than those in rural areas and women with little or no education (GDHS, 2008).

According to this study, most of the respondents had not attained senior high education and the majority (97.5%) had less than tertiary education. However, the study found that few (5%) respondents had no formal education which is very much less than the findings of the GDHS (2008) showing 21% of women have no education. This could be influenced by the fact that the study was conducted in an urban centre. Also, the study showed about 24% and 69% of respondents have primary and secondary education respectively which is a little higher than the findings of the GDHS (2008). Again, this could be influenced by the fact that the study was conducted in an urban environment where primary and secondary education could be widely available and reflects the findings of a study in Ghana which showed that clients who patronized abortion services were quite well educated; two-fifths (37%) had had middle or junior secondary school education while about a third had received senior secondary or higher level education (Nyarko et al., 2008). Mote et al. (2009) also showed that at least 65.4% of respondents had completed basic education which is higher than the findings of this study although both studies were conducted in an urban centre. The reason for the variance, however, could be the fact that this study was hospital-based while Mote et al.'s work was population-based.

Other researchers have also reported on characteristics associated with induced abortion patients that were not predictors of induced abortion patients such as higher parity (Henshaw et al., 2008) or lower parity (Adanu et al., 2005), more education (Lema et al., 1996) and greater ever use of contraception (Bankole, 2008; Mosoko et al., 2004). The differences between the population-based studies and the data reported here may be explained by the fact that this study is hospital based; therefore, it is selective in that it only included women who had complications of an induced abortion.

On the economic status of respondents, the study showed that 33% of respondents were unemployed compared to 67% who were employed. It conforms to a study on the profile of abortion seekers in Ghana which showed a less number of respondents (16%) were unemployed with 12% as students (Nyarko et al., 2008). However, the findings disagree with a study that showed that as much as 70.4% of abortion seekers were unemployed (Mote et al., 2009) and Sundaram et al. (2012) which reported that poor women are at greatest risk of obtaining an unsafe abortion and experiencing injury or death. The variance could be explained by the differences in study population.

The study showed that majority of the respondents (61%) were Christians which reflects a study in Hohoe, Ghana that indicated majority of respondents (93%) as Christians (Mote et al., 2009). A study in southern Ghana also found that Christian women were more likely than Muslim women to seek an abortion (Ahiadeke, 2001).

Sundaram et al. (2012) also suggest that women aged 20-29 years are more likely to seek an abortion than those aged 30 years and abortion seekers are more likely to be single, working or in school and therefore be more likely to have pregnancies that are unintended. Women in their 30s may have pregnancies that are wanted and within marriage. Since young adult women have a greater share of all pregnancies, they are also more likely to have a greater share of unintended pregnancies. This may prompt women to seek an abortion. This would also explain why women who have no children are more likely to seek an abortion as depicted in this study– these may be out-of-wedlock pregnancies (Sundaram et al., 2012).

In sum, this study supports findings that suggest that clients seeking abortion care in Ghana are mostly young adults between the ages of 15 and 29 years. Many other researchers have shown that induced abortion complication patients tend to be younger and poorer and that adolescents and single women are at particularly high risk of unsafe abortion. However, other studies report otherwise and suggest that most abortion seekers were married and used abortion as a method of birth control. These variations can be explained by the fact that the median age at first marriage in Ghana has been consistently higher among women in urban areas and women with higher levels of education – as depicted by this study – than those in rural areas and women with little or no education (GDHS, 2008).

5.2 Knowledge on abortion

Safe abortion remains a barrier due to the low level of knowledge on the abortion law. The GMHS (2007) found that only 4% of women thought that abortion was legal in Ghana. Even among women with at least secondary education, only 11% were aware that abortion is legal under certain circumstances. A study among medical professionals also revealed that, only 54% of physicians were aware that abortion is legal if indicated to preserve the health of the woman (Morhe, 2007). In a study assessing the knowledge and attitudes of a group of Ghanaians surveyed in the Northern Region, only 3% of women reported that abortion is allowed according to the law in Ghana, 43% thought it was illegal and 54% did not know whether or not it was legal (Pathfinder International, 2009). According to the same study, 13% of men believed abortion was legal, 61% thought it was illegal and 27% did not know (Pathfinder International, 2009). This study also suggest a high level of ignorance on the abortion law as irrespective of respondents' socio-demographic characteristics like age group, educational status or religious background, only 4% of the respondents knew any law on abortion. All those who knew abortion in Ghana was liberal mentioned the media as their source of knowledge. However, none of them were able to state anything about the law which further signifies a high level of ignorance on the legality of abortion.

Due to the low level of knowledge on the abortion law and social deprivation, many women and men in Ghana do not realise that abortion has been made legal under certain conditions for decades in Ghana. They, therefore, do not know their legal rights to safe

abortion (Morhe and Morhe, 2006). The low level of knowledge and poor understanding of the accessibility of legal abortion contribute to the high degree of stigma attached to abortion in Ghana. Traditional and cultural values, social perceptions and religious teachings have produced negative perceptions of abortion (Lithur, 2004). Grimes et al. (2006) recognised that in addition to the negative views about abortion, the stigma associated with abortion in some third world nations resulted in the practice of clandestine, unsafe abortions even when legal services are available. Although knowledge on the abortion law is very poor in Ghana and abortion is usually stigmatized, it appears that many people consider it acceptable under certain conditions. Conditions respondents gave included rape, defilement, incest, among others. However, 17% of respondents thought that abortion should not be permitted under any circumstance. This quite varies from findings of Henry and Fayorsey (2002) which showed that nearly all respondents described situations such as being in an unstable relationship or not having enough money to raise a child in which they considered abortion to be acceptable. The study also found that as most respondents were not aware of any law on abortion, most of them were not aware that an abortion could be sought from a hospital.

5.3 Reasons for abortion

When a woman becomes pregnant, she must make a decision as to whether she is ready and willing to bring a new life into the world or not. The decision making is a complex approach affected by many factors. It is typically motivated by multiple, diverse and interrelated reasons (Finer et al., 2005). The root cause of most induced abortions is

unintended pregnancy which occurs when a woman is unable to time or limit her childbearing (Sundaram et al., 2012). The GDHS (2008) reports that 35% of married women and 20% of sexually active women have an unmet need for contraception; that is, they do not want a child soon or at all but are not using a contraceptive method. As a result, 37% of all pregnancies in Ghana are unintended: 23% are mistimed and 14% are unwanted.

This study found that none of the pregnancies reported by respondents were planned. They all indicated that they did not intend to have a baby as at the time they got pregnant and that was why they decided to terminate the pregnancy. For most of them (79%) - aged between 15 and 24 years - it was their first pregnancy but because it was not planned, they opted for termination. This supports studies that age could be a reason for a woman to terminate a pregnancy and avoid the stigma attached to childbirth out of wedlock. This study further identified reasons why women have abortion to include: not ready for a baby/married (24.4%), partner's refusal/recommendation (24.4%), financial constraints (19.4%) and not to disrupt her work/education (16.3%).

Similar findings on the reasons why women decide not to have a child revealed that for 39.7% of clients, the pregnancy was either mistimed or unwanted either by themselves and 19.8% by their partners or other family members while for 16.4% of them, they needed to get rid of the pregnancy so that they could continue with their work or education (Nyarko et al., 2008). The study supports findings by Mote et al. (2009) which gives reasons why women have abortion to include cannot cater for a baby, too young to

have children and not to disrupt education or job. Also, wanting to continue work or school has been shown in previous literature in studies by Adanu et al. (2005). In Finer et al. (2005), the reasons most frequently cited were that having a child would interfere with a woman's education, work or ability to care for dependents (74%); that she could not afford a baby now (73%); and that she did not want to be a single mother or was having relationship problems (48%). In finer et al. (2005) nearly 4 in 10 women said they had completed their childbearing, and almost one-third were not ready to have a child. Less than 1% said their parents' or partners' desire for them to have an abortion was the most important reason. Younger women often reported that they were unprepared for the transition to motherhood, while older women regularly cited their responsibility to dependents. However, findings from the study disagree with previous research by Sundaram et al. (2011), Baiden et al. (2006), Aboagye et al. (2007) and Blanc and Gray (2002) which suggests that abortion is used widely to space or limit childbearing although they also cited being financially unable to take care of a child and needing to delay childbearing in order to continue schooling or work as some of the reasons women opt for abortion. This could, however, be attributed to the difference in parity in study population.

5.4 Methods and Providers of abortion

Studies have produced conflicting evidence regarding the types of providers women turn to and the procedures they undergo to terminate a pregnancy. According to this study, majority (88%) of respondents induced their abortions at home while few (6%) sought

help from a hospital/clinic/private maternity. According to this study, none of the respondents sought the help of a physician to perform an abortion. Pharmacists were the most sought providers of abortion according to this study while friends and partner recorded 14% and 21% respectively.

However, data from the GMHS (2008) showed that many women who procure abortions do so with the help of a doctor and in a hospital setting, although significant proportions do not undergo the safest procedures available (GSS et al., 2009; Sedgh, 2010). The GMHS (2008) reported most women (57%) sought a doctor to perform an abortion, 16% went to a pharmacist or chemical seller, and 19% turned to a friend or relative or induced the abortion themselves (GSS et al., 2009; Sedgh, 2010). The remaining women sought the help of a traditional practitioner (4%) or a nurse, midwife or auxiliary midwife (3%) but this study did not record traditional practitioners as a source or provider of abortion. Among women reporting on their most recent abortion in the five years before the survey, 40% underwent dilation and curettage (D&C) (GSS et al., 2009; Sedgh, 2010).

In contrast to the GMHS (2008), a 1997–1998 study in southern Ghana found that only about 12% of women who obtained an abortion did so with the help of a physician (Ahiadeke, 2001; Sedgh, 2010). According to Ahiadeke (2001), more than two-thirds of women who sought an abortion turned to an untrained provider or induced the abortion on their own (Sedgh, 2010).

Also, most of the respondents from this study reported using misoprostol (cytotec) as the oral medication used in causing the abortion. Other methods or instruments were

herbs/home-made concoctions (13.8%) and inserting and oral medicine (11.2%). Findings from other studies also suggest that misoprostol (cytotec) is widely used in causing abortion including findings from a pilot study on medical abortion recently conducted in two hospitals in Ghana that found an overwhelming up-take of both Mifepristone and Misoprostol (Blum et al., 2007). Unlike this study, data from the GMHS (2008) showed only 16% of women said they terminated their pregnancy by taking tablets, and about 6% of women specified that they took misoprostol (cytotec) tablets (GSS et al., 2009; Sedgh, 2010). Less common methods included inserting an object, herbs or other substances in the vagina; receiving an injection; and drinking an herbal concoction (GSS et al., 2009; Sedgh, 2010) which is similar to findings from this study.

In sum, this study supports similar studies that reported that majority of women self induced abortion or turned to an untrained provider. However, some studies have also shown that most abortion seekers sought a physician to perform abortion while others report that few sought abortion from a physician which wasn't the case in this study. It is possible that the reason for the discrepancy between the studies is that respondents in the GMHS underreported abortions obtained through dubious means, while reporting more fully on abortions performed by medical professionals. By contrast, induced abortions and their circumstances among respondents from this study could assume legitimacy because respondents were recruited in a health facility after they had suffered complications from inducing abortion.

5.5 Factors related to abortion

Majority of the respondents from this study had their first sexual activity within their late teens thus between 15 and 19 years. About 74% of respondents aged 15 -19 years had first time sex within that same year group while 26% had first time sex between 10 and 14 years. Also, 89% of respondents aged 20-24 years had first time sex within the 15-19 years. It was realized that most respondents started sexual activity at a tender age and could suggest why most of them were still young. The GDHS (2008) suggest that women are likely to experience first sexual intercourse at an earlier age where 8% of women reported having engaged in sexual activity by age 15 and 44% by age 18 (GSS et al., 2009).

Ghana's contraceptive prevalence rate (CPR) is still too low (Geelhoed et al., 2002; Ahiadeke, 2005). Many studies have found that for most abortion patients, knowledge, ever-use, and current use of contraception were low (Okonofua et al. 1992). Also, recent data reveal that among women who experienced an induced abortion between 2002 and 2007, about 70% failed to use a method prior to the terminated pregnancy (GSS et al., 2009). Bongaarts and Westoff (2000) stated that low prevalence of contraception and effectiveness could lead to unintended pregnancies and induced abortion. Therefore, once there is no knowledge of, or a dislike for contraception, or use is inconsistent among sexually active women, the result will be an unintended pregnancy (Biney, 2011). The only other alternative in controlling births would be to terminate pregnancies as they occur. Results from the study seem to suggest this, and also that some of the interviewed

women may have used induced abortion as a form of birth control. Firstly, some participants had no knowledge of contraception prior to the abortion; hence abortion was the only means they knew through which to control births. Secondly, those who mentioned they had used contraception prior to the abortion may have used it inconsistently resulting in the unwanted or mistimed pregnancy (Biney, 2011). This study showed that only 14% of respondents were using a contraceptive at the time they got pregnant and suggests inconsistency in the use of the contraceptive as the reason they could have become pregnant.

The cost of safe abortion is a significant barrier to its access. Due to the clandestine nature of abortion services and the lack of clarity about legality, many doctors charge additional fees, saying they are taking a professional risk in performing abortions (GHS, 2005). Even if a public facility offers abortion, the cost relative to the income of most Ghanaians means it is out of reach (GHS, 2005). Moreover, the cost of abortion-related complication is a far more burden than the cost of a safe abortion. The burden of unsafe abortion is very huge and the cost implications very high. Moreover, abortion as permitted by law is not covered under the National Health Insurance Scheme introduced in Ghana in 2004. About 54% of respondents from this study paid the money themselves with 57% paying between GH¢ 25.00 and GH¢ 50.00. Another study found that women in three sub-Saharan African countries at tertiary hospitals were more likely to pay for the abortion complication hospital bill themselves, as opposed to anyone else — including their partners (Kinoti et al, 2004; Schwandt, 2011). An in-depth study in Accra reported

that women pay between GH¢ 3.00 and GH¢ 30.00 for a hospital or private clinic abortion (Henry and Fayorsey, 2002). As a result, poor women may be forced to seek risky abortions from untrained providers (Sedgh, 2010). More generally, it has been reported that a safe abortion is prohibitively expensive for many women because few practitioners are available to perform the procedure, and they charge very high fees (Morhe and Morhe, 2006). Sedgh (2010), reports that some providers still impose stiff fees because they know that the women who come to them are desperate. Women in Accra pay anything from $9 to $90 for an abortion in a hospital or private clinic according to a 2002 study by US doctors.

In sub-Saharan Africa, Ghana inclusive, males are recognized as heads of the households and principal decision makers in regard to fertility (DeRose et al., 2005; Dodoo et al., 2008; Schwant, 2011). Furthermore, past research has shown that, in Ghana, women's fertility intentions were affected by their partners' intentions (Ezeh, 1993; Schwant, 2011). This study revealed that most of the respondents (81%) informed their partners about the pregnancy. Of the partners who were informed about the pregnancy, 56.6% gave their consent for abortion. Browner (1979), reported that it was the response of the man and not that of other kin that had direct bearing on their decision. They usually discussed their plans with their partners before any action. Also, men in Uganda are often highly involved in the decision to induce an abortion (Nyanzi et al., 2005; Schwandt, 2011).

Despite males' reported dominance in fertility-related decision making, the 2008 GDHS reported that some women identify themselves as having the “final say” on four general household decisions (GSS et al. 2009; Schwant, 2011) while in Nigeria, nearly half of all women studied made the decision to abort themselves (Oye-Adeniran, 2004; Schwandt, 2011). Findings from this study also showed that a little over half (54%) of respondents reported never sharing the knowledge of their pregnancy with anyone. While data on why women choose not to disclose are not available in this study, other research sheds some light on this topic. Also, in Schwandt (2011), significantly more women chose not to disclose their pregnancy to their male partners.

In sum, the study revealed that if a woman had suffered complications from a previous abortion, she was less likely to induce another abortion. Also the younger a woman was, the more likely she was to abort a pregnancy. The age of the pregnancy before termination and employment status of respondents were also associated with abortion as the younger the foetus, the more likely it was to be aborted. However, level of education, religion, number of children and marital status of respondents were not found to be associated with abortion.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

This chapter summarises the key findings of the study and makes recommendations for further action.

6.1 Conclusion

This study was a descriptive study on the factors associated with decision making on induced abortion among women with abortion complications. Data was collected from 160 women who had been admitted at the Komfo Anokye Teaching Hospital using questionnaires and was analysed descriptively using SPSS version 16.

Findings from this study revealed that majority of respondents were young, single, nulliparous and Christians. Most of them had not attained SHS education but only few had no formal education. Findings from this study, however, showed that most respondents were employed although most were young. The findings that women in non-marital unions are more likely to choose induced abortion support the fact that single women have fewer options when faced with unplanned pregnancies.

The study showed a low level of knowledge among respondents which supports data from many studies on abortion especially in countries where abortion is restricted by law. Respondents did not know their legal right to safe abortion as a result of lack of knowledge and poor understanding of the accessibility of safe abortion and the state of

abortion in Ghana as permitted by law. That notwithstanding, most of them thought abortion should be permitted on broad grounds including rape, incest, defilement, teenage and unwanted pregnancy and where women cannot cater for a/an additional child.

Findings from this study further showed that none of the pregnancies that was induced by respondents in this study was planned but only few were using a contraceptive at the time of conception. Although most of them had ever heard about contraceptive, just about half had ever used a contraceptive method. Reasons respondents gave for inducing abortion, according to this study, were: not married/ready for a child, financial constraints/inability to cater for a baby, not to disrupt work/education and partner's recommendation/refusal to accept responsibility.

According to this study, most respondents induced their abortion at home but none of them sought the help of a physician. Also, pharmacists were the most sought providers of abortion methods according to this study. Misoprostol (cytotec) was the medication mostly used to cause abortion according to this study.

Findings from the study seem to suggest a low CPR as a few respondents were using a contraceptive method at the time they got pregnant. Moreover, some participants had no knowledge of contraceptives prior to the study and for those who had ever used a contraceptive, only a few were still using it. Also, inconsistent use may have resulted in pregnancy. The study also found that men are principal decision makers with regards to abortion as most respondents informed their partners about their pregnancy while more

than half of partners gave their consent for abortion and in most cases recommended abortion. Age of women, previous abortion experience, employment status and age of pregnancy before termination were found to be associated with decision to have an abortion. On the other hand, education, marital status, religion and number of children were not found to be associated with decision to have an abortion.

6.2 Recommendations

Recommendations of this study are made according to the findings of the study. Due to the low level of knowledge on the abortion law, human rights activists must make it a focal point to advocate for effective campaigns and education to raise the awareness of the legal status of abortion in Ghana. Also, the Ministry of Health (MOH), Ghana Health Service (GHS), the Ministry of Education, the National Commission for Civic Education (NCCE) and other stakeholders like Chiefs and Queen mothers, opinion leaders and the national and private media should educate and sensitize the Ghanaian public on the legal status of abortion. If women are aware that abortion can be sought in a safe way, many unsafe abortions, post abortion complications and deaths due to unsafe abortion will be avoided. Also, knowledge on the abortion law will go a long way to reduce the stigma associated with abortion and in turn reduce the incidence of clandestine, unsafe abortions.

As one of the countries with fairly liberal laws on abortion, Ghana stands a better chance of making substantial progress in achieving MDG 5. However, there is still the need to intensify programmes and policies intended to address unmet need for contraceptives and

unsafe abortion so as to save women's lives and improve maternal and reproductive health if this progress will be possible. It is imperative to address the unmet need for contraceptives and barriers to contraceptive use. As indicated earlier, the root cause of abortion is unplanned or unintended pregnancy. In Ghana, contraceptive use has not kept up with the desire for smaller family size. There is an unmet need for family planning. According to the GDHS (2008), women currently have 4 children instead of the 3.5 which they want to have. A range of contraceptive options should be made available and accessible to women while intensifying education on contraceptive options and its side effects. This will go a long way to reduce the number of unplanned/unintended pregnancies and reduce the incidence of unsafe abortion. The unmet need for family planning is also worrying especially given the high levels of knowledge on contraceptives in Ghana. There is, therefore, the need for more qualitative research among women undergoing unsafe abortions to find out more about why they are not using family planning.

The Ministry of Health (MOH), Ghana Health Service (GHS), the National Commission for Civic Education (NCCE) and other stakeholders need to organize public sensitization campaigns on the dangers of self inducing abortions and resorting to using non-qualified providers of abortion to reduce morbidity and mortality from inserting herbs and non-medical instruments or conducting abortions in unhygienic conditions. If unsafe abortions are ever to be reduced, women need to know they can legally access safe abortion services at proper health facilities and to know that they will receive non-judgemental

treatment by providers. Only in this way will women be empowered to take choices that will not needlessly endanger their lives.

While carrying out educational campaigns, the GHS should extend Comprehensive Abortion Care (CAC) to all districts in the region in order to promote access to safe and legal abortion services. Another important way of reducing unsafe abortions is to make medical abortion safely and widely available, for example through pharmacists trained to give proper instructions and advice, so that women know they can go to a pharmacist for pills they can take at home in the early weeks of pregnancy, instead of resorting to herbal concoctions and treatment from quacks. Medical abortion should also be provided for under the National Health Insurance Scheme (NHIS) to the extent stipulated by the law.

Additionally, there is the need to conduct more research in the field of abortion and unsafe abortion. Research evidence on the impact of effective family planning and contraceptive use in preventing unplanned pregnancies and unsafe abortion; the barriers to the implementation of the abortion law and the cost of Comprehensive Abortion Care compared to the cost of unsafe abortion and its complications will go a long way to inform policy recommendation and develop the political will in implementing policies.

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APPENDIX

QUESTIONNAIRE

PART A – SOCIO-DEMOGRAPHIC CHARACTERISTICS OF WOMEN

1. Age [ ]

2. Level of education
   [ ] No formal education
   [ ] Primary
   [ ] Junior High School
   [ ] Senior High School
   [ ] Tertiary
   [ ] Other, Please specify……

3. Employment status
   [ ] Unemployed
   [ ] Employed

4. Marital status
   [ ] Single
   [ ] Married
   [ ] Divorced/Separated
   [ ] Consensual union

5. Number of children [ ]

6. Intended number of children [ ]

7. Area of residence
   [ ] Rural
   [ ] Urban

8. Religion
   [ ] Christianity
   [ ] Islam
   [ ] Traditional
   [ ] Other, please specify ……

9. Ethnicity ……

PART B - SOCIO-ECONOMIC STATUS OF PARTNERS

10. Age [ ]

11. Level of education
[ ] No formal education
[ ] Primary
[ ] Junior High School
[ ] Senior High School
[ ] Tertiary
[ ] Other, Please specify……

12. Employment status
[ ] Unemployed
[ ] Employed

13. Number of children (if different) [ ]

14. Area of residence (if different)
[ ] Rural
[ ] Urban

PART C – WOMEN'S KNOWLEDGE ON ABORTION

15. What do you understand by induced abortion?
……
……
……..

16. Under what circumstance do you think abortion should be permitted?
……
……
……

17. Do you know about any law on abortion in Ghana? [ ] Yes [ ] No

18. If yes, from where did you get this information? ……....

19. If yes, what do you know about the law?
……
……
……..

20. Are you aware of any safe abortion services? [ ] Yes [ ] No

21. Do you know any methods or instruments used for abortion? [ ] Yes [ ] No

22. If yes, please name some of them……

23. Have you ever heard about contraceptives? [ ] Yes [ ] No

24. Have you ever used a contraceptive? [ ] Yes [ ] No

25. Were you using any contraceptive at the time you got pregnant?
[ ] Yes [ ] No

26. If yes, what method were you using? .....

PART D – REASONS FOR INDUCED ABORTION

27. How many times have you had an induced abortion? [ ]

28. Have you ever had complications from abortion? [ ] Yes [ ] No

29. Where did you have your current induced abortion? [ ] Home
[ ] Hospital/Clinic
[ ] Private maternity home
[ ] Other, ...

30. Why did you decide to terminate this pregnancy?
……
……
……

31. What method did you use? [ ] Oral medication
[ ] Herbs
[ ] Home-made concoctions
[ ] inserting medicines
[ ] Other, ...

32. Why did you choose that method?
……
……
……..

33. Were you aware that the method causes complications? [ ] Yes [ ] No

34. Which provider/venue/source did you go to for the method?

[ ] Friend
[ ] Partner
[ ] Relative
[ ] Pharmacist
[ ] Other, ...

35. Why did you decide on the provider/venue/source?

……
……
……

36. With whom did you make the decision? [ ] Friend
[ ] Partner
[ ] Relative
[ ] No one
[ ] Other, ...

PART E - FACTORS RELATED TO DECISON MAKING

37. Age at first sex [ ]

38. How old was the pregnancy before termination? [ ] weeks

39. How did you know you were pregnant? [ ] Delayed menstrual period
[ ] Pregnancy test
[ ] Vomiting/Nausea
[ ] Previous experience
[ ] Other, ...

40. What was your reaction upon realising you were pregnant?

[ ] Happy
[ ] Unhappy
[ ] Scared
[ ] Surprised
[ ] Other, ...

41. Did you tell your partner about the pregnancy? [ ] Yes [ ] No

42. Did he consent to the induced abortion? [ ] Yes [ ] No

43. To what extend was he involved in the induced abortion decision making?

[ ] Provided emotional support
[ ] Provided financial support
[ ] Both

44. Which other person did you tell about the pregnancy?

[ ] None
[ ] Friend
[ ] Mother
[ ] Sister
[ ] Other, ...

45. How much did you pay? [GH¢]

46. Who paid for you? [ ] Friend
[ ] Partner
[ ] Relative
[ ] Self
[ ] Other, ...

47. Would you opt for induced abortion should you have an unplanned pregnancy?

[ ] Yes [ ] No [ ]Not sure

48. Why?

……
……
……

49. Briefly describe your induced abortion experience.

……
……
……

50. What is your general perception on induced abortion?

……
……
……

THANK YOU