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TOPIC:

COMMUNITY PERCEPTIONS ON INDUCED ABORTIONS AND CONTRACEPTIVES IN THE MANHYIA AND ASAWASE SUB METROS OF KUMASI

BY

EMMA GHARTEY

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DECLARATION

I, Emma Ghartey, declare that except for references of other people's study which has been duly acknowledged, this work is the result of my own original research, and that this dissertation has not and should not be presented either in whole or in part elsewhere for the award of another degree.

AUTHOR

……

EMMA GHARTEY

MPH RESIDENT

ACADEMIC SUPERVISORS

……

PROFESSOR CLEMENT AHIADEKE

PRIMARY SUPERVISOR

……

DR REX ODURO ASANTE

SECONDARY SUPERVISOR

DEDICATION

This book is dedicated to the Lord Jesus Christ; MPH is a gift from you.

And to my son Nana Yaw Adjei, who was denied adequate care because mummy had to school.

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I am grateful to God Almighty for His Grace and Mercy. They are beyond measure.

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ABSTRACT

Improving maternal health is a key concern of the international community due to the unacceptably high maternal mortality rate. Invariably several studies have identified induced unsafe abortions as a major contributory factor to these maternal deaths. Contraceptive use, a cheap and effective preventive method of unplanned pregnancies is rather low. Ghana and for that matter Kumasi is no exception to the rule of high incidence of induced abortions and its attendant public health problems.

This cross-sectional study combines both qualitative and quantitative methods to explore the community's perceptions of induced abortions and contraceptives in the Manhyia and Asawase sub metros of Kumasi.

The members of the reproductive age group for women and men 15 to 49 and 15 to 59 respectively were, identified as the main respondents. Methods of data collection included interviews with semi-structured questionnaires, focus group discussion, and in-depth interview of opinion leaders and health workers in the community.

The results indicate a widespread knowledge of the complications associated with induced abortions in the communities. For e.g., 261 (65.5%) of respondents stated rightly three conditions that may arise from terminating a pregnancy. Recourse to induced abortions was nonetheless widespread and cuts across social and religious classes. There is high level of male involvement and participation in abortion related-decision making.

There was a high level of knowledge of both the traditional and modern methods of contraceptives among both sexes. Three hundred and eighty nine respondents representing 97.25% of the total respondents knew at least one method of contraceptive. This knowledge however, has been overshadowed by a general, perceived fear of health effects associated with contraceptive use and a belief of "not being at risk of pregnancy". In view of these, practice of contraception especially the modern methods among the communities is poor resulting in a relatively high unmet need for family planning

Interventions must be prompt and in collaboration with the media, must focus on these three:

- The physical and socio-economic complications of induced abortions
- Disabuse the minds of the community of the beliefs and misconceptions about contraceptives through vigorous mass education
- Make contraceptives attractive by highlighting its enormous contraceptive and other non contraceptive benefits.

It is believed that the views from different members of the community have provided insight into the context of unwanted pregnancies, induced abortions and knowledge of contraceptive. It again expected that the information gathered will serve as a guideline in the formulation of effective, practical, preventive policies and programmes for reducing induced abortions and its effects in the Kumasi metropolis as well as the nation.

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CHAPTER ONE

1.0INTRODUCTION

1.1 Background

Since the late 1980s, improving maternal health and reducing maternal mortality (MM) have been key concerns of several international conferences. However even at the dawn of the 21st century, maternal mortality is still unacceptably high. It is estimated that a total of 536 000 maternal deaths occurred worldwide in 2005. Slightly more than half of these deaths (270 000) occurred in the Sub-Saharan Africa (SSA) region alone (WHO 2007 Report). Hence one of the eight millennium development goals (MDG) of the United Nations, the fifth MDG aims to improve maternal health and targets reducing MM rate by 75% between 1990 and 2015 (WHO 2006).

One major contributor to these high figures of maternal deaths is the issue of induced, often unsafe abortions.

It is estimated that 70,000 women die annually from the complications of induced abortions around the world. A significant number of these deaths 23,000 occur in SSA countries alone, representing an estimated 68 deaths per 100,000 abortion procedures (Okonofua 2004). For instance, a study in Uganda estimates that 297,000 abortions were carried out in that country in 2003 alone (Singh et al 2006). A Similar study in Nigeria estimates the prevalence of induced abortions in that country to be 760,000 annually (Bankole et al 2006).

The situation in Ghana is no different. Abortion is illegal in Ghana except under three conditions that is (a) when the pregnancy is the result of rape, defilement or incest; (b) when

the pregnancy involves risk to the physical or mental health of the woman or (c) when there is substantial risk that the unborn child may develop or suffer from abnormality (PNDC Law 102 1985). The illegality has not done much to deter women from seeking abortion. Studies have indicated a high prevalence of induced abortion in the country. A study in southern Ghana by Ahiadeke (2001) concluded that 19 of every 100 pregnancies resulted in induced abortion. Yet this figure may be an underestimate as a result of the clandestine nature of the practice in Ghana. Unsafe abortion has been identified as one of five major causes of maternal deaths and disability in Ghana specifically contributing to 13% of maternal deaths in Ghana (GHS 2005).

These premature deaths are only a tip of the iceberg compared with the number of women who ends up as near misses, with disabilities or other serious complications. It has been established that hundreds of thousands of African women who seek abortions each year experience severe complications such as uterine perforation, chronic pelvic pain, haemorrhage, reproductive tract infections, septicaemia, secondary infertility, to mention a few. Globally, it is estimated that five million women are hospitalized each year for treatment of abortion-related complications, such as haemorrhage and sepsis (WHO, 2007). In Ghana, a significant number of women are admitted annually at the Korle-Bu Teaching Hospital with complications of induced abortions. Of these numbers, about 94% requires surgical intervention, (Lassey 1995), thus increasing the burden on the nation's already overstretched health care system.

In addition, induced abortion has been associated with a host of psychological consequences such as trauma, guilt, grief and a host of emotional stresses. Again, the practice has been linked to several psychological sequela such as Post Traumatic Stress Disorder (PTSD),

sexual dysfunction, suicidal attempt, increased smoking, child neglects and other psychosocial disorders (Reardon 1997). It may also bring about stigmatisation and isolation from families and communities (Hessini et al, 2006).

Further, the economic impact of abortions on the individual, her family and the state cannot be overlooked.

In an attempt to curb these deaths, complications and economic loss, several concerns have been raised. A section of the concerned social and public health expert believe that breaking the rock-hard socio-cultural stigma surrounding the subject is the solution. In her paper, Lithur (2006) emphasises the need to destigmatise abortion by expanding community awareness, breaking through traditional and cultural values, as well as breaking religious teachings and legal barriers.

Another school of thought is of the view that the provision of comprehensive abortion care in order to make abortion safe is one sure way to curbing the negative effect that accompanies the practice. The feasibility of this has been questioned considering the state of health care in Ghana particularly with respect to insufficient personnel especially in the rural towns. This notwithstanding, the Ghana Health Service (GHS) in collaboration with IPAS international is currently undertaking a training programme for willing medical officers and midwives of the service to offer abortion services in an effort to making abortion safe in the country.

Induced abortions, whether safe or unsafe, are a compelling indicator of the incidence of unintended pregnancies. Unintended pregnancy is the primary immediate reason that women throughout the world irrespective of age, level of education, religion or residence obtain abortions (Singh et al 2006). And this is the result of the incidence of an unmet need for contraceptives.

There is no doubt that unwanted pregnancies and induced abortions can be effectively and cheaply prevented—with contraceptives. In an article "abortion can be safe, legal and still rare" Cohen (2001) affirms therefore, that since most people inevitably will be sexually active for many years of their lives the most effective way to reduce abortion is to increase access to contraception.

It must be acknowledged however that the availability of and accessibility to contraceptives do not guarantee usage. It is believed that the acceptance and usage of a phenomenon like contraceptives is greatly determined by the general perceptions of the people it is intended for. Hence an exploration into the perceptions of the community on issues of induced abortions and contraceptives as well.

1.2 Problem statement

Contraceptive usage in Ghana like most West African countries is woefully low. According to the Ghana Demographic and Health Survey (GDHS), contraceptive prevalence levels stands at 25% for all methods and 19% for all modern methods (GDHS 2003). A similar figure, 22% is given by UNICEF as Ghana's prevalence rate compared to 82% prevalence in the United Kingdom, 76% prevalence for the United States and 53% prevalence in Zimbabwe, also an African country. (UNPD, March 2001)

In view of these low figures, one would have expected a corresponding high fertility rate. This is however not so. Ghana's total fertility rate (TFR) has seen a remarkable decline over the years from a TFR of 6.9 in the late 80s to 4.4 presently (Mba and Kwankye, 2007). According to the former director of the family health unit of the Ghana Health Service, Dr. Henrietta Odoi-Agyarko (2003) the decline in total fertility rate over the years far exceeds the

increase in contraceptive prevalence and is inconsistent with international experience on the relationship between fertility and contraceptive prevalence. In a similar opinion earlier, Anarfi (1996) had argued that the rapidity of Ghana's fertility decline cannot be entirely credited to contraceptive usage as there was very little correlation between fast declining fertility and contraceptive usage. Instead he implicated induced abortion as another major contributor and blamed it on the widespread and uncontrolled use of herbs in Ghana, some of which are potent enough to act as abortifacients.

This huge discrepancy between low contraceptive use and the declining fertility rate according to Mba and Kwankye (2007) can only be explained in terms of major changes in the proximate determinants; of which foetal loss or abortion is cited as one.

Studies on characteristics of women who seek abortion have confirmed this fact. In a study by Lassey et al (2006), on the complications of induced abortions, none of the 212 participants had used a modern contraceptive in the last three months preceding the pregnancy. In a similar study by Ahiadeke (2001), 64% of the women who had obtained abortions were married, suggestive of a constant active sexual life; yet all participants reported having had a previous induced abortion indicative of a lack of contraceptive use.

Kumasi, Ghana's second largest city is no exception to the findings discussed above. The prevalence of induced abortion is marked in the metropolis. Of the annual maternal death audits, septic incomplete abortion ranks among the top five causes of maternal deaths. Predictably, contraceptive prevalence is low. According to the annual report of the Kumasi Metropolitan Health Directorate (2006), contraceptive prevalence stands at 11.4% thus falling

further below the national prevalence of 19%. According to the Kumasi Metropolitan Director of Health, induced abortion poses a huge public health problem in the metropolis.

The low level knowledge of contraceptive use and the practice of unsafe abortion with its complications in the study area have informed this study. To do this, the questions to answer now are:

- Are Ghanaian women using abortions as a means of birth control in the face of an unmet need of family planning methods?
- Has society wordlessly acknowledged induced abortions as a means of birth control?
- Are people well informed about the issues of reproductive health and also about contraceptives?
- Are Ghanaians aware of the effects of induced abortion?
- Are men well informed on the methods of contraceptives?

1.3 OBJECTIVES

1.3.1 General objective

To assess community perceptions on induced abortions and contraceptive methods

1.3.2. Specific objectives

- Assess the community's knowledge on complications of induced abortions.
- To identify male participation in abortion;
- To identify cultural beliefs about abortion and contraception
- To assess the community's knowledge of contraceptives methods

1.4 Justification of study

Though the subject of abortions has been widely researched into, these studies have focused on incidence and trends of morbidity and mortality. There have been few studies on community perceptions of induced abortions. Induced abortions, safe or otherwise have physical, social and psychological consequences on the individual, the family and state resources. It is therefore appropriate that emphasis is placed on the primary preventive measures i.e. the prevention of unwanted pregnancies that lead to the abortions.

This study therefore seeks to identify the perceptions of the community on induced abortions with respect to its prevention and complications, to serve as a baseline for the formulation of practical approaches to the prevention of unintended pregnancies. It is believed that the community is where unwanted pregnancies and abortions originate and where strategies to reduce maternal morbidity and mortality from unsafe abortion must ultimately be implemented.

From literature, there are no publications on community perceptions on induced abortions in the Kumasi metropolis. Hence it is anticipated that this study into the community's perceptions will generate views from different members of the community that can provide insight into the context of unwanted pregnancy and induced abortions. The burden of abortions underscores the need to conduct the study into the perceptions of the community on the issue of induced abortion and contraceptive use and thus serve as a guideline for the formulation of effective practical preventive policies and programmes.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 introductions

This study looks into community perceptions of induced abortions with regard to the prevention of unintended pregnancies and knowledge into abortion complications. This chapter reviews available literature related to the topic under study. The studied literature relates to this study in a number of perspectives. Review of literature therefore involves the following:

- Overview of induced abortions
- Knowledge of complications of induced abortions
- Knowledge of contraceptives
- Male participation in the abortion process
- Cultural beliefs about contraceptives

The reduction in maternal deaths is a key developmental goal in the national and international public health circles. As such, no stone is left unturned in the quest for solutions. This quest has lead to the discovery of one major culprit—induced abortions. Induced abortion is defined here as the planned interruption of a pregnancy with the intention of getting rid of the unborn foetus. Two types have been described in the medical and public health circles, - safe and unsafe. The WHO defines unsafe abortion as "a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both" (WHO 1994).

Induced abortion, whether termed safe or unsafe, poses a huge public health problem to society; considering the potential physical, psychological and economic implications associated with the practice.

The practice is widespread, cutting across international, political and cultural boundaries. That is, when confronted with an unwanted pregnancy, a woman, irrespective of education or social class will often go the extremes to terminate it, with no consideration to it socio-cultural, religious or legal implications (Morhee and Morhee 2001).

The issue of induced abortion has generated a lot of concern lately in the socio-political and public health circles due to its enormous contribution to the incidence of maternal morbidity and mortality. It is estimated that 80 million unintended pregnancies occur annually throughout the world, of which about 42 million are deliberately aborted (WHO 2003). Of these abortions, a significant number, 22 million is performed under unsafe conditions which results in an estimated 70,000 women dying from their complications (Okonofua 2004). This contributes to 13% of maternal death globally (WHO fact sheet 2007). Recent studies have indicated that a woman dies every 8 minutes somewhere in a developing country from the complications of induced unsafe abortions (WHO 2007). These deaths are highest in Africa, where there were an estimated 650 deaths per 100,000 unsafe abortions in 2003, compared with 10 per 100,000 in developed regions.

The social implications beyond this numbers of deaths are immeasurable. It has been approximated that 220,000 children worldwide lose their mothers every year from abortion-related deaths (Singh 2007).

Sub Saharan Africa appears the worst hit by the pandemic, with nearly half of the deaths occurring in that region alone (WHO 2007). Induced abortion is estimated to contribute 13% of maternal deaths in Ghana, although these figure is argued to be an under estimate (GHS REDUCE 2005). Studies conducted revealed that about a quarter of maternal deaths in Ghana's two major teaching hospitals, Korle-bu and Komfo Anokye is due to complications from induced abortions (Lithur 2006). However, it should be realised that these deaths are a drop in the ocean compared with the number of women who end up with severe immediate and long term complications.

Worldwide, an estimated five million women are hospitalized each year for treatment of abortion-related complications, such as haemorrhage and sepsis. The impact of induced abortions on our health care system can therefore not be over emphasised. In Ghana a newspaper report has it that complications from abortions are the leading causes of admissions in a district in the Central Region of Ghana (Lithur 2006). Invariably, the treatment of abortion complications consumes a significant share of medical resources, including hospital beds, blood supply, medications, and often operating theatres, anaesthesia and medical specialists. These places great demands on the nation's already outstretched clinical, material and financial resources of hospitals thus compromising other maternity and emergency services.

Induced abortion has become one of the most widely debated issues of our time-ethically, legally, socially and medically. With regard to ethics, one group, called the pro-choice, believe that a pregnant woman as part of her reproductive right, has a right to choose to have an abortion. This group argues that a foetus is only a potential human being when it is able to survive outside the mother's womb. At the other end of the pole are the pro-life supporters

who believe that a foetus is a human being right from the time of conception and as such has a right to live (Microsoft Student Encarta 2008).

The debate of legalising abortions has also been held by many in the national and international public health sector. One section believes that legal restrictions on abortions will result in it being obtained clandestinely and dangerously. It has been indicated that when abortion is legalised and permitted, it is generally safe. A typical example is made of South Africa where a liberalisation of the abortion law in 1996 saw decrease in the incidence of abortion complications by 52% (WHO 2007). The incidence of unsafe abortion is highest in West Africa where abortion laws are strict in most countries. In her paper, Lithur (2006) indicated that criminalisation of abortions in Ghana among others has contributed to it being sought clandestinely and dangerously.

On the other hand, others argue that legal restrictions on abortion do not affect its incidence. In consideration of the effects of legal restrictions on abortion in Ghana, the law was amended and made relaxed in 1985. The relaxation however has not done much to improve the incidence and severity of the practice, as knowledge of rights to safe abortion is still limited to the public sector. This has been blamed on the high levels of illiteracy and social deprivation among Ghanaian women. (Morhee and Morhee, 2006)

It is also believed that legalisation or liberalisation does not mean availability and accessibility. The Ghana Health Service, in an effort to curb the morbidity and mortality associated with induced abortions, has shown increasing commitment by proving comprehensive abortion care. This includes training of staff to offer safe abortion services as

well as give special attention to the populations with special needs such as the adolescent (Morhee and Morhee, 2006). The practicality of this policy has also been questioned considering the state of the health services in Ghana with respect to the rural-urban dichotomy.

Others believe that the provision of alleged therapeutic, safe abortion services is not the one definite way to reducing the incidence of deaths and complications associated with induced abortion. In an article "Reviewing the Medical Evidence: Short and Long-Term Physical consequences of Induced Abortion" Shadigian (2005) stated that, induced abortions, obtained therapeutically is as well associated with complications which is often underestimated and overlooked due to its delayed nature. Conditions as placenta praevia, which necessitates a caesarean section in subsequent births; preterm births and maternal suicide, are known to be associated with therapeutically obtained induced abortion. Other long term risks mentioned are breast cancer, ectopic pregnancies as well as infertility.

She proposed that if the general public and women in particular are adequately informed on these consequences, the incidence of induced abortions and its attendant complications around the globe will be greatly reduced.

However, in deliberation to formulate policies and draw programmes, it is expedient that time is taken to study the communities that the policies are meant for since it from the communities that the abortions arises and where it impact is felt most.

2.1 Knowledge of abortions complications

It has been well acknowledged that ignorance is the root cause of most of the problems facing the world. Often people's level of knowledge of a phenomenon influences their views on that particular subject which tends to influence their decision making on acceptance or rejection. Several studies have identified a host of complications associated with induced abortion. Few studies however have been done to assess the knowledge of the community on these complications.

In one such study, Jagwe-Wadda et al (2006) identified community knowledge on the complications of induced abortion among members of a community in Uganda and found that though the community had adequate knowledge, induced abortion was still widely practised. Among the complication cited by the community were pain, sepsis, bleeding and infertility. The community again had adequate knowledge about the social and economic consequences on the woman and her family are exposed to such as income loss when she is unable to work.

In Ghana, Owusu-Achiaw (2003), conducted a study on the knowledge of the complications of induced unsafe abortions among adolescents in the Hohoe district and found a high level of knowledge among 99.6% of respondents. Death and infertility were the most well-known complications identified. Nevertheless, the study found that these levels of knowledge had had no influence on the sexual behaviours of these adolescents.

2.3 Male participation in contraception and induced abortion

Issues of sexuality and reproduction certainly involve men as well as it involves women although women tend to bear gravely the health consequences of whatever decision is made. Secondly, in an environment of high gender imbalances favouring men, women often have

little control over when, with whom and in what circumstances they have sex. Such women are therefore more exposed to unintended pregnancies since they must rely on the man to prevent pregnancy (Allanson & Astbury (2001). This is particularly so especially in most African cultures where decision making about sex, pregnancies and its outcome are considered to be the sole rights of the men. Consequently male involvement in reproductive health issues is being given consideration in recent times.

This notwithstanding, few studies have been conducted on men about contraceptives and abortions globally especially in Africa and Ghana in particular. These studies indicate that men are actively involved in deciding and obtaining induced abortion.

For example, in a community based study in India on husbands' involvement in abortions, majority (55%) of the respondents reported that their husbands participated in the decision to seek abortion. Twenty-five percent had stressed further that their partners were solely responsible for the decision (Indian population council, 2005)

In another study by Singh et al (2006) on abortions in the Philippines, 43% of the women who had obtained abortions had done so in consultation with their husbands or partners.

Again in Africa, it is recognized that in most cases of abortions male partners often play significant roles. Nyanzi et al (2005) conducted a study on men's perception and attitude towards induced abortion among taxi drivers in southwest Uganda. The result indicated that, men played major roles such as deciding on the abortion option; as well as providing financial means and providing the abortifacients.

In addition, male partners also influence the choice of abortion indirectly by their actions. For example, a research on adolescents in Ghana by Henry and Fayorsey (2002) found that a significant number of the women who had obtained abortion had claimed that partners' irresponsible attitude toward their pregnancies were the reasons for their choice of abortion. These studies underscore the claim that men are greatly involved in the induced abortions process as much as they are in making of the pregnancies.

However, with the subject of contraception, a very important means in the prevention of unintended pregnancies and hence induced abortions, a number of studies have revealed a rather low knowledge and poor attitude among the men folk. Odu et al (2006), in a study on men's knowledge and attitude towards family planning in a suburban community in Nigeria, found that although majority of the respondents were aware of some common contraceptive methods e.g. the condom (86.6%), knowledge of the female methods was low e.g. knowledge of the Norplant and the IUCD was 17.5% and 26.3% respectively. Again, there was poor knowledge even on some methods designed for males such as vasectomy (28.6%). Consequently, the results showed a relatively poor (52%) attitude towards the use of contraceptives.

In addition, several studies have implicated partner dissatisfaction as a major barrier to contraceptive use among women. A study by Sedge et al (2007) among selected sub Saharan African countries including Ghana reports that, 23% of women with unmet needs of family planning cited partner opposition as reason for non use.

2.2 Knowledge of contraceptives

As virtually every induced abortion is assumed to be the result of an unintended pregnancy, it can be inferred here that knowledge and effective use of contraceptives will invariably lead to a reduction of induced abortions.

Several studies have shown a correlation between increased contraceptive use and a reduction in induced abortions. Russia, a post-Communist nation had one of the highest abortion rates in the world. These rates created a legacy of significant medical problems including complications from abortion such as maternal deaths and secondary infertility and a huge burden on health services as a result of abortion morbidity. The picture has improved considerably, however, since the late 1980s, as contraception has become more available (Deschner and Cohen, 2003).

According to Singh et al, (2003) two-thirds of unintended pregnancies in developing countries occur among women who are not using any method of contraception.

This notwithstanding, contraceptive use in the developing world especially Sub Saharan Africa continues to be disappointingly low. For instance the contraceptive prevalence for Ghana and Nigeria for the year 1999 was 22.0% and 7.4% respectively compared with 82% and 76.4% for the United Kingdom and the United States respectively in the same year (UN Population Division, March 2001).

Various conferences, strategies and programmes have been developed in an effort to beef up contraceptive prevalence especially in countries where abortion poses a major public health problem.

It is believed that adequate knowledge of the benefits of contraceptives is an important drive in determining acceptance and use of the various methods. Additionally, concerning reproductive health issues, it is important that individuals possess adequate knowledge, in order to make informed choices on products and services available. This is however not so. Research has revealed rather low levels of knowledge of the various contraceptive methods among the reproductive age group.

A study at the Guttmacher institute revealed that, 32% to 38% of women in sub Saharan Africa with an unmet need for family planning gave reasons that pertained to knowledge of family planning as reasons for non use. (Sedge et al, 2007).

In a related study in Nigeria on contraceptive knowledge among adolescents, Otoide et al (2001) found that, with the exception of the condom, there was poor knowledge of the mechanism of action for modern methods, as well as poor knowledge of their non contraceptive benefits among adolescents in the Nigerian city. This low knowledge had led to low usage of contraceptive among the adolescents.

Considering a strategy for involving men in family planning issues, Petro-Nustas, conducted a cross sectional study in Jordan on men's knowledge of birth spacing and attitude towards contraceptives. The study revealed that although 98% of the respondents had heard about birth spacing, about two-thirds of them lacked knowledge on where to get information and supply of contraceptives. Further the study revealed a positive attitude toward birth spacing and contraceptive use among men with at least a secondary education and among those with a higher income than among their less-educated and less well-off counterparts (Petro-Nustas

(1999). This lack of information on contraceptives was found to be a contributor to the low levels of usage.

On the other hand, knowledge does not always lead to acceptance and practice.

In Ghana, the DHS (GSS et al 2003) reveals that contraceptive knowledge is widespread with 98% of women aged 15-49 and 99% of men aged 15-59 knowing at least one method of family planning. These high levels of knowledge unfortunately are not translated into usage. For instance, only 19% of women in union reported using any modern method of family planning.

2.3 Cultural beliefs about contraception

Several beliefs, misconceptions and myths have been associated with contraceptive use. These tend to have negative influence on usage and thus increase the prevalence of unintended pregnancies and induced abortions among the population. Negative contraceptive beliefs are defined as cognitions or interpretations about family planning methods that are not confirmed by authoritative sources, but are seriously entertained by 1 or more (often, large numbers of) person.

In a similar study in Nigeria on why adolescents preferred abortions to contraceptives, Otoide et al (2001) discovered that a strongly held misconception about fear of future infertility among Nigerian youth was an overriding factor in their decisions to rely on induced abortions which they perceived had a short term effect; rather than contraception.

In another study in Uganda, Jagwe-Wadda et al (2006), found that a general widespread misconception about contraception was the reason behind the low contraceptive usage. For

instance the perception is broadly held that modern contraceptives were ineffective and that women get pregnant on the family planning methods.

The reasons why women (married and unmarried) do not use contraceptives most commonly include concerns about possible health and side-effects and the belief that they are not at risk of getting pregnant (Sedge et al 2007). The research which was conducted among some selected countries around the globe including Ghana identified a perceived low risk of a pregnancy as a prominent reason behind non-use of contraceptive. About a third of SSA women in the study cited this as reason. A significant number gave infrequent sex as the main reason behind this perceived low risk. The study further revealed, however, that a sizeable proportion of these women (34-37%) had unprotected sex over the 3 months preceding the study.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study type

The study is a community based, cross - sectional type employing both qualitative and quantitative methods.

3.2 Study Area

The study was undertaken in Kumasi, Ghana's second largest city, located about 300km north of the national capital, Accra.

The city is 150sq km in size making it by far the largest in the Ashanti region. Kumasi is bounded by four districts: Kwabre on the north, Bosomtwe Atwima Kwanwoma on the south, Ejisu Juaben on the east and on the west by Atwima.

It has an estimated population of 1,478,869 with an annual growth rate of 3.4%. The population figure is however applicable only during the night since the day time population is above 2,000,000. (MHD Annual Report 2007)

For purpose of health services activities**,** the city is divided into ten (10) sub metros namely; Manhyia, Tafo, Suame, Asokwa, and Oforikrom. Others are Asawase, Bantama, Kwadaso, Nhyiaeso and Subin.

Kumasi is a cosmopolitan city with trading being the main occupation of the inhabitants. It contains members of most major ethnic groups from West Africa, although the indigenous Ashanti people dominate life in general especially in commerce. The Asante Twi is the dominant language that is consequently spoken and understood universally. The major religious groups are Christianity and Islam.

The metropolitan city of Kumasi is also the traditional home of the Ashanti people with their rich cultural heritage. The city is therefore filled with cultural ceremonies and busy social activities like funerals, puberty rites and marriage ceremonies. These ceremonies which are often accompanied by merry making, alcohol abuse etc often predispose them to irresponsible sexual behaviours.

The city has had its fair share of the recent trend of modernisation and western influence on most African cultures. This has lead to the infiltration of different cultures with their attendant influence on the youth of the metropolis. Again, it location at the middle belt of the country makes it a transit point for commuters between the north and south of the country. This makes the city susceptible to aliens, casual acquaintances, and risky sexual behaviours with the attendant health related problems such as unintended pregnancies leading to induced abortions as well as HIVAIDS. For instance, according to the 2007 HIV sentinel survey report, Kumasi is ranked the 6th most prevalent city in the country.

3.4 Study population

The study population consist of all women aged 15 to 49 years and men 15 to 59 years. These age groups were selected as they are the accepted reproductive age for the respective sexes. In addition, opinion leaders and health workers were interviewed as key informant for their rich experience.

3.5 Sampling

A multi stage sampling method was employed for the study as follows:

3.5.1 Selection of sub metros

Due to the very insufficient data on induced abortion in the metropolis due to it clandestine nature, figures of contraceptive prevalence and maternal mortality were used as a criteria for selection of the sub metros. The Manhyia south sub metro was therefore purposively selected as it had the lowest contraceptive prevalence and also ranked second to Asokwa as having the highest number of maternal deaths in the metropolis. Again the Manhyia south sub metro is well represented with both urban and rural communities that are characteristic of Kumasi. (The sub metro has recently been divided into the Manhyia and Asawase sub metros to conform to the political demarcations of the Kumasi metropolis).

3.5.2. Selection of communities

A list of communities of the two sub metros, as demarcated for health services, were obtained from the Kumasi Metro Health Directorate, ten communities, which constitute about 20% of the total 52 communities of the sub metro, were selected by the lottery method. Here, corresponding numbers of the list of communities were written on pieces of paper, folded and shaken together. One after the other, numbers were randomly selected without replacement until the ten communities required were attained.

Further, with a sample size of 400, a proportionate sampling method was employed to select the number of respondent required from each of the selected communities based on the size of the population of that particular community.

3.5. 2. **Selection of houses**

Since a list of houses expected to be obtained from the Ghana statistical services was not forth coming, a systematic sampling method was employed. Each day, two houses were picked independently by researcher and an assistant. The team then tossed a coin to determine which house was to be the focal point. Subsequently, every second and opposite house was selected in that order until the required number of respondents for that community was achieved.

3.5.3. Selection of individual respondents

At the households, convenient sampling method was employed for the selection of individual respondents. Thus eligible respondents who are available and willing were interviewed.

3.6 Sample size

Sample size was calculated using Epi-info version 6, a population survey/descriptive study random sampling. In reference from the 2000 Ghana population census, the total population of the reproductive age group for both sexes was 49% of the total population of the country. It was then inferred that the population for the reproductive age group constitute 49% of the total population of Manhyia and Asawase Sub metros.

The Manhyia and Asawase sub metros have a total population of 266,022. Ten communities sampled from the 52 communities of the two sub metros had a total population of 58,102. Therefore the population of the reproductive age group for the ten communities was taken as 49% of 58,102 which summed up to 28,470. Using Epi Info stat calc, the level of knowledge was assumed to be 50% expected frequency and 45% worst acceptable results. With a

confidence level of 95%, a sample size of 379 was arrived at, which was approximated to 400 to make up for loses during data collection.

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3.8 DATA COLLECTION TECHNIQUES/METHODS AND TOOLS

Both qualitative and quantitative approaches were used to study the perceptions of the community on issues about induced abortion and contraception.

The qualitative data were collected using focus group discussion (FGD) and in-depth interviews (IDI) of opinion leaders and health workers.

In addition, an interviewer administered semi-structured, predominantly open ended questionnaires were administered to 400 individual respondents in the communities.

3.9 Training of Research Assistants

Three research assistants were employed in consultation with the field supervisor. The primary basis for selection was their experience from previous studies as well as their fluency in the English and Twi languages. They were taken through a two day intensive training programme purposely for this study. The content of the training included the objectives of the study as well as techniques and tools to be used in data collection.

3.10 Questionnaire administration

The researcher with her assistants reached into the selected communities with the data collection tools. In the community, a house was selected randomly after which every third house was selected in succession.

In the selected houses, eligible respondents who were willing were interviewed. Each respondent was first taken through an introduction to the study and verbal and written consent documented. For minors, consent was sought from their parent if at home; or from their instructors if they are met at the saloons, mechanical shops and other places of work before any interviews were done.

The questionnaires were administered one on one with respondents in a private, relaxed atmosphere, usually in the Twi language in the form of an interview which lasted for about 10minutes.

3.10.1 In-depth interview

Purposive sampling was engaged to select some personalities in the communities for interviews. With letters of introduction, the researcher and her assistants called on the selected leaders for detailed interview using similar but specially developed semi structured interview guides.

Unlike in the structured questionnaire administration, participants were not asked question about their personal experiences in relation to contraceptive use or induced abortions. In all 4 opinion leaders and 4 health workers were interviewed.

Permission was sought and the interview recorded with a voice recorder as a well as notes taken.

3.10.2 Focus group discussion

Four focus group discussions (FGD) were organised, which comprised younger men aged between 18 and 30years; and older men between the ages of 30 and 45years. Same was organised for their female counterparts in the respective age brackets. Each group consisted of about 8-10 members.

The purpose of the FGD was to elicit a detailed and broader perspective of societal beliefs, norms and values as far as the issues of contraceptives and induced abortions are concerned.

Topic discussed centred on:

- The prevalence of induced abortions in the communities
- The recent trend in methods used
- Knowledge of the potential complications
- Reasons for preference for the various methods of contraception
- Beliefs about the various contraceptive methods

Prior to the discussions, a brief introduction of the participants and informed consent were documented.

During the discussions, the researcher took the role of a moderator while the assistants were each assigned the role of note taking and voice recording.

3.10.3 Quality control measures

A number of principles were followed to achieve a standard quality. First, competent research assistants were recruited and purposely trained for data collection.

Each day the researcher met with the assistants at a particular point on the field where all administered questionnaires are checked. Errors and omissions detected were discussed with

the respective research assistants and the necessary corrections made if need be. This was to ensure that all information has been properly collected and recorded.

All questionnaires were numbered and marked after each entry to prevent double entry.

3.12 Pre-test

Techniques and tools were pre tested for clarity. The pre-testing was conducted in the Tafo community (previously in the Manhyia north sub metro). With the assistance of the head of public health unit of the Tafo government hospital, a total of 40 respondents were interviewed. The research team met after the day's activity where each questionnaire was critically analysed and errors and omissions noted. These changes served as a guide that was incorporated into the final tool for the actual data collection

3.11 Ethical considerations/ issues

The study was designed to conform to the required ethical guidelines regarding the use of human subjects. Ethical clearance was obtained from the Ghana Health Service Ethical Review Committee. Permission was sought from the Kumasi Metropolitan Health Directorate in addition.

Written and verbal informed consents were again obtained from each participant before data collection. Participants had the liberty to opt out of the study at any stage of the interview or refuse to answer questions they were not comfortable with.

Anonymity and confidentiality was duly adhered to in the course of data collection. Names of participants were not recorded

3.13 Data processing and analysis

Once field work was completed, the questions and responses were coded into numeric form for data entry. A data entry structure was developed in Epi-info version3.3.2. Data entry and analysis for quantitative data were done in reference to the set objectives using the Epi-info version3.3.2. For qualitative data, all were recorded and analysed manually.

3.14 Limitations

Due to the time constraints and limited resources, only 10 communities were sampled out of the 52 communities in the sub metros and a sample size of 400 out the over 266, 025 population size. Findings may therefore not be a true representation of the views of the Manhyia and Asawase sub metros.

Again due to the inadequate funds and time, the FGD were held only in two communities instead of the 10 selected communities.

Members of the community with formal employment were under represented in the study as they had left for their respective offices by the time the interviewers got into the communities.

CHAPTER FOUR

RESULTS

4.1 Socio-demographic characteristics

A total of 400 respondents consisting of 197 males (49.3%) and 203 females (50.7) were interviewed with a semi structured questionnaires. The result reveals 15years and 56years as the minimum and maximum respective ages of respondent. For purposes of analysis, the age of the respondents were grouped mainly in categories of 10 years intervals with the mean age of 26.9years and 24years as the mode. The details of the sex and age characteristics of respondents are shown in table 1

The results also indicate that, 96.7% of respondents have had some form of formal education ranging from primary education, 3.3% to tertiary, 19% with JSS/middle category making up the majority, 33.8%

The results further indicate that majority of the respondents 63% (N=254) are unmarried. This however, is not an indication of sexual abstinence. The remaining are: married 23.5%, (N=94) cohabiting 9%, (N=36) divorced 2% (N=8) or seperated1.8% (N=7).

For religious affiliation, 80% of the respondents (N=371) were Christians with Muslims making 9.8% (N=19).

Table 1 reveals the various religious denominations.

Table 4.1 Demographic Characteristics of Respondents

Characteristics Of	Number Of Respondents	Percentage (%)

Respondents		
Age group		
15 – 19	56	14.0
20 – 29	236	59.0
30 – 39	77	19.3
40 – 49	27	6.7
50 – 59	4	1.0
Total	**400**	100
Sex distribution		
Male	197	49.3
Female	203	50.7
Educational Levels		
No formal education	13	3.3
Primary	5	1.3
Middle/JSS	135	33.8
Secondary/SSS	130	32.5
Post Secondary	40	10.0
Tertiary	77	19.3
Marital status		
Never married	254	63.5
Married	94	23.5
Consensual/Cohabitation	36	9.0
Separated	7	1.8
Divorced	8	2.0
Widowed	1	0.3
Religious affiliation		
Pentecostal/Charismatic	186	46.5
Catholic	60	15.0
Muslim	39	9.8
Methodist	38	9.5
Presbyterian	36	9.0
Anglican	11	2.8
Traditional/Spiritualist	1	0.003
No Religion	10	2.5
Other	19	4.6
Total	**400**	**100**

The analysis further reveals that only 195 of the 400 respondents provided information about their income. The mean income for respondents was GH¢147.9, with GH¢18.0 and GH¢1500.0 as the minimum and maximum income respectively.

In all 82% (N=327) of the sampled respondents said they have been sexually involved with the opposite sex, 15.8% have never had sex while 2.5% of respondents refused to answer.

Sexual relationship according to Maslow's hierarchy of needs is a basic human need, which fulfils a physiological as a well as love and belonging needs. Studies have shown that this need peaks in the adolescent stage. As shown in figure 1, a greater number of the sexually active respondents have had their first sexual encounter by the age 19 (59.9%). Among those who have had sexual relationships, the minimum age at first sexual intercourse was 10years with 33years as the maximum age. Mean age of respondents at first sex is18.97, with 19.3 for males and 18.7 for Females.

Figure 4.1 Respondents age at first sex

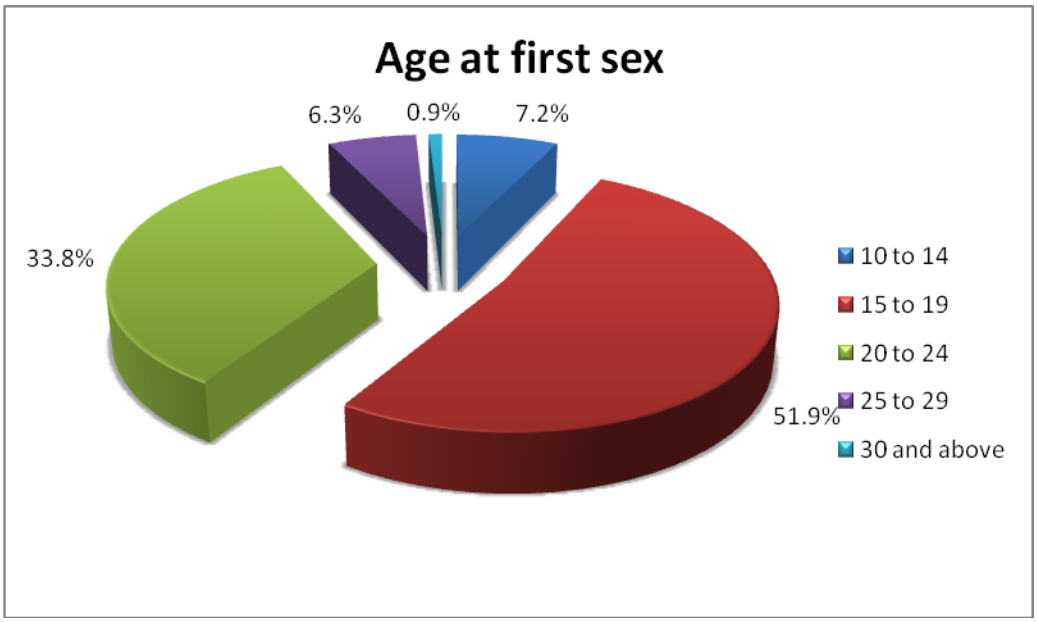
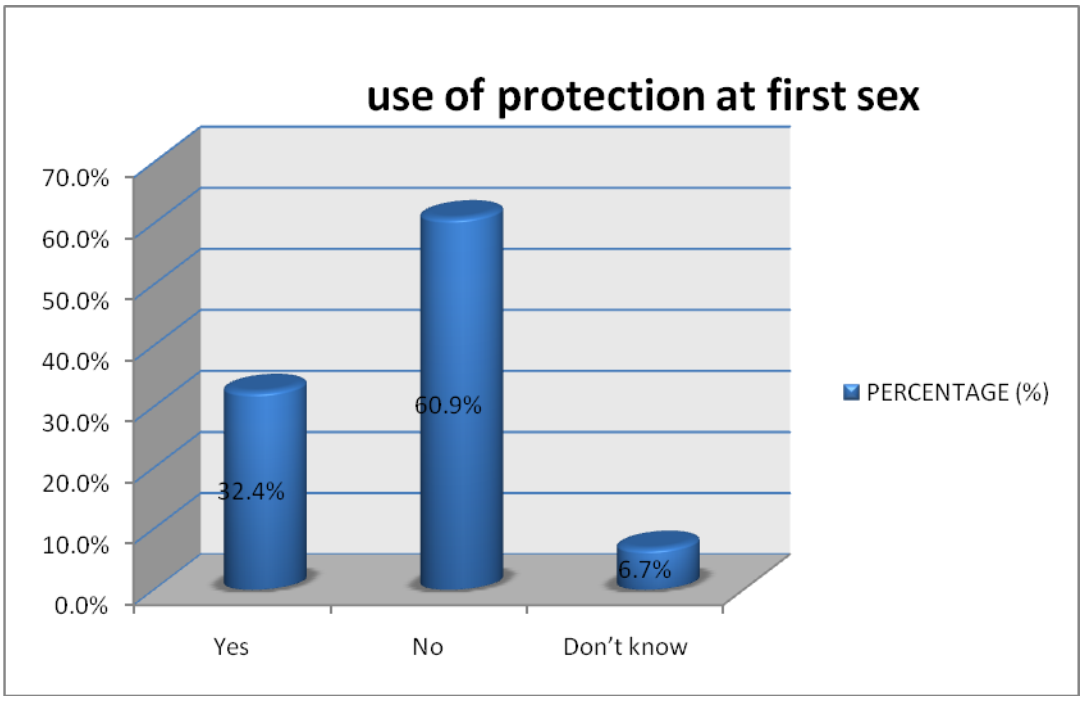


Figure 4.2 Use of protection at first sexual intercourse



As shown in figure 2, less than a third of the respondents had used any form of contraceptive during their first sexual intercourse. A greater proportion, 60.9% responded not using any protection against pregnancy. Of these, 43% gave reasons such as ignorance of contraceptives at that time; 26%, as dislike for it, while others gave unavailability of contraceptives, being in a hurry and partner refusal etc for not protecting against pregnancies.

4.2 Knowledge of abortion complications

Knowledge of the complications of induced abortions was high among the community members. Of the structured questionnaire, 95.5% respondents had some knowledge about the consequences of induced abortion. In an instance, 137 respondents stated correctly one complication associated with induced abortions. Another 125 were able to name two complications they believed may arise from terminating a pregnancy while 40 and 27 respondents gave 4 and 5 complications respectively as a consequence of the termination of a pregnancy.

Given the option of a multiple choice, 323 respondents were quick to mentioned death as a complication that can possibly arise from induced abortion. Other complications cited are sepsis (259), infertility (249), severe bleeding (145), severe pain (100) and drastic or chronic loss of weight often associated with. A small number, (8) was of the view that nothing really happens to women who terminate a pregnancy while 5 respondents said they could not think of any complications of abortion.

In addition to testing respondents' level of knowledge of physical complications they were asked to cite some perceived complication that may not have a physical bearing. A hundred and sixty two respondents (36.8% of responses) believed that guilt/regret is the primary non-physical complication often associated with the termination of pregnancies. Fear of the unknown was also cited by 132 respondents (30% of total responses), a smaller number (20% of responses) were of the view that induced abortion results in stigmatisation and a feeling of rejection. Only one person (0.2% of total responses) believed that the termination of a pregnancy brings about insanity on the woman. The respondents however, had low

knowledge of the economic and social implications associated with the practice. None of the respondents stated financial loss as a non-physical complication.

Table 4.2 Respondents' Knowledge of Complications of Induced Abortions

Complications	**Number of Responses**	**Percentage (%)**
Death	326	24.3
Sepsis	259	19.3
Infertility	251	18.7
Severe Bleeding	145	10.8
Severe abdominal pains	100	7.4
severe pallor	94	7.0
Loss of weight	88	6.5
Disability	56	4.1
Other Illnesses	15	1.1
Nothing will happen	8	0.5
Don't know	5	0.3
Total number of responses	1340	100
Would You Seek Abortion in the Event of an Unintended Pregnancy?		
Yes	90	22.5
No	306	76.5
Refused	4	1.0
Total	400	100
Primary Reasons for Opting for Abortion		
If it interrupt education /career	48	53.3
Financially incapable	32	35.5
Complication to her health	12	13.3
Raped	9	10.0
Social problems/stigmatization	2	2.2
If Partner doesn't accept pregnancy	2	2.2
Parents don't like partner	2	2.2
Total	90	100
Primary Reason for Rejecting Abortion		
Sin/Immoral/ against religion	99	29.4
Can cause death	71	21.1
Other Complications associated	77	22.7
Bad practice/amount to murder	55	16.3
Baby may have bright future/has right to live/is innocent	20	5.9
Guilt/fear of stigmatization	10	2.9
Partner won't agree	4	1.1
Total	336	100

This level of knowledge of complications notwithstanding, acceptance of abortion among the respondents was significant. Ninety out of the 396 respondents (22.7%) stated that they would opt for an abortion in the event of an unintended pregnancy.

To a question on her source of information to the facility she had obtained abortion, a 38yr old woman replied

"The first time, a friend accompanied me to the place but for subsequent ones I go by myself since I've become conversant with the place". Suggestive of a regular use of abortion as a birth control

Table 4.2 above gives details of respondents' knowledge of the possible complications as well as their views on induced abortions.

Further, out of the 327 sexually active, a significant number 116 i.e. (35.5%) reported having induced an abortion before. Of these, 50 (43%) were men whiles women made up 66 (57%). Various reasons were given by respondents for the termination of pregnancies. Forty-two respondents (35%) said they obtained abortion to enable them continue their education, 26 (21%) cited financial constraints as the cause of their decision to terminate the pregnancy, while 13(10.9%) mentioned that they opted for abortion because their last child was too young. Table 4.3 below indicates the various reasons and the place of obtaining the abortion. None of the respondents had obtained abortion for health reasons. When asked about the cost of securing an abortion, there were 68 responses with an average of GH¢52.93.

Table 4.3 Reasons for and places of obtaining abortion

Reason for abortion	Number of responses	Percentage (%)
Wanted to continue education	42	36.2
Fear of parents	11	9.4
Fear of stigmatization	4	3.4
Partner's decision	12	10.3
Financial Constraints	26	22.4
Last child too young	13	11.2
I was raped	4	3.4
Threat to health	2	1.7
Unstable relationship	3	2.5
Outside marriage	4	3.4
Total	**116**	**100**
Where Was Abortion Done		
Government Health facility	16	13.7
Private Health facility	68	58.6
Pharmacy/Drug store	11	9.4
At home	14	12.0
Provider's home	3	2.5
Refused	4	3.4
Total	**116**	**100**

During the FGD most respondents unanimously confirmed that induced abortion is a common practice in the various communities. Similar reasons such as given in table 4.3 were given for the practice as indicated in the quantitative data. During the men's discussion, however, sexual promiscuity of women lately was implicated as the primary contributor.

Of the 400 interviewed, 90.5% were of the view that, the termination of a pregnancy whether unsafe or therapeutically done has potential health consequences. A lesser number, 9.5% of respondents expressed a rather different view. This set believed that inducing abortion is dangerous to a person's health only when it is done by inexperienced persons.

Again 348 of the entire respondents have had a personal knowledge of a sufferer of at least one of the various complications of induced abortion.

This knowledge of complications of induced abortions was again expanded by most of the respondent in both sexes and ages during the FGD and the interview with key informants. The Youth Committee Chairman of the Manhyia community representing the Assembly Member of the area said reports reaching the assembly committee indicate that abortion is prevalent in the community especially among the youth. For his knowledge and views, he condemned the act outright and said it should not be encouraged.

"Abortion can have serious consequences, whether done in the hospital or induced at home. There are instances where women who have had abortion done for them by qualified personnel and yet are saddled with severe health as well as social problems as a result of the act" he said. He continued *"prevention of the occurrence of unwanted pregnancies is the solution and that is our focus in this community. We are therefore collaborating with some NGOs to intensify our education on reproductive health and especially contraceptive use among the youth".*

The matron in charge of the female ward of the Manhyia hospital however did not share this view. She was of the view that complications arise because women in their desperation seek the service from unskilled persons or through other very crude means. According to her,

even though abortion is prevalent in the Manhyia and Asawase communities, morbidity and fatalities associated with it has reduced significantly. With the introduction of the comprehensive abortion care in the hospital (a collaboration of IPAS and the GHS), the incidence of septic abortion on the wards has gradually reduced. Women with unwanted pregnancies should therefore be encouraged to seek abortion therapeutically.

"*A young woman once came here to have an abortion done. I counselled her and managed to discourage her against opting for an abortion. A few days later, she was rushed in here dying, with a stick (called nyame dua) stuck in her cervix. I felt bad"* She said

4.3 Male participation in abortion

Results from the quantitative survey indicated that men are actively involved in the abortion process. For example fifty males reported having supported their partners to get abortion. Furthermore, 18% of the women who had obtained abortion said the decision was made by their partners while another 19 (29%) of these women said the decision was jointly taken by their partners and themselves. When asked about the specific role they played in securing an abortion, 60% of the men indicated that they supported their partners financially, 26% said they accompanied their partners to the health facilities as well while another 14% said they gave their partners tablets/concoctions as abortifacients at home.

These facts were further highlighted during the FGD with the men. Here, it was obvious that men, both young and old are as much involved as women in the decision making and carrying out of the actual abortion procedure.

A man revealed during the FGD discussion with the older men

"A lady was pregnant for me. As I was thinking of what to do, my wife disclosed to me that she had taken seed. I was confused. I convinced my wife to go for an abortion because the other woman's was far advanced. Later when she got to know of it she was mad." (Older man in FGD)

An impression was however given that the younger men were however more involved with the termination of pregnancies than their older counterparts…

"A friend introduced me to a tablet that I buy from the drug store. Anytime that she misses her period, I just get it for her and sharp! It comes. Even yesterday a friend called on me with his girlfriend who has missed her period and I did it for them". (Man 29 FGD)

and are also more likely to use risky/ crude means

"There is an herb that I've been using to terminate pregnancies for some time now and it is very effective. No matter the age of the pregnancy, it will terminate it. The only problem is that it makes the girl bleed too much that sometimes I'm scared. When this happens, I buy her plenty of tin milk. She drinks the raw milk and the blood stops." (Man 24 FGD)

Furthermore, it was indicated during the FGD with the men that the modus operandi currently for the termination of pregnancies is the use of the tablet cytotec, especially when the pregnancy is in its early stage. The couple resort to seek professional help when the pregnancy is advanced or complications arise.

With respect to men accompanying their partners to seek abortion at a health facility, this fact was contradicted by the health workers at the Manhyia Government hospital. Here, service

providers made it known that women who come in for therapeutic abortion services are scarcely accompanied by their partners. It was revealed that women often came alone or accompanied by female friends.

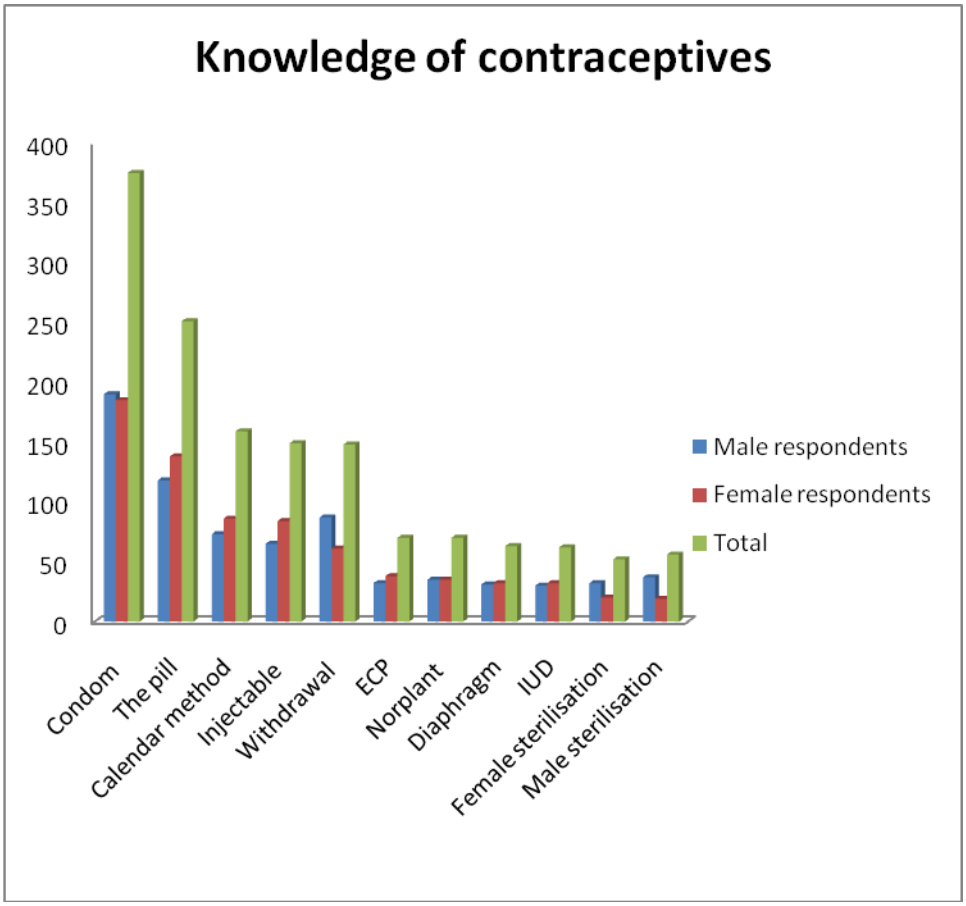
4.4 Knowledge of contraceptives

Three hundred and eighty nine of the 400 sampled members of the communities had some knowledge of contraceptive methods. Some responses given to the questions what do you know about contraceptives were: they are used to prevent unwanted pregnancies, they are used to prevent diseases, they are used to space births and similar answers.

Given the opportunity of a multiple choice, as shown in figure 4.3 below, the condom is the most commonly known among the respondents with 387 responses. This is followed by the pill (the oral contraceptive pill) with 151 responses and the calculation/calendar method with 139 responses. Another contraceptive method which was well known among respondents

especially the youth is the emergency contraceptive method which was referred to as N tablet.

Figure 4.3 Knowledge of contraceptives



When asked about the method of contraceptive they thought most effective, however the majority (146) incorrectly mentioned the condom as the most effective while another significant number (127) bluntly said they did not know which of the methods was more effective. Table 4.4 below gives the classification of the various methods as most effective by respondents.

Again, the table illustrates the most common sources of information on contraceptives methods among respondents. The media as television (272), radio (270) and also friends (158)

Table 4.4 Knowledge of sources of contraceptive methods

Sources of Information	**Number Of Responses**	**Percentage (%)**
Television	272	25.5
Radio	270	25.3
Friends	158	14.8
Health Facility	90	8.4
Pharmacy	65	6.4
Youth Programmes	61	5.7
Posters	56	5.2
School	45	4.2
Family	44	4.1
Magazines/Leaflets	31	2.9
Church Programmes	14	1.3
Internet	2	0.1
Total	**1108**	**100**
Most Effective Method	**Number Of Responses**	**Percentage**
Condom	146	**36.9**
The pill	34	**8.6**
Calculation/Rhythmic/Calender	22	**5.5**
The Injectables	18	**4.5**
Emergency Contraceptive Pill	14	**3.5**
Norplant	13	**3.2**
Withdrawal	8	**2.0**
Female Sterilization	7	**1.7**
Male Sterilization	6	**1.5**
IUCD/IUD	5	**1.2**
Don't Know	127	**32.1**
refused	5	**1.2**
Total	**400**	**100**

This level of knowledge notwithstanding, contraceptive usage in the community remains relatively low. Among the 240 currently sexually active respondents, only 121 (50.4%) are practicing contraception. These include the traditional methods which have a high failure rate.

Table 4.5 Methods currently used by respondents

Contraceptive Method	Number of Respondents	Percentage (%)
Male Condom	60	44.1
Calculation/rhythmic/Calendar	35	25.7
Emergency Contraceptive	12	8.8
The pill	11	8.0
Withdrawal	7	6.3
The Injectable	4	2.9
Norplant	3	2.2
Female condom	2	1.4
IUD/IUCD	1	0.7
Male Sterilization	1	0.7
Total Number of respondents	136	100

A sizeable number (49.6%) of respondents who are currently in sexual union said they are not practicing contraception. When asked the reasons for not using contraceptive methods, only 24 respondents (20%) gave reasons as a pregnancy is welcome. A sizeable number gave the fear of side effect (15%) and the inconveniencies such as reduced sensation associated with some contraceptives (14%) as the main reason for refusal to use contraceptives. Only one person (0.8%) gave the cost and unavailability (1.6%) of contraceptive as the basis for their not using them. Some reasons given for not practicing contraception are summarized in table 4.6. None of the respondents stated staff attitude as their reason for the non-use of

contraceptives. A significant number (17.8%) said that their reason for not practicing contraception is because they do not have sex frequently.

Table 4.6 Reasons of respondents currently in sexual relationship not using any contraceptive method

Reason	Number Of Responses	Percentage (%)
Want to become pregnant	24	20.1
Have sex rarely	21	17.6
Fear of side effects	18	15.1
Inconvenience/reduces sensation	17	14.2
Partner refuses	14	11.6
Forbidden by religion	7	5.8
Methods not reliable	4	3.3
Never really heard of/understood	3	2.5
Currently breastfeeding	3	2.5
Don't know where to get them	2	1.6
Not yet decided	2	1.6
Cost too much	1	0.8
Only one girl friend	1	0.8
Partner might think double dating	1	0.8
Passed menopause	1	0.8
Total	**119**	**100**

These reasons were further highlighted during the qualitative data analysis. During the FGD the fear of side effects were cited by most of the women as the main reason for not using contraceptives. Virtually every respondent, irrespective of sex or age had a strongly held belief especially about the modern contraceptives.

4.5 Cultural beliefs about contraceptives

Culture is the patterned behaviour resulting from social interaction" (Mercy Akumey 2007). It has also been described as a worldview, the overall perspective from which individuals see and perceive the world. Cultural beliefs shared among a community is therefore essential in determining the acceptance or otherwise of an idea or product among a community.

Shared beliefs of the community were assessed through the quantitative survey with structured questionnaire. First, respondents who were practicing contraceptives were asked to state their primary contraceptive method. Majority of the responses (40.4%) said they use the male condom to prevent pregnancies, 35 (25.7%) of the respondents indicated that they rely on the calendar method to avoid pregnancies. Further, 17 (12.5%) respondents mentioned the emergency contraceptive pill, 11 (8%) for withdrawal method and very few responses for the other modern methods as shown in figure 3.

Table 4.7 Contraceptive methods currently used by respondents

Method	**Number of Responses**	**Percentage (%)**
Male Condom	55	40.4
Calculation/rhythmic/Calendar	35	25.7
Emergency Contraceptive	17	12.5
The pill	11	8.0
Withdrawal	7	5.1
The Injectable	4	2.9
Norplant	3	2.2
Female condom	2	1.4
IUD/IUCD	2	1.4
Female Sterilization	1	0.7
Total	**136**	**100**

The reasons behind these choices and responses were further clarified in the FGD with the respective sexes. In the FGD with the women, perceived side effects that accompany the use of modern contraceptives were stated as the primary reason for their non-use. These fears were expressed both during the FGD with the younger as well as the older women. Most of them had and shared a peculiar practical example of a health consequence a relation or friend had suffered as a result of going in for family planning services. Some personal experiences were shared as well. The common side effect shared by respondents included continuous and pestering bleeding episodes, persistent general ill-health, severe weight loss, and different forms of heart problems. These examples were even more dreaded among the older women.

A lady retorted

"My elder sister who has two children was getting sick persistently. Sometimes she collapses. This went on for some time until she confessed one day that she has had the loop inserted into her womb. My mother made her have it removed immediately and gradually she was well again (FGD woman 24 years)

Another woman gave her fears as:

My friend said she did not want children again. She went to the hospital and had some pins inserted into her arm. Since then she has known no peace. It's been one problem or the other. And the nurses don't want to take it out for her, she's so frustrated.

Method failure was also sighted among the older women. One woman reported

"a colleague of mine who had 3 kids already went in for one of these methods on the persuasions of a nurse. Her periods became irregular but the nurse urged her on. Before long she was three months pregnant already without her realising. It nearly cost her marriage."

This in addition to the speculations perceived above, some younger women shared the view that some of the modern contraceptives had a permanent effect particularly the hormonal based methods. These youth would rather prefer the calendar/calculation method.

When asked to describe the safe and unsafe periods during a FGD, however, the young women gave contradictory formulas for calculating. Besides these fears of future infertility, a typical attitude of apathy towards contraceptives was also observed. An impression of "it will not happen to me" was noticed.

In an answer to male responsibility in the prevention of unwanted pregnancies, 216 (62%) of the 346 who responded said that men should be encouraged to go for contraceptive services as well. Sixty four respondents (18%) said that men should practice periodic abstinence especially when partner is in unsafe period. Fifty-five (15%) of respondents believed that the issue of contraceptives are not men's business while 11 (3%) said that men should prevent pregnancies by providing financial means for their partners.

During the FGD one woman pleaded

"Women are subjected to all sorts of pain when it come family planning--the injections and the pills as well as inserting objects into our bodies. The government should bring out more products for the men as well, so that they too can go for pills and injections that make them infertile since it takes a man to impregnate.

Further, to a men-only question on the contraceptive method they are prepared to use, 112 (63%) of the 178 respond said yes to condom. Fifteen males opted for the withdrawal method while 7 (4%) people said they will practice periodic abstinence. Only 2 people mentioned the permanent method vasectomy as preference whilst a significant number, 42 (23%) males said they will rather not use any form of contraceptive.

CHAPTER FIVE

Discussion

5.1 Knowledge of complications of induced abortions

Knowledge of possible complications of induced abortions was assessed through a one on one structured interview as well as through FGD. Ninety percent of respondents believed that abortion is prevalent in the community. The result again indicates that, knowledge of the complications of induced abortions was high among the community members. For example, 136 respondents (34%) stated correctly one possible complication associated with abortion while 261 (65.5%) stated rightly three conditions that may arise from terminating a pregnancy.

This level of knowledge notwithstanding, acceptance of induced abortions among the community was significant (22.7%). Similarly, a study in Uganda by Jagwe-Wadda et al (2006) identified a high level of knowledge of risks associated with induced abortions among the community. However, the knowledge in complications did not deter women and their partners from indulging in the act as induced unsafe abortion was found to be prevalent in the community.

Secondly, the high level of knowledge of complications associated with induced abortions has neither affected their sexual behaviour nor their attitude towards contraceptives. For instance, a sizeable number (49.6%) of respondents who are currently in sexual union said they are not practicing any form of contraception.

The findings thus disprove a claim by Shadigian (2005) that the creation of awareness of risks associated with induced abortions among women and the general public will invariably deter women from relying on abortions to control births and subsequently reduce the incidence of complications of induced abortions around the globe.

Deaths, infertility and sepsis were the most frequently mentioned complications with 326 (24%), 259 (19%) and 251 (18%) of responses respectively. This again corresponds with the Ugandan study in which majority of respondents named premature death as the first and foremost risk involved in terminating a pregnancy. Similarly, death and infertility were the most frequently cited complications among adolescents in the Hohoe district of Ghana (Owusu-Acheaw 2003).

Conversely, respondents were not familiar with the psychological complication, and to a much lesser extent socio-economic losses associated with induced abortions as was the case with the study in Uganda.

5.2 Male participation in induce abortion

The result indicates that men play active roles in securing the abortions as much as they are involved in the creation of the pregnancies. Male partners were found to be involved in the decision making about the abortion option as well as the procedure to be employed. For example, 50 males between the ages of 18 and 51years reported having assisted their partners to obtain abortion.

Additionally, 18% of women with a history of induced abortions said they had done so based on the directives of their partners. This indication of complete male involvement by the men folk in securing abortions agrees with a similar study by the Indian population council on participation of Indian men in obtaining abortion. Fifty-five percent of the women who had had abortions in the study had stated that their husbands were responsible for the decision to seek abortion.

Among roles men played in the abortion procedures are financial assistance particularly when surgical abortion is the choice; and the provision of the abortifacients in the case a medical/herbal induction. Further, 26% had gone further by taking their pregnant partners to the health facilities to obtain a surgical procedure. Similarly, a study by Nyanzi et al (2005) in Uganda found that men

played several roles steaming from taking decisions on the abortion option as well as providing the abortifacients.

Invariably, the mention of the drug "cytotec", "the small small pills" etc was common among the men during the FGD.

However, during the FGD with the men majority of them, young and old, in contrast to their actions, condemned the act outright saying it should not be considered for any reason. Participants gave reasons such as it attendant complications physical and psychological complications, in addition to religious, social and moral degradation. The older participants especially were of the view that induced abortion was responsible for all the cases of infertility in the community. They argued that no woman was created childless.

A section of participants shared a similar but different view of induced abortions. This group believes that though abortion is immoral and potentially dangerous, a pregnancy should not be carried to term if it will make a girl drop out of school or if parents are not financially prepared to care for the child. This they argue is one sure way to curb the rate of child abandonment, streetism and robberies and many more that may accompany unplanned birth.

5.3 Knowledge of contraceptives

Knowledge of contraceptive was high among community members. As indicated in the results, the study recorded a high level of contraceptive knowledge among the community. Three hundred and eighty nine respondents representing 97.25% of the total respondents knew at least one method of contraceptive.

Knowledge was high among both sexes though women were more knowledgeable than men with the modern hormone based methods. The results also indicated that the male condom is the most popular contraceptive method known among 96% of respondents. This is followed by the oral contraceptive pill and the calculation method with 37% and 34% knowledge respectively.

These high levels of knowledge correspond with that of the Ghana DHS 2003 figures. However the sterilisation methods which recorded high levels of knowledge in the DHS figures were not well known among respondents. The male sterilisation, the female sterilisation and the IUD were the least known methods as indicated in the results. This low level of knowledge of the long acting as well as the permanent methods was recognised among the male and female respondents as well. These findings are similarly to that of a study by Odu et al (2006) among a sub urban community in Nigeria. With the exception of condoms, there was a generally poor knowledge of contraceptive methods especially that of vasectomy.

The high levels of knowledge of methods however did not reflect in the knowledge of mechanism of action and effectiveness. A hundred and forty six (36.5%) of respondents mentioned the condom as the most effective method. The WHO however reports tubal ligation, implants and IUD as the most effective contraceptive methods respectively (WHO 2004). In addition, participants gave conflicting method of calculating the calendar method, the second most used method after the condom among respondents. This is an indication that though there is a high level of knowledge of the existence of these methods among respondents, the community lacks adequate knowledge into the mechanism of action as well

as it effectiveness and other non contraceptive health benefits. Similarly a study in Nigeria found poor level of knowledge on the mechanism of action and other health benefits of contraceptives (Otoide et al (2001)

This gap between knowledge of existence and mechanism of action and thus effectiveness should be addressed appropriately if individuals are to make informed choices on contraceptive use. In addition, other non contraceptive health benefits of the various methods should be promoted as well in order to increase acceptance. For instance, the condom has come to be accepted more due to it additional non contraceptive benefits of preventing STIs and HIV/AIDS. In same manner, education for other methods should be accompanied by its other benefits as well. For example, the combined oral contraceptives pill is known to significantly protect against some life threatening disease such as ovarian cancer, endometrial cancer and ectopic pregnancy as well as some serious other diseases such as iron deficiency anaemia, benign breast diseases, menstrual problems and ovarian cysts. In addition the Progestin-only contraceptive in its course of action reduces the monthly blood loss and therefore help protect against anaemia as well as against some STDs and pelvic inflammatory disease (WHO 1994).

In the face of this high level of knowledge among respondents, contraceptive usage remains disappointingly low. As indicated in the results, there is poor attitude towards contraceptives among both sexes but more profound among the men folk. Of the 240 respondents who are currently in a stable sexual relationship, only 27 (11.2%) are using any modern method of contraceptive excluding the condom. Of the remaining, only 20 (8.3%) gave indication that a pregnancy will be welcome. The rest are relying on the traditional methods such as the

withdrawal method which has a high failure rate (WHO 2004), or not practicing any method of contraceptive at all.

It is also worth mentioning here that a significant number, 12 (8.8%) mentioned the emergency contraceptive pill (ECP) as their contraceptive of choice. Evidence from the FGD gives indication that this figure may be grossly underestimated. This regular use of the ECP is a deviation from its normal purpose and is an indication of a lack of information. According to the WHO 2004 report, a reliance on the ECP as a contraceptive method requires counselling of the woman on other methods. The report continues that frequently repeated ECP use may be harmful for women with certain medical conditions.

Another misconception that was recognised during in the results is the notion that is takes a sustained sexual relationship to make a pregnancy happen. A considerable number 21 (8.75) gave their reason for non-use of contraceptive that they have sex occasionally, an indication that vital information on reproductive health is lacking among a section of the population. The above misinformation is in line with a study by sedge et al (2007) in which a sizeable proportion perceived themselves as low risk of getting pregnant although about a third of them had had unprotected sex over the last three months preceding the study. This is suggestive of a lack of essential information on sexual and reproductive health.

With regards to sources of information on contraceptives, the majority of respondents mentioned television 25.5% (N=272) and radio 270 (25.3%) as their primary sources of information on contraceptives. An additional important source of information as stated by respondents was peers/friends with 158 (14.8%) of responses. The family, a core point of socialisation and education is among the least mentioned as source of information with only

44 (4.1%) of total number of responses. This finding is contrary to the study by Mendoza et al (2001) in which friends and parents were the most mentioned sources of information on contraceptives among studied adolescents.

It is however worth noting that the difference in the results may partly be due to the differences in the cultural settings. As expected, issues of sex and contraceptives may not be as sensitive and difficult to discuss in a Cuban family where Mendoza et al conducted their study as it may be among a family in Ghana. This bias notwithstanding, the results indicated in this study on family as a source of information is rather on the low side. It is therefore expedient that parents and other family members are sensitised to regard sex education and contraceptive use as an integral part of the socialisation and educating duties of a family irrespective of the cultural setting.

In addition, partners should be encouraged to discuss their reproductive health and contraceptives in particularly

5.4 Cultural belief about contraceptives

An objective of the study is to identify beliefs surrounding contraceptives in the community that may be influencing acceptance and usage of contraceptive products. The findings indicate that the effects of beliefs and misconceptions on the use of contraceptives may have been under estimated.

The fear of side effect was identified as very strongly held and widespread misconception among the women folk especially, and a section of the men as well. During the quantitative structured

questionnaire, a significant number of sexually active respondents not using any form of contraceptive stated the fear of side effects as the reason behind non use. These perceived fears were further discussed during the FGD with the men and women. The men appeared to have less to say on the issue. On the contrary, virtually every woman regardless of age and religion had a story to tell on an experienced or rumoured adverse affect of a modern contraceptive method.

The finding above is in line with a research by Jagwe-Wadda et al (2006), which found that a general widespread misconception was the reason behind the low contraceptive prevalence among Ugandan women. Similarly, a research by Sedge et al (2007) found that a third or more of married women in six SSA countries including Ghana with an unmet need of family planning were not practicing contraception as a result of fear of side effect.

Respondents gave a legions of supposed side effects associated with the modern contraceptives especially the hormone based ones. Common ones identified were bleeding episodes, persistent general ill-health, heart problems etc. In addition the fear of interruption with future fertility--a gross misconception (WHO 2004) --was identified during the FGD with the younger women. This belief corresponds with a study by Otoide el al (2001) which identified perceived fear of future infertility as the main reason why the youth in Nigeria choose abortion over contraception as a form of birth control.

The research also found a strong rejection for the male sterilisation method, permanent and very effective method of contraceptive among the men folk. In the structured interview, 99% of respondents out of the total 178 sexually active males declared that they will never go for the male sterilisation as a form contraceptive.

This was further explained during the FGD with the men. Two reasons were prominent i.e. the fear of the unknown as a result of its permanent nature; and a general misconception about it interference with sexuality. As a result, none of the respondent had undergone a vasectomy. These findings thus confirm the Ghana DHS (2003) report in which the male sterilisation is cited as the least patronised method.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1. Conclusion

Ghana's maternal mortality figures are disturbing. Induced abortions have been identified as a prominent contributor. In addition to these deaths, unsafe abortion leaves in its trail a host of physical, psychological and social complications which invariably affect not only the woman but her family and society at large. Studies have implicated unintended pregnancies as the root cause of these unacceptable figures of induced abortions. This fact notwithstanding, usage of contraceptives—an inexpensive but effective tool in the prevention of unwanted pregnancies—continues to be disappointingly low; even amidst a host of international and national health educational programmes.

The study indicated a high knowledge of the physical complications of induced abortions on the woman among the community. There was however less knowledge of the potential socio-economic impact on the woman and the nation. Regardless of these facts, induced abortion is still widely practised among women; with active participation of their husbands or partners.

The community exhibited relatively high levels of knowledge of the various methods of contraceptives. This knowledge is however, has been overshadowed by hosts of widespread misconceptions about their supposed negative effects. Consequently, there is a low level of acceptance and usage of contraceptives especially the modern, hormone based and more reliable methods.

The public health implications of these findings are very profound and must be addressed promptly. Health education is urgently needed to reverse the trend of high abortion rates and low

contraceptive prevalence. Health education must focus on highlighting the very many complications of induced abortions; dissuade the mind of the community on the general misconceptions about the side effects of contraceptives; and enhance the contraceptive as well as non contraceptive benefits of the various methods.

6.2 RECOMMENDATIONS

6. 2. 1 Make contraceptives known and attractive:

- **Sustained Education with Media as partner**

  Education on contraceptives should be intensified. There should be improved collaboration with the media particularly the electronic media as they are the primary sources of information. Information on contraceptives can be packaged in form of advertisements, documentaries, TV dramas, TV talk shows, soap operas etc.

- **Lessons from the National AIDS Control Programme**

  Health education ought to highlight the enormity of dangers and risks involved in induced abortion: physically, mentally and socio-economically, alongside the perceived side effects or inconvenience associated with contraceptives. A characteristic example may be taken from the NACP's slogan for the condom which says "its not nice with condom but its worse with HIV/AID"

- **Incorporate Contraceptive education at every point in service delivery**

  The Ministry Of Health/ Ghana Health Service (MOH/GHS) should incorporate contraceptive education at every point of the health service delivery. Possible locations are: the waiting rooms at the Out Patients Departments (OPD) as a daily health talk; in the consulting rooms as part of medical advice; on admissions at the various wards e. g. benefits on vasectomy at the genitor-urinary units. Education on the benefits of contraceptives should not be the sole responsibility of the family planning units.

Education on Emergency Contraceptive necessary

- Emergency contraception has been identified as very effective in reducing unintended pregnancies and induced abortion. However, as the name implies, it meant to be used during emergencies only and should not be used as regular method of contraceptive. Women and their partners need to be informed of this fact in order to avert any future effect of its constant use.

- **Intensify education on risk involved in induced abortions**

  There should be extensive campaign to educate women and their partners on the physical and socio-economic effects of induced abortions.

- **Encourage contraceptive education in the homes and schools**

  The MOH/GHS/ Kumasi Metro in collaboration with their media partners should encourage contraceptive education in the homes; among women and their partners, among parents and children, and among the members of the family as part of their socialisation and education functions.

- **Collaborate with the Ghana Education Service (GES) vital**

  Collaboration with the GES is necessary in order to include contraceptive education in the basic school curricula. This will ensure improved knowledge of the benefits of contraceptive.

6. 2. 2. Extensive research required

- Funds should be made available for extensive research on the psychosocial cultural and other barriers to contraceptive use among the reproductive age group of men and women.
- Extensive research should be conducted to assess the physical impact as well as economic cost of induced abortions in the districts for effective formulation of policies and programmes to curb the high incidence of induced abortions.

6. 2. 3. Increase collaboration with the private health facilities

- Even the best contraceptives are not 100% effective hence the need for abortion. The GHS / Kumasi metro should increase collaborations with the private health facilities for effective monitoring of their activities. Private health facilities should also be included as in the comprehensive Abortion Care (CAC) programmes since they are the first point of call for surgically induced abortions in the community. However, abortions should not be encouraged as form of birth control in our communities.

- Again the cost of abortions services in the public and private facilities should be critically looked at since it may be too high and thus can deter women from accessing safe abortion and tend to some crude ways in their desperate moments.

REFERENCES:

Ahiadeke, Clement (2001) Incidence of Induced Abortion in Southern Ghana International Family Planning Perspectives, Vol. 27, No. 2. (Jun., 2001), pp. 96-101+108

Anarfi J. K. (1996) the role of local herbs in the recent fertility decline in Ghana, contraceptives or abortifacients. A paper presented to the international union for the scientific study of populations. Trivandrum, India, march 1996.

Allanson S, Astbury J. (2001) Attachment style and broken attachments: violence, pregnancy and abortion. Australian Journal of Psychology, 2001, 53:146–151. 2006, No. 26

Bankole A.; Singh, S.; and Haas, T. (1998). "Reasons Why Women Have Induced Abortions: Evidence from 27 Countries." International Family Planning Perspectives 24(3):117–127.

Dailard C (2005) Promoting Prevention to Reduce the Need for Abortion: Good Policy, Good Politics the Guttmacher Report on Public Policy May 2005, Volume 8, Number 2

Encyclopedia of Public Health "Abortion." Ed. Lester Breslow. Gale Group, Inc., 2002 http://www.enotes.com/public-health-encyclopedia/abortion.

Ghana Statistical Service and Macro International Inc. Ghana Demographic and Health Survey 2003

Henry, R. and Fayorsey, C. Coping with pregnancy: experiences of adolescents in Ga Mashi, Accra. Calverton, MD, USA: ORC Macro, 2002.

Henshaw SK, Singh S and Haas T, The incidence of abortion worldwide, International Family Planning Perspectives, 1999, 25 S30–S38

Jagwe-Wadda, G; Moore, A. M; Woog, V. ;(2006) Abortion Morbidity in Uganda: Evidence from Two Communities Occasional Report, New York: Guttmacher Institute

Lassey A T (1995) Complications of induced abortions and their preventions in Ghana. East Afr Med J. 1995 Dec; 72(12):774-7.

Lithur, N. O. (2006) Destigmatising Abortion: Expanding Community Awareness of Abortion as a Reproductive Health Issue in Ghana. African journal of reproductive health. Vol. 8, No. 1 (Apr., 2006), pp. 70-74

Mba C, Kwankye S O (2007) population, health and development
Sub Saharan publishers

Mbonye, A.K (2000) Abortion in Uganda: Magnitude and Implications
African Journal of Reproductive Health / La Revue Africaine de la Santé Reproduction, Vol. 4, No. 2. (Oct., 2000), pp. 104-108

Morhee RAS and Morhee ESK (2006) Overview of the Law and Availability of Abortion Services in Ghana. Ghana Med J. 2006 September; 40(3): 80–86. Copyright © Ghana Medical Association 2006

Mendoza, PJ, Pons, O R, Sánchez, R. B (1996) Male adolescents and contraception Cuban Medical Centre

Nyanzi S, Nyanzi B and Bessie K, Contemporary myths, sexuality misconceptions, information sources, and risk perceptions of *Bodabodamen* in Southwest Uganda, *Sex Roles,*
2005, 52(1–2):111–119.

Okonofua F E(2004) Breaking the Silence on Prevention of Unsafe Abortion in Africa African Journal of Reproductive Health Women's Health and Action Research Centre Vol. 8, Num. 1, 2004, pp. 7-8

Odu O.O, Ijadunola K.T, Komolafe J.O, Adebimpe W.T. (2006) Men's knowledge of and attitude with respect to family planning in a suburban Nigerian community.
Niger J Med. 2006 Jul-Sep; 15(3):260-5.

Otoide, V.O., Oronsaye F. & Okonofua F.E(2001) Why Nigerian Adolescents Seek Abortion Rather than Contraception: Evidence from Focus-Group Discussions International Family Planning Perspectives Volume 27, Number 2, June 2001

Owusu-Acheaw E, (2003) Adolescent Perceptions On Unsafe Abortions: A Study Of Two Communities In The Hohoe District Of Ghana. An MPH Dissertation Submitted To The School Of Public Health, Legon. August 2003

Petro-Nustas Wasile (1999) Men's Knowledge of and Attitudes Toward Birth Spacing and Contraceptive Use in Jordan International Family Planning Perspectives Volume 25, Number 4, December 1999

PNDC Law 102 (1985) Criminal Code (Amendment) Law,
Assembly Press, Accra, Ghana.

Sedgh G, Henshaw S, Singh S, Åhman E, Shah IH(2007). Induced abortion: rates and trends worldwide. Lancet 2007; 370: 1338–45.

Sedgh G, Hussain R, Bankole A and Singh S. Women with an unmet need for contraception in developing countries and their reasons for not using a method, Occasional Report, New York: Guttmacher Institute, 2007, No. 37.

Singh S et al, (2003) Adding it up: the benefits of investing in sexual and reproductive healthcare New York: AGI and United Nations Population Fund, 2003.

Singh S, (2006) Hospital admissions resulting from unsafe abortion: estimates from 13 developing countries, the *Lancet*, 2006, 368(955):1887–1892.

Shadigian, E. M. (2005) Reviewing the Medical Evidence: Short and Long-Term Physical Consequences of Induced Abortion. A paper presented to the South Dakota Task Force to Study Abortion Pierre, South Dakota September 21, 2005

World Health Organisation (2000) Studying unsafe abortions, a practical guide Maternal and Newborn Health/Safe Motherhood Unit, Reproductive Health Division, Geneva

The WHO (2003) Unsafe abortion Global and regional estimates of the incidence of unsafe abortions and associated mortality in 2003
Fifth edition

World Health Organization (2007) Facts on induced abortions worldwide Department of Reproductive Health and Research 1211 Geneva 27 Switzerland

World Health Organisation (2007), Maternal Mortality in 2005 Estimate Developed by the WHO, UNICEF, UNFPA, the World Bank (2007).
http://www.who.int/reproductivehealth/publication/maternal_mortality_2005/index.html

World Health Organization (1998) Unsafe abortion: Global and regional estimates of incidence of maternal mortality due to unsafe abortion. 3rd edition Geneva.

WHO (2004) medical eligibility criteria for contraceptive use Reproductive Health And Research Unit, Third Edition, Geneva.

WHO/FHE/FPP (1994) Health Benefits of Family Planning
Family Planning and Population Division of Family Health
World Health Organization.

CONSENT FORM

My name is Emma Ghartey. I am a student from the School Of Public Health, University of Ghana, Legon. My research assistance and I are conducting a research on the perception of this community on induced abortion and contraceptives. I am inviting you to participate in the study. Below are some guidelines for your information.

Procedure

You have been randomly selected and you are among 400 other members of this community to participate in the study. Your participation requires that you answer a few guided questions. The interviewers will come to you with a questionnaire and engage you in series of questions relating to induced abortion and contraceptives in this community. We are interested in all ideas, views, comments and suggestions you have. There is no right or wrong answer. The interview will last for about ten minutes.

Voluntary participation

Your participation in this study will be voluntary. That is you may opt out anytime you feel like not continuing. You are also at liberty to refuse answer questions if you don't feel comfortable about it.

Confidentiality

Ones identity in this study will be confidential. The results may be published for dissemination purposes but it will not be associated with your name. All recorded materials will be erased after the study.

Benefits associated with the study

The study will provide useful information on the perception of this community on abortions and contraceptives. This information will serve as a guide to understanding the perceptions and behaviours of this community, which will help the district and national health officials to

draw appropriate interventions to improve the health of women as well as their families in this community.

Contact for clarifications

You may ask any questions you have. For clarifications on additional issues, you may contact this addresses

The Metropolitan Health Directorate, Kumasi

OR

Emma Ghartey on e-mail: e_ghart@yahoo.com

PARTICIPANT QUESTIONNAIRE

I D Number	
Name of area	
Name of interviewer	
Date of interview Day /Month/Year	___/___/2008
Time of interview	___/___/___/___ HRS

Socio-demographic characteristics

Number	Question	Response	skip	Code
1	Age at last birthday	☐		Sd1age
2.	Sex	[M] [F] ☐		sd2sex
3	level of education	1. No formal education 2. Primary 3. Middle/JSS 4. Secondary/SSS 5. Post secondary 6. Tertiary ☐ 77. Other (specify)		Sd3edu
4.	Marital status?	1. Never married 2. Married 3. Consensual/ Cohabitation 4. Separated 5. Divorced ☐ 6. Widowed 77. Other (specify)……		
5.	What is your religion?	1. Catholic 2. Anglican 3. Methodist 4. Presbyterian 5. Pentecostal/Charismatic 6. Other Christian 7. Moslem 8. Traditional/Spiritualist ☐ 9. No Religion 77. Other Specify		Sd4rel

6.	What is your occupation?	1. Unemployed 2. Farmer 3. Trader 4. Government employed 5...Non government employed 6...Technical/Vocational 7…Student 77. Other (specify)……		Sd6occ
7.	To which ethnic group do you belong?	1. Akan 2. Ga/Dangme 3. Ewe 4. Guan 5. Mole-Dagbani 6. Grussi 7. Gruma 8. Hausa 77. Other (Specify)……		Sd7eth
8.	What is your level of income?	Ghana cedi 1. < 100 2. 100---199 3. 200---299 4. 300---399 5. 400---499 6. >500		Sd8inc

Knowledge and access to contraceptives

9.	Have you ever been in a sexual relationship with the opposite sex?	1. Yes 2. No 3. Refused	**If No skip to Q25**	Kac9
10.	Are you currently in a sexual relationship with the opposite sex?	1. Yes 2. No 3. Refused		Kac10
11.	How old were you when you first had sexual intercourse?			Kac11
12.	Did you use any contraceptive method the first time you had sexual intercourse?	1. Yes 2. No 1. Don't remember	**If no skip to Q15**	Kac12
13	Which type of contraceptive method did you use?	2. The pill 3. IUD/IUCD 4. The Injectables		Kac13

		5. Norplant 6. Diaphragm/foam/jelly 7. Condom 8. Female sterilization ☐ 9. Male sterilization 10. Calculation/rhythmic/calendar 11. Withdrawal 77. Other specify……..		
14	Whose decision was it to use that method of contraceptive?	1. Myself 2. My partner 3. Joint decision ☐ 77. Other (specify)……		Kac14
15	What did you use the contraceptive method for?	1. Avoid pregnancy 2. Prevent STI 3. Both ☐ 77. Other specify……		Kac15
16	**Do you use contraceptives methods any time you have sex** How often do you use contraceptives	1. Always 2. Often 3. Sometimes 4. Not often ☐ 5. Never 77. Other specify……...		Kac16
17	Did you use any contraceptive method the last time you had sexual intercourse?	1. Yes 2. No ☐ 3. Don't Remember		Kac17
18	What was your reason for using that particular method of contraceptive?	1. It is affordable 2. It is available ☐ 77. Other specify……..		Kac18
19	Are you currently using any method to delay or avoid a pregnancy?	1. Yes 2. No ☐ 3. Refused	**If yes skip to 21**	Kac19
20	What are your reasons for not using a contraceptive?	1. Never really heard of /understood 2. Have sex rarely 3. Want to become pregnant 4. Currently breastfeeding 5. Fear of side effects 6. Forbidden by religion 7. Cost too much 8. Don't know where to get them 9. Partner refuses 10. Health reasons? ☐ 11. Inconvenience 77. Other (specify)……		Kac20
21	Which contraceptive method are you using?	1. The pill 2. IUD/IUCD 3. The injectables		Kac21

		4. Norplant 5. Diaphragm/foam/jelly 6. Male Condom 7. Female condom 8. Male sterilization 9. female sterilization 10. Calculation/rhythmic/calendar/ 11. withdrawal 12. Emergency Contraceptive Pill(ECP) ☐ 77. Other specify……..		
22	Where do you get them from?	1. Government Hospital/ clinic 2. Private hospital/clinic 3. Maternity homes 4. Pharmacy/drug store/chemical store 5. Community health workers 6. Mobile clinic 7. Youth programmes ☐ 8. Parents 77. Other (specify)…….		Kac22
23	What are your reason(s) for using this particular method?	Availability ☐		Kac23
24 **if no skip to 26**	Do you have any problem obtaining the contraceptive method?	1. Yes 2. No ☐		Kac24
25	What are some of the difficulties you encounter in trying to obtain them?	1. Cost 2. Distance 3. Unavailability 4. Staff attitude 5. Long waiting hours ☐ 77. Other(specify)	Skip to Q27	Kac25
26.	What Do you know about contraceptives?	They are used to avoid pregnancies They are used to delay pregnancies They are used to prevent diseases		Kac26
27	Which (other) methods of contraceptives do you know of? (Tick all that matters)	1. The pill 2. IUD/IUCD 3. The Injectables 4. Norplant 5. Diaphragm/foam/jelly 6. Condom 7. Female sterilization ☐ 8. Male sterilization		Kac27

		9. Calculation/rhythmic/calendar/ 10. withdrawal 11. Emergency Contraceptive Pill(ECP) 77. Other specify……..		
28	Where did you hear about them?(tick all that apply)	1. Health Facility 2. Television 3. Radio 4. Magazines/Leaflets 5. Posters 6. Family 7. Friends 8. Internet 9. Youth Programme 10. Church Programme 77. Other Specify…….		Kac28
29.	What in your opinion is the most effective method of contraceptive you know about?	1. The pill 2. IUD/IUCD 3. The injectables 4. Norplant 5. Diaphragm/foam/jelly 6. Condom 7. Female sterilization 8. Male sterilization 9. Calculation/rhythmic/calendar/ 10. withdrawal 11. Emergency Contraceptive Pill(ECP) 77. Other specify……..		Kac29
30.	What is the least effective method you know of	1. The pill 2. IUD/IUCD 3. The injectables 4. Norplant 5. Diaphragm/foam/jelly 6. Condom 7. Female sterilization 8. Male sterilization 9. Calculation/rhythmic/calendar/ 10. withdrawal 11. Emergency Contraceptive Pill(ECP)		Kac30
31.	What are some of the places you know of that people can obtain information/ service on contraceptives?	1. Health Facility 2. Television 3. Radio 4. Magazines/Leaflets 5. Posters 6. Family 7. Friends 8. Internet 9. Youth Programme		Kac31

		10. Church Programme 77. Other Specify…….		
32.	Do you think people encounter difficulty in their quest to access family planning services?	1. Yes 2. No 3. don't know ☐	**If No skip to Q34**	Kac32
33.	What are some of the difficulties you know of	1. Financial constraints 2. Distance too long 3. Long waiting time 4. Poor staff attitude 5. Lack of privacy 6. Stigmatisation ☐ 7. Non-availability 77. Other (specify)……..		kac33

Knowledge on abortions complications

34. **For women only**	Have you ever obtained an abortion?	1. Yes **[skip to Q36]** 2. No **[skip to Q 42]** ☐		k a b
34b. **For men only**	Have you ever assisted your partner to obtain an abortion?	1. Yes 2. No 3. refused ☐		Kab34b
35	In what way did you assist your partner to obtain an abortion?	1. Financially 2. Self medication 3. Took her to the hospital 4. Took her to the drug store 5. Gave her a concoction ☐ 6. Moral support 77. Others (specify)……. ……		Kab35
36.	What was your reason for obtaining an abortion?	1. Wanted to continue education 2. Fear of parents 3. Fear of stigmatisation 4. Partners decision ☐ 5. Financial constraints 6. Last child too young 77. Other specify……..		Kab36
37.	Where was the abortion done?	1. In a government hospital/clinic 2. In a private hospital/clinic 3. At the pharmacy/ drug store 4. In the provider's home 5. At the herbalist place ☐ 6. Took concoction at home 77. Other specify……..		Kab37

38.	How did you get the information about the place to obtain abortion?	1. From a friend 2. My partner 3. My parent(s)/family memb 4. A health professional 77. Other (specify)……		Kab38
39.	Who made the decision about obtaining the abortion	1. Myself 2. My partner 3. My parents 4. Other family members 5. Joint decision		Kab39
40.	How much did you pay for the services?			Kab40
41.	Do you think it was affordable?	Yes No		Kab41
42.	Would you go for an abortion in the event of an unintended pregnancy?	Yes No		Kab42
42b.	Give reasons for your answer	…….		Kab42b
43.	What do you think are some of the reasons why people in this community obtain abortion?			kab43
44.	What do you think are some reasons why a woman will not have an abortion though the pregnancy is an unwanted one?	1. For religious reasons 2. Fear of stigmatisation 3. Fear of complications 4. Fear of parents 5. Lack of money 6. Partners refusal 77. Other (specify)		Kab44
45.	What are some of the methods by which people in this community obtain abortions?	7. In a government hospital/clinic 8. In a private hospital/clinic 9. At the pharmacy/ drug store 10. In the provider's home 11. At the herbalist place 12. Took concoction at home		Kab45
46.	What do you think can happen to people who terminate pregnancies?	1. Nothing happened to them 2. Severe pain 3. Severe Bleeding 4. Infertile 5. Disabled 6. Died 1. Other specify		Kab46
47.	What happened to people who had abortions that you know of?	2. Nothing happened to them 3. Severe pain 4. Bleeding 5. Infertile		Kab47

		6. Disabled 7. Died 77. Other specify		
48.	Apart from physical harm, what is the person likely to experience?	1. Guilt 2. Fear of the unknown 3. Financial loss 4. Stigmatisation 5. Rejection 77. Other (specify)……..		Kab48

Cultural beliefs about contraception and abortion

49.	In your opinion what are the reasons why some people in this community might not want to use contraceptives?	1. Cost 2. Availability 3. Fear of side effect 4. Inconvenience 5. Forbidden by religion 6. Health reasons 7. Partner refuses 77. Other (specify)…….		cb49
50.	Do you think its okay for a woman to seek abortion for whatever reason?	Yes No		cb50
51.	Give reasons for your answer.			cb51

Gender roles in decisions about abortion

52.	Do you think women should seek consent from partners before obtaining abortion?	Yes No		Gr52
53.	Give reasons for your answer			Gr53

54.	What do you think men can do to avoid an unwanted pregnancy?	1. Nothing/not men responsibility 2. Abstain 3. Go for family planning services 77. Other (specify)…….. ☐		Gr54
55.	Do you think men in your community support their women in seeking abortions	Yes No ☐		Gr55
56.	Give reasons			Gr56
57 **Question for men only**	Of the contraceptive methods which are you prepared to use. .	☐		Gr57
57b.	Why this particular method	☐		Gr57b
58.	Between men and women who has power to decide whether to terminate a pregnancy or not.	1. Men 2. women have equal rights to decide 3. don't know ☐		Gr58
59.	Give reasons for your answer			Gr59