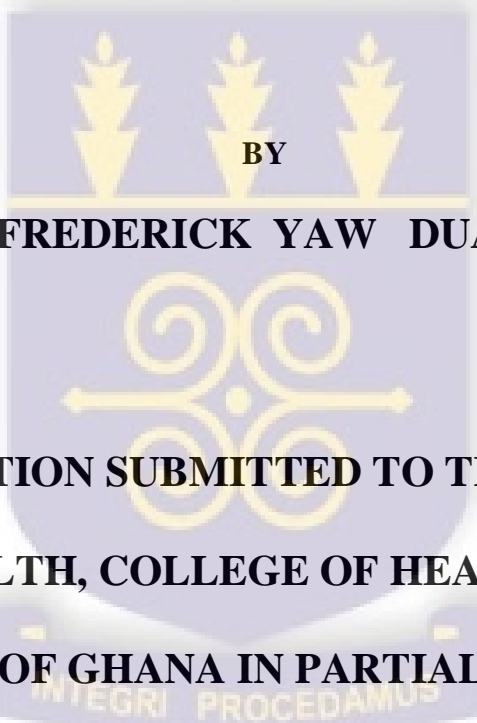


**SCHOOL OF PUBLIC HEALTH  
UNIVERSITY OF GHANA LEGON**

**METHODS OF SELF – INDUCED ABORTION. A  
COMMUNITY BASED STUDY IN THE GA- EAST  
DISTRICT OF GREATER ACCRA REGION.**



**BY  
FREDERICK YAW DUAH**

The crest of the University of Ghana is a shield-shaped emblem. At the top, there are three golden, stylized symbols resembling traditional Ghanaian motifs. Below these is a horizontal line with the word 'BY' centered. Underneath the line is the name 'FREDERICK YAW DUAH' in bold, black, uppercase letters. The shield itself is light blue with golden decorative scrollwork in the center. At the bottom of the shield, a banner contains the Latin motto 'INTEGRI PROCEDAMUS'.

**A DISSERTATION SUBMITTED TO THE SCHOOL OF  
PUBLIC HEALTH, COLLEGE OF HEALTH SCIENCES,  
UNIVERSITY OF GHANA IN PARTIAL FULFILLMENT  
OF THE REQUIREMENT FOR THE AWARD OF  
MASTER OF PUBLIC HEALTH DEGREE**

**APRIL, 2010**

## DECLARATION

I hereby declare that, except for quotations and references to other peoples work which have been duly acknowledged; I am wholly responsible for this research and that it has never been submitted in part or in whole; in this university or elsewhere for the award of another degree.

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(MPH. Resident)

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Date

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Dr. Gameli Kwame Norgbe  
( Primary Supervisor)

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Date

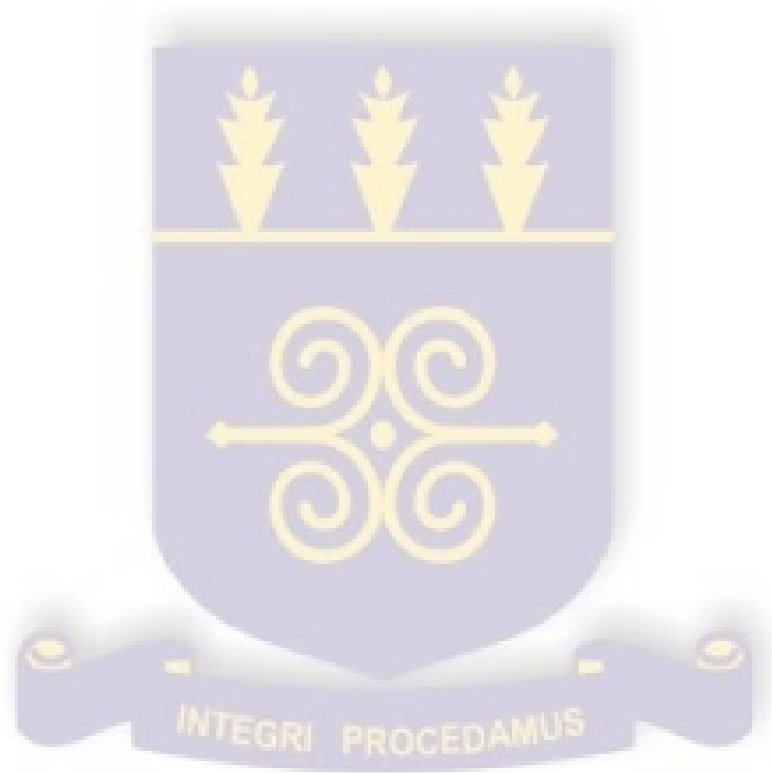
.....  
Prof. Clement Ahiadeke  
( Secondary Supervisor)

.....  
Date



## **DEDICATION**

In the name of Almighty God I dedicate this dissertation to my lovely wife Francisca, my children Angela and Fred and my parents Comfort and Valence.



## **ACKNOWLEDGEMENT**

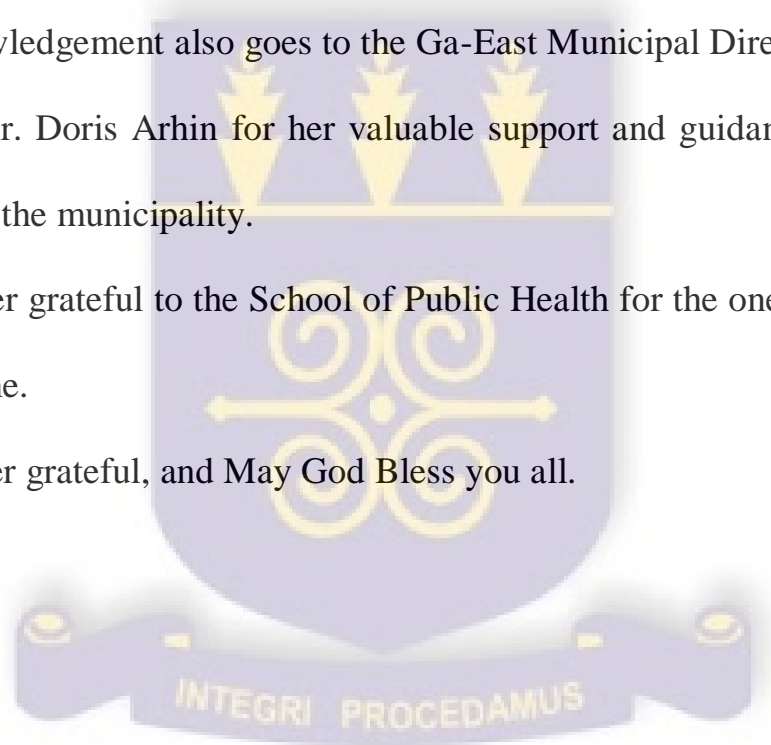
I would like to thank Almighty God for His abundant grace shown me throughout this course.

I wish to express my profound gratitude and appreciation to my supervisors, Dr. Gameli Kwame Norgbe and Prof. Clement Ahiadeke for their supervision, invaluable guidance, patience and above all their level of tolerance which made this work possible.

My acknowledgement also goes to the Ga-East Municipal Director of Health services, Dr. Doris Arhin for her valuable support and guidance during my research at the municipality.

I am forever grateful to the School of Public Health for the one year training provided me.

I am forever grateful, and May God Bless you all.



## ABSTRACT

**Purpose:** In Ghana the available statistics on unsafe abortions could only be gathered from the hospitals and the clinics especially in the major cities, leaving out the numerous cases of self –induced abortions in the rural communities where the women privately indulged in induced abortion without it being recorded in any hospital records. The purpose of this study was to investigate methods of self –induced abortion, one of the causes of maternal mortality in Ghana. This study seeks to provide information on sources of substances used, mode of application of these substances as well as the reasons why some women resort to self- induced abortion.

**Design/methodology:** The study design was cross-sectional involving the use of quantitative and qualitative methods for data collection, conducted at Ga-East district of Greater Accra region. A simple random sampling was used to identify and select 200 women in their reproductive age (between the ages of 15- 49 years) selected from six communities of Danfa –Abokobi sub district. Qualitatively, two focus group (FGD) discussions sessions were conducted and two in-depth interview (IDI) were also done.

**Findings:** The study found that 50% of the women having self- induced abortion are single, below 34years with middle levels of education (junior/senior secondary and vocational/technical schools), though significant numbers have no formal education. Those who practice self-induced abortion are mostly artisans, apprentices, traders and unemployed.

The main reasons why women obtained self –induced abortion were financial difficulty (i.e. money to maintain the pregnancy), partner denial of responsibility, to enable them pursue education and apprenticeship, contraceptive failure, fear of parent, stigmatization and not ready for a child. Modes of inducing abortion included drinking of concoctions from local herbs such as grounded ablototor leaves with paracetamol and akpeteshie, mixtures of grounded Guinness bottles in high concentration of sugar solution, concentrated laundry blue with camphor and sugar. Swallowing and insertion of cytotec tablets and insertion of local plants like leaves of nkradedua into vagina and stem of gbukagba into the cervix. These women obtained these substances mostly from quack doctors, pharmaceutical shops, and friends, got it themselves, and drug peddlers.

**Conclusion :** There is every indication that self- induced abortion rate in the rural communities are high and calls for intervention from the district health administration, district assembly, social groups, health professionals and policy makers aimed at reducing the incidence of unsafe abortion. The evidence suggested that health service providers should intensify awareness about family planning and highlight the dangers of induced /unsafe abortion. District assembly should take steps to improve the socio- economic status of women in the district. Bye- laws should be made by the district assembly to punish those who connive and abet with the women to obtain induced abortion illegally.

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## LIST OF ACRONYMES.

AGI	-	Alan Guttmacher Institute
AIDS	-	Acquired immune –deficiency virus
FGD	-	Focus Group Discussion
GDHS	-	Ghana Demographic Health Survey
HIV	-	Human immune deficiency virus.
IDI	-	In –depth Interview
NSFG	-	National Survey of Family growth
PID	-	Pelvic Inflammatory Disease
RCH	-	Reproductive and Child Health
USAID	-	United States Agency for international development
WCFH	-	Women’s Children Family’s Health
WHO	-	World Health Organization
WIFA	-	Women in fertile age

## **CHAPTER ONE**

### **1.0 INTRODUCTION**

Abortion is the loss of pregnancy before the foetus is viable (WHO, 2004). Induced abortion is deliberately tampering with the pregnancy with the intention of terminating it. Induced abortion is mostly unsafe, especially in developing countries (WHO 2004). Because of the unsafe nature of the abortions, almost 90 % of induced abortions in this region result in high maternal mortality and morbidity.

An unsafe abortion is a procedure for terminating an unwanted pregnancy performed either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both (WHO 1997). When women have powerful reasons for not wanting to be pregnant many will risk their lives to avoid unwanted births. Many reasons can be assigned for the decision to terminate a pregnancy, for example concern for their own health, the welfare of the children they already have, partner denial and the ability to continue work or schooling (WHO 2004).

Restrictive abortion laws, in most developing countries impede access to safe abortion. Inability to afford the cost of a safe abortion procedure, lack of knowledge of the abortion laws, result in most adolescents and adults women resorting to procure abortions by clandestine methods. In this case, people lacking the requisite knowledge of the physiology and anatomy of the female reproductive system may perform abortion ( Bareto et al, 1992).

### **1.1BACKGROUND**

Self- induced abortion is said to be the third most significant cause of maternal mortality globally. It has been reported that there 31 self- induced abortions for every 100 live births (WHO 2007).

Many substances are used in self induction of abortion.

These include:

- Insertion of sticks (eg.cassava sticks) roots of certain plants into the uterus.
- Application of chemicals, drugs and herbal solutions into the vagina and uterus eg. gunpowder and cytotec tablets.
- Taking orally, a high dose of quinine, chloroquine, coffee, and also herbs and other concoctions.

Late complications include ectopic pregnancy , secondary infertility, chronic pelvic pain (pelvic inflammatory diseases) and psychological problems.

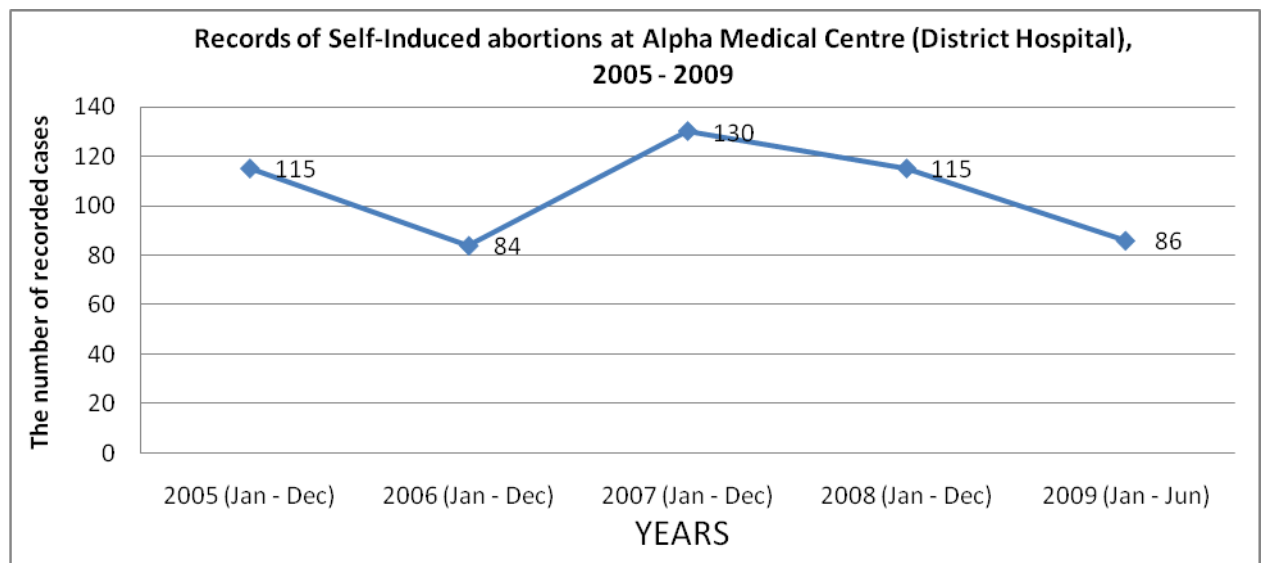
The world health organization estimates that unsafe abortions cause the deaths of at least 200 women each day and over 70,000 women each year , all as a result of complication of unsafe abortion. Between two and seven million women each year survive unsafe abortion but sustain long-term damage or disease(WHO 2003).

The global picture of induced abortions is disturbing, especially that of the developing countries with their attendant morbidity or mortality state. There was a decline in the number of induced abortions globally from 46 million to 42 million between 1995 and 2003. This decline was effective more in developed than in the developing countries. However, out of the 42 million abortions occurring annually, 35 million occur in the developing world alone. The decline in number of abortions in developed countries could be attributed to substantial increase and effective use of modern contraceptive especially Eastern Europe (WHO, 2007).

## **1.2 PROBLEM STATEMENT**

An estimated 20 million women worldwide obtain unsafe abortion each year. Of this, 97% occur in developing countries, including sub-saharan Africa. Unsafe abortion results in some 78,000 deaths annually. As high as 13% of maternal mortality worldwide is due

to unsafe abortion. Unsafe abortion also causes millions of women to suffer chronic diseases and disabilities. According to Olukoya (2001), every one out of four pregnancies is terminated by induced abortion. Abortions are induced by various methods including herbal abortifacients, physical trauma, use of drugs and clinically induced abortion which consists of the use of mesoprostol or surgical means (vacuum or manual aspiration) in clinical setting. In Ghana, between 22% and 30% of maternal mortality are as a result of abortion complications (Ghana National Reproductive Health Service and Standards, 2003). The 2008 annual report of the Ga-East district revealed that self-induced abortion is high in the district (District Health Directorate, 2008). The figures collated from the Alpha Medical Centre which is the district hospital indicate that, complications resulting from self-induced abortion over a period of five years was 530 (i.e. 2005 = 115, 2006=84, 2007=130, 2008=115, Jan-Jun 2009 = 86).



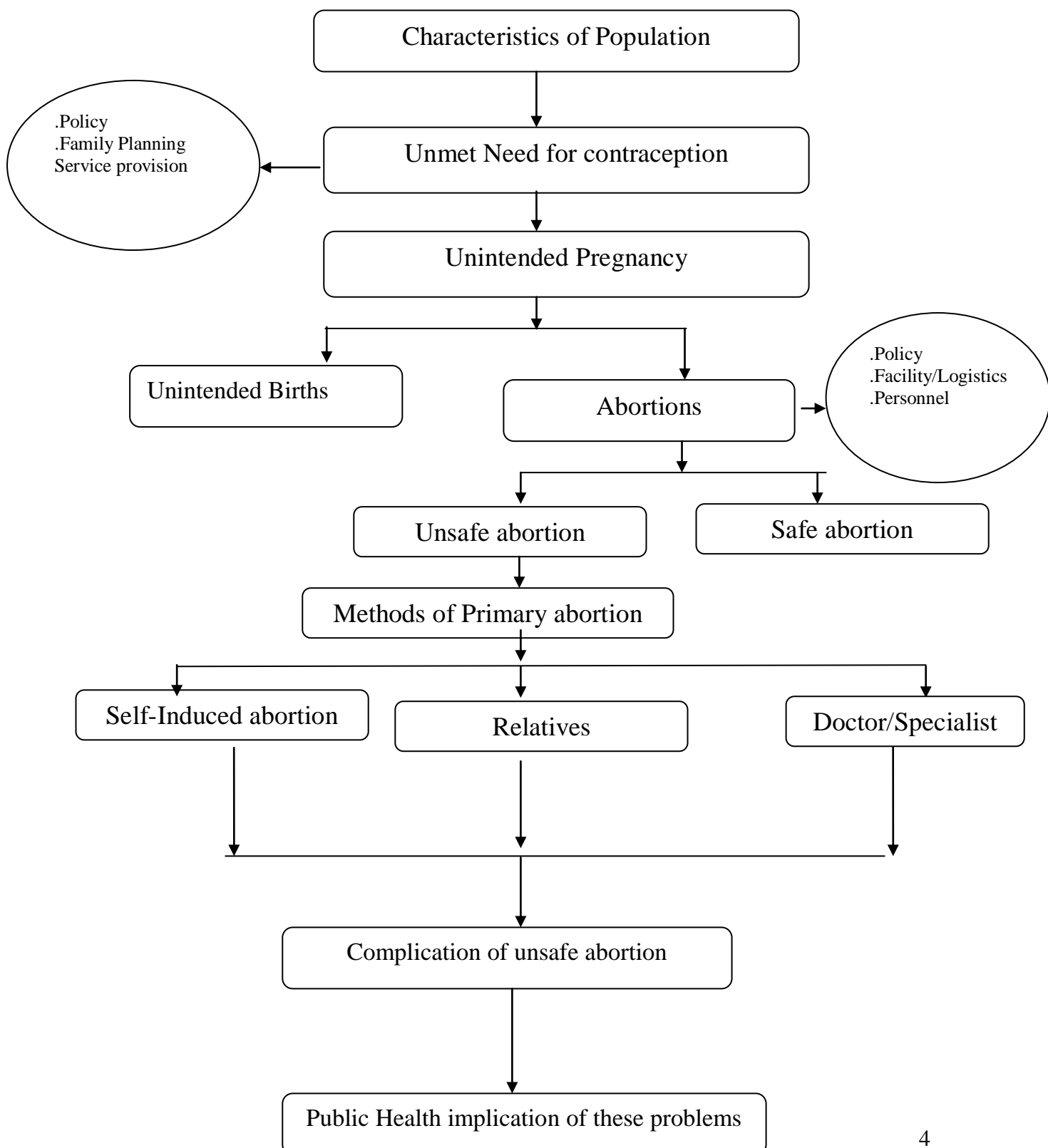
**Fig 1: Records of abortion cases reported at the Alpha Medical Centre (Maternity records, Jan 2005 – Jun 2009).**

The recorded high cases within these five year period may be contributed by many factors, amongst them may include low educational level, low income, socio-cultural practices, religious beliefs and low access to abortion services in the district. The only

hospital in the district is a mission hospital (Alpha Medical centre) and does not offer abortion services.

### 1.3 CONCEPTUAL FRAMEWORK

Methods of Self-Induced Abortion



Methods of self-induced abortion are influenced by various characteristics. Key among them include the characteristics of the population as a whole, age, race and ethnicity, education, religion, number of prior births, unmet needs for contraception and availability of family planning services. These factors, particularly educational background and cultural practices would push a married couple to obtain induced abortion. Unmet need for contraception may be dependent on these factors. Pregnancy that occurred may be intended or unintended. Some women may decide to keep unintended pregnancy, whereas others may decide to obtain an abortion. The decision to obtain an abortion is also influenced by abortion laws, fear of social stigmatization, negative attitude of health workers. Most youths would obtain an abortion under clandestine means done by self, friends, by untrained person or even relatives (Bankole et al, 1998).

Unsafe abortion comes with its attendant problems. This may be uterine perforation, infections, which finally result in infertility. In the worst scenario, self – induced abortion may lead to death.

#### **1.4 JUSTIFICATION FOR THE STUDY**

Complications resulting from various dangerous methods of induced abortion, constitute the main problem seen at the community clinic and hospitals. The effects that this have on maternal health underscores the importance of this study. Although there is much that can be learned through community studies of unsafe abortion, relatively few have been attempted.

The community is where unwanted pregnancy and abortion originate and where strategies to reduce maternal mortality and morbidity from unsafe abortion must ultimately be implemented (Ahiadeke et al,2001).

Ghana has a high young population of which adolescence constitute a high proportion(21.9%). These adolescents fall prey to unintended pregnancy as a result of rape, contraceptive failure due to incorrectly or inconsistently use or discontinuation and coercive sex, use of alcohol or drugs , leading to unprotected sexual intercourse (Glover et al, 2003). Finding out the various methods and reasons of induced abortions in the communities at the Ga-East district can elicit local solutions and support of prevention programmes and other community based interventions.

This study is important to look at the methods of administration of substances used in self induced abortion and also the sources of these substances. This will help in combating the menace of self induced abortion. The findings of the study will help educate the women on the dangers associated with the various methods of administration of substances. It will also help improve on contraceptive use, hence lower incidence of unintended pregnancies which leads to induce abortion with its complications.

### **1.5 OBJECTIVES OF THE STUDY**

#### **GENERAL OBJECTIVE:**

To investigate the methods of self induced abortion and the reasons for these abortions.

#### **1.6 SPECIFIC OBJECTIVES:**

1. To identify the methods of self - induced abortion.
2. To identify the reasons for self - induced abortion.
3. To determine the sources of substances used in self induced abortion

## CHAPTER TWO

### 2.0 LITERATURE REVIEW

The literature review focuses on the body of knowledge available on the topic under discussion. This literature is composed of data from books, articles, abstracts and the Internet, which are relevant to the research study.

#### 2.1 Characteristics of women who obtain induced abortion

##### i) Induced abortion and educational level

Women's characteristics influence their likelihood of terminating unintended pregnancies. One such characteristic is the educational level. Desired family size, the intention to have more children and actual fertility are usually higher among rural women and without formal education than among the urban and better- educated counterparts.

Better-educated women may be more successful than those with less schooling in preventing unplanned pregnancy, given their higher levels of knowledge and access to contraception; but they also may have stronger motivation to achieve a smaller family size and to prevent unplanned births. Younger, educated women may terminate an unintended pregnancy in order to complete their education or gain work experience before starting a family (Bankole et al, 1999).

In many Sub-Saharan African countries, a girl must leave school if she is pregnant, and abortion tends to be most common among young unmarried women who wish to continue their education (Salter C. et al, 1997).

##### ii) Induced abortion and marital status

One characteristic that exposes married women to the risk of pregnancy is marital status, especially if there is no intention of getting pregnant and are not on any method of contraception. In some societies, women may marry at relatively young age, in others women may marry later, and seek to avoid pregnancy before marriage.

Where women have opportunities for education, employment and career development, younger and unmarried women are the most likely to want to postpone marriage or childbearing, and to obtain abortion when pregnancy occurs.

In more than half of the countries studied, married women obtain a larger proportion of abortions than unmarried women. However, once pregnant, unmarried women are more likely than married women to choose abortion (Bankole et al,1998).

### **iii) Induced abortion and socio-culture**

Dahlback et al (2007), made a study on unsafe abortions among adolescent girls in Lusaka and came out that most of the girls who involved in unsafe abortions were in school, single and majority had no children. The reasons given for performing induced abortion were socio-cultural e.g. social stigmatization as a result of premarital pregnancies which include mockery by friends, abandonment by partner, expulsion from school and parental disapproval and fear of facing personal shame.

Induced abortion in Ghana goes with a serious stigmatization. Criminalization, traditional and cultural values, religious teachings and social perceptions have facilitated stigmatization of abortion in Ghana ( Lithur, 2004). Traditionally, abortion is regarded as a shameful act and the community may shun and give a woman who has caused an abortion derogatory names.

As a result of criminalization and stigmatization associated with abortion, pregnant women will engage in several dangerous procedures and seek for clandestine abortion provided for by charlatans. It is estimated that two-thirds of all pregnancy terminations are through unsafe abortions and large numbers of women are dying (Lithur, 2004).

## **2.2 Unmet need for contraception use and induced abortion**

It is estimated that more than 150 million married women of reproductive age have an unmet need for contraception. Many women either do not use an effective contraceptive method or experience contraceptive failure. This may be because of a lack of knowledge of modern methods, religious values regarding modern methods contraceptive use, concern about side effects, partner objections or difficulty or difficulty paying for or obtaining a modern contraceptive method (Bankole et al,1998).

Numerous studies and surveys note that women undergo abortion as a means of pregnancy resolution because they desire to delay or avoid pregnancy (Brown et al, 2001). Bankole et al reviewed 32 studies from 27 developing and developed countries of women aged 15- 49 years regarding why women had induced abortions. Between 39% and 89% of women stated that the primary reason for seeking abortion was to postpone their pregnancies or stop childbearing altogether. The second most common reason cited were socioeconomic concerns, such as disruption of education or employment, lack of support from father, desire to provide schooling for children, unemployment, or the inability to afford more children. Other reasons included relationship problems and feeling that they were too young to have a child.

### **2.3. Unintended Pregnancy**

An unintended pregnancy is a pregnancy that is either mistimed or unwanted at the time of conception. It is a core concept in understanding the fertility of populations and the unmet need for contraception. Unintended pregnancy is associated with an increased risk of morbidity for women, and with health behaviours during pregnancy that are associated with adverse effects. For example, women with an unintended pregnancy may delay prenatal care, which may affect the health of the infant. Women of all ages may have unintended pregnancies, but some groups, such as teens, are at a higher risk (Chung-Park M.S. 2008).

Unintended pregnancy is the root cause of abortion. More than one-third of all pregnancies worldwide each year are unintended, and one in five virtually end up in abortion (205 million) (Guttmancher, 2007). More than 40% of all pregnancies in developed countries are unintended, and 28% end up in abortion (23 million). More than one-third of all pregnancies in developing countries each year are unintended, and 19% end up in abortion (182 million).

In 2001, approximately one-half of pregnancies in the United States were unintended (Finer 2006), and the United States has set a national goal of decreasing unintended pregnancies to 30% by 2010.

Efforts to decrease unintended pregnancy include finding better forms of contraception, and increasing contraceptive use and adherence. Research has also focused on better understanding pregnancy intention and how it is measured. As one study suggests, “A better understanding of the multiple dimensions of unintended pregnancy also may lead to a better understanding of the consequences of these pregnancies” (Santelli 2003 ).

Unintended pregnancy is difficult to measure. It is assumed that the estimated unintended pregnancy rate is low due to inconsistencies in the reporting of miscarriage and abortion, as nearly all pregnancies ending in abortion are unintended. (Brown & Eisenberg, 1995).

The Allan Guttmacher Institute (AGI 2000) notes that nationwide there are 42 million women in the United States who are at risk of unintended pregnancy. Seven percent of these at-risk women do not use contraceptives. Women who do not use birth control comprise half of the national total of unintended pregnancies (Henshaw, 1998). By increasing the rate of contraceptive use, the number of unintended pregnancies in the United States can potentially be decreased from 3 million to 1.6 million (AGI, 2000)

Ghana Demographic and Health Survey (GDHS, 2003) data shows that unplanned pregnancies are on the increase in Ghana. It indicates that about 16% of births in Ghana are unwanted, while 24% are mistimed. The proportion of unintended births was 40% in 2003.

#### **2.4. Unintended Births**

Pregnancy is considered to be unintended when the woman did not want to be pregnant (unwanted) or desired a pregnancy later (mistimed). A pregnancy is intended when the woman wanted to be pregnant at that time or sooner. For the information presented here, an unintended birth is an unintended pregnancy that results in a live-born infant (WCFH, 2005)

Compared to women with intended pregnancies, women with unintended pregnancies are more likely to: find out they are pregnant later; initiate prenatal care later; have inadequate birth-spacing; give birth earlier or later than the prime childbearing years; have inadequate folic acid intake. Oregon women were significantly less likely to have an unintended birth compared to women in the U.S – 37.3 versus 42.6 percent, respectively (Williams I. et al, 2006).

In 2004, more than one-third (37.3 percent) of all Oregon births were unintended – 29.8 percent were mistimed and 7.5 percent were not wanted. In the same year, Oregon women less than 20 years of age were significantly more likely to have an unintended birth compared to all other age groups (Nurit F. et al 2007).

Births that are unwanted at conception are those that occur to women who say, prior to pregnancy that they did not want to have any more children. The avoidance of such births would have a surprisingly large effect on the proportion of children born to unmarried mothers. It is little appreciated how large a proportion of childbearing among unmarried women is to women of higher parity, to women over age 25, and to women who want no more children.

It is necessary to adjust for some possible misreporting of mistimed births as unwanted births. Although the estimation of "unwantedness" is quite good in the aggregate, this is a category of births for which misclassification seems to result in some bias. For example, it seems unlikely that many women who had their first child when unmarried and at a young age and who reported a birth as unwanted actually intended to remain childless in the future. In this exercise, first births to women under age 25 that were reported as unwanted at conception were recorded as mistimed. Although the resulting difference in estimated reduction of unwanted births is small (approximately 2 percent), it seems the most appropriate way to proceed (Sarah R et al, 2008)

#### **2.4.1. Methods of induced abortion**

#### **2.4.2 Methods of Primary Abortions**

Most Ghanaian women still rely on a mix of traditional practitioners, quack doctors, physicians and other sources such as qualified nurses and pharmacists to obtain abortion services (Ahiadeke, 2001, and Goldsmith, 2007). The range of abortion methods varies widely in safety and efficacy. Some women often insert strange substances such as broken-off stem of an 'osibisaba' plant into the cervix and leave it in place for three days so that the poisonous sap would be absorbed into the ovaries and thereby terminating the unwanted pregnancy. Oral abortifacients have included a mixture of finely crushed glass mixed with liquids such as sea water and laundry bluing and stout. Others prefer herbal concoctions or overdose of medicines such as Paracetamol in an effort to terminate an unwanted pregnancy. Others include quinine, ampicillin, turpentine, bleach, tea made of livestock faeces, and potassium permanganate, etc (Grimes, 2003).

#### **2.4.3 Methods of self- induced abortion**

**Methods:** There are a number of anecdotally recorded and disseminated methods of performing self-induced abortions. These include:

- Physical exertion design to bring about a miscarriage
- Abdominal massage
- Receiving blows to the abdominal area
- Attempted removal of the foetus with a coat-hanger or a similar device inserted into the uterus through the vagina
- Ingesting abortifacients, high quantities of vitamin C, or other substances believed to induce miscarriage
- Douching with substances believed to induce miscarriage

Many of the above methods present significant dangers to the life or health of the woman. In particular, attempts to insert hazardous objects into the uterus can cause punctures leading to septicaemia. Ingesting or douching with harmful substances can have poisonous results. Receiving blows to the abdomen whether self inflicted or at the hands of another, can damage organs. Furthermore, the less dangerous methods- physical exertion, abdominal massage, and ingestion of relatively harmless substances thought to induce miscarriage- are less effective (<http://www.abortiontips.com>, accessed on 27/05/09)

## **2.5. Abortions; Laws and policies**

In the 1950's abortion was illegal in most countries except for some Scandinavian and East European countries, the Soviet Union and Japan. Since then however, many more countries including the USA, China, India, and most European countries have changed their laws to permit abortion on request or for a broad range of medical and social reasons (Kunins and Rosenfield 1991).

Many developing countries still have hard-line laws, long after their former colonisers have liberalised their own legislation (Cook 1989, Dixon-Muller 1990). Latin America,

Sub-Saharan Africa and the Arabic countries have the most restrictive laws; Zambia and Uruguay are among the few developing countries in which abortion is allowed for both social and medical reasons.

In China and Vietnam abortion is promoted as a means to control population growth. Public health services for abortion and contraceptives are provided. (Henshaw, 1990). Some religious societies principally the Catholic Church, have strongly opposed the legislation of abortion and the use and provision of contraceptives. In Sub-Saharan Africa, Latin America, the Philippines and other Asian countries, the Catholic Church put more pressure on weak governments to refrain from legalizing abortion or providing contraceptives to prevent unwanted pregnancies (Liskin1992).

In Ghana abortion is legal under three conditions and this is contained in the criminal code section 58. Initially the law was strict and only allowed abortions if the pregnancy was perceived to be a threat to the life of the mother. The amendment of the law in 1985 has made it liberal thereby making abortion more readily available. The conditions that permit legal abortion are:

- Pregnancy caused by rape, incest or defilement
- Pregnancy involves a risk to the mother's life or to her physical or mental health  
or
- There is a substantial risk that the child may develop a serious physical abnormality or disease.

## **Types of abortions**

### **2.5.1. Safe Abortion**

Almost all the deaths and complications from unsafe abortion are preventable. Procedures and techniques for early induced abortion are simple and safe. When performed by trained health care providers with proper equipment, correct technique and sanitary

standards, abortion is one of the safest medical procedures. In countries where women have access to safe services, their likelihood of dying as a result of an abortion performed with modern methods is no more than one per 100,000 procedures (Alan Guttmacher Institute 1999). In developing countries, the risk of death following complications of unsafe abortion procedures is several hundred times higher than that of an abortion performed professionally under safe conditions (World Health Organization 1998). Properly provided services for early abortion save women's lives and avoid the often substantial costs of treating preventable complications of unsafe abortion (Figueroa-Talamanca et al. 1986, Mpangile et al. 1999).

### **2.5.2. Unsafe Abortions**

According to WHO (1993), Unsafe abortion refers to '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. It should however be noted that 'unsafe' is synonymous with 'illegal' or 'clandestine'. For example, legal abortions may be unsafe because of poorly trained medical personnel, inadequate facilities or both.

Even if all contraceptive users were to use methods perfectly all the time, there would still be nearly six million accidental pregnancies annually. Thus, even with high rates of contraceptive use, unwanted pregnancies will occur which women may seek to end by induced abortion (WHO, 1993)

### **2.6 Reasons for abortion**

There are probably as many reasons for abortions as there are women who have them. Some pregnancies result from rape or incest, and women who are victims of these assaults often seek abortions. Most women, however, decide to have an abortion because the pregnancy represents a problem in their lives

Some women feel emotionally unprepared to enter parenthood and raise a child; they are too young or do not have a reliable partner with whom to raise a child. Many young women in high school or college find themselves pregnant and must choose between continuing the education they need to survive economically and dropping out to have a baby. Young couples who are just starting their lives together and want children might prefer to become financially secure first to provide better care for their future children (Bankole et al. 1998).

An abortion is considered to be elective if a woman chooses to end her pregnancy, and it is not for maternal or fetal health reasons. Some reasons a woman might choose to have an elective abortion are that the pregnancy was as a result of rape or incest, contraceptive failure or perceived financial and emotional hardships if the pregnancy was carried to term (Finer et al, 2003; Bankole et al, 1998, Adanu and Tweneboah, 2004)

Abortion ratios show that in both developed and developing countries, pregnancies among unmarried women are more likely to be resolved by abortion than are those among married women. This finding is reinforced by the reasons women give for obtaining an abortion including not wanting to be a single mother, being too young, fearing their parents' objections, not wanting pregnancy to disrupt education or employment, and being unable to take care of the baby (especially without the support of the partner) (Bankole A et al, 1998 ).

## **2.7 Complications of Unsafe Abortion**

Unsafe abortion is a persistent preventable pandemic and ending the silent pandemic is an urgent public health and human rights imperative ( David A. Grimes et al, 2006)

Unsafe abortion mainly endangers women in developing countries where abortion is highly restricted by law and countries where although legally permitted, safe abortion is not easily accessible (David A. Grimes et al, 2006).

It has been estimated that globally, 70,000 women die annually from complications of unsafe abortion out of which 30,000 deaths are from Africa alone (WHO, 2004). All over the world, about 19 million women are exposed to the risk of death from unsafe abortion alone, and 18.5 million of these women are in developing countries with 4.2 million from Africa, and 59% of unsafe abortions in Africa are in the 15-24 year group (WHO, 2004), and between two million and seven million women each year survive unsafe abortion but sustain long-term damage or disease (incomplete abortion, infection (sepsis), haemorrhage, and injury to the internal organs, such as puncturing or tearing of the uterus), and infertility (Nour, 2008). In developing countries, an estimated five million women are admitted to hospital each year for treatment of complications from induced abortions (Singh, 2006).

Treatment of abortion complications in hospital uses a lot of resources, which includes hospital beds, blood supply, medications, operating theatres, anaesthesia and medical specialists. Hence, the consequences of unsafe abortion put a huge demand on scarce clinical, material and financial resources of hospitals in many developing countries, undoubtedly compromising other maternity and emergency services. Major physiological, financial and emotional costs are also incurred by the women who undergo unsafe abortion (Johnston, 2007).

## CHAPTER THREE

### RESEARCH METHODOLOGY

This chapter describes the research design, the study area, the sampling procedure as well as the data handling techniques used in the study.

#### 3.1 Study design

The study was cross sectional descriptive involving the use of quantitative and qualitative methods for data collection.

#### 3.2 Study Area

The Ga-East municipality lies in the northeastern part of Greater Accra region. It is bounded in the north by Akwapim south district, in the west by Ga West, in the east by Adentan municipal and in the South by Accra Metropolitan assembly (Okaikoi and Ayawaso sub metros). The municipality consists of 4 sub-districts, which are Madina, Dome, Taifa, and Danfa. There are 34 communities comprising mixed settlements, urban, peri-urban and rural areas.” Seventy six percent” of the entire district settlement is urban. Public services and trading are dominant in its occupational scene, followed by farming and craftsmanship. Besides, a sizeable proportion of the working force in the district is unemployed reflecting the high poverty level and for that matter their inability to pay for the health care services offered them. Two major festivals, namely Dokobi is celebrated by Sessemi inhabitants and Homowo celebrated by Boi, Teiman and the other communities in conjunction with Teshie and La inhabitants. A total of forty one (41) health facilities have been recorded in the district. Public facilities constitute only 6 (13%), thirty three are private, 1 CHAG and 1 quasi government health facility.

### 3.3 VARIABLES

The dependent variable is self- induced abortion

The independent variables are grouped as below:

Socio-demographic characteristics: Age, Educational level, Marital Status, Occupation, religion, Ethnicity.

- A. Contraceptive practices.
- B. Reasons for abortion
- C. Methods of abortion
- D. Sources of substances
- E. Types of substances

**Table 3.1: Operational Definition of Variables**

<b>Variables</b>	<b>Definition</b>
Abortion	Abortion is the loss of pregnancy before the foetus is viable
Induced abortion	Deliberately tempering with the pregnancy in order to terminate it
Age	Chronological age of the respondent
Termination of pregnancy	The process of destroying a life foetus
Educational Level	Level of educational attainment of the respondent
Ever obtained abortion	If the respondent has ever aborted pregnancy be it elective, induced or spontaneous abortion.
Marital status	The condition of being married or unmarried
Occupation	Major economic activities.
Ethnicity	Tribe the respondent belongs to
Religion	The religious affiliation of the respondent

Sources of substances	Where the substances were obtained
Reasons for self induced abortion	The purpose for self- inducing abortion
Methods of self - induced abortion	The means of self - inducing abortion
Contraceptives	Any agent or measure used to prevent conception
Unmet need for contraception	The state in which fecund woman does not intend to give birth soon, within two years or never, but does not use any form of contraception

### 3.4 STUDY POPULATION

The study population was the women of reproductive age (WIFA) between 15 to 49 years estimated to be 11,484 by the National Population Census (2008) of Danfa-Abokobi sub-district.

### 3.5 SAMPLE SIZE CALCULATION

The sample size of the study population was determined from the women of reproductive age between 15- 49 years of Danfa-Abokobi subdistrict using Epi Info Version 3.4.1. Because the study area is peri-urban with low income, they are more likely to indulge in induce abortion, hence the worst acceptable prevalence of 37% was used.

#### Estimation of sample size:

Estimated population of the female reproductive age group between 15-49 year = 11,484

Expected Prevalence of induced abortion = 30%

Worst acceptable prevalence of induced abortion =37%

Confidence Interval level = 95%

Using Epi Info Version 6, a sample size of 162 was obtained which was rounded up to 200 to make room for non- response, possible errors and incomplete questionnaires .

### **3.6 SAMPLING PROCEDURE/ METHOD**

The data collection was done at Danfa -Abokobi sub- district of the Ga-East Municipality. The sub -district (consists of Danfa, Abokobi, Pantang Teiman, Oyarifa and Obooman) has a more rural characteristics than the other sub districts (Madina, Dome and Taifa) in the municipality. All the houses in the sub-district were pooled together and the total number of houses in the communities in the sub-district ranges from 800 – 1,500. To ensure that each house stood an equal chance of selection, all the house-numbers in the community were obtained from the district assembly, written on strips of paper and dumped in a basket and thoroughly mixed. The strips of paper were then drawn from the basket without replacement. The house-number selected was taken out and listed for inclusion in the study.

In the community, the research assistants located the selected houses and compiled the list of all the women in their reproductive age, WIFA – (15 - 49 years) who were usually resident in the house by asking and writing out their names. These names were then written on strips of paper and dumped in basket and thoroughly mixed for random sampling. One person is then selected from this house to form part of the study, since the researcher wanted to select only one respondent from each of the selected houses. In cases where a selected house-numbers could not be found, or contained too little information to merit inclusion, we simply repeated the procedure to get a substitute. So the number of respondents corresponds to the number of houses in each community.

For qualitative study, 2 FGD sessions were conducted. The first group consisted of six apprentices (i.e. seamstresses, hairdressers) and four students from a local vocational school at Damfa who were selected randomly from community to form this group. The second group was made up of 8 leaders from three women groups in the community (i.e. Abokobi traders association, Methodist women fellowship at Obooman and hairdressers

association at Damfa). Two in-depth interviews (IDI) were also done. This included one youth leader (a female) and a senior midwife of Abokobi health center.

### 3.7 DATA COLLECTION TECHNIQUES

Data collection technique used was questionnaire administration, key informant interviews and focus group discussions. A random sample of 200 women in their reproductive age in the enumeration areas were selected for the survey. These women (the random sampling procedure explained on page 21) were interviewed at home, with a questionnaire, by trained interviewers. The interview included questions on demographic characteristics, sexual activities, and history of pregnancy, contraceptive practices, reasons for abortions and methods of abortion as well as general reproductive health.

### 3.8 DATA COLLECTION TOOLS

A Structured questionnaire and a checklist was used to collect quantitative data from the respondents. Discussion and interview guides were used to collect qualitative data in focus group discussion and in-depth interview respectively.

The data collection methods, tools and techniques are shown in the table below:

Table 3.2: Data collection methods, tools and techniques

Data type	METHOD	TOOLS	TECHNIQUES
Quantitative	Household Survey	Questionnaire	Interviewer-administered
Qualitative	Focus Group discussion	Discussion guide	Discussion
	In-depth interview	Interview guide	Interview

### **3.9 QUALITY CONTROL**

As part of the process of ensuring quality control, random sampling was used in the selection of respondents. This was done to ensure that all respondents had equal opportunity of being selected.

Data was cleaned by running simple frequencies and comparing it with the data from the field, so that where there were any inconsistencies, they were traced to the particular questionnaires. As part of the effort to ensure accurate data was obtained, double data entry was done after which the entries were validated and reconciled.

### **3.10 DATA PROCESSING AND ANALYSIS**

#### **3.10.1 QUANTITATIVE DATA**

Data collected was checked for accuracy, completeness and consistency. The data was then coded and entered into SPSS Version 12.

#### **3.10.2 QUALITATIVE DATA**

Focus group discussion (FGD) and IDI data was transcribed verbatim and translated into English, coded and organized into themes according to the objectives of the study.

### **3.11 ETHICAL CONSIDERATION**

Various ethical issues were looked into. This study involved prying into the private lives of participants, and required asking questions about their sex life. To consider such ethical issues, the following was addressed; the study was well explained to each participant; participation was by written informed consent; the participants have the option to withdraw from the study at any point in time without having to explain. Respondents were interviewed in privacy and the information obtained treated confidentially. Norms and Values of the community and houses were respected. Ethical

approval from the Municipal Director of Health services as well as permission from the community leaders.

### **3.12 STUDY LIMITATION**

Inadequate funding coupled with limited time could not allow an in depth study and analysis of other aspects of the subject. Hence some questions about other methods of self-induced abortion and their effectiveness amongst other things could not be addressed by this study. However, subsequent studies could look at these areas.

### **3.13 PRE-TESTING**

Data collection tools were pre-tested at New Achimota using structured questionnaires which were administered to some randomly selected apprentices of some hairdressers and seamstresses by the researcher. These groups were selected because of their similar characteristics with the study group. Based on the results from the pre-test, the necessary modifications were made and included in the final questionnaires.

## **CHAPTER FOUR**

### **DATA ANALYSIS AND INTERPRETATION**

#### **4.1 INTRODUCTION**

This chapter is a discussion of the results of the data analysed and interpretations. It discusses the socio-demographic characteristics of the respondents, methods of self-induced abortion, reasons, and sources of substances used in self induced abortion.

#### **4.2 SAMPLING**

Two hundred women in fertile age between 15 to 49 years from six communities of the Danfa-Abokobi sub municipal in the Ga-East municipality were randomly selected and interviewed. Two FGD and 2 IDI were also conducted by convenient sampling.

#### **4.3 DATA INTERPRETATION**

The results of the data analysis was evaluated and interpreted, in relation to the objectives of the research, the related existing research evidence and limitations of research methods.

### 4.3.1 SOCIO-DEMOGRAPHIC INFORMATION

**Table 4.1: The Socio-Demographic Characteristics of Respondents**

<b>1.a</b>	<b>Communities</b>	<b>Frequency</b>	<b>Percentage</b>
	Abokobi	46	23.0
	Abokobi-Teiman	32	16.0
	Abooman	27	13.5
	Damfa	40	20.0
	Pantang Village	25	12.5
	Oyarifa	30	15.0
	<b>Total</b>	<b>200</b>	<b>100</b>
<b>1.b</b>	<b>Age of Respondents</b>		
	15 – 19 years	44	22.0
	20 – 24 years	36	18.0
	25 – 29 years	40	20.0
	30 – 34 years	28	14.0
	35 – 39 years	24	12.0
	40 – 44 years	12	6.0
	45 – 49 years	16	8.0
<b>1.c</b>	<b>Ethnic background</b>		
	Akan	53	26.5
	Huasa	15	7.5
	Ewe	65	32.5
	Ga/Dangme	67	33.5
	<b>Total</b>	<b>200</b>	<b>100</b>
<b>1.d</b>	<b>Religious Affiliation</b>		
	Christianity	184	92.0
	Islam	10	5.0
	Traditional	5	2.5
	Other	1	0.5
	<b>Total</b>	<b>200</b>	<b>100</b>
<b>1.e</b>	<b>Marital Status of respondents</b>		
	Married	95	47.5
	Single (never married)	86	43.0
	Divorced	5	2.5
	Separated	6	3.0
	Widowed	1	0.5
	Co-habiting	7	3.5
	<b>Total</b>	<b>200</b>	<b>100</b>
<b>1.f</b>	<b>Educational Level</b>		
	No Formal education	25	12.5
	Primary	33	16.5
	J.H.S/Middle School	98	49
	S.H.S	23	11.5
	Technical/Vocational	13	6.5
	Tertiary	8	4
	<b>Total</b>	<b>200</b>	<b>100</b>

<b>1.g</b>	<b>Main Occupation of respondents</b>		
	Apprentice	31	15.5
	Artisan	29	14.5
	Trader	84	42
	Professional	10	5
	House work	5	2.5
	Student	22	11
	Unemployment	19	9.5
	<b>Total</b>	<b>200</b>	<b>100.0</b>

### **Item 1.a: Communities survey**

The respondents for this study were 200 women in their reproductive age (between the ages of 15 – 49 years) selected from six communities in the Ga East district in the Greater Accra region. The respondents for the study were selected from the Danfa- Abokobi communities and its environs which are more rural than other sub -municipalities. Out of the 22 published studies on abortion in Ghana conducted between 1972 and 1994, only one involved a rural area and a community based study (Ahiadeke, 2001). The Abokobi community had the highest number of respondents 46(23.0%). This was followed by Damfa Township 40(20%). The other respondents were from Abokobi-Teiman 32(16.0%), Oyarifa 30(15.0%), Abooman 27(13.5%), and Pantang Village 25(12.5%).

### **Item 1.b: Age distribution**

The ages of the respondents were grouped into various age brackets of five year interval. Majority of the respondents 44(22.0%) fell into the 15 – 19 years age bracket and this was closely followed by 25 – 29 years age group 40(20.0%). The age group with the least respondents was the 40 – 44 years group, representing 12(6.0%). The mean age of the respondents for the study was 30 years while the minimum and maximum were 15 years and 49 years respectively.

### **Item 1.c: Ethnic background**

The ethnic group of the respondents in the Municipality varied, with the Ga-Dangmes forming the majority 67(33.5%), Ewes 65(32.5)%, Akans 53(26.5%) and Hausas (15)7.5%. This is an indication of the cosmopolitan nature of the selected communities; therefore the nature of ethnic distribution allows better comparison to be made as to whether or not ethnicity also affect decisions of abortion in the community.

### **Item 1.d: Religion**

The main religious groups the respondents belong to are Christianity and Islam; however, there are traditional and other beliefs. Table 1.d above shows that majority of the respondents were Christians 184(92.0%), Moslems 10(5.0%) and Traditional Believers 5(2.5%). Only 1% did not belong to any of these familiar religious bodies but was of Hindu religion.

### **Item 1.e: Marital status**

Overall, majority of the respondents were married 95(47.5%) or single (never married) 86(43.0%). Those co-habiting formed 7(3.5%), separated 6(3.0%), divorced 7(2.5%) and widowed 0.5%.

### **Item 1.f: Educational level**

In all 25 (12.5%) of the respondents never had any formal education while approximately 33(16.5%) finished only primary school and 23(11.5%) had secondary school level education. Majority of the respondents 98(49.0%) had JSS or middle school level education. Technical or vocational training graduates formed 13(6.5%) and the least was tertiary 8(4%).

### **Item 1.g: Occupation**

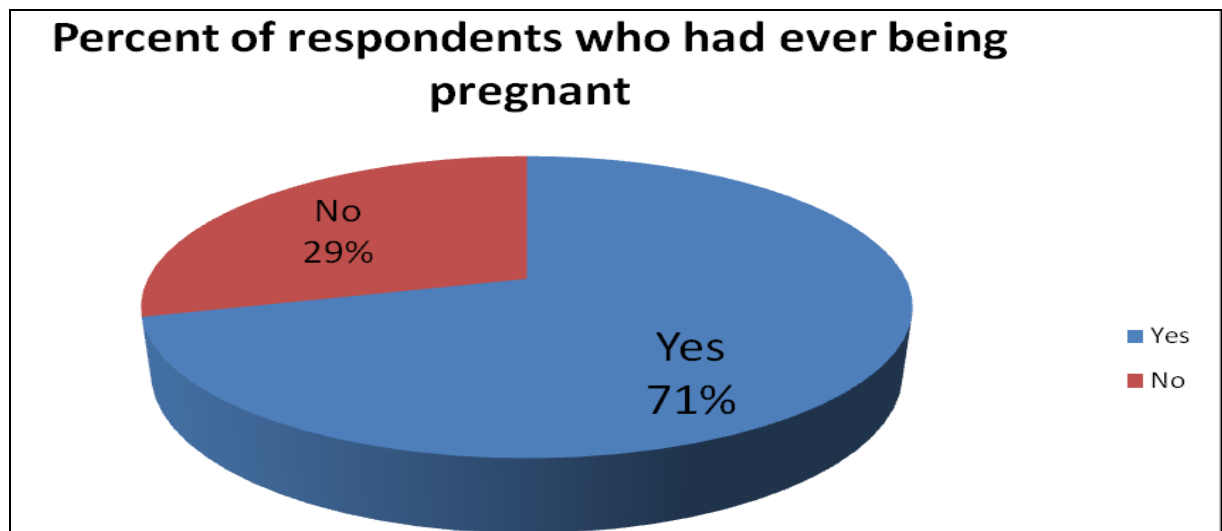
The respondents for the study were also engaged in various activities to get their source of income. Typical of a semi-urban community like the study area, most of the women 84(42.0%) interviewed were traders. The second highest respondents were apprentices 31(15.5%), artisans (hairdressers, seamstresses and masons) form 29(14.5%). In all, 22(11.0%) were students and 10(5.0%) were professionals (Bankers, accountants and teachers).Only 5(2.5%) were house workers.

### **4.3.2 FERTILITY HISTORY**

A study in Accra revealed that 90 percent of the adolescent females who were pregnant neither wanted the pregnancy nor wanted to become pregnant at the time they engaged in sexual intercourse (GDHS, 2003). Millions of women would prefer to avoid becoming pregnant either right away or ever, but they are not using contraception. In many developing countries abortion remains a common way for women to control their fertility (Robey et al, 1996).

**Item 2: ever being pregnant**

Most of the respondents 142(71.0%) had ever been pregnant while 58(29%) had never been pregnant, as shown in figure 2 below:



**Fig 2: Ever being pregnant**

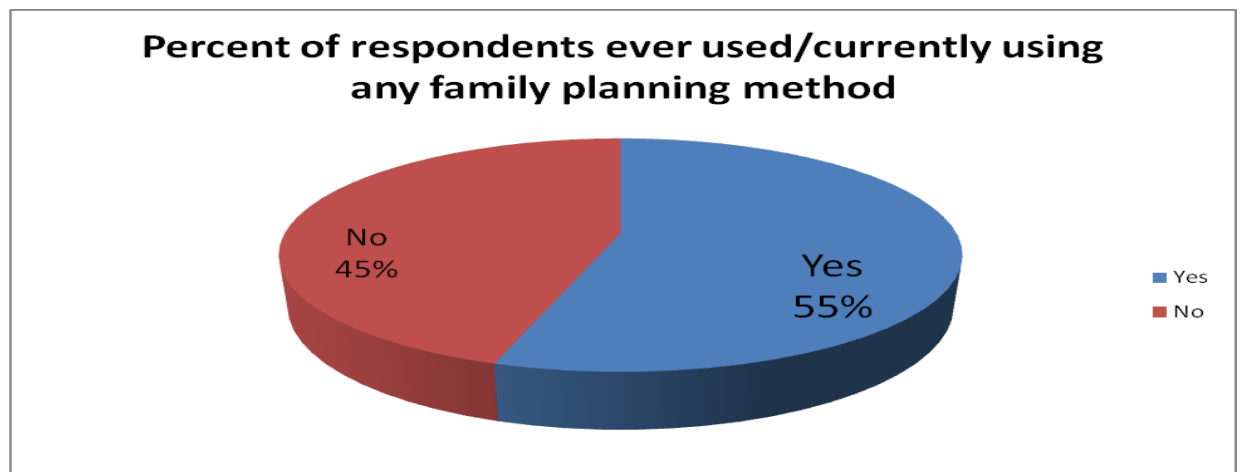
**Table 4.2 Cross tabulation of the age-group of the respondents who had ever been pregnant**

Age group in years	Ever been pregnant		Total
	Yes	No	
15 – 19	9	31	40
20 – 24	22	13	35
25 – 29	33	7	40
30 – 34	24	2	26
35 – 39	23	1	24
40 – 44	13	0	13
45 – 49	20	2	22
<b>Total</b>	<b>144</b>	<b>54</b>	<b>200</b>

The table 4.2 above shows the age group of respondents who had ever been pregnant. The age groups with the most pregnancy were the age group of 25 – 29 years and the age group of 30 – 34 years having 33 and 23 pregnancies respectively. The age group with the least number of pregnancies was the 15 – 19 years age group with nine (9) pregnancies. This however indicates that for every 10 respondents within the age group of 15 – 19 years, two (2) of them had been pregnant before.

### **Item 3: Ever used or currently using family planning method**

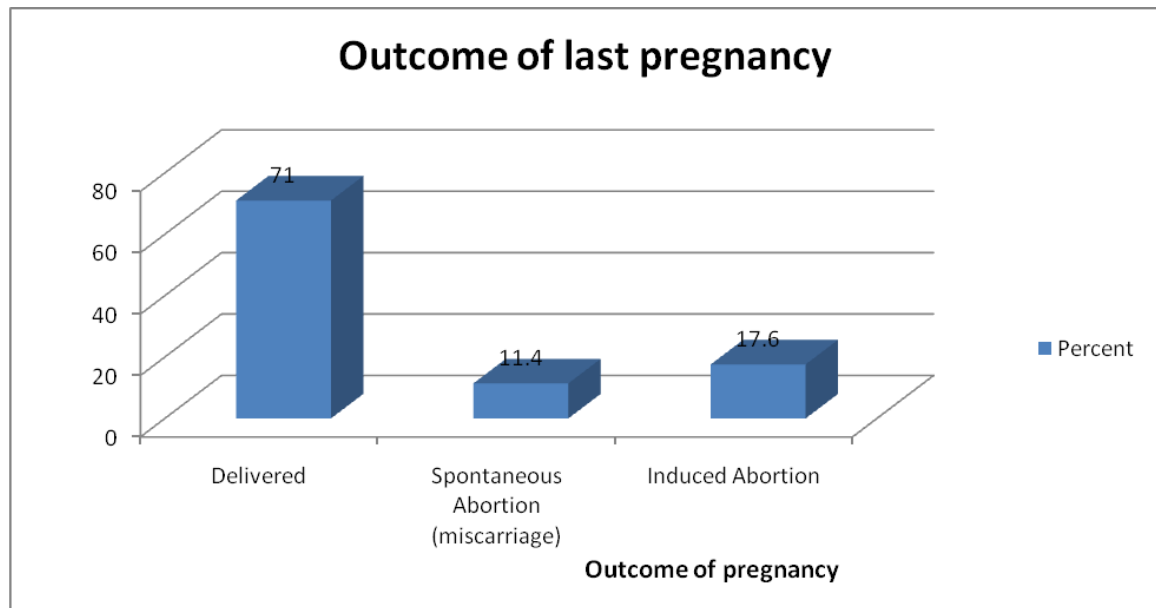
A little over half of the respondents 110(55%) had ever used a contraceptive or still on one of the various contraceptive methods while the remaining 90(45%) had not practiced any modern family planning method. Figure 3 below indicates family planning use among the respondents.



**Fig 3: Ever used/currently using any family planning method**

### **Item 4: Outcome of the last pregnancy**

The figure 4 below revealed the outcome of the last pregnancies.

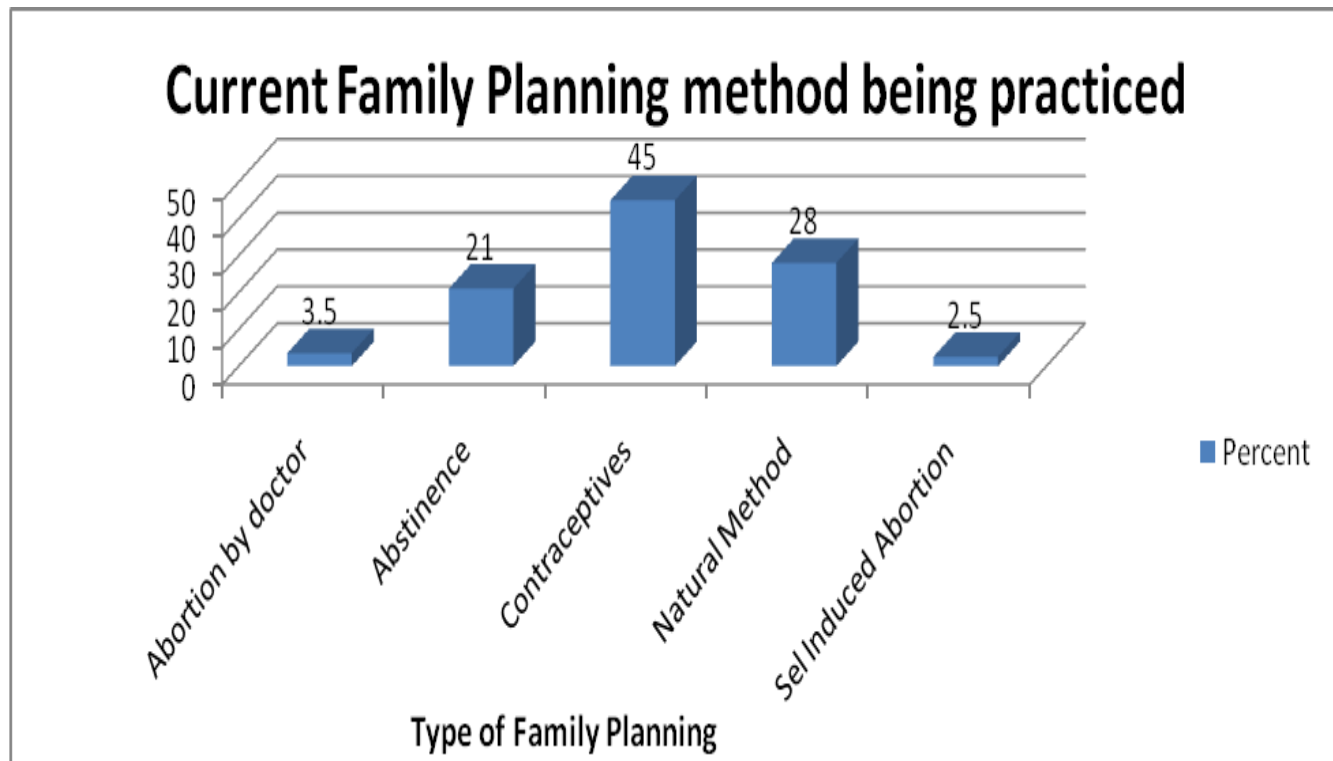


**Fig 4: Outcome of the last pregnancy**

Figure 4 above shows the outcome of the last pregnancy of the respondents. It was revealed that more than two-thirds of the respondents 101(71.0%) carried their pregnancies to term and delivered. However, one-third of the respondents 41(29.0%) aborted their pregnancy and 25(17.6%) of these had done Self-Induced abortion. The remaining 16(11.4%) of the respondents have had spontaneous abortion (miscarriage).

#### **Item 5: Current family planning method being practiced**

The figure 5 below provides the various forms of family planning method currently being practiced by the respondents.

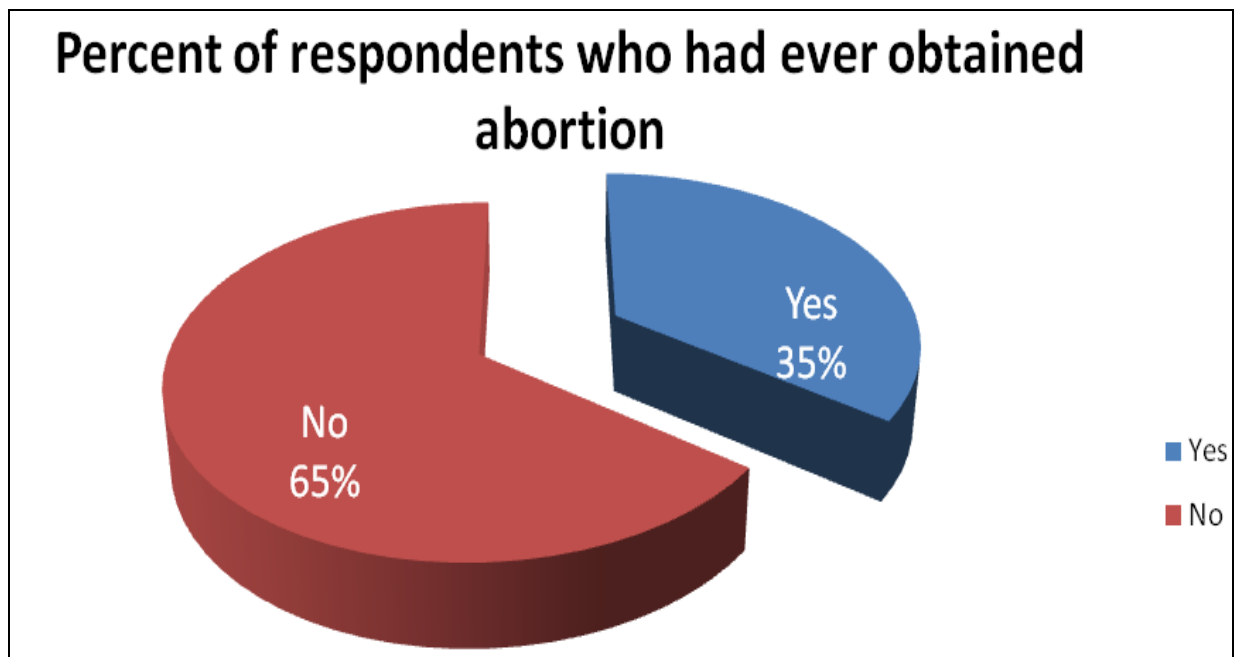


**Fig 5: Current Family Planning method being practiced**

The majority of these respondents 90(45%) were at the time of this study using one form of modern contraceptive or other (Pills, Norplant, Condom, Injectables, Secure etc.) as a way of protecting themselves from pregnancy. Respondents who use rhythm method (withdrawal or calendar method) constituted 56(28%) whereas 7(21.0%) abstain from sexual activities (sexually not active); those who got pregnant either resulted to clinical abortion 7(3.5%) or self induced abortion 5(2.5%).

**Item 6: Ever obtained an abortion.**

Figure 6 below indicate those who have ever obtained an abortion

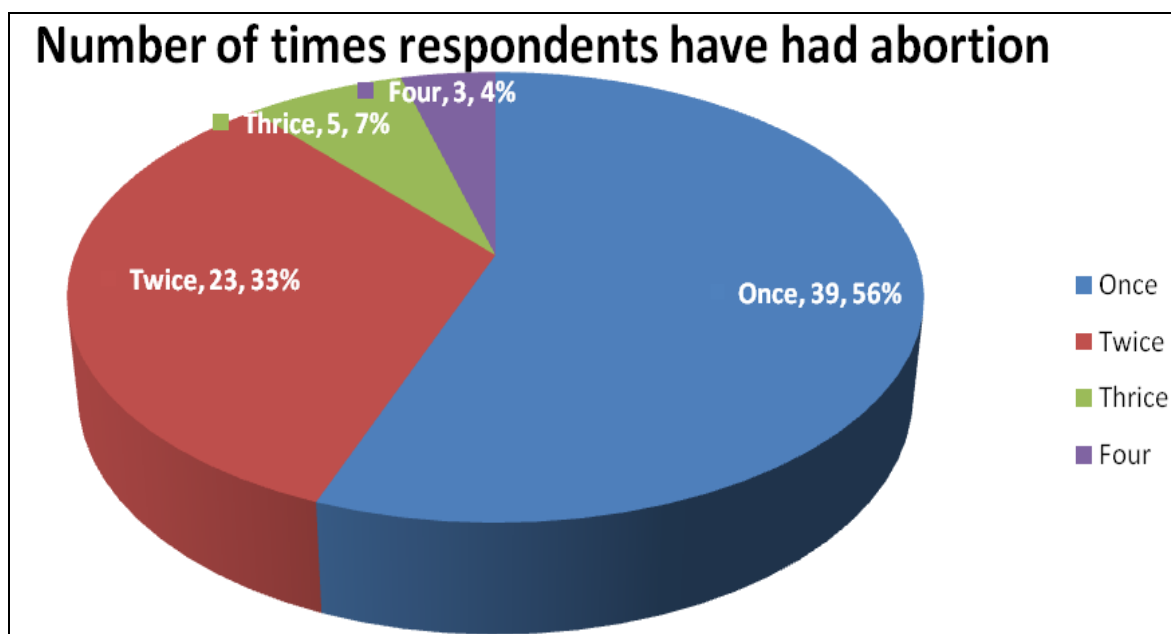


**Fig 6: Ever obtained an abortion**

In all 130(65%) of the respondents have never obtained an abortion, whereas a quarter of the respondents (70, 35%) have done so using one method or another.

**Item 7: Frequency of abortion**

Figure 7 below presents the frequency of abortion by the respondents who terminated pregnancy.

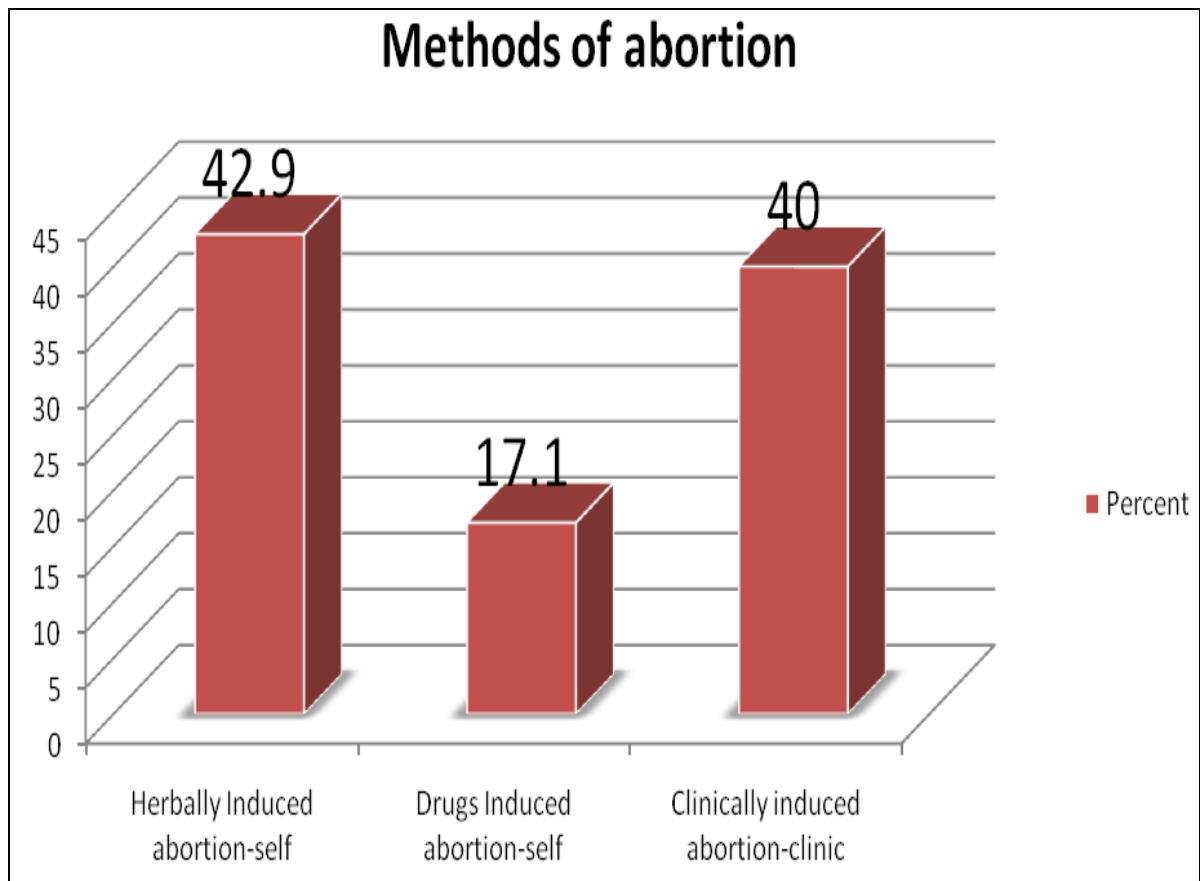


**Fig 7: Frequency of abortion**

When the respondents who terminated pregnancy were asked the number of times they had done so, 56% of them had at least aborted once since puberty, 33% twice, 7.0% three times and 4.0% four times.

**Item 8: Methods of abortion**

Figure 8 below shows the various methods of abortion being used by the respondents.



**Fig 8: Method of Abortion**

Figure 8 above shows the methods by which the respondents got their pregnancies aborted. In general, 42(60%) of the abortions were self induced and 28(40.0%) obtained their abortion from a clinic. Among those who induced their own abortion, 30(42.9%) used herbal concoction whereas 12(17.1%) used drugs.

**Item 9: Substances used in termination of pregnancy****Table 4.3: Types of Substances used in Self-Induced Abortion**

<b>Substance used</b>	<b>Frequency</b>	<b>Percent</b>
Water from Nkradedua leaves (herbs)	4	5.7
Grinded Acheampong weed	5	7.1
Grinded Ablototor leaves	4	5.7
Boiled Cassava stem and leafs	5	7.1
Over dose of paracetamol or Efpac	3	4.3
Paracetamol + akpeteshie	5	7.1
Paracetamol + malt	4	5.7
Powdered bottle + Guinness	2	2.8
Grinded groundnut + pepper ginger+ sugar,	3	4.3
Guinness, sugar, grinded bottle	7	10.0
Instrumentation	5	7.1
Guinness +sugar, coke + sugar	4	5.7
Leaves drugs from a herbalist (nim tree leaves ) + lime salt (kanwe)	4	5.7
local herbs, bitters e.g Adutwumwaa bitters	2	2.9
Cytotec , Nescoffee + sugar	3	4.3
Concentrated laundry blue, camphor + sugar	4	5.7

Alata, samina, Nansen wo ho ayefe soap	1	1.4
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There are different types of substances used by the women to induce the abortion. The results found women mixing malted beverages with paracetamol, excess sugar or nutmeg; and drinking teas of pawpaw leaf, boiled cassava leaves, ‘‘Abtototor’’ leaves, Acheamong leaves, water of Nkrandedua as well as nim wood and peel of oak bark. Some respondents said they used melted sugar with powdered/grinded Guinness bottle while a number of them used a mixture of aspirin containing drugs like Efpac, APC with local gin. However, a number of the women have been using cytotec, a prescription drug that is approved for reducing gastric ulcers but induces miscarriage. Women often obtained the pills at pharmacies that are known to 'bend the rules'. Other respondents also resort to the use of local herbs and bitters like Adutwumwaa bitters, Alomo bitters and other bitters noted for destroying pregnancy. This is seen as the best available option to women who do not want to deal with the stigma of pregnancy.

#### **Item 10: Sources of substances**

Table 4.4 below reveals the sources of substances used in self -induced abortion:

**Table 4.4: Sources of Substances**

<b>Sources of substance</b>	<b>Frequency</b>	<b>Percent</b>
Self	15	21.4
Relatives	2	2.9
Friends	18	25.7
Pharmacist/Nurses/Doctors	23	32.9
Drug peddlers	12	17.1

<b>Total</b>	<b>70</b>	<b>100.0</b>
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The study revealed that Pharmacy shops form the main source of substance acquisition for self induced abortion 23(32.9%). The influence of friend forms 18(25.7%) in providing the substances for Self-Induced abortion. Other respondents who had learnt these substances from Self-Induced abortion also got it themselves 15(21.4%). The role of the drug peddlers constituted 12(17.1%).

The results obtained from the focused group discussions were not very different from those from the quantitative studies. A young lady of 21 years, a hairdresser apprentice in discussing the sources of substances used to induce abortion, had this to say;

*“I know of a drug store which has been giving injections to ladies to induce abortion. One day, they injected a lady at the drugstore to cause abortion .The lady collapsed over there and was rushed to the hospital and died later”.*

On the other hand, a youth leader during the in-depth interview said this;

*“some got it from drug peddlers roaming from house to house or at the market side, some are aware of the herbs used to induce abortion and can go for them from the nearby bush and sometimes mothers help their daughters to abort unwanted pregnancy by providing them with the substances”.*

A young seamstress apprentice of about 24 years however stated;

*“Chemical shops or pharmacy can be a source of drugs used to induce abortion and also boyfriends and peers can be a source of substances used to induce abortion”.*

**Item 11: Method of application of substances**

Table 4.5 below shows the various methods of termination and various route of substance application by respondents involved in induced-abortion.

**Table 4 .5a: Methods of termination of pregnancy**

Method of termination	Frequency (n)	Percent (%)
<b>Herbal induced abortion</b>	<b>29</b>	<b>41.4</b>
<b>Drug induced abortion</b>	<b>14</b>	<b>20.0</b>
<b>Clinically induced abortion</b>	<b>27</b>	<b>38.6</b>
<b>Total</b>	<b>70</b>	<b>100</b>

**Table 4.5b. Methods of application of substances**

Method of application	Herbal Induced Self Abortion (n)	Drug Induced Self Abortion (n)	Clinically Induced Abortion (n)	Total (N)	Percent %
Swallowing	1	6	0	7	10
Drinking	17	4	0	21	30
Injection	0	1	3	4	5.8
Inserting into vagina	8	3	6	12	17.1
Enema	0	0	0	8	11.4
Instrumentation	0	0	18	18	25.7
<b>Total</b>	<b>29</b>	<b>14</b>	<b>27</b>	<b>70</b>	<b>100</b>

Table 4a shows the various methods that were used for termination of pregnancy by the women within the rural community of the municipality. In all 29 (41.4%) of the women who self induced used herbal concoction and 14(20.0%) used drugs. About 27(38.6%) used the clinical setting for their termination. Some of these so called clinics in the true sense are not accredited facilities and are managed by unqualified personnel and quack

doctors. Most of them get complications from these clinics and eventually end up in the hospitals.

Among the various methods of application of substances to induce the abortion (Table 4b), 21(30%) of the respondents drunk the herbs or drugs and 18(25.7%) were induced at the clinic using instruments. Again 12(17.1%) of the women inserted the herbs or drugs into the vagina while 8(11.4%) used enema. Another 7(10%) also swallowed the concoction or the drugs they used in inducing abortion. The remaining 4(5.8%) got injection to induce abortion.

A 26years old leader of traders association during one of the focus group discussions said;

*“ I know some drink mixture of Guinness with plenty of sugar .Some also drink mixture of warm concentrated coffee with extra sugar and Sobolo (normally used to treat malaria), can also be used to induce abortion by drinking plenty. ”*

A shy young lady of 16 years and a seamstress apprentice also contributed during discussion by saying;

*“The one I know they mostly use to induce abortion is cytotec. They swallow two tablets and insert two into their vagina.”*

A youth leader during the interview mentioned this which was different from quantitative views;

*“Sometimes, they use Azuma blows ( a herbal medicine also called do not touch me), mixed with hot water for enema.”*

A senior midwife at a health centre said the following during in-depth interview;

*“I have seen a woman died here in this town after taking grounded bottles she mixed with Guinness. She was vomiting blood and passing bloody stool. She died the next day at the hospital. So it is a dangerous method “*

**Item 12: Reasons for the induced –abortion**

Table 4.6 below provide various reasons for self induced abortion by the respondents.

**Table 4.6: Reasons for Self Induced Abortions**

<b>Reasons</b>	<b>Frequency</b>	<b>Percentage (%)</b>
Financial difficulty and Partner denial	20	28.6
Cost of abortion at the hospital and negative attitude of health workers	6	8.6
Fear of parents and stigmatization from the society	10	14.3
Not ready for a baby	8	11.4
Contraceptive failure	11	15.7
Fear of surgery	3	4.3
Avoid interrupting with schooling or apprenticeship	12	17.1
<b>Total</b>	<b>70</b>	<b>100.0</b>

Table 4.6 shows the reasons for induced abortion among the 70 respondents who have ever obtained it. These reasons are varied. In all 20(28.6%) had induced abortion because of financial difficulty and partner denial and 12(17.1%) did so in order to continue schooling or apprenticeship. The third most common reason given was contraceptive failure (11, 15.7%). Whiles 10 (14.3%) terminated pregnancy for fear of parents and stigmatization from the society, 8(11.4%) said they obtained it because they were not ready for a baby. Cost of abortion at the hospital and negative attitude of health workers constituted 6(8.6%). There were others who obtained it because they were for fear of surgery 3(4.3%).

During focused group discussions and in depth interviews the participants gave reasons why women resort self induced abortion, some of which are follows:

A youth leader during in-depth discussion had this to say:

*“Most often, due to financial problems, it is difficult to care for the child to be born, Coupled with the fact that the partner may denial responsibility of the pregnancy and the woman cannot afford safe abortion at the hospital.”*

A leader of Methodist women fellowship who participated in FGD also narrated that:

*“Married women who are not ready yet for a child or are caring for a baby and becomes pregnant may decide to self- induced to abort the pregnancy.”*

An 18 years old student of a local vocational institute during FGD had this to say:

*“Ladies or women who want to continue education or a trade (apprenticeship), may resort to self- induced abortion because she may risk being dismiss from school or apprenticeship”.*

A 30 years old hairdresser at the FGD reported that:

*“Church influence, i.e. shame associated with pregnancy before married (premarital sex) or fear of miscommunication by the church, a woman may resort to self- induced abortion to avoid shame.”*

A senior midwife at Abokobi health centre also gave her view that:

*“The negative attitude of health workers towards abortion seekers at the hospital is one of the reasons why women decided to self- induced at home.”*

She continued to say that:

*“The fear of instrumentation or the perception that one can die at the hospital, may cause a lady to self induce at home.”*

**Item 13 Effects of induced abortion**

The respondents who were involved in induced abortion experienced various negative effects.

The table 4.7 below states the effects.

**Table 4.7: Effects of Induced Abortions**

<b>Effects as a result of abortion</b>	<b>Frequency</b>	<b>Percent (%)</b>
Chronic headache	12	17.1
Infertility	9	12.8
Infections	6	8.6
Periodic bleeding	8	11.4
Constant Abdominal pains	11	15.7
Pains during menstruation and sex	9	12.9
No side effects	15	21.4
<b>Total</b>	<b>70</b>	<b>100</b>

Almost all the respondents who had self-induced abortion complained of the several side effects hours or days after the abortion. About seventeen percent (12, 17.1%) complained of chronic headache and 12 (15.7%) complained of persistent abdominal pains after the abortion. whiles 9 (12.8%) complained of pains during menstruation and sex, 9 (12.8%) had fertility problems and 11.4% said they experience periodic bleeding. Though 6 (8.6%) had post abortion infection, 15 (21.4%) had no side effects.

**Item 14: Complication of self induced abortions**

Table 4.8 below list complications experienced by 30 respondents involved in self induced abortion.

**Table 4.8: Complications of Self Induced Abortions**

<b>Complication</b>	<b>Frequency</b>	<b>Percent</b>
Uterine perforation	5	16.7
Unconsciousness	5	16.7
Miscarriage in subsequent pregnancy	8	26.7
Periodic bleeding	12	40.0
<b>Total</b>	<b>30</b>	<b>100.0</b>

The most common complication of self-induced abortion experienced by the respondents was periodic bleeding (12, 40.0%). Miscarriage of subsequent pregnancies constituted 8 (26.7%). Uterine perforation and unconsciousness formed 5 (16.7%) of the complications.

On the complications of self – induced abortion the respondents participating in FGD and in-depth interview talked based on their experiences and those of others.

A senior midwife interviewed narrated that:

*“It can lead to given birth to a baby with deformities due to the drug’s use to attempt abortion, and also infertility and ectopic pregnancy are associated with induced abortion due to infections.”*

A 16 years old student of a vocational institute in FGD said:

*“I know self induce abortion can lead to miscarriages in subsequent pregnancies.”*

A youth leader during in-depth interview also adds her view on complication as a result of induced abortion:

*“Self- induced abortion can lead to the destruction of the womb, and therefore it is a dangerous procedure and can lead to death.”*

#### **SCENARIO ONE:**

##### **FGD**

A leader of a hairdresser’s association at Danfa during the focused group discussion narrated this case: *“a woman who passed behind the husband (engaged in extra marital affairs with another man), became pregnant and went to the herbal doctor for some herbal medicine to abort the pregnancy secretly. But she started bleeding shortly after she drunk the concoction and some inserted into her vagina. She was rushed to the hospital to seek medical attention. In the hospital, the nurses told them that this woman would have died in the house if she was not brought to the hospital early. Later she was operated on by the doctor and her uterus removed because the doctor said her uterus was badly damaged”*.

#### **SCENARIO TWO:**

A senior midwife at Abokobi health centre during interview narrated a case she witnessed while on duty:

*“I was on duty at the clinic one day when a young lady in her early twenties was rushed to the clinic vomiting blood and bleeding severely. When the one who brought her was asked, the person narrated that the patient/victim was an apprentice in the town living with her aunt. The patient/victim was pregnant and because she did not want her aunt to see, pretended to be sick and did not go to work that day. When the aunt went to the market, she took a mixture/solution of gun powder and coca cola in an attempt to abort*

*the pregnancy. When the aunt came home later in the day, she heard her groaning in her room and when the aunt went in, she saw her lying in the pool of blood with the remaining mixture by her side. When the patient/victim was brought to the clinic she was very weak and pale and died few minutes after arrival. I was very sad that day”, she lamented.*

### **SCENARIO THREE: (PERSONAL INCIDENT)**

A young seamstress apprentice took courage to narrate an ordeal she went through during a focus group discussion:

*“I had been dating (going-out) this Trotro driver for two years when the pregnancy occurred. This Trotro driver always insisted that we had raw sex (without using a condom) whenever I visited him. But when I got pregnant he denied ownership of the pregnancy and even accused me of having another boyfriend. He warned me never to come to his house again with the pregnancy. Because I loved him, I did not tell anybody about the pregnancy and went to the drug store to get some drugs to abort the pregnancy. When I explained to the pharmacist, she gave me four tablet of Cytotec which I was instructed to swallow two tablets and insert the other two tablets into my vagina. By doing that the foetus came. I bled and bled and bled for more than five days. Since this incident I have been experiencing serious pains whenever I am in my menses” she confessed.*

## CHAPTER FIVE

### DISCUSSIONS

#### 5.0 Introduction

For all these years of trying to gather data on the existence and prevalence of self induced abortion in Ghana, hospitals especially those in the cities have been the only major source of gathering the data. The exact number of women practicing self induced abortion is unclear hence the dependence on the hospitals to provide the data on self induced abortion. Notwithstanding this, data from these hospitals are being questioned on its validity and genuineness as record-keeping in the hospitals is poor and could not be reliable and induced abortions often labelled inaccurately (Ahiadeke, 2001).

#### 5.1 Background information on the respondents

The analysis of socio-demographic data of women who obtained self induced abortion in Danfa-Abokobi district, was that majority of them were between the ages of 20-34years, and this together account for 70% of the women involved. However, two thirds of them were between the ages of 20-29 years. In a similar study by Ahiadeke (2001) in Southern Ghana, he reported that 60% of the women who obtained induced abortion were below the age of 30 years.

The women obtaining induced abortion were significantly represented in all the ethnic groups. However, Ewe and Ga/Dangme forms the majority with the later slightly above.

A larger proportion of the women were Christian 85.7% and Islam and Traditional religion forming a minority of 8.6% and 5.7% respectively.

The study also revealed that the majority of the women who obtained self induced abortion were single (50%), while the married women formed 37.1%. This findings conforms with Adanu and Tweneboah (2004) report that a larger proportion of women

who obtained induced abortion were not married. However, a similar study by Ahiadeke (2001) indicated that a larger proportion of women who obtained induced abortion were married, though he further explained that it could possibly be due to unmarried women pretending to be married to avoid stigmatization.

Young and unmarried women are less likely to access and utilized family planning services than the married women. Though the family planning policy stated that its services should be available to all, the service providers focus more on married couples. This in addition to inability to negotiate for safer sex due to inexperience and lack of economic independence are easily prone to become pregnant. In order not to be ejected from school or apprenticeship, they will secretly resort to abortion.

Majority of the respondents who obtained self induced abortion were educated (66.9%), however, a significant number (21.4%) has no formal education. Adanu and Tweneboah (2004) indicated that majority of women resorting to induced abortion in Accra had higher educational level. These were mainly hairdressers and seamstress (artisans), traders and apprentices. Only 12.9% of the respondents involved were unemployed.

## **5.2 Methods of Self-Induced Abortion and their potential effects**

The study found that most women would resort to anything to secretly induce an abortion. They would drink any mixture (concoction) or insert tablets, herbs or objects to induce abortion. The herbally induced abortion and the drinking and insertion of mixtures are most often used because of availability and cost effective of substances utilized as compared to the use of drugs due to difficulty obtaining it and cost.

Various substances were administered through various routes to achieve an abortion. A high percentage of abortion providers have no formal medical training and without the

requisite skills. This may explain the high prevalence of abortion complications that report to the district hospital (Alpha medical centre) at Madina each year.

Some of the modes of self induced abortion are horrifying. Some of the concoctions, mixtures and tablets that were ingested to induced abortion were:

- a) A mixture of grounded Guinness bottle, half a margarine tin of granulated sugar and a bottle of Guinness.
- b) A mixture of concentrated laundry blue, two balls of camphor and half a margarine tin of granulated sugar.
- c) A combination of grounded groundnut, four spoonful of dry powdered pepper, ginger and a bottle of coke.
- d) A concoction of grounded ablototor leaves, six tablets of paracetamol and two tots of akpeteshie.
- e) A mixture of eight sachet of Nescafe, half a margarine tin of a granulated sugar and a bottle of malt drink.
- f) Swallowing four tablets of cytotec.

Furthermore, other things that were inserted vaginally to induce abortion include:

- a) Grounded leaves or stem of Nkradedua (a local plant), inserted into the vagina or cervix and its extract (juice) opens the cervix to abort.
- b) Two to Three tablets of cytotec inserted into the lower part of the cervix through the vagina.
- c) The insertion of the stem of Gbukagba, a local plant into the cervix through the vagina.

An experience midwife at Abokobi health centre who has been working there for the past ten years had these to say: *I have come across many of these women who have used different dangerous modes to induced abortion.*

Ask how effective are these methods used, she said *“Despite the fact that these methods are dangerous to the life of the women, both short and long term, they are very effective and end up achieving their aim of inducing and aborting their unwanted babies”*. She also added that, the methods are cost effective since the substances and the herbs are gotten from their vicinity and nearby bush without paying for them as against going to the hospital to have it done under a hygienic condition by a skill person at a huge cost to them.

The same result was reported by Grimes (2003), that women often insert strange substances such as broken –off stem of an “osibisaba” plant into the cervix and leave it in place to terminate the unwanted pregnancy. Grimes (2003) also found in his research that women use oral abortifacients such as mixture of finely crushed glass with liquids and laundry blue and overdose of medicines such as paracetamol. Additionally, Grimes (2003) also reported the use of turpentine, bleach, tea made of livestock faeces, and potassium permanganate to self induced abortion. Adanu and Tweneboah (2004) also reported similar unsafe methods as this current study recorded.

### **5.3 Reasons for obtaining Self-Induced Abortion**

Several reasons were given by the respondents for obtaining induced abortion. A greater majority gave financial difficulty as the major reason why they obtained it. The second major reason for obtaining induced abortion was to avoid interruption with schooling or apprenticeship. This is confirmed in a similar study by Adanu and Tweneboah (2004), in Accra where they recorded education as the second major reason why women obtain induced abortion. The financial difficulty was due to several factors and these included

inability to pay for the services of abortion at a hospital, partner denial and disownment by guardians which makes it difficult for these women to take care of the pregnancy to term or the baby after delivery. Also single women may not be financially sound to support a child. These could account for relatively higher levels of induced abortion in young and single women.

Bankole et al (1998) also stated that inability to pay for services of abortion at a hospital is the main reason women resort to self induced abortion. Pregnancy is regarded as a stumbling block to educational progress whiles in school or apprenticeship. Young women would resort to anything to secretly induce an abortion for fear of dropping out of school or apprenticeship. Contraceptive failure accounted for a third major reason why women resort to self induced abortion in the district. Incorrectly or inconsistent use of contraceptives and discontinuation due to side effects results in unwanted pregnancy and subsequently induced abortion. The fear that they would be laughed at in the community (stigmatization) and also do not want their parent to know about it compelled them to induce their abortion. Culturally, childbirth outside marriage is unacceptable and could be embarrassing to the family. Therefore, to avoid disgracing ones family, single, unmarried women will go in for induced abortion. One young lady, a seamstress at focus group discussion also added that married women who are not ready yet for a child or are caring for a child who is not yet old, and becomes pregnant often go in for induced abortion.

A youth leader, during an in-depth interview also said that the negative attitude of health workers towards the abortion seekers at the health facilities drives them away. Since the women would like to abort the pregnancy at all cost, they go in for an alternative (induced abortion) which affect their health.

#### **5.4 Sources of substances used for Self-Induced Abortion**

The source of substances used in causing induced abortion is not much of a problem for women in the district. They either obtained the substances from a pharmacy shop that are known to “bend the rules” or from Doctors “quack” and Nurses. Due to the secrecy involved, these doctors and pharmacist who provide the medicines to the women also teach them how to utilize it or helped them to use it at the pharmacy or chemical shops.

Friends also form a substantial source of substances to the women who self induce abortion. The women confide in their friends who are ready to keep secrecy and provide them with the substances to induce abortion. Some of the women already have perquisite knowledge of the substances used in inducing abortion. They therefore go for it themselves and use it without consulting anybody. The drug peddlers moves from house to house, at market places, lorry stations and in buses are also a source of substances used in induced abortion. They are easily accessible to the women and cost effective to them. However, most of their products causes a lot of harm to the women since they are fake and expired and uses overdose of it. These peddlers are never traced again after selling and the women are left to their fate.

According to Ahiadeke (2001), most women still rely on a mix of traditional practitioners, quack doctors, physicians and other sources such as qualified nurses and pharmacists to obtain abortion services. This study also confirms the findings that a large proportion of abortions are performed outside the medical system (Ahiadeke, 2001).

#### **5.5 The effects and complications of induced abortion**

The implications of induced abortion on maternal health is very enormous and worth looking at.

Almost all the respondents involved in self induced abortion complained of serious abdominal pain and chronic headaches. A significant proportion of the respondents

complained of either continuous or periodic bleeding per vagina and had to be admitted at the health facilities and treated for anemia at higher cost to them. Others required surgical operation because of incomplete abortion and some even end up having their uterus removed because of perforations.

The overdose of the concoctions and drugs used in inducing abortion has severe toxicological effects. It has the potential of causing hepatotoxicity and necrosis of the renal tubules which can eventually lead to hepatic and renal failures (Katzung, 1995). The ingestion of grounded bottles and other reagents can also lead to gastro-intestinal bleeding and death. Furthermore, the insertion of hard substances such as sticks and stems of plant as well as instruments into the vagina and the uterus may cause cervical tear, uterine perforation, bleeding and infections that may be fatal to the women. According to the research findings by Singh (2006), an estimated five million women are admitted to hospital each year for treatment of complications from induced abortion alone in developing countries. The consequences of induced abortion place a lot of demands on scarce clinical, material and financial resources of hospitals, thereby undoubtedly compromising other maternity and emergency services (Johnston, 2007).

Respondents from the focus group discussion and the in-depth interview mentioned inability to get pregnant later in life (infertility), miscarriage in subsequent pregnancies, infections, deformed babies when the abortion fails and bleeding. In our culture, child bearing is cherished; therefore a woman who cannot give birth to a child is frowned upon by the society, disowned and rejected.

According to WHO, 2004, 70,000 women die globally and 30,000 die in Africa yearly as a result of complications from unsafe abortion.

## CHAPTER SIX

### CONCLUSION AND RECOMMENDATIONS

#### 6.1 CONCLUSION

The problem of unsafe abortion is still colossal and as relevant as the issue of HIV/AIDS.

The types of substances, the source of substances and the mode of application of these substances all give us a cause for concern. The number of self-induced abortion in the community and by extension in the rural area was high. The statistics available at the hospital was just a small fraction of the many self-induced abortion cases in the community. Most of the women having induced abortion in the communities were young, single and has had education only up to senior high school or vocational level. These subgroups of women should be the focus of interventions aimed at reducing the incidence of self induced abortion.

The source of the substances for the self-induced abortions is a major concern. These were mainly obtained from quack doctors, nurses, chemical and pharmaceutical shops, relatives and close allied as well as drug peddlers in the community.

The principal mode of application of these dangerous substances were orally, vaginally, or both, enema and injections. This unconventional method has the tendency to cause serious health problems to these women whether or not it is able to terminate the pregnancy. Most of the women, for the reasons of financial difficulty, the zeal to continue education or apprenticeship, contraceptive failure or fear of parents would often resort to dangerous methods of terminating unintended pregnancies in the community.

This study also found that, about 29.0% of women had had at least one induced abortion. This number of induced abortions per woman in the community is alarming because victims were not ready to disclose information on such issues for the fear of stigmatisation and persecution. The fact that those who use modern contraceptives have also had an induced abortion suggests lack of in-depth knowledge about consistent and effective use of contraceptives. This suggests a gap in educational and promotional activities of our family planning programmes, and activities in the district and that continuous education and support is needed to ensure proper family planning.

## **6.2 RECOMMENDATIONS**

- Family planning educational and promotional activities should be concentrated on behaviour change to encourage contraceptive use among all age groups.
- Family planning services provided by the health centres and clinics in the district should focus on the use of modern methods of contraception.
- District health administration in collaboration with NGOs like the PPAG and district assembly should incorporate youth centres and corners at the health facilities in the community to address youth related issues with regards to family planning and reproductive health.
- Affordable and accessible comprehensive abortion care and post abortion counselling should be instituted in all health facilities in the district with emphasis on simple and inexpensive methods such as suction aspirations to be provided by nurses and midwives.
- Public education and symposia especially for churches, schools and social groups should be organised by DHA to sensitize them on dangers of various methods of self- induced abortion.

- The district health administration should collaborate with the Ghana education service to review and intensify sex education in all basic and secondary schools, to enable young women make informed choices concerning their reproductive health.
- The district assembly should also take steps to improve the socio-economic status of women in general and young women in particular by enforcing female education and developing entrepreneurial skills of women in the district.
- Finally, Bye-laws should be made by the district assembly to punish those who connive and abet with the women to induce abortion, and the law enforcing agencies in the district should be tasked to enforce the bye-laws.

### **6.3 Limitation to the study**

The study limit was that some of the respondents who may have involved in self-induced abortion may not admit ever doing it. This may affect the generalization of the result. The other limitations were financial and time constraints which affected the scope of the study

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**APPENDIX I**  
**CONSENT FORM**

My name is -----and I am part of the research team conducting a study into self induced abortion.

You have been thoroughly briefed on the significance of this research which is being conducted by Frederick Duah (MPH resident of the school of Public Health, University of Ghana Legon).

Giving us consent to participate in this study is voluntary and not under any obligation. Therefore, you are free to withdraw at any point in time and you will not be requested to give any explanation.

Under no circumstances would your actual identity (i.e name and address) be made known to any other person(s) after providing all the information requested from you for this particular study as promised by the researcher. All your responses will not be shared with anybody who is not part of this study team and data analysis will be done at the aggregate level to ensure strict anonymity.

Participant's Signature/Thumbprint.....

Date.....

## Appendix II

### QUESTIONNAIRE

A COMMUNITY STUDY TO IDENTIFY METHODS, REASONS AND SOURCES OF  
SUBSTANCES USED IN SELF- INDUCED ABORTION.  
GA-EAST DISTRICT OF GREATER ACCRA REGION.

CODE NO.....

DATE.....

#### **Socio-Demographic/Economic characteristics of respondents.**

1. Age of respondents [      ]
2. Where do you live? .....
3. Religion  
a. Christian [   ] b. Islam [   ] c. Traditional [   ] d. Other (specify) \_\_\_\_\_
4. Ethnicity  
a. Ga/Dangme [   ] b. Akan [   ] c. Huasa [   ] d. Ewe [   ]  
e. Other (specify) \_\_\_\_\_
5. Marital status  
a. Married [   ] b. Single (never married) [   ] c. Divorced [   ]  
d. Separated [   ] e. Widowed [   ] f. Co-habiting [   ]
6. Highest level of Education  
a. No Education [   ] b. Primary [   ] c. JSS/ middle school [   ]  
d. SSS/Secondary school [   ] e. Technical/Vocational [   ]  
f. Tertiary [   ]
7. What is the main work that you do for a living?  
a. Apprentice [   ] b. Artisan [   ] c. Trader [   ] d. Professional [   ]  
e. House Work [   ] f. Students [   ] g. Other (specify) \_\_\_\_\_
8. Are you currently living with a partner?  
a. Yes [   ] b. No [   ] **IF NO, go to Q 11**
9. What is your husband/Partner's highest level of educational?  
a. No Education [   ] b. Primary [   ] c. JSS/ middle school [   ]  
d. SSS/Secondary school [   ] e. Technical/Vocational [   ]  
f. Tertiary [   ]
10. What is your husband/partner's main occupation?  
a. Professional [   ] b. Farmer [   ] c. Trader/Businessman [   ]  
d. Artisan [   ] e. Factory work [   ] f. Student [   ]  
g. Other (specify).....

**Family Planning and Reproductive Health history**

11. How many children do you have? [     ] **if None go to Q 13**
12. What is the age of your last child (in years)? .....
13. Do you know what is meant by family planning?  
a. Yes [   ] b. No [   ]
14. Have you ever practiced family planning (**contraceptives use**)?  
a. Yes [   ] b. No [   ] **if no go to Q16**
15. If yes, which method have you ever used? **Give multiple answers if applicable**
- Oral Contraceptives [   ]
  - Natural or rhythm methods [   ]
  - Injectable [   ]
  - IUD [   ]
  - Norplant [   ]
  - Condom [   ]
  - Diaphragm [   ]
  - Spermicide [   ]
  - Tubal Ligation [   ]
  - Other, specify \_\_\_\_\_
16. Do you practice any family planning now?  
a. Yes [   ] b. No [   ]

**Pregnancy and Abortion**

17. Have you ever been pregnant?  
a. Yes [   ] b. No [   ] **if NO go to Q19**
18. What happened to the pregnancy?  
a. Delivered [   ] b. Spontaneous Abortion (miscarriage) [   ]  
c. Self induced Abortion [   ]
19. What exactly do you use to prevent pregnancy?  
.....
20. Have you heard of abortion?  
a. Yes [   ] b. No [   ]
21. What is abortion? .....
- .....
22. Is abortion a form of family planning?  
a. Yes [   ] b. No [   ]

b. Give reasons for your answer.....

**Methods of self- induced abortion**

23. Which people do you know aid/help in the termination of abortion? **Tick as many as applicable**

- a. Friends [ ]      b. Relatives [ ]      c. Herbalist [ ]      d. Doctor/Nurses [ ]  
e. Pharmacist [ ]      f. Drug peddlers [ ]      g. Other (specify) \_\_\_\_\_

24. Have you ever aborted or terminated a pregnancy?

- a. Yes [ ]      b. No [ ] **if NO go to 31**

25. If yes, who aided the termination of the abortion?

- a. Self [ ]      b. Relatives [ ]      c. Friends [ ]      d. Doctor/Nurses [ ]  
e. Pharmacist [ ]      f. Drug peddlers [ ]      g. Herbalist  
h. Other (specify) \_\_\_\_\_

26. How many times have you had an induced abortion?

- None [ ]  
Once [ ]  
Twice [ ]  
Thrice [ ]  
>Four [ ]  
Other( specify).....

27. Which of the following methods of abortion was used?

- a. Herbally induced abortion [ ]      b. Drugs induced abortion [ ]  
c. Physically induced abortion [ ]      d. Clinically induced abortion [ ]  
e. Other (specify) \_\_\_\_\_

28. How was the method(s) applied?

- a. Swallowing [ ]      b. Drinking [ ]      c. Injecting [ ]  
d. Inserting into the vagina [ ]      e. Enema [ ]      f. Instrumentation [ ]  
g. Abdominal massage [ ]      h. Other (specify) \_\_\_\_\_

**Sources of substances used in abortion**

29. If you have ever caused abortion where did you obtained the substance?

- a. Self [ ]      b. Relatives [ ]      c. Friends [ ]      d. Doctor/Nurses [ ]  
e. Pharmacist [ ]      f. Drug peddlers [ ]      g. Herbalist  
h. Other (specify) \_\_\_\_\_

30. What did you used in the abortion/termination of pregnancy?

- a. \_\_\_\_\_  
b. \_\_\_\_\_  
c. \_\_\_\_\_

31. What are some of the substances that you know/heard are generally used in the abortion/termination of pregnancy?

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_

32. In your opinion, where do they normally obtain these substances used in the abortion/termination of pregnancy?

- a. Self [  ]      b. Relatives [  ]      c. Friends [  ]      d. Doctor/Nurses [  ]
- e. Pharmacist [  ]      f. Drug peddlers [  ]      g. Herbalist
- h. Other (specify) \_\_\_\_\_

**Reasons for Self Induced Abortion**

33. If you have ever done Self-Induced abortion, what were the reasons? **Give multiple responds if applicable**

- a. Financial difficulty [  ]      b. Negative attitude of health workers [  ]
- c. Stigmatization from the society [  ]      d. Not ready for a child [  ]
- e. Want to continue education [  ]      f. Contraceptive failure [  ]
- g. Fear of parent [  ]      h. Partner denial [  ]
- i. Fear of surgery [  ]      j. Cost of safe abortion [  ]
- Other (specify) \_\_\_\_\_

34. In your opinion, why do women generally resort to self-induced abortion?

.....  
.....

35. Did you seek help at the health facility (hospital) after self inducing?

- a. Yes [  ]      b. No [  ]

36. Please give reasons for your answer.

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

37. Generally, what has been the outcome of self-induced abortion?

- a. Bleeding [  ]      b. Chronic disease [  ]      c. Infertility [  ]      d. Infections [  ]
- e. Death [  ]
- f. Other (specify) \_\_\_\_\_

38. What are the complication(s) associated with self- induced abortion?

.....  
.....

THANK YOU

## **Appendix III**

INTERVIEW GUIDE FOR FOCUS GROUP DISCUSSION AND IN-DEPTH  
A COMMUNITY STUDY TO IDENTIFY METHODS, REASONS AND SOURCES  
OF SUBSTANCES USED IN SELF- INDUCED ABORTION.  
GA-EAST DISTRICT OF GREATER ACCRA REGION.

DATE.....

### **Family planning**

- Have you heard of family planning?
- What is meant by family planning?
- Why do we practice family planning?

### **Pregnancy and Abortion**

- can you tell me about your understanding of abortion?
- Is abortion a form of family planning and why do you say so?

### **Reasons**

- Can you tell me the main reasons why a woman or a lady decides to abort her pregnancy?
- I want to know why a lady may decide to abort the pregnancy herself instead of going to the hospital?
- In your opinion, why do women generally resort to self-induced abortion?

### **Methods of self –induced abortion**

- Can you tell me some of the various substances women use to induce abortion themselves?
- How are these substances use by the women to induce abortion?
- Why do they use these particular substances, is it that they are cheap and effective?
- Which people do you think influence or help the women to cause abortion themselves?

### **Sources of Substances**

- Can you tell me where do the women obtain the substances they use to induce abortion?

- Among the sources you mentioned, which one is mostly source?

### **Complications**

- In your opinion, what has been the outcome of self- induced abortion?
- What are the complication(s) associated with self induced abortion you know?
- Can you narrate to me your personal experience or that of someone you know?