

**PSYCHOSOCIAL FACTORS AND THEIR IMPACT ON UNSAFE ABORTION  
IN THE GREATER ACCRA REGION OF GHANA**

**BY**

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## DECLARATION

This is to certify that this thesis is the result of research undertaken by Appiah Emelia towards the award of the MPhil (Hons) Degree in Social Psychology in the Department of Psychology, University of Ghana.

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## ABSTRACT

*This study was done to ascertain the psychosocial factors and their impact on unsafe abortion in the Greater Accra Region of Ghana. One hundred (100) women who had ever had abortion(s) and were visiting the Family Planning Units of the Ridge Hospital and La General Hospital as well as the Obstetric and Gynaecological Unit of the 37 Military Hospital were the participants of the study with ages between 9 and 50 years. Data was collected using a questionnaire and analysed with the Logistic Regression Analysis. The results of the study demonstrated that knowledge of Ghana's abortion law and religiosity influenced the women's engagement in safe or unsafe abortion. Abortion stigma, cultural norms and values and knowledge of the existence of safe abortion services, however, did not significantly predict the women's engagement in safe or unsafe abortion. Recommendations centred mostly on intensifying education of Ghanaian women on their legal rights to safe abortion by the appropriate governmental and other legal education agencies in the country.*



## DEDICATION

I dedicate this thesis to the Lord Almighty who is my saviour and provider, my parents Mr John William Appiah and Gladys Baah Cudjoe for their care and support and to my dearest husband and friend Nana Benyin Fiifi Mends.



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**LIST OF ABBREVIATIONS**

|       |  |
|-------|--|
| APA   | American Psychological Association                     |
| CAC   | Comprehensive Abortion Care                            |
| GHS   | Ghana Health Service                                   |
| GMHS  | Ghana Maternal Health Survey                           |
| GoG   | Government of Ghana                                    |
| ICPD  | International Conference on Population and Development |
| MDG-5 | Millennium Development Goal 5                          |
| POA   | Programme of Action                                    |
| R3M   | Reducing Maternal Morbidity and Mortality              |
| SPSS  | Statistical Package for Social Sciences                |
| WHO   | World Health Organisation                              |

## **CHAPTER ONE**

### **INTRODUCTION**

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

Induced abortion is illegal in Ghana but there are a number of exceptions within the law that make it more accessible than in many developing countries (Morhee & Morhee, 2006). An induced abortion performed by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both, is regarded by the World Health Organization (WHO) as unsafe abortion (World Health Organisation, 2004). Unsafe abortion can also be termed as clandestine abortion since it is mostly done secretly either by the pregnant woman or with the assistance of another person(s).

Unsafe abortion according to Ahman and Shah (2004) is one of the neglected problems of health care especially in developing countries such as Ghana. Unsafe abortion constitutes a public health crisis, a social injustice, and a violation of women's human rights and dignity (Cook & Dickens, 2003). Globally, 19 million unsafe abortions take place each year with 70,000 of the women dying and a further 5 million suffering temporary or permanent disability including reproductive tract infections and infertility (Ahman & Shah, 2004). In Ghana, unsafe abortion contributes to 11% of maternal deaths (Sedgh, 2010) which is the second most common cause of death among women in Ghana. In all Ghanaian societies, the death of a woman from pregnancy-related complications is considered a tragic event and may sometimes require elaborate ritual purification of the whole society (Senah, 2003). In some parts of the Greater Accra region of Ghana,

particularly in Osu, in the event of such an occurrence, all pregnant women are traditionally required to have a ritual bath in the sea soon after the burial of their colleague. Unsafe abortion has a number of significant consequences aside death and disability. These according to Singh, wulf, Hussain, Bankole and Sedgh (2009) include the immediate cost of providing medical care for abortion-related complications, the cost of medical care for longer-term health consequences, lost productivity to the country, the impact on families and the community, and the social consequences that affect women and families.

A number of international summits and conferences have been organized since the late 1980's to address the issue of unsafe abortion with the quest to improving sexual and reproductive health of women. These include the International Conference on Population and Development (ICPD) in 1994 in Cairo, the Fourth World Women's Conference in 1995 in Beijing, and the Millennium summit in 2000. In Ghana, efforts are being made to address the issue of unsafe abortion, one such is the Reducing Maternal Morbidity and Mortality (R3M) program launched in 2006 by a number of organizations including Engender Health and WHO led by the Population Council to provide the commitment and financial and technical resources needed to assist the Government of Ghana (GoG) to reduce morbidity and mortality due to unsafe abortion in Greater Accra, Ashanti and eastern regions to support progress toward Millennium Development Goal 5 (MDG-5).

A number of researches have also been done in the area of unsafe abortion. Few of them have however focused on the very factors that cause unsafe abortion. Among the factors

identified as causing unsafe abortion are stringent abortion laws, lack of knowledge of the abortion law in countries where abortion is either legal or illegal but liberal (where the law allows for abortion under a considerable number of conditions), abortion stigma, cultural norms and values, religiosity, non-existent safe abortion services and lack of knowledge of the existence of safe abortion services. This present research assessed a number of these factors as causing unsafe abortion and their impact in the Greater Accra region of Ghana. These factors include knowledge of the abortion law, abortion stigma, cultural norms and values, religiosity and knowledge of the existence of safe abortion services.

Abortion law is legislation that prescribes the provision of abortion in a country. Although the legal status of induced abortion is not the only factor influencing women's ability to access abortion services in a particular country, it remains a key determinant (Rahman, Katzive & Henshaw, 1998). Abortion laws vary from country to country ranging from those in Chile, El Salvador, Nicaragua, the Dominican Republic, Malta, Uruguay and Vatican City, which ban the procedure entirely, to those in the United Kingdom, which restrict abortion after the point of foetal viability, and Canada and the United States, which have removed abortion from the Criminal Code (Boland & Katzive, 2008). In Africa, countries such as Kenya, Angola, Republic of the Congo, Democratic Republic of the Congo, Cote D'Ivoire and Egypt have very restrictive abortion laws and in most cases allow abortion only to save the woman's life. Ghana, Guinea, Namibia, Mozambique, Nigeria, Zambia, Zimbabwe have liberal abortion laws and prescribe other conditions by which abortion could be obtained legally including when pregnancy is as a

result of rape and when pregnancy pose a threat to the woman's mental health. South Africa and Cape Verde on the other hand have legalized abortion and allow it with no restrictions whatsoever (Boland & Katzive, 2008).

In countries where access to abortion is restricted by law, medically trained practitioners are usually less willing to provide the service, the cost of the service in private facilities may be high and services are rarely available in public hospitals (which are often the only source of safe medical care for low-income women). In addition, in such countries, because training in abortion procedures often is not routinely provided to physicians, outmoded medical procedures may be used to perform the service and the provision of contraceptive services after an abortion may be overlooked. Moreover, fear of prosecution may even affect physicians' treatment of women with complications arising from unsafe clandestine abortion, and may cause women to delay seeking care. In countries where abortion is legal, maternal morbidity and mortality generally are lower, often because abortions are performed by trained medical professionals, are safer and more available, and cost less (Rahman et al., 1998).

As far as Ghana is recognized as one of the countries with very liberal abortion laws (Morhee & Morhee, 2006), it is expected that a considerable number of women will access safe abortion services and the incidence of unsafe abortion will reduce. According to Morhee and Morhee (2006) "In Ghana abortion is a criminal offence regulated by Act 29, section 58 of the Criminal code of 1960, amended by PNDCL 102 of 1985" (p.84).

Morhee and Morhee (2006) state the law as:

1. Subject to the provisions of subsection (2) of this section
  - a. any woman who with intent to cause abortion or miscarriage administers to herself or consent to be administered to her any poison, drug or other noxious thing or uses any instrument or other means whatsoever; or
  - b. any person who—
    - (i) administers to a woman any poison, drug or other noxious thing or uses any instrument or other means whatsoever with intent to cause abortion or miscarriage, whether or not the woman is pregnant or has given her consent
    - (ii) induces a woman to cause or consent to causing abortion or miscarriage;
    - (iii) aids and abets a woman to cause abortion or miscarriage;
    - (iv) attempts to cause abortion or miscarriage; or
    - (v) supplies or procures any poison, drug, instrument or other thing knowing that it is intended to be used or employed to cause abortion or miscarriage; shall be guilty of an offence and liable on conviction to imprisonment for a term not exceeding five years.
2. It is not an offence under section (1) if an abortion or miscarriage is caused in any of the following circumstances by a registered medical practitioner specializing in Gynaecology or any other registered medical practitioner in a government hospital or a private hospital or clinic registered under the Private Hospital and Maternity Home Act, 1958 (No. 9) or in a place approved for the purpose by legislative instrument made by the Secretary:

- a. where pregnancy is the result of rape or defilement of a female idiot or incest and the abortion or miscarriage is requested by the victim or her next of kin or the person in loco parentis, if she lacks the capacity to make such request;
- b. where the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health and such a woman consents to it or if she lacks the capacity to give such consent it is given on her behalf by her next of kin or the person in loco parentis;
- c. where there is substantial risk that if the child were born it may suffer from or later develop a serious physical abnormality or disease (p. 84).

The law on abortion in Ghana is considered liberal for a number of reasons including the fact that the law does not specify the measure of physical or mental threat of the pregnancy to the woman before she undergoes a legal abortion neither does it explain what it means by physical and mental health, and therefore varying interpretation could be given. Threat to mental health could mean psychological distress caused by any factor that makes pregnancy difficult to carry. Some of these common factors found in Ghana include unstable relationship with the male partner, career development, poverty, lack of social support, the need to care for other young children in the family, health problems, the diagnosis of foetal abnormalities, fear of parents, and pregnancy as a result of rape or incest. Since the level of risk or the threat to the physical and mental health of the woman is not clearly stated, the law seems to allow termination of pregnancy on much broader grounds than most practitioners think (Morhee & Morhee, 2006).

The liberality of the abortion law in Ghana has however not reduced the incidence of unsafe abortion in the country. This is partly due to the fact that a significant number of Ghanaians are unaware of the nature of the law. According to the Ghana Statistical Service, Ghana Health Service and Macro International (2007) report of the 2007 Ghana Maternal Health Survey (GMHS) indicated that only 4 percent of women surveyed knew about the law of abortion in Ghana. Among educated women, i.e. those with a high school education and higher, the figure was a mere 11 percent. As a result, relatively few women go to a hospital or clinic to have the procedure performed safely. Even more surprisingly, in one clinic surveyed only half the personnel were aware of the abortion law (Ghana Statistical Service et al., 2007)

Abortion stigma is another factor that influences women to opt for unsafe abortion instead of safe abortion. According to Lithur (2004) safe abortion remains inaccessible in Ghana due to stigma. Goffman (1963, 134) defines stigma as “a language of relationship that can link attributes to particular stereotypes, rather than a priori objectified attribute”. Kusow (2007) reiterates that, the language of relationships between attributes and stereotypes is extremely important because an attribute, in itself, does not carry an inherent quality that makes it credible or incredible outside the nature of the stereotype that corresponds to it. Abortion stigma in itself is defined by Kumar, Hessini and Mitchell (2009, 4) as, “a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood”. The attributes ascribed to women in Ghana who undergo abortions include; “shame”, “murder”, “sinfulness” and “criminals”. Abortion nevertheless, dates back to the ancient

times, and it is commonly done by many women around the world, it is thus surprising that it is widely stigmatized. Even though it is quite difficult to obtain definite figures on its incidence, a number of researchers have produced intelligent estimates. As far back as 1969, Ampofo (1970) calculated the average yearly number of abortions at the Korle-Bu Teaching Hospital, in Ghana between 1963 and 1967 to be 2,541 while for the same period, the average yearly number of births was 7,036. In a study of patients with complications of induced abortion admitted to the same hospital between May 1993 and May 1994, Lassey (1995) recorded 212 acute cases. Quite recently studies by Anarfi (1996) Nabila and Fayorsey (1996) and Kenyah (2000) indicate that the practice is fairly common. However, there are lots of debating issues on its legality and necessity and these issues are being influenced by many complex legal, moral, philosophical and religious factors.

Abortion stigma causes great distress and sufferings to victims and those who help them terminate the pregnancies. Abortion stigma stems from a number of sources including family, friends and the society as a whole and can impact an individual's health in a number of ways, often acting as an obstacle for those who would otherwise seek support. The woman or young girl, who won't inform her parents about her pregnancy and wish to terminate the pregnancy because she believes her intense feelings of grief are abnormal, is experiencing the consequences of stigma. The husband who is forced to leave his faith community and find a new church to attend with his wife and kids after confiding in friends also suffers the consequences of abortion stigma likewise the mother, who is no longer invited to office parties, because she held the hand of her daughter through her

abortion. In addition, some health care providers are also precipitators of abortion stigma and sometimes victims. In most countries, even in the US, health care providers who have undergone the necessary training and are offering safe abortion services, are not respected, they are seen as criminals and are refused certain privileges (Boodman, 2009). One of the most historical occurrences in recent times is the slaying of George Tiller, a Kansas physician who performed late abortions. He was shot dead in the head on May 31<sup>st</sup>, 2009 at church, allegedly by an anti abortion activist. According to Boodman (2009) the murder of George Tiller has left a number of students in the US to ponder over their decision of terminating pregnancies in the future. Boodman (2009) writes:

Devin Miller, a 23 year old student of Virginia Commonwealth University and leader of the abortion rights group, Medical Students for Choice, having heard of the slaying of George Tiller, "took a step back" to ponder her future. The second-year student plans to become an obstetrician-gynaecologist or family physician and expects she would sometimes terminate pregnancies (p. 1).

Furthermore, in 2007, in Ghana, the staff of 90 health care facilities was surveyed by the Ghana Health Service (GHS) to find out how able and willing they were to provide safe abortion services and if they had any stigma towards abortion care. The result of the survey showed that half of the staff surveyed was hesitant to offer abortion care (Nyarko, Adohinzin, RamaRao, Tapsoba & Ajayi, 2008) and may be physically or verbally abusive towards women in need of abortion related services or seriously delay their care. Many women therefore resort to clandestine abortion which is unsafe to avoid stigma that

will be meted out to them by family, friends and health professionals if they were to seek safe legal abortion.

Cultural norms and values also explicitly influence many women into unsafe abortion. According to Machirori (2010) culture is the cohesive glue that binds communities together, but for many women, it is the hangman's noose on which their freedoms are choked. Cultural norms and values exist in almost every society or community and vary from one society or community to another. They are mostly known among members of the society or community and passed from generation to generation. These norms and values are considered ideals for living and behaviour and any deviations from them mostly result in some negative effects. For example, abortion is considered a deviation from the ideals of womanhood in Ghana because children are considered as gifts from God and every woman is expected to have children and "nurture" them no matter their number. According to Sarpong (1974) among the Asante, pregnancy is considered a happy phenomenon and traditionally, its inception is the target of most sexual activities especially in marriage. Terminating a pregnancy intentionally or inducing an abortion means that the woman is deviating from the ideal of "nurturing motherhood" which every Ghanaian woman is supposed to possess. As Kumar et al. (2009) precisely demonstrate; abortion violates two fundamental ideals of womanhood namely: nurturing motherhood and sexual purity. In addition, abortion violates cultural norms and values because it evidently demonstrates that a woman has had "non-procreative" sex and is seeking to exert control over her own reproduction and sexuality, both of which threaten existing gender norms (Kumar et al., 2009). A woman who is faced with an unwanted pregnancy

and want an abortion would most likely seek clandestine means in order to avoid the shame that comes with deviation from the norms of womanhood and expectations of the society.

Religiosity also influences a woman's decision to terminate a pregnancy clandestinely or have a safe termination. The different dimensions of religiosity according to Lewis (1978) include religiousness, orthodoxy, faith, belief, piousness, devotion, and holiness. Religiosity affects individuals in a number of ways including; developing a sense of compassion, honesty, and altruism as well as happiness and quality of life, physical health, and mental health (Beit-Hallahmi & Argyle, 1997). In religious groups where abortion is opposed, members are more likely to have unsafe abortions. This is because to that religious group, every pregnancy should be nurtured and delivered and not terminated, a woman in this religious group who is faced with an unwanted pregnancy will most likely secretly terminate her pregnancy so as to be accepted in that group. Once the pregnancy is terminated secretly without any members' knowledge, the woman fellowships in that group like any other member. She is less likely to consider terminating the pregnancy at a public hospital or registered institution (which is mostly open to the public) for fear of being seen and considered as a deviant.

Knowledge of the availability of safe abortion services also determines whether a woman will have safe or unsafe abortion when she is faced with an unwanted pregnancy. In countries where abortion is legal, such as in South Africa, safe services are provided. Likewise, in countries such as Ghana, where abortion is permitted on liberal grounds,

safe services are also provided. In Ghana, safe services are provided in almost all the public hospitals and a number of organizations such as Marie Stopes International. There is currently an adoption of a reproductive health strategic plan committed to ensuring the provision of comprehensive abortion care (CAC) in Ghana. This involves making safe abortion services available through the provision of equipment, supplies and training and developing behavior change materials to increase community awareness of CAC (Hill, Tawiah-Agyeman & Kirkwood, 2009). Despite the provision of safe abortion services in Ghana, a significant number of Ghanaian women according to Konney, Danso, Odoi, Opare-Addo and Morhee (2009) do not access safe abortion services because of their lack of knowledge of the existence of the services. They are therefore more likely to opt for unsafe services which are well known.

## **1.2 Statement of the Problem**

Until 1985, when the criminal code was amended, Ghanaian law prohibited induced abortion except when a woman's life was endangered by her pregnancy. The current abortion law however allows abortion on a number of liberal circumstances. The law is considered liberal considering the number of grounds upon which abortion can now be obtained in a recognized hospital or facility without consequent prosecution. In addition, safe abortion services are available in almost all the major hospitals in Ghana. Safe abortion Services in Ghana involves Comprehensive Abortion Care which was adopted by the Ghana Health Service and includes pre-counseling, safe abortion care and post abortion care.

The above notwithstanding, unsafe abortion accounts for 11% of maternal deaths which is the second most common cause of death among women in Ghana (Ghana Statistical Service et al., 2007). Some hospital based studies have also documented maternal deaths due to unsafe abortions. According to Deganus' study (as cited in Billings, Ankrah, Baird, Taylor, Ababio & Ntow, 1993) 22% of maternal deaths are due to unsafe abortion. Another study by Akosa (as cited in Lithur, 2004) also shows that 30% of maternal deaths are due to unsafe abortion. According to Bleek and Asante-Darko (as cited in Senah, 2003) the modes and methods used in abortion in Ghana are both "allopathic and indigenous" (p. 52).

Among the 'allopathic' methods include the following: Menstrogen tablets or injection; Mensicol capsules taken with alcoholic drink; Alophen Pills; Primodes Forte; Gynavion Pills and Dr. Bongean Pills, among others. The herbs and herbal preparations used include nkrangyedua (*Jatropha Curcas*); Nyanyara (*Passiflora Foetida*); sugar cane; nunum (*Ocimum Americanum*); cassava leafstalk (*Manihot Utitissima*) and Sorowisa (*Piper Guineense*), and severe beating or vigorous sexual intercourse, among others (p. 52).

A number of factors including lack of knowledge of the existing abortion law, abortion stigma, cultural norms and values, religiosity and lack of knowledge of the existence of safe abortion services have been identified by research as some factors which influence unsafe abortion. This study however identified which of these factors influence women in the Greater Accra Region of Ghana to engage in unsafe abortion services.

### **1.3 Aims and Objectives of the Study**

The study aims at achieving the following objectives;

1. To examine the effect of knowledge of Ghana's abortion law safe/unsafe abortion.
2. To determine the influence of abortion stigma on safe/unsafe abortion in Ghana.
3. To ascertain the relationship between Safe/unsafe abortion and Ghana's cultural norms and values.
4. To establish the effect of religiosity on safe/ unsafe abortion in Ghana.
5. To find out the influence of knowledge of Safe abortion services on the practice of safe/unsafe abortion in Ghana.

### **1.4 Relevance of the Study**

Ghana's recent reproductive health strategic plan is committed to ensuring that comprehensive abortion care (CAC) is made available as permitted by the law (GHS, 2007). This includes increasing access to services by assessing facilities and providing equipment, supplies, and training as needed and developing behavior change materials to increase community awareness of CAC. To succeed in implementing this plan, the GoG and the GHS would need to know what is impeding the use of the existing services. This research therefore presents data on the specific psychosocial factors that hinder a number of women in Ghana, from accessing safe abortion services rather than unsafe abortion services.

In the Ghanaian society childbirth is often celebrated and the death of a woman especially from pregnancy-related complications is considered a tragic event, sometimes requiring elaborate ritual of purification of the whole society. Maternal death in Ghana according to

Senah (2003) is (*honhonfi* in Akan) uncleanliness. This research therefore provides relevant information for policy formulation and implementation in order to reduce and eradicate complications of unsafe abortion and the practice of unsafe abortion itself so as to improve maternal health which is well expected of the Ghanaian society.

This study is also relevant in providing information for the economic development of the nation as a whole because according to Senah (2003) in the contemporary world, maternal mortality is considered a violation of the rights of women and its rate is perceived as a critical index of the level of development of a particular country. Data from this study is also relevant for policy formulation for the progress of the achievement of R3M project and MDG-5 which seek to improve maternal health. In addition, this research also represents an important contribution to the field of reproductive health which is a subject of human rights in recent times. Findings of this study also add to the limited information available about unsafe abortion in the country.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

The primary objective of this chapter is to provide a review of the theories underlining the relationship between the various psychosocial factors that were studied and unsafe abortion and also to provide essential empirical research. The chapter concludes with the rationale of the study, the statement of hypotheses, conceptual framework and the operational definition of terms in the study.

#### **2.2 Theoretical Framework**

There are a number of theories explaining the psychosocial factors and their impact on unsafe abortion. However, the Model of Reasoned Action by Fishbein and Ajzen (1975) and the social learning theory by Bandura (1977) were used for the purpose of this present study.

##### **2.2.1 Model of Reasoned Action**

The model of reasoned action was propounded by Fishbein and Ajzen (1975). The model postulates that the immediate psychological determinant of behavior is not a person's attitude towards the target of his act but rather his intention to perform that act. The model holds that, intentions are a consequence of two elements of a person's psychology: attitudes toward performing an act and subjective norms with regards to the act.

Subjective norms about performing an act are people's perceptions of what other people important to their lives think they should do and attitude towards performing an act is a consequence of two things: a person's estimation of the consequence of performing the activity and his/her evaluation of the consequences of the activity. This implies that if a person estimates and evaluates the consequences of an activity as worth doing he/she is more likely to carry out such activity. Secondly, the person also considers what significant others in his/her life expect from him/her. In considering the opinion and reaction of significant others before acting, Myers (2005) describes human beings as social animals who long to connect and be accepted. He adds that an individual most often do not act as though he/she is living a private life without care to anybody, but rather in consideration of what other people approve and expect and sometimes even go against self wishes just to be accepted and approved by significant others. By this society is able to influence its members in myriad of ways; through laws passed from government institutions, creating of severe punishment for antisocial behaviours, development of strong desire for ethics and morals, usually through its religious institutions and strong ethical codes of conduct. These proscribed or accepted ways of behaviour varies from one society or community to another and forms the intensions of members of that society or community and it's transmitted through socialization.

In most parts of Ghana for example, becoming pregnant without going through the accepted marriage rite of one's community is culturally unacceptable. Unmarried women who get themselves pregnant are therefore stigmatized and mostly seen to be immoral. For an unmarried pregnant woman to fit into society and live up to the expectations of

friends, family and significant others she is more likely to resort to clandestine abortion where nobody finds out about her promiscuity and tag her as immoral. Highly religious people are also more likely to resort to clandestine abortion in order to be accepted in their places of worship and fellowship.

Clandestine abortion is therefore considered after evaluation of the consequences of having a safe abortion which is normally at a public hospital where some of the health workers will have knowledge of the person's pregnancy and its resultant shame and disgrace as against a clandestine abortion which is either done by the individual secretly or by another person or hospital which secretly carries out such activity. After a successful clandestine abortion, the individual fits into the society like any other "moral" person in the society.

### **2.2.2 Social Learning Theory**

Social learning theory focuses on the learning that occurs within a social context. It considers that people learn from one another, including such concepts as observational learning, imitation, and modeling. Among others, Bandura (1977) is considered the leading proponent of this theory. Social learning theory explains that direct reinforcement is not the causal mechanism in learning, rather the social element (Mae Sincero, 2011).

Social learning theory has been useful in explaining how people can learn new things and develop new behaviors by observing other people. Bandura (1977) demonstrated this with the "Bobo Doll" experiment. In the experiment, Bandura (1977) included an adult

who was tasked to act aggressively toward a Bobo Doll whilst the children observed him. Later, Bandura (1977) let the children play inside a room with the Bobo Doll. He affirmed that these children imitated the aggressive behavior toward the doll, which they had observed earlier. After his studies, Bandura (1977) was able to determine 3 basic models of observational learning, which include; a live model, which includes an actual person performing a behavior, a verbal instruction model, which involves telling of details and descriptions of a behavior and a symbolic model, which includes either a real or fictional character demonstrating the behavior via movies, books, television, radio, online media and other media sources.

Unsafe abortion can be considered as a behavior that is learnt by women in Ghana to be the solution to unplanned unwanted pregnancies as according to Morhee and Morhee (2006) and Konney et al. (2009) a significant number of women in Ghana are unaware of the abortion law and its liberality as well as the existence of safe abortion services. Unplanned pregnancy is estimated to occur in almost every two of five pregnancies worldwide (Ahman & Shah, 2004). Unplanned pregnancy results from non-use or ineffective contraceptive use or contraceptive failure. As long as there is an unmet need for contraceptives (Ahman & Shah, 2004), and many girls in Ghana remain in school during their prime reproductive years, unplanned or unwanted pregnancies will not cease and the resultant abortion practices. Since a significant number of Ghanaian women are unaware of the liberality of Ghana's abortion law and the existence of safe abortion services, it is assumed that this significant number of women will more likely have unsafe abortion and influence people in their social context to do same. If a woman

wishes to abort a pregnancy, she either decides to do it on her own and will most likely do as she knows other people do or will seek the advice and help of partner, friends or family who will advice or aid her to do what their knowledge and experience offer. In a society where a significant number of women resort to safe abortion services, a woman faced with an unwanted pregnancy is more likely to have a safe abortion since she either would have learnt through observation or any kind of learning what others have done in such conditions or she will have the safe abortion by virtue of significant other peoples influence on her.

The social learning theory also considers the state of the mind (mental states) as crucial in learning. In this concept, Bandura (1977) stated that not only external reinforcement or factors can affect learning and behavior. There is also what he called intrinsic reinforcement, which is in a form of internal reward or a better feeling after performing the behavior (e.g. sense of accomplishment, confidence, satisfaction, etc.). This explains how individuals in a society act in ways congruent to what members in a society do or expect so as to be accepted and in effect gain some sense of accomplishment, confidence and satisfaction as against being seen as sinful, immoral, antisocial or deviant.

### **2.3 Review of Related Studies**

This section discusses various studies and findings that best helped the researcher in identifying the various psychosocial factors and their impact on unsafe abortion. These factors include: knowledge of the abortion law, abortion stigma, cultural norms and values, religiosity and knowledge of the existence of safe abortion services.

### **2.3.1 Knowledge of Abortion Law and Unsafe Abortion**

Jewkes, Gumedde, Westaway, Dickson, Brown and Rees (2005) conducted a study to explore the reasons why some South African women still abort outside designated services even though there is substantial legal service provision. The study involved forty-six women visiting three hospitals in Guateng province in South Africa with incomplete abortion who had had abortions induced outside of designated facilities. An interviewer-administered questionnaire with both open and closed questions was used. Results from the study indicated that, nearly two-thirds of the women had self-induced or had consulted a traditional healer for the abortion. Fifty-four percent of them reported to have had unsafe abortion because they did not know about the legality of the abortion law in South Africa.

Morhee and Morhee (2006) also studied Ghana's abortion law to ascertain how the law affects the availability of safe abortion services in Ghana. Critical analysis of the law, as stated in the 1999 revised version of the Consolidated Criminal Code of the Republic of Ghana, 1960, Act 29 was made as well as a review of the current Ministry of Health Reproductive Health Policy on unsafe abortion in relation to the law. Reference was made to the law on abortion in other jurisdictions particularly the current UK law since the original abortion law in Ghana is fundamentally based on the old British statute, 'the Offences against the Person Act of 1861'. The result of the study stated amongst other factors that many women in Ghana do not know their legal rights to safe abortion and therefore are susceptible to unsafe abortions.

A cross-sectional study was conducted by Morroni, Myer and Tibazarwa (2006) to investigate knowledge of abortion legislation eight years after the introduction of legal abortion services in one province of South Africa among eight hundred and thirty-one sexually-active women attending twenty-six public health clinics in one urban and one rural health region of the Western Cape Province. Semi-structured interviews were conducted in participants' home languages and lasted approximately fifteen minutes. In the analysis, responses to open-ended questions were coded and collapsed into categories. Bivariate analyses employed  $\chi$ -square test and a multiple logistic regression model was developed to examine how demographic and behavioral factors were associated with abortion knowledge. Results of the study indicated that thirty-two percent of women did not know that the law in South Africa allows for legal abortion and this proportion was higher in the rural region compared to the urban region. Among those who knew of legal abortion, few had knowledge of the time restrictions involved.

### **2.3.2 Abortion Stigma and Unsafe Abortion**

A research by Shellenberg and Kristen (2010) used quantitative and qualitative methodologies to learn about stigma among abortion patients in the US. A sample of four thousand six hundred and thirteen women was obtained from the Guttmacher Institute's 2008 Abortion Patient Survey and used for the quantitative study. Forty-nine in-depth interviews were also conducted with women at abortion clinics at three different regions of the US for the qualitative study. Analysis of the quantitative study involved the use of stratified multivariate logistic regression. Analyses of the transcripts obtained from the qualitative study were also done. Results of the study indicated that perceived and

internalised stigma exists among women seeking abortion in the US. It reported that two-thirds of abortion patients perceived stigma from other people, others perceived stigma from friends and family, healthcare providers, people in their community and the general society. Shellenberg and Kristen (2010) stated that perceived stigma was sufficient to create negative feelings of self and need for secrecy about the abortion.

Another research study conducted by Harries, Orner, Mosotho and Michell (2007) used qualitative research method to explore the reasons behind the delays in women seeking an abortion until the second trimester in South Africa where abortion is legal. Twenty-seven in-depth interviews were conducted in 2006 with women seeking a second trimester abortion at one public sector tertiary hospital and two NGO health care facilities in the greater Cape Town area, South Africa. The grounded theory approach was used to analyse data collected. Results from the study indicated that multiple and interrelated factors influenced the timing of seeking an abortion among the women. These factors included stigma associated with abortion.

Another study was conducted in Zambia by Dahlback, Maimbolwa, Kasonka, Bergstrom and Ransjo-Arvidson (2007) to find out the circumstances under which adolescent girls resort to unsafe induced abortion. The sample was thirty-four Zambian girls between ages thirteen and nineteen who were admitted to University Teaching Hospital (UTH) in Lusaka. The girls were interviewed with a semi-structured questionnaire comprising of both closed and open-ended questions. Results of the study indicated that most of these girls were single and in school. They reported that they performed unsafe abortion

because of fear of facing personal shame and social stigma such as parental disapproval, abandonment by partner and expulsion from school.

### **2.3.3 Cultural Norms and Values and Unsafe Abortion**

A research study was done by Aniteye and Mayhew (2011) on attitudes and experiences of women admitted to hospital with abortion complications in Ghana. The sample was obtained from Korle-bu Teaching Hospital and Ridge Hospital and comprised of one hundred and thirty one Ghanaian women who had experienced unsafe abortion. A semi-structured questionnaire was administered. SPSS Software, Version 10 was used for the analysis. Results indicated that majority of the respondents were single and had no children or one child. Two thirds of these respondents reported that they aborted because of socio-cultural pressures.

Omo-Aghoja, Omo-Aghoja, Okonofua, Aghedo, Umueri, Otayohwo, Feyi-Waboso and Esume (2009) did a research to determine the perceptions and attitudes of a rural community to abortion in the Niger-Delta region of Nigeria. The research was conducted in Amukpe, Delta State, Nigeria with the use of Focus group discussions (FGDs) and in-depth interviews (IDIs). Results from the study indicated that abortion particularly in the hands of quacks was a major option to handling an unwanted pregnancy. Almost all respondents agreed that the odium associated with an unwanted pregnancy in the community compelled them to have unsafe abortion.

Plummer, Wamoyi, Nyalali, Mshana, Shigongo, Ross and Wight (2008) also conducted a study on aborting and suspending pregnancy in rural Tanzania: an ethnography of young people's beliefs and practices. The study used participant observation in nine villages and group discussions and interviews in three others from 1999 to 2002. Results of the study indicated that abortion was considered illegal, immoral, dangerous and unacceptable. Many women therefore had clandestine abortion using substances such as chloroquine, ashes, and specific herbs. Most of these women were young, single, and desperate. Some succeeded, but they experienced opposition from sexual partners, sexual exploitation by practitioners, serious health problems, social ostracism, and quasi-legal sanctions.

#### **2.3.4 Religiosity and Unsafe Abortion**

Erfani (2011) conducted a study on Induced abortion in Tehran, Iran: Estimated Rates and Correlates. Two thousand nine hundred and thirty four married women aged between fifteen and nineteen were the participants of the study and were made to complete the 2009 Tehran Survey of Fertility. Estimated abortion rates and proportions of known pregnancies that end in abortion were calculated for all the women and for demographic and socioeconomic sub-groups and descriptive data were used to examine women's contraceptive use and reasons for having a clandestine abortion. Results of the study indicated that many women resort to clandestine abortion due to the restrictive nature of the abortion law and abortion rates were high amongst those who reported a low level of religiosity.

### **2.3.5 Availability of Abortion Services and Unsafe Abortion**

Konney, Danso, Odoi, Opare-Addo and Morhe (2009) conducted a study on attitude of women with abortion-related complications toward provision of safe abortion services, their socio-demographic characteristics, and their awareness of the law permitting to abortion under certain circumstances in Ghana. Two hundred and ninety six patients with abortion-related complications admitted to the Obstetric and Gynaecological department of the KATH (Komfo Anokye Teaching Hospital) were the participants of the cross-sectional study. The study used questionnaire to collect the data and used chi-square for its analyses. Results of the study indicated that the participants were unaware of the existence of safe abortion services in Ghana and expressed the need for its provision. 91% of the women indicated that they would patronize safe services for termination of an unwanted pregnancy.

Hill et al. (2009) also conducted a qualitative study on the context of informal abortions in rural Ghana. Data was obtained from eleven narratives about planned or attempted abortions and seven narratives of abortion related deaths in the Kintampo district, located in the Brong Ahafo region of central Ghana. Data obtained were analysed as the first phase of the study to identify themes around abortion methods, contexts, and care seeking in the case of a complication. The second phase consisted of conducting ten focus groups, which explored the themes that emerged from phase one and to validate the findings through triangulation. Results indicated that abortion was perceived as common, understandable and necessary even though illegal, dangerous and stigmatized. None of the respondents was aware of the legal status of abortion with most reporting that it was

illegal, neither were they aware of the existence of safe abortion services. Since they had no knowledge of the abortion law and the existence of safe abortion services, they were compelled to have unsafe abortion which they considered to be dangerous but necessary. They cited some necessary condition for an abortion as; if having a child would cause financial hardship, would interrupt the woman's education, and if the woman was unmarried or pregnant by someone other than her husband.

#### **2.4 Rationale of the Study**

Okine (as cited in Adams, 2012) has assessed Ghana as unlikely to attain MDG-5 by 2015. She noted that MDG-5 is the lone goal that has seen the least progress worldwide. According to WHO (as cited in Adams, 2012). Although Ghana's maternal mortality ratio reduced from 540/100 000 in 2000, to 451/100 000 in 2007 to 350/100 000 in 2008, the reduction is estimated to be at a rate of 3.3% annually compared to 5.5% annual rate required to attain MDG-5 target of 185/100 000 by 2015. However, according to Sedgh (2010) unsafe abortion contributes to 11% of maternal mortality in Ghana. This research however sought to identify the factors that cause unsafe abortion in Ghana and their impact so as to inform the Ghana Health Service and stakeholders to formulate their policies and take appropriate action in order to achieve the MDG-5 goal of improving maternal health.

Secondly, this research particularly focused on psychosocial factors because according to Senah (2003):

The problem of maternal mortality still confronts Ghana and other developing countries perhaps even more than ever before because, to a large extent, programs and policies to address the problem are, as usual, heavily skewed toward the medical explanatory model. In Ghana this model has led to the building of several Maternal and Child Health Clinics (MHC) across the country, the training of over 6,000 traditional midwives, the development of the Safe Motherhood Protocol for all levels of health institutions and the institutionalisation of four free antenatal visits, among others (p.48).

This according to him has not been able to address the heartbeat of the problem. He argues that “the factors which promote health and precipitate ill health or death are not purely genetic or biological, but can be social, economic, cultural and psychological and that these elements can work together or against one another in the life of an individual; that in the case of maternal mortality, especially, any strategy designed against it must recognise these dynamics” (p.48). This present study particularly focused on psychosocial factors such as knowledge of the abortion law, abortion stigma, cultural norms and values, religiosity and knowledge of the existence of safe abortion services.

Finally, this study is in response to the Ghana Health Service’s demand for a nationwide research on abortion (Odoi-Agyarko, 2003), which is one of the strategic plans put in place in Ghana towards the national reproductive health service policies and standards. These policies and standards are a response to the adopted programme of Action (POA) at the ICPD conference in 1994, in Cairo, which is considered a turning point for reproductive health, since for the first time, reproductive rights were internationally

recognized by Governments, as contained in the international human rights documents and stated in ICPD Programme of Action, paragraph 7.2 (cited in Odoi-Agyarko, 2003):

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant..... (p. 7).

## **2.5 Summary of Literature Review**

The literature demonstrates that unsafe abortion is prevalent in Ghana and other parts of Africa and the world. However, limited literature exists due to the sensitive nature of the subject. The existing literature however demonstrates that unsafe abortion exists in countries where the abortion law is illegal, legal or liberal and amongst all age groups. Amongst, other factors the literature reviewed demonstrate that knowledge of abortion law, abortion stigma, cultural norms and values, religiosity and knowledge of the existence of safe abortion services all influence women to have unsafe abortion. The

model of reasoned action and the social learning theory is used to explain how these psychosocial factors are able to influence a number of women to have unsafe abortion.

## **2.6 Statement of Hypotheses**

In view of the theories and literature above, the following hypotheses were formulated as demonstrating the relationship between the various psychosocial factors under study and unsafe abortion and safe abortion.

H1: Knowledge of Ghana's abortion law will significantly predict safe and unsafe abortion.

H2: Abortion stigma will significantly predict safe and unsafe abortion.

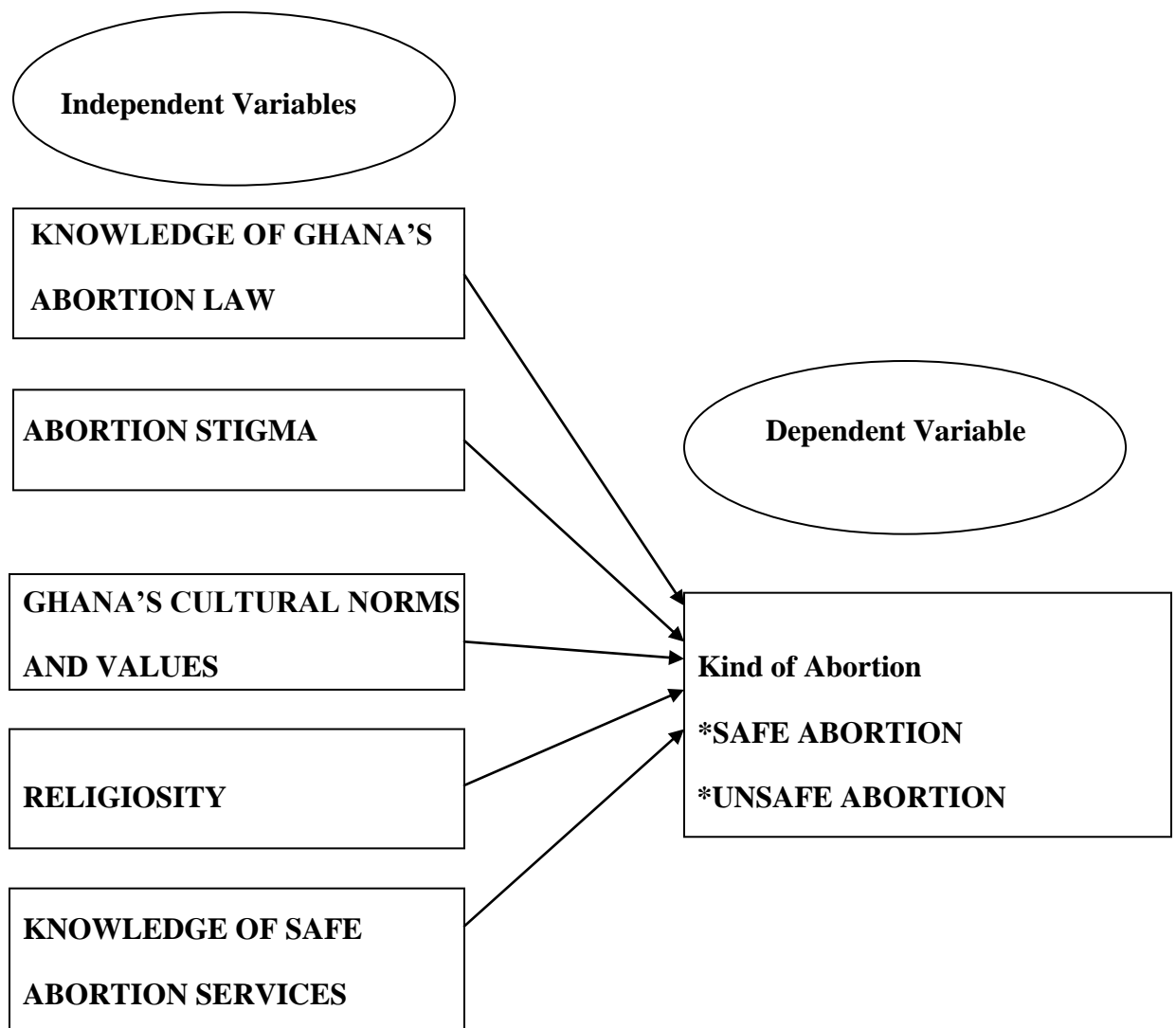
H3: Safe and unsafe abortion will be significantly predicted by Ghana's cultural norms and values.

H4: Religiosity will significantly predict safe and unsafe abortion.

H5: Knowledge of Safe abortion services will have a significant influence on the practice of safe or unsafe abortion in Ghana.

## 2.7 Conceptual Framework of the Study

**Figure 1: Summary of the hypothesized relationship between the Independent variables and the Dependent variable**



As demonstrated in figure 1 above, it was expected that knowledge of Ghana's abortion law, abortion stigma, Ghana's cultural norms and values, religiosity and knowledge of safe abortion services will have a significant relationship and impact on unsafe abortion in Ghana.

## **2.8 Operational Definition of Terms**

The following terms are defined for the purpose of this study as:

Unwanted pregnancy

Pregnancy that a woman is unwilling to keep because the pregnancy was not planned for but it is as a result of failed or improper use or non-use of contraceptives.

### **Unsafe abortion**

Taking drugs that have not been prescribed for a person by a pharmacist or a medical practitioner for the purpose of abortion or any abortion procedure done by a non-qualified and untrained person or done in an environment not recommended by the statutes of the Ghana Health Service for such a procedure.

\*an abortion procedure done by a qualified but untrained medical practitioner is an unsafe abortion.

Unsafe abortion is mostly **clandestine abortion** since it is done secretly.

### **Safe abortion**

Taking drugs that have been prescribed for a person by a pharmacist or a medical practitioner for the purpose of abortion or any abortion procedure done by a qualified and

trained medical practitioner or done in an environment recommended by the statutes of the Ghana Health Service, for such a procedure.

### **Abortion Stigma**

A sense of feeling, emotions or behavior that a person or group of people have and exhibit concerning abortion, that makes abortion a shameful, disgraceful or a dishonourable act or procedure.

### **Religiosity**

The extent to which an individual practices or is committed to his or her religion as measured on the Santa Clara's Strength of Religious Faith Questionnaire.

## **CHAPTER THREE**

### **METHODOLOGY**

This chapter provides information on the study's setting, population, sample and sampling technique, design, instruments and procedures. Ethical considerations for the study's participants are also discussed in this chapter.

#### **3.1 The Research Setting**

Three health facilities located within Accra Metropolis of the Greater Accra Region of Ghana formed the setting of the study. The three are the Ridge Hospital, 37 Military Hospital and the La General Hospital. The Family Planning Units of Ridge Hospital and the La General hospital were used as well as patients admitted to the Obstetric and Gynaecological ward of the 37 Military Hospitals. These settings are chosen because; the Family Planning Unit for Ridge Hospital operates five days a week whilst the La General Hospital operates twice a week. More so these are the facilities accessed by many individuals which offered a better opportunity for accessing enough sample within the shortest time.

#### **3.2 Population**

The population for the study was females who had ever had an abortion. The participants were English speaking and came from a variety of race, ethnicity, cultural and socio-economic backgrounds within the country. This was possible because two of the three

hospitals are referral hospitals (37 Military Hospital and Ridge Hospital) and as such receive patients from across the country.

### **3.3 Sampling Size and Technique**

A total of 100 participants were sampled from the population of women who admitted to have ever had an abortion. 54 of the participants had had unsafe abortions and 46 had had safe abortions. Of these, 56 participants were from the La General Hospital, 31 from the Ridge Hospital and 13 from the 37 Military Hospital. There was no attrition because data was collected until the desired number was arrived at. The sample size was arrived at considering the number of variables under investigation and the sensitivity of the area of study considering the fact that abortion is a highly clandestine activity in Ghana and therefore many women seldom admit to having engaged in it.

The convenience sampling technique was employed to get the individual participants for the study. This method of data collection falls under the non-probabilistic sampling techniques and involves the selection of the most accessible subjects. Patients who at the periods of data collection were found at the various hospitals and had ever had an abortion and were willing to participate in the study were used as participants until the sample size of 100 was reached.

The table below shows the demographic characteristics of the respondents.

**Table 1: Demographic characteristics of the demographic variables**

| <i>Variable</i>               | <i>Frequency</i> | <i>Percent</i> |
|-------------------------------|------------------|----------------|
| <b>Kind of Abortion:</b>      |                  |                |
| • Safe Abortion               | 46               | 46.0           |
| • Unsafe Abortion             | 54               | 54.0           |
| <b>Age:</b>                   |                  |                |
| • 9-19 years                  | 16               | 16.0           |
| • 20-30 years                 | 74               | 74.0           |
| • 31-50 years                 | 10               | 10.0           |
| <b>Marital Status:</b>        |                  |                |
| • Single                      | 58               | 58.0           |
| • Married                     | 38               | 38.0           |
| • Divorced                    | 4                | 4.0            |
| <b>Religious Affiliation:</b> |                  |                |
| • Christian                   | 74               | 74.0           |
| • Muslim                      | 18               | 18.0           |
| • Traditional                 | 8                | 8.0            |
| <b>Educational status:</b>    |                  |                |
| • Basic                       | 6                | 6.0            |
| • Senior High School          | 37               | 37.0           |
| • Tertiary                    | 57               | 57.0           |

The descriptive statistics of the demographic features of the respondents to the questionnaire presented in Table 1 above shows that of the 100 participants sampled, 46 reported to have engaged in safe abortion representing 46.0% and 54 had had unsafe abortion representing 54.0%. The age distribution of the respondents reveals that, 16 of the respondents were between the ages of 9 to 19, 74 were between 20 to 30 and 10 of them were between the ages of 31 and 50 representing 16.0%, 74.0% and 10% respectively. In terms of education, 6 had up to Basic education, 35 had up to SHS education and 57 had up to tertiary education representing 6.0%, 37.0% and 57.0%. Also, there were 74 Christians, 18 Muslims, and 8 Traditionalists representing 74.0%, 18.0%

and 8.0% respectively. Finally, 58 of the respondents were reported to be married, 38 were single and 4 were divorced at the time of the study, representing, 58.0%, 38.0% and 4.0% respectively.

### **3.4 Design of the Study**

The study design employed was the correlational study design. The correlational study design is a quantitative method of research used to establish a relationship between two or more variables under study. The variables studied in this present research include knowledge of the existing abortion law, abortion stigma, cultural norms and values, religiosity and knowledge of the existence of safe abortion services as independent variables and unsafe/safe abortion as the dependent variable.

### **3.5 Instruments and Materials**

One questionnaire with a total of five scales was used for the purpose of this study. The scales used are; knowledge of abortion Law Scale, Abortion Stigma Scale, Cultural Norms and Values Scale, Knowledge of the Existence of Safe Abortion Services Scale and the Santa Clara Strength of Religious Faith Scale. The Questionnaire was organized into two sections: A and B. Section A recorded the demographic characteristics of the respondents, whilst section B measured the psychosocial factors that were likely to influence the reasons why individuals indulge themselves in unsafe abortion or safe abortion. With the exception of the Santa Clara Strength of Religious Faith scale, all the other scales measuring the psychosocial factors were self constructed and validated in

conjunction with my supervisors. This was necessary because, at the time of the study, there were no known existing scales measuring those variables under investigation.

### **A. Knowledge Of Abortion Law Scale**

The Knowledge of Abortion Law scale is an 8 item self-developed questionnaire which measures an individuals' knowledge about the existence and content of Ghana's abortion law as a factor that could potentially inform and influence women's choice of safe or unsafe abortion practice. The validation process observed a Cronbach's Alpha of **.76**. The present data also observed a reliability of **.76**. Sample items include, "*Abortion is permitted under all circumstances in Ghana*" and "*There is access to legal abortion care in Ghana*"

#### ***Scoring of Knowledge of Abortion Law Scale***

Scoring of Knowledge of Abortion Law scale was on a five-point Likert type of scale with a response range of "*strongly disagree*" to "*strongly agree*". Total score on the Knowledge of Abortion Law Scale ranged from 8 to 40. Where 8 is the least and 40 the highest score. Higher scores were reflections of better knowledge of Ghana's abortion law and lower scores showed no knowledge on the existence and content of the abortion law in Ghana.

### **B. Abortion Stigma Scale**

The Abortion Stigma scale is also an 8 item self-developed scale which measures beliefs that make abortion a stigmatized condition and therefore are likely to make victims of unwanted pregnancy resort to unsafe abortion. The validation process observed a

reliability of **.82**. The observed reliability for the present study is **.85**. Sample items include, “*Those who have abortion are sinful*” and “*Abortion is shameful*”.

### ***Scoring of Abortion Stigma Scale***

The scale was scored on a five point Likert type of scale with a response range of “*strongly disagree*” to “*strongly agree*”. Total score on the Abortion Stigma Scale ranged from 8 to 40. Where 8 is the least and 40 the highest score. Higher scores represented an individual’s stigma towards abortion. Lower scores on the other hand were indicative of low stigmatization.

### **C. Cultural Norms and Values Scale**

The Cultural Norms and Values Scale is also an 8 item self developed measure of the beliefs of Ghanaian women on the cultural practices that makes them have unsafe abortion in Ghana. The validation process observed a Cronbach’s Alpha of **.70**. The present data however observed a reliability of **.72**. Sample items include, “*A women should perform marriage rites before getting pregnant*” and “*Abortion defiles a woman*”

### ***Scoring of the Cultural Norms and Values Scale***

Scoring of the Cultural Norms and Values Scale was on a five-point Likert type of scale with a response range of “*strongly disagree*” to “*strongly agree*”. Total score on Cultural norms and Values Scale ranged from 8 to 40. Higher score meant a stronger belief in the cultural norms and values that make women have unsafe abortion and lower score generally showed less belief in those cultural norms and values that make women have unsafe abortion in Ghana.

#### **D. Knowledge of the Existence of Safe Abortion Services Scale**

The Knowledge of Existence of Safe Abortion Services Scale is also an 8 item self-developed questionnaire measuring participants' knowledge of the existence of safe abortion services in Ghana as a psychosocial factor that could influence the type of abortion practices they may engage in. The validation process observed a Cronbach's Alpha of **.69**. The present data however observed a reliability of **.75**. Sample items include, "*Safe abortion services are only available to adults*" and "*Safe abortion services are only available to married women*"

#### ***Scoring of the Knowledge of the Existence of Safe Abortion Services Scale***

Scoring of the Knowledge of Safe Abortion Services Scale was on a five-point Likert type of scale with a response range of "*strongly disagree*" to "*strongly agree*". Total score on the Knowledge of Abortion Law Scale ranged from 8 to 40. Where 8 is the least score and 40 the highest score. Higher score on this scale is an indication of poor knowledge on the existence of safe abortion services in Ghana and lower scores are an indication of better knowledge of the existence of safe abortion services in Ghana.

#### **E. Santa Clara Strength of Religious Faith Scale**

This scale consists of questions concerning the strength of one's religious faith. This is a 10 item scale designed by Plante and Boccaccini (1997) at the Santa Clara University to measure strength of religious faith, regardless of the religious denomination or affiliation. Sample items include '*My religious faith is extremely important to me*' and '*My relationship with God is extremely important to me*'. It has a reliability of **.89** and validity

of **.96**. A reliability of **.85** was observed for the pilot study and **.90** for the present data collected.

### ***Scoring of Santa Clara Strength of Religious Faith Scale***

Scoring of the Santa Clara's Strength of religious faith scale was on a four point Likert type of scale with a response range of "*strongly disagree*" to "*strongly agree*". The total scores ranged from 10 – 40. Where 10 is the least and 40 the highest score. Higher scores were indicative of greater strength of religious faith and vice versa.

## **3.6 Procedure**

### **3.6.1 Pilot Study**

A pilot study was conducted to validate the various scales used for the purpose of this study. Four of the scales were self constructed to measure knowledge of Ghana's abortion law, abortion stigma, cultural norms and values and knowledge of the existence of safe abortion services. Construction of these scales was necessary since no standardized scales measuring these psychosocial factors were available. The Santa Clara Strength of Religious Faith Scale was also validated to determine its usefulness for the present study. The pilot study was necessary as Polit, Beck and Hungler (2001) consider pilot study as feasibility studies which are done in smaller scale versions or trials done in preparation for the major study. A sample size of twenty women who had had abortion(s) was obtained from the family planning unit of the Ridge hospital for the pilot study. The reliability coefficients observed for the scales after the pilot study are Knowledge of Abortion Law Scale (.76), Abortion Stigma Scale (.82), Cultural Norms and Values Scale

(.70), Knowledge of the Existence of Safe Abortion Services scale (.69) and Santa Clara Strength of Religious Faith Scale (.85)

In addition to obtaining the reliabilities for the various scales, factor analyses in SPSS was run with the data from the pilot study to determine the contribution of each item to the total validity of the scales used. The result of the factor analyses is represented in the tables below; Table 2-6.

**Table 2: Factor Loading for Knowledge of Abortion Law Scale**

| <b>Item</b>   | <b>Component</b> |
|---|------------------|
| A majority of Ghanaian women are aware of the existence of Ghana's abortion law                                 | .67              |
| Abortion is permitted under all circumstances in Ghana  | .62              |
| There is access to legal abortion care in Ghana   | .58              |
| Abortion is expensive if done in a recognized clinic/hospital/organization                                      | .65              |
| Every hospital or clinic in Ghana can perform abortion procedures   | .63              |
| Every Ghanaian woman has the right to have abortion   | .67              |
| The consent of only the woman is needed for an abortion procedure to be performed                               | .58              |
| The consent of other family members (e.g. Husband, fiancée) is needed for an abortion procedure to be performed | .75              |

***Extraction Method: Principal Component Analysis***

**Table 3: Factor Loading for Abortion Stigma Scale**

| <b>Item</b>   | <b>Components</b> |
|---|-------------------|
| Those who have abortion are sinful                                  | .61               |
| Abortion is murder  | .74               |
| Abortion is shameful  | .78               |
| Abortion makes one less of a woman                                  | .64               |
| Those who have abortion lose their relationship with friends        | .80               |
| Those who have abortion lose their relationship with family         | .77               |
| Those who have abortion are ignored in social gathering             | .71               |
| Those who have abortion are looked down upon in religious gathering | .53               |

***Extraction Method: Principal Component Analysis***

**Table 4: Factor Loading for Cultural Norms and Values Scale**

| <b>Item</b>   | <b>Component</b> |
|---|------------------|
| A woman should perform marriage rites before getting pregnant           | .68              |
| Every woman should bear children  | .59              |
| Every woman should be able to nurture her children no matter the number | .70              |
| Abortion defiles a woman  | .62              |
| Abortion issues should be discussed openly                              | .62              |
| It is moral to have abortion  | .90              |
| Abortion is a disgrace to one's family                                  | .78              |
| Those who have abortion should be treated as outcasts                   | .57              |

***Extraction Method: Principal Component Analysis***

**Table 5: Factor Loading for Knowledge of the Existence of Safe Abortion Services Scale**

| <b>Item</b>  | <b>Component</b> |
|--|------------------|
| Safe abortion services are available in all hospitals and clinics                                | .69              |
| Safe abortion services are available in some recognized hospitals and organization               | .67              |
| Safe abortion services are only available to married women                                       | .82              |
| Safe abortion services are only available to adults  | .83              |
| Safe abortion services are only available to first trimester pregnancies (1-3 months)            | .63              |
| Safe services are available to second trimester pregnancies (4-6 months)                         | .81              |
| Safe services are available to third trimester pregnancies (7-9 months)                          | .83              |
| Abortion is expensive if done under safe conditions in a recognized clinic/hospital/organization | .53              |

*Extraction Method: Principal Component Analysis*

**Table 6: Factor Loading for Santa Clara Strength of Religious Faith Scale**

| <b>Item</b>   | <b>Component</b> |
|---|------------------|
| My religious faith is extremely important to me             | .65              |
| I pray daily  | .57              |
| I look to my faith as a source of inspiration               | .69              |
| I look to my faith as providing meaning and purpose in life | .74              |
| I consider myself active in my faith or church              | .64              |
| My faith is an important part of who I am as a person       | .72              |
| My relationship with God is extremely important to me       | .70              |
| I enjoy being around others who share my faith              | .82              |
| I look to my faith as a source of comfort                   | .81              |
| My faith impacts most of my decisions                       | .68              |

*Extraction Method: Principal Component Analysis*

The observed reliability co-efficients and the results of the factor analyses obtained from the pilot study indicated that the scales developed were relevant and useful for the present study as well as the existing scale. It was also observed from the pilot study that a number

of women were willing and ready to provide information that initially was thought to be private and difficult to obtain from participants.

### **3.6.2 The Main Study**

#### **Ethical Considerations**

The American Psychological Association (APA) 2002 has set out code of ethics that provide a common set of principles and standards by which psychologists build their professional and scientific work. The code of ethics provides specific standards to cover situations and conditions encountered by psychologists. The aim of the code of ethics is for the welfare of the individuals and groups whom psychologists work with and educate members of the association, students and the public regarding ethical issues of the discipline.

Some of the principles of the APA's Ethics Code relevant to the present study were observed. First, the various authorities in-charge of the hospitals used for the research namely Ridge Hospital, 37 Military Hospital and the La General Hospital were served with letters from the Head of Psychology department of University of Ghana to seek their consent before commencing the data collection. The consent of the participants was subsequently sought. This was preceded by briefing the participants regarding their role and conducts and expectations of the research team. The researcher of this study and another trained for the purpose of this research formed the research team of this study. Briefing participants was done in writing and verbally. Women who at the time of visit to the Family Planning Unit of the Ridge Hospital and La General Hospital met the

requirements of the researchers and showed willingness to participate in the research were given questionnaires to fill. At the 37 Military Hospital women who were on admission at the Obstetric and Gynaecological unit for having done abortions and who showed willingness to partake in the study were also allowed to fill the questionnaire. Participants of the study were also given requisite information on the purpose of the research, expected duration and procedure. Participants were also made to understand that they were participating not of compulsion but their willingness to assist the researchers in obtaining the necessary information and for that matter they could opt out of the research for any reason they deemed fit even in the process of the research. In addition participants were made to understand the benefits of the information that they had to provide as helping the government of Ghana to formulate policies for them. Confidentiality was assured since they were informed not to provide their names or contact to the researchers. Researchers also gave the participants the opportunity to seek clarifications for any uncertainties that they had. The respondents were also told that, in answering the questionnaire there were no correct or wrong answers. Therefore all they needed to do was to answer the questions as they applied to them. The time duration needed for completing the questionnaire was approximately 15 minutes. However, it took longer for some participants. Data was collected on regular visits to the hospitals until the desired sample size of 100 was achieved.

Data obtained from the study was analysed and it is presented in the next chapter, chapter four.

## CHAPTER FOUR

### RESULTS

#### 4.1 Introduction

The study sought to examine some psychosocial factors and their impact on unsafe abortion in Ghana. It specifically sought to find out the influence of knowledge of Ghana's abortion law, Abortion stigma, cultural norms and values, religiosity and knowledge of the existence of safe abortion services on the practice of safe or unsafe abortion in Ghana. Five hypotheses were therefore stated and tested. The statistical package for social science (SPSS) version 17.0 was used in the analyses. It was done in two main stages; the first was the preliminary analysis and second involved testing the hypotheses of the study.

#### 4.2 Preliminary analysis

The preliminary analysis was done in two steps. These were: Descriptive statistics analysis, and Reliability analysis. Firstly, the descriptive statistics of the demographic data was computed. This involved summarising the raw data obtained in terms of its demographic characteristics. Results from this analysis can be found in Table 7 below.

Coefficient of internal consistency (Cronbach's  $\alpha$ ) was also computed to establish the reliability of each of the scales in the questionnaire. Measures had satisfactory reliabilities, with alpha values ranging from .72 to .90 (Table 7 below). Nunnally suggests (as cited in Kline, 1994) that the coefficient alpha should be equal or higher than .70 if a set of items can constitute a reliable scale.

**Table 7: Descriptive statistics and Reliability indices of the study variables (N = 100)**

|  | <i>Mean</i> | <i>Std. Deviation</i> | <i>Minimum</i> | <i>Maximum</i> | <i>Alpha</i> |
|--|-------------|-----------------------|----------------|----------------|--------------|
| Abortion Stigma                                  | 25.94       | 6.999                 | 8              | 40             | .85          |
| Knowledge of Abortion Law                        | 21.21       | 4.068                 | 8              | 29             | .76          |
| Knowledge of existence of Safe Abortion Services | 22.12       | 3.125                 | 12             | 32             | .75          |
| Cultural Norms and Values                        | 26.68       | 5.597                 | 8              | 35             | .72          |
| Religiosity                                      | 35.51       | 4.972                 | 20             | 41             | .90          |

### 4.3 Hypotheses Testing

To test the hypotheses of the study, the main statistical tool used was Logistic Regression Analysis. Logistic regression allows one to predict a discrete outcome such as group membership from a set of variables that may be continuous, discrete, dichotomous, or a mix. Logistic regression analysis is suitable for cases when the dependant variable is dichotomous such as Yes/No, Pass/Fail, Healthy/ill, life/death, etc., while the independent variable(s) can be nominal, ordinal, ratio or interval (Tabachnick & Fidell, 2001). Since this study sought to examine the predictive influence of psychosocial factors such as knowledge of Ghana's abortion law, abortion stigma, cultural norms and values, religiosity and knowledge of the existence of safe abortion services which are all continuous variables on the possibility of engaging in safe or unsafe abortion (dichotomous variable), the choice of this test was appropriate.

As stated earlier, five hypotheses were stated and tested. The hypotheses are as follows;

H1: Knowledge of Ghana's Abortion law will significantly predict safe and unsafe abortion.

H2: Abortion stigma will significantly predict safe and unsafe abortion.

H3: Safe and unsafe abortion will be significantly predicted by Ghana's cultural norms and values.

H4: Religiosity will significantly predict safe and unsafe abortion.

H5: Knowledge of Safe abortion services will significantly predict safe and unsafe abortion.

A direct logistic regression analysis was performed with SPSS binary logistic to assess prediction of women who practiced safe/unsafe abortion on the basis of their knowledge of Ghana's abortion law, stigma attached to abortion, Ghana's cultural norms and values, religiosity and knowledge of the existence of safe abortion services. Fifty- four women who practiced unsafe abortion and 46 who practiced safe abortion (a total of 100 women) provided data suitable for the analysis.

Hosmer and Lemeshov's goodness-of-fit test which compared observed with predicted number of cases for the two categories of abortion practice, using all the predictors in the model showed a good fit ( $X = df = 8$ ,  $p = .179$ ) as represented in table 8 below.

Table 8: Hosmer and Lemeshow Test

| Step | Chi-square | df | Sig. |
|------|------------|----|------|
| 1    | 11.422     | 8  | .179 |

Table 9: Model Summary

| -2 Log likelihood | Cox & Snell R Square | Nagelkerke R Square |
|-------------------|----------------------|---------------------|
| 108.068           | .259                 | .346                |

Table 10: Classification Table

|                    |                 | Predicted        |                 |                    |
|--------------------|-----------------|------------------|-----------------|--------------------|
|                    |                 | Type of Abortion |                 | Percentage Correct |
| Observed           |                 | Safe Abortion    | Unsafe Abortion |                    |
| Type of Abortion   | Safe Abortion   | 30               | 16              | 65.2               |
|                    | Unsafe Abortion | 8                | 46              | 85.2               |
| Overall Percentage |                 |                  |                 | 76.0               |

The ability of the model to correctly classify the women in terms of their practice of safe/unsafe abortion was found to be very high (76%). The model's sensitivity was also very high (85.2% of women who practiced unsafe abortion were correctly classified) as well as its specificity (65% of the women who practiced safe abortion were correctly classified). These are represented in table 10 above.

**Table 11: Logistic regression analysis of Safe/Unsafe abortion as a function of Abortion stigma, Knowledge of Ghana’s abortion law, Cultural norms and values, knowledge of the existence of Safe abortion services and Religiosity**

|   | B       | S.E.  | Wald   | Sig. | Odds Ratio<br>exp(b) | 95% C.I. for<br>exp (b) |       |
|---|---------|-------|--------|------|----------------------|-------------------------|-------|
|   |         |       |        |      |                      | Lower                   | Upper |
| Abortion Stigma                                     | .032    | .042  | .584   | .445 | 1.03                 | .951                    | 1.122 |
| Knowledge of Ghana’s<br>Abortion Law                | .148    | .075  | 3.934  | .047 | 1.16                 | 1.002                   | 1.342 |
| Knowledge of existence of<br>Safe Abortion Services | .130    | .093  | 1.966  | .161 | 1.14                 | .949                    | 1.367 |
| Cultural Norms and Values                           | .084    | .058  | 2.087  | .149 | 1.09                 | .971                    | 1.218 |
| Religiosity   | .133    | .054  | 6.040  | .014 | 1.14                 | 1.027                   | 1.270 |
| Constant  | -13.432 | 3.479 | 14.905 | .000 | .00                  |                         |       |

A test of the full model with the five predictors against a constant only was statistically reliable ( $\chi^2 = 24.582$ ,  $df = 7$ ,  $p < .001$ ) indicating that the predictors as a set reliably distinguished between women who practice unsafe abortion and those who practice safe abortion. The variance accounted for by practicing safe/unsafe abortion was quite high (Nagelkerke  $R^2 = .346$ ), indicating 34.6% of the shared variance between practicing safe/unsafe abortion and the set of predictors (table 9 above).

Table 11 shows the results of the direct logistic regression analysis predicting the practice of safe/unsafe abortion from Stigma attached to abortion, the knowledge of Ghana’s abortion law, knowledge of the existence of safe abortion services, Cultural norms and values and Religiosity. According to the Wald test, Knowledge of Ghana’s Abortion Law ( $\chi^2 = 3.934$ ,  $df = 1$ ,  $p = .047$ ) and Religiosity ( $\chi^2 = 6.040$ ,  $df = 1$ ,  $p = .014$ ) reliably predicted the practice of safe/unsafe abortion. Contrary to predictions made, Abortion

Stigma ( $\chi^2 = .584, df = 1, p = .445$ ), knowledge of the existence of safe abortion services ( $\chi^2 = 1.966, df = 1, p = .161$ ) and Cultural norms and values ( $\chi^2 = 2.087, df = 1, p = .149$ ) did not significantly predict the practice of safe/unsafe abortion. In view of this, hypothesis one stated as '*Knowledge of Ghana's Abortion law will significantly predict safe and unsafe abortion*' and hypothesis four stated as '*Religious beliefs will significantly predict safe and unsafe abortion*' were both supported. The rest of the hypotheses were not supported.

Table 11 also shows that the most reliable predictors of the practice of safe/unsafe abortion are Knowledge of Ghana's abortion law and Religiosity. Additionally, the odds ratio values indicate that the odds in favour of a woman practicing safe abortion increases by a multiplicative factor of 1.16 for a one unit change in Knowledge of Ghana's abortion law while the increase in odds are slightly lower (1.14) for Religiosity.

The observed relationship between the variables studied after testing the hypotheses is presented in figure 2 below.

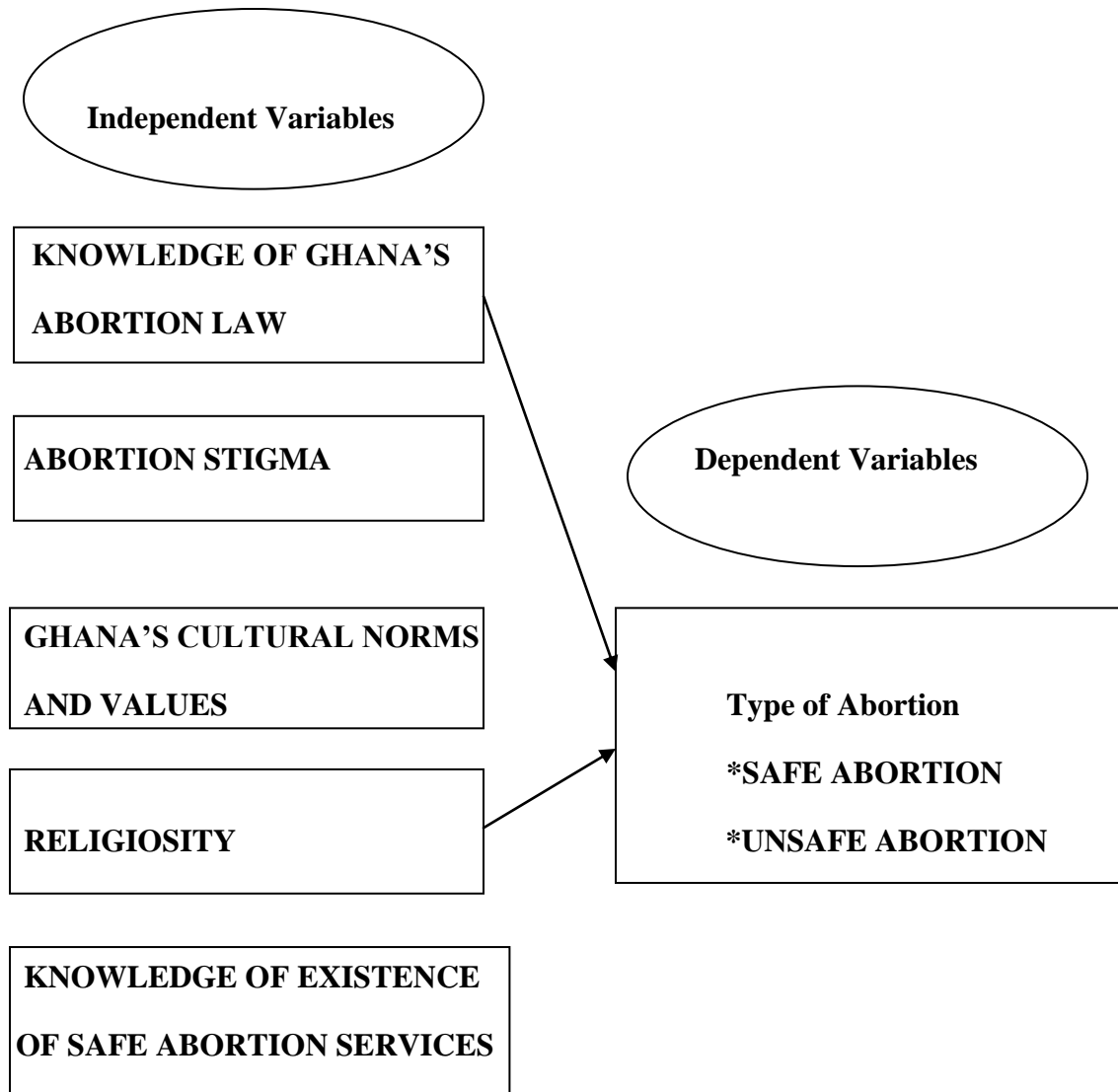


Figure 2: Observed Relationship between Variables studied

#### **4.4 Summary of Results**

The findings of the study are summarized below:

The following findings were consistent with the hypotheses of the study;

1. Knowledge of Ghana's Abortion law significantly predicted the practice of safe and unsafe abortion.
2. Religious beliefs also significantly predicted the practice of safe and unsafe abortion.

The following finding were however not consistent with the hypotheses;

3. Abortion stigma did not significantly predict safe and unsafe abortion.
4. Safe and unsafe abortion was not significantly predicted by Ghana's cultural norms and values.
5. Knowledge of Safe abortion services did not significantly predict safe and unsafe abortion.

## **CHAPTER FIVE**

### **DISCUSSION**

#### **5.1 Introduction**

The present study investigated the psychosocial factors and their impact on unsafe abortion in the Greater Accra Region of Ghana. Using a correlational study design, the researcher collected information from 100 participants drawn from a population of females in the Greater Accra Metropolis who had ever had an abortion.

#### **5.2 Summary of Findings**

The data analyses revealed that knowledge of Ghana's abortion law significantly predicted the practice of safe and unsafe abortion. Religious beliefs also significantly predicted the practice of safe and unsafe abortion, however, abortion stigma, Ghana's cultural norms and values and knowledge of the existence of safe abortion services did not significantly predict safe and unsafe abortion. These findings support only two of the stated hypotheses.

#### **5.3 Discussion of Main Findings**

##### **5.3.1 Knowledge of Ghana's Abortion Law and Unsafe Abortion**

In congruence with the expectation of the present study, the prediction that knowledge of Ghana's abortion law will significantly predict safe and unsafe abortion was supported by the findings of this study. Specifically the findings indicate that a woman who has

knowledge of Ghana's abortion law is less likely to engage in unsafe abortion than a woman who has no knowledge of Ghana's abortion law.

This result is consistent with the findings of Jewkes et al. (2005); Morhee and Morhee (2006); and Morroni et al. (2006). Results of their studies indicated that lack of knowledge of their respondents of the legality of their countries' abortion laws influenced their practice of unsafe abortion. These studies were done in South Africa (Jewkes et al., 2005; Morroni et al., 2006) where abortion is legal and Ghana (Morhee and Morhee, 2006) where abortion is illegal but permitted under a number of liberal conditions which should give a significant number of women access to safe abortion.

Ignorance of participants of this present study of Ghana's abortion law implies ignorance of the true nature or content and liberality of Ghana's abortion law. As a matter of fact, these Ghanaian women are only aware that abortion is illegal if performed in Ghana and that seeking an abortion publicly for an unwanted pregnancy is tantamount to prosecution. According to Sedgh (2010), in countries where abortion is legal or permitted on broad grounds, abortion is generally safe, and where abortion is illegal in many circumstances, it is often unsafe. For example, in South Africa, the incidence of infection resulting from abortion decreased by 52% after the abortion law was liberalized in 1996 (Sedgh, 2010). It is therefore expected that Ghana which is numbered as one of the countries with liberal abortion laws (Sedgh, 2010) will have a significant number of women practicing safe abortions. This is however not the case as demonstrated by this research and other existing data such as that of Morhee and Morhee (2006) and Ghana

Statistical Service et al, (2007) which stated that only 4% of the women surveyed knew about the law of abortion in Ghana. Among educated women, i.e. those with a high school education and higher, the figure was as low as 11%. As a result, relatively few women go to a hospital or clinic to have the procedure performed safely. Even in one clinic surveyed, only half the personnel were aware of the abortion law.

The social learning theory by Bandura (1977) which demonstrates that behaviour is learnt in a social context through such means as observation, modeling and imitation can also be used to explain this finding. Women can only access safe abortion services when they are aware that the law permits them to have it. They will on the other hand have clandestine abortion when they know the law does not permit them to have abortion. The fact that a significant number of women studied in this study and other studies (Morhee & Morhee, 2006; and Ghana Statistical Service et al, 2007) demonstrated lack of knowledge of Ghana's abortion law and subsequently practice of unsafe abortion is indicative of the fact that the behaviour or response well known to be the solution to an unwanted pregnancy in Ghana is clandestine abortion which is considered unsafe by WHO (2004). Clandestine abortion could therefore be considered as a learned response to an unwanted pregnancy.

### **5.3.2 Religiosity and Unsafe Abortion**

The researcher's prediction that religiosity will significantly predict safe and unsafe abortion, was also confirmed by the findings of the study. Specifically, this finding showed a positive relationship between religiosity and safe abortions, indicating that the

more religious a person is, the more likely she will have safe abortion and the less likely she will have unsafe abortion and vice versa. Limited studies focusing on religiosity and safe/unsafe abortions exist. However, Erfani (2011) conducted a study in this area of research and reported findings that confirm the result of the present study. He reported that unsafe abortion was high among Iranian women who had a low level of religiosity. This implies that Iranian women who were highly religious were more likely to have safe abortions.

Beit-Hallahmi and Argyle's (1997) concept of religious orientation can be used to explain this finding. According to them, people who have intrinsic orientation towards their religion, that is to say, those whose religion is deeply personal to them are more likely to take better decisions concerning their health and eventually have better health. In this sense highly religious people are more likely to take better decisions concerning their health as in this case deciding to have a safe abortion when faced with an unwanted pregnancy as against having an unsafe abortion which has numerous health implications including death and infertility.

In addition, religious people have spiritual heads that they can rely on, confide in and seek help in times of need. Instead of sharing their problems with friends and even the church members, they are more likely to confide in these mentors and spiritual heads, who in-turn counsel, and if the need arises refer them to the right facilities. Some people who would have rather resorted to clandestine abortion because of the cost of safe abortion may receive financial aid from these spiritual heads and mentors.

### **5.3.3 Abortion Stigma and Unsafe Abortion**

The findings of the present study demonstrated that abortion stigma did not significantly predict safe and unsafe abortion. This is contrary to the researcher's prediction.

This finding also contradicts some earlier findings such as that of Shellenberg and Kristen (2010); Dahlback et al. (2007) and Harries et al. (2007). Results from their study demonstrated that abortion stigma influenced their participants to resort to unsafe abortion. The participants reported facing stigma from friends and family, healthcare providers, people in their community and the general society.

Abortion stigma did not significantly predict safe and unsafe abortion which implies that probably many people are not even aware that abortion is permitted under very liberal circumstances in Ghana and that every Ghanaian woman could access safe abortion under those conditions. Therefore abortion stigma may not sufficiently predict the practice of safe or unsafe abortion on its own unless people are well informed of their legal rights.

The non significant finding can partly be attributed to internalized stigma that exists among women seeking abortion. This probably makes them immune to any form of stigma and will therefore go ahead with the abortion. Also because of fear of facing personal shame and a bigger social stigma such as parental disapproval, abandonment by partner and expulsion from school that may come with engaging in the unsafe abortion or otherwise.

As stated earlier, Abortion stigma according to Kumar et al., (2009, 4) is, "a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood". The negative attributes that

a number of Ghanaian women have towards abortion may only exist because of their lack of knowledge of the amendment of the law which initially prohibited abortion under all circumstances. The law was amended by PNDCL 102 in 1985; nevertheless a significant number of Ghanaians including health personnel are still not aware of its content. Some of the negative attributes that Ghanaians have toward abortion is that abortion is a crime which is not true under certain conditions which they are not aware of. The fact of the matter is that if there was no stigma towards seeking abortion in Ghana and women still lacked knowledge of the abortion law, they still would have unsafe abortions due to the ignorance of their legal rights. Abortion stigma or no abortion stigma therefore seems to make very little contribution to what actually influences women into having safe/unsafe abortions. As long as Ghanaian women remain ignorant of the law, there will be the practice of unsafe abortions whether abortion stigma exists or not.

#### **5.3.4 Cultural Norms and Values and Unsafe Abortion**

The hypothesis stated in the present study that cultural norms and values will significantly predict safe/unsafe abortion was not supported. This means that respondents' decision to resort to safe/unsafe abortion was not significantly influenced by Ghanaian cultural norms and values.

This finding contradicts a number of past studies done to ascertain this relationship including that of Aniteye and Mayhew (2011); Omo-Aghoja et al. (2009) and Plummer et al. (2008). Results from their study indicated that participants of their study had unsafe abortions because of socio-cultural pressures.

Participants in this present study however were not influenced into unsafe abortion by cultural norms and values because perhaps a number of Ghanaian women are increasingly becoming aware and more concerned about taking decisions about their health based on the health outcomes rather than on cultural norms and values. This is consistent with previous study done by Duda, Jumah, Hill, Seffah and Biritwum (2006) where they reported that healthier life outweighs cultural norms and values in the area of weight reduction for obese Ghanaian women. A majority of all the Ghanaian women surveyed would reduce their present body weight and size if it meant that they would have an overall healthier life instead of keeping a larger figure, so called “traditionally built” which is believed to be a sign of wealth and prosperity and a means to secure a husband (Duda et al., 2006). This implies that a number of Ghanaian women are beginning to consider the health outcome of their actions and behavior instead of inconsiderably conforming to what society proposes as accepted.

### **5.3.5 Knowledge of the Existence of Safe Abortion Services and Unsafe Abortion**

The hypothesis stated in the present study that knowledge of the existence of safe abortion services will significantly predict safe and unsafe abortion was not supported. This means that respondents’ decision to resort to safe or unsafe abortion was not significantly influenced by their knowledge of the existence of safe abortion services. This also contradicts findings of previous studies such as those of Konney et al. (2009) and Hill et al. (2009). Findings from their studies reported that lack of knowledge of safe abortion services influence women into having unsafe abortions.

Respondents' knowledge of safe abortion services may not have influenced their decision to resort to safe or unsafe abortion services because of their supposed lack of knowledge of the liberality of the content of the law. If they knew the existence and liberality of Ghana's abortion law, they would know that the safe services exist legally and would be in a better position to access the safe services knowing the conditions under which the law prosecutes victims.

A study by Hill et al. (2009) report that a study conducted in the main teaching hospital in Kumasi, Ghana, indicated that only 54% of maternal and child health-related health workers were aware of the true nature of the abortion law, with 35% believing that the law permits abortion only to save the life of the woman. They conclude that the lack of knowledge of health professionals could reflect in the community members' knowledge of the law and that a poor understanding of the law would impact on service uptake and service provision.

Secondly, Ghana's reproductive health strategic plan commits to ensuring that comprehensive abortion care (CAC) is made available as permitted by the law (Hill et al., 2009). This includes increasing access to services by assessing facilities and providing equipment, supplies, and training as needed and developing behavior change materials to increase community awareness of CAC (Hill et al., 2009). A number of studies have however shown that the implementation of this strategic plan has not reached its full potential. According to Ahiadeke (2001) only 12% of women surveyed in a research admitted to obtaining abortion from a physician. The rest of them induced it themselves,

often in collaboration with pharmacists. Meanwhile, Hill et al. (2009) report that “misoprostal”, the drug approved and recommended for abortion, was not mentioned by the respondents as being used because of its unavailability, instead hormonal preparations such as menstrogen, and Gynaecosid, ergot-based medicines, an overdose of chloroquine or pain killers, and the use of broken bottles as enaema were commonly used for abortions. Further, inaccessibility of safe abortion services despite their existence, could have accounted for the result of the present study. Most of the respondents of the study did not know that a number of public hospitals and even approved organizations such as Marie Stopes in Ghana provide safe abortion services even though they knew they were being provided somehow and somewhere. For the rural folks, the situation is even worse. According to Singh (2006) many hospitals tend to be located in urban areas, causing rural women to have particularly poor access to safe abortion care.

Inaccessibility of health care could also be accounted for by poor quality health services for women in developing countries and to the attitudes and relational practices of healthcare providers (Jewkes, Abrahams & Mvowhy, 1998). Findings of a study by Yakong, Rush, Bassett-Smith, Bottorff and Robinson (2010) on women’s experiences of seeking reproductive health care in rural Ghana, indicated that the women reported being scolded and intimidated particularly by male nurses in their quest for maternal health care. This is reflective of the general patriarchal African culture characterized by power imbalance and control and the social construction of gender (Amoakohene, 2004).

In addition, a number of Ghanaian women are concerned about the affordability and confidentiality of these safe abortion services. According to Baiden (2009, 1), “for the upper and middle class in Ghanaian society, the process of securing safe termination of pregnancy could constitute just a minor abrasion, as a walk into any of many health facilities with the asked-for-price in hand could be all it would take to secure safe and confidential termination of pregnancy. The situation is dramatically different for the majority of women in Ghanaian society, including school aged youth, who are caught in the lower class of society and battling with the daily vicissitudes of life. Women in this segment of society are vulnerable to quacks and backstreet practitioners”

#### **5.4 Limitations of the Study**

This present study assessed the psychosocial factors and their impact on unsafe abortion in the Greater Accra Region of Ghana. The study used solely quantitative research method in collecting and analyzing data. In-depth information which could have been obtained with the use of qualitative research methods such as focus group discussions and interviews may be missing.

Secondly, data from the present study cannot be generalized to women in Ghana since data was collected from women visiting the La General Hospital, Ridge Hospital and 37 Military Hospitals all situated in Greater Accra Region. Even though two of the hospitals used are referral hospitals and as such could receive patients from all over Ghana, a number of referral hospitals also exist in the various regions of Ghana to cater for their own patients. Therefore patients who mostly visit the health facilities used for the study

are women resident in Greater Accra. Secondly the sample size is too small to make a proper generalization of the results to women in Ghana. The result therefore represents the views of women in Greater Accra Region of Ghana, not women in Ghana.

### **5.5 Recommendations for Future Studies**

A combination of quantitative and qualitative research methods should be used in future studies. Qualitative methods have been identified as useful in such studies providing insight; however the sensitive nature of the topic can make respondents withhold important information, especially in the focus group where respondents feel pressurized to provide socially acceptable and normative responses (Hill et al. 2009; & Peytchev, Peycheva & Grooves, 2010). Using both quantitative and qualitative research methods will ensure that the weaknesses of either of the two methods are catered for by the strengths of the other.

This study should be replicated in the other regions of Ghana in order to ascertain the psychosocial factors that make Ghanaian women resort to unsafe abortion.

### **5.6 Contributions of the Present Study**

According to Baiden (2009) the case of unsafe abortion in Ghana appears to typify the fact that the liberality of the law is not necessarily the most important factor determining the use of safe services. This study provides information as to which particular factors do determine the use of safe services by a number of women in Ghana. These factors were found by this research to include knowledge of the abortion law and religiosity. This

finding is useful for the Ghana Health Service and other interested organizations for the successful implementation of policies and plans.

According to Senah (2003) psychological, social, cultural and economic factors aside biological factors are potent in promoting ill health and death and should therefore be addressed in the case of maternal mortality in order to make any meaningful progress in the quest to reducing its incidence. This study's focus on psychosocial factors is therefore a step in the right direction in seeking to reduce maternal mortality.

In addition, Okine (as cited in Adams, 2012) has assessed Ghana as unlikely to attain MDG-5 by 2015 and that Ghana's maternal mortality ratio reduction from 540/100 000 in 2000, to 451/100 000 in 2007 to 350/100 000 in 2008, is at a rate of 3.3% annually compared to 5.5% annual rate required to attain MDG-5 target of 185/100 000 by 2015. Information from this research is very important to the government of Ghana and other stake holders in the implementation of policies in order to improve their chances of attaining MDG-5 in 2015. This study also contributes immensely to the field of reproductive health which is a matter of human rights today.

### **5.7 Practical Implications of Study**

The results of this present study indicate that knowledge of the existence and nature of Ghana's abortion law has a probability of decreasing unsafe abortions among a number of women in Ghana. Other relevant studies such as that of Hill et al. (2009) have however pointed out the fact that a number of Ghanaians and even professional health workers are

unaware of this law and its implications/liberality. Intense education should therefore be organized by the respective organizations (Ministry of Health in conjunction with national commission on Civic Education NCCE) in order to inform Ghanaians including health professionals. Community health education for example has been reported by Baird, Billings and Demuyakor (2000) as being one of the key strategies used to combat unsafe abortion. This involves all community members including women, men, adolescents and community leaders. Community members should have the opportunity to clarify misconceptions and have their questions answered within a supportive setting to facilitate trust and identification between them and their communities. Additionally since knowledge of the existence of safe abortion services is not a predictor of safe/unsafe abortion, facilities to cater for such cases should be expanded by the health authorities with help from the central government and NGOs so as to make the services accessible by all at every part of the country.

Religiosity was also found by this present research to significantly predict safe and unsafe abortion. Specifically the more religious a woman is, the less likely she will have unsafe abortions. Religious groups should therefore be involved in the fight against unsafe abortion. They should be educated and encouraged to instill discipline and morals into the lives of their congregation. Religious studies in the secondary schools should also include issues of pregnancy and abortion and the implications of safe and unsafe abortion.

Even though cultural norms and values are potent in influencing a number of decisions women take in Ghana, Duda et al. (2006) found that a number of Ghanaian women are increasingly becoming aware and concerned about their health and taking decisions based on their health outcome and not on society's demands. Ghanaian women should be educated by the Ministry of Health in conjunction with the National commission for civic education (NCCE) on the health implications of safe and unsafe abortion and also the need to have safe abortions in order to preserve their lives.

The present study demonstrates that the aim of Ghana reproductive health strategic plan committed to ensuring that CAC is made available and accessible to Ghanaian women is yet to be achieved and that more efforts and requisite plans and policies should be put in place by the Ministry of Health.

### **5.8 Summary and Conclusion**

The present study used the correlational research design to explore the psychosocial factors and their impact on unsafe abortion in the Greater Accra Region of Ghana. The study revealed that knowledge of the existence of Ghana's abortion law predicts engagement in safe or unsafe abortion. Health professionals, women and even men should be educated on the existence and nature or liberality of Ghana's abortion law to encourage the practice of safe abortion services in order to reduce the maternal mortality index in Ghana.

Religiosity was also found to predict safe and unsafe abortion. Specifically, more religious people are likely to engage in safe abortion. Religious groups should be made to instill discipline and commitment in members so that they will make the right decisions when they are faced with unwanted pregnancies. Spiritual heads should be open and available to their members in order to provide the necessary support they need. Cultural norms and values, abortion stigma and knowledge of the existence of safe abortion services were not found to be predictive of safe and unsafe abortion.

As information on the nature of Ghana's abortion law is properly disseminated, women are made aware of the health implications of the choices they make to have either safe or unsafe abortion, and safe abortion services are made available, accessible and confidential, unsafe abortion will decline, effecting a decline in Ghana's maternal mortality and enhancing the attainment of the R3M and MDG-5.

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## APPENDICES

### QUESTIONNAIRE

#### INFORMATION FOR PARTICIPANTS

This survey is to help the researcher find out what makes women in Ghana opt for unsafe abortion even though safe services are available.

Please note that the information you provide will not be disclosed to anyone, your name will not be mentioned in the answer sheet, and the information you provide will only be used for research purposes.

#### SECTION A

##### DEMOGRAPHICS

Please tick the answer that best applies to your situation.

1. Age                    9 -19 ( )      20 – 30 ( )      30 – 50 ( )      50 – 60 ( )
2. Marital status    Single ( )      Married ( )      Divorced ( )      Separated ( )
3. Religion      Christian ( )      Moslem ( )      Traditional religion ( ) other(s)  
specify.....
4. Educational status    Primary education ( )    Secondary education ( )  
Tertiary education ( )
5. How many abortions have you had      1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 and above ( )
6. How many were unsafe                    none ( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 and  
above ( )
7. Which of the following methods did you use? Tick the particular method(s) you used.
  - I. Drinking “concoctions”
  - II. Taking over-the-counter drugs (Using drugs sold for other illness)
  - III. Inserting sticks

- IV. In-humane activities (eg jumping from high heights)
- V. Other(s).....

8. Which of the following person(s) or facility(s) provided the particular method(s) that you used?

- I. Friends
- II. Family/Relatives
- III. Clinics/hospitals
- IV. personal

## **SECTION B**

### **PSYCHOSOCIAL FACTORS OF UNSAFE ABORTION**

#### **A. STIGMA OF ABORTION**

The following are beliefs of many that make abortion a stigmatized condition and therefore make victims of unwanted pregnancy resort to unsafe abortion.

How do agree to each statement below? Tick appropriately using the following guide.

- |                      |                   |
|----------------------|-------------------|
| 1. Strongly disagree | 4. Agree          |
| 2. Disagree          | 5. Strongly agree |
| 3. No opinion        |                   |

|     | <b>ITEM</b>   | <b>1</b> | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> |
|-----|---|----------|----------|----------|----------|----------|
| 9.  | Those who have abortion are sinful                                  |          |          |          |          |          |
| 10. | Abortion is murder  |          |          |          |          |          |
| 11. | Abortion is shameful  |          |          |          |          |          |
| 12. | Abortion makes one less of a woman                                  |          |          |          |          |          |
| 13. | Those who have abortion lose their relationship with friends        |          |          |          |          |          |
| 14. | Those who have abortion lose their relationship with family         |          |          |          |          |          |
| 15. | Those who have abortion are ignored in social gathering             |          |          |          |          |          |
| 16. | Those who have abortion are looked down upon in religious gathering |          |          |          |          |          |

## **B. KNOWLEDGE OF ABORTION LAW**

The following are statements about the existence and content of Ghana's abortion law.

How do you agree to each statement below? Tick appropriately using the following guide.

- |                      |                   |
|----------------------|-------------------|
| 1. Strongly disagree | 4. Agree          |
| 2. Disagree          | 5. Strongly agree |
| 3. No opinion        |                   |

|     | <b>ITEM</b>  | <b>1</b> | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> |
|-----|--|----------|----------|----------|----------|----------|
| 17. | A majority of Ghanaian women are aware of the existence of Ghana's abortion law.                               |          |          |          |          |          |
| 18. | Abortion is permitted under all circumstances in Ghana   |          |          |          |          |          |
| 19. | There is access to legal abortion care in Ghana  |          |          |          |          |          |
| 20. | Abortion is expensive if done in a recognized clinic/hospital/organisation                                     |          |          |          |          |          |
| 21. | Every hospital or clinic in Ghana can perform abortion procedures.   |          |          |          |          |          |
| 22. | Every Ghanaian woman has the right to have abortion.   |          |          |          |          |          |
| 23. | The consent of only the woman is needed for an abortion procedure to be performed.                             |          |          |          |          |          |
| 24. | The consent of other family members (eg. husband, fiancée) is needed for an abortion procedure to be performed |          |          |          |          |          |

### **C. KNOWLEDGE OF THE EXISTENCE OF SAFE ABORTION SERVICES**

The following are statements about the existence of safe abortion services in Ghana.

How do you agree to each statement below? Tick appropriately using the following guide.

- |                      |                   |
|----------------------|-------------------|
| 1. Strongly disagree | 4. Agree          |
| 2. Disagree          | 5. Strongly agree |
| 3. No opinion        |                   |

|     | <b>ITEM</b>  | <b>1</b> | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> |
|-----|--|----------|----------|----------|----------|----------|
| 25. | Safe abortion services are available in all hospitals and clinics                                |          |          |          |          |          |
| 26. | Safe abortion services are available in some recognized hospitals and organizations              |          |          |          |          |          |
| 27. | Safe abortion services are only available to married women                                       |          |          |          |          |          |
| 28. | Safe abortion services are only available to adults  |          |          |          |          |          |
| 29. | Safe services are only available to first trimester pregnancies (1 – 3 mnths)                    |          |          |          |          |          |
| 30. | Safe services are available to second trimester pregnancies (4 – 6 mnths)                        |          |          |          |          |          |
| 31. | Safe services are available to third trimester pregnancies (7 – 9 mnths)                         |          |          |          |          |          |
| 32. | Abortion is expensive if done under safe conditions in a recognized clinic/hospital/organisation |          |          |          |          |          |

#### **D. CULTURAL NORMS AND VALUES**

These are the beliefs of most people on cultural practices that make women have unsafe abortion.

How do you agree to each statement below? Tick appropriately using the following guide.

- |                      |                   |
|----------------------|-------------------|
| 1. Strongly disagree | 4. Agree          |
| 2. Disagree          | 5. Strongly agree |
| 3. No opinion        |                   |

|     | <b>ITEM</b>   | <b>1</b> | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> |
|-----|---|----------|----------|----------|----------|----------|
| 33. | A woman should perform marriage rites before getting pregnant       |          |          |          |          |          |
| 34. | Every woman should bear children                                    |          |          |          |          |          |
| 35. | Every woman should be able to nurture children no matter the number |          |          |          |          |          |
| 36. | Abortion defiles a woman  |          |          |          |          |          |
| 37. | Abortion issues should be discussed openly                          |          |          |          |          |          |
| 38. | It is moral to have abortion  |          |          |          |          |          |
| 39. | Abortion is a disgrace to one's family                              |          |          |          |          |          |
| 40. | Those who have abortion should be treated as outcasts               |          |          |          |          |          |

**E. SANTA CLARA STRENGTH OF RELIGIOUS FAITH**

This section consists of questions concerning the strength of one's religious faith. You are required to indicate the level of agreement (or disagreement) for each statement by ticking the number that matches your level of agreement on the line before the statement.

- |                      |                   |
|----------------------|-------------------|
| 1. Strongly disagree | 3. Agree          |
| 2. Disagree          | 4. Strongly agree |

|     | <b>ITEM</b>   | <b>1</b> | <b>2</b> | <b>3</b> | <b>4</b> |
|-----|---|----------|----------|----------|----------|
| 41. | My religious faith is extremely important to me             |          |          |          |          |
| 42. | I pray daily  |          |          |          |          |
| 43. | I look to my faith as a source of inspiration               |          |          |          |          |
| 44. | I look to my faith as providing meaning and purpose in life |          |          |          |          |
| 45. | I consider myself active in my faith or church              |          |          |          |          |
| 46. | My faith is an important part of who I am as a person       |          |          |          |          |
| 47. | My relationship with God is extremely important to me       |          |          |          |          |
| 48. | I enjoy being around others who share my faith              |          |          |          |          |
| 49. | I look to my faith as a source of comfort                   |          |          |          |          |
| 50. | My faith impacts many of my decisions                       |          |          |          |          |

Thank you!