UNIVERSITY OF CAPE COAST

DECISION-MAKING FOR INDUCED ABORTION IN ACCRA METROPOLIS, GHANA

BY

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DECLARATION

Student's Declaration

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

Candidate's signature----------Date----24/06/2014----

Name: Fred Yao Gbagbo

Supervisors' Declaration

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

Principal Supervisor's Signature---------- Date----24/06/14----

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ABSTRACT

Induced abortions are common in Ghana yet the decision-making process for induced abortion is insufficiently documented. This study therefore examined decision-making process for induced abortion in the Accra metropolis using the Health Belief Model. The study design was retrospective and cross sectional based. Data collection methods were quantitative and qualitative. Questionnaire and interview guides were used to obtain data from 401 and 30 women respectively who had abortion between January and December, 2010, in the Accra metropolis. Quantitative data were analyzed using SPSS version 16 and STATA version 8, while qualitative data were manually analyzed.

The study found that, women of various profiles make different abortion decisions with justifications based on peculiar situations during pregnancy. Legal restriction, cost, safety and privacy influenced choice of place and method for abortion. In making abortion decisions, women collaborated with people who influenced the decision-making process. First time pregnancies were mostly aborted regardless of gestational ages and partners' consent. Pressure from partners, circumstances surrounding onset of pregnancy, reproductive intentions and institutional sanctions of pregnant women were push factors for abortion.

The study concluded that a decision on abortion is a process that is not always an expression of a woman's own choice, hence recommended policies to support pregnant women in school/apprenticeships to have their babies if they so desire without any hindrances. A further research with respondents' partners was also recommended to compare abortion decision-making among men in Ghana.

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DEDICATION

To all women who lost their lives or had complications during induced abortion.

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LIST OF ACRONYMS

FWCW	Fourth World Conference on Women
GHS	Ghana Health Service
GSS	Ghana Statistical Service
HBM	Health Belief Model
ICPD	International Conference on Population and Development
ISSER	Institute of Statistical, Social and Economic Research
MOH	Ministry of Health
MSI	Maries Stopes International
MSIG	Marie Stopes International Ghana
NGO	Non Governmental Organization
R3M	Reducing Maternal Mortality and Morbidity
SPSS	Originally, Statistical Package for the Social Sciences, later modified to read Statistical Product and Service Solutions
STATA	A portmanteau of the words Statistics and Data
TPB	Theory of Planned Behaviour
TRA	Theory of Reasoned Action
UCC	University of Cape Coast
UNFPA	United Nations Population Fund
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

Background to the Study

Every year, about 205 million women worldwide become pregnant and nearly one in five (40-50 million) choose to terminate the pregnancy for various reasons. This figure corresponds to approximately 125,000 abortions per day of which close to 20 million are estimated to be unsafe (Ahman & Shah, 2002; 2004).

The global abortion rate was stable between 2003 and 2008, with rates of 29 and 28 abortions per 1000 women aged 15-44 years, respectively, following a period of decline from 35 abortions per 1000 women in 1995. The average annual percentage change in the abortion rate was about 2.4 percent between 1995 and 2003 and 0·3 percent between 2003 and 2008. Worldwide, about 49 percent of abortions were unsafe in 2008, compared to 44 percent in 1995 and it is estimated that about one in five pregnancies ended in abortion in 2008. The abortion rate was lower in sub-regions where more women live under liberal abortion laws (Guttmacher Institute, 2012).

In African countries such as Uganda, induced abortion is common despite the restrictive abortion laws. About 300,000 induced abortions occur annually among women aged 15-49 and a large proportion of these women require treatment for post-abortion complications (Singh, Prada, Mirembe & Kiggundu, 2005). The decision-making process for induced abortion has been a major social

and public health problem globally for decades. For many women, the occurrence of a pregnancy is the first time that they have to deal with a decision about their health and future plans (WHO, 2006).

In 1994, at the International Conference on Population and Development (ICPD) in Cairo, governments agreed that in countries where induced abortion is legal, it should be safe. Governments later reaffirmed and built on this consensus at three global conferences such as the 1995 Fourth World Conference on Women (FWCW) in Beijing, the five-year review of ICPD in 1999 (ICPD+5) and the five-year review of FWCW in 2000. In ICPD+5, governments reiterated that in circumstances where abortion is not against national laws, health systems have an obligation to train and equip health-service providers to ensure that adequate decisions are made for accessibility of safe induced abortion services by women (Sai, 2004). Addressing the growing incidence of induced abortion globally and in sub-Saharan Africa where induced abortion has become a public health problem (Population Council, 1988), requires a better understanding of the complexities of abortion decision-making since it has links with the profile of women seeking induced abortion services.

There appears to have been heated debates that have made some countries to either shift grounds by permitting induced abortion, made modifications in their abortion laws or remain indifferent (Hord & Wolf, 2004). In some countries, people have simply agreed on health grounds to let a woman in consultation with her physician and/or significant others to make decisions about whether to have abortion or not (WHO, 2004; PNDC Law 102, 1985). Despite these

developments, World Health Organization (2006) reported that information on decision-making for induced abortion is inadequate particularly in developing countries where clandestine induced abortions remain a challenge to public health efforts.

In Ghana for instance, decision-making for induced abortion has been reported as a dynamic and complex process (Ahiadeke, 2001). Although factors such as maternal health, prevailing socio-demographic and economic situations, cultural norms and values regarding pregnancy and childbirth may be relevant, these alone do not explain abortion decision-making processes (Blanc & Grey, 2002). Studies conducted by Campbell and Lees (2000); Odoi-Agyarko (2003); Yeboah (2003); Quality Health Partners and Ghana Health Service (2005) have shown that, in some Ghanaian communities, women and their partners having challenges with unwanted pregnancies, opted for induced abortion. Nevertheless, decision-making for induced abortion is done secretly because the Ghanaian society frowns on induced abortion particularly when it relates to young and married women (Ghana Health Service, 2007). This study therefore investigates the decision-making process for induced abortion in the Accra metropolis.

Statement of the Problem

Epidemiologically, the 20 million unsafe induced abortions that occur every year in the world are done by people lacking the requisite skills, or in environments lacking minimum medical standards or both (Guttmacher Institute, 2012). The estimated figure in Africa is about 6.4 million (Grimes, Benson,

Singh, Romero, Ganatra & Okonofua, 2006). Although data on induced abortion trends are important indicators of decision-making to improve maternal health, global estimates of induced abortion have only reported statistics on 1995 and 2008 to reflect the consequences of decisions that individuals make on induced abortion (WHO, 2012).

According to the Ghana Health Service (2007), incidences of induced abortion in Ghana are common and the unsafe abortion practices constitute about 35 percent of maternal deaths. Although induced abortions generally occur in every Ghanaian society, there are few studies conducted to investigate issues relating to the decision-making process for abortion. Previous abortion studies were generally limited to reviewing records of hospital admission cases (Adanu & Tweneboah, 2004; Olukoya, 2004).

There are several stakeholders, each with conflicting rights, who must be considered and whose rights must be balanced well to arrive at a description of the nature of decision-making on induced abortion in Ghana. First, the right to life of the product of conception (foetus), secondly, the right of human beings carrying the foetus (the mother), thirdly, the rights of the father to the product of conception (normally totally ignored) and fourthly, the rights and responsibilities of parents to decide on induced abortion for their pregnant children (Moore, Jagwe-Wadda & Bankole, 2004).

Sena, (2006) argued that the sociological dimensions of induced abortion decision-making processes in Ghana are not well understood probably because existing data on induced abortions, come mainly from hospital records, and most

often do not adequately capture the decision-making process for an induced abortion for public health interventions. Consequently, issues underlying abortion decision-making, the stakeholders involved and their roles in arriving at a final decision for an induced abortion, issues relating to choice of place and methods for induced abortion have not been fully explored to unearth what women undergo when deciding on abortion in Ghana. This is a research gap, which the current study attempts to fill.

Research Questions

The following research questions were raised to guide the study:

1. What were the profiles of women who sought induced abortion in the Accra metropolis?
2. What factors informed women's decision to terminate a pregnancy?
3. Who were the collaborators in decision-making for induced abortion?
4. What factors influenced the choice of place for an induced abortion in the Accra metropolis?
5. What factors influenced the choice of method for an induced abortion in the Accra metropolis?

Objectives of the Study

The main objective of this study was to assess the decision-making processes for induced abortion in the Accra metropolis, Ghana. The specific objectives were to:

1. Examine the profile of women seeking induced abortion services;

2. Discuss the factors that influenced abortion decision-making processes;
3. Analyze the factors that influenced choice of place for an induced abortion, and
4. Assess the key collaborators involved in induced abortion decision-making.

Hypotheses of the Study

The hypotheses of the study were:

1. There is no significant association between the educational status of a pregnant woman and her choice of place for an induced abortion.
2. There is no significant association between occupation of a pregnant woman and the gestation period at which a pregnancy is terminated.
3. There is no significant association between marital status of a pregnant woman and partner's consent for a decision on an induced abortion.

Justification of the Study

Various advocates over the last two decades have expressed the need for an assessment of why women decide to have induced abortions in Ghana and the processes involved in arriving at a decision for an induced abortion particularly at the community level. This advocacy call was with a view to understanding the complexities of decision-making processes of having induced abortion to inform public debate, policy and programmes (Ghana Health Service, 2007).

According to Adanu and Tweneboah, (2004) previous abortion studies that attempted to respond to this call based their discussions on hospital admission data and were quite speculative due to the lack of comprehensive documentations of abortion records, which has a major challenge with accuracy and validity of institutional data. In this regard, data gathered from health facilities for previous abortion studies had limitations of incompleteness, inaccuracy and most often reflected the experiences of only those women who suffered abortion related complications and not others who had a safe termination using various options.

Few hospital-based abortion studies went further to include questions on previous abortions and the reason(s) for the current abortion, but had limitations to establish the myriad of issues at the community level that informed the decision at the time of having an induced abortion (Ghana Health Service, 2007; Yeboah, 2003).

Henry and Fayorsey (2002), who attempted to do a qualitative study on induced abortion within Ga Mashie, a suburb of Accra in Ghana, observed that most girls think induced abortion is morally wrong, but cited practical reasons why it was acceptable for a girl to have abortion. There were, however, limited information on the decision-making process particularly about preferred methods of abortion, choice of facility for the abortion and the financial implications. It was from this background that this study became very necessary and relevant because, it took primary data from women who have already done an abortion not only in hospitals so as to compare findings of previous abortion studies that explored induced abortion decision-making in the Accra metropolis, Ghana.

Chapter Organization

The study is organized in seven chapters. Chapter One is the introduction which covers background to the study, problem statement, research questions, study objectives, research hypothesis, rationale of the study, and chapter organization. Chapter Two reviews relevant literature (empirical and theoretical) in relation to the study and adapts a conceptual framework to guide the study.

Chapter Three is in four parts. The physical, demographic, socio-cultural and economic characteristics of the Accra metropolis are presented in the first part of Chapter Three. The second part of Chapter Three focuses on methodological issues such as the study design, data sources, study population, sample size and sampling. The third part of Chapter Three is based on ethical considerations relating to studies of this kind that involves using human subjects. The fourth part of Chapter Three describes the preparations for the fieldwork such as orientation of field assistance, pretesting research instruments and validation of data, whilst the rest of the fourth part of Chapter Three looks at experiences from the field and data analysis to set the pace for discussion of results.

The profile of respondents, including their background characteristics such as age, education, marital status, number of living children, religious affiliation, occupation and their decisions for induced abortion are presented in the first part of Chapter Four. The rest of the Chapter describes the experiences of respondents concerning their initial reactions at the time the pregnancy occurred, history of previous abortions, circumstances surrounding onset of the pregnancy, reasons for abortion and gestation period of the pregnancy at termination.

Chapter Five examines the collaborators involved in the decision making process for an induced abortion with specific focus on characteristics of persons responsible for the pregnancy terminated, person(s) first informed about pregnancy when it occurred and consenting to the abortion. The ultimate concern is whether the respondents involved other people in the decision making process for their abortions or not. Where other persons were involved, the study investigated the identity of these people, the reasons for and the extent of the involvement of such persons in the decision making process.

Chapter Six presents findings on the decision made and factors considered by respondents in choosing a place for abortion. The chapter also looks at how respondents heard about the place of abortion, the abortion methods/options available, cost of the abortion services and the various options/abortion methods available to women on arrival at the designated places of choice for an abortion.

Chapter Seven concludes the study with summary of key findings, conclusions, contribution to knowledge, policy and programme implications, recommendations and suggested related areas for future abortion research.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

Introduction

This chapter consists of three main sections. The first section reviews empirical literature about studies that had been done on decision-making for induced abortion, methodologies used, key findings and recommendations. It also reviews technical papers presented at various fora globally and in Ghana. The second section reviews a number of theories and models that had been advanced to explain human behaviours and decision-making processes relevant to this study. This section also discusses the strengths and weaknesses of each theory, model or approach and its relevance to decision making for induced abortion. The third section presents the conceptual framework for the study.

Empirical Literature

Globally, various studies have been conducted looking at different aspects of induced abortion in the past (United Nations Population Fund, 2006). The review of empirical literature focused on the following subheadings to guide the study: profile of abortion seekers, factors influencing abortion decision-making, collaborators involved in abortion decision-making, factors influencing choice of place for an induced abortion and situational analysis of induced abortion in Ghana.

Profile of Abortion Seekers

Globally, women with varying profiles make decisions for induced abortions every year. About 18 percent of these women are usually young unmarried women and in their 20s and 30s (WHO 2012). According to United Nations Population Fund (2006) the age, educational, occupational, religious and marital status of women could affect decisions to abort unplanned or unintended pregnancies.

A community based abortion study in India involving 250 respondents in the year 2001, observed that about 6 percent of young abortion-seekers were unmarried (Ganatra & Hive 2002). Facility-based studies report higher percentages, ranging from 15 percent to 90 percent of all adolescent or young abortion-seekers (Ganatra 2000). Other studies in Manipur that focused on women seeking to terminate their first pregnancies found that, 76 percent of the women were nulliparous, aged 14-19 years (Trikha, 2001) and 90 percent were unmarried (Devi & Akoijam, 2007).

Aras, Pai and Jain, (1987) observed in Mumbai, Maharashtra, that about 59 percent of unmarried adolescents sought second trimester abortion compared to about 26 percent of married adolescents. Even in rural areas, as many as 72 percent of unmarried abortion seekers, mostly adolescents, delayed seeking services until the second trimester, compared to 43 percent of married abortion seekers (Chhabra, Gupte, Mehta & Shande 1988). Evidence from another community-based study in Pune district suggests that large numbers of unmarried

young women terminated pregnancies resulting from non-consensual sex (Ganatra & Hive 2002).

In a Southern European study conducted by Font-Ribera, Pérez, Salvador and Borrell, (2007), to describe socio-economic inequalities of unintended pregnancy in abortion decision-making in Barcelona, Spain, it was indicated that unintended pregnancies accounted for 41 percent of the total pregnancies. Out of these pregnancies 60 percent ended in induced abortion. From all pregnancies reported, the proportion of induced abortion reached 25.6 percent among women with university education. Women with primary level education were 7.22 times more likely to have induced abortions compared to women with other educational backgrounds. A similar pattern was also observed among women of lower socio-economic profiles compared to those in the upper socio-economic class.

A study conducted [on 148 women seeking induced abortion from doctors in Malaysia] to explore the influence of socioeconomic, ethnic, religious, and educational factors on the practice of induced abortion in Malaysia indicated that out of 148 women seeking induced abortion from doctors in Malaysia, 135 of the women were married; 13 were unmarried. About 22 percent of the women did not complete primary education, 51 percent of the women completed primary education, and 26.3 percent completed secondary education. About 30 percent of the women were from rural areas, and the remaining 10 percent of women lived in towns and suburbs. Almost 62.2 percent of the women were housewives, 29.7 percent were unskilled workers, and 8.1 percent were skilled workers. About 107 of the respondents were Buddhist, thirty-one were Muslims, four were Hindus,

two were Catholics, two were Protestants, and two were free thinkers (Chia-Sze-Foong, 1982).

In Africa, a similar study was conducted in south-western Nigeria with 1876 women using a prospective hospital-based approach and a questionnaire to understand the characteristics of abortion seekers. The results show that about 60 percent of the respondents were between the ages of 15 and 24 years, of which adolescents between the ages of 15 and 19 years constituted 23.7 percent. Most (63.2%) of the respondents were unmarried, but married women also constituted a significant proportion (30.2%) of the abortion seekers. Students were the single highest group, while the predominant economic activity (26.7%) was trading (Oye-Adeniran, Adewole & Fapohunda, 2004). Another study in South Africa that examined the epidemiological relevance of age to incomplete abortion observed that women over 30 years (65.5%) were significantly less likely than those between 21 – 30 years (75.2%) or under 21 years (76.4%) to have induced abortion (Jewkes, Rees, Dickson, Brown & Levin, 2005).

Other studies by Population Council, (1996) in Nigeria indicated that respondents with tertiary education were four times more likely to report an induced abortion, followed by those with secondary level education who were two times more likely to report an induced abortion relative to those without education. Similarly, professional women (teachers and biomedics) who were often better educated were more likely to report an abortion than unemployed women. Divorced, widowed and unmarried women were most likely to report having had an induced abortion among the marriage category (Nana, Fomulu &

Mbu, 2005). The profiles of abortion seekers suggest that various factors influence abortion decision-making processes globally.

Factors Influencing Abortion Decision-making

The factors influencing abortion decision-making globally are diverse hence; different reasons were given for an induced abortion (WHO, 2012). Generally reported, the pregnancy is unplanned or unwanted at the time it occurred (Singh & Sedgh, 2001; Oye-Adeniran, 2004). According to Bankole, Singh and Haas (1998), some of the most common factors influencing abortion decisions include: postponing childbearing to a more suitable time or to focus energies and resources on existing children, being unable to afford a child in terms of the direct costs of raising a child, the loss of income while pregnant, lack of support from the father, inability to afford additional children, desire to provide schooling for existing children, disruption of one's own education, relationship problems with a partner, the perception of being too young to have a child, unemployment, failed contraception, as well as aborting pregnancies resulting from out of wedlock sex to protect a family's name and/or one's own integrity.

Medico-legal factors such as threat of a pregnancy to a woman's life; gross foetal abnormality, baby's sex, not willing to carry a pregnancy resulting from rape or incest as well as disputed paternity of pregnancy have also been identified as factors influencing abortion decision-making (Buga, 2002; Mirembe, 2005). An additional factor (societal pressure) is becoming a primary reason for induced abortion as cited in over a third of reported reasons for induced abortion

in India and china (Uwaezuoke, Uzochukwu & Nwagbo, 2004). This observation in India and china was also due to preference for children of a specific sex, disapproval of single or early motherhood, stigmatization of people with disabilities or efforts toward population control (such as China's one-child policy), which sometimes result in compulsory abortion (Finer, Frohwirth, Dauphinee, Singh & Moore, 2005). Another study done in India revealed that although official records in India reports contraceptive failure and risk to mother's health as the leading reasons given for seeking abortion, preference for sons is becoming widespread resulting to second trimester sex-selective abortions (Santhya & Shalini, 2004).

Further specific abortion studies on married women indicates that induced abortion is a major solution to unintended pregnancies in marriage although considerations of a woman's age, occupation, family, educational background, parity, number of living children and history of domestic violence are of significant concern (Kaye, Mirembe & Bantebya, 2005). Research in other settings has found that partner denials of responsibility are a main reason for married women terminating a pregnancy (Bankole, Sedgh, Oye-Adeniran, Adewole, Hussain & Singh, 2008). In another study, partner participation in the abortion decision-making was to implement their wishes (Bennet, 2001). One study in Nigeria found that nearly 20 percent of women inducing abortions did so due to problems with the male partner. When the male partner was not involved or he had not consented to the abortion, the women were less likely to terminate

the pregnancy prior to eleven weeks gestation or go to a professional health care provider (Bankole, et. al., 2008).

In Madhya Pradesh, women reported the achievement of desired family size as the reason in 41 percent of attempted abortions, and the need for spacing in 30 percent of abortion attempts. A few recent studies indicate that risk to women's health is also a relatively common reason for seeking abortion. In the same study, women reported health reasons in 22 percent of attempted abortions. The not-so-commonly-reported reasons for seeking abortion include contraceptive failure (<5%), pregnancies occurring soon after marriage (6%) or occurring outside of marriage (8%) or foetal abnormalities (5%) (Santhya & Shalini, 2004).

In Sweden, an abortion decision-making study conducted among 25 teenage women using in-depth interviews 3-4 weeks post abortion at different periods in 2003, 2005 and 2007, found that, women aged 16-20 had the most abortions because of unplanned pregnancy although the abortion decision was difficult and accompanied by mixed emotions (Ekstrand, Tydén , Darj & Larsson 2007). In other studies, deferring childbirth and limiting family size were 85.8 percent of the reasons for abortion. There was no significant difference between women deferring childbirth and women limiting family size when comparing the racial, religious characteristics, the period of amenorrhea, occupation, and marital status (Chia-Sze-Foong, 182).

Studies by Ganatra (2000) and Dalvie (2008) have compared factors influencing abortion decisions of married and unmarried young women focusing on the timing of abortion highlighted that the unmarried are more vulnerable than

the married when making abortion decisions. This finding indicates that factors that influence women decisions for induced abortion reflect acts of desperations. Histo-pathological reports from some Nigerian fertility hospitals in 2003 confirming this finding indicated that most married women seeking induced abortion services were not after all pregnant at the time of decision-making for abortion (Ekanem, Etuk, Udoma & Ekanem, 2003).

The literature reviewed show that a decision for an induced abortion is complex and specific to a woman taking into account her own needs, a sense of responsibility to her partner, existing children and the potential child as well as contributions of significant others including the society in which a woman finds herself when a pregnancy occurs. These require some collaboration when making abortion decisions.

Collaborators Involved in Abortion Decision-making

At a first glance, it may seem like the decision-making process for an induced abortion solely relies on the pregnant woman yet, social norms and pressures from male partners, family members, and significant others strongly influence an abortion decision (Gipson & Hindin, 2008). Making a decision to terminate a pregnancy is therefore a very difficult one and each situation is different (Guttmacher Institute, 2012). Although the decision to have an abortion is extremely personal, many questions are answered and many emotions are expressed, which require reliable and accurate information as well as the required financial and emotional support compelling some women to collaborate with

various people to make an abortion decision and to have the decision implemented (WHO, 2004).

Hull and Hoffer (2010) traced women collaborations with health workers on abortion decision-making processes from the nineteenth century forward, and found that, midwives most often managed pregnancy and related issues including induced abortion. Women started to lose power in the nineteenth century when the profession of medicine rose in public regard. The shift in control over pregnancy from sympathetic midwives to male physicians occurred as doctors asserted both medical and moral authority over pregnancy and abortion under the guise of protecting women from poorly trained abortionists. Women's desire to safely terminate unwanted pregnancy and the professional responsibility of health workers have been cited as basis of the need for collaboration with health workers to induce abortion, although it has also been noted that desperations of some abortion seekers and misinformation had resulted in collaborating with quarks during abortion decision-making (Ipas, 2001).

The question of whether a minor should collaborate to terminate a pregnancy without parental consent has been one of the most contentious issues in abortion decision-making (Ipas, 2001). In a study by Henshaw and Kost (1992) to determine parental involvement in minors' abortion decisions, it was noted that out of 1,500 unmarried minors who had an induced abortion in the United States about 61 percent of the respondents said that one or both of their parents (usually the mother) knew about the abortion. About 75 percent of respondents informed their mothers of the pregnancy. Only 26 percent of the respondents said their

father knew about the abortion. Furthermore, 57 percent of the mothers who knew about their daughters' pregnancy did not tell their fathers. Majority of the parents supported their daughters' decision to have an abortion.

Among the minors whose parents found out without being told by the minor, 18 percent said their parents forced them to have an abortion and 6 percent reported physical violence, being forced to leave home or damage to their parents' health. Minors who did not tell their parents were aged 16 or 17 and employed. The minors' most common reasons for not telling their parents were wanting to preserve their relationship with their parents and wanting to protect the parents from stress and conflict. Of those who did not tell their parents, 30 percent had experienced violence in their family, feared that violence would occur or were afraid of ejection from home. Among minors, whose parents were unaware of the pregnancy, some consulted someone other than clinic staff about the abortion (i.e. boyfriend (89%), an adult (52%) or a professional (22%).

According to Coleman and Nelson, (1999), abortion decisions have a potentially meaningful effect on the lives of men. In their study of 1,387 college students, it was observed that both men and women generally believe men have the right to be involved in abortion decisions.

In sub-Saharan Africa, males are recognized as heads of households and principal decision-makers on fertility (Dodoo & Frost, 2008). In African countries which exhibit a male-dominant culture, men control most of the financial resources hence they play a critical role in the decision-making for a health care if the need arises. In such situations, women are in vulnerable

situations that makes it difficult for them to exercise autonomy in decision-making including issues relating to abortion (Singh, Prada, Mirembe & Kiggundu, 2005).

In a study to examine men's role as collaborators in decision-making to determining women's access to a safer abortion and post-abortion care, 61 women aged 18-60 and 21 men aged 20-50 from Kampala and Mbarara in Uganda were used. The study found that most men believed that if a woman is having an abortion, it must be because she is pregnant with another man's child. This confirms why some men will take keen interest in the decision-making process for an abortion by their female partners and decide where it must be done (Moore, Jagwe-Wadda & Bankole 2004). A woman may therefore decide to hide a pregnancy from a male partner for a variety of reasons including fear of accusations of infidelity and discordant fertility preferences with her partner (Hill, Tawiah-Agyemang, Kirkwood, 2009; Schuster, 2005). Nondisclosure of the termination of pregnancy by women in separate studies conducted in Nigeria and Ghana recorded as high as 40 percent in Nigeria and 18 percent in Ghana (Bankole, Sedgh, Oye-Adeniran, Adewole, Hussain & Singh, 2008).

Factors Influencing Choice of Place for an Abortion

The decision to choose abortion as an alternative to continuing a pregnancy is often a difficult choice. It is also an issue that most women do not talk about openly, hence, choosing a place for quality care may be challenging to women since not all abortion providers advertise publicly (WHO, 2004).

Consequently, access to abortion services remain limited for the vast majority of women in developing countries where there is no ready access to information on health choices and women do not have the power to make health decision independently and implement them (UNFPA,1999).

Studies conducted in the United States have documented that women find medical abortion acceptable, hence, would choose it again if they needed to terminate another pregnancy or would recommend a place where such abortion methods are offered to their friends (Winikoff ,1995). Women's choice of place for an abortion method was not related to demographic characteristics, prior experience with abortion or level of comfort with the decision to have an abortion (Wiebe, 1997).

In a synthesis report exploring why women continue to seek and receive abortion services from unqualified providers, even in countries with liberalized abortion laws, it was noted that many factors such as: the lack of awareness of legality of abortion services, limited access to services, poor quality of services, cost of service, gender roles and norms, influenced decisions on choice of place for an abortion. Another study in a legally restrictive abortion environment (Kenya) showed that, a woman's economic status determined the choice of place and methods for an abortion (Santhya & Shalini, 2004). Similar findings were also observed in Maputo, Mozambique (Baker & Khasiani, 1992). In urban Mozambique, women are highly motivated to find early pregnancy termination techniques that they deem socially and clinically low-risk. Consequently about 96 percent of women reported comfort with home management and satisfaction with

all methods of abortion even if initial methods fail and pain medications are not given (Mitchell, Kwizera, Usta, & Gebreselassie, 2006).

Decisions on place for an abortion was also noted in another study to have been influenced by limited awareness of locations of abortion services, limited involvement in abortion-related decision-making, fear of stigma and preference for confidentiality rather than safe services, and that these compelled many to travel long distances to obtain abortion from particular places sometimes from unqualified providers (Ganatra, 2000). The availability of abortion service was observed in a study of Nigeria, to have influenced choice of place for an abortion. Friends, through word of mouth, introduced about 35.5 percent of women seeking abortion services to abortion providers (Oye-Adeniran, Adewole, Umoh & Fapohunda, 2004).

Induced Abortion in Ghana

In Ghana, induced abortion remains a major public health problem despite apparent liberalization of the abortion law since 1985 (Morhee & Morhee, 2006). Because data to quantify the incidence of induced abortion are scarce, existing data on induced abortions in Ghana come mainly from hospital records, which are unreliable due to poor record-keeping and inaccurate classification of abortions (Ahiadeke, 2001). Nevertheless, various issues (e.g. legal, medical, social and economic) inform decision-making processes for induced abortion in Ghana (Ghana Health Service, 2007).

Ghana has a legal and policy framework that regulates decision-making for induced abortion. The Ghanaian abortion law (Law No. 102 of 22 February, 1985) dates back to 1960 and was modified in 1985. The law, prior to 1985, and placed under the Criminal Code of 1960 (Act 29, sections 58-59 and 67), stated that, induced abortion was prohibited unless the pregnancy endangered a woman's life. Consequently, anyone providing or self-inducing an abortion when arrested, could be fined and/or imprisoned to serve a 5-year maximum jail term. The abortion law was amended in 1985 (Appendix D). The Ministry of Health, Ghana Health Service and its partners in 2003 revised the National Reproductive Health Policy to incorporate the provision of comprehensive abortion care as permitted by law within health facilities in Ghana (Quansah-Asare, 2008).

Despite the liberal abortion laws, the abortion statistics in Ghana is not too different from what pertains in other African countries. Ghana has seen an increasing trend of induced abortions in recent times. Sixteen thousand-one-hundred and eighty-two (16,182) girls and young women were reported as having had abortion in 2011 as against 10,785 in 2010 and 8,717 in 2009. This implies, about 15/100 pregnancies end up in induced abortions in Ghana (MOH, 2012). Over fifty-three (53) different abortion methods (e.g. combinations of pills, injections, herbal preparations mixed with alcoholic, sweet drinks, dilation and curettage) are commonly used in Ghana (Ghana Health Service, 2007).

The decision-making process for induced abortion is insufficiently documented and poorly understood in Ghana (Ahiadeke, 2001). Despite this challenge, available evidence from institutional records indicates that unintended

pregnancies are more frequent in young, poor, and/or unmarried women. The data further indicate that the proportion of pregnancies that end in induced abortion increases substantially with levels of education from 2 percent among women with no education to 17 percent among women with secondary level education or higher. Similar patterns are also observed among wealth quintiles (Ghana Health Service, 2007).

The Ghana Adolescent Health and Development Programme report, (2006) indicated that, about 216 cases of abortion involving girls aged 10 to 14 were recorded in 2009; 331 cases in 2010 and 582 in 2011. In the case of girls 15 to 19 years of age, 5,525 abortion cases were recorded in 2009; 6,679 in 2010 and 7,800 in 2011. The report further indicated that for young women aged 20 to 24 years, 7,800 abortion cases were recorded in 2011; 6,679 in 2010 and 5,525 in 2009 (Ministry of Health, 2012).

Data from a larger survey comprising 18,301 women aged 15-49 years from the 10 regions of Ghana provided some more empirical evidence on the extent of induced abortion decision-making particularly in Ghana. The study indicated that about 19 induced abortions per 100 pregnancies or 27 induced abortions per every 100 live births occurs in Ghana, and these estimates might just be the tip of the iceberg. About 60 percent of the women who had an induced abortion were younger than 30 years of which 36 percent were nulliparous. Less than 12 percent of the respondents sought an abortion service from a physician indicating a large proportion of the abortions were sought outside a medical

facility. Nearly half of the respondents had self-induced abortions or sought services from pharmacists (Ahiadeke, 2001).

In Ghana, few health care facilities however offer abortion services due to the sensitive nature of abortion in Ghana. Although those that offer abortion services often do not publicly advertise these services, abortion seekers get to know of them through word of mouth. Consequently, little is known about the cost components (i.e. financial, time, and societal) of abortion in Ghana (Sedgh, 2009). There are a few community-based studies on factors influencing decision-making process for induced abortion in Ghana. However, data from hospital studies on analysis of abortion-related complications presented by women admitted in Ghanaian hospitals indicate that immediate explanation that most abortion seekers often give for having an induced abortion is that the pregnancy was unplanned or unwanted (Srofenyoh & Lassey, 2003).

A study of maternal heath in Ghana found that among the sample of women with an induced abortion in the preceding five years, 57% went to a physician, 16% went to a pharmacist, 10% had no assistance, 9% were aided by a friend or relative, and 4% went to a traditional practitioner. Three percent of women sought the assistance of a nurse/midwife. It was not known whether the nurse/midwives were trained in safe abortion care, as they are in many countries in the developing world. About 38% of the women went to a private hospital or clinic for the abortion whilst 30% induced the abortion at home. Only 15% went to a government hospital or clinic for an abortion. The choice of abortion method differed among these women. About 40% received a dilation and curettage

(D&C), 16% took tablets, 6% specified taking Cytotec tablets (misoprostol; used for medical abortion), and 12% had manual vacuum aspiration (Ghana Statistical Service, Ghana Health Service, & Macro International, 2009).

In July 2008, The Population Council conducted a study exclusively on the profile of abortion seekers in Ghana and their decision-making processes to provide baseline information that will inform institutions providing abortion in the design and implementation of client-oriented services to reduce maternal mortality in the Greater Accra Region. The results indicate that clients seeking abortion care in Ghana are mostly young adults of ages ranging from 14 to 41 and a mean of 25 years.

The distribution by age group shows that the 20-24 year age group alone accounted for 41 percent of these clients while those aged between 14 and 19 years made up 18 percent. The clients who patronized abortion services were quite well educated. About 37% had had middle or junior secondary school education while about a third had received senior secondary or higher level education. About (36%) and (23%) of the clients were traders and public servants respectively. Those in professional, technical, administrative and clerical occupations accounted for 10 percent while the unemployed and students made up 16 percent and 12 percent of the study sample respectively. Almost a quarter (24%) of the clients lived with their husbands. The rest were mostly living with their sisters (17.8%), mothers (10.3%), both parents (10.3%) or other relatives such as children, aunties, uncles and in-laws (15.1%). In terms of obstetric history and personal abortion experiences, about 32 percent of the clients indicated that,

the first pregnancy they ever had was the one terminated. About 93 percent of the clients indicated that the current pregnancy was the result of their willing sexual encounters.

A qualitative study conducted by Henry and Fayorsey (2002) involving 13–19-year-old females in Ga Mashie District, Accra, who had experienced at least one unintended pregnancy found that, most girls used clinics and hospitals for their abortions (23 of the terminated pregnancies were clinic abortions and five were herbal). In the same study, all the respondents said that their first pregnancies and most of the subsequent ones were unplanned. Twenty-three (23) out of 49 pregnancies reported were aborted in order to delay childbearing or space birth intervals. Although respondents indicated that induced abortion was morally wrong, the abortion decisions were taken mainly to avoid community sanctions, shame associated with pre-marital childbearing and to ensure that their conditions of living improved before making babies.

Another research on abortion in Ghana conducted by Alliance for Reproductive Health Rights, Ipas and Marie Stopes International (2008) showed that knowledge of a woman who has had an abortion was higher in urban settlements (41%) than in rural areas (38%). Self-reported cases of abortion were however at about the same level for rural (18%) and urban (17%) dwellers. Analysis of the age at first abortion from the viewpoint of both males and females reveals that about two out of five of those reporting an abortion took that line of action for the first time when the pregnant woman was aged 15–19 years. A similar number also indicated the age of the pregnant woman at her first abortion

to be 20–24 years. The import of this analysis is that before age 25, at least one in 10 of most females would have aborted unwanted pregnancy.

In a community survey, it was evident that women who were self-employed had more incidence of abortion than the unemployed did. The majority of the women (65%) worked outside their homes, and almost half of them were self-employed (Ahiadeke, 2001). This is an indication that the incidence of induced abortion could cut across all professional or occupational backgrounds and consequently on income levels among women. This observation defeats the general perception that unemployed women had higher incidence of abortion than those employed in Ghana. Adanu and others therefore recommended that for effective intervention, programmes to reduce induced abortion should focus on women with low economic standing (Adanu *et.al.* 2005).

In terms of collaboration for an induced abortion, Gbagbo (2006) observed that, the general situation in Ghana is such that once a woman becomes pregnant, her body no longer becomes hers. Many at this stage are at the mercy of health workers, family members, sexual partners and/or significant others who influence the decision to have an induced abortion irrespective of any limitations. Research on household decision-making in Ghana, including women's health care decision-making, has shown that women who have more household decision-making power, or are socio-economically empowered are more likely to decide on their reproductive intentions (Crissman, Adanu & Harlow, 2012). These highlighted the fact that abortion is a means for some women to exert some control over their fertility (Guttmacher Institute, 2012).

Yeboah, (2003) observed that, where abortion services are available, they usually are not tailored to women's social circumstances and individual needs to help in providing adequate information to make an informed decision for an induced abortion. In some cases, health providers may provide an abortion only in exchange for high fees and other favours (Ahiadeke, 2001). This phenomenon has been documented as one of the reasons why women collaborate with unscrupulous people for induced abortion amidst grave implications for the woman, her future reproductive intentions, career pursuits, her children, family and the entire community in which she belongs (Brookman-Amissah, 2004).

In Ghana, issues about informed consent in making induced abortion decisions have critically been debated considering various scenarios (Ghana Health Service, 2005). Lithur, (2004) however argues that women seeking abortion do not require consent from anybody since there is no mention of husband's/partner's consent in the Ghanaian abortion law. The abortion act thus, permits a woman to take unilateral decisions without necessarily involving the sexual partner since she is the one directly involved and immediately affected by the pregnancy. Although the consent of the husband/partner may be obtained as good clinical practice, husband's/partner's objection however, is not legally valid to oppose an abortion in Ghana (Tellefsen, 1996; GHS, 2003).

Relationship problems have been cited as a reason for induced abortion without partner consent in Ghana (Bankole, Singh & Haas, 1998). Because consenting to an induced abortion is becoming predominantly the prerogative of pregnant women, it appears legally, men are now being excluded from actively

participating in abortion decision-making processes by their partners. However, in the event that a woman's consent cannot be readily obtained, then such consent could be given on her behalf by her next of kin or person standing in as her parent. Such consent as stated in the Abortion Act (section 14) should be an 'informed consent and should be given by a female of sound mind and at least sixteen years of age'. This legal provision raises the question whether the law allows parents of pregnant minors a veto over the decision to have abortion and whether clinics or practitioners should inform or notify parents of such minors who require abortion (Turkson, 2006; Bleek, 1981). Although it may make social sense for pregnant women to collaborate when seeking an induced abortion, the Ghanaian abortion law explicitly indicates that in all cases, the pregnant woman must give her consent, and thus, while women may decide on an induced abortion, men may not.

The literature reviewed shows that, issues relating to induced abortion decision-making appeared highly philosophical and multi-faceted. The secular debates over decision-making for induced abortion have not changed much over the years but simply grown in volume and intensity. Previous abortion studies have not clearly indicated the stage-by-stage process involved in abortion decision-making. The issues raised by critiques of abortion laws are complicated and require high intellectual capabilities to understand and interpret. Limitations observed from the empirical literature reviewed suggest an inadequacy of community based studies on abortion in Ghana. This study will therefore contribute to knowledge on abortion.

Theoretical Literature

According to Grolier Incorporated (1985), research theories are based on assumptions, accepted principles, and rules of procedure devised to analyze, predict, or explain the nature or behaviour of a specified set of phenomena. Such knowledge or system is distinguished from experiment or practice by abstract reasoning, broad speculation, hypothesis or supposition. The theoretical literature reviewed therefore include: Health Belief Model, Theory of Reasoned Action and Theory of Planned Behaviour.

Health Belief Model

The Health Belief Model (HBM) is one of the oldest social cognitive, health behaviour change and psychological models developed in the 1950s by Hochbaum, Rosenstock and Kegels who were then working in the U.S. Public Health Services to explain and predict health behaviours of people (Mullen, Hersey & Iverson, 1987; Conner & Norman, 1996). Originally, the HBM focused on attitudes and beliefs of people in response to failure of free tuberculosis screening programme. The model assumes that a person's view or perceived threat of a disease is influenced by their perceived susceptibility to the disease and how they perceive the severity or seriousness of the disease. Cues for action from the media, health professionals, family and significant others, also influence the perceived threat as do the person's demographic status. As well, perceived benefits of seeking treatment and perceived barriers to treatment influence self-efficacy for taking an action (Figure 1).

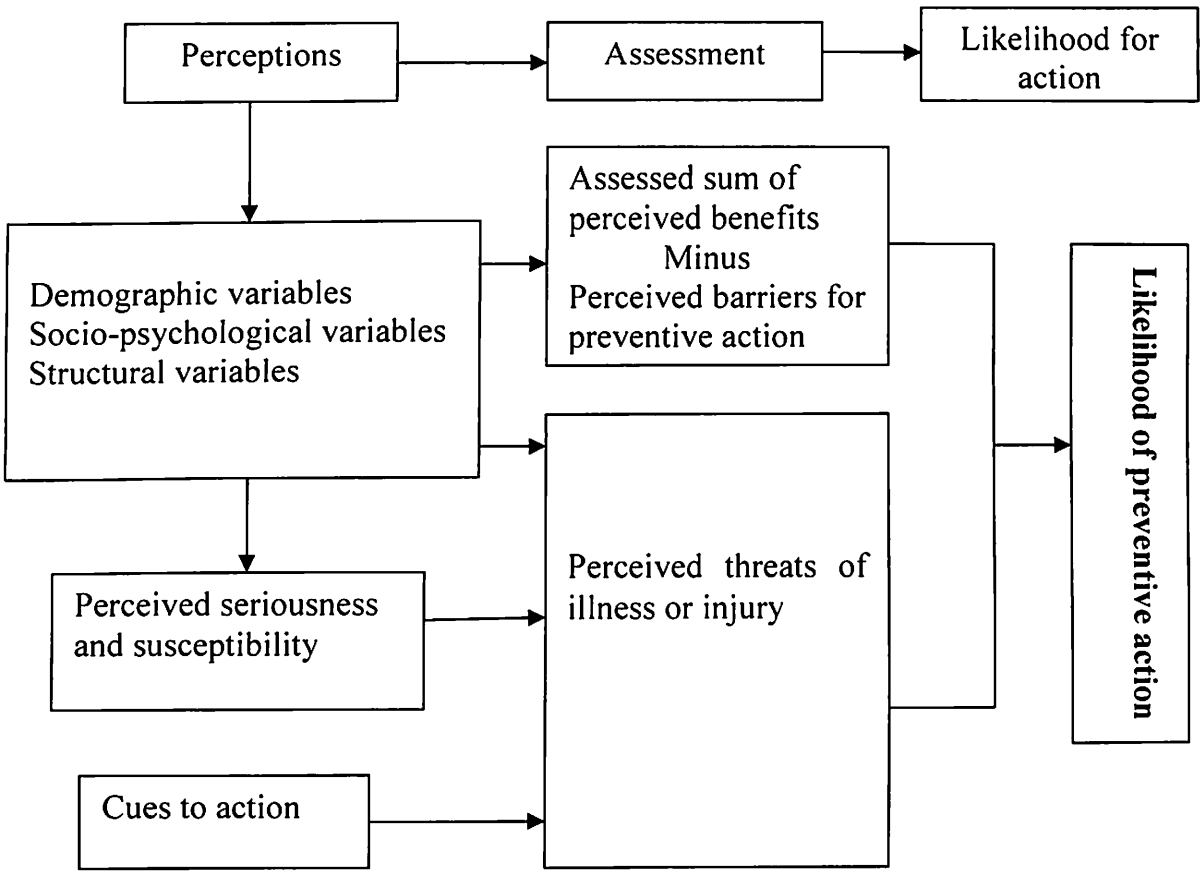

Figure 1: The Health Belief Model

Source: Rosenstock, Hochbaum and Kegels (1950)

Rosenstock (1974) modified the original model based on which Becker (1978) furthered the model in the 1970s and 1980s. Subsequent amendments to the model were made in late 1988 to accommodate evolving evidence generated in public health about the role that knowledge and perceptions play in personal responsibility relating to health behaviours (Glanz, Lewis & Rimer 2002). Since then, the HBM has been adapted to explore a variety of long and short-term health seeking behaviours, including sexual and reproductive health seeking behaviours (Ogden, 2007).

The Modified Health Belief Model assumes two types of beliefs that influence people's preventive actions. These beliefs relate the readiness to take an action and beliefs to modifying factors that facilitate or inhibit actions. The variables that are used to measure readiness to take an action include perceived susceptibility to illness (i.e. having an unwanted pregnancy and the perceived challenges/risk of carrying the pregnancy to term). Benefits, (i.e. the perceived advantages of action), and barriers (i.e. the perceived costs or constraints of the specific action), are the main modifying variables (Abraham & Sheeran, 2005). An addition to the HBM is the concept of self-efficacy, or one's confidence in the ability to perform an action successfully. A measure of value for health and an added concept, 'cues to action', activate that readiness to stimulate an overt behaviour (Rosenstock, 1974; Becker, 1978).

According to Abraham and Sheeran, (2005), the HBM is different from other models in that there are no strict guidelines as to how the different variables predict health-seeking behaviours. The HBM proposes that, the independent variables in the model are likely to contribute to the prediction of a health seeking behaviour. This has been successfully used in predicting a variety of behaviours including risky sexual behaviours, (Basen-Engquist & Parcel, 1992; Hingson, Strunin, Berlin & Heeren, 1990); exercising, eating sweets, fried foods and smoking (Mullen, Hersey & Iverson, 1987); driving while intoxicated (Beck, 1981); as well as sunbathing and sunscreen use (Keesling & Friedman,1987).

The main criticism of the Health Belief Model is that this model is too flexible and lacks structure at the individual and interpersonal levels. The model

assumed people think and behave in logical and rational ways, but this depends greatly on the individual's background. The amount of control an individual perceives to have, has a great effect on self-efficacy. Most often people having health related problems do not always follow specific stages and often are not rational thinkers during such situations (Conner & Norman, 1996). The flexibility of the Health Belief Model however, makes it adaptable to predicting a variety of health seeking behaviours including decision-making for induced abortion.

Theory of Reasoned Action

Fishbein and Ajzen (1975) developed the Theory of Reasoned Action (TRA) purposely for prediction of behavioural intention, spanning predictions of attitude and predictions of behaviour. The subsequent separation of behavioural intention from behaviour allows for explanation of limiting factors on attitudinal influence (Ajzen, 1985). This theory was derived from previous research that started out as the theory of attitude, which led to the study of human attitudes and behaviours. The theory was, "born largely out of frustration with traditional attitude-behaviour research, much of which found weak correlations between attitude measures and performance of volitional behaviours" (Hale, Householder, & Greene, 2003).

The components of TRA are three general constructs: (i.e. behavioural intention (BI), attitude (A), and subjective norm (SN)). TRA suggests that a person's behavioural intention depends on the person's attitude about the behaviour and subjective norms (BI = A + SN). According to Ajzen and Fishbein,

(1975), behavioural intention measures a person's relative strength of intention to perform behaviour. The attitude towards behaviour therefore consists of beliefs about the consequences of performing the behaviour multiplied by valuation of these consequences. The subjective norm is a combination of perceived expectations from relevant individuals or groups along with intentions to comply with these expectations.

Simplifying the definitions, a person's voluntary behaviour is predicted by the attitude towards that behaviour and how individuals think other people would see them if they performed the behaviour. Fishbein and Ajzen, (1975), further indicated that a person's attitude, combined with subjective norms, forms his/her behavioural intention although the attitudes and norms are not weighted equally in predicting the behaviour. Miller (2005) was of the view that depending on an individual's situation, these factors might have very different effects on behavioural intentions; thus, a weight is associated with each of these factors in the predictive formula of the theory. For example, one might be the kind of person who cares little for what others think about his/her behaviour. If this were the case, then the subjective norms would carry little weight in predicting one's behaviour.

According to Hale, Householder and Greene (2003), the TRA has been adapted in numerous studies across many areas including dieting (Ajzen & Fishbein, 1980), using condoms (Greene, Hale & Rubin, 1997) and consuming genetically engineered foods (Sparks, Shepherd & Frewer, 1995). Using this model, there must be distinction between a goal intention and a behavioural

intention. Additionally, the presence of choice may dramatically change the nature of the intention formation process and the role of intentions in the performance of behaviour hence, there are times when one intends to do something but does another (Figure 2).

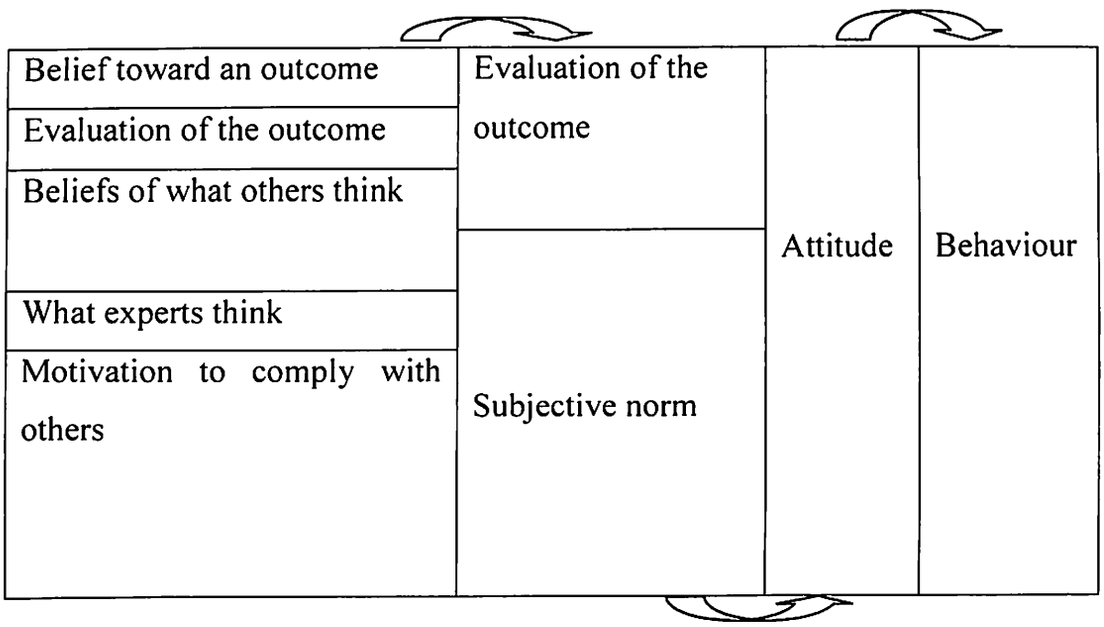

Figure 2: Theory of Reasoned Action

Source: Ajzen, 1980

Sheppard, Hartwick and Warshaw (1988) criticized this theory and proposed that for certain situations in life, a behavioural intention will predict the performance of any voluntary act, unless intentions change prior to performance or unless the intention measure does not correspond to the behavioural criterion in terms of action, target, context, time-frame and/or specificity. Sheppard et.al (1988) further criticized the theory that it had two limiting conditions (i.e. (1) the

use of attitudes and subjective norms to predict intentions and (2) the use of intentions to predict the performance of a behaviour).

Earlier, Bentler and Speckart, (1979) were of the view that such behaviours are excluded because their performance might not be voluntary or because engaging in the behaviours might not involve a conscious decision on the part of the individual taking the decision. Based on these criticisms, Ajzen in1985 revised and expanded the 1980 TRA flow model to express a conceptual model that accounts for actual behavioural control. A criticism of the Modified Theory of Reasoned Action is that, the theory's explanatory scope excludes a wide range of behaviours such as those that are spontaneous, impulsive or habitual (Hale, Householder & Greene ,2003).

Theory of Planned Behaviour

Based on the various criticisms, Ajzen further expanded the Theory of Reasoned Action, formulating the Theory of Planned Behaviour (TPB), which emphasizes the role of intention in behaviour performance and cover situations in which a person is not in control of all factors affecting the actual performance of behaviour. The TPB states that 'the incidence of an actual behaviour performance is proportional to the amount of control an individual possesses over the behaviour and the strength of the individual's intention in performing the behaviour' (Ajzen, 1985, 1988; Ajzen & Madden, 1986; Schifter & Ajzen, 1985; Miller, 2005). Ajzen (1988), further hypothesizes that self-efficacy is important in determining the strength of an individual's intention to perform a behaviour.

According to this theory, people perform certain actions because they form an intention to carry out the action. On the contrary, Conner and Sparks, (1996) believe that human intentions are a function of three determinants (i.e. beliefs, salient referents and perceived behavioural control). Thus, the attitude towards the behaviour is determined by the person's evaluation of the outcomes associated with the behaviour. The more positively the person evaluates the outcomes and believes that the behaviour will achieve these outcomes then the more likely it is that the person will perform the behaviour (Figure 3).

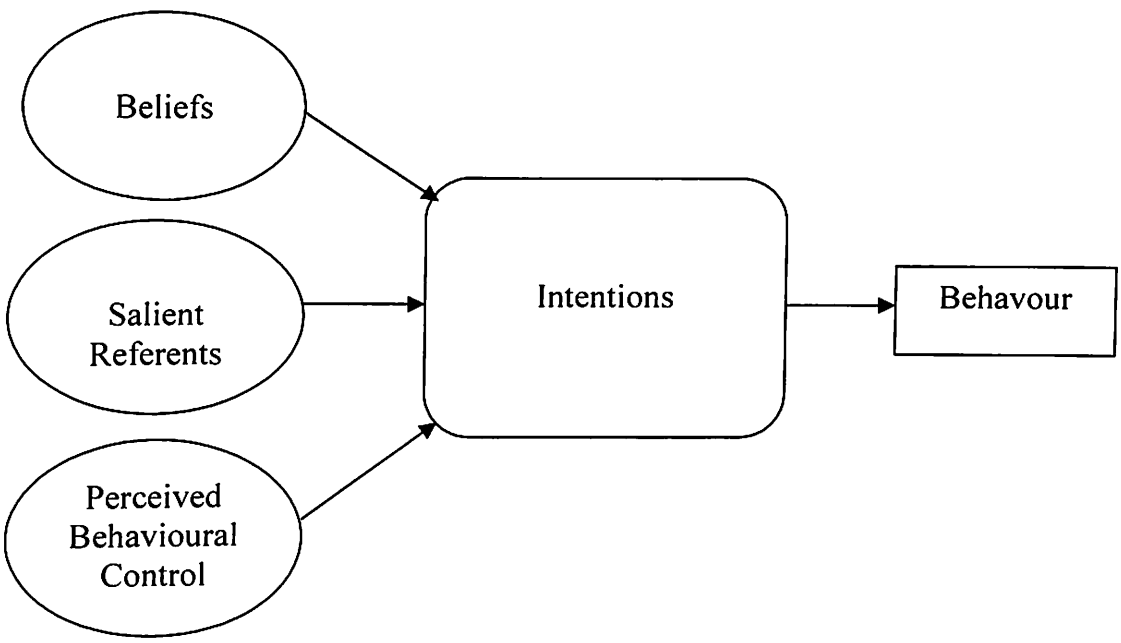

Figure 3 : Theory of Planned Behaviour

Source : Ajzen, 1988

In Figure 3, behavioural beliefs link the behaviour to certain outcomes. For example, a person may believe that terminating unplanned pregnancy (the

behaviour) leads to concealing premarital sex, hence preventing disgrace (the outcome). The salient referents are individuals or groups that an individual believes will approve or disapprove of performing the behaviour. The important referents often include the person's parents, spouse, partner, close friend, co-workers and, in some cases, people such as their doctors, lawyers, among others. The perceived behavioural controls refer to the perceived ease or difficulty of performing the behaviour. The greater a person's perceived behavioural control, the stronger the intention to perform the behaviour. Thus, if one considers that he/she has the resources (e.g. time, money, transport, knowledge) to have an abortion, then he/she may be more likely to make a decision to have an abortion.

Each of the three determinants of planned behaviour: behavioural beliefs, salient referents and perceived behavioural control contributes to the strength of a person's intention to perform a behaviour. This is just because a person forming an intention to perform behaviour does not invariably mean that he/she will actually perform the behaviour. Additionally, the length of time that passes between forming an intention to perform a behaviour and the actual time when the behaviour is to be performed is potentially influential. If the duration between intention and timing of the behaviour is short then it is more likely that the behaviour will be performed. However, if the duration is long then other factors may intervene that might cause an individual to reconsider and reshape his/her attitude towards the behaviour. Factors likely to influence/reshape human behaviours such as abortion decision making in recent time are usually grounded in moral theories.

Conceptual Framework

The conceptual framework for the study is an adaptation of the Health Belief Model because of the flexibility of its adaptation for decision-making on various health issues. As observed by Carlson, Kacman and Wadsworth (2002) this conceptual framework integrates variables relevant to decision-making processes of induced abortion that impact directly on the research questions and links the variables being investigated to meet the study objectives. In adapting the Health Belief Model as the conceptual framework, some specific areas of the original Health Belief Model were modified to focus on women and abortion decision-making.

This conceptual framework has three decision-making points (perceptions and modifying factors on abortion, assessment and likelihood for having induced abortion). The modification included introducing additional variables such as modifying factors that influence women's perceptions on induced abortion. The demographic variables were specifically background characteristics of abortion seekers, which include age, marital status, religion, educational background and number of living children. The socio-psychological variables included a woman's prior knowledge of abortion and/or contacts for induced abortion. Structural variables were not relevant to this study, hence were omitted from the conceptual framework (Figure 4).

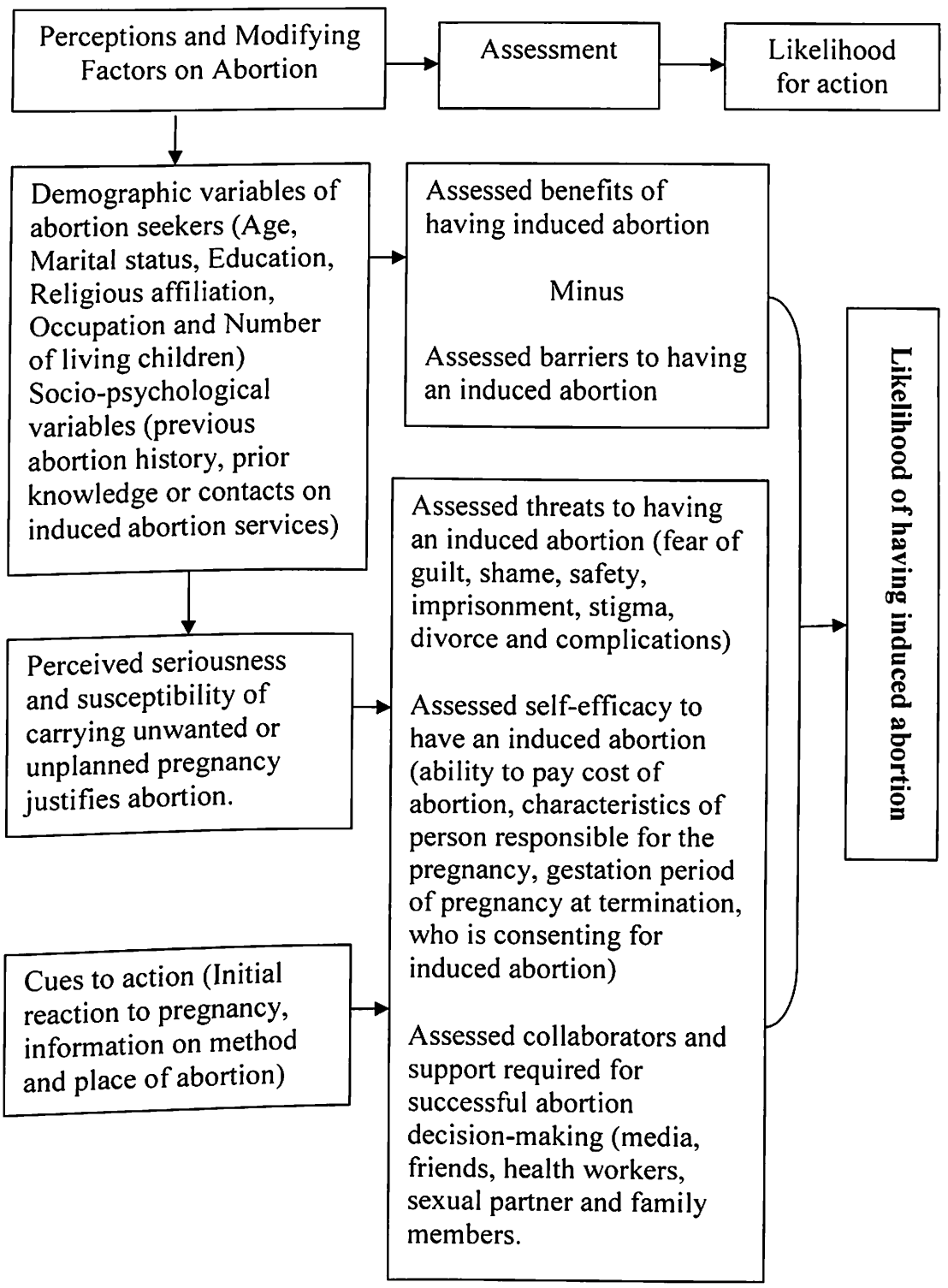

Figure 4: Conceptual Framework (Adapted Health Belief Model)

Source : Adapted from Rosenstock, Hochbaum and Kegels (1950)

The issue of social and medico-legal pressure was considered under the concept of perceived seriousness of carrying an unwanted/unplanned pregnancy to term. Concerns about an individual's carrier development, reproductive intentions at the time of pregnancy, affordability, accessibility and availability of abortion services and the recommended abortion methods were considered under the concept of perceived susceptibility to abortion. The concept of cues to action focused on respondents' initial reactions to a pregnancy, information on methods and places of abortion.

The concept of assessment was expanded to reflect benefits, barriers and threats associated with abortion. In this regard, specific issues such as safety, self-efficacy, partner consent, cost of abortion and collaborators were considered. Collaborators for abortion introduced in the conceptual framework were broadened to reflect sources of information about place and methods of abortion and the support that women receive from significant others. A concept of self-efficacy was used to describe women's capabilities to induced abortion without collaborating with anybody during abortion decision-making and implementation stages of the decision.

Each of the decision-making points has concepts based on variables that relate and influence the various aspects of the decision-making process for induced abortion. The first abortion decision-making point (perception and modifying factors on abortion) indicates that, induced abortion decisions occur within the context of individual background characteristic and prevailing conditions in which the individual finds herself at the time a pregnancy occurs. In

relation to this, an abortion decision-making process becomes multifaceted and involves the consideration of women's background characteristics, their perceived seriousness of the potential dangers of keeping an unwanted or unplanned pregnancy, susceptibility to abortion, collaboration with available support systems and an evaluation of a woman's self-efficacy, which leads to a second decision-making point of assessment. At this point, a cost benefit analysis is done on the need/benefits of induced abortion and overcoming barriers to abortion.

Concerns about privacy of abortion, safety, cost, accessibility, effective abortion methods and women's limitations of control on some issues necessitate collaborations for induced abortion. By so doing gender and power relations with respect to negotiation, consenting and approval for an abortion drives the pregnant woman to collaborate with some key people closer and/or distant to her who have means of contributing to implementing the abortion decision.

The abortion decision at this point is no longer personal, since a pregnant woman would have to consider the perceived seriousness of carrying a pregnancy, and then seek help for an abortion. In doing this, a reflection on circumstances surrounding the onset of a pregnancy and the persons responsible for the pregnancy leads to an initial reaction towards the pregnancy, which compels the pregnant woman to do a cost/benefit analysis of keeping a pregnancy bearing in mind the implications to her health, life ambitions, social, economic and religious status. Where a desire for an abortion is paramount and necessary support available, perceived barriers or threats to having an induced abortion is overcome to pave way for likely implementation of an abortion decision.

The decision-making points identified in the conceptual framework have some ethical issues that the Ghanaian society perceives as legal and/or moral, which moves away from absolute standard of judgment to social standards (Jones, 1991). However, these ethical issues relate to individual's interpretation of a problem (an intended pregnancy) and an ethical decision-making process to have such a pregnancy terminated because it is unwanted. The optimal happiness that induced abortion later brings to a woman informed the adaptation and use of this conceptual framework.

Making an ethical decision for an induced abortion in the framework also identified issues of medico-legal and moral arguments relating to the circumstances surrounding the onset of a pregnancy (i.e. rape/ defilement/ incest, accidental/failed contraceptive, testing fertility, extra-marital affairs, as well as consented sexual affairs) and the person responsible for the pregnancy. A cost/benefit analysis of keeping a pregnancy focusing on the health implications, religious implications, socio-economic implications, expectations about future (school/work/goals) and situational changes influences an individual's desire for an abortion.

Table 1 presents at a glance, how the concepts identified in the conceptual framework are operationalised to reflect the processes that women undergo, when an unwanted pregnancy occurs and decisions they make for an induced abortion.

Table 1: Operationalizing the Conceptual Framework

Concept	Relating concept to Pregnancy	Application to induced abortion
1. Perceived Susceptibility to abortion	Women believe, for a pregnancy to be wanted it must be planned	Women believe the pregnancy was unwanted hence abortion
2. Perceived Seriousness of unwanted or Unplanned pregnancy	Women believe that the consequences of carrying unplanned/unwanted pregnancy are significant enough to try to prevent a pregnancy occurring.	Women believe that they cannot bear the consequences of carrying unplanned or unwanted pregnancy hence take decisions to have an induced abortion when pregnant
3. Benefits for having abortion	Women believe that deciding on induced abortion when unwanted pregnancy occurs would enable them achieve their life ambitions.	Women believe that collaborating with significant others on abortion decisions will yield beneficial results such as financial support, education on place and methods as well as contacts for safe abortion.

Table 1 continued.

4.	Barriers to abortion	Women identify challenges associated with abortion (i.e. accessibility and affordability of abortion as well as risks of abortion related complications	Women identify their personal challenges to have an abortion (i.e. legal implications, cost of services, safety, privacy and confidentiality) and explore ways to eliminate or reduce these challenges for action.
5.	Collaborations for abortion	Women receive support from significant others in the form of money, information on abortion providers and abortion methods	Women receive reminder cues for action in the form of insistence on abortion by a partner, medical advice, referrals by Drs/nurses.
6.	Self-Efficacy	Women confident to decide on pregnancy outcome without anybody's consent, limitations/delay.	Women have enough money, autonomy, courage and adequate information on place of abortion and opt for an abortion method
7.	Likelihood of having abortion	Women think the pregnancy was unplanned or unwanted	Fear of health, social, economic carrier/educational implications if pregnancy is not terminated.

Source: Author's construct, 2013

The conceptual framework is quite flexible and therefore could be used to study different sexual and reproductive health decision-making processes. It has comparative advantage over other frameworks since it introduces the involvement of collaborators during abortion decision-making processes thereby elaborating on the effect of societal influences on individuals' decision-making for an induced abortion. This conceptual framework however has the following limitations:

1. Despite the flexibility of adaptations of this conceptual framework, it does not entirely address the effect of societal influences on individuals' abortion decisions as well as other related sexual and reproductive health decision-making processes. For instance, the concept of self-efficacy is too broad and may not be very useful for all analysis.

2. Additionally, it is not clear how an intrinsic factor such as gestational period of a pregnancy will affect decision-making for an induced abortion regardless of societal influences.

3. Finally, the perceived severity/need for an abortion as well as perceived barriers is very subjective and difficult to measure since what one individual may perceive, based on her background, as a severe need or a barrier for an induced abortion, may be differently perceived by another with even similar background characteristics.

CHAPTER THREE

RESEARCH METHODOLOGY

Introduction

This chapter presents methodological issues relating to the study. The chapter outlines the philosophy underpinning this study, the study area, research design, methods of data collection, study population, sample size, sampling, research instruments used, pretesting of the research instruments, data analysis and ethical considerations relating to using human subjects in social science research.

Philosophical Underpinnings of the Research

The study was guided by the philosophy of utilitarianism. Utilitarianism has been an old philosophy of thought among Chinese and Greeks. The utilitarian doctrine originated in the 18th century when Shaftesbury and Hutcheson tried to find a natural foundation for moral motivation of spontaneous benevolence that people feel for others. In the 19th century, English philosophers and economists, Jeremy Bentham and John Stuart Mill promoted utilitarianism indicating that an action is right if it tends to promote happiness and wrong if it tends to produce the reverse of happiness not just the happiness of the performer of an action but also that of everyone affected by it.

According to Mill (2012), in Utilitarianism, to make a moral decision, a person must treat the choice as a "utility". Using the utilitarian theory, an

individual must ask himself or herself, "what would provide the greatest good for the greatest number of people?" According to Mills (2012), the principle of utility states that, an action is right if it produces as much or more of an increase in happiness of all affected by it than any alternative action, and wrong if it does not. Its basis is the idea that pleasure and happiness are intrinsically valuable, that pain and suffering are intrinsically invaluable, and that anything else has value only in its causing happiness or preventing suffering. To distinguish it from intrinsic value, this latter kind of value is given the name "instrumental" (or, less commonly, "extrinsic") value, and represents value (usefulness) as means to an end.

Clearly, a person who confesses to live according to the utilitarian moral theory must weigh all decisions on the outcome of a choice and how much overall happiness it will cause. From the utilitarian philosophical standpoint in this study, pregnancy termination at any gestational period is a decision or choice that one makes in life for a particular reason at the time. This decision or choice presumably is expected to result into an overall happiness for the pregnant woman and/or significant others that she collaborated with in making the abortion decision at the time.

A criticism of the utilitarian philosophy is that, the issues informing decision making on life choices seem very dangerous to some people because it leaves the "door" open for subjective interpretation of happiness. How does one really know what will make others happy? Is not a person only really interested in his/her own happiness? Indeed, the decision for an induced abortion from the

utilitarianism point of view will amount to what will bring the ultimate happiness to the one mostly affected by a pregnancy. In this regard, the happiness that an abortion might bring may not favour the pregnant woman but rather the sexual partner and/or significant others. Hence, these people will pressurize a woman to have an abortion for their own selfish ambitions. This brings to the fore various justifications and logic that relates profiles of women and induced abortion decision-making to understand the reality of issues that will answer fundamental questions about what influences a woman's decision for an induced abortion, the collaborators involved in the decision making process, the choice of place and method for the abortion within the study area.

Study Area

This study was conducted within the Accra metropolis. According to the Ghana Statistical Service (2010), the Accra metropolis is the most densely populated urban metropolis in Ghana with an estimated total population of about 2,242,505. Women in reproductive age constitute about 841,533 of this population. There are many ethnic groups with approximately 44 spoken languages in the metropolis. The Akan language (Twi) is the most commonly spoken languages and trading is the main economic activity among people living in the Accra metropolis.

Geographically, the Accra metropolis is sub-divided into eleven sub-metros. Each of these sub-metros is treated as an administrative district because of their population sizes and complexity of the sub-metro health systems. The Accra

metropolis is bordered by four sub-districts: Ga East, Ga West and Ga South on the west, Ledzokuku-Krowor sub-district on the east and Tema metropolis on the north. The Gulf of Guinea forms the coastline of the metropolis on the south (Figure 5).

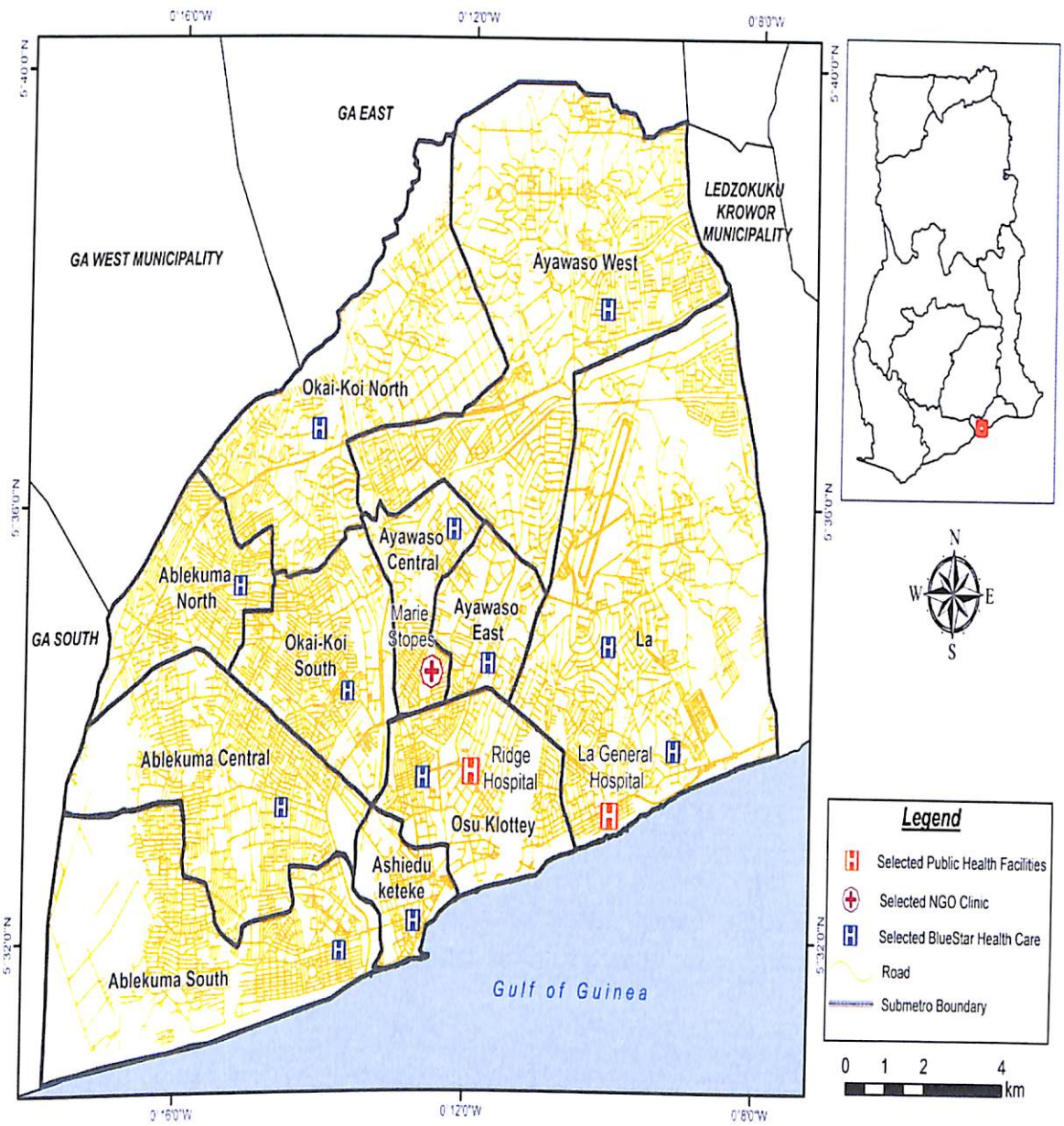

Figure 5: Administrative Map of the Accra metropolis, Ghana.

Source: University of Cape Coast, Department of Geography & Regional Planning, Geographic Information Systems Laboratory (2013)

The Accra metropolis has four hundred and eighty-one (481) health facilities registered with the Ministry of Health (Table 2).

Table 2: Profile of Registered Health Facilities in Accra metropolis

Type of health facility	Numbers
Government hospitals: (Achimota, La, Princess Marie Louise Children's and Ridge hospitals)	4
Polyclinics: (Mamobi, Kaneshie, Adabraka, Dansoman, Ussher Fort, Korle-Bu and Mamprobi polyclinics)	7
Quasi-government hospitals: (37 Military, Police, Trust and University hospitals)	4
Private hospitals	49
Private Clinics	270
Company clinics	39
Private maternity homes	79
NGO/ Mission hospitals	29
Total	481

Source: Ministry of Health, 2010

The Ghana Health Service with support from an 'anonymous donor' in 2006 initiated the Reducing Maternal Mortality and Morbidity (R3M) project to prevent abortion related deaths and illness in the Accra metropolis. As one of the key project deliverables, there is a well-coordinated referral and data collection system for comprehensive abortion care services in selected health facilities, which makes abortion data collection more feasible in the Accra metropolis (Ghana Health Service, 2007). The key induced abortion providers who were collaborated with in the Accra metropolis for this study are: Marie Stopes International Ghana, BlueStar HealthCare Network, La and Ridge Hospitals.

Marie Stopes International Ghana (MSIG) is a non-governmental multinational organization in over 45 countries worldwide. In Ghana, MSIG was established in September, 2006, and is committed to upholding the fundamental rights of individuals and couples to decide freely and without coercion the number and spacing of their children and the right to obtain both the information and means to do so. In support of this goal, MSIG's mission is to ensure the individuals fundamental human right to have "children by choice not chance." MSIG has one clinic in the Accra metropolis (Kokomlemle) that provides wide range of sexual and reproductive health services including comprehensive abortion care services as permitted by Law.

BlueStar HealthCare is one of the affiliates of Marie Stopes International Ghana as per the partnership agreement in quality reproductive health service delivery. It is a network of private hospitals, Pharmacies and chemical shops. Established in 2007 in Ghana, BlueStar, Franchise private medical practitioners

and pharmacies e.g. doctors, midwives, nurses, pharmacists and licensed chemical sellers within their own private facilities in a partial franchise fashion to provide sexual and reproductive health information and services within their communities. The pharmacists and licensed chemical sellers in this health care network serve as a first point of call in the community from which abortion seekers are referred to accredited health facilities for safe abortion services. By geographical spread of BlueStar Franchisees, over 80% of franchised clinics are located in the Accra Metropolis (Marie Stopes International Ghana, 2006).

Ridge and La Hospitals are both government hospitals in the Accra metropolis. Both hospitals are adequately resourced and their capacities built to provide comprehensive abortion services within the full extent as permitted by the abortion laws of Ghana (GHS, 2011).

Ridge is the regional hospital for the Greater Accra region and the second most important public health facility in Accra after Korle Bu, the national teaching and referral hospital in Ghana. Ridge hospital was initially established to cater for the health needs of the expatriate staff in the pre-independence period of Ghana. Today, it is located in the centre of Accra and serves as the regional hospital of the Grater Accra Region. It offers general and specialized medical and surgical services and also functions as the referral hospital for the region.

La General Hospital, a sub-metropolitan public hospital, is located in one of the traditional suburbs (La), in Accra. It ranks as a major health facility after Ridge hospital and provides general and specialist medical, surgical and gynaecological services. Recently rehabilitated, it also serves as a referral point

for satellite clinics in some of the old areas of Accra including Osu, Teshie, Nungua and Cantonments.

The Accra metropolis was chosen for the study because of it's densely population size (Ghana Statistical Service, 2010). Additionally, the metropolis was reported to have recorded more cases of induced abortion than any other metropolis in Ghana and had the presence of more accredited health facilities providing induced abortion services (Ghana Health Service, 2007).

Study Design

According to Babbie (1989), conducting social science research requires the use of an appropriate study design to unearth human complexities about social issues to make inferences on the research topic. In relation to this, the study design was a retrospective (reflecting back on the past) cross sectional examination of decision-making process for induced abortion. With this design, participants were required to reconstruct details of the circumstances under which they decided to have an induced abortion at the time of pregnancy regardless of any challenges and uncertainties they faced at the time of abortion decision-making.

The study used a mixed method approach employing both qualitative and quantitative methods in collecting, analyzing, interpreting, and reporting data. According to Ellis (2000), combining qualitative and quantitative methods for research incorporates the strengths of both qualitative and quantitative methods, which provided a more comprehensive view of the phenomenon being studied.

Another justification as proposed by Blaikie, (2000) for using multi-method or multiple operations research methods was to minimize peculiar biases associated with either the quantitative or the qualitative methods, which consequently improved the validity of the hypothesis tested. The relevance of using a mixed method approach in this study was to facilitate a better understanding of the data analyzed and the interpretation of the results (Creswell, 2003).

In the context of the research topic and its objectives, the inclusion criterion was women who had induced abortion at a specified period in the Accra metropolis. The aim was to determine associations between different variables, make inferences about possible relationships and gather preliminary data that would be use for further research. The study also explored in-depth on the responses given because there were few earlier studies on decision-making for induced abortion in Ghana for reference. Hence, this approach was to gain insight and familiarity with the issues for further investigation. The study further described in details from women perspectives the processes involved in decision-making for induced abortion in the Accra metropolis.

Sources of Data

Data for the study were obtained from secondary and primary sources. Secondary data were from desk review of abortion related reports obtained from the Ghana Health Service/Ministry of Health. Primary data were obtained from the fieldwork to support the secondary data. Induced abortion data from the

Military, Police, University and Teaching hospitals in the Accra metropolis were excluded from this study because the abortion data from these facilities were not segregated, thereby making it difficult to distinguish induced abortions from the spontaneous abortions. Additionally, the data set available were mainly on management of abortion related complications, which was not the focus of this study.

The inclusion criteria for data collection were: all respondents were women who had an induced abortion within the Accra metropolis between January and December 2010 and are willing to be part of the study voluntarily. In this context, a woman is a female who has had an induced abortion.

Methods of Data Collection

A structured questionnaire was used during interviews to examine the socio-economic and demographic characteristics of the respondents. This approach also explored the factors influencing decision-making process for induced abortion in the study area, hence describing variations across socio-economic and demographic subgroups of respondents. The qualitative component of the study used in-depth interviews to compliment the quantitative data.

Research Instruments

The research instruments used for data collection include questionnaire and in-depth interview guide. Questionnaires used in previous separate but similar abortion studies by Pathfinder International Ghana, (2007) and Population

Council, (2008) were adapted. The questionnaire captured the socio-economic and demographic characteristics of abortion seekers, factors influencing their decision making for an induced abortion, the key collaborators involved in decision making for the induced abortion and the factors that influenced the choice of place(s) for the induced abortion.

The qualitative data were collected using structured in-depth interview guide adapted from Henry and Fayorsey, (2002). The interview guide focused on the reasons for induced abortion, the decision-making processes for an induced abortion, roles of their sexual partners/husbands in the decision making processes for induced abortion and how they felt after having an induced abortion. Both the questionnaires and interview guides were available in English. However, in situations where respondents could not communicate in English, the questions were interpreted into the local languages during the interview process to enable these respondents to understand and respond appropriately. Data collection using the questionnaire and in-depth interviews each lasted 1-hour (appendices B & C).

Pre-testing of Research Instruments

In order to retain the appropriate language and sequencing of questions, the research instruments were pre-tested in Kumasi metropolis, which has similar characteristics as those of the Accra metropolis. Twenty (20) questionnaires and five (5) in-depth interviews were pretested in Marie Stopes centre at Adum in Kumasi. The lessons learned from the pretest were used to finalize the research instruments.

Study Population

The study population comprised women who had an induced abortion between January and December, 2010 in the Accra metropolis. This reference period was anticipated for fresh memories of the decision making process of induced abortion. It was also anticipated that by this period, respondents might have fully recuperated from any side effects or complications (i.e. medical, social, psychological) that might have occurred due to the abortion and would have become capable of effective communicating their experience if they so desired.

Sampling

The sampling process was multistage. A purposive sampling method was used to select abortion providers accredited by the Reducing of Maternal Mortality and Morbidity (R3M) project (i.e., La General hospital, Ridge hospital, Marie Stopes centre and its affiliated BlueStar Health care network abortion providers). These facilities were selected because, they were noted to be more organized and open about their abortion services compared to other facilities. A formal request was then sent to each of the identified facilities to solicit their permission and support for the study.

Induced abortion data from January to December, 2010 in each of the R3M accredited facilities were obtained based on which the sample size for the study was calculated. Further request was made to the facilities to contact clients to whom they had provided abortion services during the period under review to discuss modalities for the interview and to agree on time, venue and medium for

the interview. Consequently, the study respondents were individually contacted through service providers from whom they had their pregnancies terminated. The identified respondents were subsequently interviewed at various venues of their choice and convenience such as their homes, places of work, drinking sport and facilities where they had their abortions.

Sample Size

The minimum sample size of respondents calculated for the quantitative component of the study is 370. The study however, made a 10% (37) upward adjustment in the sample size making a total sample size of 407 to cater for non-response and missing questionnaires. An online Raosoft sample size calculator was used to calculate the sample size.

The sample size calculation was based on a recorded total population of 9494 women who had induced abortion services in the identified facilities from January to December 2010, using 95% confidence interval, 5% margin of error and 50% response distribution. In terms of the figures, the sample size n and margin of error E are given by:

$$x = Z(^{c}/_{100})^{2} r(100-r)$$

$$n = {}^{Nx}/_{((N-1)E^{2}+x)}$$

$$E = \text{Sqrt}[{}^{(N-n)x}/_{n(N-1)}]$$

Where N is the population size, R is the fraction of responses that the study is interested in, and Z(c/100) is the critical value for the confidence level c. The calculated number of respondents were then randomly selected for the interview

using the questionnaire. The distribution of respondents interviewed was based on proportionate sampling of women reported to have had induced abortion services from the identified health facilities in the Accra metropolis (Table 3).

Table 3: Distribution of Respondents by Abortion Providers

R3M Accredited Abortion providers in Accra metropolis	Sample size distribution of respondents interviewed		
	Absolute numbers (A) (Jan-Dec) 2010	Percentage Distribution (D) [A/T x 100]	Proportionate Sample Size distribution [D/100 x Sample size]
Marie Stopes Clinic	1574	16.6	61
BlueStar facilities	5575	58.7	217
Ridge Hospital	1350	14.2	53
La General Hospital	995	10.5	39
Total Abortions	9494	100	370 (+ 10% extra=407)

Sources: Marie Stopes International Ghana, Ridge Hospital and La General Hospital 2010.

With regards to the qualitative sampling, the study purposively sampled 35 respondents comprising 5 previously married women, 10 unmarried women and 20 married women to explore their decision-making processes for induced abortion. The sampling distribution included 20 women in BlueStar, 5 in Ridge, 5 in La and 5 in Marie Stopes facilities. A total of 401 out of 407 women, initially sampled for the study were successfully interviewed during the field work.

Ethical Considerations

In line with ethical requirement for health related studies involving human subjects in Ghana, the Ghana Health Service gave the ethical clearance for the study (Appendix I). Additionally, permission for community entry was obtained from the Accra Metropolitan Health Directorate before the field interviews commenced (Appendices G & H). All interviews were conducted after a respondent had voluntarily consented to participate in the study. The informed consent described briefly the objectives of the study, the procedures to be followed in data collection, the type of information to be collected, the potential risks and benefits, the voluntary nature of participation, right of refusal to answer any or all questions, and procedures for maintaining anonymity and confidentiality of responses.

The field officers/data collectors first obtained verbal consent from a potential respondent willing to be interviewed and chose which interview option (via telephone or face to face) preferable to avoid any possible embarrassment of knowing a respondent. After agreeing to participate in the study the respondent was then requested to consent for participation in the study (Appendix A). For those respondents who were interviewed on phone, verbal consent was obtained after explaining the content and relevance of the study to them on the telephone.

Respondents had the right to withdraw their consent of participation from elements of the study or from the study entirely at any time without any coercion. The field officers were also trained to handle the administration of withdrawing consent of participation. The field officers addressed each situation on a case by

case basis and responded to the respondent who wished to withdraw their consent via the means deemed most appropriate. In cases where there was a complaint or an uncertain situation, the field officers referred the respondent's decision to withdraw to the principal investigator for advice.

Field assistants trained for the purpose of the study handled data collection. The field assistants were informed on the types of data to be collected, importance of quality control, and the ethical procedures to be followed. In this regard, the interview sessions were strictly private and confidential. All interviews began with a verbal or written informed consent by each respondent interviewed. All interviews were conducted on individual basis at a place away from ear short of others. Names, physical contact addresses and telephone numbers of respondents were documented separately and were not captured on the research instruments or in the data set to ensure strict anonymity so that no third party could trace information provided during the interviews to a respondent.

In this regard, data analysis presented only aggregated counts, observations, field experiences and verbal statements or expressions by respondents. The data collected were returned to the field supervisor at the end of each working day except for data that were collected on weekends and statutory holidays, which were submitted to the supervisors in the early morning of the next working day. Where applicable, all data collected were entered promptly into a computer that was password protected. The completed survey questionnaires were stored in a locked cabinet to ensure data quality subsequent to data collection that

was later handed over to the principal investigator to be burnt three months after completing the final research report.

The likelihood that some field assistants or respondents may have some emotional distress, or become uncomfortable having an interview on a morally sensitive issue of abortion was anticipated. This is because some may have to re-live some painful moments in their decision-making process to have an abortion in the past. The consent form therefore clearly indicated that participation in the study was voluntary. In relation to this, interviewers were oriented on the importance of minimizing anxiety or stress by being unobtrusive to protect the privacy of respondents and to keep in strict confidence any information provided during and after the study. The study minimized this by administering a short interview in a strictly non-judgmental manner. Respondents who became emotional during interviews were referred to pre-identified trained counselors at the Ridge hospital and Marie Stopes centres for appropriate counseling support.

No monetary incentives were given to any of the respondents. However, a non-monetary token of 10 Ghana cedis worth of preferred mobile phone credit was provided each respondent interviewed, to facilitate communication relating to the study before, during and after the interview to address any follow-up concerns. Although the Principal Investigator is an employee of Marie Stopes International, there is nothing by any means depicting conflict of interest in this study. This is because, this study is purely an academic exercise and neither Marie Stopes International nor any organization involved in abortion services globally or locally is by any means driving the study directly or indirectly for its

organizational gain. In exception of two thousand dollars (USD$ 2,000) received from Hewlett-Packard Foundation in 2010 as research grant in support of tuition fees, the entire study and academic tuition fees were self-financed.

Fieldwork

The Fieldwork, which took seven (7) months to complete commenced on 1st June, 2011 and ended on 1st December, 2011.

Field Assistants

Ten field assistants recruited for data collection were nurses and nurse aids from the identified institutions providing abortion services in the Accra metropolis. In addition to this, one other person with previous experiences in similar studies was also recruited as a field supervisor to coordinate activities of the field assistants. Both the field assistants and their supervisor were fluent in either English and Twi or English and Ga. This was purposively done to enable them translate and record data obtained from respondents in local languages into English. Due to the sensitive nature of induced abortion in Ghanaian communities, the selected field assistants and supervisors were given an orientation on ethical and methodological issues relating to the study.

Field Experiences

A number of challenges were encountered during the fieldwork. Four respondents (1.0%) stopped midway because one became emotional distressed discussing her abortion experiences whilst the rest demanded some monetary remuneration that was not budgeted in this study. Although the field assistance explained the purpose of the study to every respondent, the general feeling of unwillingness to be interviewed by some of the respondents and suspicions about the purpose of the study made some respondents very reluctant to provide information about decision-making for their abortions.

In thirty instances, five field assistants booked several appointments before they could meet respondents for an interview and these delayed the fieldwork. With these experiences, it is possible some respondents will not have provided the correct information about circumstances surrounding the onset of their pregnancies and the reasons for their abortions. However, it is very difficult to determine which of the information provided by the respondents during the fieldwork was true or false. The findings on the circumstances surrounding the onset of pregnancies and reasons for the abortions should therefore, be discuss cautiously.

Despite these challenges, the study provided an opportunity for the researcher to gain valuable experiences in community based studies relating to sensitive issues. For instance, rigorous measures were followed to pass the requirements for obtaining the ethical clearance from the Ghana Health Service for the study. The researcher also acquired the skills of handling confidential and

sensitive issues in a professional and ethical manner. This has given the researcher some confidence in fieldwork and therefore made him more capable to lead a research team to conduct research on induced abortion in Accra metropolis and beyond.

Data Analysis

The quantitative data analysis was done using two statistical softwares (SPSS version 16 and STATA version 8) because data capturing and data analysis were done separately. The process of data analysis began by reviewing the data set and cleaning the raw information collected from the field. The information obtained from the data set was then organized by topics to provide answers to the research questions. For each topic, a list of questions that were asked about that general topic was created. Each of these topics were then analyzed looking at the responses to the questions as well as variables of the study using SPSS.

The tests of hypotheses were done using STATA to explore associations between the background characteristics of respondents and the various variables of study. The validity of the data collected was tested by systematically searching each questionnaire looking for deviant responses. The Field supervisor also reviewed the results separately rechecking the data collected to resolve any issues of disagreement between background characteristics of respondents and responses given to the questions asked during the interviews.

In line with the research objectives, data analysis was guided by the independent variables (i.e. demographic and socio-economic characteristics of the

respondents including age, education, marital status, religious affiliation, parity and occupational status). This was done to establish a relationship with the dependent variables (i.e. circumstances surrounding onset of pregnancy terminated, reasons for the termination, decision on choice of place for the termination, collaborators involved in the decision making for the abortion as well as implications of the abortion law on choice of place for the abortion).

The data preparation for analyses began with data cleaning. In cleaning the data, invalid, impossible, or extreme values were removed from the dataset. Each missing value was also labeled with the reason in order to guarantee accurate bases for analysis. The cleaned data were then imported from SPSS into STATA for analysis due to convenience of usage. The study used graphics and tables to illustrate information collected in a visual background for a better understanding. The data was summarized and presented as mean and percentages, to provide answers to the research questions.

The test of hypothesis used Chi-square tests to examine differences in reason for induced abortion and to establish associations across the demographic subgroups and the level of significance of these associations. Bi-variate logistic regression model, binary logistic regression model and multinomial logistic regression were then used to remove confounding variables, examine extent to which the independent variables influenced decision-making for induced abortion in the study area and the extent to which or the likelihood at which a dependent variable influenced the independent variables. Further analysis of the data were done to write in reasons and sub-reasons relating to decisions for an induced

abortion. All analysis for significance associations were done at 95% confidence interval.

The qualitative data analysis was done manually using a framework approach. This approach entailed systematic sifting, charting and sorting of data according to key issues and themes based on the research questions. Responses relating to each question were grouped and paraphrased looking for patterns and relationships both within a collection, and across collections. Other responses were reported verbatim to explain general observations about decision-making processes for induced abortion to compliment result obtained from the quantitative data. For this reason, the conclusions drawn from inferential statistics extended beyond the immediate data alone. For instance, inferences were made from responses on what the respondents underwent to have an abortion and deductions were made about the likelihood of observed independent variables being dependent on one another or on dependent variables or happening by chance in some situation.

The data quality largely depended on the validity and reliability of the research instruments used. The validity of the research instruments was ascertained because the research instruments were able to measure what they were designed to measure. The reliability of the research instruments were checked in the field through the test-retest method. This involved re-interviewing some of the respondents with the same instruments by different interviewers. The results of this activity were found consistent with the information that the field assistants had already collected. This is an indication that the data collected by field

assistants using the research instruments were reliable. Additionally experienced field supervisors edited the research instruments checking for inconsistencies, incorrect recording of information and omissions in the research instruments.

Limitations of the Study

It must be acknowledged that, there are some areas that warrant attention, which the current study could not touch and which could be considered as limitations of this study.

The first of such limitations was associated with the study design. The study area and its duration did not involve a wider coverage and sample size to comprehensively explore the phenomenon under study due to funding and time to complete the study. It would have been more appropriate to have expanded the research area, respondents and sample size to compare decision-making processes for induced abortion among various ethnic groups, geographical locations and from men's perspectives which probably would have explained the phenomenon under study better. However, this approach would have required enormous time, human resources, logistics and financial implications that were beyond the means of the researcher.

Secondly, fallout from the first limitation was the respondents being restricted to only females who have had an induced abortion within a specified period. The experiences of persons responsible for the pregnancies terminated during the decision making process for an abortion coupled with that of the identified service providers on the decisions made on choice of method for an

induced abortion would have enriched the discussions looking at the views of such important collaborators on abortion decision making. The use of one player in such an all inclusive aspect of halting a human life (foetus) is not good enough.

Thirdly, as with all other social science studies that elicit information from human subjects, the reliability and validity of the information obtained depends on the accuracy of the responses provided. For sensitive topics such as induced abortion, misreporting and underreporting can occur. Additionally, there could be recall errors for research questions that sought information relating to past abortion experiences. The study addressed these challenges by building good rapport with the respondents as well as carefully developing and administering the research instruments in a non-judgmental manner and giving respondent ample time to respond to the questions.

CHAPTER FOUR

PROFILE OF RESPONDENTS AND ABORTION DECISIONS

Introduction

This chapter presents the demographic and socio-economic profile of respondents and their decisions for induced abortion. The chapter also describes the experiences of respondents with regards to their initial reactions at the time the pregnancy occurred, circumstances surrounding onset of the pregnancy, reasons for abortion, gestation period of the pregnancy and previous abortions.

Background Characteristics of Respondents

Table 4 presents the background characteristics of women who had induced abortion in the Accra metropolis between January and December 2010. The main background characteristics described and used in interpreting the findings on decision-making for induced abortion are age, marital status, education, religious affiliation, occupational status and number of living children of respondents.

The age distribution of respondents shows that women between the ages of 20 and 24 years had the highest induced abortions (33.7 percent) within the Accra Metropolis. This was followed by respondents in the 25-29 year age group who recorded about 28 percent of the total abortion cases.

Table 4: Background Characteristics of Respondents

Background Characteristics	Frequency	Percentage
Age group		
15-19	49	12.31
20-24	134	33.67
25-29	111	27.89
30-34	65	16.33
35+	39	9.00
Total	398	99.2
Marital status		
Never married	199	50.00
Married/ in union	167	41.96
Previously married	32	8.04
Total	398	100
Education		
None	27	6.73
Primary	51	12.72
Secondary	221	55.11
Higher	102	25.44
Total	401	100

Table 4 continued.

Religious affiliation		
Christian	326	81.30
Moslem	70	17.46
Other	5	1.25
Total	401	100
Occupational status		
Unemployed	45	11.36
Self employed	148	37.37
Student/Apprentice	134	33.84
Other	69	17.42
Total	396	99.99
Number of living children		
0	212	53.00
1	78	19.50
2	57	14.24
3	33	8.23
4+	20	5.00
Total	400	99.97

Source: Field Survey, 2011

In terms of marital status of the respondents, women who were never married had the highest (50 percent) abortion figure compared to women of other marital statuses. The previously married women (i.e. divorcees and widowed) reported the least abortions of 8.0 percent. About 42 percent of respondents who were either married or in union also aborted their pregnancies for various reasons.

Slightly more than half (55.1 percent) of the respondents prior to having an induced abortion had a secondary level education. Respondents with no formal education had the least (6.7 percent) recorded induced abortions. The religious affiliations of the respondents show that about 4 in 5 of the respondents indicated they belonged to the Christian religion. Other forms of religious affiliations such as Hinduism, Buddhism and African Traditional religion combined recorded the least abortion figures of about 1.3 percent.

In terms of occupational status, the unemployed respondents had the lowest abortion records of about 11.4 percent compared to respondents who had some form of employment. About 17.4 percent of respondents in the other occupational categories such as teachers, bankers, security personnel, health workers and staff in the hospitality industry also aborted their pregnancies. There was only a small percentage difference of about 3.6 observed among the self-employed (37.4 percent) and the students/apprentice (33.8 percent) and these occupational groups combined recorded the highest abortions of about 71 percent in the study area.

Information on the parity of respondents showed that high cases of induced abortions occurred among respondents with no living children. For

instance, more than half (53 percent) of respondents with no living children terminated their pregnancies compared to about 5 percent of respondents who had four or more living children.

Initial Reaction to Pregnancy

The decision to have a pregnancy terminated was reported to have begun with an initial reaction towards a pregnancy when it was first discovered. The reactions as reported were that of shock, guilt, worry, embarrassment or happiness. About 42 percent of the respondents expressed worry whilst 6 percent expressed initial happiness. There were about 23 percent of respondents who expressed some form of shock; an indication that they least expected to have been pregnant at the time the pregnancy occurred (Table 5).

Table 5: Initial Reaction to Pregnancy by Background Characteristics

Background Characteristics	Initial reactions after pregnancy was discovered				
	Shocked (n=92)	Guilty (n=70)	Worried (n=165)	Embarrassed (n=46)	Happy (n=28)
%Total	23.41	17.81	41.98	11.20	5.60
Age group (χ^2=14.40; p=0.569)					
15-19	34.69	18.37	38.78	8.16	0
20-24	24.24	18.18	43.94	9.17	4.55
25-29	22.02	15.60	39.45	13.76	9.17
30-34	20.63	15.87	44.44	12.70	6.35
35+	16.22	21.62	43.24	16.22	2.70

Table 5 continued.

Marital status (χ^2=29.59; p=0.000)					
Never married	29.59	19.39	36.22	13.27	1.53
Married/in union	19.02	15.95	46.01	7.98	11.04
Previously married	9.68	9.68	58.06	19.35	3.23
Education (χ^2=19.60; p=0.075)					
None	19.23	15.38	46.15	15.38	3.85
Primary	31.37	11.76	35.29	19.61	1.96
Secondary	23.85	18.81	43.12	10.55	3.67
Higher	19.39	18.37	41.84	8.16	12.24
Religious affiliation (χ^2=14.03; p=0.081)					
Christian	22.26	16.93	44.83	11.91	4.08
Moslem	28.99	20.29	28.99	8.70	13.04
Other	20.00	20.00	40.00	20.00	0
Occupational status (χ^2=8.99; p=0.703)					
Unemployed	23.26	20.93	30.23	18.60	6.98
Self employed	22.60	15.75	45.21	11.64	4.79
Student/apprentice	25.76	20.45	40.15	9.85	3.79
Other	19.40	14.93	46.27	10.45	8.96
Number of living children (χ^2=21.44; p=0.162)					
0	28.10	18.57	40.00	8.10	5.24
1	18.67	20.00	45.33	12.00	5.33
2	23.64	12.73	43.64	14.55	5.45
3	9.38	12.50	53.12	15.62	9.38
4+	15.00	25.00	30.00	30.00	0

Source: Field Survey, 2011

The age distribution of respondents was statistically not significantly associated with initial reactions of respondents towards a pregnancy when it was first discovered (χ^2=14.40; P=0.569). However, it was observed that respondents within the 25-29 age group (about 9 percent) expressed an initial happiness towards their pregnancies whilst about 16 percent of those age 35 years and above indicated that they were embarrassed to have been pregnant at the time. None (0%) of the respondents within the 15-19 years age group expressed initial happiness about a pregnancy rather, about 35 percent of these respondents were shocked when diagnosed pregnant at the time. This observation was reinforced during an in-depth interview where a teenager reported:

> *'I was very much shocked when my mother informed me that my laboratory results had tested positive for pregnancy. How could I become pregnant just after having sex for the very first time in life even when my boyfriend used the redrawal method'? (16 year old student).*

Another respondent reported that:

> *'My teacher told us in class that virgins don't become pregnant during their first sexual encounter. They need to have many sexual affairs to enable their eggs grow before they can become pregnant when they have unprotected sex. I was therefore shocked to become pregnant just doing it once with him. Perhaps my teacher lied to us' (17 year old student).*

These responses from the in-depth interview supports previous abortion studies in Ghana, where it was reported that knowledge about sexuality among teenagers is low (Henry & Fayorsey (2002). A similar observation was made by Awusabo-

Asare et. al; (2006) where it was revealed that young people within ages 15-19 years do not plan for sex. It is something that just happens most of the time without any contraceptive hence resulting into unplanned pregnancies with the associated devastating consequences.

The study however, statistically observed a significant association between marital status and initial reaction to pregnancy (χ^2=29.59; p=0.000). Majority (about 58 percent) of the previously married (i.e. divorcees and widowed) were worried at the time their pregnancies occurred. Consequently, about 19 percent of the previously married expressed an initial reaction of embarrassment towards the pregnancy. This observation also emerged during the in-depth interview where a widow expressed her initial feelings as follows:

> *'What an embarrassing situation! I was very much worried about the pregnancy because people will think I was a flirt even in my matrimonial home whilst my husband was alive and still flirting around even though I am suppose by our tradition to stay away from all men until I finish morning my late husband' (35 year old widow).*

The variations in initial reactions to pregnancy among the married/in union women however, does not conform to the general expectations of Ghanaians because pregnancy in such union is usually expected by the Ghanaian society, yet about 46 percent of such women were worried and only 11 percent were happy about the pregnancy.

According to Sena (2006) the Ghanaian society cherishes pregnancy in marriage. Hence it is the expectation of society that every married woman in any

form of recognised sexual relationship should prove their fertility through pregnancy. It is with this background that perhaps women who were married were the happiest among the marital status category to have realised they were pregnant. This initial happiness was noted to have been an expression of joy in relation to confirmation that they and/or their sexual partners were fertile and thus have the ability to bear children when they so desire.

Despite the expression of initial happiness when the pregnancy occurred, about 11 percent of married women later decided on an induced abortion and mobilised resources to have the decision implemented. Sena (2006), was of the view that the sentiments expressed by the previously married are expected particularly within the Ghanaian context where such category of women are expected to be abstaining from hetero sexual acts for which reason they are unlikely to be pregnant at the time. Additionally, the expression of worry about pregnancy in marriage/in union contradicts previous observations made by Sena (2006), because the Ghanaian society expects pregnancy in marriage to be happily welcomed.

There was no statistical significant association observed between educational background and initial reaction to a pregnancy (χ^2=19.60; p=0.075). About 46 percent of respondents with no formal education were reported to have expressed an initial reaction of worry. Respondents with higher educational attainments (about 12 percent) were reported to have expressed an initial reaction of happiness when they discovered they were pregnant at the time.

The religious affiliation of respondents also did not show any statistical significant association with their initial reaction to a pregnancy (χ^2=14.03; p=0.081). Among the identified religious groupings, respondents belonging to the Islamic faith (Moslems) considered the pregnancy as a gift or blessing from "an almighty." Consequently, there was an initial reaction of happiness to the pregnancy and this response was the highest recorded percentage (13 percent) among the responses of happiness within the group. With this belief, the Moslem respondents were the least worried (29 percent) about the occurrence of a pregnancy compared with respondents belonging to the Christian faith (about 45 percent). A Moslem woman reported during the in-depth interview that:

> *'Although I was initially happy that 'Allah' had proven to me that I was not barren after all, I was shocked to know I was carrying a three month old pregnancy even though I was still having my normal menses all this while. I felt guilty because I left my previous man who was obviously responsible for the pregnancy to a new one just a month ago' (29 year old Teacher).*

The study findings on initial reactions to pregnancy indicate that, a woman's initial reaction towards a pregnancy, irrespective of her background characteristics, commences the decision making process on the pregnancy outcome. Where the initial feelings is that of happiness, the chances of having an induced abortion is lower compared to an initial ill feeling about a pregnancy when it occurs. The statistical significant association between marital status and initial feelings about a pregnancy when it occurred may therefore be attributed to women's reproductive intentions and how a marriage was contracted. Some

married women who might have become pregnant because of extra marital sexual relationships may express an initial feeling of worry or shock which might fuel the implementation of an abortion decision. Additionally, women may be under pressure from their sexual partners to terminate a pregnancy if they are worried about the implications of carrying a pregnancy to term. In such situations, the absence of a biological child even in marriage may not prevent a woman from terminating a pregnancy if that will make her happier and may do so repeatedly irrespective of the gestational period at decision making or any limitations.

The findings thus far indicate that the marital status of a pregnant woman influenced her initial reactions to a pregnancy and this affected her perceived seriousness/need for an abortion when a pregnancy occurs. Ultimately, what fuels an initial reaction to a pregnancy emanated from a woman's background characteristics, her reproductive experiences and circumstances leading to the onset of a pregnancy.

In line with the conceptual framework of this study (Figure 4), a cost/benefit analysis of keeping a pregnancy in situation when a pregnancy is unplanned either overrides or supports the initial reactions thereby leading to implementing an induced abortion. These findings bring to bear the importance of marital status as a key variable, which influenced a woman's decision-making process for induced abortion. This finding was also in line with findings from previous studies (see Ahiadeke 2001; Mote, Otupiri & Hindin 2010; Sundaram, Juarez, Bankole & Singh 2012).

Reasons for Pregnancy Termination

When asked about reasons for having an induced abortion, the respondents enumerated various reasons and justifications why they had their pregnancies terminated at the time. The majority of the respondents (about 61 percent) had an induced abortion because they wanted a child at a later time. About 6 percent terminated a pregnancy based on medical advice, whilst about 14 percent were reported to have been under some form of pressure to have an abortion. There was however some variations observed in the reasons given for an abortion with respect to the background characteristics of the respondents. For instance, there was a statistical significant association between age and the reasons given for having an induced abortion (χ^2=58.35; p=0.000).

Within the age distribution, about 46 percent of the respondents belonging to the 15-19 year age group terminated a pregnancy to postpone childbirth. About 69 percent of respondents within the 25-29 age group also aborted for a similar reason (Table 6).

Table 6: Reasons for an Abortion by selected Background Characteristics

Background Characteristics	Wanted a child later (n=234)	Forced sex (n=27)	Medical advice (n=22)	Infidelity (n=21)	Pressured (n=12)	Schooling (n=13)	Other (n=15)
% Total	60.94	7.03	5.73	5.47	13.54	3.39	3.91
Age group (χ^2=58.35; p=0.000)							
15-19	45.83	20.83	8.33	0.00	14.58	6.25	4.17
20-24	58.14	5.43	6.20	6.98	13.95	6.98	2.33
25-29	68.27	6.73	5.77	7.69	8.65	0.96	1.92
30-34	67.74	3.23	3.23	1.61	20.97	0.00	3.23
35+	57.89	2.63	2.63	7.89	13.16	0.00	15.79
Marital status (χ^2=45.84; p=0.000)							
Never married	57.67	11.11	6.35	4.23	13.23	5.82	1.59
Married/In union	63.58	3.09	4.94	8.02	15.43	1.23	3.70
Previously married	66.67	0.00	6.67	0.00	0.00	6.67	20.00
Education (χ^2=18.77; p=0.406)							
None	66.67	3.70	3.70	11.11	11.11	0.00	3.70
Primary	58.70	10.87	6.52	2.17	13.04	4.35	4.35
Secondary	56.48	9.72	5.09	6.02	15.28	3.70	3.70
Higher	70.53	0.00	7.37	4.21	10.53	3.16	4.21

Table 6 continued.

Religious affiliation (χ^2=13.05; p=0.365)							
Christian	61.86	7.05	4.45	4.49	14.10	2.88	4.17
Moslem	56.72	5.97	7.46	10.45	11.94	5.97	1.49
Other	60.00	20.00	0.00	0.00	0.00	0.00	20.00
Occupational status (χ^2=44.56; p=0.000)							
Unemployed	65.12	16.28	4.65	2.33	9.30	2.33	0.00
Self employed	61.11	2.78	5.56	9.72	11.81	2.08	6.94
Student/Apprentice	55.04	12.40	7.75	3.88	12.40	6.20	2.33
Other	69.23	0.00	3.08	1.54	21.54	1.54	3.08
Number of living Children (χ^2=46.48; p=0.004)							
0	60.89	8.91	7.92	5.45	10.40	4.95	1.49
1	65.79	3.95	3.95	3.95	14.47	3.95	3.95
2	68.52	7.41	1.85	1.85	12.96	0.00	7.41
3	51.52	6.06	3.03	12.12	24.24	0.00	3.03
4+	36.84	0.00	5.26	10.53	26.32	0.00	21.05

Source: Field Survey, 2011

In response to the question on reasons for an induced abortion during the in-depth interview, a respondent indicated that:

'The reality is that, I can't afford to be pregnant this time. This pregnancy was certainly not the right time for me.' (21 year old apprentice).

Another respondent indicated that:

'I cannot even take very good care of myself let alone giving birth. This is a wrong time to be pregnant' (19 year old National service person).

Pressure to have an induced abortion was observed to have specifically accounted for about 21 percent of the reasons given for an abortion among women within the 30-34 age groups. This observation was also made during the in-depth interview, where a respondent reported that:

'We just can't start all over again making new babies when our last born of the three children we already have is 12 years. The three boys we already have are more than enough daily pressure for us to cope with' (34 year old nurse).

Forced sex was also observed as an important reason for pregnancy termination. About 20.8 percent of respondents, aged (15-19 years) had an induced abortion because the pregnancy occurred due to forced sex. This was also observed during the in-depth interview where some older men were reported to have taken advantage of young girls. A respondent narrated her experience as follows:

Although I resisted, my teacher forced me and had sex with me when I visited him. I became pregnant after that sexual encounter with him.

Although I was initially happy for carrying a baby for such an intelligent man, his behaviour towards me after the pregnancy and later thoughts of what will happen if my parents discover I was pregnant really scared me. I was in SHS and not ready for a baby so I terminated the pregnancy. I was really disappointed in myself and I did not want to deal with my parents' disappointment too hence the abortion (18 year old, student).

Marital status of respondents also showed a statistical significant association with the reported reasons for induced abortion (χ^2=45.84; p=0.000). About 11 percent of the respondents who were never married had an induced abortion because of a pregnancy occurring from forced sex. A married woman, whose pregnancy occurred due to forced sex, narrated her experience during the in-depth interview as follows:

'I woke up in his room half-naked after the party and realized that 'beast' had slept with me whilst I was drunk. I did not waste time deciding on an abortion when the pregnancy occurred because, a delay could have ruined my future ambitions' (21 year old married administrative secretary).

Among the married/in union, about 8 percent had to terminate a pregnancy occurring from infidelity. Since pregnancy could be one of the evidences against women for having an extra marital affair. It was observed that about 15 percent of married women who became pregnant due to having extra marital affairs, consequently reported to have been under some pressure to implement their decision for an induced abortion. This observation was further probed during the in-depth interview where a respondent narrated her experience as follows:

I was under intense pressure when I realized I was carrying a two months old pregnancy for my lecturer who has just gotten married to my friend. Although I was convinced I am fertile because this was my first pregnancy after two years of marriage, I could not express my joy nor inform anybody about the pregnancy, most especially when my wedded husband is due to return from a one year study leave abroad in six months time. I had sleepless nights deciding on what to do with myself till I finally decided to have an abortion to save my marriage and reputation (27 year old, married woman).

Another married woman reported that:

I did not know I could become pregnant even with a condom. I was just having the usual fun with my boyfriend whilst my husband was away busily looking for money. I had to abort the pregnancy to keep my marriage and reputation (27 year old married woman).

In some instances, the pressure-related reasons for an induced abortion were spiced by various concerns such as husbands not having fully paid the bride price, financial irresponsibility and marital unfaithfulness. A respondent narrated her experience as follows:

'Although we have no biological children and I really look forward to my own, I had an abortion because my husband had not fully paid my bride price. He has stopped providing money for the upkeep of the home and had just become a very serious womanizer spending lavishly on other women since I became pregnant' (25 year old, married woman).

Another respondent indicated that:

> *'Un usual of him, my husband started dating other women including my close friends after I became pregnant. In anger, I had an induced abortion and left him. Although I sometimes feel guilty for having had the abortion, I am convinced I made the right decision (26 year old, married woman).*

This finding indicates that even if a woman happily offered herself for sex and becomes pregnant as a result, she may change her mind to have an abortion due to adverse behavioural changes by her sexual partner after she becomes pregnant.

There were experiences of some married women (about 5 percent) who would have loved to keep their pregnancies had it not been for some health challenges they encountered whilst pregnant. According to one of such respondents during the in-depth interview, it was challenging and emotional for her to have the pregnancy terminated. Narrating her ordeal, she indicated that:

> *Two months into my pregnancy, my husband and I tested positive for HIV. We were both shocked at the news and started blaming each other as the source of the disease. Although I love my husband so much and would have wished to give him a baby, the fear of the unknown future for my unborn baby and the pressure from my mother to end the relationship gave me sleepless night. I therefore settled down for an abortion and later divorced my husband because in my opinion my husband was unfaithful to me and brought me a disease (22 year old, married woman).*

Although some marriages were reported to have been dissolved and in others a male sexual partner is dead, the ex-couples in the broken marriages always had some reasons to meet each other; likewise, the widows also had reasons to meet other men during which time sexual encounters occurred resulting in pregnancies that were later aborted. This situation was observed among the previously married respondents among which group about 20 percent of the induced abortions occurred for other reasons such as decisions never to have a child again after divorce or death of a sexual partner, preventing disgrace and self-embarrassment. A respondent during the in-depth interview reported her encounter as follows:

> *Although we separated a year ago, I do visit him for money for the upkeep of our child who is in my custody. He used the opportunity to sleep with me and I became pregnant of which he denied responsibility. Because I was then in the second year of my apprenticeship and did not want any embarrassment, I had an abortion to enable me complete the training and have my own profession (20 year old, apprentice).*

It was also noted during the in-depth interview that some married women who were forced into marriages they are really not happy about may become pregnant to please people around them but will later induce an abortion and pretend as though it was a miscarriage. A respondent shared her experiences as follows:

> *'For me getting married was not to start making babies immediately with someone I really do not love. My parents forced me into that marriage*

soon after school. This was because, the man was from a rich home and his parents sponsored my brother's education. Because everybody around me waited to see our first child soon, I chose to become pregnant soon after marriage, to prove my fertility and to please everybody around me. As a strategy to delay child birth to plan my future in this marriage, I secretly aborted the pregnancy soon after my husband returned to his base abroad and pretend as though it was a miscarriage (21 year old married woman).

Although the reasons given by the married/in union women for pregnancy termination are similar to those of their unmarried counterparts, in the situation of the married/in union group, the decision for an abortion came with much more rationalizations and reflections over the immediate situation, consequences, future implications on reproductive intentions, and the aftermath effects of the abortion on their marriage as well as relationships with their spouses and significant others. These findings support those of Buga, 2002; Kaye, Mirembe and Bantebya, 2005; Oye-Adeniran, 2004, who generally observed that some married women use induced abortion to delay child birth in order to pursue their life goals.

Statistically, there was no significant association between educational status of respondents and their reasons for an induced abortion (χ^2=18.77; p=0.406). However, about 71 percent of respondents with higher educational qualifications had an abortion because they wanted a child later. About 10.9 percent of respondents with primary level education and about 11.1 percent of respondent with no formal educational attainments had an induced abortion

because their pregnancies were due to forced sex and infidelity respectively. There was no reported incidence of pregnancy termination among respondents with higher levels of educational attainments as a result of forced sex. There was no record of respondents who have no formal education having had an abortion because of schooling.

Although all the respondents belong to some religious faith, yet statistically, there were no s significant associations between religion and reasons for induced abortion (χ^2=13.05; p=0.365). About 20 percent of respondents belonging to the other religious groups (i.e. Hinduism, Buddhism and African Traditional Religion) reported to have aborted a pregnancy occurring from forced sex. It was also observed that, about 11 percent of the pregnancies terminated on grounds of infidelity occurred among Moslem women. Whilst about 14 percent of Christian women indicated that, they had an abortion because they were pressurised.

A Moslem respondent shared her experience during the in-depth interview as follows:

> *I realized I was two months pregnant for my ex-boyfriend a week after my Islamic wedding. Due to the strict Islamic sanctions relating to infidelity by women and the position of my father in the community as an Imam, I had no alternative than to abort the pregnancy secretly in order to keep my marriage and my family reputation (25 year old, Moslem married woman).*

Another respondent indicated that:

> *'As an Ussher in my church, I had to abort a two-month old pregnancy because in my church, a pregnant woman is not married neither is the marriage of a pregnant woman blessed in church until such a time when she gives birth. When the pregnant woman is discovered, she is ridiculed openly to serve as a deterrent for others. The embarrassment by my church, which I did not want, compelled me to have an abortion to pave way for my church wedding ceremony (27 year old, Christian Student).*

Another respondent indicated that:

> *My boyfriend and I really wanted the pregnancy but we were under pressure to terminate it because our church would not bless our marriage and I would have been disgraced if I was found pregnant during counseling before our church wedding (25year old, Christian Nurse).*

Another respondent indicated that:

> *As the only daughter of my parents who are very much respected marriage counselors in our church, I couldn't have carried that pregnancy without being properly married, thus my mother persuaded me to have an abortion to save our reputation in the church (21year old, Christian Pharmacist).*

These responses seem to suggest that, religiosity is not much considered during abortion decision-making, but the fear of embarrassment associated with premarital pregnancy in the church pushed the young women to have an abortion even though they indicated they would have loved to carry the pregnancy to term.

The occupation of respondents statistically showed a significant association with the reasons respondents gave to have a pregnancy terminated (χ^2=44.56; p=0.000). Evidence from this study shows that, about 22 percent of respondents were under occupational related pressure to consider induced abortion because either they, their employer, or a third party viewed their pregnancy as being incompatible with their professional code of practice, assigned roles and responsibilities in their paid jobs. The abortion experiences of respondents from various occupational backgrounds as narrated during the in-depth interview are as follows:

> *'I really wanted to have my first child at this time. Unfortunately, this pregnancy coincided with my promotional interview and nomination to lead a contingent on peace keeping abroad. This is a rare opportunity that I did not want to miss, hence I had an abortion' (30 year old, married military woman).*

A second respondent reported that:

> *'The work that I struggled to get is competitive and demanding even without pregnancy. I could not cope with the pregnancy during the period of probation hence; I had the abortion to secure my job' (23 year old, married teacher).*

Another respondent with a similar justification for an abortion reported that:

> *'It is unacceptable to become pregnant in this industry when one haven't finished serving a full year probation. Although I love children and would*

like to have my own soon, the pregnancy was unplanned, so I had to abort it to save my job' (25 year old, married Banker*).*

A student during the in-depth interview reported that:

I was in the final year in one of the nursing training school in Ghana when I became pregnant after my very first sexual experience with my boyfriend. As the only child of my parents, my mother was very caring and prepared to support me have a baby whilst in School. Unfortunately, the educational policy in the nursing training school I attended did not allow pregnant women in school and the penalty was dismissal. Because I did not want to ruin my nursing career I had a secret abortion and informed my mother and husband I had a miscarriage (31 year old student nurse).

The reasons observed for an induced abortion in this study thus far indicate that pregnancy can sometimes have a significant impact on a woman's ability to follow her normal routine at work that can adversely affect productivity. For this reason, some women would find various means to delay or postpone childbirth including using abortion. This observation supports similar findings by Ghana Health Service, (2007); where it was reported that, some women use abortion to delay childbirth.

In other separate but related studies by Oye-Adeniran, (2004); Harari & Fantahun, (2006), it was found that women's reasons particularly in marriage/union for induced abortion are complex and contingent, taking into account their own needs, feelings and implications for their developmental goals

and future. It is therefore worthy of note that a woman's occupational considerations can statistically have significant influence on abortion decisions.

It can however be inferred based on available evidence from this study that, some Ghanaian married women resort to induced abortion to delay, space or limit childbirth so as to meet their set carrier objectives. This finding supports those of previous studies on reasons for low contraceptive uptake reported by Ghana Health Service in 2007; Aboagye et. al., 2007; Baiden et. al., 2006; Oye-Adeniran et. al., 2004; Blanc and Grey, 2002.

In terms of parity, statistically there was a significant association between the number of living children of respondents and induced abortion decision making (χ^2=46.48; p=0.004). It was noted during the in-depth interview that, the absence of a living biological child did not prevent some respondents even those in stable marital relationships from having an abortion when it was deemed very necessary for them to do so. One of such respondents who was married for two years without a child reported that:

> *'Although I don't have a child of my own yet, I decided to have an abortion for personal reasons. For me, being a married woman does not mean one is a 'baby making machine', which must start operating soon after its installment to recoup the investment made. The babies can wait till I think I am ready for them to come' (23 year old married woman).*

Women with four or more living children (about 26 percent) were also observed to have been under pressure to have their pregnancies terminated. The main reasons given by such respondents for an induced abortion was related to

economic hardships. A respondent during the in-depth interview expressed her reasons for terminating her recent pregnancy as follows:

> *My husband was very devastated after finding out that I was pregnant again. That was to have been our sixth child despite using contraception. My husband and I had lost our jobs. We could barely look after ourselves and the five children, we already had on the little savings we had. Although I had wanted to keep the pregnancy this time, my husband did not and persuaded me to have an abortion despite our religious values against abortion. When he realized I was not yielding to his persuasions, he pressurized me in various ways until I eventually had my twenty weeks pregnancy terminated just to please him (32 years old, married woman).*

There were other reasons (e.g. high risk pregnancies occurring in older aged women with some associated health complications mid-term and failed contraception) given by about 7 percent of the self employed respondents for having an induced abortion. A respondent during the in-depth interview reported that:

> *'I developed an uncontrolled high blood pressure two months into the pregnancy and my doctor advised on the abortion to save my life' (43 years old, teacher).*

Another respondent indicated that:

> *'I had an IUD four months after my last child. However, I became pregnant despite the IUD in place. When I went to the hospital, the pregnancy was confirmed and I was told it was a contraceptive failure,*

which is expected in a few women. I decided with my husband on an induced abortion because our baby was very young (35 year old married woman).

The study thus far indicates that the reasons/motivation to terminate an unintended pregnancy may vary among women based on their respective background characteristics. For instance, the likelihood of obtaining an abortion among women between the ages of 20-24 years is more than among teenagers (15-19 years) and could be because the women in the former group are more sexually active and have a higher probability of becoming pregnant, hence may also have a higher rate of unintended pregnancies that end in induced abortion. Such women may have a higher probability of seeking induced abortions than women of age 30 or older will do. This is because, a greater proportion of pregnancies among women aged 30 or older may be wanted and within marriage, and because women aged 30 or older may have lower pregnancy rates as a result of the decline in fecuundity with age (Rao & Demaris 1995; Brewis & Meyer 2005). Additionally, the never-married women may be less sure of their partners' financial support in bringing up a child; hence, majority of the women will have a pregnancy terminated when it occurs.

At an adolescence age, there is a strong desire for the opposite sex (GHS, 2005). It is during this period that the opposite sexes become attracted to each other hence the commencement of sexual activities that is likely to result in unintended pregnancies and abortion. Because most adolescents at this stage are likely to be pursuing secondary level education and the educational policies of

Ghana do not allow women at this level to be pregnant in school, most women who might become pregnant at this level will be more likely to decide on induced abortion to avoid possible dismissal from school (Awusabo-Asare et.al., 2006). The opportunity cost of seeking an abortion among women attaining secondary level education may therefore reflect their greater firsthand information of what to do and where to go if they experience an unintended pregnancy in the course of secondary level education.

The observation that Christian women had greater frequencies of induced abortion compared to women in the other religious affiliations may be attributable to the fact that, because Christianity is the largest religious affiliation within the Accra metropolis, Christians will have the greatest number of pregnancies, hence a higher portion of unintended pregnancies, compared with other religious groups (Clements & Madise 2004). Women who have no living children may be compelled to decide on an induced abortion when pregnant because many of these pregnancies may be due to premarital sex, hence they may decide to have such pregnancies terminated to avoid the stigma associated with premarital pregnancy or childbearing. Such women may also want to delay their first birth until marriage, hence women who have never been married are more likely to seek an induced abortion.

The conceptual framework of the study (Figure 4) linked the background characteristics of women to their perceptions about implications of carrying an unwanted pregnancy to term. These implications are based on women's situational assessment in the light of cost-benefit-analysis when a pregnancy

occurs. This drives a woman to make abortion decisions and ensure that their decisions are implemented.

Gestation of Pregnancy at Termination

There were marked variations in the gestation periods of pregnancy at termination. First trimester (1-3 months) abortions recorded the highest abortion numbers compared to terminations during higher gestational periods. Among all categories of respondents, it was observed that, about 38 percent of the induced abortions occurred in the second month of gestation. Majority of the respondents (about 76 percent) had induced abortion within the first trimester (1-3 months gestation) whilst about 1.8 percent of the reported pregnancies terminated were close to term (6-7 months). The percentages of respondents however decreased with increasing gestations at termination (Figure 6). This implies that, the bigger the gestational age at the time of abortion decision-making, the less likely it was for a pregnancy to be terminated, due to limited access to mid-trimester abortions.

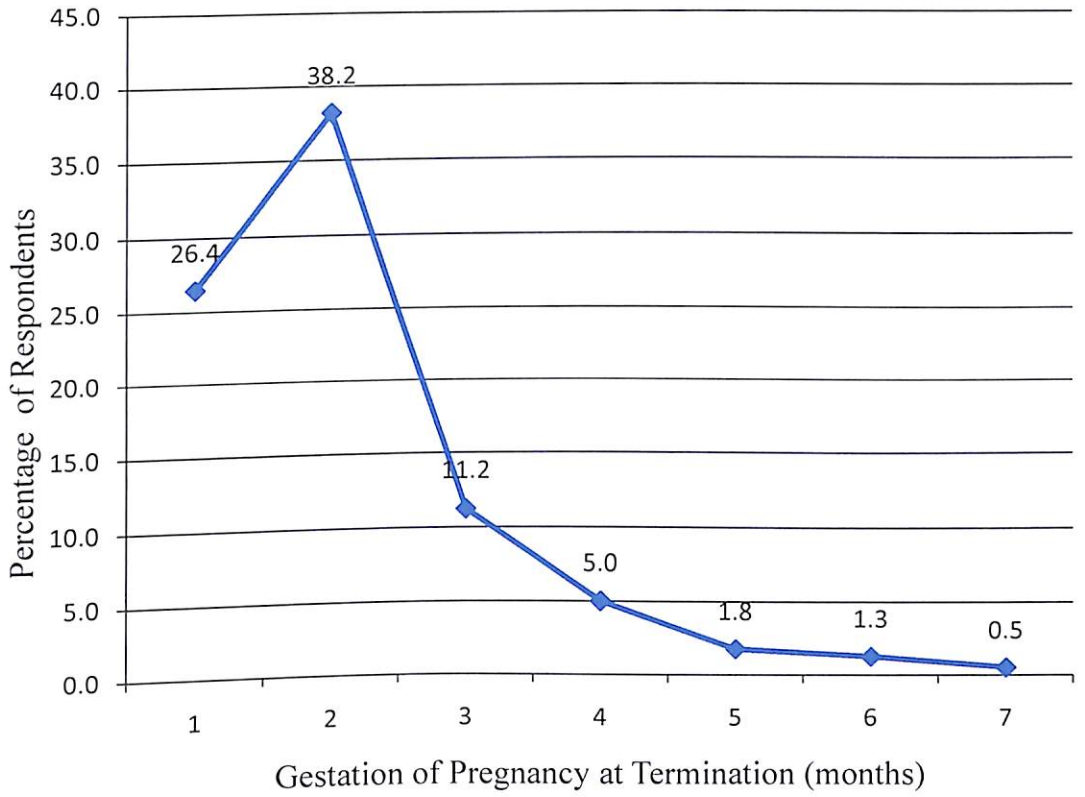

Figure 6: Gestation of Pregnancy at Termination

Source: Field Survey, 2011

There were variations in gestational period at termination across the various background characteristics of respondents. It was observed that, about 38 percent of the induced abortions occurred during the second month of pregnancy and the percentage terminations decreased sharply to about 5 percent for terminations occurring after the fourth month of pregnancy. About 16 percent of respondents however did not know the gestational ages of the pregnancies they terminated. The background characteristics of respondents show variations with respect to the gestational ages at which an induced abortion occurred (Table 7).

Table 7: Gestation of Pregnancy Terminated by Background Characteristics

Background Characteristics	Gestation period at termination (Months)				
	1 (n=106)	2 (n=153)	3 (n=45)	4+ (n=34)	Don't know (n=63)
% Total	26.43	38.15	11.22	8.48	15.71
Age (χ^2=32.71; p=0.008)					
15-19	20.41	42.86	10.20	2.04	24.49
20-24	38.06	34.33	9.70	8.96	8.96
25-29	18.02	37.84	13.51	10.81	19.82
30-34	20.00	46.15	6.15	12.31	15.38
35+	28.21	30.77	20.51	2.56	17.95
Marital status (χ^2=10.18; p=0.253)					
Never married	30.15	37.69	9.55	7.54	15.08
Married/In union	20.96	38.92	14.97	8.38	16.77
Previously married	31.25	37.50	3.12	15.62	12.50
Education (χ^2=14.32; p=0.280)					
None	22.22	37.04	14.81	11.11	14.81
Primary	23.53	31.37	17.65	9.80	17.65
Secondary	28.51	34.38	12.67	8.14	16.29
Higher	24.51	50.00	3.92	7.84	13.73

Table 7 continued.

Religious Affiliation (χ^2=10.43; p=0.236)					
Christian	27.61	36.65	11.04	7.98	14.72
Moslem	22.86	37.14	11.43	11.43	17.14
Other	-	20.00	20.00	-	60.00
Occupational status (χ^2=13.24; p=0.351)					
Unemployed	17.78	35.56	8.89	11.11	26.67
Self employed	25.68	35.81	16.22	9.46	12.84
Student/Apprentice	29.10	38.06	8.96	7.46	16.42
Other	27.54	44.93	7.25	7.25	13.04
Number of living children (χ^2=18.47; p=0.297)					
0	27.83	40.57	9.91	6.13	15.57
1	23.08	37.18	10.26	8.97	20.51
2	29.82	35.09	7.02	12.28	15.79
3	18.18	30.30	35.00	15.00	9.09
4+	30.00	35.00	15.00	10.00	10.00

Source: Field Survey, 2011

The age of respondents was significantly associated with the gestation period of pregnancy termination (χ^2=32.71; p=0.008). It was observed that the highest percentages of the reported induced abortions occurred within the second month of gestation and among the 15-19 years (about 43 percent) and 30-34 years

(about 46 percent). This observation suggests that adolescent girls and middle aged women resort to induced abortions when confronted with unplanned pregnancies compared to women in other age groups.

The association between marital status of respondents and the gestation period of pregnancy termination was not statistically significant (χ^2=10.18; P=0.253). However, about 30 percent of the never married and 31 percent of the previously married respondents had their pregnancies terminated within the first month of pregnancy. It was also noted that, about 16 percent of the previously married delayed the termination until the fourth or beyond months of pregnancy. A respondent during the in-depth interview explained her delay as follows:

> *I never knew I was pregnant because I did not experience any of the pregnancy symptoms that I had during the first three months of my past pregnancies. It was surprising to be diagnosed pregnant. Initially, I decided to keep the pregnancy but the idea of not having a father for my baby because of my multiple sexual partners later compelled me to have the pregnancy terminated (45 year old previously married).*

Although there was no significant association between education and gestation period of pregnancy termination (χ^2=14.32; P=0.280), the distribution observed suggests that respondents with higher levels of education (50 percent) had their abortion early and did so within the first two months of pregnancy. About 11 percent of respondents with no formal education had mid-trimester abortions at gestation periods of four months and above.

Religious affiliation of respondents was statistically not significantly associated with the gestation period for an abortion (χ^2=10.43; P=0.236). It was however observed that about 11 percent of respondents belonging to the Islamic faith (Moslems) had a mid-trimester abortion (abortion at 4+ gestation period). The occupation of respondents with respect to the gestational period of pregnancy termination was not significant neither did it show any consistent variations or any pronounced pattern. Although there was no significant association between the number of living children a respondent had and the gestational period of pregnancy termination, it was observed that 35 percent of women having three children had an induced abortion during the third month of their pregnancy and about 9 percent could not tell the gestation period at which a pregnancy was terminated.

Asking probing questions during the in-depth interview to ascertain the gestational period at which a pregnancy was terminated, it was observed that irrespective of the background characteristics of a respondent, the decisions on mid-trimester abortions (abortion at 4+ months) was either very difficult or a spontaneous means of escaping a situation that was negatively impacting on women and in which they did not feel safe and thus wished the pregnancies did not occur at the first place. One married woman recounted her experience as follows:

'Although I achieved the aim for terminating my pregnancy at the time, I regretted and wept bitterly for having decided to terminate a pregnancy which I later got to know was a twin pregnancy. I still suffer from the guilt

when I recall how I aborted my twin pregnancy at 5months gestation, which I wish the pregnancy did not occur at the first place. I know God understands me and he has forgiven me.' (31 year old married woman).

Researchers investigating reactions by women during abortion decision making report only one positive emotion of relief. These emotions arise especially in the light of the fact that the majority of women terminating a pregnancy report feeling under intense pressure to have an induced abortion regardless of the gestational period (Francke, 1978; Reardon, 1978; Turkson, 2006). Medically, it was inappropriate to note that about 16 percent of respondents did not know the gestation period of the pregnancy terminated. This observation could also imply that such respondents might not have been pregnant after all despite making decisions on induced abortion.

The current study finding thus far supports that of Ekanem, Etuk, Udoma and Ekanem (2003); where it was reported that, histo-pathological reports from some Nigerian fertility hospitals in 2003, indicated that most women seeking induced abortion services were not after all pregnant at the time of decision-making for an induced abortion. This underscores the desperations of women getting rid of unwanted pregnancies and the over zealousness of an abortionist doing everything possible to satisfy the request of such people desiring termination of their unwanted pregnancies by all means and at all cost.

The gestational period at which a pregnancy was terminated was linked to persons responsible for pregnancy (Figure 7).

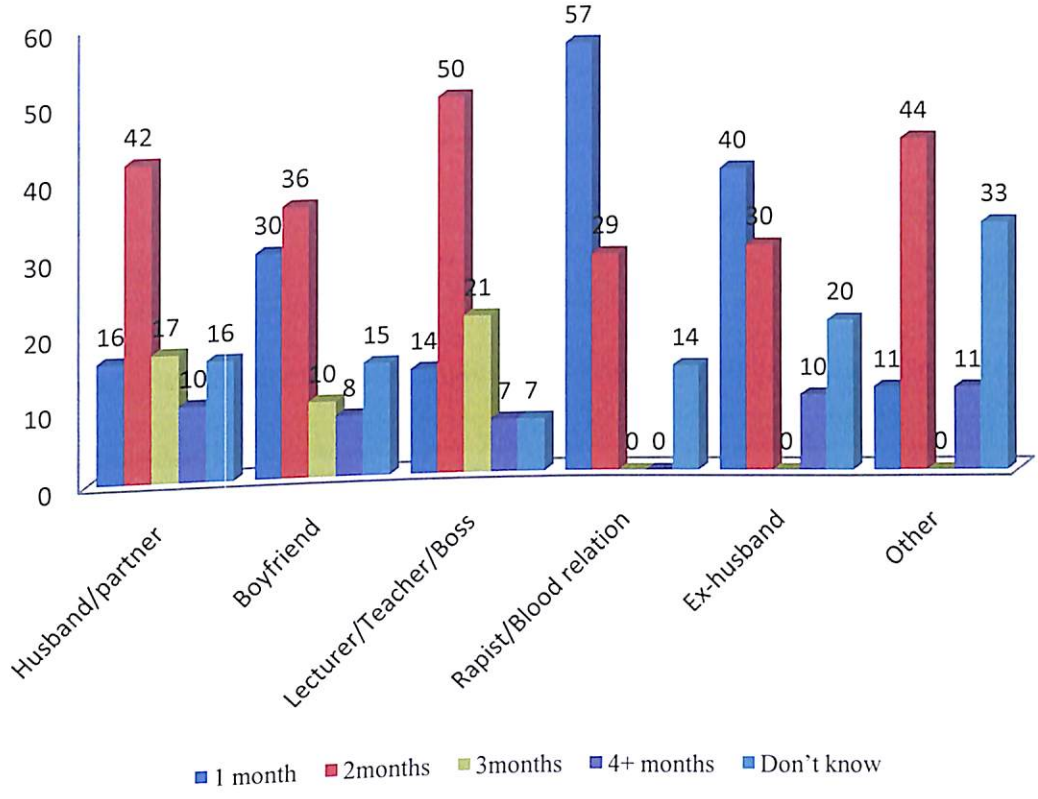

Figure 7: Gestation at Termination by Person Responsible for the Pregnancy

Source: Field Survey, 2011

There exist some differentials in the figures, which are worth commenting on. Among those impregnated by a rapist or blood relation, more than half (about 57 percent) of them had the termination at one-month gestation period. A similar early termination was observed among those impregnated by their ex-husband with about 40 percent of them having a termination at one-month gestation period. About 50 percent and 44 percent of respondents impregnated by their lecturer/teacher/boss as well as men within the other category of groupings (i.e. clients of commercial sex workers, school mates, church mates etc.) respectively did not go beyond the second month of gestation period, which suggests that the decision and action for the termination was rapid.

Findings from this study, thus supports (Morhee & Morhee, 2006; Sena, 2006; Turkson, 2006), who were of the view that, the exceptions of pregnancies emanating from rape, incest and defilement are understandable basis for an induced abortion, especially, since these are sexual offences and violent acts, which are usually committed without the consent of a victim who, it is assumed, would experience some immediate psychological distress, hence the rapid decision for abortion.

Another observation made to have influenced the decision-making process for an early induced abortion was related to persons responsible for a pregnancy and the implications to the respondents. During the in-depth interview, some of the respondents indicated that they had to undergo an early abortion mainly to prevent people from noticing that they were pregnant in order to avoid disgrace and embarrassment to themselves and families. One of the respondents indicated that:

> *My course mate raped me one Saturday evening, during a discussion in his room whilst in school. As soon as I realized I had missed my period the following month, I quickly did a pregnancy test to see if it was a pregnancy. When pregnancy was confirmed, I had to go for an abortion without letting anybody know about my predicaments. I kept these all to myself to protect my personal image and the reputation of my family (21 year old, student).*

Another respondent indicated that:

I cannot really recall exactly how it all happened but all I realized was feeling 'funny' only to be told at the hospital that I was two months pregnant. Although this was not too surprising news to me because in the previous months I had had unprotected sexual intercourse with my boyfriend, my boss, and my sugar daddy at separate times whilst in my safe period. My worry however is who was responsible for this pregnancy? To avoid any embarrassment, I quickly had the pregnancy terminated (25 year, old banker).

To establish whether the association between occupation of respondents and the gestational period of pregnancy termination was statistically significant; hypothesis 1, which states: 'There is no significant association between occupation of a pregnant woman and the gestation period at which a pregnancy is terminated' was tested using binary logistic regression model (Table 8).

Table 8: Binary Logistic Regression Model result of Occupation and Gestation at Abortion

Background Characteristics	Model 1	95% CI	Model 2	95% CI
Occupational status				
Unemployed (ref)	1	. [1,1]	1	[1,1]
Employed	1.467	[0.488–4.413]	2.431	[0.705–8.383]
Student/Apprentice	1.821	[0.576–5.764]	1.655	[0.483–5.667]
Others	1.964	[0.524–7.357]	3.292	[0.728–14.88]

Table 8 continued.

Marital status				
Never married (ref)			1	[1,1]
Currently married			1.349	[0.501–3.633]
Previously married			0.585	[0.148–2.308]
Age group				
15-19 (ref)			1	[1,1]
20-24			0.240	[0.0288–2.005]
25-29			0.205	[0.0225–1.872]
30-34			0.285	[0.0254–3.193]
35+			2.299	[0.0994–53.19]
Education				
No education (ref)			1	[1,1]
Primary			0.803	[0.159–4.053]
Secondary			0.979	[0.191–5.015]
Higher				
Number of living children				
0			5.593	[0.571–54.75]
1			3.090	[0.374–25.51]
2			2.134	[0.287–15.88]
3			0.968	[0.127–7.372]
4 (ref)			1	[1,1]
Cons	5.600***	[2.162–14.50]	4.094	[0.154–108.8]
Log likelihood	-109.2		-100.7	
Chi-squared	1.287		17.35	
N	334		329	

Exponential coefficients; 95% confidence intervals in brackets * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

Source: Field Survey, 2011

The expectation was that pregnant women who are students/apprentices are more likely to have an abortion at an early gestation period than women of other occupation categories. This expectation was based on the prohibition of pregnancy in Ghanaian schools or during apprenticeship.

For instance on the first of March 2011 at 12: 30 pm a local FM station (Adom FM) in Ghana reported that the Ghana Education Service has backed the decision by authorities of Aduman Senior High School in the Afigya-Kwabre District of the Ashanti Region to sack 17 female students from the school for getting pregnant. According to the radio report the Deputy Director of Education, said that the decision to send the girls home, is in line with the Ghana Education Service policy. With such a stringent policy, women who become pregnant whilst in school would prefer a quick abortion to avoid sanctions that could result into embarrassment. As a result, the hypothesis that 'there is no significant association between occupation of a pregnant woman and the gestation period at which a pregnancy is terminated' was first tested with a bi-variate model, focusing only on the dependent variable and the main explanatory variable, thus occupation. Respondents who were not employed were used as the reference category.

The results showed that the employed were more likely (OR=1.47; 95% CI=0.488-4.413) to abort within the first trimester than the reference. The same is noted for the students/apprentice and those in the "others" categories as shown in Table 8 (Model 1). In a second model where other possible explanatory variables were included in the model (Table 8), the odds for the employed and "others" increased in relation to first trimester abortion but remained statistically

insignificant. In respect of the model specification, Model 2 of Table 8 slightly fits better than Model 1 in the same Table. This can be observed from the -2log-likelihood of -100.7 compared to -109.2 in Model 1. Thus, the smaller the log-likelihood, the better the fit.

Overall, the hypothesis that there is no significant association between occupation and gestation period at which abortion occurs could not be rejected even after controlling for other covariates. This suggests that some groups of women are more likely than others to seek first trimester abortions when a pregnancy occurs. It is therefore important that education on abortion decision making be tailored to meet the different needs of various categories of women in Ghana.

A finding that students and unemployed women were more prone to requesting for abortion services creates a need to target them with correct and timely messages on available opportunities for first preventing "unwanted/unplanned" pregnancies and secondly, places where safe abortion services could be obtained when a need for making abortion decisions arises.

Previous Abortions History

This information was obtained to examine if a client's past abortion history influences decision-making process for the current induced abortion. More than half of the respondents (about 53 percent) had at least one previous induced abortion prior to the current one. There was no significant association between age and the number of previous abortion a respondent had (χ^2=24.47; p=0.080).

However, about 34 percent and 8 percent of the respondents aged 35 years and above had two and three previous induced abortions respectively prior to the current one (Table 9).

Table 9: Number of Previous Abortions by Background Characteristics

Background characteristics	Number of previous abortions				
	0 (n=113)	1 (n=200)	2 (n=62)	3 (n=15)	4+ (n=11)
%Total	23.40	53.19	16.49	3.99	2.93
Age group (χ^2=24.47; P=0.080)					
15-19	38.10	50.00	4.76	4.76	2.38
20-24	26.56	55.47	13.28	1.56	3.12
25-29	18.45	57.28	16.50	4.85	2.91
30-34	19.35	53.23	19.35	4.84	3.23
35+	15.79	39.47	34.12	7.89	2.63
Marital status (χ^2=14.79; P=0.063)					
Never married	25.41	53.51	11.35	5.95	3.78
Married/ in union	22.29	54.14	19.75	1.27	2.55
Previously married	16.13	48.39	29.03	6.45	-
Education(χ^2=17.22; p=0.1410)					
None	26.92	46.15	15.38	11.54	-
Primary	22.92	58.33	10.42	4.17	4.17
Secondary	23.30	54.85	13.59	4.37	3.88
Higher	22.92	48.96	26.04	1.04	1.04

Table 9 continued.

Religious affiliation (χ^2=8.98; p=0.344)					
Christian	21.38	53.95	16.78	4.61	3.29
Moslem	32.35	51.47	13.24	1.47	1.47
Other	25.00	25.00	50.00	-	-
Occupational status (χ^2=22.42; p=0.033)					
Unemployed	24.39	60.98	12.20	-	2.44
Self employed	15.71	53.57	19.29	6.43	5.00
Student/Apprentice	31.75	49.21	12.70	4.76	1.59
Other	24.62	55.38	20.00	-	-
Number of living children (χ^2=30.10; p=0.017)					
0	30.41	50.52	11.86	4.12	3.09
1	17.33	61.33	16.00	2.67	2.67
2	11.11	59.26	25.93	3.70	-
3	25.00	46.88	21.88	-	6.25
4+	10.00	45.00	25.00	15.00	5.00

Source: Field Survey, 2011

The marital status of respondents was also statistically not significantly associated with the number of previous abortions that respondents had (χ^2=14.79; p=0.063). Whilst about 25 percent of the never married had no history of induced abortion prior to the current one, about 7 percent of the previously married had three previous induced abortions prior to the current termination. There were no

records of the previously married respondents having four or more terminations prior to the current one.

The educational background of the respondents was statistically not significantly associated with the abortion history of the respondents (χ^2=17.22; p=0.1410). Nevertheless, about 58 percent of respondents who attained primary level education had a history of one previous induced abortion. With regards to respondents with higher educational qualifications, about 26 percent and 1 percent recorded two and more than four previous induced abortions respectively prior to the current one.

Religious affiliations of respondents was statistically not significantly associated with the number of previous induced abortions (χ^2=8.98; p=0.344). However about 3 percent of Christians and 2 percent of the Moslem respondents had four or more abortions prior to the current termination.

There was a significant association between the occupation of respondents and the number of previous abortions prior to the current one (χ^2=22.42; p=0.033). About 61 percent of the unemployed had one previous induced abortion while 5 percent of the self-employed had at least four or more induced abortions prior to the current termination. A respondent during the in-depth interview reported that:

> *As a growing child then at age 17, I did not know what life was about hence I got myself pregnant. My mother was very disappointed in me and angry about the pregnancy as well as the boy responsible. She however helped me to have the pregnancy aborted in my own interest (25 years old seamstress).*

Another respondent indicated that:

I seemed to be unlucky with pregnancy and my profession. All the three pregnancies that I terminated occurred any time I am nominated for peace keeping abroad (36 year old security officer)

The number of living children a respondent had was observed to have been significantly associated with the previous abortion history (χ^2=30.10; p=0.017). This observation was supported with available evidence from the in-depth interview. First time pregnancies were mostly aborted than subsequent ones. A respondent from the in depth interview reported that:

Although I was gainfully employed when I became pregnant for the first time, I was not certain whether I would like to marry the new man responsible for that pregnancy. Because I already have two children and in this uncertainty, I terminated that pregnancy to plan my life and choose the man I will like to marry in future (30 year old, trader with children).

The finding from this study that first time pregnancies were commonly terminated than subsequent ones, was also documented by, the Ghana Health Service, (2007) in a similar abortion study in Ghana. Generally, repeat induced abortions were most common particularly among the unmarried respondents. The number of previous abortions increased consistently with the number of living children. The distribution is not presented by wealth quintile and therefore it is likely that wealth quintile of the respondents would act as an important intermediary and a confounding factor in explaining the relationship between the number of previous abortions and that of living children.

Results presented in Table 9, support some findings documented in the 2006 Alan Guttmacher Institute report on repeat induced abortions in the United States. For instance, in that study findings, women having a history of previous abortions were different from women having a first time abortion. These women were more than twice likely to be age 30 or older and even after controlling for age, almost twice as likely to have had a child. Additionally, women having a history of multiple previous abortions might have had unpleasant sexual and reproductive experiences in the past that influenced their abortion decisions.

The conceptual framework of the current study (Figure 4) explains this observation by relating the perceptions and modifying factors for an induced abortion to the background characteristics of women seeking abortion services. An individual's background characteristics influence the perceived seriousness/need for an induced abortion when a pregnancy occurs. This leads to a reflection on the perceived threats or benefits to having an abortion, hence the likelihood to have an abortion decision implemented. In a situation where pre and post abortion counseling, and collaboration for support become inadequate, women become emotionally disturbed and suffer post abortion syndromes in the form of depression that emanates from the guilt and stigma sometimes associated with induced abortion (Sai, 2004).

CHAPTER FIVE

COLLABORATORS IN ABORTION DECISION-MAKING

Introduction

This chapter focuses on the collaborators involved in the decision-making process for an induced abortion. The ultimate concern is whether the respondents involved other people in the decision-making process for their abortions or not. Where other persons were involved, the study investigated the identity of these people, the reasons for and extent of involvement of such persons in the decision making process.

Characteristics of Person Responsible for Pregnancy

Various characteristics of persons were reported to have been responsible for the pregnancy terminated. These persons included husbands, boyfriends, teachers, lecturers, bosses, ex-husbands, rapists and blood relations. The other categories of persons mentioned to have been responsible for the pregnancy terminated are religious leaders, house boys, family friends, visitors, schoolmates and colleagues at work places. Majority of the respondents (about 64 percent) reported to have been impregnated by their boyfriends, whilst sex related offences (rapist/incest) were the least reported response, which accounted for about 1.8 percent responses (Table 10).

Table 10: Characteristics of Person Responsible for Pregnancies Terminated

Background Characteristics	Husband/ Partner (n=93)	Boyfriend (n=253)	Lecturer/ Teacher/ Boss (n=16)	Rapist/ Blood relation (n=9)	Ex-husband (n=12)	Other (n=18)
Total	23.74	63.89	3.54	1.77	2.53	4.55
Age group (χ^2=102.82; p=0.000)						
15-19	2.04	69.39	6.12	6.12	0.00	16.33
20-24	12.12	72.73	4.55	3.03	1.52	6.06
25-29	27.52	67.89	3.67	0.00	0.92	0.00
30-34	46.15	47.69	0.00	0.00	3.08	3.08
35+	44.74	39.47	2.63	0.00	13.16	0.00
Marital Status (χ^2= 283.3424; p= 0.000)						
Never married	0.00	85.71	5.61	2.55	0.00	6.12
Married/in union	56.36	38.18	1.21	0.61	0.00	3.64
Previously married	0.00	65.62	3.12	0.00	31.25	0.00
Education (χ^2=12.5223; p=0.639)						
None	25.93	62.96	0.00	0.00	7.41	3.70
Primary	23.53	62.75	1.96	0.00	1.96	9.80
Secondary	22.73	63.64	4.08	3.18	3.18	4.09
Higher	25.51	65.31	4.08	0.00	2.04	3.06

Table 10 continued.

Religious affiliation (χ^2=9.45; p=0.490)						
Christian	23.99	63.55	2.49	2.18	2.80	4.98
Moslem	22.86	64.29	8.57	0.00	1.43	2.86
Other	20.00	80.00	0.00	0.00	0.00	0.00
Occupational status (χ^2=78.99; p=0.000)						
Unemployed	6.67	84.44	2.22	0.00	0.00	6.67
Self employed	33.56	54.79	3.42	0.00	5.48	2.74
Student/apprentice	7.52	76.69	4.51	5.26	0.00	6.02
Other	46.27	43.28	2.99	0.00	2.99	4.48
Number of living children (χ^2=78.9941; 0=0.000)						
0	3.85	80.29	5.29	3.37	0.96	6.25
1	34.62	55.13	1.28	0.00	2.56	6.41
2	49.12	45.61	1.75	0.00	3.51	0.00
3	65.62	28.12	3.12	0.00	3.12	0.00
4+	45.00	40.00	0.00	0.00	15.00	0.00

Source: Field Survey, 2011

Statistically, there was a significant association between age of respondents and characteristics of persons responsible for pregnancies terminated (χ^2=102.82; p=0.000). About 6.1 percent of those respondents impregnated by a rapist or blood relation or by other men (16.3 percent) were young people between the ages of 15-24 years. This observation probably indicates that young women between the ages of 15-24 years, are being sexually abused and/or exploited without adequate protection and coerced to have an abortion when a pregnancy occurs.

The marital status of respondents was also statistically associated with characteristics of persons responsible for pregnancy termination (χ^2= 283.3424; p= 0.000). About 86 percent of the never married attributed the pregnancy to their boyfriends whilst about 56 percent of the married/in union respondents, reported to have been impregnated by a husband/sexual partner. More than a quarter of the married respondents (38.2 percent) also mentioned their boyfriends as responsible for the pregnancies that were terminated. Some of the married respondents during the in-depth interview gave convincing justifications for having boyfriends aside their husbands including sexual satisfaction. A respondent reported that:

> *For five years of marriage, my husband has been simply a 'log'. Besides, he is always out of home on official trips. When he comes home, he seems too tired and religious even on our matrimonial bed. I hardly enjoy sex with him thus the need for a boyfriend who could satisfy my sexual feelings without me making babies for him (35 year old house wife).*

Although quite unusually reported in marriage, it was observed that less than 1 percent of the married women reported having decided on an abortion because the pregnancy occurred from rape/incest. In the case of the previously married about 31 percent of the respondents terminated a pregnancy that was due to a sexual relationship with an ex-husband. A respondent during the in-depth interview reported that:

'Although we have been officially divorced for about five years now, we still love each other and occasionally find time to enjoy ourselves and have fun together. We have both for personal reasons, decided to live our lives independently and are fine this way' (40 year old Business woman).

There was no significant association between the educational status of respondents and the characteristics of persons responsible for the pregnancies terminated (χ^2=12.5223; p=0.639). Although boyfriends accounted for more than 60 percent of the pregnancies across all the educational status categories, lecturers/teachers were observed to have contributed to about 4 percent of the pregnancies occurring among respondents who attained secondary or higher educational levels respectively. About 3 percent of the pregnancies occurring among respondents with secondary level education were attributed to a rapist/blood relation.

In terms of religious affiliations, there was no significant association with religion and persons responsible for a pregnancy (χ^2=9.45; p=0.490). Boyfriends were however, observed to have been responsible for over 62 percent of pregnancies among respondents in the various religious groupings. The

occupation of respondents was significantly associated with the characteristics of persons responsible for the pregnancy terminated (χ^2=78.99; p=0.000). Boyfriends were once again the most observed responses across the indicated occupational categories. Respondents who were students (about 5 percent) attributed their pregnancies to their lecturers/teachers whilst in school or their bosses during industrial attachment with some organizations. It was observed that these women were compelled to sleep with the men for various favours such as academic favours whilst in school as well as job placement and salary increments during industrial attachments. A respondent whilst in school narrated her experiences as follows:

> *I was the only female student among my colleagues whose project work was delayed. My lecturer one day invited me to his office and demanded from me sex. I gave in based on advices from my female colleagues and my project work was passed. When I became pregnant, he told me to terminate the pregnancy in my own interest (24 year old student).*

Another respondent at the time of her industrial attachment in a company narrated her experiences as follows:

> *'I never had the promised job despite sleeping with three men on different occasions within the same organization whilst doing my attachment there. To complicate my plight, I became pregnant as a result and had it terminated. I felt abused but I had no choice because I needed the job badly at the time and was told that is the strategy these days' (22 year old attachment trainee).*

Another respondent indicated that:

'Although I did very well during the industrial attachment, the man in-charge of placements after attachment requested sexual favours from me before finalizing the process. To secure the job, I had to give in and this resulted in the pregnancy I terminated. Because I could not cope with the regular harassments from him and attitudes of the other female workers that I met on the job, I quit that work and decided to look for another job with a more decent employer' (25 year old apprentice).

The number of living children a woman had at the time of pregnancy, statistically also showed a significant association with the characteristics of persons responsible for the pregnancy terminated (χ^2=78.9941; 0=0.000). In all the statistical significant associations observed, boyfriends again stood tallest among the reported persons responsible for the pregnancies aborted. About 80 percent of the nulliparous respondents attributed the onset of the pregnancies terminated to their boyfriends.

About 15 percent of respondents having four or more children who had an abortion were reported to have been impregnated by an ex-husband. This observation when probed during the in-depth interview revealed that, the existence of children among ex-couples creates an opportunity for sexual reunions some of which results into abortions. For instance, a respondent reported that:

'I visit him monthly for money for the upkeep of our five children who are with me. This has been the arrangement since we divorced. On some of such visits, we sometimes have sex when our love for each other is

rekindled. He promised to take me back as his wife when he realized I was pregnant. But I don't want any more children hence the abortion' (40 year old unemployed).

Observations made by Sena (2006), indicates that in the Ghanaian community, it is generally considered as irresponsible regardless of a woman's background to become pregnant without being able to identify a 'responsible person' to claim ownership of the pregnancy. In indigenous Ghanaian societies, when this occurs, society chastises the pregnant woman, her family and the baby, when born, is described as a bastard. To avoid the bearing of the consequences of such situations, it was observed during the in-depth interview that, some respondents who had challenges with the ownership of their pregnancies resorted to induced abortion.

The conceptual framework of this study in looking at cost/benefit analysis of keeping a pregnancy also reflected on the implications of getting pregnant without being able to identify the person responsible for the pregnancy. When this happens, avoidance of the religious and socio-economic implications (i.e. perceived seriousness/need for an abortion) to the pregnant woman and/or her family becomes a push factor to have a pregnancy terminated at all cost.

Person(s) First Informed about Pregnancy

The respondents were asked to indicate the person(s) they first informed when they realized they were pregnant. This was to examine the social support systems available to the women and the confidence they had in such people to be

able to disclose to them such personal information for the required support. Among the key persons identified in this study to have been first informed about a pregnancy, when it occurred, include sexual partners, mothers and friends.

Majority (74 percent) of the respondents first informed their sexual partners, whilst a small group (3 percent) informed other trusted people such as distant relatives, religious parents and health workers. Those who were first informed about the occurrence of a pregnancy were also indicated as the main collaborators who advised and assisted in various ways towards the termination (Table 11).

Table 11: Person(s) First Informed about the Pregnancy

Background characteristics	Person(s) first informed about pregnancy				
	Partner (n=295)	Mother (n=24)	Friends (n=40)	Nobody (n=30)	Other (n=12)
% Total	74.31	5.74	9.73	7.23	2.99
Age group (χ^2=34.21; P=0.005)					
15-19	46.94	16.33	20.41	10.20	6.12
20-24	78.36	5.97	8.96	2.99	3.73
25-29	76.58	4.50	9.01	8.11	1.80
30-34	80.00	3.08	61.5	9.23	1.54
35+	76.92	0.00	7.69	12.82	2.56

Table 11 continued.

Marital Status (χ^2=44.33; p=0.000)					
Never married	68.34	8.04	14.57	5.53	3.52
Married/In union	85.63	2.40	3.59	5.39	2.99
Previously married	53.12	6.25	12.50	28.12	0.00
Education (χ^2=19.13; p=0.085)					
None	62.96	0.00	18.52	14.81	3.70
Primary	64.71	5.88	11.76	11.76	5.88
Secondary	75.57	7.69	9.95	5.43	1.36
Higher	79.41	2.94	5.88	6.86	4.90
Religious affiliation (χ^2=2.14; p=0.976)					
Christian	73.62	6.13	9.82	7.36	3.07
Moslem	75.71	4.29	10.00	7.14	2.86
Other	100.00	-	-	-	-
Occupational status (χ^2=20.34; p=0.061)					
Unemployed	82.22	-	6.67	11.11	-
Self employed	72.97	6.08	12.16	7.43	1.35
Student/Apprentice	70.90	8.96	11.19	5.97	2.99
Other	79.71	2.90	2.90	7.25	7.25

Table 11 continued.

Number of living children (χ^2=26.95; p=0.042)					
0	70.28	8.49	11.32	5.19	4.72
1	74.36	3.85	10.26	20.26	1.28
2	77.19	-	8.77	14.04	-
3	93.94	3.03	3.03	-	-
4+	80.00	5.00	5.00	10.00	-

Source: Field Survey, 2011

There was a significant association between the age of respondents and person(s) first informed about the pregnancy when it occurred (χ^2=34.21; p=0.005). Eighty percent of respondents aged 30-34 years first informed their partners whilst about 16 percent and 20 percent of respondents within the teenage group (15-19 years) respectively first informed their mothers or friends about the pregnancy when it occurred. None of the respondents in the older age groups (35 years and above) informed their mothers about the pregnancies terminated. Additionally about 13 percent of those aged 35 years and above kept the news of the pregnancy to themselves and did not inform anybody about it.

A respondent during the in-depth interview reported that:

> *My husband is always particular about small family sizes hence I thought it right to first inform him about the pregnancy which occurred despite using a contraceptive so that we could decide together on what to do with the pregnancy since we already have four children (32 year old housewife).*

Another respondent indicated that:

My mother on monthly basis looks out for my menses hence she was the first to have been informed that I was pregnant (17 year old student).

Marital status of the respondents was also significantly associated with persons first informed about a pregnancy when it occurred (χ^2=44.33; p=0.000). In the case of married women, about 85 percent of them first informed a sexual partner about the pregnancy. This implies that close to 15 percent of the married women even if they later did, initially hide the pregnancy from their sexual partners. This observation suggests that even in marriage, some women may have induced abortion without the knowledge of their sexual partners, since the partners, in the first case, might not have been informed about a pregnancy. A respondent during the in-depth interview reported that:

I initially did not inform my husband about the pregnancy aborted because, he was jobless at the time I became pregnant. I informed him after the abortion and explained to him that, I aborted the pregnancy to postpone childbirth until such a time when he gets a job that will generate regular source of income for the family upkeep (25 year old married woman).

In the case of the never married, about 15 percent of them first informed a friend about the pregnancy whilst about 28 percent of the previously married (i.e. widowed, separated and divorcees) did not discuss the pregnancy with anybody.

There was no significant association between educational attainments of respondents and the persons first informed about a pregnancy when it occurred

(χ^2=19.13; p=0.085). However, over 75 percent of respondents having attained secondary or higher education first informed a partner about the occurrence of a pregnancy prior to its termination. Close to 19 percent of respondents with no formal education first informed their friends of their pregnancies or decided not to inform anybody at all (about 15 percent).

Although religious affiliations of respondents were also not significantly associated (χ^2=2.14; p=0.976) with persons first informed about a pregnancy prior to its termination, it was observed that more than 70 percent of respondents belonging to the Christian or Moslem religious affiliations informed a partner about the pregnancy prior to its termination. Additionally, about 10 percent of the Christian and Moslem respondents also first informed a friend when a pregnancy occurred.

The occupational status of a respondent as observed was also not significantly associated (χ^2=20.34; p=0.061) with the persons first informed about a pregnancy. It was however noted that about 82 percent of the unemployed first informed a partner about the pregnancy when it occurred whilst about 9 percent of students/apprentice informed their mothers. None of the unemployed respondents informed a mother about a pregnancy prior to its termination and about 11 percent kept the pregnancy as a secret. Friends were reported by about 12 percent of the self-employed as the first recipients of the news about their pregnancies.

The number of living children of a respondent was significantly associated with the persons first informed about a pregnancy when it occurred (χ^2=26.95; p=0.042). About 93 percent of respondents with three living children first

informed a partner when the pregnancy occurred. None of the respondents having two children first informed a mother about the pregnancy terminated. About 11 percent of respondents with no living child first informed a friend when discovered pregnant whilst respondents with only one living child decided not to inform anybody about the pregnancy and had an induced abortion all alone.

It was noted during the in-depth interview that, respondents who first informed a partner when a pregnancy occurred did so because they believed it was the right thing to have done at the time for a collective decision on the pregnancy outcome. A respondent indicated that:

> *My parents dislike my partner and warned me severally to stop going out with him but I refused. Because of this, he was the first person I informed about the pregnancy so that we could together decide on what to do about the pregnancy before my parents got to know (20 year old student).*

Another respondent indicated that:

> *My partner is like a father and advisor to me hence it was right to have first informed him when I became pregnant for him. Besides, he is sponsoring me and has promised to marry me as soon as I complete the apprenticeship (19 year old apprentice).*

Another respondent explained that:

> *I first informed my partner about the pregnancy because, I was surprised and could not figure out how the pregnancy could have been possible since we had always successfully used condoms to prevent pregnancy for the past three years that we have been together(21 year old student).*

The conceptual framework used for this study (Figure 4) indicates that collaborating on decision-making for an induced abortion originates from some perceived threats (i.e. individual challenges, gender and power relations) that a pregnant woman might have had whilst making a decision for an abortion.

To overcome the perceived threats in order to pave the way for an abortion decision, a pregnant woman carefully confides in people whom she perceives trustworthy/supportive. The background characteristics and prevailing circumstances in which she became pregnant influence the choice of collaborators for abortion decision-making and its implementation.

Consent for Induced Abortion

In line with medico-legal requirements relating to informed consent prior to an induced abortion in Ghana (PNDC, Law 102) respondents were asked if they consented to the decision for the abortion and/or needed anyone's consent to have the abortion. About 67 percent answered in the affirmative and 33 percent answered in the negative.

It was observed that majority of the respondents (about 54 percent) relied on a sexual partner's consent for an abortion. Whilst about 33 percent of the respondents self consented for the abortion. It is worthy of note that the one who consented for the induced abortion to be performed also took the final decisions to have an induced abortion decision implemented. By final consent, it means if the one giving the final consent declined, then the abortion was likely not to have been done (Table 12).

Table 12: Person who finally consented for the Induced Abortion

Background characteristics	Person giving final consent for induced abortion			
	Self-consent (n=131)	Sexual partner (n=218)	Mother (n=32)	Other (n=19)
% Total	32.67	54.36	8.25	4.74
Age group (χ^2=31.10; p=0.002)				
15-19	38.78	32.65	24.49	4.08
20-24	29.10	55.97	9.70	5.22
25-29	33.33	58.56	5.41	2.70
30-34	30.77	63.08	1.54	4.62
35+	38.46	51.28	2.56	7.69
Marital status (χ^2=9.84; p=0.131)				
Never married	32.66	50.25	11.56	5.53
Married/ Living in union	31.74	58.68	4.79	4.79
Previously married	40.62	56.25	3.12	0.00
Education (χ^2=13.66; p=0.135)				
None	44.44	51.85	0.00	3.70
Primary	39.22	39.22	11.76	9.80
Secondary	32.58	55.20	9.05	3.17
Higher	26.47	60.78	6.86	5.88

Table 12 continued.

Religious affiliation (χ^2=12.25; p=0.056)				
Christian	35.58	50.92	7.98	5.52
Moslem	21.43	68.57	8.57	1.43
Other	0.00	80.00	20.00	0.00
Occupational status (χ^2=38.69; p=0.000)				
Unemployed	26.67	60.00	2.22	11.11
Self employed	43.92	47.97	5.41	2.70
Student/Apprentice	29.85	50.75	15.67	3.73
Other	17.39	72.46	2.90	7.25
Number of living children (χ^2=20.90; p=0.052)				
0	30.19	50.94	12.74	6.13
1	39.74	53.85	3.85	2.56
2	38.60	56.14	1.75	3.51
3	24.24	72.73	0.00	3.03
4+	30.00	60.00	5.00	5.00

Source: Field Survey, 2011

Results from Table 12, statistically shows some significant associations among the indicated background characteristics of respondents and the persons giving the final consent for an abortion to be performed. For instance, the age of the respondents was significantly associated with the person giving the final consent for the abortion (χ^2=31.10; p=0.002).

More than 60 percent of the respondents aged 30-34 years depended more on their partners consent to have a pregnancy terminated. Although it was contrary to the medico-legal requirements relating to informed consent for minors prior to an induced abortion in Ghana (Criminal Code 1960), about 39 percent of respondents aged 15-19 years reported that they made their own decisions and procured abortion medications from pharmacy shops without any form of consenting.

A teenager who self consented for her induced abortion reported during the in-depth interview that:

I was 17 years in a Senior High School when I became pregnant during school holidays. As the first female child of a Reverend Minister, my parents had so much confidence in me and had inspired me to always conduct myself uprightly so as to serve as a role model to my younger siblings. In order not to betray the confidence my parent's had in me, I did not inform anybody about my pregnancy when it occurred and self-consented to have it terminated in a very confidential manner (17 year old student).

Although some respondents within the teenage age group (about 25 percent), had a mother's consent to have an induced abortion, it is worth noting that, in the case of some minors working as house helps, they were forced against their wish by their 'madams' when discovered pregnant, to have an abortion. These madams consented for the termination on their behalf as though they were

their biological mothers. One of such respondents during the in-depth interview narrated her experience as follows:

'When my madam realized I had missed my period, she dragged me to the hospital for pregnancy test. When the test result showed positive for pregnancy and she realized her son was responsible for the pregnancy, she requested for an immediate abortion for me because she did not want the pregnancy to be associated to her son who was at the university. Although I did not like the decision to abort the pregnancy for fear of future complications I had no choice.' (16 year old house help).

Although marital status of respondents was statistically not significantly associated with persons giving the final consent for an abortion to be performed (χ^2=9.84; p=0.131), consenting for induced abortion in marriage was observed as one of the issues that posed the greatest challenge to abortion decision-making in this study. Nevertheless, more than 50 percent of respondents with varying marital status had their sexual partners to finally consent for the induced abortion to be done. About 41 percent of the previously married reported to have self consented for their induced abortion, whilst about 12 percent of the never married had a mother to give the final consent for the induced abortion decision that was implemented.

The educational background of a respondent was statistically also not significantly associated with persons giving the final consent for an induced abortion (χ^2=9.84; p=0.131). Nevertheless, more than 55 percent of respondents who had attained secondary or higher educational levels depended more on the

final consent of a sexual partner for induced abortion. About 12 percent of respondents who had primary level education relied on the final consent of a mother to have an induced abortion. None of the respondents having no formal education was reported to have depended on the final consent of a mother for an induced abortion.

In terms of the religious affiliations of the respondents, there was no statistically significant association with persons giving final consent for induced abortion (χ^2=12.25; p=0.056). However, majority of the respondents about (51 percent Christians and 69 percent Moslems) had the final consent for the induced abortion from their respective sexual partners. The occupation of respondents statistically showed a significant association with persons giving the final consent prior to an induced abortion (χ^2=38.69; p=0.000). About 44 percent of the self employed, self consented for their abortions whilst 60 percent of the unemployed respondents sought the final consent for their abortions from a sexual partner. About 16 percent of the respondents who at the time of making a decision for an abortion were either students or apprentices sought the final consent for their abortions from a mother.

The number of living children that a respondent had at the time of decision making for an induced abortion was significantly associated with the persons giving the final consent for an abortion decision to be implemented (χ^2=20.90; p=0.052). About 38 percent of the respondents who had one living child self consented for the induced abortion. Although more than 50 percent of all the respondents in this category had their sexual partners to consent for the abortion,

about 73 percent of respondents who had three living children relied most on a partner's consent for an induced abortion.

It was also observed that about 13 percent of respondents with no living child had the final consent from their mothers to have an induced abortion done. Additionally, partner consent for an induced abortion decreased with increasing number of living children among the respondents, which was observed from parity 0 to 3. There was however a discontinuation of this trend from parity 3 and above.

It was observed during the in-depth interview that, the general reported high percentages of partner involvement and dependency for final consent in the abortion decision making arose for reasons of financial and emotional support during the abortion. In some reported situations, partner involvement was due to the insistence of the male partners for reasons of distrust, which was observed in three situations. The first was a general shift in taking responsibility for the pregnancy, the second being whether the supposed pregnant woman is actually pregnant and not telling the partner a lie just to extort money and the third was for the partner who was not ready for a pregnancy to be rest assured that the pregnancy was successfully terminated. There was however, no direct evidence that respondents who did not involve anybody in the decision-making process for the abortion and self consented for the abortion had any adverse result.

As would have been socially expected within the Ghanaian context induced abortion even if required in marriage as an option to a pregnancy outcome should have been thoroughly discussed and an agreement reached

between both partners for the consent to have the abortion decision implemented. On the contrary, the abortion standards and protocols of Ghana (GHS, 2003) explicitly indicate that partners consent is not a requirement for an induced abortion in Ghana, which implies that a woman irrespective of her marital status can have an abortion without necessarily seeking the consent of her partner. Findings of this study however did not support the implementation of this policy directive within the Accra metropolis. A respondent indicated during the in-depth interview that:

> *'My partner was the first to know about the pregnancy although he initially did not believe the news. He insisted on accompanying me to a hospital to confirm the pregnancy. He further pleaded with me to terminate the pregnancy and provided money for it. To be sure that the pregnancy was fully terminated, he made time to accompany me to the hospital on the review date and gave a big sigh of relief when we were told the pregnancy had been successfully terminated' (19 year old student).*

Another respondent indicated that:

> *When I realized I was pregnant, I did not inform anybody because I was the one carrying the pregnancy hence the decision for an abortion is absolutely mine. When I however realized I could not afford the five hundred Ghana Cedis being charged for the abortion, I then decided to inform my husband to seek his consent mainly for financial assistance to be able to pay for the abortion (30 year old married woman).*

In relation to these observations, the second research hypothesis, which states that there is no significant association between a woman's marital status and her decision to have an abortion without requesting partner's consent, was tested using a bi-variate logistic regression model. The bi-variate model focused only on the dependent variable and the main explanatory variable (marital status).

In the first instance, using never married as the reference point, currently married women were about (OR=1.03; 95% CI=0.67-1.26) times more likely to seek the consent or opinion of another person, probably the partner than the reference. However, the formerly married group was less likely (OR=0.70; 95% CI=0.32-1.52) to seek a third party's approval for an abortion. In Model II where the effect of marital status was controlled for, the odds of seeking a third opinion on abortion improves minimally to about OR=1.11 or about 11.5 percent (95% CI=0.63-1.96) while the odds for formerly married and never married rarely show any difference as indicated in Model II (Table 13).

Table 13: Bi-variate Logistic Regression Model results of women's Marital Status and Decision to have a Self-consented Induced Abortion.

Variable	Categories	Mode I	95% CI	Model II	95% CI
Marital status	Never married (ref)				
	Currently married	1.03	0.67-1.26	1.11	0.63-1.96
	Formerly married	0.70	0.32-1.52	0.99	0.40-2.46
Education	No education (ref)				
	Primary			1.36	0.49-3.72
	Secondary			1.59	0.67-3.74
	Higher			1.55	0.58-4.17
Occupation	Unemployed (ref)				
	Employed			0.40	0.18-0.90
	Student/apprentice			0.79	0.35-1.77
	Others			1.38	0.51-3.70
Age group	15-19 (ref)				
	20-24			1.04	0.33-3.28
	25-29			1.84	0.69-4.88
	30-34			1.66	0.65-4.19
	34+			1.62	0.63-41.5
Number of living children					
	0			0.70	0.18-2.69
	1			0.53	0.14-1.90
	2			0.60	0.17-2.13
	3			1.47	0.36-5.97
	4+ (ref)				
Model summary	*Observations*	398		390	
	Chi square	0.94(2)		25.92(16)*	

Source: Computed from field data 211 ***p<0.001; **p<0.05; *p<0.10

The analysis presented in table 10 sustains the null hypothesis and can therefore be concluded based on the available evidence that at 95 percent level of significance, there is no significant association between a woman's marital status and the decision making process to have an abortion without anybody's consent.

In situations where some married women sought their partner's consent for an induced abortion in contradiction to the Ghanaian Abortion Standards and Protocols (2003) which indicates that partner's consent is not required for an induced abortion, the study explored the reason(s) why such women sought their partner's consent before the abortion. The dominant reason that emerged was the fact that it was right to inform the person responsible for the pregnancy before it is terminated. A respondent during the in-depth interview reported that:

> *It is unfair to have an abortion without informing my partner. I know he loves me so much as I do and he would have wished we keep this pregnancy had it not been that we were both not prepared for a baby at the time (21 year old student).*

Another respondent indicated that:

> *I did not become pregnant all by myself. A man impregnated me hence he must be informed about the decision to abort so that he will bear the total cost of the termination and also take responsibility of any problems that might be associated with the abortion (35 year old married woman).*

Although previous studies (WHO, 2004; GHS 2007) reported some similarities regarding collaborations for an induced abortion, findings from this study show remarkable differences in challenges faced by women during

collaborations for an induced abortion with respect to their background and collaborators involved. It was observed that, the reasons given for a pregnant woman to collaborate with someone during abortion decision making process is multifaceted and includes issues of trust, safety, security and financial support during the abortion. For instance, a respondent during the in-depth interview reported that:

> *My boyfriend rejected me and denied responsibility of the pregnancy when he realized I was pregnant. I had to struggle and look for money all alone for the abortion and this delayed the time at which I had the abortion done (19 year old apprentice).*

From this, it is observed that persons responsible for a pregnancy are more likely to be the first to be informed about a pregnancy when it occurs. Additionally this people are also more likely to influence the gestation period at which a pregnancy is terminated. This observation therefore indicates the importance of collaborations particularly with a sexual partner in abortion decision making. Additional importance in collaborating with a partner on decisions for induced abortion enables partners support and commitment towards implementing a decision to terminate a pregnancy. This level of collaboration enables decisions on abortion to be quick hence pregnancy termination is likely to occur within the first trimester compared to others who are completely alone in the decision making process, for which reason they might have late terminations due to a lack of adequate information and/or support for action.

The lack of significant associations between a woman's marital status and decision to have a self-consented abortion supports the concerns about informed consent prior to induced abortion as indicated in the Standards and protocols for Comprehensive Abortion Care of Ghana (Ghana Health Service, 2005). Additionally, absence of evidence that women who did not collaborate with anybody during abortion decision making had any adverse effects during termination might allay women's fears about making independent abortion decisions in their own interest.

The conceptual framework of this study (Figure 4) indicates the importance of collaborators in abortion decision-making process, which the study findings support. The study results indicate that while some women were quick to decide on an induced abortion because they had collaborators who positively supported the decision to have an induced abortion, other women who had no collaborators, and hence were left without any support were completely alone in the decision-making process which invariably resulted them having induced abortions at an advanced gestational age.

The implication of this finding indicates that results in decision-making on a pregnancy outcome are best when shared with other people. The sharing creates an enabling environment to mobilize the necessary support and resources that will enable a pregnant woman who is confused at the time a pregnancy occurs to make a quick decision that will help her to achieve the desired results in relation to her reproductive intentions. This finding supports a previous study by Henry and Fayorsey (2002).

CHAPTER SIX

CHOICE OF PLACE FOR ABORTION SERVICES

Introduction

This chapter presents findings on the factors considered by respondents in choosing a place for an induced abortion. The focus was on how respondents heard about the place of abortion, methods/options available, cost of an abortion service, the various options available to women on arrival at the place they chose for induced abortion as well as reasons for the choice of place and method used.

Place of Abortion

As part of the decision-making process, respondents reported to have resorted to various places to have their pregnancies terminated. The reported sources of induced abortion included both clinical (i.e. NGO, public and/or private hospital/clinic) and non-clinical environments (pharmacy/chemical shops, drug peddlers in open markets and home based remedies). About 78 percent of the respondents had induced abortion initiated in a clinical environment whilst the rest (22 percent) had it done in a non-clinical environment (Table 14).

Table 14: Background Characteristics by Place of Abortion

Background characteristics	Place of abortion			
	NGO hospital/clinic (n=114)	Public hospital/clinic (n=134)	Private hospital/clinic (n=66)	Other (n=87)
% Total	28.43	33.42	16.46	21.70
Age group (χ^2=16.305; p=0.178)				
5-19	34.71	26.51	10.24	28.60
20-24	25.40	33.61	18.70	22.42
25-29	30.62	30.63	16.21	22.53
30-34	35.43	30.80	12.32	21.51
35+	15.42	51.31	23.14	10.33
Marital status (χ^2=4.861; p = 0.562)				
Never married	29.12	32.70	14.14	24.11
Married/in union	29.90	33.51	18.03	18.62
Previously married	18.80	34.42	25.00	21.90
Education (χ^2=17.814; p = 0.037)				
None	40.70	22.21	18.53	18.51
Primary	21.60	41.22	9.82	27.54
Secondary	25.31	35.71	14.51	24.43
Higher	35.33	27.50	23.50	13.72

Table 14 continued.

Religious affiliation (χ^2=15.0281; p = 0.020)				
Christian	25.21	35.6	17.52	21.80
Moslem	40.03	25.72	11.41	22.91
Other	80.02	0.00	20.0	0.00
Occupational status (χ^2=11.767; p = 0.227)				
Unemployed	26.72	35.61	17.80	20.01
Self employed	23.01	40.53	14.91	21.61
Student/apprentice	34.34	26.90	14.23	24.63
Other	30.42	30.41	23.24	15.91
Number of living children (χ^2= 8.036; p = 0.782)				
0	30.70	33.03	14.21	22.20
1	26.91	30.81	14.13	28.21
2	22.80	36.80	22.81	17.53
3	30.33	36.41	18.24	15.22
4+	25.00	35.01	25.03	15.01

Source: Field Survey, 2011

The background characteristic of respondents with respect to place of abortion indicates that, statistically, there is no significant association between the age of a respondent and the choice of place for an induced abortion (χ^2=16.305; p = 0.178). However, majority of the respondents (about 51 percent) belonging to the age group of 35 years and above had their pregnancies terminated in a public hospital/clinic. Additionally, the proportion of women aged 35 and above, who had an induced abortion from a public or private provider was almost double the corresponding percentage for the women in the other age groupings.

There was also no statistical significant association between the marital status of respondents and choice of place for an induced abortion (χ^2=4.861; p = 0.562). Nevertheless, more than 30 percent of the respondents in all marital status categories had their abortions done in a public hospital whilst about 25 percent of the previously married accessed the abortion services from a private provider.

Statistically, there was a significant association between the educational background of a respondent and choice of place for an induced abortion (χ^2=17.814; p = 0.037). Respondents with primary level education (41.2 percent) and those with no formal education (40.7 percent) respectively had their abortions done in a public or NGO health facility, whilst about 24 percent of respondents with higher educational attainments resorted to the private abortion providers for their terminations. A University graduate explained the basis for her choice of place for an abortion during the in-depth interview as follows:

Because of the attitudes of nurses in other hospitals, I preferred to have my abortion in the NGO clinic because I was informed they have good

international standards, their service charges are reasonable and they seemed more professional in handling abortion issues in a more confidential and none judgemental manner'(45 year old polytechnic graduate).

Another respondent indicated that:

I preferred the private sector for the abortion because I was told the system there is very fast and there is no time wasting through the asking of many questions before the abortion is done. Once the cost of the service is fully paid, the provider is alerted to provide the service without much delay (31year old University graduate doing National Service).

Statistically, the religious affiliation of a respondent was significantly associated with choice of place for an induced abortion (χ^2=15.0281; p = 0.020). About 80 percent of respondents belonging to other religious affiliations such as Hinduism, Buddhism and African traditional religions collectively had their pregnancies terminated in an NGO hospital/clinic. It is worth noting that, none of the respondents in this category of religions had an abortion from a public hospital/clinic nor used other sources such as an over the counter sales of abortificients. A respondent during the in-depth interview indicated that:

'I did not want to complicate my problems by going to an unfamiliar place for the abortion. I wanted a credible facility where everything could be done safely and confidentially, hence the choice of NGO hospital because of their high standards and quality of care' (35 year old Buddhist).

The occupational background of a respondent was not significantly associated with choice of place for an induced abortion (χ^2=11.767; p = 0.227). It was however observed that about 41 percent of the self employed had their pregnancies terminated in a public hospital/clinic whilst about 25 percent of the students/apprentices resorted to other places such as pharmacies, chemical shops or home based remedies for their terminations. Statistically, there was also no significant association between the number of children that a respondent had prior to the current abortion and choice of place for the abortion (χ^2=8.036; p =0.782). It was however observed that, about 37 percent of respondents having two children had the current termination in a public hospital/clinic whilst 25 percent of respondents having four or more children had the abortion done in a private hospital/clinic.

Probing further during the in-depth interview to ascertain the rationale behind the choice of place for an induced abortion; the study noted that, issues about time, cost, staff attitude and availability of the needed service were of much concern to a woman seeking abortion. Mid-trimester (4+ months) abortions were mostly available in private facilities compared to the public and NGO facilities. A respondent during the in-depth interview reported that:

'After visiting many public hospitals to no avail, a nurse later introduced me to a private clinic that specialized in providing abortion for bigger gestations where my five months pregnancy was successfully terminated' (35 year old housewife).

Another respondent indicated that:

'I first visited an NGO clinic but I was referred to a public hospital after initial assessment because my pregnancy was about 4 months 2 weeks old. At the public hospital, I was humiliated and asked to pick a card and start attending antenatal clinic. In agony, I went home and a friend later introduced me to a private clinic where I later had my pregnancy terminated' (28 year old apprentice).

It is worth noting from the in-depth interview that, prior to going to a health facility for an abortion; about 4 in 5 of all the unemployed respondents interviewed had first attempted a self-induced abortion using some form of medication predominantly 'cytotec.' The medication was noted to have been procured over-the-counter from pharmacies/chemical shops because of the perceived ready availability at a cheaper cost. Respondents who used this channel, only went to a hospital when a complication arose, when there was an abortion failure or to confirm if the termination was successful. A respondent during the in-depth interview reported that:

"Why should I waste time and money going to a hospital for an abortion if I can just buy 'cytotec' in a nearby pharmacy at a cheaper price, take 2-up-2 down, bleed for a few days and have that bastard removed secretly? I can later then go to the hospital for treatment if there is any associated complication" (21 year old, unemployed).

This observation supports previous findings by Marie Stopes International Ghana (2006). It is an indication that even with the availability of designated health facilities providing safe abortion services in the study area hospital

procured abortion services may not be the first option when decisions on place of abortion is being made. The conceptual framework (Figure 4) indicates a process of assessment during abortion decision-making. This is an indication that a pregnant woman might have assessed various options before decision-making. The observation that some respondents would prefer self-medication for an abortion poses public health challenge because even with knowledge about abortion medications there is always the need for some form of professional clinical assessment prior to an abortion to identify potential health problems to be addressed medically before, during and/or after an abortion.

Sources of Information about Place of Abortion

The reported sources of information on place and method for induced abortion in the study area ranged from electronic media to friends through word of mouth. About 85 percent of the respondents reportedly heard of the place of abortion through 'word of mouth' [i.e. friends (50.87%), sexual partners (27.18%) and family members (6.48%)]. The role of the media as a means of conveying information on abortion providers and/or marketing abortion providers was very minimal and indirect (7.2 percent). This approach appeared to be used by the NGO facilities and providers of home based remedies focusing on 'pregnancy crisis management' and/or menstrual regulation. About 2 percent of the respondents heard of an abortion provider through an inter hospital referral note. Detailed analysis of the results on sources of information about place of abortion and background characteristics of respondents is shown in (Table 15).

It is evident from Table 15 that respondents collaborated with various kinds of people on various issues whilst making decisions for an induced abortion. As indicated in the conceptual framework for this study (Figure 4), an aspect of the collaboration involved information about places where induced abortion services are provided within the Accra metropolis.

Table 15: Sources of Information about Place of Abortion

Background characteristics	Source of information about place of abortion					
	Media (n=29)	Friends (n=204)	Sexual partner (n=109)	Family members (n=26)	Referred (n=9)	Others (n=24)
Total	7.23	50.87	27.18	6.48	2.24	5.99
Age group (χ^2=30.382; p = 0.064)						
15-19	2.01	51.01	22.41	18.43	2.03	4.10
20-24	4.50	47.00	33.60	7.51	2.22	5.21
25-29	9.90	52.32	26.12	3.60	2.71	5.42
30-34	12.31	50.81	26.22	1.52	3.12	6.21
35+	7.70	56.41	17.90	5.11	0.0	12.80
Marital status (χ^2=13.598; p = 0.556)						
Never married	6.51	52.32	26.31	7.51	2.02	5.51
Married/in union	9.02	47.31	29.99	4.80	3.03	6.02
previously married	3.13	62.50	18.80	9.41	0.0	6.20

Table 15 continued.

Education (χ^2=14.5989; p= 0.567)						
None	11.1	33.34	33.31	7.40	7.40	7.41
Primary	2.31	58.80	23.51	5.91	0.0	9.80
Secondary	6.80	51.61	27.60	7.22	1.81	5.00
Higher	9.81	50.00	26.51	4.91	2.92	5.90
Religious affiliation (χ^2=19.16; p=0.038)						
Christian	7.41	51.81	25.22	7.70	1.21	6.71
Moslem	7.13	47.12	34.31	1.41	7.13	2.90
Other	0.0	40.11	60.00	0.0	0.0	0.0
Occupation (χ^2=15.2643; p=0.433)						
Unemployed	4.41	48.90	31.13	4.42	2.21	8.91
Self employed	6.12	54.11	25.70	4.13	2.01	8.13
Student/apprentice	6.01	53.72	25.41	9.01	2.24	3.71
Other	14.53	40.62	29.03	8.72	2.91	4.34
Number of living children (χ^2=20.246; p = 0.443)						
0	6.14	48.12	28.33	9.41	2.81	5.21
1	7.72	53.81	25.64	2.62	2.63	7.70
2	5.31	61.42	26.31	1.82	0.0	5.33
3	15.21	45.50	24.21	9.14	3.03	3.01
4+	10.0	50.0	25.0	0.0	0.0	15.04

Source: Field Survey, 2011

The age of respondents statistically was not significantly associated with sources of information on place for an induced abortion (χ^2=30.382; p = 0.064). Nevertheless, with exception of about 47 percent of respondents within the 20-24 age group who indicated otherwise, more than 50 percent of the respondents in all other age groups heard about the place where their pregnancies were terminated through a friend by word of mouth. The marital status of a client was also statistically not significantly associated with source of information about place of abortion (χ^2=13.598; p=0.556). However, about 3 percent and 63 percent of the previously married were respectively informed by the media and friends of where their pregnancies were terminated. None of the previously married was reported to have had an inter hospital referral note to any place for pregnancy termination.

With respect to the educational background of respondents, there was no statistical significant association with the source of information about place of abortion (χ^2=14.5989; P= 0.567). Majority (about 59 percent) of respondents with primary level education were however informed by a friend about the place of abortion. The media was the source of information on place of abortion to about 2 percent of respondents attaining primary level education. It is worthy of note that there was no reported case of any respondent with primary level education being referred by anybody to any facility for an induced abortion. There was also a statistical significant association (χ^2=19.16; p=0.038) between sources of information on place of induced abortion and religious affiliations of respondents probably because of the sensitive nature of induced abortion among the identified religious groups. Respondents belonging to the other category of religious

affiliations such as Hinduism, Buddhism and African traditional religions relied mostly on a sexual partner (about 60 percent) in deciding on the choice of place for the pregnancy terminated.

The occupational status of a respondent was statistically not significantly associated with choice of place of induced abortion (χ^2=15.2643; p=0.433). Nevertheless, about 54 percent of the self employed and 54 percent of students/apprentices at the time of termination relied on a friend for information on place of abortion. The number of living children that a respondent had at the time of abortion decision-making was statistically not significantly associated with the source of information on place for the current termination (χ^2=20.246; p=0.433). It was however observed that, for respondents having two children, about 61 percent of them were informed about the place where they had their induced abortions by a friend. There was no reported case of women having two living children being referred for an abortion.

The conceptual framework of the study (Figure 4) indicates perceived threats to abortion decision-making, which presumably informs an individual's decision on choice of place for abortion. This finding, which supports that of Santhya and Shalini (2004) also, buttresses the position of UNFPA (1999) on the importance of women empowerment with correct information on abortion in Ghana in order to make informed decisions on choice of place when the need for an abortion arises. There is also a need for accredited abortion facilities in Ghana to be advertised publicly other than the current predominant word of mouth

approach that rather drives women to unqualified providers and/or unsafe facilities within the study area.

Factors Considered when Choosing a Place for an Abortion

The mere information on abortion providers alone was noted as not enough for decision making on choice of place for an abortion. Some other factors were also reported to have been considered in settling on the place for the current termination. For instance, about 30 percent of the respondents were concerned about privacy in choosing a place for an abortion. The reported factors classified under the group of 'other' (i.e. abortion method, staff attitude, proximity and availability of mid-trimester abortion services) were the least single factor considered when choosing a place for an abortion (Figure 8).

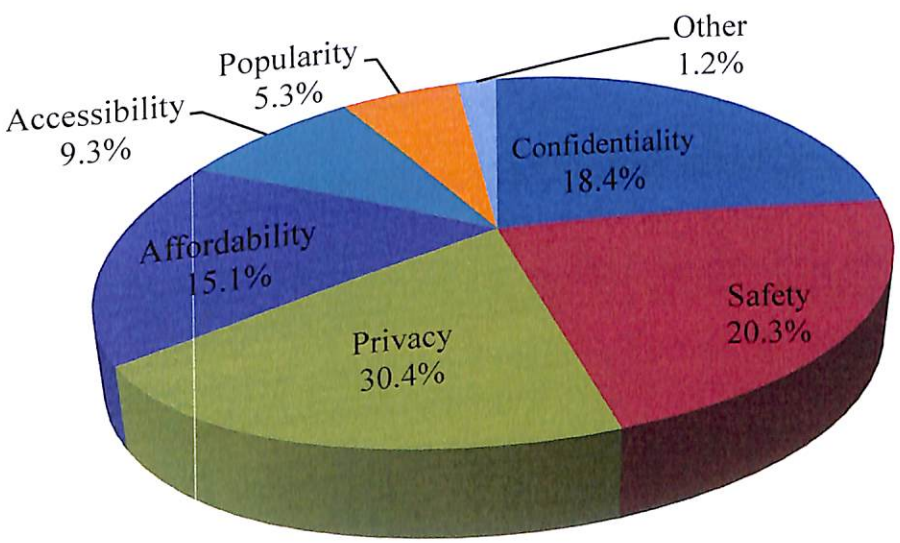

Figure 8: Factors Considered when Choosing a Place for an Abortion

Source: Field Survey, 2011

The observed perceived threats indicated in the conceptual framework of this study (Figure 4), posed the most challenge to the individual seeking induced abortion at the time of decision-making on choice of place to have a pregnancy terminated. The observed challenges, which were further investigated as they emerged from the in-depth interviews, support decisions on choice of place for an induced abortion in Ghana. A respondent indicated that:

> *'As a married woman and mother of one, it was more difficult for me walking into a hospital compared to a pharmacy shop to say I need help to have an abortion. The attitudes of nurses in the hospitals towards women seeking abortion services coupled with the many questions that I was told I will be required to answer put me off (25 year old, married woman).*

Another respondent remarked that:

> *"My friends informed me about a very nice NGO clinic where abortion is not too expensive. The women are treated nicely, provided with quick and confidential service without complications. Because I wanted a safe and secret abortion I took their advice and went to the place (21 year old, apprentice).*

Another respondent was of the view that:

> *'As an educated woman, I deemed it very important to seek help from a well trained abortion provider. I don't believe in self medication because of its adverse implications. In my opinion, the hospital was the best and safest environment to have an abortion, hence my choice' (22 year old teacher).*

Responses obtained from the in-depth interview on choice of place for an induced abortion is suggestive that the educational background of respondents influenced the choice of place for an induced abortion. Consequently, the third hypothesis of this thesis, which states that 'there is no significant association between the educational status of a pregnant woman and choice of place for an induced abortion' was set to explore this association.

This hypothesis was tested using the binary logistic regression model, which examined the effects of other variables on respondents' educational background and choice of place for induced abortion. Testing the hypothesis that 'there is no significant association between the educational status of a pregnant woman and her choice of place for an induced abortion, the a-priori logic was that highly educated women would seek abortion services from accredited providers to ensure their safety.

From the results presented in Table 16, Models 1 and 2, clearly indicate that, no significant differences exist in probability of abortion occurring in a safe and unsafe facilities by level of formal education. This was noted even in spite of the fact that women with tertiary education in Model 1 (OR=1.429; 95% CI=0.465–4.391) and Model 2 (OR=1.255; 95% CI=0.370–4.252) of Table 16 were more likely to have a pregnancy terminated in an accredited health facility. Based on these observations, there was no empirical evidence to reject the null hypothesis, which surmises that there was no significant relationship between level of formal education and choice of place of an induced abortion in the Accra metropolis.

Table 16: Binary Logistic Regression Model Results of Relationship between Educational Status and Choice of Place for an Induced Abortion.

Background Characteristics	Model 1	95% CI	Model 2	95% CI
Educational status				
No education	1	[1,1]	1	[1,1]
Primary	0.601	[0.190–1.896]	0.595	[0.179–1.982]
Secondary	0.703	[0.254–1.946]	0.706	[0.247–2.018]
Higher	1.429	[0.465–4.391]	1.255	[0.370–4.252]
Marital status				
Never married			1	[1,1]
Currently married			1.177	[0.626–2.215]
Previously married			0.907	[0.323–2.550]
Occupational status				
Unemployment			1	[1,1]
Employed			0.881	[0.360–2.152]
Student/Apprentice			0.795	[0.329–1.924]
Others			0.980	[0.334–2.874]
Age group				
15-19			0.364	[0.084–1.570]
20-24			0.502	[0.135–1.863]
25-29			0.397	[0.113–1.399]
30-34			0.424	[0.118–1.523]
35+			1	[1,1]

Table 16 continued.

Number of living children				
0			1.018	[0.206–5.032]
1			0.677	[0.148–3.102]
2			1.322	[0.280–6.245]
3			1.178	[0.222–6.259]
4(ref)			1	[1,1]
_Cons	4.400**	[1.666,11.62]	10.97*	[1.563–76.98]
Log lik.	-206.6		-196.6	
Chi-squared	6.293		13.16	
N	401		390	

Exponential coefficients: 95% confidence intervals in brackets. * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$. Source: Field Survey, 2011

Person who Introduced Respondents to Abortion Methods

The study explored who introduced a respondent to the abortion method used at the place where the termination was done. In all the responses, it was noted that various people (i.e. medical practitioners, pharmacist, friends, sexual partners, midwives and other groups of people such as pharmacy/chemical shop attendants, relatives and drug peddlers on the open market) introduced the respondents to the method used for the termination at the places they went seeking for an abortion. This observation was dependent on previous experiences that a respondent had with an induced abortion and the places where a respondent

finally settled for the abortion. About 43 percent of respondents were introduced to the method used for terminating their pregnancies by a medical practitioner. Friends of respondents constitute about 22 percent of persons who introduced a respondent to an abortion method whilst other identified groups of people such as pharmacy/chemical shop attendants, relatives and drug peddlers on the open market constitute about 4 percent of persons who introduced a respondent to an abortion method (Table 17).

Table 17: Person who Introduced Respondents to Abortion Methods used by Background Characteristics of Respondents

Background characteristics	Persons who introduced respondents to abortion method					
	Medical Practitioner (n=172)	Pharmacist (n=52)	Friends (n=90)	Partner (n=48)	Midwife (n=21)	Others (n=18)
Total	42.89	12.97	22.44	11.97	5.24	4.49
Age group (χ^2= 27.1494; p = 0.131)						
15-19	30.61	16.33	30.61	6.12	8.16	8.16
20-24	44.03	11.19	17.91	14.18	9.70	2.99
25-29	43.24	14.41	24.32	12.61	1.82	3.60
30-34	46.15	15.38	23.08	9.23	3.081	3.080
35+	46.15	5.13	23.08	15.38	-	10.26
Marital status (χ^2= 20.8814; p = 0.022)						
Never married	33.67	14.07	27.64	13.07	6.53	5.00
Married/in union	49.72	12.57	19.76	10.18	3.59	4.13
Previously married	65.62	9.38	3.12	12.51	6.25	3.10

Table 17 continued.

Education (χ^2= 22.6561; p = 0.092)						
None	40.74	7.41	22.22	14.81	7.41	7.41
Primary	27.45	11.76	29.41	15.69	7.84	7.84
Secondary	38.91	15.38	23.08	12.67	5.43	4.52
Higher	59.8	9.8	17.65	7.84	2.94	1.96
Religious affiliation (χ^2= 14.8088; p = 0.139)						
Christian	40.8	11.66	24.54	12.88	5.21	4.91
Moslem	48.57	20.00	14.29	8.57	5.71	2.86
Other	100.00	-	-	-	-	-
Occupation (χ^2= 20.2010; p = 0.164)						
Unemployed	40.96	17.78	28.89	8.89	-	4.44
Self employed	41.22	14.86	19.59	14.19	5.41	4.73
Student/apprentice	37.31	9.70	28.36	12.69	8.21	3.73
Others	57.97	13.04	14.49	7.25	2.90	4.35
Number of living children (χ^2= 25.4686; p = 0.184)						
0	37.74	11.79	24.53	14.62	5.66	5.66
1	47.44	11.54	26.92	7.69	5.13	1.28
2	50.88	14.04	15.79	10.53	5.26	3.51
3	57.58	18.18	6.06	3.03	6.06	9.09
4+	30.00	20.00	30.00	20.00	-	-

Source: Field Survey, 2011

Results from Table 17 show that, statistically, there is no significant association between the age of a respondent and the person who introduced a respondent to the abortion method used (χ^2= 27.1494; p = 0.131). It was however observed that in exception of the teenagers (15-19 age group) of whom about 31 percent were introduced to an abortion method (cytotec) by friends, more than 40 percent of respondents belonging to the age grouping (20-35+) were introduced to various abortion methods (i.e medication, MVA, D&C) by a medical practitioner. Fewer women (about 5 percent) aged 35 years and above were reported to have been introduced to an abortion method (medication) by a pharmacist. There were no reported observations that midwives introduced respondents who were 35 years and above to an abortion method, but referred them to a medical practitioner who introduced respondents to methods available in their facilities.

The marital status of a respondent statistically shows a significant association with the persons who introduced a respondent to the method used for terminating a pregnancy (χ^2= 20.8814; p = 0.022). About 66 percent of the previously married were introduced to the methods used for their abortions by a medical practitioner whilst only 3 percent were introduced to a method by either a friend or other identified groups of people such as pharmacy/chemical shop attendants, relatives and drug peddlers on the open market. This observation indicates that the previously married depended more on professional services probably to ensure that the pregnancy was professionally terminated in a safer environment. A respondent during the in-depth interview reported that:

'As a young widow, I still have many years ahead of me and will definitely remarry. This is why I sought advice from a medical practitioner on the best method to be used for an abortion to avoid any abortion related complications '(26 year old teacher).

There was no statistical significant association between educational background of a respondent and the person who introduced a respondent to the method used for an abortion (χ^2= 22.6561; p = 0.092). About 60 percent of respondents with higher educational backgrounds however, were introduced to an abortion method by a medical practitioner. It was only about 2 percent of respondents with higher educational backgrounds who were reported to have been introduced to an abortion method by other groups of people such as pharmacy/chemical shop attendants, relatives and drug peddlers on the open market. A respondent during the in-depth interview reported that:

'I was so much devastated when I realised I had become pregnant two months after I was raped in school. I did not know what to do with myself and the pregnancy. For two weeks, I kept to my room weeping daily until my mother discovered my situation and gave me some medications which I took to terminate the pregnancy' (21 year old medical student).

Another respondent reported that:

Despite my high educational background I had to rely on my mother's advice on the best method to be used for my abortion. This is because she had introduced people to various abortion methods in the past which were successful and had fast results (27 year old nursing student).

The religious affiliation of a respondent statistically was not significantly associated with persons who introduced a respondent to an abortion method (χ^2= 14.8088; P = 0.139). All respondents belonging to other religious affiliations such as Hinduism, Buddhism and African traditional religions were introduced to the method used for the abortion by a medical practitioner.

Statistically, there was also no significant association observed between the occupation of respondents and persons introducing a respondent to an abortion method (χ^2=20.2010; P = 0.164). Nevertheless, in exception of students/apprentice of whom about 37 percent had a medical practitioner introducing them to an abortion method used, over 40 percent of respondents who were either unemployed, self employed or belonging to other occupations, were introduced to the method used for an abortion by a medical practitioner. There was no reported record of midwives, introducing any unemployed respondent to any of the methods used for abortion.

The number of living children that a respondent had at the time of terminating a pregnancy was statistically not significantly associated with the person who introduced the respondent to the method used for the termination (χ^2=25.4686; P = 0.184). Medical practitioners were however reported to have introduced over 50 percent of the respondents having two or three living children to the methods used (D&C or MVA) for their abortions. There were no reported records of women having four or more children being introduced to an abortion method by either a midwife or other groups of people such as pharmacy/chemical shop attendants, relatives and drug peddlers on the open market.

The observation that medical practitioners were the single largest source of information on abortion method to the respondents indicates that, medical practitioners are either promoting safe abortion services in the Accra metropolis or providing 'abortion on demand' without adequately counseling clients on alternatives to induced abortion. This observation also confirms findings by Ekanem, et.al (2003) in their study which underscored the desperations of women getting rid of unwanted pregnancies and the over zealousness of medical practitioners doing everything possible to satisfy the request of people desiring termination of their unwanted pregnancies. In line with the conceptual framework (Figure 4) the desperation of women to have an abortion could be linked to a woman's perceived threats to abortion and this affected the factors considered in choosing a place for an abortion.

Decision on Abortion Methods in Health Facilities

As a pregnant woman arrives in a health facility for an abortion, her reasons for opting for an abortion in the health facility among others include privacy, confidentiality and safety (Figure 8). Consequently, another decision making point is the choice of method and/or options that will ensure that the reasons for opting to use a health facility for an abortion is accomplished. Among the various methods reported to have been used for pregnancy termination in the chosen health facilities include medication (about 45 percent), vacuum aspiration (about 41percent), dilatation and curettage (about 8 percent) and other methods such as laparotomy and hysterectomy constituting about 6 percent of the reported

abortion methods used. Analysis of abortion methods by background characteristics of respondents showed some significant association between the various background characteristics of respondents and the abortion methods used. For instance the age of respondents was significantly associated with the method used for the abortion (χ^2=34.49; P=0.001) (Table 18).

Table 18: Profile of Respondents and Abortion Method used in Health Facilities

Background characteristics	Abortion method used by respondents			
	Medication (n=180)	Vacuum Aspiration (n=166)	Dilation & Curettage (n=31)	Other (n=24)
Total	44.89	41.40	7.73	5.99
Age group (χ^2=34.49; P=0.001)				
15-19	63.27	28.57	0.00	8.16
20-24	54.48	38.06	5.22	2.24
25-29	31.53	50.45	10.81	7.21
30-34	41.54	44.62	9.23	4.62
35+	33.33	38.46	12.82	15.38
Marital status (χ^2=8.29; p=0.217)				
Never married	50.75	37.19	7.04	5.03
Married/ in union	36.53	47.90	8.38	7.19
Previously married	50.00	34.38	9.38	6.25

Table 18 continued.

Education (χ^2=9.69; p=0.376)				
None	40.74	44.44	11.11	3.70
Primary	50.98	33.33	9.80	5.88
Secondary	48.87	38.91	7.24	4.98
Higher	34.31	50.00	6.86	8.82
Religious affiliation (χ^2=13.08; p=0.042)				
Christian	43.56	40.80	8.59	7.06
Moslem	54.29	40.00	4.29	1.43
Other	0.00	100.00	0.00	0.00
Occupational status (χ^2=19.95; p=0.018)				
Unemployed	55.56	26.67	8.89	8.89
Self employed	38.51	43.92	10.14	7.43
Student/Apprentice	53.73	36.57	5.22	4.48
Other	34.78	56.52	7.25	1.45
Number of living children (χ^2=9.84; p=0.630)				
0	48.11	41.51	5.66	4.72
1	44.87	38.46	11.54	5.13
2	40.35	42.11	8.77	8.77
3	33.33	45.45	9.09	12.12
4+	45.00	45.00	10.00	0.00

Source: Field Survey, 2011

The teenage respondents (15-19 years) had the most observed medication abortion records of about 63 percent. None of the respondents in this age group opted for dilatation and curettage as a method for terminating their pregnancies mainly because of fear. A teenager during the in-depth interview reported that:

The doctor explained to my mother all the abortion methods available at his facility and the cost of each for her to decide. Because I was a virgin prior to becoming pregnant, and for the fear of possible complication which might affect my future reproductive intentions, we settled on the medication option for the termination (18 year old student).

It was also observed that majority (about 51 percent) of the vacuum aspirations occurred among respondents aged 25-29 years. It was noted from the in-depth interview that women of this age group wanted a onetime method that will give them an immediate relief from the trauma of carrying an unwanted pregnancy. A respondent reported that:

I had sleepless nights deciding on a method that will safely and completely be used to terminate this pregnancy without any prolonged side effects. At the hospital, I was introduced to the manual vacuum aspiration method which sounded quite a better option to me hence the choice of that method (27 year old legal practitioner).

About 15 percent of the respondents aged 35 years and above had either laparotomy or hysterectomy as a last option available to complete the abortion mainly on medical grounds of saving their lives in the hospital. A respondent described her experiences during the in-depth interview as follows:

'I kept bleeding with heavy blood clots weeks after I took a herbal preparation mixed with cytotec to terminate my pregnancy. I then went to a hospital for vacuum aspiration because I was told the medication I took did not work as expected. I later became very weak, had offensive vagina discharges with occasional fainting episodes. I one morning woke up in a hospital where I was told my husband rushed me after I had collapsed at home the previous night. In that critical condition, my badly damaged womb as I was told had to be removed to save my life (27 year old apprentice).

There was no statistical significant association between the marital status of a respondent and the choice of method used for terminating a pregnancy (χ^2=8.29; p=0.217). However about 51 percent of the never married and 50 percent of the previously married used a medication for inducing an abortion whilst about 48 percent of the married/in union opted for the vacuum aspiration method. The reasons given by the never married and the previously married for the choice of method as gathered from the in-depth interview were similar and were predominantly associated with having a method that they can take control over to ensure optimal privacy and safety. For instance, a respondent explained that:

I was told some medical practitioners in providing an abortion services to clients first rape them before the procedure is done. Because I did not want to expose my private parts to any provider which might have resulted into me being raped as reported by friends, I opted for something that I

can administer by myself hence the medication abortion option (35 year old business woman).

There was also no statistical significant association between the educational background of a respondent and the method used for an induced abortion in a health facility (χ^2=9.69; p=0.376). However, about 50 percent of respondents with primary level education and 50 percent of those with higher educational levels respectively used medication and vacuum aspiration options for their abortions in the health facilities visited for the termination. About 11 percent of respondents with no formal educational background resorted to dilatation and curettage option.

Statistically, the religious affiliation of respondents was significantly associated with the methods used for an induced abortion (χ^2=13.08; p=0.042). All the respondents (100 percent) belonging to the other religions such as Hinduism, Buddhism and African Traditional religions opted for vacuum aspiration, whilst more than half (about 54 percent) of respondents belonging to the Islamic faith used medications to have their pregnancies terminated. A respondent during the in-depth interview explained why she used the medication option for her abortion as follows:

As a Moslem woman, I felt guilty terminating my pregnancy. To me it was like killing an innocent child for which reason I had to isolate myself from prayers for some time. To achieve this, I opted for the medication abortion option because I was told with that option I will bleed for some time. Because my partner was not aware of the pregnancy, I thought I can

inform my partner to excuse me from prayers under the pretense that I am in my menses (30 year old moslem and house wife).

Another respondent was of the view that:

'I preferred to use cytotec for my abortion because, it is affordable and safer compared to the D&C. I was told with D&C, the doctor will have to insert things into your womb and when you are not lucky you may not be able to have children later in your life.' This might compound the guilt I already have as a Moslem woman terminating a pregnancy (21 year old pupil teacher).

There were also statistically significant associations observed between the occupation of respondents and their choice of method for an induced abortion in a health facility (χ^2=19.95; p=0.018). More than 35 percent of respondent across all occupational groups used the medication abortion option whilst majority of respondents (about 57 percent) reported to have belonged to other occupational groups such as security personnel, teachers and health workers opted for vacuum aspiration. A health worker explained her choice of vacuum aspiration during the in-depth interview as follows:

The medications I initially used for abortion failed on two consecutive times. Hence, I had to resort to vacuum aspiration because, by my professional knowledge intra uterine death of my feotus had already occurred after the first dose of the abortion medication for which reason, my uterus had to be evacuated at all cost, to prevent later complications (24 year old midwife).

Another respondent reported that:

I read extensively about the options available for induced abortion in hospitals and decided to opt for medication abortion because to me, it appears to have been the safest, most reliable, cheapest and convenient option among other available abortion methods. (26 year old nursing student).

There was no statistical significant association between the number of living children a respondent had at the time of terminating a pregnancy and her choice of an abortion method in a health facility providing the abortion service (χ^2=9.84; p=0.630). However, about 48 percent of respondents with no living child opted for medication abortion option in the facility. About 45 percent of respondents who had more than three living children opted for vacuum aspiration. There were no reported cases of opting for other abortion methods such as laparotomy and hysterectomy among respondents who had four or more children.

Available evidence from this study thus far indicates that, given the options, most women would prefer medication abortion to other methods of abortion in health facilities. Despite the observed high preference for medication abortion over other abortion methods in health facilities, there were reported instances during the in-depth interview, which suggest that some respondents had no choice than to complete their abortions with vacuum aspiration (manual or electric) in a health facility because initial doses for medication abortion failed. Additionally in some reported cases the last option resorted to in the hospitals was

laparotomy or hysterectomy to save the life of a respondent at the time of terminating a pregnancy when a complication occurred.

As it would have been expected, the decision on choice of method for an induced abortion in a health facility would have been based on clinical indications and findings from preliminary medical examination results and not necessarily the decision/choice of clients. It was however reported during the in-depth interview that, in some facilities, respondents were presented with the various methods available and the cost of each method from which they were to make a choice based on what they could afford and not based on any clinical indications for a method. In sharing her experience during the in-depth interview, a respondent reported that:

> *'At the hospital, I did not have any counseling. The doctor presented to me various methods available for abortion and the price list to make a choice. Because I wanted a painless and one time termination, I opted for Vacuum Aspiration under general anesthesia, which was quite expensive. When the abortion was done, I became sad and depressed for days because I realized I did not make an informed decision (24 year old secretary).*

The in-depth interviews also revealed that there was no use of Dilatation and Curettage (D&C) in the NGO facilities as an option for induced abortion. The use of D&C was more prevalent in the private hospitals/clinics mainly because of terminating mid-trimester abortions and/or managing incomplete abortions. Women also reported using herbal preparations and other forms of unorthodox methods as an initial step to induce abortion in the study area. In line with the

Conceptual Framework (Figure 4), an assessed self-efficacy to decide and implement abortion decisions inform choice of method to use for an abortion. Women who have power and means to make abortion decisions usually obtain abortion services from safer places because they are well informed and have the means to pay (UNFPA,1999).

Cost of Procuring Abortion Services

Global abortion studies have shown that the cost of abortion is not only limited to its monetary value because there are some other aspects that are considered as the cost to the pregnant woman and/or her partner. For instance, there are some possible costs due to the side effects of the procedure to the body as well as associated post abortion emotional effects (WHO 2006).

In this study however, the focus was only on monitory cost of abortion to the client. Findings indicate variations in the cost of abortion services by place where the service was obtained and the method used for the termination. About 58 percent of the respondents spent between 50-99 Ghana Cedis on pregnancy termination irrespective of the place of abortion and the method(s) used; about 16 percent spent less than 49 Ghana Cedis whereas about 6 percent spent between 200-400 Ghana cedis for an induced abortion (Table 19).

Table 19: Cost of Induced Abortion by Place and Method

Source of abortion & Method used	Cost of abortion in Ghana Cedis				
	<49 (n=66)	50-99 (n=232)	100-149 (n=43)	150-199 (n=35)	200-400 (n=25)
% Total	16.41	57.90	10.72	8.70	6.33
Place of abortion (χ^2=19.947; p=0.012)					
NGO hospital/clinic	4.91	95.10	0.00	0.00	0.00
Public hospital/clinic	11.20	47.71	16.81	13.10	11.23
Private hospital/clinic	12.11	41.40	17.21	20.71	8.61
Other	45.62	32.41	11.80	4.42	5.90
Abortion Method (χ^2=14.246; p=0.018)					
Medication	27.50	54.21	5.23	5.90	7.21
Vacuum Aspiration	6.50	64.53	15.91	8.04	5.13
Dilation & Curettage	7.72	53.80	15.43	11.51	11.50
Other	11.10	44.41	11.14	33.32	2.01

Source: Field Survey, 2011

Results presented in Table 19 indicate a significant association between place of procuring an induced abortion and the cost of service (χ^2=19.947; p=0.012). About 46 percent of respondents who indicated they had an abortion from 'other' sources apart from clinical environments, although such sources of abortion by the Ghanaian abortion standards could be described as unsafe, the study shows that the service was provided at a relatively cheaper cost (<49 Ghana cedis) to the client. Comparatively within the clinical environment, abortion services in NGO hospitals/clinics were the cheapest with about 95 percent of the respondents spending between 50-99 Ghana cedis for having their pregnancies terminated. There were no reported records of any respondent spending more than a hundred Ghana cedis on induced abortion in an NGO hospital/clinic in the study area.

The method used for pregnancy termination was also significantly associated with the cost of providing the service (χ^2=14.246; p=0.018). Medication abortion appeared as the cheapest abortion method available in the study area for which about 28 percent of the respondents spent less than 49 Ghana cedis for the service.

About 65 percent of the respondents who used vacuum aspiration method spent between 50-99 Ghana cedis whilst about 2 percent who used other abortion methods such as laparotomy or hysterectomy spent over 200 Ghana cedis on an abortion service. Regardless of where the abortion was done and the method used, respondents were further asked about their views on the cost incurred in having an induced abortion in the study area. Whereas about 48 percent of respondents

found the cost of abortion affordable because they had compared prices before deciding on place and method for the termination, about 2 percent had no idea about what to say because they in their opinion had no basis for abortion cost comparism (Figure 9).

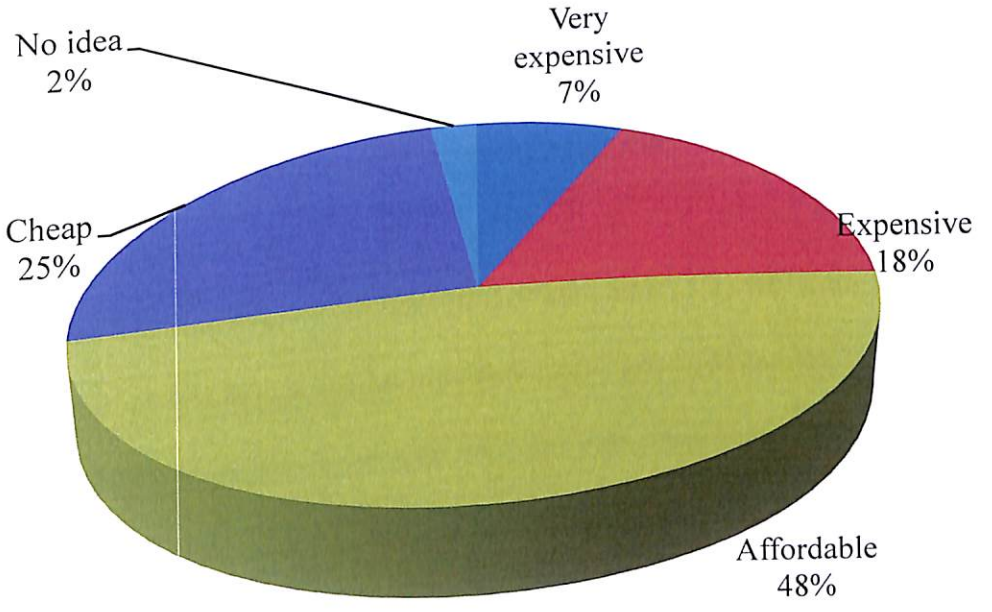

Figure 9: Respondents' perception about Cost of Abortion in Accra metropolis

Source: Field Survey, 2011

The in-depth interview reports indicate that respondents who saw the cost of abortion as very expensive constitute students/apprentices who had mid-trimester abortions in private hospitals/clinics. A respondent expressed her views on the cost of abortion as follows:

I had to sell some of my personal belongings to mobilise Ghc 350 to have my four-month old pregnancy terminated in a private hospital. To me this cost was very expensive but I had no choice because I certainly couldn't have coped with a pregnancy at the time it occurred (21 year old student).

The relationship observed between source of information on place of abortion, choice of place for abortion and methods being used for an abortion, might have been influenced by other variables such as, privacy of abortion method, safety, confidentiality, costs, accessibility, staff attitudes, availability of mid-trimester abortion services, willingness of service providers to advertise abortion services in the Accra metropolis publicly, as well as the wide availability of methods for pregnancy termination in non-clinical environments.

Advertising abortion services and methods requires a lot of tact and wisdom to overcome stigma and legal battles relating to the promotion of 'abortion on demand', which is reportedly being done well by NGOs and private abortion providers. With this innovative form of advertising by abortion providers in the Accra metropolis, public hospital procured abortion services may not be the first option for women when decisions on place for an abortion is being made, but may serve as an important last resort to manage any abortion related complications when they occur hence the likelihood of increasing numbers of post abortion care cases in public facilities.

The observation from the study that prior to going to a health facility for an abortion, about 4 in 5 of the unemployed women had first attempted a self-performed abortion using some form of medication procured from

pharmacy/chemical shops or on the open market is an indication that women generally would prefer self-medication to have a pregnancy terminated. This preference however poses a public health challenge. This is because even with high level of knowledge about medications used for induced abortion, as well as where to have abortion services in the Accra metropolis, good clinical practice requires some form of professional clinical assessment, prior to an abortion to identify potential health problems that must be medically addressed before, during and/or after an abortion for safety (Ipas, 2001; GHS,2007).

Another observation that mid-trimester (4+ months) abortions services are mostly available in private facilities although at higher charges creates an opportunity for unsafe abortion services in the Accra metropolis. This is because some private providers may not be licensed and may lack the minimum standards for mid-trimester abortions (Ghana Health Service, 2007). Additionally, the finding that medical practitioners are the single largest source of information on abortion method in the Accra metropolis is a probable indication that medical practitioners in the Accra metropolis are either promoting safe abortion services or providing 'abortion on demand' without adequately counseling clients on alternatives to induced abortion.

An assumption of this study that women who sought mid-trimester abortions were those likely to have had challenges with collaborators for required resources for abortion was supported by Lithur 2004; Mayhew & Adjei 2004. Some women who were observed as vulnerable and disadvantaged become victims of unsafe abortion out of desperation to have an abortion at all cost. To

reduce the incidence of unsafe abortions as well as mitigate any negative consequences associated with providing abortion on demand there is an urgent need to develop strategies that would address these problems on different fronts. This finding points to unavailability of mid-trimester abortion services in public health facilities within the Accra metropolis and the high cost of such services in the private sector as a major barrier that limits disadvantaged women from accessing abortion services as permitted by law at safer places. Findings by Baker and Khasiani (1992), on the cost of abortion services in Kenya support that of the current study. Self efficacy of a woman seeking abortion as indicated in the conceptual framework (Figure 4) is informed by women's ability to pay for an abortion when required. Thus the ability to pay for an abortion determines place and method used regardless of gestation of pregnancy at time of termination.

CHAPTER SEVEN

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

The study has made some observations from the analysis and the discussions of the research findings presented in chapters 4, 5 and 6. The overall view is that processes involved in making a decision for induced abortion are multi-faceted in nature. This chapter therefore presents a summary of the study, its key findings, conclusions, recommendations, contribution to knowledge in the area of abortion decision-making and proposed areas that require further research.

Summary

The main objective of this study was to assess decision-making for induced abortion in the Accra metropolis. To achieve this broad objective, the study focused on background characteristics of respondents, reasons for abortion, key collaborators involved in the abortion decision-making, factors influencing choice of place and method for abortion. After reviewing relevant empirical and theoretical literature relating to the research topic, the Health Belief Model was adapted as the conceptual framework to drive the study. The study design was a retrospective and cross sectional based study. Using a mixed method approach, quantitative data were obtained from 401 randomly sampled women and qualitative data from 35 purposively sampled women who have had induced abortion within the Accra metropolis between January and December, 2010. The

Ghana Health Service reviewed and approved the research proposal. Data collection took a period of seven months (June-December 2011). The data analysis was done using SPSS version 16 and STATA version 8. Qualitative data were analyzed manually and results discussed in line with the research objectives to respond to the research questions raised.

The study found that, decision-making for induced abortion is a process that hinges on the profile of a woman in need of an abortion service. Women of various background characteristics made different abortion decisions for many reasons. The decision-making process as observed, was complex and multifaceted, because, issues such as person responsible for the pregnancy, circumstances surrounding onset of pregnancy, initial reaction to pregnancy when it was noticed, stakeholder influences, perceptions, availability and affordability of abortion services to women in need affected the abortion decision-making process.

Young women between the ages of 20-24, women who have never married, the self-employed, women who have no living children, women with secondary level education and those belonging to the Christian faith, were observed as those having the highest induced abortions in the Accra metropolis. More than half (about 55 percent) of the respondents, prior to having an induced abortion had a secondary level of education. All respondents belonged to at least one religious affiliation (i.e. Christians, Moslems, Hindus, Buddhist and African Traditional Religions) yet, religion was not significantly associated with abortion

decisions. There were high reported cases of pregnancy termination among women with no living children for various reasons.

The decision for an induced abortion was reported to have begun with a woman's initial reaction towards pregnancy when it was first discovered. Among the initial reactions observed include, the feeling of shock, guilt, worry, embarrassment and happiness. These feelings were dependent on the background characteristics of the women and the circumstances surrounding the onset of a pregnancy. Marital status of a woman at the time of pregnancy was also significantly associated with a woman's initial reaction towards pregnancy (χ^2=29.59; p=0.000). The majority of the respondents (about 65 percent) were worried and shocked at the time they became pregnant, hence, the need for an abortion because, they did not want a child at the time. It was also noted that, some married women who were forced into marriages had their pregnancies terminated and pretended as though it was a miscarriage.

The reasons given by the married/in union women for pregnancy termination were similar to their unmarried counterparts. For the married women however, the decision for an induced abortion was made with much more rationalization and reflection over the immediate situation, consequences, future implications on their reproductive intentions and relationships with their spouses before and during pregnancy. Pressure from a sexual partner to have an induced abortion was also observed as a major push factor for having an abortion particularly among women within the 30-34 age group. The strict enforcement of religious standards that prohibit premarital pregnancy in some churches was also

noted as a major push factor for having an abortion particularly among young women prior to church weddings.

There was a statistical significant association between occupation and decision for an induced abortion. Some carrier women and students used induced abortion as a means to delay or space childbirth so as to meet their set carrier/educational objectives. Consequently, first time pregnancies were mostly aborted than subsequent ones. Additionally, repeat induced abortions were most common among the unmarried respondents. The absence of a living biological child did not prevent women, not even those in stable marital relationships, from having an induced abortion when abortion was deemed very necessary at the time a pregnancy occurred.

The gestation of pregnancy did not hinder abortion decisions because, there were marked variations in the gestation periods of pregnancy at termination. First trimester (1-3 months) abortions recorded the highest abortion numbers (about 76 percent), compared to terminations during advanced gestational ages. The test of the hypothesis on occupation and gestation at pregnancy termination indicates no significant association between occupational status of a woman and gestation period at which a pregnancy is terminated. Rather, persons responsible for a pregnancy were noted to have influenced the gestation period at which a pregnancy was terminated. For instance, among those impregnated by a rapist or blood relation, more than half (about 57 percent) of the women had a termination at one month gestation, which suggests that, the decision and action for the termination was quick. The decision for mid-trimester abortion (abortion at 4+

months) was observed as a difficult decision for the respondents but it was taken as a means of escaping a situation that was negatively affecting the health, education, social life and/or carrier development of the pregnant woman.

The study observed that various people were involved in the abortion decision-making process. The choice of these collaborators began with the characteristics of persons responsible for the pregnancy. It was noted that, when a woman became pregnant, various people (i.e. sexual partners, friends, rapists and blood relations) were allegedly reported to have been responsible for the pregnancy. Majority of the respondents (about 64 percent) reported to have been impregnated by their boyfriends, whilst pregnancies resulting from sex related offences were predominant among young women between the ages of 15-24 years.

Because the pregnancy was unwanted at the time it occurred, the pregnant women had to first inform certain people (e.g. sexual partners, friends, health workers and blood relations), who were perceived as relevant at the time, about the occurrence of a pregnancy for help in deciding on the pregnancy outcomes. Although majority of the women (74 percent) first informed a partner when a pregnancy occurred, few women (about 7 percent) including those in stable marital relationships, hid the pregnancy from their sexual partners due to personal dislike of their partners.

The person who was first informed about a pregnancy when it was discovered, was the same person reported as a key collaborator to have the pregnancy terminated. The extent and level of collaboration with such people on

abortion decision-making was however dependent on the background characteristics of the respondents and their expectations. The main reasons women enumerated for collaborations during abortion decision-making included soliciting financial and emotional support for the termination, direction to abortion provider, consenting for an abortion, advice/education on expectations during and after the abortion, safety as well as a general feeling of doing the right thing by involving significant others in the abortion decision-making process.

It is worthy of note that, the one who consented for the abortion to be performed also took the final decisions to have the abortion done. It was evident that if the person expected to have given the final consent for an abortion declined, then the abortion was likely not to have been performed or as likely to have been delayed. More than 60 percent of the respondents aged 30-34 years collaborated more with their partners and had their partners' consent to have an abortion. It was also noted that about 39 percent of respondents (teenagers) made their own abortion decisions and procured over-the-counter medications from pharmacy shops to self induce abortion.

Partner involvement and dependency for final consent in abortion decision-making appeared to have arisen for reasons of financial and emotional support during pregnancy termination. In some reported situations however, partner involvement was due to the insistence of the male partners for reasons of distrust or to be rest assured that the pregnancy was real and has been successfully terminated. Women whose collaborators in the abortion decision-making process

supported their decision to terminate a pregnancy were quick to abort their pregnancies and had it done within the first trimester.

Others were completely alone in the decision making process which delayed the time for the abortion hence the late terminations observed among some respondents. There was however no significant association between a woman's marital status and her decision to have an abortion without anybody's consent. There was also no evidence that women who did not collaborate with anybody during abortion decision-making processes nor sought any body's consent for the abortion had any adverse effects during pregnancy termination.

Another decision-making point for induced abortion was the choice of place for the termination. A number of factors such as privacy, safety, confidentiality, costs, accessibility, staff attitudes and availability of mid-trimester abortion services were some of the key considerations for women choosing a place for an abortion in the Accra metropolis. About 78 percent of women had their abortions initiated in a clinical environment (i.e. NGO, public and/or private hospital/clinic) whilst the rest (22 percent) had it in non-clinical environments.

Mid-trimester (4+ months) abortions were mostly patronized in private facilities compared to the public and NGO facilities. It is worth noting that, prior to going to a health facility for an induced abortion, about 56 percent of the unemployed women had first self-attempted abortion using some form of medication procured from pharmacy/chemical shops or on the open market. Most women involved in this went to a hospital only when there was an abortion failure or a complication.

It was also noted that, prior to choosing a place for an abortion, some consultations were made with people perceived by respondents as resourceful. The reported sources of information on place and method for abortion in the study area ranged from, electronic media to friends through word of mouth. About 85 percent of women reportedly heard of the place of abortion through 'word of mouth' [i.e. friends (50.87%), sexual partners (27.18%) and family members (6.48%)]; whilst others were through inter hospital referrals. This observation implies that, marketing induced abortion in the Accra metropolis was predominantly by 'word-of-mouth'.

Choosing a method for induced abortion was another decision-making point. Various people (i.e. medical practitioners, pharmacists, friends, partners, midwives pharmacy/chemical shop attendants, relatives and drug peddlers) were noted as those who introduced women to the methods used for their abortions. Among the methods reported to have been used for an abortion were, medication (about 45 percent), vacuum aspiration (about 41 percent) as well as dilatation and curettage (about 8 percent). Laparotomy and hysterectomy constituted about 6 percent of the reported abortion methods used mainly at the hospital level to manage complications emanating from unsafe abortion.

Statistically, the age, religious affiliation and occupational status of a pregnant woman showed a significant associated with the choice of methods used for pregnancy termination. Respondents, regardless of their background characteristics, indicated that, given the option, they would prefer medication abortion to other abortion methods to have optimal privacy and self-control over

the termination. This was emphatic in the response of young people age 15-19 years of whom about 63 percent reported their preference for medication abortion option. Nevertheless, about 51 percent of the vacuum aspirations occurred among respondents aged 25-29 years, because they wanted a one-time method that could give them an immediate relief from the trauma of carrying an unwanted pregnancy. Laparotomy/hysterectomy was reported abortion method undergone by about 15 percent of respondents aged 35 years and above. This was mainly done to manage complications that occurred during abortion to save lives.

The use of Dilatation and Curettage (D&C) was reported to have been more prevalent in the private hospitals/clinics. Herbal preparations and other forms of unorthodox methods used to induce abortion were still being used and patronized by women in the Accra metropolis. There was however no reported use of, dilatation and curettage for an abortion in any of the NGO facilities in which respondents had their terminations. The method used for pregnancy termination was significantly associated with the cost of termination (χ^2=14.246; p=0.018).

Generally, respondents indicated that the cost of induced abortion in the Accra metropolis was affordable (48 percent). However, those who were students/apprentices indicated that, mid-trimester abortion services obtained from private hospitals were very expensive. About 58 percent of women spent 50-99 Ghana cedis on abortion irrespective of place of abortion and method(s) used. About 16 percent spent less than 49 Ghana Cedis, whereas about 6 percent spent 200-400 Ghana cedis. Comparatively, over-the-counter drugs and abortificients

from the open market were the cheapest sources of abortion for women in the Accra metropolis. Women who successfully used these sources of abortion spent less than 49 Ghana cedis.

As would have been professionally expected, a decision on choice of method for an induced abortion in a health facility should have been based on sound clinical indications and findings from preliminary medical examination results and not necessarily the decision/choice of clients or provider (GHS, 2007). On the contrary, it was noted that, in some facilities that respondents had their abortions, they were only presented with the various abortion methods available and the cost of service from which they were to make a choice which was not based on any clinical indications or counseling. Some abortion providers were reported to have been the final abortion decision-makers. In some instance, respondents' later discovered that, they were misinformed about details of the abortion to either spare their feelings or extort money from them, which made them later regret their decisions to have an abortion or suffer emotionally.

Conclusions

The under listed conclusions are drawn based on the research findings. The profile of women seeking induced abortion services in the Accra metropolis indicates that women are using induced abortion as a family planning method, which is not a recommended health practice by WHO.

The reported prohibition of premarital pregnancy with its associated sanctions imposed on women found pregnant before marriage within the Christian

faith, might account for the incidence of induced abortion among young unmarried Christian women prior to weddings in order to avoid embarrassment.

Factors that influenced abortion decisions in the Accra metropolis were complex and multifaceted. Although the background of pregnant women had inform decisions for induced abortion, other factors such as circumstances surrounding onset of pregnancy, person responsible for the pregnancy and societal pressure could push a woman to have an induced abortion against her wish. Discussions on induced abortion should therefore be done in a non-judgmental manner because, for some women, it is a last solution to problems encountered.

The findings that some married women who are forced into marriage might have their pregnancies secretly terminated and pretend as though it was a miscarriage, calls for thorough marital counseling and consent of women for the marriage before marriage rites are performed.

The levels of induced abortions observed among students/apprentices are attributable to strict policies that prohibit women at certain stages of education from becoming pregnant. There is therefore a need to review national policies that relate to pregnancy whilst in school/apprenticeship, to enable women, who become pregnant whilst pursuing educational or carrier development programmes in certain institutions, to have their babies if they so desire, without any imposed sanctions such as dismissal. This will prevent women in school/apprenticeship from having induced abortions against their wish.

Various people collaborated with a pregnant woman during abortion decision-making process. Although the profile of a pregnant woman might be

central to an abortion decision-making, the interest of collaborators involved in the decision-making process might push a pregnant woman to have an abortion against her wish due to limited self-efficacy and autonomy in decision-making.

The finding that medical practitioners were the single largest source of information on abortion method in the Accra metropolis is a probable indication that medical practitioners in the Accra metropolis are either promoting safe abortion services or providing 'abortion on demand' without adequately counseling clients on alternatives to induced abortion.

The observation that about 78 percent of women seeking abortion services in the Accra metropolis would visit a hospital for an abortion provided issues of privacy, safety, confidentiality, costs, accessibility, staff attitudes and availability of medication abortion services could be assured them, calls for repackaging safe abortion campaigns in Ghana to prevent self-medications for induced abortion.

The limitation of mid-trimester abortions to private facilities at high cost as reported by the vulnerable population (students/apprentices) could pose a public health challenge of unsafe abortion in the Accra metropolis if Ghana Health Service does not make adequate provisions in the public health facilities to respond to demands of mid-trimester abortion services.

The observation that, given the options, pregnant women who seek an abortion would prefer medication abortion against other abortion methods due to cost, privacy and convenience, is a wake-up call to the Ghana Health Service, Ministry of Health and partners to repackage safe abortion campaigns to highlight safer ways of using medication abortion to prevent abuse and complications.

The observation that decision-making process for induced abortion is multifaceted implies it involves not only women but also significant others such as partners, family or community, and these actors interact with health facilities and providers, formal and informal as well as with legal and religious institutions. Economic constraints, lack of power, lack of financial autonomy, male domination, values and attitudes towards abortion, ensuring sexual and reproductive rights and poor quality of care are some of the key issues that hinder women's "free" decision for induced abortion in Ghana.

Recommendations

Findings from this study have the under listed implications for public health policy and programme interventions. About policy interventions, it is being recommended that the Ministry of Health should:

1. Renew efforts at making elective mid-trimester abortion services within public health facilities in the Accra metropolis accessible and affordable to clients when needed. An integration of abortion services into a health insurance scheme with an aim to prevent maternal mortality and morbidity resulting from unsafe abortions will be in the right direction towards meeting the millennium development goal 5.

2. Formulate policy directives against use of abortion as a family planning method in communities. Additionally, the Ghana Health Service should coordinate the implementation. The feasibility of arranged adoption of babies by couples or individuals, who need babies but could not make one biologically,

could be further explored as alternative options to aborting unwanted mid-trimester pregnancies that are not based on medical grounds.

The Ghana Food and Drugs Authority should come out with a statement condemning the wide unregulated sales of abortificients in chemical and pharmacy shops and strengthen monitoring systems to regulate such unsafe practices within the Accra metropolis.

The Ministry of Gender, Children and Social Protection should make pregnancy whilst in school a human right issue so that, women found pregnant in schools would not be dismissed. This will enable them to have their education uninterrupted if they can cope with academic requirements and challenges of pregnancy whilst in school.

The National Population Council should review the existing National Population Policy to incorporate emerging issues relating to induced abortion in Ghana to guide national advocacy strategies for policy decision-making on safe abortion as a population issue in Ghana.

The study also made some recommendations for programme interventions. The study called on the Ghana Health Service to use findings of this study to:

1. Solicit funding for disseminating information and public education on the abortion laws of Ghana and the abortion standards and protocols to inform public decision-making for safe abortions services.
2. Develop health promotion campaigns against the use of induced abortion as a family planning method as against contraception for family planning.

3. Guide and facilitate efforts needed by other ministries, departments and agencies including Non-Governmental Organizations (NGO) and religious bodies to provide focused interventions on prevention of induced abortion. The reasons identified in this study for induced abortion could be used in developing indicators required in assessing and financing reproductive health programmes focused on reducing unsafe induced abortions to save lives.

The study also recommended that the Christian Council of Ghana should use findings of this study as an evidence-based resource material to address concerns of women who might have wanted a pregnancy but had to resort to an induced abortion prior to church weddings in order to avoid embarrassment by the church. This observation is an indication of challenges faced by the Christendom to enforce religious doctrines relating to premarital sex and pregnancies. Evidence from this study indicates a need for churches to introduce sex education in church programmes to guide young women to make informed sexual and reproductive health choices including decisions on safe abortion.

Contribution to Knowledge

Phillips and Pugh, (1994: 61–2) indicated that, within the context of doctorial research, an original contribution to knowledge is a very shaded term since it does not mean an enormous breakthrough in research but rather to demonstrate that one has a good grasp of how research is normally done in a proposed area of study being specialized in. Similarly, Silverman (2007:180-184), also argued that within the context of demonstrating an independent critical

thought by a researcher, the ability to contribute to knowledge could be displayed in four key areas (i.e developing a concept, thinking critically through the methodology, building on an existing study and being prepared to change directions). In this regard, this study can be seen as generally contributing to knowledge in the field of sexual and reproductive health, specifically in induced abortion in Ghana. Among the modest contributions made by this study to knowledge in this area are:

First, few abortion studies in Ghana explore decision-making processes. Studies that attempted to investigate this phenomenon focused on secondary data from hospital admission records or from patients admitted in hospitals for abortion related complications. The current study examined the decision-making process for induced abortion, tracing respondents to the community after they had terminated a pregnancy. The study also combined both qualitative and quantitative tools backed with relatively sound ethical considerations.

Second, there are limited studies in Ghana that adopted qualitative approaches to unearth what informs women's decision for induced abortion, with respect to the collaborators involved in their decision making process, factors that influenced their choice of place for an induced abortion, methods used as well as the implications of abortion law on their decision making process. The current study to a large extent, has been able to provide information on these issues.

Third, the present study has also statistically highlighted the level of associations between selected background characteristics of women with respect

to the core identified indicators that influenced or were likely to have influenced an abortion decision making process within the study area.

Fourth, abortion studies in Ghana have so far been biased towards unmarried women. In building on previous knowledge in this area, this study had to an extent been able to demonstrate that induced abortion among married women is becoming an immerging issue in Ghana with some married women having late trimester abortions for various reasons; some of them do not even inform their partners. The observation that some married women who are forced into marriage would become pregnant to please significant others, but would later deliberately have a termination and pretend as though it was a miscarriage, should inform marriage counselors, husbands and significant others not to underestimate the power of women when decisions on marriage and pregnancy are being made.

Fifth, this study thus far revealed that induced abortion occurs among women with varying background characteristics. Statistically the study has demonstrated that there is an association between background characteristic of a woman and her choice of place for an induced abortion. Women who seek an induced abortion may be more concerned about the conditions under which the abortion will be done, cost of service, the care she will receive after the abortion, the medical consequences of abortion and implications for her future reproductive intentions. This information would be useful to the Ghana Health Service and its partners in designing advocacy programmes on safer choices of place for induced abortion when required.

Areas for Further Research

First, the study was limited only to the Accra metropolis and it covered a short period (i.e. January-December 2010). Such a study should be replicated in other metropolises of Ghana as well as in other countries to see if there are any similarities or variations in abortion decision-making processes to inform public health policy and programme interventions.

Second, the background characteristics of respondents examined were limited to age, marital status, education, religious affiliation, occupation and number of living children. Such a study can also be replicated to include more background variables such as years of marriage, wealth quintiles and ethnicity to explore if these additional background characteristics have any significant implications on decision-making for induced abortion in Accra metropolis.

Third, the study focused only on decision-making processes by women and did not solicit information on the men responsible for the pregnancies. This study can also be replicated to include sexual partners as well to have a comparative assessment of differences in the decision-making by male sexual partners for induced abortion and that of females in the Accra metropolis.

Fourth, over-the-counter procured abortificient for self-induced abortions appears to be highly patronized in the Accra metropolis. A study on the incidence of post abortion complications emanating from over the counter use of abortificients in the Accra metropolis would provide some evidence to facilitate an objective discussion of issues and the formulation of programmes relating to self-induced abortions in Ghana.

Fifth, it was evident from the study that, women terminated their pregnancies mainly because they wanted a child later. A study on contraception and induced abortion in the Accra metropolis would be relevant to explore why women are using induced abortions as a family planning method despite availability of various contraceptive methods/options in the Accra metropolis.

BIBLIOGRAPHY

Aboagye, P. K., Hailemichael, G., Quansah-Asare, G., Mitchell, E.M.H., & Addy, J. (2007). *Assessment of the Readiness to offer Contraceptives and Comprehensive Abortion Care in the Greater Accra, Eastern and Ashanti Regions of Ghana.* Chapel Hill, NC: Ipas.

Abraham, C., & Sheeran, P. (2005). The health belief model. In: Conner, M., Norman, P. (2005) *Predicting Health Behaviour.* Maidenhead: Open University Press.

Adanu, R.M.K., Ntumy, M.N., & Tweneboah, E. (2005). Profile of Women with Abortion Complications in Ghana. *Journal of Tropical Medicine. 35*:139–142.

Adanu, R.M.K., & Tweneboah, E. (2004). Reasons, Fears and Emotions behind Induced Abortions in Accra, Ghana. *Research Review, 20* (2): 1–9.

Ahiadeke, C. (2001). Incidence of Induced Abortion in Southern Ghana. *International Family Planning Perspectives, 27*(2): 96-101 & 108.

Åhman, E., & Shah, I. (2002). Unsafe Abortion: Worldwide Estimates for 2000, *Reproductive Health Matters, 19*: 13–17.

Åhman, E., & Shah, I. (2004). *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2000.* Fourth ed., Geneva: World Health Organization.

Ajzen, I. (1985). *From Intentions to Actions: A Theory of Planned Behaviour* in Kuhl, J. & Beckmann, J. (ed.) Action-control: From Cognition to Behaviour Heidelberg: Springer, pp 96-105.

Ajzen, I. (1991). The Theory of Planned Behaviour. *Journal of Organizational Behaviour and Human Decision-making Processes, 50*: 179-211.

Ajzen, I. (1988). *Attitudes, Personality and Behaviour.* Buckingham Open University Press. Englewood Cliffs, NJ: Prentice-Hall.

Ajzen, I., & Fishbein, M. (1980). *Understanding Attitudes and Predicting Social Behaviour.* Englewood Cliffs, NJ: Prentice-Hall.

Ajzen, I., & Madden, T.J. (1986). Prediction of Goal-directed Behaviour: Attitudes, Intentions and Perceived Behavioural Control, *Journal of Experimental Social Psychology, 22*: 453-474.

Akosa, A.B. (2004). Induced Abortion in Ghana. *Annual Lecture Series 25,* Ghana Medical Association. Accra.

Alan Guttmacher Institute, (1999). *Sharing Responsibilities: Women, Society, and Abortion Worldwide.* New York: The Alan Guttmacher Institute.

Alan Guttmacher Institute (2012). *Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008.* New York, USA. Accessed from: gsedgh@guttmacher.org on 10/4/2013.

Alliance for Reproductive Health Rights., Ipas., & Marie Stopes International Ghana. (2008). *Project Swan-Baseline Research for a KAP Study on Abortion in Ghana.* Final Report- Unpublished.

Aras. R., Pai, N.P., & Jain, S.G. (1987). Termination of Pregnancy in Adolescents. *Journal of Postgraduate Medicine 33*(3): 120-124.

Awusabo-Asare, K., Biddlecom, A., Kumi-Kyereme, A., & Patterson, K. (2006). *Adolescent Sexual and Reproductive Health in Ghana: Results from the*

2004 National Survey of Adolescents. Occasional Report, New York: Guttmacher Institute, 2006, No. 22.

Babbie, E.R. (1989). *The Practice of Social Research.* 5th Edition. Belmont CA: Wadsworth.

Baiden, F. K., Amponsa-Achiano, A.R., Oduro, T.A., Mensah, R., & Hodgson A. (2006). Unmet Need for Essential Obstetric Services in a Rural District in Northern Ghana: Complications of Unsafe Abortions Remain a Major Cause of Mortality, *Journal of the Royal Institute of Public Health, 120*(5): 421–26.

Baker, J., & Khasiani, S. (1992). *Induced Abortion in Kenya: Case Histories.* Management Sciences for Health, Boston, MA 02130.

Bankole, A., Sedgh, G., Oye-Adeniran, B.A., Adewole, I.F., Hussain, R., & Singh, S. (2008). Abortion-seeking Behavior Among Nigerian Women. *Journal of Biosocial Science, 40*(2):247-68.

Bankole, A., Singh, S., & Haas, T. (1998). Reasons Why Women Have Induced Abortions: Evidence from 27 Countries. *International Family Planning Perspectives, 24*(3):117-27.

Basen-Engquist, K., & Parcel, G.S. (1992). Attitudes, Norms and Self-efficacy: A Model of Adolescents' HIV-related Sexual Risk Behaviour. *Health Education Quarterly, 19*: 263-277.

Beck, K.H. (1981). Driving while under the Influence of Alcohol: Relationship to Attitudes and Beliefs in College Population. *American Journal of Drug and Alcohol Abuse, 18*: 377-388.

Becker, M.H. (1978). The Health Belief Model and Personal Health Behaviour. *Health Education. Monographs, 2* (4).

Becker, M.H., Radius, S.M., & Rosenstock, I.M. (1978). Compliance with a Medical Regimen for Asthma: a test of the Health Belief Model, *Public Health Reports, 93*: 268-77.

Bentham, J. (1873). *Introduction to Utilitarianism,* Accessed: on 15th June 2010 from: http://www.utilitarian.org/utility.html#note

Bentler, P.M., & Speckart, G. (1979). Models of Attitude-behaviour Relations, *Psychological Review, 86*: 452-464.

Bennett, L.R. (2001). Single Women's Experiences of Premarital Pregnancy and Induced Abortion in Lombok, Eastern Indonesia. *Reproductive Health Matters 9*(17):37-43.

Beauchamp, T., & Childress, J. (2001). *Principles of Biomedical Ethics*, 5th Ed, Oxford: Oxford University Press.

Blanc, A.K., & Grey, S. (2002). Greater than expected Fertility Decline in Ghana: Untangling a Puzzle, *Journal of Biosocial Science*, *34*(4):475-495.

Blaikie, N. (2000). *Designing Social Research: The Logic of Anticipation.* Oxford: Polity Press.

Bleek, W. (1981). *Avoiding Shame: the Ethical Context of Abortion in Ghana.* Accessed from www.popline.org/docs/0529/006226.html on 7th July, 2009.

Brewis, A., & Meyer, M. (2005). Marital Coitus across the Life Course. *Journal of Biosocial Science 37*(4): 499–518.

British Broadcasting on Religions, (2009). Accessed: on 10th June 2010. from:http://www.google.com/search?hl=en&rlz=1W1SKPB_en&q=Hindu ism+and++abortion&aq=f&aqi=g1&aql=&oq=&gs_rfai=

Brookman-Amissah, E. (2004). Woman-centered Safe Abortion Care in Africa. *African Journal on Reproductive Health, 4* (1): 37-42.

Buah, F.K. (1980). *A history of Ghana.* Accra: MacMillan Publishers.

Buga, G.A.B. (2002). Attitude of Medical Students to Induced Abortion. *East African Medical Journal, 79* (5): 259-262.

Bùi, K.C., Gammeltoft, T., Nguyen, T.T., & Rasch, V. (2004). *Induced Abortion among HIV-positive Women in Quang Ninh and Hai Phong, Vietnam.* Institute for Population and Development Studies, General Office for Population and Family Planning, Hanoi, Vietnam.

Campbell, S., & Lees, C. (2000). *Obstetrics by Ten Teachers.* 17th Edition. New Delhi. Edward Arnold (pp. 269-271).

Carlson, D.S., Kacmar, K.M., & Wadsworth, L.L. (2002). The Impact of Moral Intensity Dimensions on Ethical Decision Making: Assessing the Relevance of Orientation. *Journal of Managerial Issues, 14*(1), 15-30.

Catholic Encyclopedia, (1981). *St. Augustine on Faith and Reason. 5*: 808.

Chhabra. R., Gupte. S.N., Mehta. A., & Shande. A. (1988). MTP and Concurrent Contraceptive Adoption in Rural India. *Studies in Family Planning 19*(4): 244-247.

Chia-Sze-Foong. (1982). A Study of Characteristics of Women Seeking Abortion in Malaysia. *Medical Journal of Malaysia, 37*(4):318-21.

Clements, S., & Madise, N. (2004). Who is being Served Least by Family Planning Providers? A Study of Modern Contraceptive use in Ghana, Tanzania and Zimbabwe, *African Journal of Reproductive Health, 8*(2): 124–136.

Coleman, P.K., & Nelson, E.S. (1999). Abortion Attitudes as Determinants of Perceptions Regarding Male Involvement in Abortion Decisions. *Journal of American College of Health, 47*(4):164-71.

Conner, M., & Norman, P. (1996). *Predicting Health Behavior. Search and Practice with Social Cognition Models.* Open University Press: Ballmore: Buckingham.

Conner, M., & Sparks, P. (1996). The Theory of Planned Behaviour and Health Behaviours in *predicting Health Behaviours.* In Conner, M. & Norman, P. (eds). pp121–162. Buckingham: Open University Press.

Creswell, W.J. (2003). *Research Design: Qualitative, Quantitative and Mixed Methods Approaches,* Second Edition. New Delhi: Sage Publication Inc.

Crissman, H.P, Adanu, R.M.K., & Harlow, S.D. (2012). Women's Sexual Empowerment and Contraceptive use in Ghana. *Studies on Family Planning 43*(3):201-12.

Dalvie, S. (2008). Second Trimester Abortions in India. *Reproductive Health Matters 16* (31) (May supplement): 37-45.

Devi, T.I., & Akoijam, B.S. (2007). Characteristics of Primi-gravid Women Seeking Abortion Services at a Referral Center in Manipur. *Indian Journal of Community Medicine, 32* (3): 175-77.

Diejomaoh, F.M.E. (2004). *Abortions in Agboola, Textbook of Obstetrics and Gynaecology for Medical Students.* Vol. 1. Ibadan Heinemann Educational Books. pp.103-126.

Dillard, P., & Pfau, M. (2004). *The persuasion handbook: Developments in theory and practice* (pp. 259 – 286). Thousand Oaks, CA: Sage.

Dodoo, F.N., & Frost, A.E. (2008). Gender in African Population Research: The Fertility/Reproductive Health Example. *Annual Revision Sociology 34*:431-52.

Ekanem, A.D., Etuk, S.J., Udoma, E.J., & Ekanem, I.A. (2003). Fertility Profile following induced abortion in Calabar, Nigeria. *Tropical Journal of Obstetrics and Gynaecology, 20*:89-92.

Ekstrand, M., Tydén, T., Darj, E., & Larsson, M. (2007). *An Illusion of Power: Qualitative Perspectives on Abortion Decision-making Among Teenage Women in Sweden.* Department of Public Health and Caring Sciences, Uppsala University, Uppsala, Sweden.

Ellis, F. (2000). *Rural Livelihoods and Diversity in Developing Countries.* New York: Oxford University Press Inc.

Fishbein, M., & Ajzen, I. (1975). *Belief, Attitude, Intention, and Behavior: An Introduction to Theory and Research.* Reading, MA: Addison-Wesley.

Finer, L.B., Frohwirth, L.F., Dauphinee, L.A., Singh, S., & Moore, A.M. (2005). Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives. *Perspectives on Sexual and Reproductive Health 37* (3):110–118.

Font-Ribera, L., Pérez, G., Salvador, J., & Borrell, C. (2007). *Socioeconomic Inequalities in Unintended Pregnancy and Abortion Decision.* Health Information Service, Agency of Public Health of Barcelona, Barcelona, Spain.

Francke, A. (1978). *The Ambivalence of Abortion.* New York: Random House.

Ganatra, B.R. (2000). *Abortion Research in India: What we Know and What we Need to Know.* In: Ramasubban R, Jejeebhoy S, Editions. Women's Reproductive Health in India. Jaipur: Rawat Publications, pp 186-235.

Ganatra, B.R., & Hive, S.S. (2001). Ethical Dilemmas in Social Science Research-A Field Study on Induced Abortion. *Issues in Medical Ethics, January, 9* (1).

Ganatra, B.R., & Hive. S.S (2002). Induced Abortions Among Adolescent Women in Rural Maharashtra. *Reproductive Health Matters, 10* (19): 76-85.

Gbagbo, F.Y. (2006, July 8). Abortion-related Deaths are Preventable. *Daily Graphic*, pp. 11.

Geelhoed, D.W., Nayembil, D., Asare, K., Leeuwen, J. S., & Roosmalen. J. (2002). Contraception and Induced Abortion in Rural Ghana, *Tropical Medicine and International Health* 7(8): 708–716.

Ghana Health Service. (2003). Prevention and management of unsafe abortion: Comprehensive abortion care services standards and protocols. Accessed from www.ipas.org/abortion-guidance on 16/05/2011.

Ghana Health Service. (2005). *A strategic assessment of comprehensive abortion care in Ghana: Priority setting for reproductive health in the context of health sector reforms in Ghana,* Occasional paper

Ghana Health Service. (2007). *Induced Abortion.* Reproductive and Child Health Department of the Family Health Division: 2007 Annual Report.

Ghana Statistical Service. (2010). *Population and Housing Census, Preliminary Results, Population of Ghana.*

Ghana Statistical Service. (2002). *Population and Housing Census 2000: Special Report on 20 Largest Localities in Ghana,* Accra: The GSS.

Ghana Statistical Service (GSS)., Ghana Health Service (GHS)., & Macro International. (2009). *Ghana Demographic and Health Survey 2008.* Accra: GSS, GHS, and Macro International.

Ghana Statistical Service (GSS)., Ghana Health Service (GHS)., & Macro International (2009). *Ghana Maternal Health Survey 2007.* Calverton (MD): GSS, GHS, and Macro International.

Gipson, J.D., & Hindin, M.J. (2008) Having Another Child would be a Life or Death Situation for her: Understanding Pregnancy Termination Among Couples in Rural Bangladesh. *American Journal of Public Health. 98* (10):1827-32.

Glanz, K., Lewis, F.M., & Rimer, B.K. (2002). *Modified Health Belief Model.* Accessed from http://en.wikipedia.org/wiki/File:Healthbeliefmodel.png on 23/04/2011

Grolier Incorporated, (1985). *Academic American encyclopedia, 5*:1986:1335 Accessed from www.nhu-pac.library.state.nh.us/ipac20/ipac.jsp?session= 1207OI754G375.26980 & profile=nhais&uindex=ALLTITL& term= Academ. On 10/4/2013

Greene, K., Hale, J. L., & Rubin, D. L. (1997). A Test of the Theory of Reasoned Action in the Context of AIDS Messages. *Communication Reports.10:* 21-33.

Grimes, D.A., Benson, J., Singh, S., Romero, M., Ganatra, B., & Okonofua, F.E. (2006). Unsafe abortion: The Preventable Pandemic. *Lancet, 368*:1908–19.

Guttmacher Institute. (2012). Facts on Induced Abortion Worldwide. Accessed from http://www.who.int/reproductivehealth/...abortion/induced_abortion_2012. on 23/04/2011

Hale, J. L., Householder, B.J., & Greene, K.L. (2003). The Theory of Reasoned Action. In J.P. Dillard & M. Pfau (Eds.), *The Persuasion Handbook: Developments in Theory and Practice* (pp. 259 - 286). Thousand Oaks, CA: Sage.

Harari, W.S., & Fantahun, M. (2006). Unintended Pregnancy and Induced Abortion in a Town with Accessible Family Planning Services: The Case of Narar in Eastern Ethiopia. *Ethiopian Journal of Health and Development, 20*(2): 79-85.

Henry, R., & Fayorsey, C. (2002). *Coping with Pregnancy : Experiences of Adolescents in Ga Mashi, Accra.* Calverton, Maryland, USA : Macro.

Henshaw, S.K., & Kost, K. (1992). Parental Involvement in Minors' Abortion Decisions. *Family Planning Perspectives, 24* (5):196-207, 213

Hill, Z.E., Tawiah-Agyemang, C., & Kirkwood, B. (2009). The Context of Informal Abortions in Rural Ghana. *Journal of Women's Health, 18* (12):2017-22.

Hingson, R.W., Strunin, L., Berlin, B.M., & Heeren, T. (1990). Belief about AIDS, Use of Alcohol and Drugs, and Unprotected sex among Massachusetts Adolescents. *American Journal of Public Health*, 80: 295-299.

Howell, J., Miller, P., Hyun Hee, P., Sattler, D., Schack, T., Spery, E., Widhalm, S., & Palmquist, M. (1994 - 2012). *Reliability and Validity*. Writing @ CSU Colorado State University. Accessed on 28/10/2012 from http://writing.colostate.edu/guides/guide.cfm?guideid=66.

Hookway, C. (2008). *The pragmatic philosophy*. Accessed on 20th February, 2011 from plato.stanford.edu/entries/pragmatism/.

Hord, C., & Wolf, M. (2004). Breaking the Cycle of Unsafe Abortion in Africa. *African Journal of Reproductive Health, 8* (1): 29-36.

Hull, N. E. H., & Hoffer, P.C. (2010). *Roe v. Wade: The Abortion Rights Controversy in American History, 2nd Edition.* Lawrence: University Press of Kansas.

Ipas, (2001). *Children, Youth and Unsafe Abortion.* Chapel Hill, New York City

Jewkes, R., Rees, H., Dickson, K., Brown, H., & Levin, J. (2005). The Impact of Age on the Epidemiology of Incomplete Abortions in South Africa after

Legislative Change. *Bi-annual Journal of Obstetrics and Gyneacology, 112* (3):355-9.

Jones, T. M. (1991). Ethical Decision-making by Individuals in Organizations: An Issue-contingent Model. *Academy of Management Review, 16* (2): 366-395.

Kaye, D.K., Mirembe, F., & Bantebya, G. (2005). Reasons, Methods and Decision-making for Pregnancy Termination Among Adolescents and Older Women in Mulago Hospital, Uganda. *East Africa Medical Journal, 82* (11): 579-585.

Keesling, B., & Friedman, H.S. (1987). Psychosocial factors in sunbathing and sunscreen use. *Health Psychol.* 6 (5): 477–493. [PubMed]

Kirkman, M., Rowe, H., Hardiman, A., Mallett, S., & Rosenthal, D. (2009). *Reasons Women give for Abortion: A Review of the Literature*. Key Centre for Women's Health in Society, The Melbourne School of Population Health, University of Melbourne, Melbourne, Australia.

Lentz, C. (2000). *Ethnicity in Ghana: The Limits of Inventions*. London: Palgrove.

Lewis, P. W. (1998). *A Pneumatological Approach to Virtue Ethics*. Accessed from http://www.apts.edu/ajps/98-1/98-1-lewis.htm/ on 15th August 2011.

Lithur, N.O. (2004). De-stigmatizing Abortion: Expanding Community Awareness of Abortion as a Reproductive Health Issue in Ghana. *African Journal of Reproductive Health, 8* (1): 70-74.

Maguire, D.C. (2009) *Abortion and Religion: Diverse Religious Traditions on the Morality of Abortion.* Accessed on 6th May, 2009, from http://atheism.about.com/od/abortioncontraception/p/Religions.htm.

Marie Stopes International Ghana, (2006). *Health Sector Research Report.* prepared for Marie Stopes International, October 2006.

Mayhew, S. H., & Adjei, S. (2004). Sexual and Reproductive Health: Challenges for Priority-setting in Ghana's Health Reforms, *Health Policy and Planning 19* (Supplementary): i50–i61.

Mbele, A.M., Snyman, L., & Pattinsm, R.C. (2006). Impact of the Choice on Termination of Pregnancy Act on Maternal Mortality in West of Pretoria. *South African Medical Journal, 96* (11): 1196-1198.

Mill, J.S. (2012). *Utilitarianism.* The University of Adelaide Library, University of Adelaide, South Australia 5005. Accessed on 10th April, 2013, from http://ebooks.adelaide.edu.au/m/mill/john_stuart/m645u/index.html

Mosley, A. (2011) *Philosophical theories on induced abortion.* Accessed on 10th May, 2011 from http://www.utm.edu/research/iep/e/egoism.htm.

Miller, K. (2005). *Communications Theories: Perspectives, Processes, and Contexts.* New York: McGraw-Hill.

Ministry of Health. (2010). Profile of registered health facilities in Accra metropolis. Unpublished report.

Ministry of Health. (2012, May 24). More Girls Cause Abortion in Ghana. *Daily Graphic*, pp. 18.

Mirembe, F. (2005) "The Incidence of Induced Abortion in Uganda", *International Family Planning Perspectives*, Volume 31, Number 4.

Mitchell, E.M., Kwizera, A., Usta, M., & Gebreselassie, H. (2006). *Choosing Early Pregnancy Termination Methods in Urban Mozambique.* Academic

Medical Center, University of Amsterdam, CINIMA, Amsterdam, Netherlands.

Moore, A.M., Jagwe-Wadda, G., & Bankole, A. (2004). *Mens' Attitudes about Abortion in Uganda*. Guttmacher Institute, New York, USA.

Moore, K.L., & Persuad, T.V.N. (2003) *The Developing Human: Clinically Oriented Embryology*. 7th Edition; Published in Saunders, p. 16.

Morhee, E.S.K. (2006). *Views of Doctors on Institutionalization of Termination of Pregnancy in Ghana.* Long Commentary for FWACS Part II Examinations.

Morhee, R.A.S., & Morhee, E.S.K. (2006). Overview of the Law and Availability of Abortion Services in Ghana. *Ghana Medical Journal, 40*(3): 80–86.

Morrison, E.E., & Monagle, J.F. (2008). *Health Care Ethics: Critical issues for the 21st Century*. 2nd Edition. Accessed from http://books.google.com.gh/books, on 28th May 2009 .

Mote, C. V., Otupiri, E., & Hindin, M.J. (2010). Factors Associated with Induced Abortion among Women in Hohoe, Ghana, *African Journal of Reproductive Health, 14*(4): 115–121.

Mullen, P.D., Hersey, J., & Iverson, D. C. (1987). Health Behavior Models Compared. *Journal of Social Science and Medicine, 24*:973–981.

Nana P.N, Fomulu J.N., & Mbu R.E. (2005). A four-year retrospective review of post abortal surgical complications at a Central Maternity Yaounde, Cameroon. Clinics in Mother and Child Health. 2(2): 349-63

Odoi-Agyarko, H. (2003). *Profile of Reproductive Health Situation in Ghana.* Document prepared for the World Health Organization.

Ogden, J. (2007). Textbook of Health Psychology. 4th Edition. Maidenhead, England: Open University Press, pp 34-51.

Oliveras, E., Ahiadeke, C., Adanu, R.M.K., & Hill, A.G. (2008). Clinic-based Surveillance of Adverse Pregnancy Outcomes to Identify Induced Abortions in Accra, Ghana. *Studies in Family Planning 39* (2): 133–140.

Olukoya, P. (2004). Reducing Maternal Mortality from Unsafe Abortion among Adolescents in Africa. *African Journal of Reproductive Health, 8* (1): 56-62.

Oye-Adeniran, B.A. (2004). *African Journal of Reproductive Health, 8(3):103-115*

Oye-Adeniran, B.A., Adewole, I.F., & Fapohunda, O. (2004). Characteristics of Abortion Seekers in South-western Nigeria. *African Journal of Reproductive Health, 4*(1):69-72.

Pathfinder International Ghana. (2007). Community Survey Questionnaire on Knowledge, Attitude, and Practice of Abortion for Women 15-49 years.

Phillips, E.M., & Pugh, D.S. (1994; 2012). *Abortion Issues.* Accessed from books.google.com.gh/books?isbn=1848600348. on 10th February, 2012.

Population Council. (1996). *Women's Experiences of Unwanted Pregnancy and Induced Abortion in Nigeria.* In Robert H. Ebert Program on Critical Issues in Reproductive Health pp 35. One Dag Hammarskjold Plaza. New York, USA.

Population Council. (1988). Induced Abortion in Sub-Saharan Africa: What we do and do not Know. *Studies in Family Planning, 19* (3):186-90.

Population Council. (2008). *Profile of Abortion Seekers in Ghana and their Decision-making Processes*. Unpublished Report.

Provisional National Defense Council (PNDC). Law 102: The Criminal Code (Amendment) Law. *The Constitution of Ghana*; 1985. Accra: State Publishers.

Quality Health Partners., & Ghana Health Service. (2005). *Facility Baseline Assessment of Regional Hospitals and Facilities in 28 Target Districts in Seven Regions of Ghana*. Unpublished Report.

Quansah-Asare, G. (2008). Induced abortion in Ghana. Presentation at National Health Summit, Ghana.

Rao, K.V., & Demaris. A. (1995). Coital Frequency among Married and Cohabiting Couples in the United States, *Journal of Biosocial Science, 27*(2): 135–50.

Raosoft Sample Size Calculator Accessed on 2nd July, 2012 from http://www.raosoft.com/samplesize.html

Reardon, C. (1978). *Aborted Women-Silent No More*. Chicago: Loyola University Press.

Religious Studies Blog. (2009). *Abortion as an ethical issue*. Assessed from: http://www.lotsofessays.com/ on 2nd June, 2010.

Rosenstock, I.M. (1974). Historical Origins of the Health Belief Model. *Health Education Monographs, 2* (4).

Rosenstock, I.M., Hochbaum, G.M., & Kegels, S. (1950). Health Belief Model: History and Orientation. Accessed on 10/06/2011 from http://www

faculty.ksu.edu.sa/14790/Lectures%20382/Health%20Belief%20Mode%20382(2).pdf

Rue, V. C., & Tellefsen, C. (1996). The Effects of Abortion on Men. *Ethics & Medics, 21*: 3-4.

Santhya, K.G., & Shalini, V. (2004), Induced Abortion: The Current Scenario in India. *Regional Health Forum, 8* (2).

Schifter, D. E., & Ajzen, I. (1985). Intention, perceived control, and weight loss: An application of the theory of planned behavior. *Journal of Personality and Social Psychology, 49* (3), 843-851.

Schuster, S. (2005). Abortion in the Moral World of the Cameroon Grass Fields. *Reproductive Health Matters, 13* (26):130-8.

Schwandt, H.M., Creanga, A.A., Danso, K.A., Adanu, R.M.K., Agbenyega, T., & Hindin, M.J. (2011). A Comparison of Women with Induced Abortion, Spontaneous Abortion and Ectopic Pregnancy in Ghana. *Contraception, 84*:87-93.

Sena, K. (2006). *Maternal Mortality in Ghana*: Seminar Presentation at School of Public Health, University of Ghana, Legon.

Sheppard, B. H., Hartwick, J., & Warshaw, P.R. (1988). The Theory of Reasoned Action: A Meta-analysis of Past Research with Recommendations for Modifications and Future Research. *Journal of Consumer Research, 15*:325-343.

Sai, F. (2004). International Commitments and Guidance in unsafe abortion. *African Journal of Reproductive Health, 8* (1):15-28.

Sedgh, G. (2009). *Abortion in Ghana.* In Brief, New York: Guttmacher Institute; 2010, No. 2.

Silverman, D. (2012) *Doing Qualitative Research, 3rd Edition.* Accessed from books.google.com.gh/books?isbn=1848600348 on 10th February 2012.

Silverman, H. (2007). *Ethical Issues during the Conduct of Clinical Trials.* Proceedings of the American Thoracic Society, 4(2): 180-184.

Singh, S., Prada, E., Mirembe, F., & Kiggundu, C. (2005). The Incidence of Induced Abortion in Uganda. *International Family Planning Perspective, 31*(4):183-91.

Singh, S., & Sedgh, G. (2001). The measure of induced abortion levels in Colombia using Random response technique Accessed 23/06/2011 from http://www.aprendeenlinea.udea.edu.co/revistas/index.php/ceo/article/viewFile/7044/6460.

Srofenyoh, E.K., & Lassey, A.T. (2003). Abortion Care in a Teaching Hospital in Ghana, *International Journal of Gynecology and Obstetrics 82*(1): 77-78.

Sparks, P., Shepherd, R., & Frewer, L. J. (1995). Assessing and Structuring Attitudes towards the use of Gene Technology in Food Production: The Role of Perceived Ethical Obligation. *Journal of Basic and Applied Social Psychology, 16*: 267-285.

Sundaram, A., Juarez, F., Bankole, A., & Singh, S. (2012). *Factors Associated with Abortion Seeking and Obtaining a Safe Abortion in Ghana.* Unpublished paper.

Tellefsen, C. (1996). The Effects of Abortion on Men: its Emotional, Psychological and Relational Impact Accessed on 15/10/2011 from http://www.catholicculture.org/culture/library/view.cfm?id=8089

Trikha, S. (2001). Abortion Scenario of Adolescents in a North Indian City-Evidence from a Recent Study. *Indian Journal of Community Medicine, 26* (1).

Turkson, R.B. (2006). *Legal and Policy Aspect of Comprehensive Abortion Care in Ghana*. Paper presented at Stakeholders workshop on Abortion Care in Erata Hotel, Accra, Ghana, April, 2006.

United Nations Population Fund, (2009): *State of the World Population report 2008* accessed from http://www.unfpa.org/swp on 7th September, 2009.

United Nations Population Fund (2006). *UNFPA Country Profiles. A*ccessed on 12th April 2013, from *http://www.unfpa.org/profile/ghana.cfm*;

United Nations Population Fund (1999). International Conference on Population and Development, *(ICPD+5). Conference Report.*

Uwaezuoke, A.L.O., Uzochukwu, B.S.C., & Nwagbo, D.F.E. (2004). Determination of Teenage Pregnancy in Rural Communities of Abia State, South East Nigeria. *Journal of the College of Medicine, 9*(1): 28-33.

Wallerstein, E. (1972). Psychosocial Sequelae of Therapeutic Abortion in Young Unmarried Women. *Archives of General Psychiatry.* Volume 27.

Wiebe, E.R. (1997). Choosing between Surgical Abortions and Medical Abortions Induced with Methotrexate and Misoprostol, *Contraception, 55*(2):67-71.

Winikoff, B. (1995) Acceptability of Medical Abortion in Early Pregnancy, *Family Planning Perspectives, 27*(4): 142-148 & 185

World Health Organization (2004). *The Prevention and Management of Unsafe Abortion: Report of a Technical Working Group.* WHO/MSM/92.5. Geneva, World Health Organization.

World Health Organization (2006). *World Health Statistics,* Geneva, Switzerland, p24.

World Health Organization (2012). Abortion Statistics by the World Health Organization. Accessed from http://www.worldometers.info/abortions/ on 21st September, 2012.

Yeboah, R.W.N. (2003). Abortion: The Case of Chenard Ward, Korle Bu from 2000 to 2001. *Institute of African Students Research Review, 19* (1):57-66.

Ysseldyk, R. (2010). *Religiosity as Identity: Toward an Understanding of Religion from a Social Identity Perspective.* Carleton University, Ottawa, Ontario, Canada.

APPENDICES

Appendix A: Informed Consent Form

UNIVERSITY OF CAPE COAST

FACULTY OF SOCIAL SCIENCES

DEPARTMENT OF POPULATION AND HEALTH

ID No Interviewee:_____

ID No Interviewer:_____

Purpose of the Study

Good day! My name is..... and I am a research field assistant. We are conducting a study on 'decision making for induced abortion in the Accra metropolis, Ghana'.

In relation to this, we are seeking information from women who have had an induced abortion in the Accra Metropolis during January to December 2010. The information required is on what informed their decision for an abortion at the time of pregnancy. The information that you will provide will contribute to knowledge in this area that will be helpful to review policies and programmes relating to abortion services in Ghana.

Procedures

My role is strictly to document some information about your background, circumstances surrounding the occurrence of the pregnancy aborted, why the decision to abort and what you went through during decision making and/or service delivery. I would like you to know in advance that your personal information may become known to me during the interview. However, this interview will be strictly confidential and will not be disclosed to any other person. The interview will take about one hour and your participation in the study is strictly voluntary.

Anonymity and Confidentiality

Since I will not be collecting your name or address, your identity will be anonymous. Further, all your responses will be kept confidential and not shared with anybody who is not directly part of the study.

Before taking consent

Do you have any questions that you wish to ask? (If yes, note the questions)-------

---

If you have questions later, you may contact Mr. Fred Gbagbo at MSIG, PMB, 267, Accra North. Tel: **0243335708**. Email: gbagbofredyao2002@yahoo.co.uk

Consent

I have read this entire consent form/it has been explained to me and any questions I had, have been answered to my satisfaction. I agree to participate in the study.

Signature/Thumbprint of Respondent .....Date .....

Signature/Thumbprint of Witness if respondent is illiterate. Date.....

Signature of Interviewer .....Date .....

Interviewer's statement:

I, the undersigned, have explained the objectives of this study to the subject in the language that she understands and has agreed voluntarily to participate in the study.

Signature of Interviewer .....Date .....

Immediate post interview remarks

[YES] [NO]

Interview successfully completed .....

If no please give reason(s).....

.....

Appendix B: Questionnaire

UNIVERSITY OF CAPE COAST

FACULTY OF SOCIAL SCIENCES

DEPARTMENT OF POPULATION AND HEALTH.

DATA PROCESSING PARTICULARS

Place where respondent had the last abortion_____

Code for respondent:_____

Code for Interviewer:_____

Medium of communication during the interview_____

Interview Date:_____

A). BACKGROUND CHARACTERISTICS OF RESPONDENTS

[I would like to ask you a few questions regarding your background. Please feel free to answer the following:]

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
1	How old are you? (Record in completed years)	Age in years [ ]	
2	To which ethnic group do you belong?		
3	In which town do you usually live? (Specify exact location)		
4	What is your religious affiliation?	Christian.....1 Islam.....2 Atheist.....4 Other specify.....5	
5	What work do you currently do?	Not working----------1 Self employed----------2 Student/Apprentice----------3 House wife----------4 Other specify----------5	
6	What is the highest level of school you	None.....1	

	have completed?	Primary.....2 JSS/MSLC.....3 Secondary.....4 Post Secondary.....5 Tertiary.....6	
7	What is your marital status?	Never Married.....1 Married.....2 Divorced.....3 Separated.....4 Living in union.....5 Widowed.....6	
8	How many children do you have? How many are sons and how many are daughters? (Record '00' if none).	Sons..... ☐☐ Daughters..... ☐☐ Total..... ☐☐	

B). BACKGROUND CHARACTERISTICS OF RESPONDENTS AT LAST ABORTION

[I would like to ask you a few questions regarding your background at the time of having your immediate past abortion. Please feel free to answer the following:]

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
9	How old were you when you aborted the immediate past pregnancy? (Record in completed years)	Age in years [ ]	
10	Who was responsible for the pregnancy you last aborted?		
11	Where were you living at the time you aborted the immediate past pregnancy? (Specify exact location)		
12	Where were you working (employed) at the time you aborted the immediate past pregnancy?	Not working----------1 Self employed----------2 Student/Apprentice----------3 House wife----------4 Other specify----------5	
13	What was the highest level of school you have completed at the time you aborted the immediate past pregnancy?	None.....1 Primary.....2 JSS/MSLC.....3 Secondary.....4 Post Secondary.....5 Tertiary.....6	

14	What was your marital status at the time you aborted the immediate past pregnancy?	Married.....1 Living in union.....2 Divorced.....3 Separated.....4 Widowed.....5 Single.....6	
15	How many children did you have at the time you aborted the immediate past pregnancy? How many are sons and how many are daughters? (Record '00' if none).	Sons..... ☐☐ Daughters..... ☐☐ Total.....	

C). INDUCED ABORTION DECISION-MAKING PROCESS

[I would like to ask you a few questions regarding decision making for your previous induced abortion(s). Please feel free to answer the following]

16	How many induced abortions have you had in the past? (Specify month of each termination)		
17	What was/were your immediate reactions after you discovered you were pregnant? (record all mentioned)	Shocked.....1 Guilty.....2 Worried.....3	

		Embarrassed.....4 Happy.....5 Other specify.....6	
18	For what reason(s) did you abort the immediate past pregnancy? (record all mentioned)	Want a child at a later time .....1 Forced sex.....3 Medical advice.....4 Extra marital pregnancy.....6 Pressured.....7 Other specify 8	
19	Mention some of the challenges you faced (if any) at the time when making decision to have an induced abortion.		

D). KEY STAKEHOLDERS INVOLVED IN THE DECISION MAKING PROCESS

[I would like to ask you a few questions regarding the people involved in the decision making for your previous induced abortion(s). Please feel free to answer the following]

20	Who was the first person you informed when you realized you were pregnant?	Male sexual partner----------1 Mother----------2 Friends----------3 No body----------4 Other specify----------5	

21	Why did you inform this person?		
22	Did you need anyone's consent to have an abortion?	Yes.....1 No.(Skip to Q 25).....2	
23	Whose final consent did you require before undergoing the abortion?	Male sexual partner.....1 Mother-in-law.....2 Mother.....3 Father-in-law.....4 Father.....5 Other specify.....6	
24	Why did you have to obtain the consent before an abortion?		
25	How old was the pregnancy you last terminated?	☐☐ Months Do not know.....	
26	What method was used for your last induce abortion?	Medication ☐☐ Vaccum Aspiration ☐ Dilataion & Curettage ☐ Others specify_____	
27	Who introduced you to the method(s)	Medical Practitioner----------1 Pharmacist----------2 Friends----------3 Male sexual partner----------4 Other specify----------5	

28	Why did you decide to use the above method(s)?		
29	What type of immediate care did you receive after the abortion was done? (Record all mentioned in starting order)	None----------1 Counselling----------2 Antibiotics----------3 Heamathenics----------4 Contraceptives----------5 Other specify----------6	→ Stop → to30
30	Specify the type of contraceptive you accepted soon after your last abortion.	BTL----------1 Implant----------2 IUCD----------3 Depo provera----------4 Contraceptive pills----------5 Female condom----------6 Male condom----------7 Noristrat----------8 Norigynon----------9 Other specify----------10	

E). FACTORS INFLUENCING CHOICE OF PLACE FOR ABORTION.

[I would like to ask you a few questions about why you decided to have an abortion at the place you went. Please feel free to answer the following]

31	Describe briefly the place where your past abortion was done?		
32	How did you hear about such a place	Media.....1 Friends.....2 Male sexual partner.....3 Family members.....4 Other specify.....5	
33	Why did you go for the abortion at this place? (Record all mentioned & seek reasons)	Desire for privacy.....1 Affordable Cost.....2 Accessible.....3 Popularity.....4 Confidentiality.....5 Safety.....6 Other specify.....7	
34	In total, how much did you spend to have an induce abortion at this place?		
35	What are your views about the cost involved to have an induce abortion	Very expensive.....1 Expensive.....2	

	where it was done?	Affordable.....3 Cheap.....4 Other specify.....5	
36	Apart from where you had your abortion, is there any other place in your community where abortion is done? (Record all mentioned)	Yes.....1 No.....2 Don't know.....3 Other specify.....4	→ STOP
37	How many months into pregnancy can abortion be done at the place where you had your last abortion?	☐☐ Weeks Don't know.....	
38	Did you experience any complications after the abortion? (Record all mentioned)	Developed infections..... .....1 Bleed profusely.....2 Did not conceive again.....3 Had perforated Uterus .....4 Had severe lower abdominal. Pains...5 No complications.....6 Other specify.....7	
39	What is your opinion about women seeking induced abortion from where you had your last abortion? (Record all mentioned & seek reasons)	I recommend/approve.....1 I don't recommend/approve.....2 It is up to the individual.....3 Other specify.....4	

F). FAMILIARITY WITH THE POLICY AND LEGAL FRAMEWORKS INFLUENCING INDUCED ABORTION IN GHANA.

[I would like to ask you a few questions about the policy and legal frameworks influencing induced abortion in Ghana]

40	What is the current legal situation concerning induced abortion in Ghana?	Abortion is legal.....1 Abortion is Illegal.....2 Don't know.....3 Others specify.....4	→ STOP
41	As per the law, for what reasons can one seek or be granted abortion in Ghana? (Record all mentioned)	Pregnancy due to rape.....1 Pregnancy due to defilement .....2 Pregnancy due to incest.....3 injury to phy & mental health .....4 Gross foetal abnormalities.....5 Other specify.....6 Don't know.....7	
42	How many weeks of pregnancy is it legal to have an abortion in Ghana?	☐☐ Weeks Don't know.....	
43	As per the law, who can induce an abortion in Ghana? (Record all mentioned)	Gynaecologist.....1 Medical Doctor.....2 Trained midwife/nurse.....3 Anybody pregnant.....4 Other specify.....5 Don't know.....6	

44	Is anybody's consent required to induce an abortion in Ghana?	Yes.....1 No.....2 Don't know.....3	→ STOP
45	Whose consent is most required to induce an abortion in Ghana? (Record all mentioned)	Pregnant woman.....1 Abortion provider.....2 Male sexual partner of a woman.....3 Other specify.....4 Don't know.....5	
46	Where can abortion services be legally obtained in Ghana? (Record all mentioned)	Government Hospital.....1 Private Hospitals.....2 Maternity homes.....3 Chemical shops.....4 Pharmacy shops.....5 Don't know.....6 Other specify.....7	

Appendix C: In-Depth Interview Guide

UNIVERSITY OF CAPE COAST

FACULTY OF SOCIAL SCIENCES

DEPARTMENT OF POPULATION AND HEALTH

DATA PROCESSING PARTICULARS

Place where respondent had the last abortion_____

Code for respondent:_____

Code for Interviewer:_____

Medium of communication during the interview_____

Interview Date:_____

Topic: 'Decision making for induced abortion in the Accra Metropolis, Ghana'

Warming up questions

The interview will start with an introduction and explanation of the purpose of study to participants. In addition participants will be made aware that their participation is voluntary and they can opt out at anytime. In addition, anonymity and confidentiality issues as well as the purpose for the information being solicited from the participants will be explained to them. Furthermore, participant's consent will be solicited for the interview including permission to record. Participants will also be encouraged to use the local language if they are more comfortable with it.

a) ***Background Information:***

1. Please tell me about yourself?

   Probe: Age, religious affiliation, place of residence, length of stay at residence, marital status, number of living children, occupation, highest level of education completed.

b) **Heterosexual relationship and sexual experiences**

Now I will like to ask you some questions about your sexual relationships and experiences. I know that some of these questions are quite sensitive, and might

make you uncomfortable, but be as frank as possible. I will like to assure you that your responses will be kept in strict confidence.

2. i) If you can recall, at what age did you start dating?

ii) What can you remember about your first sexual experience?

Probe: The circumstance that led to it, was it consensual, coercion or forced. If consensual find out if any protection was used.

3. Now, let us talk about the present. Please tell me about your current partner

Probe: If a second marriage, how was your previous marriage?

4. Reflecting on your pregnancy. When did you realize you were pregnant and how did you react towards it? **Prompt:** Missed or delayed period, pregnancy test or went to see a doctor?

5. What led to the pregnancy?

Probe: Number of weeks pregnant before finding out

6. Whom did you tell about the pregnancy and why? What was their reaction?

7. Was this your first pregnancy or you have been pregnant before?

Probe: number of pregnancies experienced. Ones that ended in life birth, induced abortion or miscarriage.

c) *Abortion decision-making*

8. Why did you decide to abort your pregnancy? **Probe:** For various reasons

9. When did you decide to abort your pregnancy?

Probe: How old was the pregnancy when you had the abortion? Is this your first abortion or you have had previous abortions. If there were previous ones, how long ago was the previous abortion and how old was the pregnancy when it was aborted?

10. Did you discuss it with anybody before terminating the pregnancy? If yes whom did you discuss it with and why? If no why didn't you discuss it with anybody?

11. Was your sexual partner/husband aware and in support of the abortion? If yes what were his reasons for supporting it? If partner was not aware, why was he not informed?

12. Who took the final decision to terminate the pregnancy? **Probe:** basis for the decision

d) ***Processes involved in the termination of pregnancy***

Women do many things when they want to induce an abortion. Can you recall some of the things you did when you decided to terminate this pregnancy?

13. Did you do anything on your own to terminate the pregnancy, such as taking some herbs, home-made remedies, medicines or inserting something into yourself?

Probe: Find out what was used and the results, if bleeding etc. resulted, what was done to remedy it?

14. What about your sexual partner, friends and family, what assistance did they give you during the pregnancy? Did anybody assist in any form in the termination of pregnancy? If yes, who and why that person?

15. What made you finally decide to terminate the pregnancy in a health facility?

Probe: For various reasons

16. How did you locate this facility? **Probe**: the means of locating the facility.

17. Why did you choose this facility instead of others? **Probe:** For various reasons

18. Did anybody accompany you there? If yes, why and who was that person?

If no why not?

19. Were you counseled before the abortion?

20. What were some of the things discussed during the counseling session?

21. What method was used in terminating the pregnancy?

22. Why did you choose that method?

23. Were you given any advice on family planning after the abortion? **Probe**: previous contraception and type of family planning method accepted after abortion.

24. What about medication? **Probe**: For type of medication given, dose and dosage.

25. In total how much money did you pay for the abortion? **Probe**: the cost for abortion, medication, family planning and other services received.

26. Who paid the bills?

27. What does the abortion experience mean to you? (What lessons have you learnt from this experience?)

28. What positive and negative effects did the abortion have on you?

29. Did you have any regrets aborting the pregnancy? **Probe** for the regrets and coping strategies at the time of abortion and now

30. What do you know about the laws governing abortion in Ghana? **Probe** for persons mandated to induce abortion, gestation period for abortion and place for abortion.

e) ***We have reached the end of the interview. Thanks very much for participating I once again assure you that your information will be kept very confidential and there will be no clues to trace the responses to you.***

f) **Closure and Debriefing**

Tell me what it was like talking to me about these things? What was difficult, what was easy? What would make it easier? Is there anything else you would like to tell me? Is there anything you'd like to ask me?

Appendix D: The Abortion Law of Ghana

1. Subject to the provisions of subsection (2) of this section:

a. any woman who with intent to cause abortion or miscarriage administers to herself or consent to be administered to her any poison, drug or other noxious thing or uses any instrument or other means whatsoever; or

b. any person who—

i. administers to a woman any poison, drug or other noxious thing or uses any instrument or other means whatsoever with intent to cause abortion or miscarriage, whether or not the woman is pregnant or has given her consent

ii. induces a woman to cause or consent to causing abortion or miscarriage;

iii. aids and abets a woman to cause abortion or miscarriage;

iv. attempts to cause abortion or miscarriage; or

v. supplies or procures any poison, drug, instrument or other thing knowing that it is intended to be used or employed to cause abortion or miscarriage; shall be guilty of an offence and liable on conviction to imprisonment for a term not exceeding five years.

2. It is not an offence under section (1) if an abortion or miscarriage is caused in any of the following circumstances by a registered medical practitioner specializing in Gynaecology or any other registered medical practitioner in a government hospital or a private hospital or clinic registered under the Private Hospital and Maternity Home Act, 1958 (No. 9) or in a place approved for the purpose by legislative instrument made by the Secretary:

a. where pregnancy is the result of rape or defilement of a female idiot or incest and the abortion or miscarriage is requested by the victim or her next of kin or the person in loco parentis, if she lacks the capacity to make such request;

b. where the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health and such a woman consents to it or if she lacks the capacity to give such consent it is given on her behalf by her next of kin or the person in loco parentis;

c. where there is substantial risk that if the child were born it may suffer from or later develop a serious physical abnormality or disease.

Source: {Consolidated Criminal Code, 1960, section 58, Act 29; PNDC Law 102, 1985.}

Appendix E: Letter of Introduction from Maries Stopes International

MARIE STOPES INTERNATIONAL
Ghana

OUR REF: MSIG/CD/03A/11/011

YOUR REF:.....

21st February 2011

The Director
Ethical Review Committee
Ghana Health Service
Accra

Dear Sir / Madam,

LETTER OF INTRODUCTION
RE: FRED YAO GBAGBO

We write to introduce Mr. Fred Yao Gbagbo, the Medical Development Team Manager of Marie Stopes International Ghana.

Fred has been with Marie Stopes International Ghana since January 2007 and has been very instrumental in the development and maintenance of high clinical standards within our facilities and on outreach.

Fred is undergoing a PHD programme at the University of Cape Coast and writing on "The decision making processes by women for induced abortion in the Accra Metropolis, Ghana" and we are fully aware and support him.

Marie Stopes International Ghana began operation in 2006 and in partnership with the Ghana Health Service and working through a consortium of other NGOs known as the R3M (Reducing Maternal Mortality and Morbidity), we have made great strides in empowering women, men and young people to achieve their sexual and reproductive health and rights through increasing community access to quality SRH services and safe abortion.

We shall be grateful if you accord him the necessary assistance for the conduct of this research.

Yours sincerely,

Faustina Fynn-Nyame
Country Director

Providing choices in reproductive healthcare
Marie Stopes International Ghana
C900/4 Meriam Sarbah Rd
Private Mail Bag 267
Accra, Ghana
Telephone
+233 21 241517
Email
info@mariestopes.org.gh
Website
www.mariestopes.org.gh
Registered Charity No
265543
Company No
EAT 1 046
Chief Executive
Dana Hovig
Registered Office
8 Dr Isert Road, Accra
North Ridge, Accra
P O Box TF 330
Accra, Ghana
Country Director
Faustina Fynn-Nyame
Board of Director
Baroness Flather
Philip D Harvey
Atula Nandyakkara
Timothy M Rutter FRCS
Edgar W Standford
Catherine Stopes

Appendix F: Letter of Introduction from the University of Cape Coast

UNIVERSITY OF CAPE COAST
FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF POPULATION AND HEALTH

Telephone 042-32440/4 & 32480/3 Direct 042-30416
042-30680
0289538048
Fax 233-42-34072/30416, UCC, GH
Telex 2552, UCC, GH
Telegrams & Cables University, Cape Coast

UNIVERSITY POST OFFICE
CAPE COAST, GHANA

1st March, 2011

Our Ref: DPH/G.3/13

Your Ref:

The Chairman
Ethical Clearance
Research and Development Division
Ghana Health Service
Accra

Dear Sir/Madam,

LETTER OF INTRODUCTION

The bearer of this letter Mr. Gbagbo Fred Yao is a PhD student of the Department of Population and Health, Faculty of Social Sciences, University of Cape Coast. His research topic is:

"Decision-making for Induced Abortion in Accra Metropolis, Ghana"

Due to the sensitive nature of his topic he has been advised to seek ethical clearance.

We should be very grateful if you would review the proposal and the research instruments for his thesis.

Thank you for your cooperation in this matter.

Yours faithfully,

Dr. Akwasi Kumi-Kyereme
Head

Appendix G: Permission to Conduct Research in the Accra metropolis

C/o MARIE STOPES INTERNATIONAL GHANA,
PMB 267.
ACCRA-NORTH GHANA W/A.
TEL. (+233—243335708).
E-MAIL : gbagbofredyao 2002@yahoo.co.uk.

19/03/2012

Dear Sir/Madam,

PERMISSION TO CONDUCT RESEARCH IN THE ACCRA METROPOLIS.

I am a PhD Student at the university of Cape Coast and an employee of Marie Stopes International, Ghana.

I am conducting a study on 'Decision making processes by women, for induced abortion in the Accra metropolis, Ghana'.

In relation to this, I will be seeking information from women who have had an induced abortion in the Accra Metropolis. The information required is on what informed the women's decision for an induced abortion at the time of pregnancy.

This is a community based study and purely an academic exercise. The information that will be obtained will contribute to knowledge in this area which may also be helpful to review policies and programmes relating to safe abortion services in Ghana.

Please find attached for your consideration a copy of the ethical clearance for this study.

Many thanks in anticipation of a favourable response.

Yours faithfully,

FRED YAO GBAGBO

THE DIRECTOR,
ACCRA METROPOLITAN HEALTH DIRECTORATE,
GHANA HEALTH SERVICE,
ACCRA, GHANA.

Appendix H: Approval to Conduct Research in the Accra metropolis

In case of reply the Number and date of this letter should be quoted.

My Ref. :AM/

Your Ref. No.

Metro Health Directorate
Ghana Health Service
Private Mail BagTUPM 14
TUC Post Office
Accra

Tel: (Main Line) 233-21-665879
(Direct Line) 233-21-687000
(Fax) 233-21-680575
Email:
accrametrohealthdirectorate@yahoo.com

May 10, 2012

MR. FRED YAO GBAGBO
C/O MARIE STOPES INTERNATIONAL GHANA
PMB 267
ACCRA NORTH,
GHANA

Dear Sir / Madam,

APPROVAL TO CONDUCT RESEARCH IN THE ACCRA METROPOLIS, GHANA

We write to give approval for your request to conduct a research on the decision making process for Induced Abortion in the Accra Metropolis.

We advise you to comply with the ethical requirement for such studies and submit a copy of your study to the Metropolitan Health Directorate when completed.

Thank you.

Yours faithfully,

DR. JOHN B. K YABANI
ACCRA METRO DIR. OF HEALTH SERVICES

Appendix I: Ethical Clearance

GHANA HEALTH SERVICE ETHICAL REVIEW COMMITTEE

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra

Tel: +233-0302-681109
Fax + 233-0302-685424
Email: Hannah.Frimpong@ghsmail.org

In case of reply the number and date of this Letter should be quoted

My Ref: GHS-ERC: 3
Your Ref. No

May 13, 2011

FRED YAO GBAGBO - Principal Investigator

ETHICAL CLEARANCE - ID NO: GHS-ERC: 11/01/11

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol titled:

"Decision Making Processes by Women for Induced Abortion in Accra Metropolis"

This approval requires that you submit periodic review of the protocol to the Committee and a final full review to the Ethical Review Committee (ERC) on completion of the study. The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Please note that any modification of the project must be submitted to the ERC for review and approval before its implementation.

You are also required to report all serious adverse events related to this study to the ERC within seven days verbally and fourteen days in writing.

You are requested to submit a final report on the study to assure the ERC that the project was implemented as per approved protocol. You are also to inform the ERC and your mother organization before any publication of the research findings.

Please always quote the protocol identification number in all future correspondence in relation to this protocol

SIGNED.....
PROFESSOR FRED BINKA
(GHS-ERC CHAIRMAN)

Cc The Director, Research & Development Division, Ghana Health Service, Accra