

UNIVERSITY OF CAPE COAST

PERCEPTIONS OF SENIOR HIGH SCHOOL GIRLS IN THE  
NEW JUABEN MUNICIPALITY ON LEGALISATION OF  
ABORTION IN GHANA

BLISS DZIEDZORM ADDO

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ABORTION IN GHANA

BY

BLISS DZIEDZORM ADDO

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of the Faculty of Education, University of Cape Coast, in partial fulfilment of the  
requirements for award of Master of Philosophy Degree in Health Education

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## DECLARATION

### Candidate's Declaration

*I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.*

Candidate's Signature: ..... Date:.....

Name: Bliss Dziedzorm Addo

### Supervisors' Declaration

*We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.*

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Co-supervisor's Signature ..... Date:.....

Name: Dr. Joseph K. Ogah

## ABSTRACT

The study investigated the perceptions of Senior High School girls in the New Juaben Municipality on legalisation of abortion in Ghana. Four research questions were posited to guide the descriptive survey design. A combination of purposive, stratified and simple random sampling techniques were used to select the sample size of 455 girls from the schools in the municipality. A self-constructed questionnaire was used to collect data. The data were analysed using descriptive statistics of frequencies, percentages and tables. The study revealed that SHS girls had inappropriate knowledge of methods of abortion, but adequate knowledge of safety methods (mixture of sugar and Guinness, n = 235), venues (clinic, n = 408) and providers of abortion (medical doctor, n = 419). They resort to abortion to enable them continue with their education (n = 218). They considered abortion not to be a right and suggested that it should not be legalised but only provided at the government hospital (n = 272) without the NHIS covering it (n = 370). The students' perception about legalisation of abortion is that abortion is not a right and should not be legalised. It is recommended that the Government through the National Commission for Civic Education should educate SHS students on the abortion law in Ghana so that individuals will know what is required of them on issues connected with abortion.

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## **DEDICATION**

To my dear parents, Mr. Anthony Futukpor and Miss Ruby Adio and my siblings, Selorm, Kekeli and Selase, for their love, understanding and support.

## TABLE OF CONTENTS

	Page
DECLARATION	ii
ABSTRACT	iii
ACKNOWLEDGEMENTS	iv
DEDICATION	v
LIST OF TABLES	x
LIST OF FIGURES	xi
CHAPTER	
ONE INTRODUCTION	1
Background to the Study	1
Statement of the Problem	4
Purpose of the Study	5
Research Questions	5
Significance of the Study	5
Delimitation of the Study	6
Limitations of the Study	6
Definition of Terms	7
Organisation of the Rest of the Study	7
TWO REVIEW OF RELATED LITERATURE	8
Theoretical Framework	9
Concept of Abortion	10
Definition of Abortion	10
History of Abortion	12

Types of Abortion	13
Complications of Abortion	20
Gestational Age Limit	24
Dilemma of the Pregnant Adolescent	25
Developments in Reproductive Rights in Africa	26
Reasons why Adolescents seek Abortion	28
Legalisation of Abortion	29
Abortion Laws	30
Abortion Law in the USA	37
History of Abortion Legalisation in Africa	39
Abortion in Ghana	42
Abortion Legalisation	43
Advantages and Disadvantages of Legalising Abortion	47
Developments in Abortion Legalisation in Africa	48
Abortion: Should it be Legalised?	50
Socio-Cultural aspects of Adolescent Pregnancy	56
Cultural aspects of Adolescent Pregnancy	57
Abortion: The link between Legality and Safety	59
Studies related to Abortion	62
Studies related to Knowledge on Abortion	68
Minors' Opinions and Perceptions about Abortion	71
Abortion Legalisation within a Human Rights Framework	72
Reproductive Health and Human Rights	74
Summary of Literature Review	81



THREE METHODOLOGY	84
Research Design	84
Population	85
Sample and Sampling Procedure	86
Instrument	87
Data Collection Procedure	88
Data Analysis	89
FOUR RESULTS AND DISCUSSION	91
Research Question 1: What is the Knowledge Level of SHS Girls on Abortion Practices?	91
Research Question 2: Why do SHS Girls seek Abortion when they are Pregnant?	97
Research Question 3: What is the Knowledge Level of SHS Girls on Abortion Law?	99
Research Question 4: What is the Perceptions of SHS Girls about Legalisation of Abortion?	101
FIVE SUMMARY, CONCLUSIONS AND RECOMMENDATIONS	108
Summary	108
Overview of the Study	108
Key findings	109
Conclusions	110
Recommendations	110
Suggestions for Further Research	111
REFERENCES	112

APPENDICES	129
A QUESTIONNAIRE FOR STUDENT GIRLS	129
B PERMISSION TO CONDUCT RESEARCH	135

## LIST OF TABLES

Table		Page
1	Students' Awareness of Methods of Abortion	92
2	Students' Views on Safety of Methods of Abortion	93
3	Students' Knowledge on Venues for Abortion	93
4	Students' Knowledge on Providers of Abortion	94
5	Students' Sources of Information on Abortion	94
6	Students' Views on Abortion as an Option when Pregnant	98
7	Students' Reasons for Abortion	98
8	Students' Knowledge of the Law on Abortion	100
9	Students' Views about Selective Legalisation of Abortion	101
10	Students' Views about Abortion being a Right Issue	102
11	Students' Views on Abortion Services	102
12	Students' Views on why Abortion should be Legalised	103

## LIST OF FIGURES

Figure	Page
1 Chart of Types of Abortion	14

## **CHAPTER ONE**

### **INTRODUCTION**

#### **Background to the Study**

Abortion is one of the most controversial issues of modern times because of its nature, process and consequences as well as the moral and ethical issues relating to it. So getting accurate data on abortion is difficult to come by in Ghana. Abortion is the termination of a pregnancy by the removal or expulsion of a foetus or embryo from the uterus (Dutt, 1998). Again abortion is where a powerful suction tube with a sharp cutting edge is inserted in the womb through the cervix. This suction destroys the body of the developing baby and tears the placenta from the wall of the uterus, sucking blood and other tissues into a bottle (Ghana Celebrities, 2011). An abortion can occur spontaneously due to complications during pregnancy or can be induced in humans and other species. In the context of human pregnancies, an abortion induced to preserve the health of the gravida (pregnant female) is termed a therapeutic abortion, while an abortion induced for any other reason is termed an elective abortion.

Abortion has a low risk of maternal mortality except for abortions performed unsafely, which results in 70,000 deaths and 5 million disabilities per year globally (Shah & Ahman, 2009). Unsafe abortion is a significant cause of maternal mortality and morbidity in the world. Most unsafe abortions

occur where abortion is illegal (Rosenthal, 2007) or in developing countries where health care is at a generally low level (Chaudhuri, 2007). About one in eight pregnancy-related deaths worldwide have been associated with unsafe abortion (Maclean & Gaynor, 2005)

The World Health Organisation (WHO) reports that each year nearly 42 million women are faced with unintended pregnancies. They go ahead to have abortions, of which 20 million are unsafe (WHO, 2011; Rosenthal, 2007). According to WHO and Guttmacher Institute (2010), approximately 68,000 women die annually as a result of complications of unsafe abortion and between two million and seven million women each year survive unsafe abortion, but sustain long-term damage or disease such as incomplete abortion, infection (sepsis), haemorrhage, and injury to the internal organs (tearing of the uterus).

Glenn (1996) indicates that about 50 million self-induced abortions occur per year worldwide and half of these occur outside the health care system. Since most of the self-induced abortions are performed outside the health care system, the risks are higher for the girls. In order to reduce the risks and loss of lives, there are still struggles as to whether abortion should be legalised or not though it is illegal in Ghana now, Glenn concludes.

Research review by Yeboah and Kom (2003) states that between 10% and 15% of all pregnancies terminate as spontaneous abortion and about 10-60% are terminated by an induction either legally or illegally. About 80% occur in the first trimester that is within the first to the third months of pregnancy. This can lead to hazards such as pain, ill health, infertility as well as other long-term complications (Taylor & Ablordey, 1993).

Research conducted by Pathfinder International (2009), an international non-governmental organisation, revealed that the proportion of women aged 15-19 who had had an unsafe abortion in Africa, was higher than any other region in the world. Pathfinder International also reported that about 60% of worldwide unsafe abortions are performed on African women under the age of 25, causing danger to their reproductive health (Modern Ghana, 2008).

In an interview on abortions by the Ghana News Agency (GNA) Mrs Hectorina Yebuah, Deputy Director of Nursing Services, Korle-Bu, indicated that the Department of Obstetrics and Gynaecology treats at least a case of unsafe abortion a day. She gave the monthly trend in 2005 as 91 cases in January; 99 in February; 100 cases in March; 103 cases in April and 75 cases in May.

According to Ayiku (2007), the teenager saves at least 20 pesewas a day at a nearby “susu” kiosk so that when they are pregnant they can use that money for abortion, although they are aware of diseases, abstinence and condom use, but still cannot do without sex because, they earn a living through sex. Some also see sex as fun and a way of showing love to their boyfriends.

It cannot be said that the Senior High School (SHS) girls in the New Juaben Municipality are all unblemish, are innocent or do not engage in unsafe abortions on their own. Indeed, it is common knowledge that some of these school girls do engage in unsafe abortions using high doses of paracetamol, chloroquine, ergot, coffee, grounded bottle, alcoholic drinks, grounded ants, cockroaches, gun powder and herbal preparations inserted into the vagina or enemas (GNA, 2005).

## **Statement of the Problem**

It is common knowledge that Senior High School (SHS) girls engage in unsafe abortions. Boseley (2009) reports that about 70,000 women die every year and many more suffer harm as a result of unsafe abortions in countries with restrictive laws on ending a pregnancy. The abortion law in Ghana, enacted in 1985, state that an abortion performed by a qualified medical practitioner is legal if the pregnancy is the result of rape, incest or defilement; if continuation of the pregnancy would risk the life of the woman or threaten her physical or mental health; or if there is a substantial risk that the child would suffer from a serious physical abnormality or disease. This leaves room for untrained personnel to engage in dangerous abortion procedures (Morhee & Morhee, 2006). Also the pregnant school girls who are afraid of talking to their parents about their pregnancy for fear of being beaten or thrown out of the house solicit help from their friends. These friends introduce them to traditional or crude methods of aborting their unwanted pregnancy by drinking grounded bottle, washing detergents “blue”, local gin, and inserting hot metal into their vagina, so that they can continue with their education. These methods cause infertility, sexually transmitted infections, miscarriages and death.

A report by Goldsmith on Wednesday, 10<sup>th</sup> January 2007 on BBC radio 4's Crossing Continents indicated that thousands of women in Ghana are seeking dangerous illegal abortions every year with many ending in death or disability. According to her as many as two-thirds of all terminations are unsafe and large numbers of women are dying. In 2003, 1,356 cases of unsafe abortion was reported at the Komfo Anokye Teaching Hospital and 1,368 in



2004 which represents 29% and 32% of maternal death (GNA, 2005). On the other hand, Eastern Region recorded 3,867 abortion cases in 2005, 500 being students and 157 deaths (GNA, 2006).

Owing to these reports, it can be deduced that several young productive women who are the future of our nation are being lost through unsafe abortion related cases. Should abortion be legalised so that these teenagers can freely access safe abortions to forestall the high incidence of unsafe abortion-related deaths? It is therefore imperative to research into the perception of SHS girls on whether legalisation of abortion in Ghana, would help reduce its unsafe practices.

### **Purpose of the Study**

The purpose of this study was to investigate the perceptions of Senior High School girls in the New Juaben Municipality on legalisation of abortion in Ghana in the light of the many reported cases of unsafe abortions and the numerous health problems associated with them.

### **Research Questions**

The following research questions were posed to guide the study;

1. What is the knowledge level of SHS girls on abortion practices?
2. Why do SHS girls seek abortion when they are pregnant?
3. What is the knowledge level of SHS girls on abortion law?
4. What is the perception of SHS girls on legalisation of abortion in Ghana?

### **Significance of the Study**

The stakeholders such as health educators, parents, teachers, and students will find this study useful. It will help to increase the understanding and

knowledge of issues bothering on unsafe abortion and its health complications to the general public so that they will support the legalisation of abortion. To law makers and government, these can serve as formative feedback for law review. It will provide policy makers with ideas about actual competencies relevant to unsafe abortion among the school girls for establishment of a competency based education in the future.

### **Delimitation of the Study**

The issues concerning abortion are so numerous that it is not feasible for a single study to capture all such issues. For example abortion law, abortion effects, abortion statistics, abortion risks, teenage abortion, abortion history, among others, but the focus of this study was to investigate the perception of SHS girls towards legalising abortion. The study was delimited to only SHS girls pursuing programmes of study in the New Juaben Municipality. The instrument was delimited to questionnaires; data analysis was in percentages and tables.

### **Limitations of the Study**

The study was restricted to some selected school in New Juaben Municipality. Therefore, the findings cannot be generalised to the whole Municipality. Despite the care taken by me to reassure the respondents that they would remain anonymous, it was possible that the findings were still to some extent affected by the Hawthorne effect, and that some of the respondents gave what they believed to be a socially acceptable response. Such a limitation is to be expected in the case of such a sensitive subject.

## **Definition of Terms**

**Abortifacients:** drugs used for abortion.

**Back alley:** illegal abortion.

**Boyfriend:** a male friend whom a girl has sexual relationship with.

**De facto:** something that exists whether legally recognised or not.

**Quack doctor:** somebody who pretends to have medical knowledge or skill that he or she does not actually possess.

**Susu:** one of the forms of saving money.

## **Organisation of the Rest of the Study**

The rest of the study was organized in four chapters. Chapter two dealt with review of related literature. Topics such as types and reasons for abortion and the abortion law were covered. Chapter three talked about methods used in conducting the study. The research design, population, sample and sampling procedure, data collection and data analysis were highlighted. Chapter four focused on the results and discussion, while the final chapter looked at the summary, conclusions and recommendations of the study. Suggestions for further research have also been included.

## **CHAPTER TWO**

### **REVIEW OF RELATED LITERATURE**

The purpose of this study was to investigate the perceptions of Senior High School girls in the New Juaben Municipality on legalisation of abortion in Ghana in the light of the many reported cases of unsafe abortions and the numerous health problems associated with them. To this end several literature have been reviewed on the following sub-headings;

1. Theoretical Framework
2. Concept of Abortion
3. Developments in Reproductive Rights in Africa
4. Reasons why Adolescents seek Abortion
5. Legalisation of Abortion
6. Socio-cultural aspects of Adolescent Pregnancy
7. Cultural aspects of Adolescent Pregnancy
8. Abortion: The Link between Legality and Safety
9. Studies Related to Abortion
10. Studies Related to Knowledge on Abortion
11. Minors Opinion and Perception about Abortion
12. Abortion Legalisation within a Human Rights Framework
13. Reproductive Health and Human Rights

## **Theoretical Framework**

Scheper-Hughes and Lock (as cited in Alemu, 2010) conceptual framework of the “Three Bodies”, namely the Body Self, the Social Body and the Body Politic are the main framework applied to analyze the research theme. I used this theoretical framework to explain and elaborate the girls’ access and awareness to safe abortion service. Scheper-Hughes and Lock expressed the human body as a physical and symbolic artefact that is both naturally and culturally produced. They argue that apart from the biological nature of the body, individuals within different cultures have different perceptions, experiences and constructions about the body.

Cultural constructions of the body are useful in sustaining particular views of society and social relations (Scheper-Hughes & Lock [as cited in Alemu, 2010]). Scheper-Hughes and Lock identified three bodies: individual body-self, social body, and body politic. The authors described these three bodies as individual body-self (both physical and psychological) is a biological body which is obtained by birth. The second body or the social body is a socially defined and culturally constructed body; it is a body which is needed in order to live within a particular society and cultural group; it is a means whereby the physical functioning of individuals are influenced and controlled by the society that they live in. The larger society or body politic exerts a powerful control over all aspects of the individual body; its behaviour, in reproduction and sexuality, in work, in leisure and in other forms of deviance and human differences. The social aspects of the body and body politic are important concepts to explain the lived experience of the girls’ contraceptive use and abortion. “Cultures are disciplines that provide codes

and social scripts for the domestication of individual bodies in conformity with the needs of social and political order and that the stability of the body politic depends on its capability to control the social bodies and to discipline the individual bodies” (Scheper-Hughes & Lock [as cited in Alemu, 2010]). The authors argue that the relationship between the individual and social body is about power and control of the body politic; the body politic has two main purposes; one is to shape the bodies according to the needs of the society, and the other is to control the external boundaries of the group to maintain a particular social order within the society. In this study abortion in the case of minors is influenced by the body politic (abortion legislation) and the social body (societal norms, values and perceptions) which shape the perception and decisions of minors to where, whether, how and when to undertake abortion.

Abortion is highly debatable in Ghana where culture and religious values are widely practiced. Abortion is condemned by religions in Ghana. Moreover, wide presence of gender inequalities hindered women from deciding over their own bodies. Safe and unsafe abortions are performed on women’s body in which they are the primary beneficiaries as well as victims of physical, psychological and economic damages. Even though, women are the primary beneficiaries or victims, they cannot decide on the self body because they should consider self body position in the culture and society. Above all their decision is directly or indirectly influenced by the body politic, abortion law.

### **Concept of Abortion**

#### **Definition of Abortion**

The termination of pregnancy is commonly known as abortion. Abortion may be defined as the intentional ending of pregnancy through the evacuation

of the uterus before the foetus has a reasonable chance of survival (Marshal, Gould & Roberts [as cited in Mamabolo, 2009]). Searle (as cited in Mamabolo, 2009) state that abortion means interference with the pregnant uterus in order to expel the foetus with the aim of killing it or causing its death.

To Jali and Phil (as cited in Mamabolo, 2009), abortion means foeticide for legal purposes; the intentional destruction of the foetus in the womb, or any untimely delivery brought about with intent to cause the death of the foetus. Saifuddin (2002) also defined abortion as the act of stopping pregnancy before the foetus has a chance to live (age of pregnancy 22 weeks and weight less than 500gram). In support, Manuaba (2001) reiterated that abortion is failed pregnancy before 20 weeks or the foetus weighing less than 1000grams.

Abortion in simple terms is the natural or induced expulsion of the foetus from the womb. Commenting on this, Jail and Phil (as cited in Mamabolo, 2009) saw it as the expulsion or removal of the products of conception from the uterus. To the authors Pro-life groups, human life begins from the moment of conception, so abortion is the murder of a defenceless human being.

The Macmillan English Dictionary for Advanced Learners (2002) defines abortion as “a medical operation in which a developing baby is removed from a woman’s body so that it is not born alive” (p. 3). It is an operation or other procedure to terminate pregnancy before the foetus is viable or the premature termination of pregnancy by spontaneous or induced expulsion of a foetus from the uterus. When performed safely, a medically induced abortion is one of the safest types of surgery.

Termination of Pregnancy Act 92, as cited in Mamabolo (2009) sees abortion as the separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman. It is the premature expulsion or removal of conception from the uterus or womb during the period of gestation. It can be deduced from the foregoing that abortion is failed pregnancy, threat or dismissal of conception before delivery.

### **History of Abortion**

Women throughout recorded history have been terminating unwanted pregnancies. Abortion raises controversial and serious ethical questions worldwide. It was restricted or forbidden by most religions in the world, but legislative action in the twentieth century has been permitting termination of unwanted pregnancy for medical, social or private reasons (Microsoft Encarta Encyclopaedia plus as cited in Mamabolo, 2009).

In over 5000 years ago, the Chinese Emperor Shen Nung, described the use of mercury for inducing abortion (Glenc, 1957). Abortions at the woman's request were first performed in post revolutionary Russia in 1920 followed by Japan, then several East European nations after world war II. In the late 1960s abortion regulations became more liberal worldwide (Mamabolo, 2009).

As far back as 1967, the World Assembly recognized abortion as a serious health problem, but about 30 years later, not much was achieved in terms of solution. This necessitated for the 1987 conference on safe motherhood held in Nairobi where abortion among other health topics was discussed (Grimes, Benson, Singh, Romero, Ganatra, Okonofua, & Shah, 2006). Following several of these discussions, the WHO has protocols and guidelines



specifically for the management of unsafe abortion including those resulting in incomplete abortion.

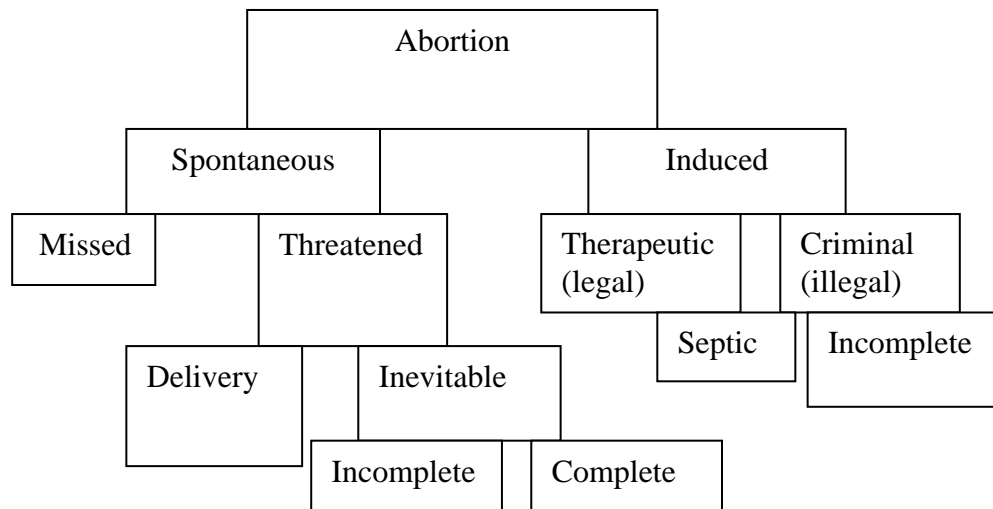
Abortion is illegal in many Roman Catholic and Islamic countries, although it may be carried out in cases where the mother's life is immediately at risk. It is legal in France and Italy, but illegal throughout England, Ireland, Wales and Scotland. WHO (2004) estimates that of the 58,500 maternal deaths that occur worldwide each year, 99% are in the developing world. A number of nations have either legalised or liberalised abortion, in order for women to have these procedures done in the most hygienic environment (Microsoft Encarta Encyclopaedia plus, as cited in Mamabolo, 2009). The use of misoprostol and its increase access has been recognised to have improved the outcome of abortion procedures as it has recorded between 87-97% success rate (Rogo, 2004). This method is now preferred to the use of vacuum extraction. Until the use of this method the Alan Guttmacher Institute in New York conducted a study on the traditional methods used for induced abortion and listed over 100 methods including the use of detergents, solvents, and bleach as methods used by women in developing countries (Alan Guttmacher Institute, as cited in Engelbrecht, 2005). Abortion was a secretive and private subject, but now is being debated in public in most countries, with religious groups and pro-life activists opposed to the liberalisation of abortion (Marissa & Ventura, 1999, as cited in Mamabolo, 2009).

### **Types of Abortion**

All forms of abortion fall under two main categories: spontaneous (miscarriages) and induced (Bennett & Brown, 1999) or unintentional and intentional (Clowes, 2010). Induced or intentional abortion is the voluntary

termination of pregnancy by oneself or someone else whilst spontaneous abortion is the medical term for a miscarriage.

Figure 1 portrays the different types of abortion and their components.



**Figure 1: Chart on Types of Abortion.**

Source: Bennett and Brown (1999)

From Figure 1, abortion is either induced or spontaneous. Induced abortion could be either therapeutic or criminal. Both have septic as a component (Bennett & Brown, 1999), and further under criminal is incomplete abortion. Spontaneous abortion have missed and threatened abortion as components. Making up threatened abortion are delivery and inevitable abortion, and under inevitable abortion are complete and incomplete abortion (Bennett & Brown, 1999).

According to Clowes (2010), missed abortion is when a woman does not miscarry a pre-born child who died more than eight weeks previously. Threatened abortion is a condition that usually includes vaginal bleeding but not cervical dilation and may or may not lead to a condition of inevitable abortion.

Inevitable abortion is a condition marked by vaginal bleeding and cervical dilation that indicates an impending miscarriage that cannot be prevented. It follows a condition of threatened abortion. Incomplete abortion is an intentional or unintentional abortion in which parts of the pre-born child and or placenta remain within the uterus. Complete abortion is when all of the contents of the uterus (that is, the pre-born child and the placenta) have been expelled from the uterus (Clowes, 2010).

Induced abortion is an intentional abortion brought on by mechanical (surgical) or chemical (abortifacient) means (Clowes, 1980). Therapeutic abortion is termination of early pregnancy deemed necessary by a physician (Mosby's Medical Dictionary, 2009). The current medical literature equates legal abortion with therapeutic abortion. The definition of the word “therapeutic” however, means treatment of disease. The use of the term is another pro-abortion attempt to sanitise a repulsive act, and it also implies that pregnancy is a disease (Tignor, 2010). Criminal (illegal) abortion is any abortion committed outside the parameters set by law. For instance, an abortionist commits a criminal abortion if he aborts pregnancy for a minor without her parent's permission, in a state where parental consent laws exist, on a woman at 28 weeks gestation, for convenience purposes, except in the case of severe foetal anomalies (Clowes, 1980).

In addition, unsafe abortion is a major public health problem in developing countries where abortion is restricted by laws which seek to prevent and punish this form of behaviour. These laws aim at preventing the occurrence of abortion and to deter people with like minds from indulging in such practices. History however, shows that abortion is a fundamental human

behaviour that has been practiced in all cultural settings and that no level of restrictive laws has succeeded in controlling it. Cook and Dickens (1981) indicated that when a woman decides to end an unwanted pregnancy she will often go to the extreme length to do so, regardless of whether the procedure is safe or legal. As long as there is unwanted pregnancy, abortion will be a fact of life. Unsafe abortion accounts for at least 13% of global maternal mortality that is disproportionately high in Africa (Alan Guttmacher Institute, 1999; WHO, 2004). Most of these deaths as well as the long-term complications of unsafe abortion are preventable through improved access to effective family planning methods and contraception. This reduces the incidence of unwanted pregnancy, post-abortion care and provision of safe abortion services. Besides the health complications of unsafe abortion, the socio-economic cost is so high that in some centres in developing countries, treating abortion-related complications may consume up to 50% of hospital budgets and resources. This includes medical staff time, medicines and supplies (WHO, 1998).

Until the second half of the 20th century abortion was illegal in most countries and was associated with high illegal and unsafe abortion rate and correspondingly high maternal morbidity and mortality (WHO, 1998). Recent years have seen the liberalization of abortion laws in almost all countries of the European Union, the United States and Canada. This together with better and wide promotion and use of contraceptives led to rapid decline in the rate of unsafe abortion and its associated mortality in the developed world (Cook & Dickens, 1981; Rahman, Katzive & Henshaw, 1998). It has been observed that in many developing countries safe abortion services are not available to the full extent permitted by law. Cook and Dickens points out that in Ghana,

despite the amendment of the law on abortion in 1985 to broaden the indications for legal abortion, unsafe abortion remains a major public problem and a leading cause of maternal deaths in the country. It also causes a significant morbidity among women in reproductive age.

It is important to note that the translation of the law into services requires enabling policy formulation and implementation which in turn depend heavily on the clarity of the law. The contention however, is that the current law on abortion in Ghana makes enforceability difficult and leaves room for untrained personnel to engage in dangerous abortion procedures and that there is the necessity and pressing need for law reform. This overview is aimed at bringing into focus how the current law affects the availability of safe abortion service in Ghana and to make suggestions that may be useful in future amendment of the law.

The estimation of the prevalence of incomplete abortion in entire populations globally has been a challenge due to the sensitive nature of the subject matter. Estimates made are limited largely based on hospital records, which to a great extent is perceived as a tip of the iceberg. In such efforts to determine national estimates, Singh (2006) compiled related trends in 13 developing countries including Egypt, Uganda, Nigeria, Bangladesh, Pakistan, Brazil, Columbia, Peru, Burkina Faso, Kenya and Ghana. Singh established that annual hospitalisation rate varies from a low of about 3 per 1000 women in Bangladesh to a high of about 15 per 1000 in Egypt and Uganda. Nigeria, Pakistan, and the Philippines have rates of 4-7 per 1000, and two countries in Latin America with recent data have rates of almost 9 per 1000. In the developing world as a whole, an estimated five million women are admitted to

hospital for treatment of complications from induced abortions each year. This equates to an average rate of 5.7 per 1000 women per year in all developing regions, excluding China. By comparison, complications from abortion procedures or hospitalisation are rare in developed countries (Rahman et al., 1998).

Ahiadeke (2001) admitted that the estimates of the prevalence of induced abortion in particular has been difficult in Ghana, however after studying eight communities in four out of the 10 regions in the country and sampling 1,689 pregnant women, he puts estimates of induced abortion at 17 per 1,000 women of childbearing age. There were 19 abortions per 100 pregnancies (or 27 abortions for every 100 live births). Adanu, in a hospital based survey estimated an induced abortion prevalence of 31% at Korle-Bu Teaching Hospital (KBTH), the largest hospital in the capital town of Ghana (Adanu, 2005).

There are no national statistics on the prevalence of abortion in Ghana; statistics can be obtained from hospital based and other research work on abortion. A study on contraception and induced abortion in rural Ghana (Geelhoed et al., 2002 as cited in Adanu, 2005) found that 22.6% reported having induced abortion. In a Maternal Health Survey Project, Ahiadeke (2001) recounted that abortion ratios were 19 per 100 pregnancies, 27 abortions per 100 live births and induced abortions were 17 per 1000 women of reproductive age.

However, abortions constituted 38.8% of admissions to the gynaecological ward of Komfo Anokye Teaching Hospital (KATH) in 1994 (Turpin et al., 2002 as cited in Adanu, 2005). Hospital based studies at

KBTHand KATH indicate that 22% and 30% respectively of maternal deaths are due to unsafe abortion (Wilson & Lassey, 1998)

Maternal mortality is defined by the WHO as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of pregnancy, from any cause related to or aggravated by the pregnancy or its management (Rance, 1997 as cited in Adanu, 2005). Twenty-four deaths from abortion complications were listed under maternal mortality. Rance indicated that when an abortion has been induced, there is a need to look critically at the categorisation of the event which is generally (although not always) characterised by the woman's decision against becoming a mother.

In Ghana today, deaths from badly practised abortions are still labelled maternal deaths. Yet the unsafe nature of such abortions is the price women are expected to pay for having transgressed by refusing maternity. This punishment is socially selective. However, those women who can least afford to pay for qualified care are triply sanctioned. As well as being the ones most at risk from unsafe interventions, they are also the ones who are publicly accused of reckless self-exposure, and if they die, their deaths are cited as evidence that abortion is physically and morally dangerous.

If the prevention of unsafe abortion were merely a technical matter, the solution would be relatively simple. It is the interference of moral prejudice that blocks solutions to health problems like this (Rance, 1997 as cited in Adanu, 2005). This same type of interference falsifies statistical data on the causes of maternal mortality. Deaths from haemorrhage and sepsis associated

with abortion are whitewashed and grouped under these same causes of death in pregnancies reaching full term.

Abortion is constructed as socially dangerous for reasons far removed from any concern for public health. Rather, it is represented as risky because it puts at risk patriarchal control of women's sexuality and fertility, a system of belief which fears rejection of maternity by a woman mother (Rance, 1997 as cited in Adanu, 2005). Abortion must remain unsafe according to the unwritten law of patriarchal power, the law of the father. Muraro (as cited in Adanu, 2005) posits that this is not the flesh and blood father, nor the father in a purely symbolic sense, but a certain type of society and organisation of power.

### **Complications of Abortion**

Unsafe abortion is a major cause of injury and death among women worldwide. Although data are imprecise, it is estimated that approximately 20 million unsafe abortions are performed annually, with 97% taking place in developing countries (Grimes et al., 2006). Grimes et al. indicated that unsafe abortion is believed to result in approximately 68,000 deaths and millions of injuries annually. The legal status of abortion to Berer (2000; 2004) is believed to play a major role in the frequency of unsafe abortion. For example, the 1996 legalisation of abortion in South Africa had an immediate positive impact on the frequency of abortion-related complications (Jewkes, Rees, Dickson, Brown & Levin, 2005) with abortion-related deaths dropping by more than 90% (Bateman, 2007). Berer accounts that groups such as the WHO have advocated a public health approach to addressing unsafe abortion, emphasising the legalisation of abortion, the training of medical personnel,



and ensuring access to reproductive-health services. Complications of unsafe abortion according to Oye-Adeniran, Umoh and Nnatu (2002), account for 30-40% of maternal deaths in Nigeria.

Deaths related to unsafe abortion in developing regions are estimated as high as 100 deaths per 100,000 abortions in Latin America, 400 deaths per 100,000 abortions in Asia, and 600 deaths per 100,000 abortions in Africa (WHO, 1994). In contrast, the aggregate mortality rate from complications of legal abortions in 13 countries, most of them developed, for which accurate data are available is 0.6 deaths per 100,000 abortions (Henshaw, 1990). The mortality rate is low because in these countries abortions are performed largely by skilled providers using appropriate equipment under aseptic conditions.

From a range of studies, WHO estimates that 10-50% of women undergoing unsafe abortions in developing countries need subsequent medical care (WHO, 1994). Four factors along with the overall health of the woman, determine the risk that a woman undergoing an abortion will experience medical complications or die from the procedure (1) the abortion method used, (2) the provider's skill, (3) the length of gestation, and (4) the accessibility and quality of medical facilities to treat complications if they occur (Liskin, Doucette & Christie, 1980; Royston & Armstrong, 1989).

The most common abortion complications according to studies (Aggarwal, 1984; Konje, Obisesan, & Ladipo, 1992; Ladipo, 1989; Ladipo, 1990; WHO, 1994) are incomplete abortion, sepsis, haemorrhage, and intra-abdominal injury. Except for intra-abdominal injury, all complications can result from either spontaneous abortion (miscarriage) or induced abortion. Left

untreated, each can lead to death (Kamau, 1990; Konje, Obisesan & Ladipo, 1992). Also, women surviving immediate abortion complications often suffer life-long disability or face elevated risk of complications in future pregnancies (Herz & Measham, 1987; Liskin, 1992; WHO, 1994).

Studies (Ladipo, 1989; Stubblefield & Grimes, 1994; WHO, 1995) reviewing incomplete abortion related that when uterine tissues remain in the womb after either miscarriage or unsafely induced abortion, the woman suffers incomplete abortion; the most common abortion complication. Typical symptoms include pelvic pain, cramps or backache, persistent bleeding, and a soft and enlarged uterus,

Another complication according to Ladipo (1989) is sepsis. Septic abortion results when the endometrial cavity and its contents become infected usually after contaminated instruments are inserted into the cervix or when tissue remains in the uterus (WHO, 1995). In addition to suffering the general symptoms of incomplete abortion, women with sepsis have fever chills and foul-smelling vaginal discharge. Bleeding may be either slight or heavy (Ladipo, 1989; Stubblefield & Grimes, 1994; WHO, 1995). The first signs of septic abortion usually appear a few days after the miscarriage or unsafe abortion. The infection can quickly spread from the uterus to become generalised abdominal sepsis. High fever, difficulty in breathing, and low blood pressure often indicate a more extensive infection (Sweet & Gibbs, 1990).

Ladipo (1989) again indicated haemorrhage as yet another complication. Haemorrhage or heavy bleeding according to Ladipo, can occur when incomplete abortion is left untreated. Also, some techniques to induce

abortion, such as sharp curettage or inserting sticks or other objects into the cervix can result in intra-abdominal injuries that cause heavy bleeding. Herbs, drugs, or caustic chemicals swallowed or placed into the vagina or cervix can cause toxic reactions and also lead to haemorrhage. Chaudhuri (2007) and WHO (1991) recounted that the risk of post-abortion haemorrhage increases with gestational age, as well as with the use of general anaesthesia during unsafely induced abortion.

Elaborating further the WHO (1994) cited intra-abdominal injury. This is when instruments are inserted into the cervix to cause abortion. When this happens the cervix, the uterus, or other internal organs can be cut or punctured. The most common injury is perforation of the uterine wall. The ovaries, fallopian tubes, bowel, bladder, or rectum also can be damaged. Intra-abdominal injury can cause internal haemorrhage with little or no visible vaginal bleeding.

Women experiencing spontaneous abortion (miscarriage) need prompt, compassionate medical care. In Egypt, for example, one-third of the women seeking treatment at the 86 public-sector hospitals apparently had experienced miscarriage. They showed no signs of induced abortion and stated that the pregnancy was planned and desired (Egyptian Fertility Care Society [EFCS], 1997). Like women undergoing unsafe abortions, women experiencing miscarriage face unnecessary health risks, permanent disability, or even death where post-abortion care is unavailable or ineffective (Greenslade, McKay, Wolf & McLaurin, 1994; Malla, Kishore, Padhye, Hughes, Kerrigan, McIntosh & Tietjen, 1996; Wolf & Benson, 1994).

In Kenya for example, two hospital-based studies conducted during the 1980s found that women with post-abortion complications accounted for 60% of all gynaecological admissions (Aggarwal & Mati, 1982; Omu, Oronsaye, Faal & Asuquo, 1981). Also, Konje, Obisesan & Ladipo (1992) in a 7-year study, emphasised that abortion complications constituted 77% of all emergency gynaecological admissions at University College Hospital in Ibadan, Nigeria. Throwing more light on the issue, EFCS (1997) studied 86 public-sector hospitals and found that 28,000 women seek post-abortion treatment at these facilities each month.

In Latin American cities, where abortions are increasingly performed by medical providers, poor women are more likely to be hospitalised for abortion complications than wealthy women, who seek safe abortions in private clinics (Gyepi-Garbrah, Nichols & Kpedekpo, 1995; Winikoff, Carignan, Bernardik & Semeraro, 1996).

In addition to causing many deaths and much suffering, abortion complications consume a large portion of health-care budgets and scarce medical resources. In some areas, for example, large amounts of resources such as blood supply are used for treating complications of unsafe abortion.

### **Gestational Age Limit**

In obstetric practice, pregnancy could be interrupted at any gestational age to save the woman's life. Thus the Ghanaian law seems to allow therapeutic abortion and therefore sets no limit to the gestational age at which pregnancy could be lawfully terminated. In absence of appropriate policies on abortion this could be exploited by an abortionist to perform the procedure even in the advanced stages of pregnancy with very serious maternal complications. This

allows the conclusion that Ghanaian law compared with similar legislations from other jurisdictions seems to be very flexible and gives abortionists a great deal of protection. It is clear that there may be the need to amend the law on abortion so as to set a limit to the gestational age at which safe abortion could be carried out. Inspiration could be drawn from the current British legislation in which legal abortion is only permitted before the 24th week of amenorrhea except in some circumstances.

It is worth noting that as the law becomes more liberal safety of abortion becomes paramount, and there would be the need to set a limit to the gestational age at which safe abortion may be permitted. There would therefore be the need for the medical and legal experts in the sub-region to take a look at the survival of preterm babies and the safety of late abortions. This is important, especially between 24–27 weeks so as to redefine viability for the sub-region in conformity with the existing laws and standard.

### **Dilemma of the Pregnant Adolescent**

According to Akinde (2009), the decision to terminate a pregnancy is the woman's. All adolescents who are considering opting for termination of the pregnancy need adequate support and counselling before and after the procedure. Akinde revealed that the decision to terminate a pregnancy is usually a difficult one and often taken as a last resort. Culturally, in Ghana any woman who goes for an abortion is seen as a wicked woman who can kill her own child. Adolescents most often resort to abortion because of fear of disappointing their parents and the community. At times, parents procure abortion for their adolescent girls. According to Akinde, most of these abortions are unsafe, as adolescents who need them cannot access abortion

services openly. This is because both the provider and the client are liable to imprisonment if caught by the law.

### **Developments in Reproductive Rights in Africa**

African women could benefit greatly from improvements in reproductive health services mandated by the International Conference on Population and Development (ICPD). Since 1994 there have been noteworthy developments in abortion care in Africa, ranging from new or expanded post-abortion care (PAC) programmes to significant debates concerning the revision of restrictive abortion laws (Otsea, 2004). More specifically, with regard to policy developments:

1. In 1997 the WHO Regional Office for Africa (WHO-AFRO) developed the reproductive health strategy for Africa Region 1998-2007, which was adopted by the African Health Ministers. The intention of the strategy is for AFRO's 46 member states and their partners to develop programme priorities in the reproductive health field.
2. In March 2003 in Addis Ababa, the landmark conference entitled Action to reduce maternal mortality in Africa was held. A regional consultation on unsafe abortion took place. More than 100 participants from 15 African countries, representing diverse specialities and perspectives including doctors, lawyers, politicians, activists, journalists, religious leaders, youth leaders, and so on, came together to openly discuss the toll that unsafe abortion was taking on African women. The focus of the conference was on the actions needed to prevent unsafe abortions from taking place (Brookman-Amisshah,

2004). The conference called upon governments to fund programmes addressing unsafe abortion and to review and amend laws in accordance with international agreements (Otsea, 2004).

3. In July 2003, the Assembly of the African Union approved the Protocol to the African Charter on human and people's right relating to the right of women. The protocol called for protection and advancement of reproductive rights for women, including access to abortion for reasons such as sexual assault and incest. All member states were urged to sign and ratify the protocol, which was the first human rights document to formally acknowledge abortion as a reproductive right (African Union, as cited in Otsea, 2004). A key objective mentioned in this strategy is the reduction of morbidity and mortality resulting from unsafe abortion (WHO Regional Office for Africa as cited in Otsea, 2004).

Recent activities undertaken to plan for abortion service delivery in Africa included an international meeting entitled "Expanding access: Advancing the role of midlevel providers in menstrual regulation and elective abortion care", held in South Africa in 2001. Representatives from Kenya, Mozambique, South Africa and Zambia worked together with delegates from six non-African countries to examine the role of midwives in abortion care. A list of key recommendations for involving midlevel providers in abortion care were developed (International projects advisory service [Ipas] as cited in Otsea, 2004). In 2002, the first-ever regional conference was held in Senegal. This focused on unsafe abortion and PAC in Francophone Africa. Fourteen African countries were represented at the conference. The conference reviewed the

impact of unsafe abortion in their respective countries and Africa in general. This occasion also saw the launch of the Francophone PAC initiative which has undertaken PAC programme planning and implementation in seven countries in the region (IntraHealth as cited in Otsea, 2004).

Advocacy for access to abortion services has also been widely embarked upon since the ICPD. The African Partnership for Sexual and Reproductive Health and Rights of Women and Girls initiated a ten year plan (1999-2009) to implement reproductive health and rights strategies in Africa based on recommendations from the ICPD and Beijing Conferences (Amanitare as cited in Otsea, 2004). Medical professionals have also taken up the fight to end unsafe abortion. At the bi-annual meeting of the Confederation of African Medical Associations and Societies in 1997, the focus was exclusively on unsafe abortion and governments were called upon to review and revise the existing laws and policies, as well as to train health care providers in PAC. In addition, the past decade has seen an increase in networks advancing women's reproductive health in Africa. These networks include the IPPF, AFRO, Ipas, the African Alliance for Women's Health and Rights, and the Regional Prevention of Maternal Mortality Network (Otsea, 2004)

### **Reasons why Adolescents seek Abortion**

According to the Federal Ministry of Health ([FMOH] as cited in Akinde, 2009), adolescents seek abortion for different reasons, including: shame and stigma associated with unwanted pregnancy, desire to continue a school education, pregnancy as a result of rape or incest, pregnancy endangering the health of the adolescent, pressure from the partner responsible for the pregnancy, uncertainty about the paternity of the pregnancy and fear of



being forced into marriage. In a related bid Mote, Otupiri and Hindin (2010) enumerated; not to disrupt education or employment , too young to bear a child, could not afford to cater for a baby and partner refused to accept pregnancy as the reasons for adolescents seeking abortion.

Akinrinola, Susheela, and Haas (1998) have stated that worldwide, the most commonly reported reason women cite for having an abortion is to postpone or stop childbearing. The second most common reason socio-economic concern (this includes disruption of education or employment, lack of support from the father; desire to provide schooling for existing children; and poverty, unemployment or inability to afford additional children). In addition, relationship problems with a husband or partner and a woman's perception that she is too young constitute other important categories of reasons.

Ghana Health Service annual report (2007) by Pathfinder International state the reasons as unexpected or accidental conception, premarital pregnancy, want a child at a later time, want no more children, extramarital pregnancy and health problems. Mandelbaum (2011) in a study stated reasons like; need to continue working, partner's rejection of the pregnancy, insufficient finance and social stigma as the core reasons.

### **Legalisation of Abortion**

To legalise means to make lawful or legal, to confirm or validate something previously unlawful (Macmillan English Dictionary for Advanced Learners, 2002). In this study, it refers to freedom to access abortion services if adolescents so desire.

Since the 1980s there has been a clear trend towards the removal of barriers to abortion access, yet the right to choose abortion remains disabled or under threat in many parts of the world (Oye-Adeniran, Long & Adewole, 2004). The history of the criminalisation of abortion indicates that the approach was, in part, informed by the need to protect women from unsafe abortions. The same law tends to work in reverse today however, by exposing women more to the risk of unsafe abortion (Atsenuwa, 2005). Oye-Adeniran et al contend that the 94% of developing countries with laws prohibiting abortions have the highest rates of maternal and foetal mortality from abortion-related cases. Berer (2002) maintains that until a society accepts that women need abortion, those women and the abortion providers should not be punished for it. Legal abortions will then be rarely provided except in exceptional circumstances.

Noteworthy statistics are that in Ghana, abortion was legalised in 1985 and within six months the admission for septic and incomplete abortion dropped by 41% (Yeboah & Kom, 2003). Soon after Romania had legalised abortion in 1990, its abortion-related mortality rate dropped from 142 to 47 deaths per 100 000 live births (Berer, 2002)

### **Abortion laws**

Abortion, according to Jagnayak (2005), has been a controversial subject throughout history due to the moral and ethical issues that surround it. It has been regularly banned and otherwise limited, though abortions have continued to be commonplace in many areas where it is illegal. Almost two-thirds of the world's women currently reside in countries where abortion may be obtained on request or for a broad range of social, economic or personal reasons.

Abortion laws vary widely by country, with some countries allowing nearly total liberalisation, and others banning abortion under any circumstances. There are also countries that do not have any laws restricting abortion, such as Canada. Jagnayak (2005) states that in the United States, abortions are legal in all 52 states up to the time of birth, although many physicians are reluctant to perform extreme late-term procedures for fear of litigation.

In Egypt and Libya, abortion is prohibited, but may be permitted to save a woman's life. The same applies in many other African countries. In the Sudan, abortion is permitted only to save a woman's life and in special cases such as rape, incest or foetal impairment or abnormality. Spousal consent is required in some countries. In Gambia and Ghana, it is permitted on physical or mental health grounds and in special cases. In Tunisia and Cape Verde abortion is permitted on economic and health grounds (Population Reference Bureau as cited in Jagnayak, 2005). In South Africa abortion is legal with certain conditions. Midwives are able to perform termination of pregnancy until 12 weeks gestation. Pregnant women are able to choose to terminate their pregnancy until 12 weeks gestation (Choice on Termination of Pregnancy in South Africa [Act 92], 1996).

Until 1985, abortion in Ghana was governed by the Criminal Code of 1960 (Act 29, sections 58-59 and 67). Under the Code anyone causing or attempting to cause an abortion, could be fined and or imprisoned for up to 10 years. 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 law 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. Two studies conducted among physicians and lawyers in the early 1970s confirmed that the law was so vague that different persons had varying interpretations of it. The studies also found that the overwhelming majority of physicians supported the drafting of a clearer and more liberal abortion law in Ghana.

Ghana enacted a new abortion law in 1985 (Law No. 102 of 22 February). It states that an abortion performed by a qualified medical practitioner is legal if the pregnancy is the result of rape, incest or defilement of a female, if continuation of the pregnancy would risk the life of the woman or threaten her physical or mental health; or if there is a substantial risk that the child would suffer from a serious physical abnormality or disease (Morhee & Morhee, 2006). In general, under this law 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 is guilty of an offence. Such a person is liable to imprisonment for a term not exceeding five years, regardless of whether the woman is pregnant or has given her consent. 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 Ghana Maternal Health Survey (GMHS) found that in 2007, only 4% of women thought that abortion was legal in Ghana (Ghana Statistical Service, 2007). Even among women with at least a secondary school education, only 11% were aware of this fact. Knowledge of the country's moderately liberal abortion law seems to be substantially higher, but still not widespread, among medical professionals. In one small study, 54% of physicians were aware that abortion is legal if indicated to preserve the health of the woman (Morhe, Morhe & Danso, 2007).

Abortion is widely stigmatised in the Ghanaian society, but it appears that many people consider it acceptable under certain conditions. In in-depth interviews with adolescent females 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 or necessary (Henry & Fayorsey, 2002). Among doctors at a teaching hospital in Ghana, 80% favoured establishing safe abortion units within national health facilities (Morhe, Morhe & Danso, 2007). Only 19% of physicians (the majority of whom did not work in obstetrics or gynaecology) said they would play no role in abortion care; some in this group indicated that they would perform the procedure if they were properly trained.

Knowledge of abortion law is minimal, with the vast majority of both women and men thinking it is wholly illegal (Pathfinder International, 2009). Pathfinder International said though the government has promoted safe

abortion under certain conditions as part of reproductive health, they are under pressure from the pervasive social stigma. This stigma reduces public impetus to promote knowledge of the law and access to services. According to Pathfinder International 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. Almost 13% of men believed it was legal, 61% thought it was illegal, and 27% did not know. Respondents who believed abortion to be legal were asked for the reasons why one can be granted an abortion.

Doohana and Ziem (2010) said even though there is a law in Ghana to ensure that women gain access to abortion services without too much hindrance and with less complications, it still appears that most women are unaware of the existence of such a law. They make the hospital their last resort when they do not succeed in their attempt to cause abortion through unsafe procedures. Doohana and Ziem (2010) again commented that among the many types of abortions, illegal abortion is more life threatening. This is because it is done by unqualified (quack) persons who lack knowledge and skills to do this, and use different methods to carry out this procedure depending on the age of the pregnancy. Besides, the environment in which this procedure is carried out is not satisfactory as infection can be introduced during the procedure (Doohana & Ziem, 2010). More so, there are also no contingency measures put in place to resuscitate the patient in case her condition is deteriorating in the process. These are some of the reasons why this type of abortion is not advisable. Some people also take concoctions as a way of inducing labour to expel the uterine content. One may expel the foetus but not the placenta (Doohana & Ziem, 2010).

“Abortion in Ghana” a new report released by the New York-based Guttmacher Institute brings together data from various studies, including the Ghana Maternal Health Survey (GMHS) ( as cited in Doohana & Ziem, 2010) to present what is known about abortion in Ghana. The information includes incidence, abortion providers and the procedures used, and the characteristics of women having abortions.

A major factor contributing to unsafe abortion in Ghana is that only 4% of women surveyed in 2007 were aware that abortion is legal under fairly broad grounds. Unaware that they can legally obtain a safe abortion procedure, many women turn to unsafe providers or procedures. Women also face other barriers to accessing safe abortion services, including high cost, a limited number of qualified abortion providers and concerns about social stigma (GMHS, as cited in Doohana & Ziem, 2010).

According to GMHS (as cited in Doohana & Ziem, 2010), at least 7% of all pregnancies in Ghana end in abortion, and 15% of women aged 15-49 admitted to having had an abortion. Abortion rates were highest among 20-24-year-olds, educated and wealthier women, and those living in urban areas. According to the same survey, just over half of the women (57%) who admitted that they had had an abortion sought the services of a doctor, while most others turned to pharmacists or traditional midwives to induce abortion. Almost 1 in 5 women induced the abortion themselves or had the help of a friend. The most common reason women sought an abortion was not having the financial means to take care of a child. Other frequently reported reasons included wanting to delay childbearing or complete school.

More than a third of all pregnancies in Ghana (37%) are unintended. This high level of unintended pregnancy is due to the fact that many women who do not want to become pregnant are not using an effective method of contraception. It is estimated that 35% of married women who wish to avoid pregnancy are not using a method of contraception—a much higher proportion than the average level of unmet contraceptive needed in the African continent as a whole (22%). The survey recommended that in order to save women's lives and improve maternal health, government should increase access to family planning services and counselling in all health institutions nationwide. The government should also improve education for young people in our schools and communities about reproductive health. This should include information about the risks of unprotected sexual intercourse and strategies for preventing unintended pregnancy. There is also the need to increase public awareness about Ghana's abortion law (GMHS, as cited in Doohana & Ziem, 2010).

Illegal abortion can end one's life within a matter of seconds, and if for any reason one has to abort a pregnancy, one should not hesitate to go to a recognised hospital or clinic for counselling and proper services. Doohana and Ziem (2010) contend that an illegal abortion done once can make one barren all her life. The authors advised females to say no to illegal abortion and save their uterus. They concluded that prevention is better than cure so adolescents should protect themselves if they think you do not want a pregnancy.

Doohana and Ziem (2010) indicate that the situation in fact calls for serious efforts to increase awareness of the law, combined with better access to family planning services to radically reduce deaths and injuries, and



improve the lives of women and families in Ghana. It is for this reason that in a bid to help ensure that legal abortions are provided safely, the Ghana Health Service and Ministry of Health developed protocols for the provision of safe abortions. These guidelines according to Doohana and Ziem (2010) was adopted in 2006. It outlined the components of comprehensive abortion care, including counselling and the provision of contraceptives; define mental health conditions that could qualify a patient for an abortion; and call for expanding the base of abortion providers by authorising midwives and nurses to perform first-trimester procedures.

### **Abortion Law in the USA**

Prior to 1800, there was no specific legislation relating to abortion in any of the American States. British Common Law, as interpreted by the American Courts, was used to govern the legal status of abortion and it was believed that aborting a “quickened” foetus was a crime. The first anti-abortion statutes were passed in the decades prior to the civil war and focused on the safety of women. After the end of civil war, states began to adopt a stricter approach to abortion and the focus shifted to criminal penalties for women having an abortion as well as for the providers of abortion services. This criminal status of abortion was firmly entrenched in all American States by 1900 (Warren, 1989).

The lawsuit of Roe vs. Wade marked the turning point in abortion law in America. Prior to Roe vs. Wade in 1973, the legality of abortion essentially rested with the legislature of the states. After the Supreme Court decision in 1973, abortion became an issue of federal constitutional law by holding that abortion was a constitutional right (Abortion Law, 1996). The Roe case arose

due to Texas law prohibiting legal abortion. At that time several other states had similar laws to the one in Texas. These laws led to many women resorting to illegal abortions; Jane Roe, a 21 year old pregnant woman, represented women wanting abortion but who could not legally obtain one because of restrictive laws. Henry Wade was the Texas Attorney General who defended the law that made abortions illegal. The Supreme Court ruled that Americans have the right to privacy, including the woman's right to decide whether to have children or not. Furthermore, the woman and her doctor had the right to decide, without state interference, at least during the first trimester of pregnancy, whether or not she should have an abortion (National Abortion Federation, 2004)

The reaction to Roe vs. Wade was mixed. Supporters of abortion felt that they had won the battle, while those opposed to legal abortion immediately began to work towards preventing federal or state funding of abortion procedures and also attempted to undermine or limit the effect of the court's ruling. Anti-abortion violence escalated, services at abortion clinics were disrupted, women trying to enter abortion clinics were harassed, access to abortion clinics was blocked, property was vandalised, bombings occurred and physical attacks and even murder took place (Mkhondo, 1998; National Abortion Federation, 2004).

While the outcome of Roe vs. Wade in 1973 was to allow women the freedom to choose during the first trimester without state interference to have an abortion, it was not considered how marginalised and low income women who are dependent on public health care would access the service (Ngwena, 2004). Since this landmark court ruling, the USA Supreme Court has begun to

allow numerous restrictions on abortion, which are briefly mentioned below (National Abortion Federation, 2004).

1. 1976: Congress adopted the first Hyde Amendment, which barred the use of Federal Medicaid funds for abortions for low income women.
2. 1977: Revised Hyde Amendment permitting states to deny Medicaid funding of abortion except for rape, incest, or severe and long – lasting damage to the woman’s physical health.
3. 1984: Mexico City Policy (Global Gag Rule) restricted NGOs in developing countries that received USAID funding from engaging in abortion activities (Crane & Dusenberry, 2004).
4. 1991: Rust v. Sullivan upheld the constitutionality of the Global Gag
5. 1992: Planned Parenthood of South Eastern Pennsylvania v. Casey reaffirmed the arguments of Roe that women have a right to abortion before foetal viability, but allowed states to restrict access so long as these restrictions did not impose an undue burden on women
6. 1994: Freedom of Access to Clinic entrances Act passed by Congress in response to the murder of Dr. David Gunn which forbade the use of force, threat of force or physical obstruction to prevent someone from providing or receiving reproductive health services.
7. 2003: A federal ban on abortion procedures was passed by Congress and signed into law.

### **History of Abortion Legalisation in Africa**

Prior to colonialism, the availability of abortion in Africa was governed by customary law and it was colonisation that introduced a general law on abortion to the continent (Ngwena, 2004). The colonial models may be

divided into two broad categories namely models based on criminal law (France, Belgium and Portugal) and those based on common law (Britain and South Africa) (Braam & Hessini, 2003).

African countries under French rule adopted abortion laws based on the French Napoleonic code of 1810 and its successive formulation in French criminal law. While the prohibition of abortion under this model was absolute, it was taken that abortion was legally justifiable if it was done to save the life of the woman. This was however, not explicitly provided for in French criminal law until 1939 and also was not explicit in pre-independence Anglophone Africa. The French penal codes of 1810 (as amended in 1839) were adopted by the colonies, although some colonies were more orthodox in their interpretation of the law as to whether an abortion should be allowed to save the woman's life (Braam & Hessini, 2003).

Countries colonised by Portugal derived their abortion law from Portugal's criminal code of 1886 as amended. The Portuguese criminal code was strongly influenced by the Napoleonic code of 1810 and also in part by Spanish Law (Braam & Hessini, 2003). In general, abortion was prohibited and no exceptions were provided for, however, it was accepted that an abortion conducted to save a woman's life was a valid defence. Similarly, Belgian colonies adopted the penal code of Belgium, which prohibited abortion absolutely, but tolerated abortions performed to save the life of the woman. The Belgian code was also based on the Napoleonic code (Ngwena, 2004)

Abortion law in the British colonies was mainly determined by the offences against the person act of 1816 with the following provisions: it was a

crime for a pregnant woman to unlawfully procure a miscarriage. Any person who carried out an act with the intent to procure a miscarriage committed a crime and a person who supplied or procured a substance or instrument, knowing that it would be used to unlawfully obtain a miscarriage, committed a lesser crime. Most African countries under British control adopted similar provisions in their legal systems. A step further was the court decision in *R. V. Bourne*, whereby it was ruled that an abortion was not unlawful according to the offences against the person act if it was done in good faith to preserve the life of the woman or her physical or mental health. Therefore, in one respect Anglophone African countries had a more liberal abortion law at independence than other African countries, as they explicitly acknowledged that an abortion could be performed to save the life of the pregnant women, as well as leaving the door open for abortions to be performed to preserve the physical and mental health of women. However, as with the laws of other African countries, there were no guidelines for the procedure to be followed when an abortion was legally justifiable (Braam & Hessini, 2003; United Nations, 2001).

While the colonial powers, except for Portugal, amended their abortion laws in light of the dangers associated with unsafe abortion and in recognition of reproductive rights, many African countries associated with unsafe abortion and in recognition of reproductive rights, many African countries after achieving independence, have been slow to reform their abortion laws. Factors contributing to this slow reform process include social and economic crises, patriarchal system, and social status of women, cultural and religious beliefs and practices, and a lack of political will. Francophone countries were far less

comprehensive and did not follow the models of their former colonial rulers. Change has also been slow to occur in countries once controlled by Belgium, Portugal, Italy, Germany and Spain (Braam & Hessini, 2003).

### **Abortion in Ghana**

Ghana has one of Africa's most liberal abortion laws, but because of lingering stigma, fear and misunderstanding, safe, affordable abortion services remain virtually non-existent and unsafe (IRIN, 2011). IRIN comment that abortion is the major cause of death. While some activists are pushing for lifting restrictions altogether, health experts say the focus should be on ensuring that the health sector effectively provides what the current law allows under a law passed in 1985. According to IRIN, abortion is allowed in cases of rape or incest, defilement of the mentally handicapped, foetal impairment and to save the life or physical or mental health of the woman. But stigma attached to abortion and ignorance about the law are such that even women who are within their legal rights are afraid to seek an abortion, and many health facilities do not offer such services. IRIN indicates because of the fear of falling foul of the law, health facilities will not dare to offer abortion services. In IRIN's works Faustina Finn Nyame of the Ghana office of Marie Stopes International said women who seek abortion cannot get access to quality abortion care. They either do it themselves through crude means or go to traditional medicine men for the service. Nana Ama Asantewa, 19, used a common method by drinking a concoction made of powdered soap and broken glass. She also inserted a stick into her uterus to end her three-month pregnancy. Asantewa survived after an emergency surgery, but many women do not. Maternal mortality in Ghana according to IRIN stands at about 540 per

100,000, and it is estimated that 22-30% of those deaths are from unsafe abortion.

WHO (2011) indicated in a report that as of 2003 nearly 12,000 women in West Africa were dying annually from unsafe abortion. “A woman dies every eighth minute somewhere in a developing country due to complications arising from unsafe abortion” (p. 36). WHO revealed that the Ghana Health Service was working to expand abortion services in public hospitals. Gloria Quansah-Asare, national family planning manager, told IRIN that safe abortion services exist in some private facilities but the cost put the procedure out of the reach for many (IRIN, 2011).

### **Abortion Legalisation**

Legalisation of abortion means that the law allows abortion. The process by which abortion was legalised in the United States in the early 1970s is an integral component of the identification strategy (Oltmans, Gruber & Levine, 2004). Prior to the late 1960s, abortion was illegal in every state in America except when necessary to preserve a pregnant woman’s life. Between 1967 and 1973, a number of states implemented modest reforms making it legal for some women to obtain abortions under very special circumstances, such as rape, incest or a serious threat to the health of the mother.

Abortion, however, became widely available in five states in 1970. In four of these states (New York, Washington, Alaska, and Hawaii), there was a repeal of anti-abortion laws. In the fifth; California, there was a “de facto” legalisation. Since the late 1969 the California State Supreme Court has ruled that the pre-1967 law outlawing abortion was unconstitutional. Following the 1973 Supreme Court decision in *Roe vs. Wade*, abortion became legal in all

states. These events, according to Oltmans, Gruber and Levine (2004), contributed to a dramatic increase in the frequency with which women chose to end a pregnancy through abortion. Although it is difficult to determine the number of abortions performed prior to legalisation, they further contended that the trend in its immediate aftermath was dramatic. The abortion rate almost doubled in the years following *Roe vs. Wade*. This heightened prevalence of abortion came at the same time as an ongoing steep reduction in fertility rates. Because births had been falling precipitously even before the introduction of legalised abortion, it is not clear to what extent the introduction of legalised abortion contributed to the decline, lamented Oltmans et al.

Abortion laws in African Commonwealth countries according to Cook and Dickens (1981), traces the origins of the laws to their colonial predecessors, and discusses legal reform that would positively provide for legal termination of pregnancy. Cook and Dickens claim that the range of these laws demonstrates an evolution that leads from customary or common law (Lesotho and Swaziland) to basic law (Botswana, Gambia, Malawi, Mauritius, Nigeria's Northern States and Seychelles) to developed law (Ghana, Kenya, Nigeria's Southern States, Sierra Leone, and Uganda), and, finally, to advanced law (Zambia and Zimbabwe).

On January 22, 1973 the U. S. Supreme Court announced its decision to legalise abortions in the state of Texas. *Roe vs. Wade* led the way to legalised abortions nationwide (Donahue & Levitt, 2001). The authors claimed that before this incremental case, there were 750,000 abortions and 3.1 billion live births in 1973. In the time period after 1980, there were over 1.6 million abortions and 3.6 million life births annually. In relation to crime, there is an



obvious connection as to why crime rates would be less in the following years. Clearly, 1.6 million abortions led to 1.6 million less chances of a crime being committed. Along with this apparent assumption, there are other factors that link abortion and declining crime rates. Donahue and Levitt stated two main reasons why this link exists; in general, women who have abortions are those most at risk to give birth to children who would engage in criminal activity and women who use abortion to optimize the timing of child bearing. In a later publication, Levitt (2004) stated that unwanted children are at greater risk for crime and legal abortion leads to a reduction in the number of unwanted babies.

Legalisation of abortion in developed countries has been identified to have promoted access to safe abortion and contributed to high incidence in unsafe abortion in developing countries (Centre for Reproductive Rights, as cited in Lokko, 2009). About 72 countries mostly in developing nations have prohibited and or allowed abortion only when it is to save a woman's life. From 1995-2005 only 12 countries joined countries with legal instruments related to abortion (Nune & Delph, as cited in Lokko, 2009) suggesting the slow pace by which the varied women empowerment issues influences legalising abortion.

In Ghana, the abortion law as contained in article 33 (5), the Criminal code section 58 (2) suggests to some extent ambiguity yet criminal interpretation of the act of conducting abortion (Lokko, 2009). This legal framework for abortion in Ghana generally could be said to be very liberal in most respect, but provides limits in assessing abortion information and services by clients who so desire without discrimination of stigmatisation

(Lokko, 2009). According to Lokko, the Ministry of Health (MOH) and Ghana has the responsibility of providing the policy framework within which the law can be implemented. However, the policy framework as entailed in the guidelines by the MOH does not suggest promoting friendly and safe abortion services for women who have unintended pregnancies.

Ghanaian women are unaware of abortion and its legalisation. According to Gloria Ampofoah, a 22-year old SHS student (who has had 2 abortions before) during a conversation, the first method she used was to grind leaves of a bush plant, mix it with “kawu” (a local stone that is used for cooking, etc) and insert into the vagina. When it did not yield the required results she inserted the branch of a bush plant which did the trick. Blood started coming out in large proportions not long after. Gloria's second abortion was barely six months ago. First, her friend gave her melted sugar with hot Guinness to no avail. Then 10 paracetamol tablets mixed with local gin (akpeteshie). When this could also not yield the required results she tried grounded broken bottles mixed with seawater and “blue”, a washing detergent, which she soaked in a cotton cloth and inserted into her vagina. Minutes afterwards, she lamented, the foetus oozed out. The aftermath was clot bleeding for about 5 continuous days (Ampofoah, 2010).

Reports say more than 1 in 10 pregnancy-related deaths in Ghana are the result of unsafe abortions. In addition, 13% of Ghanaian women who have had an abortion experience complications resulting from unsafe procedures, and fewer than half of them received the needed follow-up care. These statistics are all remarkable because Ghana is one of the few African countries where abortion is legal under fairly wide justifications. Abortion performed by a

qualified medical professional under proper conditions is an extremely safe procedure (Lokko, 2009).

### **Advantages and Disadvantages of Legalising Abortion**

Ferreira (1985) summarises the advantages and disadvantages of legalising abortion:

#### **Advantages.**

1. Reduction in illegal abortion, with a concomitant positive impact on maternal health and a reduction in pressure on medical resources needed to treat complications resulting from illegal abortions.
2. Hygienic environments, as trained personnel in clinical settings conduct legal abortions.
3. Back-up if contraceptives fail or if contraceptives were not used. The credibility of contraceptive use is promoted and reinforced, and in turn reduces the need for abortions.
4. High risk groups such as adolescent are offered a legal way out of a difficult situation when faced with an unwanted or unplanned pregnancy. This is critical, especially when connected to interruption social implications such as schooling does not of schooling and prevention of forced marriages.
5. High risk pregnancies lack of contraceptive use or failure of the method, pregnancy after 35 years of age, where there are already four children, and pregnancies that are spaced less than two years apart can be avoided.
6. The experience of a legal abortion is likely to be less traumatic than an illegal abortion, which is generally perceived as unsafe.

7. Facilities are available to all women, not only the affluent.
8. Allow women to avert unwanted births and to achieve the family size that they desire.
9. Provides an opportunity for post-abortion contraceptive education and service.

**Disadvantages.**

1. Providers and promoters of abortion services are likely to be the targets of criticism.
2. Costly service to provide.
3. Churches and other religious organisation are likely to provide much opposition to legal abortion.
4. Not all medical professionals will be willing to provide TOP services and some medical facilities may refuse to allow abortions to be conducted.
5. An abortion ‘mentality’ may arise amongst health personnel providing this service.

**Developments in Abortion Legalisation in Africa**

There has been a growing response from some African governments to international consensus and pressure to develop or adapt policies geared toward the enhancement of women’s well being and reproductive health. More specifically, some countries have strengthened their commitment to women’s rights and bodily integrity. Since 1960, there has been a movement toward abortion law reform. The process commenced in Anglophone Africa and tended to mirror adaptations made by the former colonial powers. For example, in 1972 Zambia adopted one of the most liberal abortion laws in

Africa, which was based on the British 1967 Abortion Act. The Seychelles later followed suit. Severe restrictions in Botswana, Ghana and Zimbabwe were also relaxed, allowing broader indications for abortion. Additionally, according to Sai (2004) changes occurred in Tunisia (1965), Burkina Faso (1997) and South Africa (1996).

Despite the developments in reproductive rights, advocacy for safe abortion and liberalisation of abortion laws internationally, the majority of African countries still have restrictive abortion laws, which contribute to the more than four million unsafe abortions that are conducted annually. Worldwide, approximately 78,000 women die annually as a result of unsafe abortion, 44% of these women are African. The average unsafe abortion ratio in Africa is 110 deaths per 10000, which is more than twice that of any other region in the world (Ahman & Shah, 2002; Braam & Hessini, 2003; WHO, 1997).

Liberalised laws do not necessarily guarantee expanded access for women. Impediments to access abortion such as shortage of health care providers and refusal of health care providers to perform abortions do not disappear once laws have been liberalised (Sai, 2004). This became clear in the Free State study where it was found that six years after the introduction of the Choice on Termination of Pregnancy Act (CTOPA), negative attitudes and hostility towards abortion continued to prevail amongst health care workers. Negative attitudes and hostility impact on service delivery in that there are a limited number of health care workers willing to provide abortion service. Those health care workers who are willing to provide abortion service are stigmatised, while women seeking abortions are also stigmatised and hesitant

to request referral to a facility providing such services. In addition, a lack of public awareness about abortion and facilities providing such services also serve to impede access to abortion (Boonstra & Nash, 2000). Clearly, this is reason for concern, as women in South Africa, despite the introduction of an extremely liberal abortion law in 1996, still encounter impediments in accessing abortion services. This raises the question of the problems encountered by women residing in African countries that have restrictive abortion laws. In this regard, it was deemed appropriate to investigate the stance of abortion legislation in neighbouring South Africa in order to determine the possible effects of the CTOPA on other African countries. South Africa and Cape Verde are the only African countries that allow abortion without restriction.

#### **Abortion: Should it be Legalised?**

These have been controversial questions that have been bordering the Ghanaian populace of late. Ehrlich (2006) suggested that abortion should be legalised to reduce the detrimental, emotional and physical trauma which affects women who are unable to access professional help to induce the abortion. Most end up being barren because of the fear to seek professional help due to the stigma and legal aspects associated with the procedure. Such women would rather have their pregnancy terminated by a quack who uses crude methods but cannot be traced by law. Barring access of legal abortion procedures has led to more women seeking the backstreet clinics (Ehrlich, 2006).

Abortion has a long history and many people have developed various methods and procedures to terminate pregnancies over the years.

Traditionally, herbal “abortifacients” and sharp tools were used to terminate pregnancies. These resulted in large numbers of deaths of women who could not withstand the intense pain inflicted by the tools used. In the medical field, medications and surgical procedures to induce abortion were used and some are still applicable even today (United Nations Population Division[UNPD], 2010).

The abortion procedures induced by medical professionals are deemed to present very few health problems and deaths. However, they are quite expensive and only a few people can afford to have an abortion carried out by a qualified doctor. The larger percentage of Ghanaians have no choice but to visit backstreet clinics which are run by unqualified staff with equipment which are not sterile (Ehrlich, 2006).

According to WHO (2006), an unsafe abortion remains a global public health concern due to the high incidence and severity of complications that are associated with it. Cases of incomplete abortion, haemorrhage and damage of the uterus leading to barrenness are not strange. WHO estimates that 19 million unsafe abortions occur each year all over the world and among these, 68,000 women die during and after the procedure.

Legalising abortion has been seen as the only way in which these problems can be overcome. Other than legalising abortion because of the complications that arise as a result of seeking help, women should be given a right to terminate a pregnancy if they are not ready for a baby. Sometimes married women may accidentally become pregnant or worse still they could conceive with someone else other than their marriage partner (UNPD, 2010). Instead of presenting a serious case of infidelity to the husband, the women

may opt to go for an abortion to avoid being caught in embarrassing situations. Thus, the family will be maintained and the husband will never get to know about his wife's infidelity. Alternatively, couples will be given a chance to terminate pregnancies when they realise that they have conceived again and they are incapable of providing for another baby. These will exempt poor families from increased burdens being imposed on them.

Research (Donohue & Levitt, 2001) has shown that since the legalisation of abortion in America, crime rates have gone down such that most people argue that the pregnancies which were terminated must have been those of criminals-to-be. According to that research, unwanted children are more likely to end up in criminal activities

The other reason why abortion should be legalised according to Ehrlich (2006) is because currently moneyed people living in countries where abortion is illegal engage in medical tourism to areas where abortion is legal. They travel on medical grounds and once they land in their destination they are able to afford the services of qualified medical personnel to conduct the procedure. Consequently, those who cannot afford the tour have no option but to conduct the procedures themselves or else consult quack doctors.

Based on the reasons why women want abortion to be legalised, it is quite evident that the reasons are mere excuses which can be prevented. Reasons such as the pregnancy is unwanted can be avoided if only proper education of family planning is provided. Young girls are especially at risk of falling pregnant as they may be ignorant on issues concerning family planning. Most of them also engage in unprotected sex from quite an early age. Therefore, counselling and proper sex education for this category may be helpful.



Alternatively, Donohue (2001) reiterates that family planning services should be easily accessible to all who are in the reproductive age bracket.

The only case that abortion is legal is when the mother's health is dependent on termination of the pregnancy or when the health of the unborn baby is at risk. However, Donohue (2001) stresses that in such cases thorough professional check up is always conducted to determine the necessity of termination. This also calls for alternative procedures such as inducing birth then placing the baby in an incubator especially during the last trimester. In this case, the author concluded, termination of pregnancy is only conducted as a last resort and not as a way of evading responsibility of the pregnancy.

Legalising abortion has been predicted to cause increased moral erosion, especially among women who will engage in immoral activities knowing that there will be someone to clean the mess. This has also been linked to exploitation by health professionals who may set exorbitant fees for conducting the procedures because their services will be widely sought. Legalising the procedure will reduce the stigma such that people will no longer pay much attention to family planning. Therefore, other issues related to immorality such as increased HIV infections may arise (UNPD, 2010).

Although legalising abortion will mean that few deaths will occur due to availability of professional medical care, the emotional trauma associated with abortion cannot be avoided. Consequently, the guilty feeling and subsequent miscarriage may not be avoided as well. This may affect the woman greatly and may even lead to reduced productivity in her career or her academic life may be thwarted due to psychological trauma (Ehrlich, 2006).

Doctors may take advantage of the legalisation to abandon their line of duty in promoting life and sustaining it into carrying out abortions. This is especially evident by the fact that currently even backstreet doctors will always advocate for an abortion without prior suggestion of available options such as adoption. The doctors should be on the forefront to advocate the role of women as mothers and bearers of children thus; they should be allowed to carry the baby to full term. After birth they should then look for ways of getting rid of the baby which is quite difficult. Thus, lives would be saved and another human being will be given a chance to enjoy life (UNPD, 2010).

Sengupta (2010) state that people from different ethnic groups are either in favour or against legalisation of abortion. Some deem abortion as illegal and against their religious law while others say that after abortion was legalised, it has reduced rate of unwanted pregnancies and criminalism. The current U. S. president, Barack Obama has also supported abortion - a legally approved act.

A study conducted by WHO has estimated the population of women who die from unsafe abortions. The abortion facts and statistics showed that nearly 68,000 women risk their life due to certain dangerous and malefic methods. Serious side effects of abortion are also averted with safer medical procedures. Before 1973, abortion was illegal and many pregnant women died due to various complications. It included premature and unpredicted pregnancies that compelled women to abort their babies. Therefore, WHO is in complete favour of abortion as a legal act (Sengupta, 2010).

Pro-choice people are practical in their judgment as they are not concerned about bioethical issues. The arguments for pro-choice abortions

according to Sengupta (2010), indicates that those who believe abortion should be legal generally believe that the decision to end a pregnancy belongs to each individual woman. They believe that women must have the right to protect their body. A foetus does not have any rights until its personhood is established and that begins after 22 weeks of pregnancy. Sengupta referred to this as viable point and a woman can undergo termination before this. Thus pro-choice people lend support to the U.S. Supreme Court's decision.

Pro-life people consider the judgment of U. S. Supreme Court as horrific, barbaric and cold. Pro-life's principle believes that "an egg becomes a fully fledged human life the moment it is fertilised, and that destroying it should be legally equivalent to murder". Their anti-abortion arguments are moulded by ethical values and reasons. For them, abortion is equivalent to a gruesome act that involves taking the life of an innocent one (Sengupta, 2010).

Deists consider themselves as not conservative or liberal. Their faith revolves around God-given reasons and they execute their own thoughts. They have a balanced opinion about the pros and cons of abortion, considering it wrong for the sake of convenience, although they consider that a woman holds the right for her body. Deism does its reasoning scientifically, with the view that a foetus is a distinct individual with separate genetic material. What matters most to Deists is reason, reality, and life, not opinion (Sengupta, 2010).

Abortion should be legalised at all costs because women have a right to make decisions involving their lives, careers and social life. WHO (2006) thinks that making abortion legal will not only increase productivity in building the country's economy, but will also make them achieve their own

goals for the advantage of the entire family. To the body, allowing a woman to bear the burden of the pregnancy alone, especially among teenage girls is more or less reducing her chances of excelling in life.

Sometimes when a woman becomes pregnant as a result of incest or rape, it is more human to terminate the pregnancy. This was buttressed by Donohue (2001) when he emphasised that it will be psychological torture to allow the woman to carry the baby to full term only to give birth to a replica of the rapist. This means that the woman will constantly be reminded of the ugly incidence each and every time she looks at her child. Thus, in such a case the woman will be protected from subsequent memories of such an ordeal and emotional healing may take place more easily in addition to being immediate.

Concerning the reduction of crime and other social vices due to unwanted pregnancies being terminated, this will make countries spend less in fighting crime such that money aside to prevent crime is used to improve health care. More equipment could be provided at all medical centres to increase access of the facilities by women intending to terminate their pregnancy (UNPD, 2010).

### **Socio-Cultural aspects of Adolescent Pregnancy**

Adolescents are likely to drop out of school as a result of pregnancy. This may lead to unemployment with a tendency to crime. Unintended pregnancy can lead to low self-esteem, which may result in drug, alcohol and other substance abuse and predispose the girl to violence and criminal activities, together with other antisocial behaviour (Federal Ministry of Health, 2001).

South Africa, for instance, has a very high rate of adolescent pregnancy and parenthood. The average age of the adolescent mother is about 18 years (Cronje & Grobler, 2003 as cited in Engelbrecht, 2005). Although many

adolescent mothers do achieve a successful outcome of their pregnancy and parenting, mortality and morbidity amongst babies born to these mothers is increased and the mothers show a higher risk of developing complications such as hypertensive disorders and intra partum complications (Fraser, Cooper & Nolte, 2006). For many adolescent mothers, pregnancy and parenthood mean an early conclusion to their education, with consequently reduced career opportunities and increased likelihood that they will find themselves socially excluded and living in poverty (Fraser et al 2006).

### **Cultural aspects of Adolescent Pregnancy**

In Nigeria it is not culturally acceptable for a girl to get pregnant before marriage (Akinrinola, Oye-Adeniran, Singh, Adewole, Wulf, Sedgh & Hussein, 2006:42; Henshaw, Singh, Oye-Adeeniran, Adewale, Iwere & Cuca, 1998; Irinoye, Oyeleye, Adeyemi, & Tope-Ojo, 2004). There are widespread differences in the perceptions of conception, pregnancy and birth among different cultural groups (Elder, 1998). One of such is that if one aborts a pregnancy one may not have children in future. The inherited belief system of a particular society informs members about the nature of conception, the proper conditions of procreation and child-bearing, the workings of pregnancy and labour, and the rules of pre- and post-natal behaviour.

Beliefs about the functioning of the body, and the nature of conception and pregnancy, especially when the woman is most likely to conceive, are a key aspect of any birth culture. In all societies, the division of the social world into male and female categories means that boys and girls are socialised in different ways (Helman, 2007). They are educated to have different expectations of life, to develop emotionally and intellectually in particular

ways, and are subject in their daily lives to different norms and behaviour. Whatever the contribution of biology to human behaviour, it is clear that culture also contributes a set of guidelines, both explicit and implicit, that are acquired from infancy onwards, and tell the individual how to perceive, think, feel and act as either a male or a female member of society.

One of the most basic elements of social structure and an important part of the symbolic system of any particular society is the division of society into two gender cultures. In a study among Muslim Swahilis, Kenya, on the division of norms, Helman (2007) found that men considered women to be sexually enthusiastic and sexually responsible, given the opportunity. Women were expected to be dependent on men, but at the same time the men also feared the polluting power of their menstrual blood. Men were expected to support and therefore control both women and children. This control was considered most effective when exerted over the virginity of their unmarried daughters, but less effective when dealing with the faithfulness of their wives (Helman, 2007). For an adolescent girl in that community, marriage and its consummation were the only way to female adulthood.

Different attitudes to contraception and abortion seem to vary widely between cultures. The particular “population policy” of a culture may include a widespread tolerance of abortion, acceptance of abortion under certain limited circumstances or strict taboos against it at any stage (Helman 2007). In the Western world, the debate on abortion centres on both whether the woman is entitled to control over her own body and fertility, and whether the foetus is regarded as a person, with the same rights as other members of the society, or merely as an organ or collection of cells (Helman 2007). Abortion is a

controversial issue in many societies, and there are many different cultural attitudes towards it. In Nigeria, as pointed out in Chapter 1, abortion is illegal.

### **Abortion: The link between Legality and Safety**

Over the years the reproductive health policy of Ghana on reduction of unsafe abortion only dwelt on promotion of family planning, contraception and post-abortion care, but not provision of safe abortion within the confines of the law as recommended by WHO. However, termination of pregnancy to save the mother's life in cases of serious medical conditions like hypertensive disorders, renal failure, etc. and obstetric emergencies like acute haemorrhage in pregnancy has been available in virtually all public and private hospitals in Ghana. Termination of pregnancy on medico-social grounds as indicated in the current law is, however, not readily available in national health institutions in the country. Such services are available in some private institutions especially in urban centres. As a result of illiteracy and social deprivation many women in Ghana do not know their legal rights to safe abortion. There is also anti-abortion social stigma and for many, safe abortion is cost-prohibitive since the service has been left in the hands of a few private practitioners who charge exorbitant fees. Consequently, legal abortion is only available to wealthy and educated women. Thus, although the law criminalises abortion but gives quite liberal grounds on which legal abortion may be permitted, unsafe abortion remains a major cause of maternal morbidity and mortality in Ghana.

Following the inclusion of “provision of abortion” in the reproductive health policy of December, 2003, the Ministry of Health has taken up the

challenge to have the policy implemented within the confines of the current law. Service protocols have also revealed an advanced stage of development.

Between 1955 and 1975 most industrialised countries liberalised their abortion laws. Since then, progress in efforts to legalise abortion elsewhere has slowed almost to a standstill. Access to legal abortion continues to elude much of the Third World (Kissling, 1993).

In many countries almost all abortions are illegal; in others, moderate laws are simply not implemented. Recently, organised opposition to legalising abortion has grown and become stronger in some countries, notably eastern Europe, and abortion laws have become more, not less restrictive (Kissling, 1993).

Kissling (1993), recognising the overwhelming difficulty of extending legalisation and the terrible toll of “back-alley” abortions, some abortion rights advocates have shifted their efforts from legalisation to the provision of safer illegal or quasi-legal abortion services. These services have been widely discussed in the international community. Although they reach only a small minority of women seeking abortions, they have vastly improved the quality and safety of abortion for those women they do serve. Not only are they substantially safer medically than back-alley abortions, many are organised by caring individuals who offer more than abortion itself, by providing counselling, legal assistance and other reproductive health services. They are frequently cited as model programmes, and their expansion is offered as a possible alternative to legislation.

It is not surprising that the success of these services, coupled with the difficulty of legal change, has led to an increasing separation of the question of



abortion safety from that of its legalisation. The call for safe and legal abortion has been effectively replaced by the call for merely safe abortion. (Kissling, 1993).

This concept of a safe but illegal abortion should not be accepted at face value, for it raises at least three serious questions: First, what do we mean by a safe abortion? is safety to be defined largely within the parameters of medicine? Second, even if one adopts a medical definition of safety, are there limits to a provider's ability to deliver a medically safe abortion where the procedure is illegal? Finally, will the promotion of the concept of safety detach from legality and reduce the already troubled drive to legalise abortion?

#### **What do we mean by safe?**

At the most basic level, those who talk about safe abortion want to avoid the mortality and morbidity associated with illegal abortion. This is an important goal and, given the increasing simplicity of abortion technology, it is increasingly possible to achieve this end. However, it is only the first step toward safety. Abortion is much more than a medical procedure. Women's well-being is more than the absence of mortality and morbidity. It includes social, psychological and so long as abortion is illegal political dimension (Kissling, 1993).

Kissling (1993) said there is nothing safe about the risk of imprisonment either for the woman or the provider. Women's well-being is poorly served if we are required to become criminals in order to have control over our fertility. Even where the state knowingly tolerates illegal abortion, women and providers never know when a crackdown will occur. A woman does not know if the clinic will be late with a protection payment the week she visits. She

does not know if a new minister of health or police chief will respond to right-to-life pressure by raiding the clinic the day she is there. She does not know if the clinic is under observation and whether or not that will be the night her home will be visited and black mail begin.

Participation in illegal abortions requires both provider and patient to circumscribe other aspects of the exercise of freedom in order to minimise the risk of exposure and even criminal charges. It may also influence decisions about political activism on a range of issues, particularly those that require taking positions likely to challenge government policy on any issue. Some women have expressed concern that an illegal abortion would be revealed if they worked to legalise abortion or on related women's rights issues, or even more broadly to correct human rights abuses. Some have been reluctant to run for political office (Kissling, 1993).

History shows that when abortions are performed illegally, the power relationship between patient and provider is profoundly skewed in favour of the provider. Even a medically competent physician might use this power relationship in a manner that is not in the interest of the patient.

It would be tragic if, in our desire to prevent women from suffering the medical consequences of illegal abortion, we unwittingly undermine raising consciousness about the injustice and absence of human dignity always present in illegal abortions.

### **Studies related to Abortion**

Several attempts have been made in different parts of the world to study abortion. A brief summary of some of the related studies are present. Sudev (as cited in Jagnayak, 2005) reported on the reason for the acceptance of

induced abortion in Trivandrum. It tries to determine the reason for the abortion for all marital status groups. Important reasons for the out-of-wedlock conceptions were false promises of security given by the man, promises of marriage and lack of knowledge about the consequences of sexual intercourse. The major reason for unwanted conception among married women who were exposed to the risk of conception was contraceptive failure. The general finding of the study is that the better-educated women had benefited from the programme of legalised abortion better than the less educated.

Lauvie Schbim Zabim et al. (as cited in Jagnayak, 2005) studied the consequences of abortion among adolescents with respect to education and their psychological status in Maryland. The author found that those who obtained abortions were adversely affected by their abortion experience. The study pointed that those who had obtained abortion were better off economically and the analysis of psychological stress showed that those who terminate their pregnancy had experienced no greater levels of stress and they were no more likely to have psychological problems two years later.

Sarkar (as cited in Jagnayak, 2005) conducted a study on Legally Induced Abortion in India and re-evaluated legally induced abortion in the perspective of the national family planning programme. A large proportion of their acceptors were in their twenties. Acceptors of legally induced abortion by a large number of young women have shown that the concept of a small family is gaining importance.

Sureendar et al (as cited in Jagnayak, 2005) made an attempt to find out the prevalence of abortion during the period 1976-77 and 1988-89 in the major

states of India. The results revealed that the incidence of abortion has been declining over the years and there has been a decline in the percentage of those opting for abortion at their late duration of pregnancy. The failure of contraception has been the major reason given by those who opted for abortion in both 1976-77 and 1988-89.

The paper “Adolescent Premarital Childbearing” of Lundberg et al (as cited in Jagnayak, 2005) pointed out that welfare, abortion and family planning policy variables do not explain premarital childbearing. Miller (as cited in Jagnayak, 2005) makes an analysis of the risk factors for adolescent non-marital childbearing. The author as a high-risk population views teenagers, because 72% of teenage births in 1992 were non-marital which is an increase from 15% in 1960 (US). It is concluded that there is not only any single factor responsible for teenage non-marital childbearing, but adolescents from disadvantaged families and communities are at great risk.

Based on the data obtained from eleven European countries, Creatsan (1995) analysed the pattern of adolescent pregnancy in Europe. Findings indicate that adolescent pregnancy rates during 1985-89 remained stable or declined. Germany had the highest rates of adolescent pregnancy, followed by United Kingdom. The Netherlands had the lowest adolescent abortion rate with 0.4% in 1987.

The paper by DeClerque (1995) which summarized findings from the rural Adolescent Pregnancy Project, analysed secondary data on rural adolescent pregnancy and fertility during 1985-94 in the southern States of the US. It was found that in 1990, birth rates for rural teens aged 18-19 years,

birth rates from rural teens aged 18-19 years for all the states were 17% higher than for teens in urban areas.

The Center for Health Services Research University of North Carolina (1995 [as cited in Jagnayak, 2005]) conducted a comprehensive analysis of adolescent pregnancy and its prevention in some states of US. The study's major finding was the adolescent pregnancy and birth rates for 15-19 year olds in rural as in urban areas, while the abortion rate was substantially lower in rural areas. And 84% of programmes that serve rural youth are located in an urban or suburban area.

Goldenberg and Kleman (1995) analysed adolescent pregnancy in US with a different perspective. It is reported that in 1992, more than 9 million pregnancies in women under the age 20 years resulted in 12.7% of all live births, 14% of the pregnancies ended in miscarriages and 35% in induced abortion.

Pearson et al (as cited in Jagnayak, 2005) revealed important information about the special family planning needs of this population. About 71% of the teenagers were using contraception at the time of conception and 98.2% of teens had heard of family planning clinics. A high rate of contraceptive failure in this groups suggest the need for school-based sex education programmes to increase knowledge of the proper use of methods such as condoms and greater promotion of more effective contraceptive methods.

The health facility to examine pregnancy outcomes and incidence of pregnancy complications among adolescents are also studied by Unger et al (as cited in Jagnayak, 2005). The study was conducted in selected hospitals in Rome between 1984 and 1993. It was found that adolescents were likely to

have had a spontaneous abortion. Foetal distress was more common in adolescents than in the 20-24 year old group. It was also found that the average birth weight for infants born to adolescent mothers was lower than that for those born to controls and it was especially low for 14-15 year olds.

In a study by Kosunen et al (as cited in Jagnayak, 2005) population register was used to examine regional patterns of adolescent pregnancy and abortion in Finland's provinces during 1976-93. Findings revealed that pregnancies among girls aged 15-19 years and adolescent abortion declined during 1975-1993. During the study period, induced abortion was more frequent than childbirths among young adolescents. Older adolescent childbirths and abortions varied in the early 1990s between southern and northern provinces.

Esiet (as cited in Jagnayak, 2005) using data from the Nigerian country Report for the ICPD indicate that 25% of sexually active teenage females in Nigeria have had at least one complication arising from usage of induced abortion and it is the leading cause of death among adolescent female students in the country. The author supports the recent approval of National Council on Health regarding National Policy on Adolescent Health.

Montessoro (as cited in Jagnayak, 2005) studied public policy and adolescent pregnancy in United States. The study reveals that in the US, 45% of female adolescent engage in premarital sex, 40% will become pregnant before reaching the age of 20, and four-fifth of these pregnancies will be unintended. Another study by American Academy of Pediatrics Committee on Adolescence (1996) reveals that adolescents have the right to confidential care when they are considering an abortion.

Scommegna (as cited in Jagnayak, 2005) studied “Teens Risk of Aids” and found that approximately 1.6 million of the world’s population are 10-24 years old. The proportion of teen births to unwed mothers had risen by 50 percent in the US since 1980 and by almost 70 percent in Kenya during the 1980s. Approximately, 2 million adolescent women in developing countries have illegal, unsafe abortions each year, with at least 10 percent of all abortions worldwide occurring among ages 15-19.

In a study Johansson (as cited in Jagnayak, 2005) explored the circumstances of abortions from women’s perspectives. The study results revealed that most abortions among women in the study villages were performed quite early in the pregnancy, and none were reported after the 12th week. Only 9% of the women undergoing abortion in this study were younger than 25 years. As a conclusion, the authors suggest that the rapid increase in abortions in recent years is the combined effect of stricter population policies and a wish for smaller families while contraceptive services are still inadequate.

Eutwisie et al (as cited in Jagnayak, 2005) describes findings from a new source of data for estimating the incidence of induced abortion in the Russian Federation. According to Eutwisie, the abortion rate in 1994 was 56 per 1000 women, an estimate that varies from that advanced by official sources and other studies. The sensitivity of this estimate to survey design, under reporting of abortion and potential confusion about mini abortions is considered. Consistency of abortion estimates with patterns of contraceptive use is also evaluated. A significant advantage of the present data is the ability to estimate abortion rates specific to respondent characteristics.

### **Studies Related to Knowledge on Abortion**

A comparative study of spontaneous and self induced abortion cases in married women at two Calcutta hospitals indicated that 350 cases of spontaneous abortion cases were registered during 1972 to August 1973. On examination it was found that most of these cases were septic, which revealed that many self induced abortion cases were admitted to the hospitals on the pretext of being spontaneous. The study showed that most of the women were illiterates and of low social economic status and nearly 46 cases were detected as self induce; insertion of a stick form a shrub was the method of practice used to induce abortion and a follow up was done at home or at clinics thereafter (Bose as cited in Jabagany, 2005).

Banerjee, Sinha, Kriplani, Roy and Takkar (as cited in Jagabany, 2005) conducted a study to identify the factors involved in the occurrence of unwanted pregnancy in 402 women seeking medical termination of pregnancy and to describe their contraceptive practices. Information was collected about their demographic variables, contraceptive practices and reasons for the unwanted pregnancy. The results showed that all the women were married and multifarious and the husband's unwillingness for contraception and the improper use of condoms were responsible. One-third of all pregnancies (11.3%) of women believed that lactation could protect pregnancy, and 6.3% were not aware of any contraceptive method. The study suggested that giving attention to public health programmes regarding these aspects will help in decreasing the number of unwanted pregnancies.

A retrospective study was undertaken by Goyaux, Yace-Soumah, Welffens-Ekrac, and Thonneau (as cited in Jabagany, 2005) among 472



women admitted to obstetrics department in Abidjan, Ivory Coast to assess the effect of various abortion practices on maternal health. The authors assessed the social demographic and medical characteristics of the women. Results demonstrated that introduction of plant stems into the uterus was the most frequently used abortion method (31%). About 176 maternal deaths were recorded, giving a maternal mortality rate of 3.6%. A high number of previous pregnancies and the ingestion of plants to provoke abortion were the factors associated with the highest risk of maternal death. The complications resulting from local abortion methods account for a high proportion of maternal deaths, the authors concluded.

Palukuu, Mabuza, Madun and Ndimande (2010) in a study on the sources of information of abortion methods of girls in secondary schools in Goma indicated that their sources were radio (66.2%, N=217), friends (31.7%, N=104), parents (1.5%, N=5) and church (0.5%, N= 2). The health consequences of illegal abortion mentioned by the girls were death, infertility, infection and bleeding. Of the participants, 9.8% (32) had committed an abortion before and 46% (151) knew where to obtain it; 76.2% (250) of the participants were against illegal abortion, while 23.8% (78) supported it. Palukuu et al. concluded that the girls in secondary schools in Goma had good knowledge of the illegal abortion practice and its consequences. The authors also said a fifth of the secondary girls were in support of the procedure. So the Democratic Republic of Congo (DRC) government may need to consider legalising abortion to secure a healthy future for affected girls.

In a study conducted in Korea, it was found that the mass media had informed the public about several sexual problems facing that country,

including early sexual intercourse among the youth, unwanted pregnancies and increased rate of induced abortions. Kang (as cited in Palukuu, Mabuza, Maduna & Ndimande, 2010).

Stone and Wazak (1992) in a study of adolescents from cities across the United States revealed that the adolescents lacked accurate knowledge about abortion and the law governing it. The authors say most of the adolescents expressed enormous beliefs about abortion, describing it as medically dangerous, emotionally damaging and widely illegal. The study also revealed that antiabortion views, conservative morality and religious beliefs were the primary sources of these adolescents' attitudes towards abortion (Palukuu, Mabuza, Maduna & Ndimande, 2010).

In a cross-sectional descriptive study carried out between July 1995 and June 1996 on adolescents aged 10-19 years in schools in Nairobi and Kiambu districts, and a group of immediate post-abortion adolescent girls in some health facilities in Nairobi, Mutungi, Karanja, Kimani, Rogo and Wango (1999) related that 1,952 adolescents comprising 1,048 school girls, 580 boys, 192 post-abortion girls and 132 adolescents in the focus group discussions, formed the study sample. The results indicated that more than 90% were aware of induced abortion. Seventy-one percent of school girls, 84% of post-abortion and 40% school boys were aware of abortion-related complications, the most common being infections, death and infertility. Eighty-three percent of post-abortion girls felt that complications were preventable by seeking care from a qualified doctor compared to one quarter each for the school boys and school girls. Fifty-six percent post-abortion girls, 69% school boys and 72% school girls felt that abortions were preventable. However, less than 40%

proposed abstinence as a primary strategy. The most important source of information on abortion was the media followed by friends and teachers.

Kumar, Malik, Qureshi, Khurram, Chaudhary, Paul, Malik and Mahmud (2010) conducted a cross-sectional opinion survey study to determine the knowledge, attitudes and perceptions regarding induced abortions among university students of Karachi and compared these aspects among medical and non-medical students. Of the 381 students interviewed, 201 were medical and 180 were non-medical. Results showed that more medical students were aware of the correct definition of induced abortion. But the authors say there is a need to improve awareness regarding induced and unsafe abortions and their consequences.

Jagnayak (2005) research study observed that majority of the respondents had fairly good knowledge about the term abortion in general. Over 97.5% of the total respondents had knowledge about the term abortion.

### **Minors' Opinions and Perceptions about Abortion**

During focus group discussions (FGDs) and in-depth Interviews (IDIs) most minors expressed that abortion is considered as sin, socially immoral, murder, and crime (Alemu, 2010). Only two of the informants and discussants explained that abortion is not good for mental and physical health, but commented that it is a good solution for our anxiety. Therefore, they did not consider it as committing sin and crime. Alemu (2010) said one of the discussants believes that early pregnancy is blood and has no life until three months but abortion after three months is killing human beings. When the question was posted to the FGD participants what they would do if unintended pregnancy happened to them? Out of eleven girls in the FGDs, five girls

mentioned that they will terminate the pregnancy (Alemu, 2010). They also added that “we are from poor family and living condition is getting worse. Though we know abortion is killing and killing is sin, we prefer to undertake abortion than giving birth for a baby that we “cannot raise properly. Since God is merciful; he will forgive us and we will abort and confess .Giving birth and exposing your child to suffer in poverty is also sin” (Alemu, 2010). The remaining girls replied that they will give birth and give the baby to those who can raise the baby instead of killing the innocent and committing unbearable sin. They prefer life after death which they described as eternal whereas life in this world is temporary. Surprisingly one of the girls in FGD opposing abortion said “if I cannot find adoption center or individuals to raise the baby I will put my baby at the gate of a rich person’s house” (Alemu, 2010).

### **Abortion Legalisation within a Human Rights Framework**

Despite decades of international debates, maternal mortality remains unacceptably high in many of the world’s poorest countries. The difference in levels of maternal mortality between the developing and industrialised world is greater than for any other health indicator (Tinker et al as cited in Hord & Wolf, 2004). In developed countries, women generally have access to safe pregnancies, birth and motherhood due to the availability of high quality obstetric and maternal health –related care. However, inadequate access to such care in developing countries poses a threat to the lives of many women.

An important contributor to pregnancy – related death in the developing world is unsafe abortion (Hord & Wolf, 2004). The WHO (1997) defines an unsafe abortion as a procedure for the termination of an unwanted pregnancy that is performed by someone who lacks the necessary skills or which takes

place in an environment that lacks minimum medical standards, or both. Hord & Wold (2004) note that this clinical definition of unsafe abortion obscures the reality of the situation, which is one of utter desperation faced by many women confronted with unwanted pregnancies and having no other option but resort to crude methods and unskilled practitioner.

Approximately 95% of all unsafe abortion procedures occur in the developing world (WHO, 1997). Africa is faced with 4.2million unsafe abortions annually, which translates to an unsafe abortion rate of 2 per 1000 women, or one unsafe abortion for every seven live births. In comparison, developing countries experience roughly one unsafe abortion per 25 live births (Ahman & Shah, 2002). It is estimated that death due to unsafe abortion accounts for a global average of 13% of all pregnancy related mortality (WHO, 1997). In 2000, an estimated 30, 000 deaths resulted from unsafe abortion practices throughout Africa, equalling 40% of all unsafe abortion – related deaths. Of all the regions, Africa has by far the highest unsafe abortion mortality rate (100 for every 100 000 live births) due to the use of high risk unsafe abortion methods and poor access to health services (WHO, 2004).

In recent decades, most countries have come to realise the importance of reproductive health, in particular for women. Achieving reproductive rights awards great benefits for economic and social life. Given the choice, most men and women prefer to have smaller families, which lowers the morbidity and mortality burden, lessens the devastation of hunger and improves the education and opportunities for people. This has led many countries to ratify various treaties and programmes regarding population and development. (UNFPA, 1999 as cited in Engelbrecht, 2005). The 1990s are heralded as an

outstanding decade for bringing issues of reproductive health and health rights to the centre of global and national dialogue on human rights and development (UNFPA, 2004 as cited in Engelbrecht, 2005). The 1994 ICPD, the 1995 Beijing Conference and the 1999 ICPD +5 led to the development of specific consensus documents focusing on various aspects of women's health. Each consensus document progressively elaborates on women's rights and more particularly, reproductive health and safe abortion.

### **Reproductive Health and Human Rights**

According to United Nations Population Fund (UNFPA) (1999), rights, whether for women or men, lay the foundation for prosperity and a better quality life for all people. More specifically, "reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents" these rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in

human rights documents”(Beijing Platform for Action, 1995 as cited in Engelbrecht, 2005).

The right to reproductive health is not new; it is an essential component of long established and internationally recognised human rights. The concept of protecting individual dignity and rights was codified with the adoption of the United Nations’ Universal Declaration of Human Rights in 1948. The declaration laid the foundation for the development of treaties and covenants which outline standard and obligations for human rights to which signatory countries must adhere. This led to the establishment of international committees and courts that are tasked to monitor compliance with human rights (Sai, 2004). The right to reproductive health is captured in the following basic human rights:

1. The rights to life, survival and sexuality. In order to achieve these rights, governments are required to remove barriers to basic services needed for reproductive and sexual health (e.g. essential obstetric care) (Cook et al, 2003 as cited in Engelbrecht, 2005). Restrictive abortion laws encourage unsafe abortion and therefore, governments promoting such laws may be guilty of failing to recognise the right to liberty and security of the person. In addition, governments that deny women access to abortion services may be ignoring the right to be free from inhuman and degrading treatment. As such, it is considered that the South African CTOPA removes barriers to abortion by offering every woman in South Africa the opportunity to have a safe and legal abortion. Designated facilities throughout the country have trained doctors, midwives and registered nurses to perform and assist with

abortion procedures. However, this is not to say that access to abortion in South Africa is without impediments.

2. The rights to reproductive self - determination and free choice of maternity. Included under this framework are: the right to decide freely on the number and spacing of one's children and the right to private and family life; the right to marry and to have a family; and, the right to maternity protection (Cook et al., 2003 as cited in Engelbrecht, 2005). Traditional Black South African women are at a disadvantage as they are controlled to various degrees by customary law, which prohibits them from making their own decisions. This impacts on their reproductive choices, amongst others. the decision to use contraceptives.
3. The rights to health and the benefits of scientific progress. An important aspect of these rights is the right to the highest attainable standard of health. The right to health depends on the availability, accessibility and quality of health services. Governments need to ensure that health care facilities, goods and services, as well as essential drugs, are readily available and that sufficient quantities are on hand. Accessibility comprises four overlapping dimensions: non-discrimination (i.e. accessible to all), physical accessibility, economic accessibility, and information accessibility. In addition, health care facilities should be acceptable, which implies that these services are ethically and culturally appropriate. Quality of services suggests that the services provided at health care at health care facilities should be scientifically and medically appropriate and of good quality. Hence



there should skilled personnel, approved drugs that have not expired and appropriate equipment available at health care facilities (CESRC, 2000: article 12). In line with this, section 3 of the CTOPA outlines various requirements, including access to personnel, equipment and drugs, that must be available before a facility (both public and private) may render abortion services in South Africa.

4. The rights to non-discrimination and due respect for difference. Persons have the right not to be discriminated against on the basis of race colour, sex, language, religion, political, beliefs, origin, prosperity, birth or any other status (international covenant on civil and political rights, 2(1), 1976). The constitution (1996) promotes reproductive rights by ensuring that internationally recognised human rights are also maintained in South Africa. More specifically, the constitution (1996) implicitly makes provision for the right not to be discriminated against significantly; everyone has the right to freedom of conscience, belief, religion, thought and opinion (section 15(1)).
5. The rights to information, education and decision – making. According to Article 19(2) and (3) of the international covenant on civil and political rights (1976), “everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice”. In addition, Article 13 recognises that everyone has the right to education. Article 18, acknowledges the right to freedom of thought, conscience and religion. Similarly, the South African

Constitution (1996) recognises that everyone has the right to education (section 29(1)) and access to information (section 32(1)). Additionally, the CTOPA requires health care workers to provide women requesting a TOP with information concerning the legal requirements for TOP and the location of facilities providing the service.

The intention of human rights is to empower those who are powerless and, as is to be expected, much resistance has been encountered from those who have enjoyed privileges and power. This is also true in the reproductive health field where the paternalistic control of reproductive health decision has continued to prevail. Human rights are useful tools to shape and mould reproductive and sexual freedom, as well as for monitoring the work of international rights treaties (Cook, Dickens & Fathalla, 2003). Seen broadly, reproductive rights entail two principles: the right to reproductive health care and the right to reproductive self determination.

The right to reproductive health care. Reproductive health is an essential facet of women's well-being. Lack of access to safe, quality health services may result in complications such as maternal mortality and morbidity, unwanted pregnancies and sexually transmitted infections (S T Is). Therefore, reproductive rights imply that governments should ensure the availability of comprehensive reproductive health care services, which include; measures to promote safe motherhood, treatment of HIV/AIDS related illnesses and S T Is, abortion, infertility treatments, and contraceptive, including emergency contraceptives. The right to reproductive health care is encompassed in international human rights instruments which protect life and health, including: the Universal Declaration of Human Rights and the International

Covenant on Civil and Political Rights (Centre for Reproductive Law and Policy, 2000).

Article 12 of the international covenant on Economic, Social and Cultural Rights (1966) recognises the right of everyone to the highest achievable standard of physical and mental health. The WHO (1948) (as cited in Engelbrecht, 2005) defines health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. Similarly, the Programme of Action of the ICPD (1994 as cited in Engelbrecht, 2005) defines reproductive health as complete well-being in all matters relating to the reproductive system and its function and processes. The right to ensure that health care is available. According to the international covenant on economic, social and cultural rights (1966 as cited in Engelbrecht, 2005) governments should create ‘conditions which would assure to all medical services and medical attention in the event of sicknesses.

International human rights agreements and instruments recognise the right of individuals to health and more specifically, the right to reproductive health care. Countries party to such instruments are obliged to ensure that health care is available. Understandably, the quality of such care differs from country to country depending on, amongst others, socio-economic and cultural factors. The South African constitution (1996 as cited in Engelbrecht, 2005) “gives conspicuous expression to the idea of a fundamental right to health care for all. It translates to the health care sector the values of social justice, equality under the law and respect for human right” (Van Rensburg & Peiser, 2004). Therefore, the foundation is laid for a liberal and egalitarian health care sector in South Africa, which guarantees everyone the right of access to basic health

care service. More specifically, in terms of reproductive health, the constitution 1996 guarantees everyone the right to:

1. Bodily and psychological integrity, including the right to make decisions concerning reproduction (section 12(2), which in conjunction with the CTOPA, allows women to choose to have an abortion. This links with the right to reproductive self-determination, which is discussed in the following paragraph (2.2 the right to reproductive – self determination).
2. Security in and control over their body (section 12(2).
3. Have access to health care services, including reproductive health care (section 27(1)(a))
4. Have access to emergency medical treatment (section 28(1) (c )).

The right to reproductive self-determination: the right to reproductive self –determination refers to the right to plan one’s family and the right to freedom from violence and coercion that may influence a woman’s sexual or reproductive life. The CEDAW (1979 as cited in Engelbrecht, 2005) affirms and gives legal force to the right to plan one’s family in terms of the number and spacing of children. This implies that governments will make available, to men and women, various contraceptive methods as well as information about sexual and reproductive health (Centre for Reproductive Law and Policy, 2000). According to the programme of Action of the ICPD (1994 as cited in Engelbrecht, 2005), women have the right to make reproductive choices “free of discrimination, coercion and violence”. The CEDAW (1979, as cited in Engelbrecht, 2005) notes that governments party to the convention should “take all appropriate measures to eliminate discrimination against women in

the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning”.(p.12)

Moodley (1995) notes that for women in developing countries the notion of choice and right to control over one’s body is meaningless if women do not have any resources or power, let alone an awareness of their rights . For example, women are generally more socially vulnerable than men as they lack education, social status, resources and decision-making power. This is especially true when it comes to deciding whether, when, and under what circumstances they will have sexual relations and if or how often they want to have children. Cultural and economic reasons often prevent women from accessing certain services. Due to their biological and social vulnerability, women need to be able to make choices concerning their sexual and reproductive lives. It is in this area that human rights instruments can play an important role. In order for improvements to occur in women’s health, not only is better science and health care needed, but also state action to address injustices to women.

### **Summary of Literature Review**

Abortion is the termination of pregnancy. It is the procedure where a developing baby is removed from a woman’s body so that it is not born alive. The individual self, the social body and the body politic come together to elaborate on girls’ access and awareness to safe abortion service. Apart from the biological nature of the body, individuals within different cultures have different perceptions, experiences and constructions about the body, hence the

different perceptions about abortion. Abortion is highly debatable in Ghana where culture and religious values are widely practiced.

Literature has it that abortions at the woman's request were first performed in post revolutionary Russia in 1920 followed by Japan, then several East European nations after world war II. In the late 1960s abortion regulations became more liberal worldwide. This has existed since then till now. The WHO has thus formulated protocols and guidelines specifically for the management of unsafe abortion including those resulting in incomplete abortion. This became manifested when WHO revealed that, of the 58,500 maternal deaths that occur worldwide each year, 99% are in the developing world.

Spontaneous (miscarriages) and induced or unintentional and intentional abortion are the two main types of abortion identified, each of which has its sub-forms. A study by Ahiadeke (2004) on the prevalence of induced abortion revealed that eight communities in four out of the 10 regions in Ghana engage in induced abortion at 17 per 1,000 women of childbearing age. This was when he sampled 1689 people. In a hospital based survey, Adanu estimated an induced abortion prevalence of 31% at Korle-Bu Teaching Hospital.

The unsafe nature of such abortions is the price women are expected to pay for having transgressed by refusing maternity. Unsafe abortion is a major cause of injury and death among women worldwide. Although data are imprecise, it is estimated that approximately 20 million unsafe abortions are performed annually, with 97% taking place in developing countries. The most common abortion complications are incomplete abortion, sepsis, haemorrhage, and intra-abdominal injury.

Adolescents seek abortion because of shame and the stigma associated with unwanted pregnancy, desire to continue education, pregnancy as a result of rape or incest, pregnancy endangering the health of the adolescent, pressure from irresponsible partners, uncertainty about the paternity of the pregnancy, fear of being forced into marriage, too young to bear a child, inability to cater for a baby, and partner's refusal to accept pregnancy.

The current law on abortion reveals that pregnancies could be aborted when they are to save the mother's life in cases of serious medical conditions like hypertensive disorders, renal failure, and obstetric emergencies like acute haemorrhage. Termination of pregnancy on medico-social grounds is not readily available in national health institutions in Ghana. Such services are available in some private institutions, especially in urban centres. The spiral-web in which abortion finds itself calls for concerted efforts to adequately manage it in all fronts of life. It is therefore imperative to seek the perceptions of SHS girls in New Juaben Municipality on legalisation of abortion in Ghana.

## **CHAPTER THREE**

### **METHODOLOGY**

The main aim of this study was to investigate the perceptions of Senior High School girls in the New Juaben Municipality on legalisation of abortion in Ghana in the light of the many reported cases of unsafe abortions and the numerous health problems associated with them. The methods and procedures of obtaining data for the study were given treatment in this chapter. Specifically, it focused on the research design, population, sample, and sampling procedure, instrument, validity and reliability of instrument, data collection and data analysis procedure.

#### **Research Design**

The research was a descriptive survey which assessed the perceptions of SHS girls on legalisation of abortion. The purpose of such a design is to provide an explicit description of the phenomenon explored so that it can be addressed in the main issue (Burns & Grove, 2005). According to Neuman (1997), a descriptive study “seeks to give details about characteristics of a phenomenon of interest”. At times, descriptive research is concerned with how and what is, or how what exists is related to some preceding event that has influenced or affected a present condition or event (Ofo, 2005).



## **Population**

A population of 1,739,535 aged six years and older representing 30.6% in the Eastern region have never attended school. The proportion of Middle or Junior High School (JHS) education is 30.1% while 25.5% have primary education. Only 2.0% have reached the tertiary level. The level of educational attainment for both males and females varies. Of the male population aged, six years and older, 24.0% have never attended school, compared with 37.1% for the females. Of the total enrolment of 513,068 aged six years and older, in schools in the region, 62.4% are at the primary level, 23.1% at the Junior High School and 6.9% at the SHS levels (Ghana Education Service [G.E.S] Eastern Regional Office, 2010).

The target population consisted of all SHS girls in New Juaben Municipality. The accessible population comprised all the 9,100 girls in the seven female inclusive public SHSs in New Juaben Municipality. New Juaben Municipality falls within the Eastern Region of Ghana. The Municipality covers an estimated area of 110 square kilometres constituting 0.57 % of the total land area of the Eastern Region. The Municipality has 48 electoral areas.

The Municipality shares boundaries with East-Akim Municipality to the Northeast, Akwapim North District to the East and South and Suhum Kraboa Coaltar District to the West. Koforidua City (New Juaben) is made up of several towns and neighbourhoods, including Effiduase, Asokore, Oyoko, Suhyen, Dansuagya, Betom, Srodae, and so on. The Municipality has nine SHSs, eight basic schools; one university, one college of education and one nurse's college.

## **Sample and Sampling Procedure**

A combination of the purposive stratified and simple random sampling techniques were used to conduct the study. Purposive random sampling technique was used for the selection of the seven SHSs in the Municipality. Each school was considered as a stratum. This sampling technique was used because the issue under discussion which was abortion involved girls. A random sample of 455 out of 9,100 SHS girls in New Juaben Municipality was used for the research. This sample size was used based on Bouma and Atkinson's study (as cited in Agyedu, Donkor & Obeng, 2007) on determination of the sample size to use for research. The authors indicated that:

1. If statistics are to be used in the analysis and the interpretation of the data, there are usually requirements for sample size. Some statistics demand that the sample size must be large whilst others do not.
2. The more accurately we accept the data to reflect the total population, the larger will be the sample size and the more reliable and valid the results based on it will become.
3. The more questions asked, the more controls introduced, and the greater the details of analysis of the data, the larger the size will have to be in order to provide sufficient data for the analysis.

Nwana's study (as cited in Agyedu, Donkor & Obeng, 2007) stipulates that if the population is few hundreds a 40% or more sample size will do; if several hundreds a 20% sample size will do; if a few thousands a 10% sample will do; and if several thousands 5% or less sample will do. However, this

scheme can help only when it is viewed in relation to the three issues raised by Bouma and Atkinson.

Based on the fact that the accessible population for this study could be described as several thousands (9,100), I used 5% to derive the sample; thus  $5/100 \times 9,100$  equals 455. This comprised 65 respondents from each of the seven SHS. A table of random numbers was used to generate at least 16 respondents from each year group in each school using random numbers generated from the computer. In this regard, data that were obtained from this sample was the one from which generalisations or inferences about the entire population were made.

### **Instrument**

A researcher-developed questionnaire was the main instrument used for the study (see Appendix A). Nworgu (1991) stated that with questionnaire, “we can obtain data on the feelings and perceptions of a group of people toward certain things such as their attitudinal disposition” (p. 19).

The questionnaire was favoured because it requires little time of the respondent, allows for broad geographic sampling, cost of distribution and return is low. This was in line with the guidelines suggested by Nwana (as cited in Nworgu, 1991). The questionnaire consisted of five sections, namely data on views section A sought for demographic data of the respondents. Only a single question was asked here, section B was made up of 19 modified four-point Likert scale questions of strongly agree (SA), agree (A), disagree (D), strongly disagree (SD) on students knowledge of legalisation of abortion.

Next was knowledge on the law on abortion (13 items). Section D was on knowledge on awareness of abortion methods (9 items), abortion venues (2

items), abortion providers (2 items) and source of information on abortion (1 item). The final section E was reasons for abortion (2 items). This yielded a total of 48 questionnaire items. On the reasons for abortion, respondents could choose more than one option. The totals and percentages were calculated on the number of options chosen by the respondents. Question 34-45 were used to answer research question one. Question 46 and 47 answered research question two, question 21-33 answered research question three while research question four was answered with questions 2-20.

To ensure the validity and reliability of the instrument, draft copies were submitted to some students of the HPER department to read thoroughly for their suggestions. Next the expert views of the supervisors were taken into consideration to improve on wording and ambiguity.

A pilot study of the instrument was then carried out on a total of 40 students from four SHSs in the Lower Manya District of the Eastern Region. These students were purposively chosen. The pilot was carried out to test the suitability of the instrument for the study in line with Polit and Beck's (2004) exposition on biasness and offer of information. The Cronbach alpha coefficient, a measure of internal consistency, was used to determine the reliability. An internal consistency reliability coefficient of 0.68 was realised. This coefficient was found to be equivalent to the 0.70 that Fraenkel and Wallen (2000) stipulated to be the minimum acceptable figure for statistical analysis.

### **Data Collection Procedure**

I wrote a permission note to the various school heads to use their students for the study and also give out some teachers to assist in collecting data. In

the note that was given out, the purpose or reason for the study was well stated (see Appendix B).

At each school, I gave a brief talk on the relevance of the study to prepare respondents' minds for the task ahead. Data collection took one month. Two weeks for four schools and two weeks for the other three schools. The questionnaire was distributed to school girls through the teachers selected by the heads to assist. Questionnaires were administered either immediately after school, or during break-time and each participant was required to complete the form offhand in the classroom. They were asked not to write their names on the questionnaire to ensure confidentiality. The students were asked to sit alone, to avoid influencing others. Also envelopes were given out to the respondents to put completed questionnaires in. Completed forms were then collected by the teachers who gave them out, thus ensuring a 100% recovery rate.

### **Data Analysis**

The completed questionnaires were numbered, the items coded separately and frequency counts administered through the Statistical Package for Service Solutions (SPSS) Windows 16.0 software. Descriptive statistics of percentages, tables and ranges were then used to discuss the results. For research questions one and two, respondents chose more than one option. The totals and percentages were calculated on the number of respondents that chose the option.

The 13 items on the laws of abortion (research question 3) were marked over 13 and the scores were grouped into a frequency distribution. Those who scored 10-13 were classified as having adequate knowledge; 5-9 were those

with moderate knowledge and 0-4 as inadequate knowledge on the law on abortion.

Research question four (4) was analysed using frequencies and percentages. The strongly agree and agree were fused to be agree and strongly disagree and disagree were also fused to be disagree for analysis.

## **CHAPTER FOUR**

### **RESULTS AND DISCUSSION**

The purpose of this study was to investigate the perceptions of SHS girls in the New Juaben Municipality on legalisation of abortion in Ghana in the light of the many reported cases of unsafe abortions and the numerous health problems associated with them. This chapter covers the presentation, interpretation and discussion of the results collected from primary data.

#### **Research Question 1: What is the Knowledge Level of SHS Girls on Abortion Practices?**

This question was asked to find out the knowledge level of SHS girls on abortion practices. The outcome of the responses given are presented in Tables 1-5, representing students' level of awareness of abortion methods, safety of abortion methods, abortion venues, abortion service providers, extent of the safety of abortion services, and sources of abortion information, respectively.

From Table 1, the top three most popular methods of abortion among the students were sugar with Guinness (52%, n = 235), broken bottles (51%, n = 230) and concoctions (47%, n = 216). The most unpopular method was bicycle spokes (20%, n = 92). From Table 2, the top three methods most students indicated to be safe were sugar with Guinness (91%, n = 214), concoctions (93%, n = 201) and cytotec (63%, n = 112).

**Table 1: Students' Awareness of Methods of Abortion**

Methods	Yes		No	
	n	%	n	%
Sugar with Guinness	235	52	220	48
Broken bottle ground up with seawater, blue and washing detergent	230	51	225	49
Concoctions	216	47	239	53
Paracetamol tablets ground up with alcohol	204	45	251	55
Dilation and Curettage	184	40	271	60
Cytotec	177	39	278	61
Alcohol and lime	161	35	294	65
Boiled Guinness	150	33	305	67
Bicycle spokes or coat hanger	92	20	363	80

Broken bottle (87%, n = 201) and paracetamol with alcohol (71%, n = 145) were those indicated to be the top two most unsafe methods of abortion. It is worthy of note that although D & C is the only recommended method of abortion, only 40% (n = 184) knew about it, ranking fifth out of the nine methods. Worse still, of those who were aware of it, only 40% (n = 74) said D & C was safe, ranking fourth among the nine methods. The most popular venue for abortion as shown in Table 3 is the clinic (90%, n = 408). Although 35% (n = 157) of the students mentioned doctor's house as a venue for abortion, making it the least popular, 38% (n = 174) also mentioned the home as a venue for abortion.



**Table 2: Students' Views on Safety of Methods of Abortion**

Methods	Safe		Not safe		Total	
	n	%	n	%	n	%
Sugar with Guinness	214	91	21	9	235	100
Concoctions	201	93	15	7	216	100
Cytotec	112	63	65	37	177	100
Dilation & Curettage	74	40	110	60	184	100
Paracetamol tablets ground up with alcohol	59	29	145	71	204	100
Alcohol and lime	53	33	108	67	161	100
Boiled Guinness	47	31	103	69	150	100
Bicycle spoke or coat hanger	33	36	59	64	92	100
Broken bottle ground up with seawater, blue and detergent	29	13	201	87	230	100

**Table 3: Students' Knowledge on Venues for Abortion**

Place	Yes		No	
	n	%	n	%
At home	174	38	281	62
A chemist shop	345	76	110	24
Doctor's house	157	35	298	65
At clinic	408	90	47	10

**Table 4: Students' Knowledge on Providers of Abortion**

Providers	Yes		No	
	n	%	n	%
Self	203	45	252	55
Medical doctor	419	92	36	8
Friends	154	34	301	66
Nurse	314	69	140	31

**Table 5: Students' Sources of Information on Abortion**

Source	Yes		No	
	n	%	n	%
Hospitals	392	86	63	14
Family Planning Centre	325	71	130	29
Guidance and Counselling unit	309	68	146	32
Schools	288	63	167	37
Mass Media	277	61	178	39
Books	270	59	185	41
Friends	190	42	265	58
Homes	177	39	278	61
Church	165	36	290	64

From Table 4, the medical doctor is the most popular provider of abortion as indicated by 92% (n = 419) of the students. Although friends were mentioned as the least popular providers of abortion (34%, n = 154), 45% (n = 203) of the girls said that abortion is provided by self. From Table 5, the top

three most popular sources of information for the girls on abortion were hospitals (86%, n = 392), family planning centre (71%, n = 325) and guidance and counselling unit (68%, n = 309). The most unpopular source of information was church (36%, n = 165).

The result affirmed that of Dzissah (2010) which indicated that 70% of respondents in a study were aware of mixing sugar with Guinness for termination of pregnancy. However, Guttmacher Institute (2010) had a contrary view. The institute showed that D & C and cytotec were the preferred methods used for abortion. The response revealed that inserting objects, herbs or other substances in the vagina; receiving an injection and drinking herbal concoctions were the least methods employed in a population study. The results indicate that females generally do not have adequate knowledge of abortion methods. The implication is that they will engage in rampant heterosexuality and go ahead to abort pregnancies if they become pregnant using unorthodox or crude means, including seeing quack doctors. Once they have knowledge of the safe ones which do not cost much, they will employ them.

Again, among the listed methods of abortion, only 20% mentioned the use of bicycle spokes or coat hanger. The remaining 80% had no knowledge of that method. How safe a method of abortion is depends on how it has helped the individual to achieve results without regard for the long term effects. On the perceived safety of the methods used in abortion, majority of the SHS girls said that the safest method of abortion is a mixture of sugar and Guinness followed by concoctions. Accounting for this might be the high cost of

accessing D & C, since the doctors charge exorbitant fees for the service, the least amount ranging between GH¢ 200.00-300.00.

In line with the study result the Ghana Statistical Service (2007) reiterates that adolescents seek abortion in all sorts of places such as hospital, at home, chemist shop, and doctor's house. This is not different from what pertains at the New Juaben Municipality. This knowledge of abortion venues will force teenagers to go to places of their choice be they safe or otherwise to seek abortion with the majority settling for the clinic.

When students are educated on the good methods of abortion and given adequate information, maternal mortality due to unsafe abortion related cases could be a thing of the past. Mote, et al. (2010) affirmed this study showing that majority of the respondents in a study preferred the medical doctor as the best abortion provider to oneself, friends and nurses. A finding by the Ghana Statistical Service (2007) contradicts this study. The service indicates that more than two-thirds of women who sought an abortion turned to an untrained provider or induced the abortion on their own. Could it be a case of inadequate funds to enable one see the specialist, or the belief and trust in the provider?

In corroboration with the finding from the sources of information on abortion, Palukuu, et al. (2010) indicated that 80% of school girls in a study had their information from friends with the least from the church. IRIN (2011) also affirmed the study result by indicating that majority of girls receive information about abortion from hospitals, schools, family planning centres and friends.

It was found from a study in Korea that the mass media had informed the public about several sexual problems facing that country, including early

sexual intercourse among the youth, unwanted pregnancies and increased rate of induced abortions (Kang, 1990). This was supported by a study done in Kenya on the knowledge and perceptions of abortion among adolescents (Mutungi, et al., 1999). The study demonstrated that churches, youth clubs and guidance and counselling units provide little knowledge on abortion to girls. Parents were also found to play a minor role in delivering information on abortion to adolescents in studies done in Kenya (Castro & Palomar, 1991) and Zambia (Pillai & Yates, 1993). This could be due to the fact that talking about sex is often regarded as a taboo in many African societies including Ghana.

In all, the result shows that the students had adequate knowledge of abortion practices. The data in lieu of the respondents' awareness on safety of abortion methods, venue, and providers of abortion informed this decision. The only contradiction was the inadequate knowledge of the methods of abortion leading to a ratio of 3:1. In support Ayiku (2007) laments that students save 20 pesewas a day at "susu" shops towards abortion.

### **Research Question 2: Why do SHS Girls seek**

#### **Abortion when they are Pregnant?**

This question was asked to find out from SHS girls whether they will seek abortion if pregnancy occurs and the reasons to that effect. The outcome of the responses given is presented in Tables 6 and 7.

Research Question 2 sought to find out why students seek abortion when pregnant. From Table 6, 66% (n = 301) responded yes to opt for abortion when pregnant, 29% (n = 132) responded no while 5% (n = 22) were uncertain.

**Table 6: Students' Views on Abortion as an Option when Pregnant**

Abortion	n	%
Yes	301	66
No	132	29
Don't know	22	5

**Table 7: Students' Reasons for Abortion**

Reason for abortion	Yes		No	
	n	%	n	%
To continue my education	218	72	83	28
I don't want people to know	194	64	107	36
Pregnancy after being raped	155	51	146	49
To save myself from shame	153	51	148	49
Pregnancy as a result of incest	120	40	181	60
Afraid of my parents	116	39	185	61
If my parents insist that I terminate it	104	35	197	65
Pregnancy that I don't want	99	33	202	67
If my boyfriend supports it	95	32	206	68

From Table 7, the two most popular reasons the students gave for opting for abortion when pregnant were to continue their education 72% (n = 218), and not to be exposed (64%, n = 194). The last reason the students gave for opting for abortion was if boyfriend supports abortion (32%, n = 95) then they will opt for it.

The results imply that adolescents are not usually interested in carrying pregnancies to term at that tender age. Educational pursuits could account for this, but the question is why would they engage in sex if they are not interested in babies? Opting for abortion, according to the responses, is to enable students continue with their education. This outcome is in support with FMOH (as cited in Akinde, 2009) that adolescents seek abortion in view of the desire to continue a school education. If they relegate this option to the background their educational pursuits will come to a halt.

They would also not want people to know that they are pregnant. This is in line with the exposition by FMOH (as cited in Akinde, 2009) that teenagers have different reasons why they abort pregnancies, including shame and stigma associated with unwanted pregnancy.

One can thus infer that, even though most of the respondents were indecisive on reasons for seeking abortion as an option, those who opted for abortion cited their desire to continue their education as the over-arching reason for opting for abortion.

### **Research Question 3: What is the Knowledge Level of SHS Girls on Abortion Law?**

This question was asked to find out the knowledge the respondents have of the law on abortion in Ghana. It was to determine if they have adequate, moderate or inadequate knowledge of the laws on abortion. The level of adequacy was assessed in the different year groups and the collated data were put together and presented. The outcome of the responses given is presented in Table 8.

**Table 8: Students' Knowledge of the Law on Abortion**

Class	Inadequate		Moderate		Adequate	
	n	%	n	%	n	%
SH 1	31	7	29	6	52	11
SH 2	85	19	12	3	15	3
SH 3	84	18	16	4	12	3
SH 4	88	19	14	3	17	4
Total	288	63	71	16	96	21

Research Question 3 sought to find out students' knowledge of the law on abortion in Ghana. From Table 8, the two most cited forms or classes with adequate knowledge was Senior High (SH) 1 students (11%, n = 52). The remaining classes had inadequate knowledge; SH 4 (19%, n = 88), SH 2 (19%, n = 85) and SH 3 (18%, n = 84).

This means that students cannot make informed decisions when it comes to matters relating to abortion, hence, indulging in illegal abortion. This finding is corroborated by Pathfinder International (2009) that knowledge on abortion law is minimal, with the vast majority thinking otherwise. Clowes (2010) revealed that because adolescents do not have enough knowledge on laws governing abortion they are likely to perform unsafe abortions. Similarly, the findings point to Ayiku (2007) observation that students save money each day for abortion which shows that the students do not know the abortion law that states that any woman who tries to abort her own pregnancy by any means is guilty of the law and will be punished. Again, Pathfinder International (2010) affirmed Ayiku's observation when he stressed that most people do not



know that when they do abortion by themselves, or helped by a friend to abort a foetus they will be punished by law. Ampofoah (2010) said though students are aware of going to hospital for specialists to do the abortion for them, they do not know that they have to see accredited medical doctors to do the abortion. They are also unaware that they have to check whether the hospital or clinic is registered. From the results it can be concluded that most of the respondents are not knowledgeable when it comes to abortion law in Ghana.

The study contradicts what Morhe, et al. (2007) revealed. They contended that knowledge of the country's abortion law seems to be substantially higher, but not widespread among medical professionals.

#### **Research Question 4: What is the Perceptions of SHS**

##### **Girls about Legalisation of Abortion?**

This sought to find out from the respondents whether abortion should be legalised. The responses have been put into four sections except for the item that asked whether people should be free to decide to have an abortion or not.

**Table 9: Students' Views about Selective Legalisation of Abortion**

Statement	Agree		Disagree	
	n	%	n	%
Abortion should be legalised for married people	99	22	356	78
Abortion should be legalised for adults	80	18	375	82
Abortion should be legalised for girls below 18 years	44	10	411	90
Abortion should be legalised for school girls	58	13	397	87
Abortion should be legalised for victims of rape	217	48	238	52

**Table 10: Students' views about Abortion being a Right Issue**

Statement	Agree		Disagree	
	n	%	n	%
Abortion is fair to unborn babies	55	12	400	88
Abortion is fair to fathers	49	11	406	89
Abortion is fair to mothers	77	17	378	83
It is okay to abort a pregnancy that is less than 3 months old	190	42	265	58
It is okay to abort a pregnancy that is more than 3 months old	59	13	396	87
Abortion is killing innocent babies	372	82	83	18
Abortion is murder	366	80	89	20

**Table 11: Students' Views on Abortion Services**

Statement	Agree		Disagree	
	n	%	n	%
Abortion services should be made available to the general public	102	22	353	78
Abortion services should be provided in government hospitals	272	60	183	40
Abortion services should be covered with National Health Insurance	85	19	370	81

Research question 4 sought to find out students perceptions about legalisation of abortion. The result shows that majority of the students

representing 64% (n = 293) responded that people should not be given the chance to decide on whether to have an abortion or not, while 36% (n = 162) agreed that people should be given the chance to decide to have an abortion when pregnant. From Table 9, the most popular views about legalisation of abortion among the students were that abortion should not be legalised for girls below 18 years (90%, n = 411), school girls (87%, n = 397) and adults (82%, n = 375). From Table 10, the top two most popular views about abortion being a right issue among the students indicated that abortions were unfair to fathers (89%, n = 406) and to unborn babies (88%, n = 400), because the students viewed abortion as killing of innocent babies (82%, n = 372) and murder (80%, n = 366). Responses from Table 11 indicate that abortion services should be provided in government hospitals (60%, n = 272) but should not be covered with National Health Insurance (81%, n = 370).

**Table 12: Students' Views on why Abortion should be Legalised**

Statement	Agree		Disagree	
	n	%	n	%
Making abortion legal will prevent people from using unsafe methods of abortion	248	55	207	45
Legalising abortion will make people avoid contraception	248	55	207	45
Legalising abortion will make people promiscuous	204	45	251	55

Also, Table 12 shows that making abortion legal will prevent people from using unsafe methods of abortion (55%, n = 248) and also not make people

promiscuous (45%, n = 204), but also perceive that legalising abortion will make people avoid contraception (55%, n = 248)

The result means that though SHS girls in the Municipality would abort their pregnancies, they prefer that abortion is not legalised. This decision could be the result of religious beliefs. Ehrlich (2006) commented that questions on legalisation of abortion have been perceived as controversial among many Ghanaians of late. Dzissah (2010) lamented that abortion should not be legalised for married women and girls below 18 years, but the law should make provision for school girls to do abortion for once depending on the situation. Dzissah had mixed reactions when he stated that the first pregnancy by school going girls is out of ignorance so they should be given the chance to do abortion by professional doctors.

On the contrary, Ehrlich (2006) postulated that abortion should be legalised to rescue girls from detrimental emotional and physical trauma which affects girls who were unable to access professional help to induce the abortion. WHO (2006) also rooted for the legalisation of abortion and stated that abortion should be legalised at all costs because women have a right to make decisions involving their lives, careers, and social life. Donohue and Levitt (2001) made a case for abortion to be legalised for married people by saying “instead of presenting a serious case of infidelity to the husband, the women may opt to go for an abortion to avoid being caught in embarrassing situations” (p. 59). Alternatively, couples should be given a chance to terminate pregnancies when they realise that they have conceived again and they are incapable of providing for another baby. This difference came because Donohue and Levitt used married women as their sample. The authors

defended their statement by saying, “that is the way poor families will be exempted from increased burdens being imposed on them” (p. 88). United Nations Population Division (2010) believes that legalising abortion is the only way to overcome unsafe abortion which comes with complications.

To Engelbrecht (2005), the decision to do abortion would have long term emotional, physical and spiritual effects on a girl and that she needs to be protected from such effects by requiring her to obtain parental consent, or at least requiring her to consult parents or guardians, receiving mandatory pre-and-post abortion counselling, having a period for reflection between the decision to have the abortion and the proceeding itself, and not considering a minor to be the same as an adult woman. According to Ehrlich (2006), legalising abortion will mean that few deaths will occur due to availability of professional medical care.

The influence is that abortion legalisation will not only increase productivity in building the country’s economy, but also make adolescents achieve their own goals for the advantage of the entire family. It will also prevent people from using unsafe methods of abortion.

The results indicate that abortion is unfair to unborn babies. To them abortion is murder or killing of innocent babies in line with the revelation by Sengupta (2010). Religious beliefs could greatly account for this stand. This exposition should deter any intention to abort pregnancies contrary to the earlier revelation which incites abortion rampantly. Life begins at conception and, therefore abortion ends life (Engelbrecht, 2005). The author laments that everyone has a right to life, and this should apply to the foetus. The foetus has constitutional rights, and the choice on termination of pregnancy act is thus

contrary to the 1996 constitution (Mda, 1998; Morris & Williams, 1998; Ngwena, 1998).

The defendants in the case; Minister of Health of the Gauteng Provincial Government, the Reproductive Right Alliance and the Commission for Gender Equality argued that the foetus does not have constitutional right. Section 11 of the constitution does not rule out abortion as reflected by the choice on termination of pregnancy act. Furthermore, it was argued that the right to choose to have an abortion is supported by various provisions of the constitution. Judge McCreath found in favour of the defendants supporting the fact that the foetus does not have a legal persona under the 1996 constitution and therefore, that the choice on termination of pregnancy act does not breach section 11 of the 1996 constitution (Ngwena, 1998).

Also the results revealed that abortion services should be provided at government hospitals but should not be covered under the national health insurance scheme. This could throw a lot of pregnant minors to the health centres to seek or access the facility, since they would not be required to pay for the services. The implication is that this will create great repercussions on the economy since a lot of resources will have to be channelled into satisfying these promiscuous youth at the detriment of national development. Anambane (2011) refuted the finding by saying that the National Health Insurance Scheme should be made to cover abortions because of financial constraints. This means abortion should also be allowed at the hospital as well.

In a proposal to American Medical Association, Halfmann (2003) (as cited in United Nation Population Division, 2010) indicated that abortion services should be made readily available and easily accessible to prevent

herbal “abortifacients” and sharp tools used to terminate pregnancies. Also WHO (2006) supported by seeing it as a global public health concern due to the incidence and severity of complications such as haemorrhage, death and damaging of uterus leading to barrenness. The differences came as a result of settings of the study and age of respondents.

The majority also disagreed to the fact that legalising abortion will make people promiscuous. The contention is that once abortion is legalised the populace will desist from using other traditional and unsafe methods and rather go to the health centres to see specialists for the required abortion.

The WHO advocated for reproductive rights on family planning service, sex education and abortion. These recommendations concur with this study where 36% of the respondents have the right to abortion which is less than the 64% who reported that they do not have the right to decide on abortion (Akinde, 2009). This finding could be attributed to the restrictive abortion laws in Ghana on the one hand and respondents’ knowledge of their rights on the other hand.

From the foregone students’ perception about legalisation of abortion is that abortion is not a right because laws determine its accessibility otherwise innocent babies will continue to be killed. They also hold the view that abortion needs not be legalised and must not be covered by the NHIS.

## **CHAPTER FIVE**

### **SUMMARY, CONCLUSIONS AND RECOMMENDATIONS**

The purpose of this study was to investigate the perceptions of SHS girls in the New Juaben Municipality on legalisation of abortion in Ghana in the light of the many reported cases of unsafe abortions and the numerous health problems associated with them. The findings that emanated from the study have been extensively captured in chapter four. In chapter five the findings have been summarised and presented. Conclusions have also been drawn and recommendations made based on the findings. Suggestions for further research have also been included.

#### **Summary**

##### **Overview of the Study**

Abortion is highly debatable in Ghana where culture and religious values are widely practiced. In Ghana today, deaths from badly practised abortions are still labelled maternal deaths. Yet, the unsafe nature of such abortions is the price women are expected to pay for having transgressed by refusing maternity. There are no national statistics on the prevalence of abortion in Ghana; statistics can be obtained from hospital based and other research work on abortion. A study on contraception and induced abortion in rural Ghana indicated that 22.6% reported having induced abortion. Legalisation of abortion in developed countries has been identified to have promoted access to



safe abortion and contributed to high incidence in unsafe abortion in developing countries.

Several literature regarding the concept, types and complications of abortion, reasons why adolescents seek abortion, legalisation of abortion, and abortion laws have been reviewed on the problem. Four research questions bordering on the mentioned variables were advanced to guide the descriptive survey research. The research population constituted of female students in SHS in New Juaben Municipality of the Eastern Region in Ghana. From this, a sample of 455 was drawn using a combination of proportionate, stratified and purposive sampling procedures. A self-constructed questionnaire was administered on the students to collect data for the study. The data were analysed using descriptive statistics of frequency counts, ranges, tables and percentage scores.

The study found out that adolescents are more likely to engage in heterosexual sex than all other forms of sexual behaviour. When they become pregnant they resort to abortion in alarming proportions. They had inadequate knowledge of the methods of abortion, but adequate knowledge of safety methods, venues and providers of abortion. They resort to abortion to enable them continue with their education. They considered abortion not to be a right and suggested that it should not be legalised and only provided at the government hospital without the NHIS covering it.

### **Key Findings**

1. The study revealed that the students have knowledge about many inappropriate abortion practices.

2. The main reason for accessing abortion is to enable them continue with their education.
3. The students have inadequate knowledge of the abortion laws in Ghana.
4. The students' perception about legalisation of abortion is that abortion is not a right and should not be legalised.

### **Conclusion**

Based on the findings, it is concluded that since the students have knowledge about many inappropriate abortion practices to the extent that some perceive them to be the safest, these students will continue to engage themselves using the inappropriate abortion practices that they are aware of. When this happens the issue of unsafe abortion and the risk of maternal mortality will still be resolved. Since the results indicated that abortion should not be legalised, girls who become pregnant will quietly use inappropriate methods to abort the pregnancies to enable them continue with their education. Also, since they have inadequate knowledge of the abortion laws in Ghana, they can easily fall foul of the law on abortion

### **Recommendations**

Based on finding of the study, the following recommendations were given:

1. The Ministry of Health through the Ghana Education Service should include in the curricular of SHSs a subject like Family Life Education. Abortion practices and abortion law should be involved in the course structure to sensitise SHS girls on the dangers inherent in abortion.
2. The Government through the National Commission for Civic Education should educate SHS girls and the general public on the

abortion law in Ghana. Once the populace becomes aware, the law courts should enforce the required penalties on the perpetrators to deter significant others from following suit. The education can be done at clinics, hospitals, lorry parks, churches, hotels and bars, homes, and work places by means of television, radio, mobile van broadcasts, newspapers, and notices on billboards.

3. Parents, counsellors, and health centres should provide counselling interventions to students to realise that pregnancy is not the end of ones education. They should be convinced beyond reasonable doubt that one can continue with one's education after child-birth. This will prevent them from accessing inappropriate abortion practices and subsequently maternal mortality.

### **Suggestions for Further Research**

The issue of abortion accessibility and legalisation is complex. There is therefore the need to take a careful look at the phenomenon and adequate remedial measures streamlined to forestall it. The following areas of research have therefore been suggested to help improve upon the awareness of the situation in the country:

1. A comparative analysis of the reasons for unsafe abortions: A case study of urban and peri-urban communities in the Eastern Region.
2. Abortion providers' attitude toward abortion performance and related procedures at Government Hospitals.
3. Perception of Senior High school girls in Northern Ghana on Legalisation of Abortion in Ghana.

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## **APPENDICES**

### **APPENDIX A**

UNIVERSITY OF CAPE COAST

#### **QUESTIONNAIRE FOR STUDENT GIRLS**

I am an M. Phil student of Department of Health, Physical Education and Recreation of University of Cape Coast conducting a thesis study on the topic **Perception of Senior High School Girls on Legalisation of Abortion in Ghana.**

You are kindly requested to read through the items and respond to them as frankly and objectively as possible. Tick (✓) one or more answer (s) where applicable in the box corresponding to your choice concerning each statement below.

Your responses will be treated confidentially and will be used solely for academic purpose. Do not write your name on the questionnaire since this is not a test and you will not be identified with the results.

Thank you for taking time to help with this research.

**Name:** Bliss Dziedzorm Addo

**Contact:** 0244963202

## SECTION A – DEMOGRAPHIC DATA

1. Form:    SHS 1 [ ]    SHS 2 [ ]    SHS 3 [ ]    SHS 4 [ ]

## SECTION B – Perception on Legalisation of Abortion

	<b>Your view about legalisation of abortion.</b>	<b>Strongly disagree</b>	<b>Disagree</b>	<b>Strongly agree</b>	<b>Agree</b>
2	People should be free to decide whether to have an abortion or not.				
3	Abortion should be legalised for married people.				
4	Abortion should be legalised for adults.				
5	Abortion should be legalised for girls below 18 years.				
6	Abortion should be legalised for school girls.				
7	Abortion should be legalised for victims of rape.				
8	Abortion is fair to unborn babies.				
9	Abortion is fair to fathers.				
10	Abortion is fair to mothers.				
11	Abortion services should be made available to the general public.				
12	Abortion services should be provided in government hospitals.				
13	Abortion services should be covered by National Health Insurance.				
14	Making abortion legal will prevent people from using unsafe methods of abortion.				
15	Legalising abortion will make people avoid contraception.				

16	Legalising abortion will make people promiscuous.				
17	It is to abort a pregnancy that is less than 3 months old.				
18	It is to abort a pregnancy that is more than 3 months old.				
19	Abortion is killing innocent babies.				
20	Abortion is murder.				

### SECTION C-- Knowledge of the law on Abortion

Select the correct answer by ticking (✓) Yes/No and tick don't know if you have no idea.

No	Your knowledge on the law on abortion.	Yes	No	Don't know
21	The law on abortion allows any unwanted pregnancy to be aborted.			
22	It is illegal for a pregnancy due to rape to be aborted.			
23	It is legal for pregnancy due to incest to be aborted.			
24	It is illegal for pregnancy due to defilement to be aborted.			
25	It is legal for pregnancy due to defilement of an idiot or mentally challenged person.			
26	It is illegal for pregnancy to be aborted even if it endangers the mother's health.			
27	It is legal for pregnancy to be aborted if the child is likely to be severely abnormal.			
28	Any person who helps a pregnant woman to attempt an abortion is guilty.			
29	Any person who sells a drug or equipment to another to cause abortion is guilty.			
30	A woman who tries to abort her own pregnancy by the use of instrument or any other means is guilty.			
31	A legal abortion must be done by an accredited medical officer.			
32	A legal abortion may not necessarily be done in a registered health facility.			
33	Abortion is allowed if a married woman is made pregnant by another man.			

**SECTION D -- Knowledge of the Methods, Venues  
and Providers of Abortion**

Instruction: If you answer yes, please answer how safe by ticking the appropriate option.

Are you aware of these methods of abortion?

	Methods	Yes	No	How safe		
				Very safe	Safe	Not safe
34	Taking in Cytotec					
35	Melted sugar with Guinness					
36	Broken bottle ground up with seawater and blue and washing detergent					
37	Boiled Guinness					
38	Paracetamol tablets ground up with local gin					
39	Taking in concoctions to remove pregnancy					
40	Drinking "ogogoro" (local gin) and lime to remove pregnancy					
41	Use bicycle spoke or coat hanger to remove pregnancy					
42	Have a dilatation and curettage (D&C) done to remove pregnancy					



43. Where can abortion be done?

PLACE	YES	NO	HOW SAFE		
			VERY SAFE	SAFE	NOT SAFE
At home					
At a clinic					
Doctor's house					
At a chemist shop					
At hospital					

44. Whom would you prefer for abortion

	YES	NO	HOW SAFE		
			VERY SAFE	LITTLE SAFE	NOT SAFE
Self					
Medical Doctor					
Friends					
Nurse					

45. Where would you obtain information on abortion? tick only one.

Source	Yes	No
Hospitals		
Family Planning Centre		
Guidance and Counselling unit		
School		
Mass Media		
Books		
Friends		
Home		
Church		

**SECTION E – Reason for Abortion**

46. Would you go for abortion when pregnant as a student?

Yes [  ]

No [  ]

47. If yes, for which reasons or conditions would you consider an abortion?

(tick the appropriate option)

S/n	Reason for abortion	
1	To save myself the shame of unwanted pregnancy	
2	To continue my education	
3	If my boyfriend supports it	
4	I don't want people to know	
5	Pregnancy after being raped	
6	Pregnancy as a result of incest	
7	Pregnancy that I don't want	
8	Afraid of my parents.	
9	If my parents insist that i terminate the pregnancy	

## **APPENDIX B**

Asesewa Senior High School

P. O. Box 4

Asesewa.

Date: 7<sup>th</sup> November, 2011.

The Headmaster

Ghana Senior High School

P. O. Box 163

Koforidua

Dear Sir/ Madam,

### **PERMISSION TO CONDUCT RESEARCH**

I am Master of Philosophy final year student majoring in Health Education in University of Cape Coast. I am conducting a study on “Perceptions of Senior High School Girls in the New Juaben Municipality on Legalisation of Abortion in Ghana”. I should be grateful if you could allow 65 students in your establishment to participate in this research. All data obtained will be kept strictly confidential.

If you have inquires, please feel free to contact me on 0244963202. Your help would be greatly appreciated.

Yours sincerely,

(Bliss Dziedzorm Addo)