COLLEGE OF HUMANITIES

UNIVERSITY OF GHANA

MALE PARTNERS' INVOLVEMENT IN ABORTION AND UPTAKE OF POST-ABORTION FAMILY PLANNING SERVICES.

BY

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THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF PHD POPULATION STUDIES DEGREE.

REGIONAL INSTITUTE FOR POPULATION STUDIES

JULY 2018

ACCEPTANCE

This thesis is accepted by the College of Humanities, University of Ghana, Legon, in fulfilment of the requirement for the award of PhD Population Studies degree.

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DECLARATION

I, Esinam Afi Kayi, hereby declare that except for references to other people's work, which have been duly acknowledged, this is the result of my own research and it has neither in part nor in whole been presented for another degree.

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ABSTRACT

Male involvement in abortion and post-abortion family planning use is pivotal in reducing unintended pregnancies while optimising contraceptive use. While literature is extant with the positive outcomes of men's role in abortion and contraceptive use, there is insufficient interrogation of the relationship between male partners' involvement in abortion and post-abortion family planning uptake. This study sought to examine the relationship between male partners' involvement in abortion and immediate use of post-abortion contraception in the Greater Accra Region. The specific objectives were to: explore the extent of male partners' participation in abortion; women's expectations of their partners' roles in the abortion and barriers to partners' inclusion and participation in abortion.

Using a sequential mixed method approach, data were obtained first through in-depth interviews and participant observations from women and their male partners, followed by a survey of only women. The data collection was conducted in four purposively selected health facilities in the Greater Accra Region. At the end of the study, 41 interviews were conducted and 356 respondents participated in the survey. Thematic analysis of the qualitative data was done using the Nvivo software. Multiple logistic regression analysis was performed with SPSS to determine the relationship between male partners' involvement in abortion and uptake of post-abortion family planning.

The results of the study showed three main themes which characterised male partners' involvement during abortion: knowledge of the abortion, the role of male partners during the abortion decision-making process, and provision of support for the abortion. Women's expectations of receiving financial support from their male partners was highly prioritised over the expectation of their partners' involvement during the abortion decision-making process and expectation of emotional support. Some women hoped to receive emotional and material support after the abortion whilst others had no expectations of receiving support from their partners. Barriers to male partners' participation and inclusion in the abortion was a result of their lack of knowledge of and secrecy surrounding the pregnancy and abortion, partner abandonment, ambivalence about the pregnancy outcome, work-related demands, and parental responsibility for the pregnancy. Furthermore, communicative support provided by the male partners during the abortion process strongly predicted women's use of post-abortion contraception. Women were less likely to adopt a contraceptive method after the abortion if they received emotional support from their male partners at the time of the abortion. The woman's employment, self-efficacy and level of family planning knowledge were significantly associated with post-abortion family planning uptake whilst male partners' educational level, ethnicity and knowledge of family planning strongly predicted women's use of post-abortion contraception.

The findings from this study elucidate several theoretical and practical implications. Post-abortion services should aim at increasing women's autonomy in contraceptive decision-making while encouraging inter-couple communication on contraceptive use. Availability of on-site family planning consumables, skilled abortion-care providers and comprehensive discussions on contraception should be integrated into the package of comprehensive abortion care delivery at health facilities in order to increase the prevalence and initiation of post-abortion contraception.

DEDICATION

This work is dedicated to all the women who participated in this study.

ACKNOWLEDGEMENTS

To the **GOD** who makes all things possible!

The successful completion of this thesis was made possible through the collective efforts of my family, thesis supervisors, RIPS Faculty, friends, and healthcare providers.

I'm sincerely indebted to my mum, Delasi and Kafui, and Dr. Von Vordzogbe for their prayers, support and encouragement during this entire journey. It would have been quite difficult without their presence on this journey. My deepest appreciation goes to my supervisory team: Professors Stephen Owusu Kwankye and Richard Komla Adanu, and Dr. (Mrs.) Delali Badasu. I am very grateful to Prof. Kwankye for all the constructive criticisms, suggestions, counsel and encouragement during the difficult moments in researching on this topic. I'm also indebted to Prof. Adanu for accepting to be on my supervisory committee during one of the most trying times of this journey. Your intellectual contribution has been tremendous! Sincere thanks also goes to Dr. Badasu for the guidance, encouragement and constructive inputs in shaping this thesis. God bless you all! I wish to acknowledge Prof. Francis Dodoo and Prof. de-Graft Aikins for their scholarly contribution to this work during its conceptualization. Special thanks to the entire RIPS Faculty for being very academically supportive from the beginning of this programme.

Hearty cheers to all the healthcare providers in all the participating hospitals where data was collected especially Aunty Fati, and Sophia of Ga West Municipal Hospital; and to my research team Rita, Gifty, Afrah and Charlotte Ofori who selflessly devoted their time and effort to assist with the field work. To all my colleagues turned friends at RIPS thank you for being part of this successful journey. Finally, to all my genuine friends, family and well-wishers, who are not mentioned here, I am grateful.

This is my testimony; a journey of miracles!

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LIST OF ABBREVIATIONS

CAC	- Comprehensive abortion Care
FP	- Family Planning
GAR	- Greater Accra Region
GMHS	- Ghana Maternal Health Survey
ICPD	- International Conference on Population and Development
MA	- Medical Abortion
PAC	- Post-abortion Care
PAFP	- Post-abortion Family Planning
WHO	- World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Induced abortion is one of the major public health issues in many countries and it is a common reproductive health feature in the lives of women in their reproductive ages (Lohr et al., 2014). Estimates from the World Health Organization (WHO) indicate that globally, 210 million women become pregnant annually (WHO, 2011). Of this estimate, 135 million result in live births; 80 million are unintended pregnancies, 44 million have an induced abortion of which 22 million are unsafe abortions (WHO, 2011; Sedgh et al., 2012). Recent estimates show that 56 million induced abortions occur yearly, of which 54.9 percent are unsafe (Sedgh et al., 2016; Ganatra et al., 2017).

Post-abortion family planning has been recommended as integral to reducing the high rates of induced abortions due to unintended pregnancies (WHO, 2011; High Impact Practices in Family Planning (HIP), 2012; International Federation of Gynaecology and Obstetrics (FIGO), International Confederation of Midwives (ICM), International Council of Nurses (ICN), and United States Agency for International Development, 2009). The aim of post-abortion family planning (PAFP) immediately after an induced abortion is to reduce the risk of unintended pregnancies immediately after the abortion since fertility returns quickly thereafter (Wilcox, Dunson and Baird, 2000; WHO, 2006). Also, PAFP is aimed at preventing repeat abortions, and to reduce the risk of adverse maternal and perinatal outcomes for pregnancies after a spontaneous or induced abortion (WHO, 2006; High Impact Practices in Family Planning, 2012).

There have also been calls for the inclusion of men in sexual and reproductive health matters because of the recognition that men are gatekeepers in women's use of reproductive health

services. For example, at the International Conference on Population and Development (ICPD) in 1994, the priority for member states was to promote active male involvement in all sexual and reproductive issues (ORC, 2005). The ICPD explicitly called for men's inclusion in women's reproductive health through three avenues; first, to promote men's use of contraceptives through increased education and distribution; second, promote men's involvement in roles supportive of women's sexual and reproductive decisions particularly, contraception, and third, encourage men's responsible sexual and reproductive practices to prevent and control sexually transmitted infections (STIs) (Basu, 1996; DeJong, 2000).

In response to a greater inclusion of men in reproductive issues, many countries adopted and implemented reproductive health programmes, including family planning services into their health systems to improve women's maternal and reproductive health outcomes (White, Greene and Murphy, 2003). Evidence from some health systems show marked improvements in the utilization of maternal health services, specifically, family planning services through availability of support from men (Brunson, 2010).

Whilst several studies have examined men's participation and roles in women's reproductive and sexual issues, there is insufficient interrogation of how men's involvement in abortion influences post-abortion contraception uptake (Schwandt et al., 2013; Altshuler et al., 2017). The paucity of empirical studies in this area of fertility research particularly in Ghana underscores the need to examine the circumstances surrounding male partners' involvement in abortion, and factors which affect post-abortion contraception use. It is hoped that results from this study will provide evidence-based information to sexual and reproductive health practitioners to design innovative interventions to encourage male participation in women's sexual health.

1.2 Statement of the Problem

Male involvement is a key component of the WHO's recommendations on health promotion interventions for maternal and child health (WHO, 2015). The argument in support of male involvement in maternal healthcare (including family planning use) is based on evidence found in patriarchal contexts which demonstrate that men are primary decision makers in fertility and sexual decisions (Dodoo, 1993; Ezeh, 1993; Kwambai et al., 2013; Ganle, 2014).

Since the post-Cairo era, many countries have integrated sexual and reproductive health programmes into their health systems to reduce maternal morbidity and mortality, improve maternal health outcomes, and also improve the sexual health needs of men (Sternberg and Hubley, 2004). However, male participation in reproductive health initiatives in response to the ICPD Programme of Action, and the development of new reproductive health paradigms have been reportedly low. Some researchers argue that there is limited evidence to indicate men's participation in family planning programmes (Helzner, 1996; Kero et al., 1999). Other studies have pointed out that successful family planning programmes and their implications from a gender perspective are lacking, which further contributes to limited knowledge of men's roles, responsibilities and involvement in family planning.

Another concern which is central to the limited evidence of men's active involvement in family planning programmes is related to the nuances associated with the term 'male involvement' (Helzner, 1996). The lack of universal description and clarity associated with the definition of involvement, plus the complex forms it takes in different contexts suggest that of 'support', 'roles', and 'responsibility'. Therefore, while men may not be seen as being part of or being involved in reproductive decision-making matters, the kind of overt or covert support, direct and indirect roles and responsibilities they provide may be overlooked, underestimated, or underreported in that particular context. The deficiency of the clear meaning of involvement thus, creates a false sense that men play limited roles in women's reproduction issues.

The 'male role' theory provides evidence for men's involvement in reproductive decision-making. The position of the traditional male role theory assumes that men wield significant influence on women's reproductive decisions by virtue of bride wealth payments, lineage, and kinship (Ezeh, 1993; Dodoo, 1993, 1998; Isiugo-Abanihe, 1994b; Bankole, 1995; Ngom, 1997). Per this assumption, high fertility is valued and encouraged, while attempts to reduce fertility are met with male opposition, and social sanctions. Consequentially, the male role dominance creates gender disparities in reproductive health with women having limited rights to exercise their fertility goals. Ultimately, it will be less likely for men to participate in fertility reduction programmes. Neither will they be willing to encourage and support their partners' use of family planning methods to reduce child bearing.

In furtherance to male opposition in fertility reduction programmes, for instance, family planning use, existing empirical evidence indicates that barriers to men's participation in family planning use hinge on fear of their sexual partners' engagement in extramarital relations, fear of side-effects associated with modern contraceptive use, lack of knowledge on contraception, socially perceived myths surrounding family planning use and negative provider attitudes towards men (Beekle and McCabe, 2006; Mullany, 2006; Peer, Morojele and London, 2013).

It is evident from several fertility researches conducted in patriarchal settings that the high unmet need for modern contraception is a consequence of male role dominance in reproduction (Bongaarts and Westoff, 2000; Casterline and Sinding, 2000). Unmet need for family planning has been found to be one of the primary causes of induced abortions (Westoff, 2005; Jones et al., 2006; Smith et al., 2009). Multiple proximate and distal factors account for unmet need for family planning. These include lack of contraception knowledge, fear of side effects of contraception, misperceptions and myths associated with family planning use (Casterline and Sinding, 2000; Campbell, Sahin-Hodoglugil and Potts, 2006; GSS, GHS, IFC Macro, 2009; Ochako et al., 2015), contraceptive method failure; social and familial

disapproval (Bongaarts and Bruce, 1995); and men's disapproval and opposition to contraception (Bankole and Singh, 1998; Miller, Severy and Pasta, 2004; Dudgeon and Inhorn, 2004; Yue, O'Donnel and Sparks, 2010). The causes of unmet need are further complicated by social and cultural contexts, socio-cultural norms, and the nature of relationships.

In most patrilineal societies, a substantial amount of empirical evidence suggests that men play important roles in reproductive decisions at the 'micro' family level as "partners of women and fathers of their children" (Dudgeon and Inhorn, 2004). Men influence women's reproductive outcomes in positive ways through increasing family planning utilisation, antenatal and maternal health care services (Terefe and Larson, 1993; Abdel-Tawab et al., 1999; Mullany, 2006; Kululanga et al., 2011; Ganle, 2014; Nyondo et al., 2015). Negative outcomes of male participation in women's reproductive issues have been found to result in poor maternal health outcomes and child mortality (Brunson, 2010). With reference to abortions, evidence suggests that it is traditionally (or socio-culturally) viewed as a woman's domain and responsibility (Wambui, Ek and Alehagen, 2009).

In Ghana, the contextual and sociological dimensions of induced abortion decision-making are not well understood partly because empirical studies do not fully examine processes leading to decisions to abort, while the use of hospital data limits in-depth exploration of such issues (Ampofo, 1970; Senah, 2006). Decision-making pertaining to abortions are made within the context of 'utmost secrecy' (Ahiadeke, 2001) because of social and ethical sensitivities, socio-cultural norms, religious differences and political issues surrounding its contentious nature. Socio-cultural norms as well as religious differences further define appropriate roles for both men and women who decide to have abortions.

Limited abortion studies conducted in Ghana have not paid much attention to investigating the associations between men's involvement in women's abortion and post-

abortion contraception uptake (Bleek, 1981; Bleek & Asante-Darko, 1986; Ahiadeke, 2001; Henry and Fayorsey, 2002). For instance, a qualitative study by Schwandt et al. (2013) focused on decision-making processes involved in abortion and found that male partners' involvement was mainly through orders to abort the pregnancy and through denial of responsibility of the pregnancy. Other studies also focus narrowly on women's reports of their male partners' roles in the abortion decision-making process but fail to examine the extent of partners' involvement in post-abortion contraceptive decisions (Kumi-Kyereme, Gbagbo, and Amo-Adjei, 2014).

The limited data on fertility-related issues such as this is quite worrying in Ghana because it only reinforces the assumptions that abortion (whether safe or unsafe, legal or illegal) is a logical outcome of ending unintended or unwanted pregnancies which is a serious public health concern. The difficulty in conducting abortion studies due to the rather personal, and sensitive nature of abortions further goes on to limit health practitioners' understanding of the dynamic contextual issues surrounding termination of pregnancies, and contraceptive use among post-abortion women.

In view of the paucity of research in interrogating the linkage between male partners' involvement in abortion and post-abortion family planning uptake[1], and drawing on a variety of methodological approaches, this study sought to fill the research gap on men's involvement in abortion and post-abortion family planning uptake. It is hoped that the research focus and methodological approach utilised in the current study will provide detailed exploratory insights on the contextual circumstances surrounding male partners' involvement in women's abortion. Also, this study contributes to unravelling the progress achieved so far with the provision and delivery of legal comprehensive abortion services in the Greater Accra Region of Ghana.

[1] Post-abortion family planning is used interchangeably with post-abortion contraception. Uptake is used in this context to mean 'use'.

In the light of the foregoing issues discussed, this study sought to answer the following research questions:

i. What are the sexual, and reproductive behaviours and partnership characteristics of women seeking abortion?
ii. What is the extent of male partners' involvement in abortions and post-abortion family planning uptake?
iii. Do female partners have any expectations about their partners' roles in the pregnancy resolution process?
iv. What factors limit male partners' involvement in abortions and post-abortion contraception use?
v. Does male partner participation in abortion influence post-abortion family planning use?

1.3 Research Objectives

The main objective of this study is to examine male partners' involvement in abortion and post-abortion family planning uptake as a way of reducing unintended pregnancies and the incidence of induced abortions. Specifically, the study seeks to:

i. Describe women's sexual, reproductive and partnership characteristics.
ii. Explore the extent and nature of male partners' involvement in their female partners' abortion experiences, and post-abortion family planning uptake.
iii. Examine women's perspectives of male role expectations in pregnancy termination.
iv. Identify and explain barriers to male partners' participation in pregnancy termination, and post-abortion family planning uptake.
v. Investigate the relationship between partners' involvement in abortion and post-abortion contraceptive method choice and use.

1.4 Rationale of the study

This study is important and timely because of its implications for programming and policy decisions in safe abortion care services delivery in particular, and sexual and reproductive health care in general.

Reducing maternal mortality through the provision of safe and comprehensive abortion care has become a public health issue of global importance and concern. It is in line with this reasoning that the Ghana Health Service (GHS), in collaboration with a consortium of non-governmental organisations, implemented guidelines for Comprehensive Abortion Care (CAC) in 2006. Included in the CAC model is the provision of post-abortion counselling and family planning services as a means to prevent future unplanned pregnancies and future abortions. A research of this nature is, therefore, relevant in shedding more light on how effective post-abortion family planning services are being provided and organised in health facilities providing safe abortion care. Study outcomes are informative in guiding abortion service providers to be innovative (where necessary) in the delivery of abortion-related services; design specific interventions to target male partners, and provide evidence-based information to assist in monitoring and evaluating CAC services in facilities where such services are being offered.

The incidence of abortion and associated morbidity and mortality is considered to be highest among women aged 20-24 years (Baird, Billings and Demuyakor, 2000). The proportion of women in Ghana who have had an induced abortion has increased over the decade. For instance, the 2007 Ghana Maternal and Health Survey (GMHS) reports that 15% of women have had an induced abortion in their lifetime. This percentage increased to 20% in the 2017 GMHS report. These estimates provide evidence that abortion is still a critical public health issue which requires public health interventions. Since post-abortion family planning counselling and services are integrated in CAC, a research of this nature would assist in offering

critical and useful recommendations to develop friendly services to target men's participation in PAFP counselling. Health providers would also be informed on how to integrate couple-oriented family planning services into post-abortion care.

This study further contributes to research and knowledge within the field of reproductive health in many respects because the findings will supplement the limited existing research in fertility studies especially in respect of male involvement in abortion and post-abortion contraception; thereby filling the research gaps on such issues. Although a large body of research on men's involvement in, and experiences of abortion provides useful results, abortion research in Ghana has not sufficiently interrogated male partners' involvement and support in women's abortion decisions and experiences; neither has the male-female dyadic dimensions involving relationship quality, gender and power differentials, and contraception use after abortions been fully explored.

The relationship between male partners' participation in abortion and uptake of contraception after abortion appears to be complicated because several factors (for instance, pregnancy unwantedness by the male partner, perceived barriers to contraceptive use, attitudes towards family planning or contraception) might mediate this relationship. Yet, this aspect of reproductive decision-making has received limited rigorous attention in Ghana and therefore, this study helps fill the research gap in this area of fertility research (specifically, abortion) and therefore, the study is not only timely, but important based on these contributions it is positioned to make.

1.5 Organisation of the study

The study is organised into nine chapters: Chapter one presents the background to the study, problem statement, research questions and objectives, and rationale of the study. In chapter two, a review of relevant literature focussing on the evolution and definition of male

involvement, men's role in reproduction, maternal and child health, impact of male involvement in abortions and post-abortion contraception use, predictors of post-abortion contraception use, and barriers to male participation in reproductive matters including abortion are presented. Also included in this chapter is the theoretical and conceptual framework of the study. The theoretical framework provides relevant theories underpinning the study, whilst the conceptual framework shows the interrelationships between the variables in the study and how they influence the outcome variable (post-abortion contraception uptake).

Chapter three provides an overview of the methodological approaches employed in the collection of primary data for the study. A detailed description of the data collection process, involving both quantitative and qualitative strategies has been presented in chronological order. Chapter four outlines the results of the study by presenting the socio-demographic characteristics of all study participants. In Chapter five, the sexual, reproductive behaviour and partnership profile of the study population is presented. Chapter six contains female partners' narrative accounts of their male partners' participation in abortion and post-abortion contraception uptake. The main thematic areas which emerged during the thematic analysis together with sub-themes and sample quotes have all been presented. Additionally, barriers influencing partner participation in seeking abortion-related care are also presented in this chapter.

Women's expectations of their partners' roles during the pregnancy termination is examined in the seventh chapter. The eighth chapter outlines results from the bivariate and multivariate analyses in the study. Bivariate tests of association with the Chi-square tests and binary logistic regression analysis to determine the relationship between male partner involvement in abortion and PAFP uptake are presented. Chapter nine is the last chapter in this thesis and it outlines a summary of the key findings of the study, conclusion and recommendations.

CHAPTER TWO

REVIEW OF RELEVANT LITERATURE

2.1 Introduction

Globally, issues on maternal, sexual and reproductive health, particularly safe and unsafe abortions, have gained priority attention in many health systems because of their implications for public health interventions. The literature reviewed in this chapter focuses on the evolution and definition of the concept of male involvement, men's role in maternal health, reproduction and family planning, the impact of male involvement in induced abortions, predictors or determinants of post-abortion contraception use, and barriers to male participation in reproduction and abortion.

The legal context of safe abortion in Ghana's health care system is also presented to provide a legal framework for the delivery of abortion care services in Ghana. In addition, the theories and models underpinning this study are outlined with explanations for their suitability and applicability. Based on the literature review, the conceptual framework for the study is also presented.

2.2 Evolution and definition of male involvement

Prior to the ICPD, fertility programmes aimed at reducing population growth in developing countries (including sub-Saharan Africa) targeted women and neglected men's involvement in reproductive matters due to the recognition that men opposed 'artificial' or non-traditional fertility regulation methods. These programmes also failed to address issues on gender inequities in reproduction and women's status (Kritz and Gurak, 1989). While little progress was achieved with the traditional woman-focused approach, concerns arose as to how the "unfinished transition" could be attained (Population Council, 1996).

A number of approaches were used to implement male involvement in reproductive health post-ICPD. "Men as clients" approach was first implemented with emphasis on the provision of reproductive health services to men in the same way that women received these benefits (Ndong et al., 1999). This approach, however, reflected a limited interpretation of male involvement as it advocated a remedial focus on men who have been excluded from traditional reproductive health programmes. The second approach viewed "men as partners" to reflect men's position in women's reproductive health and contraceptive use as either promoters or inhibitors (Cates, 1996). Under this approach, men were considered as allies to improve contraceptive prevalence rates and other dimensions of reproductive health (Kuseka and Silberman, 1990). However, similar to the focus on men as clients, this approach did not address the gender inequities that constrain health (Greene et al., 2006).

The third approach emphasized "men as agents of positive change". This approach reflects the intent and goals of the ICPD where men are regarded as key actors and players in women's sexual and reproductive health. This strategy acknowledges the fundamental role men play in supporting women's reproductive health and in transforming the social roles that constrain reproductive health and rights. Additionally, with men seen as agents of positive change, this approach implicitly reinforces gender equity and service provision rather than specifying which reproductive health services should be provided.

Following the implementation of the male involvement approaches, different terms were used to describe men's involvement in reproductive health such as men's participation, men's responsibility, male motivation, male involvement, men as partners, and men and reproductive health (Helzner, 1996b; Verme et al., 1996; Danforth and Jezowski, 1997; Finger et al., 1998). A number of researchers have noted that there is no consensus on which term best describes this perspective on men, what these terms mean, and how men can best be involved

in reproductive health activities (Danforth et al., 1994; Verme et al., 1996; Danforth and Roberts, 1997).

The definition of male involvement is considered as an ambiguous term; lacking a universal and operational definition (Helzner, 1996; Greene et al., 2006 Aluisio et al., 2011). Although male involvement has been widely used in fertility research, there is no generally accepted understanding of the meaning of male involvement because "it hides a variety of meanings and philosophies" (Helzner, 1996). In the absence of a general meaning of what male participation constitutes, the term is used interchangeably with male support. Some researchers have suggested that the concept of male involvement is broad and encompasses several elements (Khalifa, 1988; Adamchak and Mbizvo, 1991).

Other researchers have proposed a definition of male involvement to mean: men's reproductive health and contraceptive/family planning knowledge; attitudes towards contraceptive use; spousal communication on family planning; choices or preference for contraceptive methods, and emotional and behavioural involvement in a woman's contraceptive use (Clark, Yount and Rochat, 2008). In their study of male involvement in women and children's HIV prevention, the authors measured male involvement in two ways: men's physical presence in the antenatal clinic, and women's self-report of men's previous HIV testing. Essentially, regardless of the ambiguity surrounding the concept of male involvement, its purpose is to describe a complex process of social and behavioural change that is needed for men to play more responsible roles in reproductive health. "Men's participation can be seen as a means to an end, rather than as a goal in itself" (Greene et al., 2006).

2.3 Men's role in reproduction, maternal health and family planning

Literature on men and reproduction in Africa, including sub-Saharan Africa (SSA) consistently show that men play significant roles in women's reproductive decisions, such as childbearing,

determination of family size, number of children ever born, use of maternal and antenatal health care services, and family planning (Bankole, 1995; Dodoo, 1993, 1995, 1998; Ezeh, 1993; Mbizvo and Adamchak, 1991; Brunson, 2010; Kwambai et al., 2013; Nyondo et al., 2015; Ganle et al., 2016; Wigginton et al., 2018). There is substantial evidence that involving men in women's reproductive issues is beneficial and results in positive health outcomes for both mothers and children. For instance, a meta-analysis on male involvement and maternal health outcomes conducted by Yargawa and Leonardi-Bee (2015) showed that male involvement during pregnancy and at postpartum resulted in greater benefits for women by reducing postpartum depression and improved utilisation of maternal health services.

Furthermore, in Malawi and Uganda, men's inclusion in maternal health services is seen as a strategy for accessing quick service for women during antenatal visits, labour and delivery (Kululanga et al., 2011; Byamugisha et al., 2010). Pal (2000) found that when Indian men were involved in their partners' pregnancy, they were more likely to have their deliveries in health facilities or in the presence of skilled health professionals compared to women whose husbands were not involved. Other studies conducted elsewhere similarly report positive benefits of male involvement in maternal health which include: increased maternal access to antenatal and postnatal services (Redshaw and Henderson, 2013); discouragement of unhealthy maternal practices such as smoking (Martin et al., 2007); improved maternal mental health (Stapleton et al., 2012; Plantin and Olukoya, 2011); increased likelihood of contraception usage (Mekonnen and Worku, 2011; Yue, O'Donnell and Sparks, 2010) and allayment of stress, pain and anxiety during delivery (D'Aliesio et al., 2009).

While there is substantial evidence that demonstrates the significant benefits of men's involvement in maternal and reproductive issues, contrary studies have found the negative impact of male involvement in maternal health. For example, Ganle et al. (2016) explored the perspectives of childbearing women on their partner's involvement in maternal and childcare

in Northern Ghana. Their results showed that majority of the women had negative attitudes and opinions of their men's involvement. Brunson's (2010) research conducted in Nepal showed that men's roles in their women's pregnancy resulted in delays in transfer of pregnant women from home to health facilities during obstetric emergencies.

While evidence from several anthropological and demographic studies maintain that couple decision-making on reproduction issues differs under strong patriarchal conditions (Beckman, 1983; Oppong, 1987; Blumberg, 1988), men are still dominant decision makers in fertility issues (Fayorsey, 1989; Mbizvo and Adamchak, 1999; Dodoo and Frost, 2008). However, these studies also point out that sexual and fertility decision-making involves couple negotiations with each partner having different fertility goals (Dodoo and Seal, 1994; Thomson and Hoem, 1998). According to some researchers, more responsibility rests on women when it is related to abortion than on determination of family size (Kabagenyi et al., 2014).

2.4 Male involvement in abortion

The disclosure of an unintended or unplanned pregnancy may most likely predict male participation, support, or non-involvement in the pregnancy resolution. Disclosure of the pregnancy may, however, vary according to multiple issues surrounding the dyadic relationship, social and cultural norms, and contextual issues. The duration and quality of the relationship, commitment to the relationship, and presence of intimate partner violence may affect pregnancy disclosure and subsequent male participation in the abortion (Jones, Moore and Frohwirth, 2011).

In some societies, the decision to have an abortion depends on the nature of relationship between the couple or partners other than on social and cultural norms. For instance, Gursoy (1996) asserts that in some countries (like Turkey), women need their husband's permission to have an abortion. However, in other contexts, a man might encourage his female partner to

terminate a pregnancy because social sanctions might apply to them for having a child out of wedlock (Rausch and Lyaruu, 2005). This suggests that the social context is crucial in regulating and defining how male partners are involved in pregnancy termination, and their respective roles in reproductive decision-making which is tied to the nature of the male-female dyadic relationship. Further, the directness of the male partners' involvement is determined by the nature of the relationship between the man and the woman and socio-cultural contexts, whilst indirect involvement depends on social norms (Dudgeon and Inhorn, 2004).

A review of earlier and current literature on male involvement shows that men play direct and indirect roles in women's abortion. They also have limited, or sometimes no participation in women's abortion experiences. In the absence of a common understanding of 'male involvement', several empirical studies conducted in different contexts demonstrate the different forms by which men are involved in women's abortion experiences (Leshabari et al., 1994; Johansson et al., 1998; Abdel-Tawab et al., 1999; Kalyanwala et al., 2010; Tong et al., 2012; Altshuler et al., 2016; Freeman, Coast and Murray, 2017; Nguyen et al., 2018). Overall, the body of literature on male involvement suggests that it is characterised by instrumental, informational, emotional and behavioural support.

Previous research has investigated male partner accompaniment at the health facility at the time of an elective abortion. A study conducted by Shostak, Mclouth and Seng (1994) indicates that 50 percent of women receiving abortion in 30 U.S. clinics were accompanied by their male partners. Another study showed that minors having abortions in 46 health facilities were accompanied by their boyfriends (Henshaw and Kost, 1992). Studies conducted by Major et al. (1985), Cozzarelli et al. (1994) and others by Kalyanwala et al. (2010, 2012) conclude that men's accompaniment to the hospital for their partners' abortion is an indicator of male involvement during abortion care and a source of social support.

Major et al. (1985) and Cozzarelli et al. (1994) further investigated whether male partners' accompaniment to the hospital/clinic was associated with women's emotional distress after an abortion. Both studies, however, found no significant association between accompaniment and improvement in women's psychological distress after the abortion. Women who were not accompanied reported similar levels of distress compared to women accompanied by their partners. In a similar study, Kalyanwala et al. (2012) examined the significance of male partners' accompaniment to the facility for a pregnancy termination. They concluded that men who accompanied their female partner to the health facility served as a source of emotional support to them. They also found that the man responsible for the pregnancy was more likely to be present at the hospital with their female partner for an abortion than the woman's relatives.

Aside the physical presence of men at a health facility, evidence from other studies indicate that men are supportive and participate in the abortion decision-making process (Johansson et al., 1998; Kero et al., 1999; Puri et al., 2007; Jones, Moore and Frohwirth, 2011; Costescu and Lamont, 2013). For instance, Kero, Lalos and Wulff (2010) reported in their study that the majority of male partners supported and participated in the decision to have an abortion. Some studies have also found that male partners navigate the abortion-seeking process by collecting information on places where abortion care services are offered, provide transportation, and financial resources (Leshabari et al., 1994; Tong et al., 2012). Norris et al. (2011) concluded in their study that men contributed in the abortion-seeking process by alleviating cultural and social stigma's surrounding the receipt of abortion care. Similarly, women attending a U.S. clinic for pre-abortion counselling reported that they received support from their male partners during the abortion decision-making process and this support contributed to a positive experience (Becker et al., 2008).

Another body of abortion-related studies suggests that male partners responsible for an abortion bear the financial expenses of the abortion after the abortion decision is made (Calves, 2002; Henry and Faryosey, 2002; Nguyen et al., 2018). For instance, in Calves' (2002) study using biographical data obtained from Cameroonian adolescents undergoing an abortion, it was found that male partners' involvement in the abortion was mainly financial support. More than 60 percent of the young women reported that their partners paid the fee for the abortion. Similar findings were reported by Henry and Fayorsey (2002). They found that the boyfriends of young adolescent girls usually supplied some funds for the pregnancy termination, especially when both of them participated jointly in the abortion decision-making process. Nguyen et al. (2018) also conducted interviews with men whose female partners were seeking abortions from two clinics. Their results showed that male partners provided instrumental support, mainly transportation and financial, and emotional support (through companionship and reassurance) during the abortion process.

There is a paucity of research that investigates emotional support by male partners at the time of an abortion. The few studies conducted do not establish whether the presence of the male partner and receipt of emotional support reduce anxiety levels among their partners receiving an abortion (Viega et al., 2011).

2.5 Impact of male involvement in abortions

A body of research indicates that male involvement in abortion decision is associated with positive and negative outcomes. Male support in abortion results in improved psychosocial well-being (Adler et al., 1990; Major et al., 1997) as well as "confidence in pregnancy decision-making" (Foster et al., 2012). Other studies report that male partners' participation in the abortion was mainly financial (Major, 1992; Calves, 2002; Henry and Fayorsey, 2002). Some studies have also suggested that male partners can positively influence women's use of female

contraceptive methods through consensus and effective dialogue (Blanchi-Demicheli et al., 2003). Abdel-Tawab et al. (1999) found that husbands' emotional support during the abortion was positively associated with their wives' emotional recovery. Furthermore, there is evidence that the inclusion of male partners in family planning education and services increases utilisation of family planning methods in several contexts (Piotrow et al., 1992; Terefe and Larson, 1993; Becker, 1996; Soliman, 1999). Positive consequences that result from men's involvement in family planning extends to continuous use of family planning methods by improving spousal communication and reduced male opposition (Bawah, 2002; Sternberg and Hubley, 2004; Hartman et al., 2012).

Conversely, poor partner support during abortion decision-making is associated with poor long-term emotional outcomes for women (Kimport, Foster and Weitz, 2011) and likelihood for repeated abortions (Beenhakker et al., 2004). Reich and Brindis (2006) have argued that whilst little partner support during the abortion decision making can reinforce a woman's self-autonomy, but it can at the same time place additional emotional or psychological burden on her.

2.6 Predictors of Post-abortion Contraceptive use

The WHO (2003) handbook on safe abortion, technical and policy guidance recommends that women undergoing an elective abortion should be offered non-judgmental counselling about contraceptives as part of post-abortion care (PAC). Women should also be offered a range of contraceptive options to choose from, expressed in a language which is comprehensible to them. Post-abortion contraception is an essential component of comprehensive abortion care (CAC) and PAC (WHO, 2012). Post-abortion contraception involves the provision of comprehensive contraceptive counselling and services immediately at the time of, and after an

induced abortion. Also, it takes into account women's health needs, personal circumstances and ability to obtain services (Hyman and Kumar, 2004).

Evidence from several abortion-related studies suggest that factors other than male partners' involvement influence post-abortion contraception use. For example, Banerjee et al. (2015), in their study found that post-abortion contraception uptake and acceptance by women were not associated with the male partners' involvement in abortion. Rather, reasons for post-abortion family planning adoption and acceptance depended on woman's age, type of health facility, gestational age of the pregnancy, abortion method, and post-training mentoring support by trained doctors. Keene et al.'s (2015) retrospective study that investigated the effect of previous induced abortions on post-abortion contraception selection also showed that women with a history of abortion, and women having living children were more likely to use highly effective contraceptive methods after the abortion. Other studies have reported that facility level factors, socio-cultural and individual factors impact on post-abortion contraceptive use (Wang et al., 2016). The availability of on-site family planning supplies, adequate infrastructure, well-trained and committed staff influence women's initiation and acceptance of contraception.

However, there are a number of studies which provide evidence to demonstrate that male partners influence post-abortion contraceptive use. Esber et al. (2014) examined the effect of male partners' approval of post- abortion contraceptive use among women in Tanzania. Their results from a survey showed a strong association between partner approval of contraceptive use and intention to use post- abortion contraception. Another study conducted in Egypt to examine the effect of husband's involvement in post-abortion recovery and use of contraception found that husband support for family planning predicted contraceptive use or intention to use contraception (Abdel-Tawab et al., 1999). Kero and Lalos (2005) also provide empirical evidence on the impact of male partner involvement in post-abortion contraception

use. They found that when male partners were involved in post-abortion counselling, their women continued to use contraception after one year.

2.7 Barriers to male participation in sexual and reproduction issues

Substantial scholarly work specifically in sub-Saharan Africa, on fertility and reproductive health issues largely demonstrate that while male involvement in family planning programmes and other reproductive health issues can significantly increase women's contraceptive use and reduce unmet contraceptive need, there are still prevailing barriers which discourage male participation in reproductive health matters.

The extant literature is conclusive on multiple factors which directly and indirectly impede men's full (and somewhat partial) participation in family planning use. These identified factors range from predominantly intrapersonal level factors, to interpersonal, socio-cultural or community-level characteristics, organisational and policy level variables. Interpersonal factors mainly relate to partners' attitude and behaviour which may inhibit contraceptive use. For example, some studies have found that men's disapproval of contraceptive use and lack of participation in family planning account for low contraceptive prevalence (Dudgeon and Inhorn, 2004; Tubro et al., 2009; Yue, O'Donnel and Sparks, 2010).

Other studies have found that women's secret and latent use of family planning was due to their male partners' resistance to birth control methods (Bankole and Singh, 1998; Miller, Severy and Pasta, 2004). Kabagenyi et al. (2014) and Adanikin, McGrath and Padmadas (2017) found in their studies that men expressed fears that their female partners' use of contraception would encourage extramarital affairs, hence their lack of participation in fertility control methods. In addition, fear of spousal retaliation arising from a lack of consensus has been shown to impede women's use of family planning (Biddlecom and Fapohunda, 1998).

In most patriarchal settings such as in sub-Saharan Africa, Asia and Latin America, socio-cultural norms, beliefs and practices prevent fertility control mechanisms intended to regulate family size as high fertility is encouraged. Early and contemporary studies which have examined male non-involvement in contraception uptake indicate that traditional male role preference for large family size for security purposes presents a strong resistance for contraception adoption (Ezeh, 1993; Bankole and Singh, 1998). Further, gendered norms and relationship power dynamics prescribe reproduction and contraception to be the domain of men with women having limited participation (Wambui, Ek and Alehagen, 2009; Kabagenyi et al., 2014).

2.8 Legal context of Induced abortion in Ghana

Before the amendment of the law permitting legal abortion in Ghana in 1985, it was a criminal offence for women to have an abortion either by themselves or by other individuals, including health providers. Abortion was a criminal offence regulated by Act 29, Section 58 of the Criminal code of 1960, amended by PNDCL 102 of 1985.

The conditions or circumstances under which abortion was illegal prior to the amendment of the law was: (i) any woman with the intention to terminate a pregnancy or consents for an abortion to be done by someone else through the ingestion of any chemical substance or through surgical means; (ii) when an individual induces or attempts, or consents to cause abortion, or conspires to terminate a consenting woman's pregnancy surgically or through the administration of a chemical substance; (iii) when an individual purchases chemicals or surgical equipment with the intention to terminate a pregnancy, or aids or abets a woman to terminate a pregnancy. Under these circumstances, an individual or a woman was guilty with an imprisonment term of not more than five years.

However, abortion is legal and permissible in the cases of rape, incest or defilement, health risk to the woman or the unborn child (whether psychological, or physical), and if the pregnancy is terminated by a registered health facility approved under the Private Hospital and Maternity Home Act, 1958 (No. 9).

2.9 The Context of Safe Abortion or Comprehensive Abortion Care (CAC) in Ghana

The 1997 Reproductive Health Policy which was implemented by the Ministry of Health made provisions for the management of unsafe abortions and post-abortion care (PAC), but not safe induced abortions. In 2003, this policy was revised in response to the high mortality rates due to unsafe abortions, and also to address gender based violence and sexual health issues. The current 2003 National Reproductive Health Policy from the Ministry of Health was amended to address the high maternal mortality rates for which provisions were not made in the 1997 Reproductive Health Policy. The Ghana Health Service developed a strategic plan to reduce the high levels of unsafe abortion by adopting the following strategies:

a. Dissemination of the law on abortion to health workers, the general public and health partners
b. Training of health professionals (specifically, doctors and midwives) on performance of safe abortion and PAC
c. Nationwide research on abortion
d. Development of appropriate information, education, and communication materials and
e. Promotion of family planning (FP)

The policy also includes a section on the guidelines for the provision of CAC within the limits of the law (GHS, 2005).

In line with efforts to ensure the full implementation of this policy, the Ministry of Health in collaboration with a consortium of six international health organizations and partners

launched the programme 'Reducing Maternal Mortality and Morbidity' (R3M) in September, 2006. The core objective of the programme was to reduce morbidity and mortality due to unsafe abortion and increase access to CAC, and to widen access to FP services in order to minimize unwanted pregnancies that result in abortions (Aboagye et al., 2007).

Since then, CAC services were integrated into Ghana's reproductive health policy. From that time, it became one of the five components of the key objective "reduce maternal morbidity and mortality" of the 2007-2011 Ghana Reproductive Health Strategic Plan (Ghana Statistical Service (GSS), Ghana Health Service (GHS) and Macro International, 2009). In line with this policy, new standards and protocols for safe abortion services that include direction for interpreting Ghana's abortion law were released. These standards were developed in collaboration with IPAS, WHO, and other stakeholders (Aboagye et al., 2007).

The R3M programme was initiated in three regions: Greater Accra, Ashanti and Eastern. A total of seven districts were chosen in each region. One of the main objectives was targeted at health care providers by providing training in abortion techniques and contraceptive services. The consortium also provides technical advice, and assistance to health facilities, as well as provision of products and equipment to communities. Health providers are sensitized on abortion-related services (Sundaram et al., 2014).

An evaluation of the R3M programme was conducted in the pilot regions with the aim of examining the programme's impact on the provision of safe abortion services and PAC. Primary data for the programme assessment were obtained using a quasi-experimental design. The sample comprised of a treatment group (districts/regions where R3M intervention had been implemented) and two control groups (districts in Greater Accra Region, Ashanti and Eastern); and districts from Brong-Ahafo. Analysis was conducted using propensity score weighting.

The results showed that health care providers in the treatment groups were six times likely to provide safe abortion compared to the control groups (Sundaram et al., 2014).

However, in many cases few researchers suggest that the law still tends to be interpreted as prohibiting abortion, and availability of abortion is limited in the public sector. A recent survey of health care facilities in ten districts found that less than one in every seven public health facilities reported offering legal abortion services; only 21 percent of providers knew all the legal indications for abortion; 23 percent of providers incorrectly reported that the abortion law requires written consent from the woman's partner; and around half of providers reported having concerns about providing abortion services because of their religious beliefs (Aboagye et al., 2007).

2.9.1 Incidence of abortion in Ghana

According to the 2007 Ghana Maternal Health Survey (GMHS), seven percent of all pregnancies end in abortion and about 15 abortions are performed for every 1,000 women of reproductive age (15-44) annually. (GSS, GHS and Macro International, 2007). In a study conducted by Ahiadeke (2001) in southern Ghana, 17 abortions were observed for every 1,000 women of reproductive age. Comparing Ghana's abortion rates to Western Africa, it is apparently clear that the level of abortion in Ghana is lower than in Western Africa as a whole, where the rate stands at 28 procedures per 1,000 women (WHO, 2007).

While it is noteworthy to state that the incidence of induced abortion and corresponding estimates may be compromised by underreporting, the evidence is lucid that 37 percent of births in the country are unplanned; 23 percent is mistimed and 14 percent is unwanted (GSS, GHS and ICF Macro, 2009). By implication, this stands to imply that more than 300,000 infants are born as a result of unintended pregnancies each year.

2.9.2 Characteristics of women having an Induced abortion in Ghana

Studies have found that several social and demographic variables such as age, educational attainment, socio-economic status, religious affiliation, employment status, and number of living children are important in influencing decisions on abortion (Ahiadeke, 2001; Bankole, Singh and Haas, 1999; Jones, Finer and Singh, 2010; Tong et al., 2015).

Previous scholarly work conducted by Ahiadeke (2001) to investigate the incidence of induced abortion in Southern Ghana showed that most Ghanaian women living in urbanized areas, working outside their homes, self-employed, and were in their 20s were more likely to have an abortion compared to unemployed women and women in rural areas. He also found that women undergoing abortions had already a previous abortion, were unmarried, had some secondary or higher education and were Christians. Similar results were also found in a recent study by Adjei et al. (2015) using the Kintampo Health and Demographic Surveillance System, among a representative sample of females aged 15-49. Compared to 20-29 year-old women, women aged 13-19 years were more likely to have an abortion. Wealthier women were three times more likely to receive an abortion than poor women.

2.10 Summary of reviewed studies and identified gaps

The reviewed literature in this chapter shows that research on the 'male role' in reproduction has been extensive and spanned across several decades. Most of the studies reviewed for this study are context-specific, mostly in sub-Saharan African countries. The majority of these studies utilised secondary data while a few focused on qualitative approaches. The results from these studies demonstrate that in most patrilineal contexts, the male figurehead is the primary decision-maker in reproductive and sexually-related health matters. The male partner controls the reproductive rights of his female partner by virtue of marriage and bride wealth payments. Thus, women have limited decision-making power in the reproductive dyad.

The importance of the male partner in fertility issues is significant for improving maternal and child health outcomes, and even men's sexual health. The literature on male participation in women's abortion experiences suggest that men play direct and indirect roles. Mixed results have been reported in studies which investigated men's involvement in abortion and family planning. Whilst existing evidence in some contexts show that men provide supportive roles during pregnancy termination, women are viewed as having primary responsibility in abortion.

Despite the scholarly work on the male role in fertility matters, a few fundamental research gaps are worth noting. First, few studies have employed qualitative methodologies to understand male involvement in abortion while majority focus on quantitative survey data. Apart from few recent studies employing mixed methods in studying male partners' participation in abortion, this methodological gap limits a comprehensive exploration on the diverse ways by which men are involved in women's abortion experiences.

Second, data is, however, limited for examining how the constructs of the Health Belief Model (HBM) and Theory of Planned Behaviour (TPB) explain the relationship between male partners' participation in abortion and post-abortion family planning uptake. Third, the reviewed studies show that the link between male partners' in abortion and post-abortion family planning use is under-researched. These are the research gaps that this study sought to fill.

2.11 Theoretical framework

Considering the extensive fertility research conducted in several contexts, different theoretical models have been posited to explain and predict individual's behaviour specifically, in adopting healthy promotive behaviours.

2.11.1 Theory of Planned Behaviour

The Theory of Planned Behaviour (TPB) was developed by Icek Ajzen as an attempt to predict human behaviour (Ajzen, 1991). The planned behaviour theory consists of four constructs which provide explanation of the likelihood of engaging in or performing a specific behaviour or not. These constructs are; attitude toward the behaviour, subjective norm, perceived behavioural control and behavioural intention.

The first construct is behavioural intention, which consists of motivational factors that influence behaviour (Ajzen, 1991). The stronger the intention to engage in a given behaviour, the more likely that the behaviour will be performed. The second construct is attitude towards the behaviour which is the extent to which a person has a favourable or unfavourable appraisal of a specific behaviour. Attitude consists of behavioural beliefs and outcome evaluations. Subjective norm is the third construct and it involves social pressure to perform or not to perform a particular behaviour. A combination of normative beliefs and motivation to comply constitute subjective norm. Perceived behavioural control which is the fourth construct also plays a key role in the TPB and it refers to individuals' perception of the ease or difficulty of performing specific behaviours.

2.11.2 Health Belief Model (HBM)

The health belief model (HBM) was developed by Rosenstock (1966) and it specifies that individual perceptions of four variables, namely; susceptibility, severity, benefits, and barriers predict and explain behaviour. The model argues that if individuals perceive a negative health outcome to be severe; perceive themselves to be susceptible to it, perceive the benefits to those behaviours that reduce the likelihood of that outcome to be high, and perceive the barriers to adopting those behaviours to be low, then performance of the specific behaviour is likely for those individuals (Carpenter, 2010).

The model's ability to explain and predict a variety of behaviours (including health behaviours) associated with positive health outcomes (for example, contraceptive use) has been replicated severally (Janz and Becker, 1984; Brown, Ottney and Nguyen, 2011; Yue et al., 2015). However, variations have been found to exist in the ability of each individual component or variable of the model to predict health behaviour (Harrison, Mullen and Green, 1992). For instance, Carpenter (2010) did a meta-analysis of 18 studies and found that perceived benefits and barriers were consistently the strongest predictors out of the four variables.

Besides the four variables proposed in the original model by Rosenstock, two other variables, cues to action and self-efficacy, were later added to expand and provide further explanations to the model. However, some studies have reportedly found these variables to be underdeveloped and rarely measured or researched (Janz and Becker, 1984; Rosenstock, 1974; Zimmerman and Vernberg, 1994).

The HBM states that individuals will be more motivated to act in healthy ways if they believe they are susceptible to a particular negative health outcome (Rosenstock, 1996). Second, the model predicts that the stronger individual's perceive the severity of a negative health outcome, the more they will be motivated to engage in positive behaviours in order to avoid that outcome. Rosenstock argues that if the undesirable health outcome will not have a large impact on an individual's life, the individual will not be motivated to act to avoid it. The susceptibility and severity variables thus, deal with perception of a negative health outcome.

The third and fourth constructs, benefits and barriers are concerned with the perception of engaging in specific behaviours that are likely to reduce or prevent negative health outcomes. A person must perceive that a specific behaviour will provide strong positive benefits that will prevent the negative health outcome. Finally, the model posits that a person's perception of strong barriers to the adoption of preventative behaviour will result in non-performance of the

behaviour. Cues to action involve the situation where individuals are spurred to adopt a preventive behaviour by some additional or external element or cues. Self-efficacy was proposed for inclusion in the model to account for the overall motivation to pursue healthy behaviour (Becker, 1974; Rosenstock, Strecher and Becker, 1988).

2.11.3 Male role theory

Decades of scholarly work largely in sub-Saharan Africa have shown that in patriarchal societies, men are dominant decision-makers in the sexual and reproductive matters of their wives by virtue of cultural norms, traditional gender roles and power, and bride wealth payments (Ezeh, 1993; Bankole, 1995; Mbizvo and Adamchak, 1995; Dodoo and Tempenis, 2002). Quite apart from sub-Saharan Africa, there is substantial evidence from other patriarchal contexts (such as Asia and North-America) which buttresses male authority and influence in maternal and reproductive health decisions of women, largely a consequence of social structures and gender power dynamics (Brunson, 2010; Thapa and Niehof, 2013). Men, therefore, have full control and authority over their female partners' reproductive decisions and choices including contraceptive use.

2.11.4 Applicability of theories

Ajzen's (1991) theory of planned behaviour has been verified for its efficiency in explaining and predicting health behavior (Godin and Kok, 1995; Albarracin et al., 2001). Godin and Kok (1995) found that the TPB explains behaviour intention significantly. Attitude toward the action and perceived behavioural control were most often the significant variables which explained variation in intention. Intention remained the most important predictor, but perceived behavioural control contributed to the prediction. Albarracin et al. (2001) also performed a meta-analysis to determine how well the Ajzen's (1991) theory predicted and explained contraceptive use (for example, condom use). They found that consistent with the theory,

perceived behavioural control was related to contraceptive use intentions. However, it did not contribute significantly to contraceptive use.

The male role theory, HBM and TPB theories offer logical explanations and applicability for this study, as well as the possible associations or relationships between the explanatory variable (male partners' involvement in abortion) and outcome variable (PAFP uptake or non-uptake). In applying these theories to this study, substantial evidence indicates that women's socio-demographic and reproductive characteristics influence contraceptive initiation and post-abortion contraceptive uptake (Bankole, Singh and Haas, 1999; Rose et al., 2012; Keene et al., 2015). For instance, some studies have shown that factors that significantly correlate with post-abortion contraception uptake include marital status (unmarried versus married), residential dwelling (rural versus urban), educational status, and employment status (Keene et al., 2015). Other factors that are likely to influence post-abortion contraceptive use relate to previous contraceptive use, previous history of abortion, and knowledge of contraception (Keene et al., 2015).

The constructs in Ajzen's planned behaviour theory also provide explanations for women's likelihood of using contraception after an abortion. For instance, post-abortion women with positive attitudes towards using family planning (FP) or contraception to avoid future unintended pregnancies and abortions may be more willing to initiate contraception immediately after an abortion compared to women with negative attitudes about FP. Also, women who perceive a relative ease in adopting a contraceptive method after having an abortion to prevent repeat unintended pregnancies are more likely to uptake post-abortion family planning than women who perceive strong difficulties in using contraception. The perception of difficulty in FP initiation and use may stem from their male partners' characteristics, lack of self-confidence, negative beliefs about contraceptive use, and socio-cultural factors such as myths, misperceptions, and norms.

The HBM lists six perceptual constructs to explain and predict the probability of engaging in positive health behaviours to prevent negative health outcomes. Of these variables, which relate to this study variables, the perception of serious negative health outcomes after an induced abortion, and significant benefits associated with using contraception to reduce future unintended pregnancies and abortions are likely to result in contraception use after abortion. Furthermore, there is a higher likelihood of post-abortion contraception uptake among women who have a high self-efficacy, and who are autonomous in making reproductive decisions compared to women with a lower self-efficacy and who depend on their partners for contraceptive decision-making.

Conversely, the perception of side-effects and negative health outcomes associated with contraceptive use might prevent and serve as barriers to PAFP uptake among women. The 'male involvement factor' has potential to influence use or non-use of post-abortion contraception especially when male partners play important roles in contraceptive decision-making, decision-making surrounding the abortion, desire to limit fertility and unintended pregnancies. Male partners who are knowledgeable about contraceptives are also more likely to offer support for continued use of post-abortion contraception for their women than those who are opposed to contraceptive use. Additionally, male partners who are ultimately responsible for bearing the financial costs of health care of their partners may be motivated to encourage their female partners to adopt protective measures to prevent future abortions.

In summary, all the three theories proffer potential factors and possible explanations which provide a logical basis to hypothesize an association between male partners' involvement in abortion and post-abortion family planning uptake. There is evidence to demonstrate that the HBM and TPB models are applicable in studying positive health behaviours (including sexual and contraceptive behaviours). Since contraception behaviour is a healthy preventative action engaged in by individuals to avoid unintended pregnancies and abortions, the variables

extracted from these models apply to the variables in this thesis. These socio-psychological theoretical frameworks were used to examine the association between male partners' involvement in women's abortion, and post-abortion contraception uptake.

2.12 Conceptual Framework

The conceptual framework adopted for this study was informed by empirical research, the HBM, and the theory of planned behaviour. The framework illustrates the interconnections and relationships with respect to partner involvement and post-abortion contraceptive use. The framework also considers post-abortion contraceptive uptake to be predicated on several factors which are explained in the ensuing paragraphs. In the framework shown in Figure 2.1, partner involvement in abortion is the main explanatory (independent) variable which directly influences post-abortion family planning (PAFP) uptake (dependent variable). The intermediate (psychosocial factors) and control variables (socio-demographics) are also depicted in the diagram.

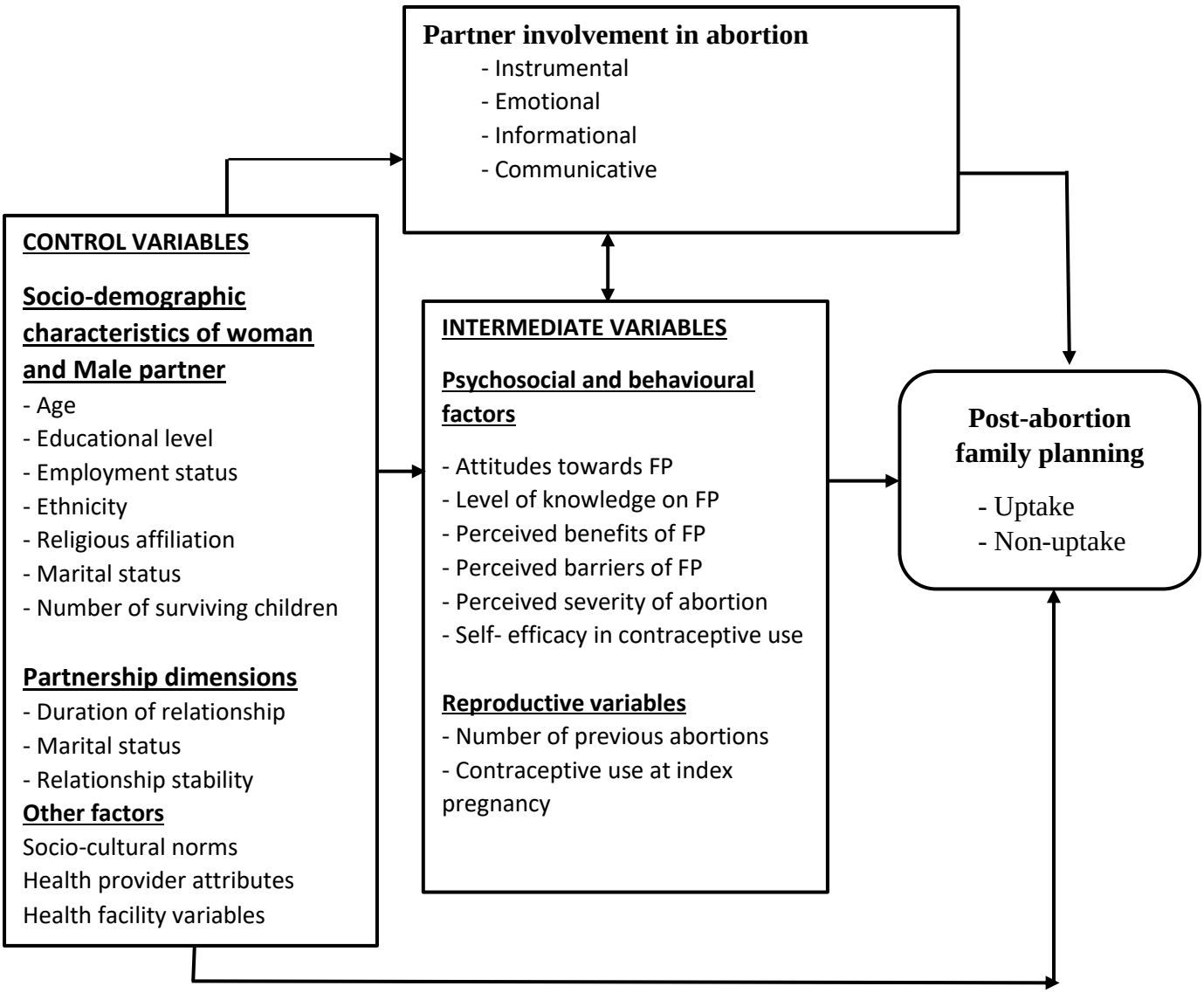
In this thesis, partner involvement is conceptualized as any form of support which is expressed and provided by the male partner either through actions or inactions (for example, a kind empathetic word), tangible and intangible, from the time of pregnancy knowledge and disclosure up until post-abortion contraception uptake or non-uptake. Four types of male partner involvement factors were identified in the literature and from the results of the qualitative interviews made up of instrumental (including financial, accompaniment by male partner), emotional, informational and communicative factors.

The socio-demographic characteristics of a woman and her male partner are important factors determining post-abortion contraceptive use. As indicated in the literature, woman's age, education, employment, marital status and number of surviving children account for contraceptive use (Frost and Lindberg, 2013; Eliason et al., 2014; Solanke, 2017). Therefore,

this study has included these variables. Similarly, partner socio-demographic characteristics may affect decisions on contraceptive use. For instance, some studies have demonstrated that young women with older sexual partners are less likely to use hormonal contraceptives because such young women tend to have less power within the relationship and lower self-efficacy (Zabin et al., 2000; Ford, Sohn and Lepkowski, 2001; DiClemente et al., 2002). This is, however, different in relationships where the age difference between the male partner and the woman is small.

In this study, the woman and male partner's socio-demographic characteristics include age, employment status, occupation, educational status, ethnicity, religious affiliation and marital status. Number of living children was included for the woman but not her partner.

FIGURE 2. 1 CONCEPTUAL FRAMEWORK TO UNDERSTAND MALE PARTNER INVOLVEMENT AND SUPPORT IN WOMEN'S ABORTION, AND LIKELIHOOD OF POST-ABORTION FAMILY PLANNING USE.



Source: Author's construct, 2017

Additionally, partnership dimensions were included in the framework to be controlled for as they could potentially influence a woman's uptake of FP after the abortion. Few studies have found that the duration of an intimate relationship inhibits contraceptive use and vice versa (Osei et al., 2014; Manlove et al., 2014). There are also studies which lend support that the quality of relationship or partnership affects contraceptive use (Osei et al., 2014; Wildsmith, Manlove and Steward-Streng, 2015). For instance, relationships with partner conflicts, less commitment, lower stability, and intimate partner violence report lower contraceptive use compared to stable and committed relationships with no partner conflicts.

A woman's decision to initiate and use post-abortion contraception may be influenced by psychosocial and behavioural variables which could eventually modify or mask the direct influence and relationship between male partner involvement and PAFP uptake. These intermediate/modifying factors include: attitudes towards FP; level of knowledge on FP; perceived benefits and barriers of contraception; perceived severity of abortion and negative health outcomes, number of previous abortions, and contraceptive use at index pregnancy and self-efficacy.

The self-perception variables were adopted from the HBM. The constructs in the HBM have been used in earlier researches to explain contraceptive use (Moos, Bartholomew and Lohr, 2003; Gaudet, Hahn and Reid, 2004; Lopez et al., 2009; Brown, Ottney and Nguyen, 2011). When a woman perceives negative health outcomes (such as infertility) as a result of abortion, there is a high likelihood of post-abortion contraception uptake to avert the possibility of future infertility and complications. However, contraceptive resistance may persist if the perception of negative side-effects of contraception is weighed more strongly than the health effects of having an abortion. Similarly, the perception and knowledge of a repeat unwanted pregnancy immediately after an abortion is likely to influence post-abortion contraceptive uptake. Self-efficacy is explained as an individuals' confidence in the ability to successfully

perform an action. Self-autonomous women with a high self-efficacy and lower dependency on their male partners have a higher chance to be autonomous in initiating contraception after an abortion compared to women with a lower self-confidence.

From the TPB, four main constructs are posited to influence an individual's positive behaviour change: behavioural intention, perceived behavioural control, subjective norm and attitude. A plethora of studies report that community beliefs and perceptions strongly influence and regulate a woman's or couple's contraceptive use (Castle, 2003; Hall et al., 2008; Ankomah et al., 2011; Sedgh and Hussain, 2014). So it is possible that, women who desire to or have the intention to prevent an unplanned pregnancy in future may be limited in initiating a contraceptive method out of fear of these community beliefs and myths surrounding contraception.

Favourable and positive attitudes towards FP to prevent an unintended pregnancy will encourage and influence contraception use after abortion. Assuming a less effective contraceptive method was earlier used and which resulted in method failure, or was used inconsistently, there is a higher likelihood for the adoption of a more effective method in future.

This study acknowledges that multiple factors at the individual, interpersonal, societal and health facility level may influence women's contraceptive use after having an abortion. Health facility level factors such as post-abortion FP counselling, provider-controlled FP methods, and availability of FP at the health facility were, however not controlled for in this study though they have the tendency to directly or indirectly influence post-abortion contraception uptake. The difficulty in controlling these facility level factors was due to the lack of procedural uniformity in offering abortion services in each hospital, as well as the differences in the nature of abortion-related care services.

2.13 Hypotheses

Two hypotheses were formulated on the basis of the potential influence of partner involvement factors on women's post-abortion contraception uptake. It is hypothesized that:

i. Women who receive communicative support from their partners during an abortion are more likely to use post-abortion contraception than women who do not receive any communicative support from their partners.

ii. Women who are supported financially by their partners for the abortion costs are more likely to adopt a contraceptive method after the abortion than women who are not financially supported.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter presents the methodology of the study which is on male partners' involvement in abortion and post-abortion family planning uptake. The chapter begins with the study design and its justification. This is followed by the purpose of conducting the qualitative phase of the study before proceeding with the quantitative phase of data collection.

3.2 Study strategy

This study adopted the sequential exploratory mixed methods research strategy. In-depth interviews were first used to explore and generate themes on male partners' involvement in abortion and post-abortion contraception uptake. Based on these themes, a survey instrument was designed to examine post-abortion women's views on their partners' involvement in induced abortion and family planning uptake. Male partners who were available during data collection were included in the study to obtain their perspectives.

The rationale for using the sequential exploratory mixed method design was for the purposes of cross validating and complementing findings from both qualitative and quantitative methods (Creswell, 2009). Using both methods also provided a more detailed exploration and understanding of partner involvement and support during abortions and post-abortion contraception uptake. Hence, the weaknesses inherent in each method (qualitative and quantitative) were compensated for.

3.3 Qualitative Data

3.3.1 Purpose of conducting qualitative phase

The qualitative phase of the sequential exploratory mixed method study was conducted first using in-depth interviews and participant observations. Generally, the aim was to explore into detail, contextual issues surrounding male partners' involvement in induced abortion from both male and female partners' perspectives in order to fully explore, understand, situate, and generate an analytical framework of how male partners are involved in their partners' abortion. Another reason for the qualitative component of the study was to gain a thorough understanding of the underlying dimensions and factors in the dyadic relationship which might possibly help to understand male involvement and further support in the abortion and uptake of post-abortion contraception. Also, results from the qualitative analysis were used to identify variables and generate themes that were used in developing the survey instrument.

3.3.2 Selection of study site

The study site for the in-depth interviews was Ga West Municipal Hospital. The participating hospital was selected randomly from a list of health facilities providing comprehensive abortion care (CAC) in the Greater Accra Region. A list of all health facilities offering CAC was obtained from the Ghana Health Service[2] after permission was granted from the appropriate offices. The selection process began with a determination of a cut-off number for elective and induced abortion statistics for the period January to December 2015. The cut-off was determined by computing the mean number of elective/induced abortion cases across all the facilities. The resulting figure (>100) was used as a criterion to select the health facilities. All the names of health facilities who met this selection criterion were then written on pieces

[2] The Ghana Health Service (GHS) is a nationally recognized institution which provides published data and figures on health indicators in the country by region and facility basis.

of papers, folded and placed into a bowl. After this, a field assistant of the researcher randomly picked one of the folded papers from the bowl. The randomly selected paper picked was Ga West Municipal Hospital.

3.3.3 Description of Study Site

The study site was Ga West Municipal Hospital located at Amasaman in the Greater Accra Region. The hospital is centrally located between Achimota and Nsawam making it a highly accessible and a preferred location to individuals living within its environs. The hospital began its operations as a health centre within the catchment area until 2008 when it was converted to the status of a Municipal hospital. Available information from the hospital's annual reports indicate that its conversion to a Municipal hospital was necessitated by an increased demand for other health services such as maternal and ante-natal health care services. As a major public hospital in the area, it provides an extensive range of in-patient and out-patient services to clients within the entire municipality and beyond.

3.3.4 Sample design

This study employed the cross-sectional design to explore male partners' involvement in women's abortion experiences at a point in time. Primary data was collected using in-depth interviews, participant observations and survey.

3.3.5 Methods of data collection

3.3.5.1 In-depth interviews

In-depth interviews and participant observation were used in primary data collection. In-depth interviews provided a means of obtaining a detailed exploration of the 'personal worldview' (Gaskell, 2000) of study participants. Gaskell (2000) notes that in-depth interviews place

respondents at 'centre stage', and allow respondents time and space to engage in reflections and narrative construction of past events. The in-depth interviews were most appropriate and useful technique for collecting detailed information from participants on a sensitive and contentious topic like 'abortion' in the Ghanaian social and cultural milieu. The appropriateness of the in-depth interviews was because it provided a conducive 'anonymity environment' for study participants to feel at ease, recount, and share their experiences (both past and present) in the decisions leading to the abortion, and their partners' roles and participation in the abortion process.

It also ensured privacy and confidential revelation of responses, and a channel for the researcher to share useful sexual and reproductive health information to clients who needed guidance[3]. There was an opportunity for the researcher to familiarize herself with the study participants, and counsel them with important information on their sexuality.

3.3.5.2 Participant observation

Participant observation was used to capture overt behaviours and non-verbal cues which could not be obtained directly from the in-depth interviews. The observations provided additional descriptive information on events that could not be recorded with the audio-tapes such as the study participant's experience of anxiety, pain before and after the abortion procedure, emotional expressions like weeping, and support from individuals who accompanied them to the hospital for the abortion.

[3] Prior to data collection, the researcher had received some training on the various methods of family planning at a non-governmental institution offering family planning services during her internship.

3.3.6 Inclusion Criteria

The inclusion criteria was all females receiving an induced or elective abortion, post- abortion care, and PAFP at the health facility. In addition, male partners who accompanied women for an abortion and were at the same time responsible for the woman's pregnancy qualified to participate in the study.

3.3.7 Exclusion Criteria

All other women visiting the hospital with spontaneous or missed abortion were excluded from the study. Men who accompanied women for an abortion at the hospital but were not the partners responsible for the pregnancy were also excluded. Other individuals such as siblings, parents and friends who accompanied women for an abortion did not participate in the study. Their responses (where necessary), however, provided descriptive accounts for the field observations.

3.3.8 Study Participants

Study participants comprised of women in all age categories who had had an induced/elective abortion at the hospital, and couples (irrespective of their marital status) visiting the hospital for a safe induced abortion. Also, male partners who accompanied their female partners to terminate a pregnancy were recruited and interviewed to provide insights on the extent of their involvement in the abortion process before and during the abortion. The purpose of the male perspective was to examine how their opinions and positions differed from their female counterparts with the aim of understanding the gendered nuances in abortion decision-making.

Women seeking post-abortion care (PAC) also formed part of the study participants. This category of women reported at the health facility with bleeding, incomplete abortion[4] or missed

[4] Incomplete abortion is when pregnancy has ended and the product of conception is partially expelled.

abortion[5] and severe abdominal pain. Other women who qualified to participate in the study were women seeking to adopt a family planning or contraceptive method after CAC. Last but not the least was healthcare provider(s) delivering CAC services at the facility as they could provide information on how CAC services were organised and delivered notwithstanding challenges associated in service provision. Apart from being interviewed, the provider and her assistant were needed to assist in recruiting and selecting potential clients for the study.

3.3.9 Participant recruitment and selection

Participants who met the eligibility criteria were invited to be interviewed by the provider[6]. The provider afterwards introduced the researcher to the potential interviewee. Prior to the data collection, the purpose and nature of the study was described to the provider and her assistant to solicit their assistance in recruiting potential study participants. This invitation of participant recruitment was important in getting access to potential respondents due to the sensitive nature of abortion, and the 'clandestine manner' in which some people sought abortion-related care at the facility. This strategy also facilitated an increase in the response rate and minimized the number of missing cases. In addition, this approach made potential study participants feel at ease to be interviewed and increased their level of trust and confidence in the researcher as the interview proceeded. Participants were interviewed after detailed description of the study was provided and informed consent was obtained.

[5] Missed abortion refers to women whose pregnancies got terminated as a result of unexplained or natural causes without any deliberate action.

[6] The main provider of CAC at Ga West Municipal hospital was a trained professional midwife and nurse. She also d oubled as the main scan provider.

3.3.10 Sample size

The initial plan was to interview 60 people (young women and couples included). However, by the 39th interview, no new responses were forthcoming; meaning that saturation had been achieved so the interviews had to end. Further interviews were stopped because similar patterns, connections, and themes were observed during interview discussions and no new responses were generated to answer the research questions.

3.3.11 Research Instrument

Three semi-structured interview guides were designed prior to fieldwork for the male and female partners, and the healthcare providers. The interview guides were informed by the literature reviewed and the research questions of the study. The guides were further refined through two processes. First, pilot interviews helped to rephrase a few questions on the guide and provided insights into the appropriate choice of words to elicit precise responses with the aim of minimizing ambiguity. Question sequence in the guide was corrected after the first three interviews were conducted. Second, because of language barriers to non-English speaking participants, the interview guides for the male and female partners were translated into two local languages ("Twi" and "Ga"). This helped to choose the most appropriate words that reflect the meaning of the English guide. These two local languages are the most commonly spoken languages in Ghana according to the 2010 Population and Housing Census.

In designing the guides, questions were segmented into distinct thematic areas/sections based on the research objectives to be addressed. For all the three guides, the first section focused on respondents' socio-demographic characteristics: age, educational level attained, employment status, occupation, number of surviving children, religious affiliation, marital status, duration of union/relationship, ethnicity, living arrangement with partner responsible for pregnancy, and place of residence. The other sections focused on dimensions of the sexual

relationship, contraceptive knowledge, reproductive history (pregnancy and abortion history), pregnancy wantedness, disclosure and intention, abortion decision-making, reasons for pregnancy termination, expectations of male partner support in abortion, and finally, post-abortion family planning uptake. The detailed study instrument is presented in Appendices 1 and 2.

The interview guides for the abortion care providers was to obtain their perspectives on how elective abortions were conducted in their health facility, issues in the provision of abortion care, and post-abortion contraception uptake by women who undergo an elective abortion. A summary of the guide is presented in Box 1.

Box 1: Summary of Interview topics for Health Providers

- Background characteristics
- Meaning of CAC and PAC
- Procedure for elective abortion-related care
- Issues discussed during counselling
- Post abortion contraception uptake
- Challenges encountered in delivery of CAC

3.3.12 Pre-testing of interview guide

Pretesting of the interview guides was conducted from 28th April to 13th May, 2016 at La General Hospital, precisely at the R3M[7] building. The aim was twofold: to ensure whether the questionnaires captured the relevant areas and exhausted all the research questions, and to cross-check if the guides reliably measured all the relevant variables of interest gleaned from the literature in order to minimize any omissions.

[7] R3M is an acronym for Reducing Maternal Mortality and Morbidity. R3M is a popularly known term at the hospital. A variety of services are provided in the building. These include CAC, family planning services, adolescent health services, HIV/AIDS counselling, screening and testing and other procedure rooms for cervical cancer screening, and two administrative offices.

Before the interviews commenced, a recruitment strategy was adopted to increase the chances of enrolling a large number of participants in the study. It involved the invitation of potential respondents by the abortion care provider to be interviewed by the researcher. Interviews were conducted either before pre-abortion or after post-abortion counselling for women opting for medication or medical abortion (MA). On the other hand, women undergoing surgical abortion were interviewed thirty minutes after the procedure. Interviews were conducted in English, 'Ga' and 'Twi'. Informed consent was sought for the interview and audio recordings. The duration of each interview was between 30 and 45 minutes. A total of 10 females participated in the pre-test interviews. During the interviews, ambiguous meanings to some questions were rephrased, flexibility in asking and probing questions was maintained, and strict adherence to the guide was discouraged.

3.3.13 Data collection procedure

Data collection began from 31st May to 6th September, 2016 at Ga West Municipal Hospital, Amasaman. Institutional and ethical approval prior to the initiation of the study was obtained from the Ghana Health Service Ethical Review Committee (GHS-ERC) and the Regional Director of Health Services. An introductory letter from the University of Ghana was also obtained and presented at the health facility as part of procedures in conducting research projects at the health facility. Access to commence field work at the hospital was granted after approval by the Medical Superintendent and hospital administrator. An interactive session was conducted by the in-service coordinator for the purpose of understanding the nature of the study, potential harm to respondents, benefits, and ethical issues to be adhered to by the researcher. After providing satisfactory explanations, the researcher was introduced to the unit/departmental heads at the family planning clinic, and the CAC provider.

The CAC provider[8] during an informal interaction reported that elective abortion services at the hospital were not structured/organised. Induced abortions were carried out at four different facilities in the hospital. These were: the scan room, gynaecology ward (also maternity ward), family planning unit, and labour wards. MA was offered in the scan room after the gestational age of the pregnancy had been ascertained by the CAC provider. Afterwards, the woman was made to orally ingest the pill and later instructed on the mode of drug administration for the remaining tablets[9]. On the other hand, women who chose surgical abortion (MVA) had the procedure performed at the gynaecology ward, or labour ward. At the gynaecology ward, two separate rooms were reserved for MVA: a counselling room, and a procedure room. After the pregnancy termination was completed, the women moved to the FP unit. Sometimes, an FP nurse was invited to perform an Intrauterine device (IUD) insertion if the client preferred the IUD as her post-abortion method choice.

Following the recruitment strategy and suggestion from the provider, the in-depth interviews were conducted at the FP Clinic where post-abortion women took up FP after the abortion. So after the surgical abortion, the provider's assistant brought the post-abortion women to the FP Unit for an FP method. She introduced the post-abortion women to interact with the researcher. On occasions when post-abortion women were unaccompanied to the FP Clinic, the researcher liaised with the FP nurses to identify and introduce any post-abortion woman for an interview.

After ten days of less than 15 interviews conducted, the strategy for recruiting respondents was changed in light of some observations noticed during data collection: first, potential respondents who objected to adopt a PAFP method were missed as they did not come

[8] A professional trained midwife and nurse, and also mainly responsible for providing scanning services to clients.

[9] Tablets or pills for MA comprised of five tablets (Mifepristone 200mg to be orally ingested; Misoprostol 800mcg to inserted vaginally or buccal)

to the FP Clinic at all. Second, when the abortion provider's assistant did not accompany post-abortion women to the FP Clinic, they declined to be interviewed when approached by the researcher. At other times, the FP nurses forgot to introduce post-abortion women to the researcher for the interview resulting in missing cases. Third, some women complained of time constraints and a reluctance to spend more waiting time at the hospital. This problem was compounded on occasions when the caseload of induced abortions was high.

The new recruitment strategy was to conduct the interviews before the abortion procedure in order to minimize missing potential respondents. This strategy meant that the researcher had to be seated in the counselling room where pre-abortion counselling was provided before the MVA was performed. This strategy was effective because it increased the sample size and minimized loses. Additionally, it provided an opportunity to interact and observe participants' reactions, and expectations prior to the surgical procedure. The rapport established with respondents before and during the interview also made them receptive, and willing to be followed-up on a post-abortion contraceptive method. On many occasions, the abortion provider and her assistant had to be prompted to invite and introduce clients to have a discussion with the researcher. All the ethical procedures (voluntary participation, informed consent, withdrawal from the study, benefits and risks) were observed.

To supplement the recruitment strategy, permission was sought from the provider to grant the researcher access to sit in the scanning room to identify women coming for MA. The reason for the additional plan was because no participant opting for MA had been interviewed yet by the 20th interview. Women who preferred MA were missed due to the following reasons: (i) provider's forgetfulness to invite potential respondents to be interviewed (ii) women choosing MA arrived earlier before the researcher did (iii) sometimes, the researcher was in the middle of an ongoing interview which was difficult to end.

Recruitment of study participants began from the scan room with permission from the health provider. Her assistance was still sought in introducing potential respondents to be interviewed. From the observations, when women came for a pregnancy scan, they told the nurse about their intention to terminate the pregnancy. Of these, nearly all of them requested the health provider's assistance to abort the pregnancy. Depending on the gestational age of the pregnancy, for example, if less than nine weeks, the woman was counselled on medication abortion unless she preferred MVA. The cost of abortion was then negotiated before the abortion was carried out.

Couples in the study were interviewed separately to avoid the risk of response bias; allow free articulation of opinions without fear of harassment or threats or arguments, and to prevent potential relationship conflicts that may be generated during the interviews upon disclosure of a past incident. However, one couple was interviewed together due to data storage challenges with the audio recorder. It was realized after two minutes into the interview that the audio recorder was 'full' so no further recording was possible. Responses were, therefore, hand-written. The couple were also interviewed together.

The average length of interviews was 40 minutes, and incomplete interviews lasted for 10-15 minutes. Written consent was obtained for almost all respondents, and 15 women verbally consented. Parental assent was obtained from two parents who brought their children less than 18 years for an abortion. Only one interview was not audio-recorded due to data storage issues. Nine (9) interviews were conducted in 'Twi', three (3) were in 'Ga' and the remaining one was in English.

3.3.14 Participant observations

A checklist was developed to guide fieldwork observations and included the following areas: process of procuring an abortion, accompaniment to the hospital, participants' experiences after

the abortion, and uptake of post-abortion FP. The field observations were accompanied with informal conversations.

3.3.15 Data management and analysis

3.3.15.1 Data storage

All but one interview responses were recorded with an audio-tape after obtaining respondents' consent. At the end of each day's interviews, recordings were stored on a laptop, with unique identifiers for client data protection purposes. The laptop was only accessible by the researcher with a safely protected password.

3.3.15.2 Data analysis

The Framework Method analysis was adopted and utilized in the management, organisation and analysis of the qualitative interviews. This method of analysis has been used since the 1980s for managing and analysing qualitative data (Ritchie and Lewis, 2003). This analytic method was chosen because it is conflated with a deductive approach to qualitative analysis (Pope, Ziebland and Mays, 2000; Pope and Mays, 2009). Since a more deductive approach was utilized in the instrument development and data collection, its sequential and methodical framework suited the approach to data organisation and analysis. Additionally, the semi-structured interview guides used during the data collection produced semi-structured transcripts that allowed flexibility in generating new thematic areas. The Framework Method analysis as noted by qualitative researchers, sits within the family of thematic analysis or qualitative content analysis (Gale et al., 2013). In sum, the stepwise systematic approach to qualitative data analysis of the Framework Method was adaptable and suitable for this study.

3.3.15.3 Stages in the analytic process

Many of the English and Ga interviews were transcribed by the researcher. Transcription and translation of the interviews conducted in Ga was relatively less cumbersome due to the researcher's fluency and mastery of the language. However, to ensure a high degree of validity and credibility, the transcripts were given to an independent adept research assistant specialised in conducting interviews in local languages (specifically, Ga) to validate the translated version against the Ga responses. Two research assistants fluent in the Akan language assisted with transcription and translation of all Akan interviews.

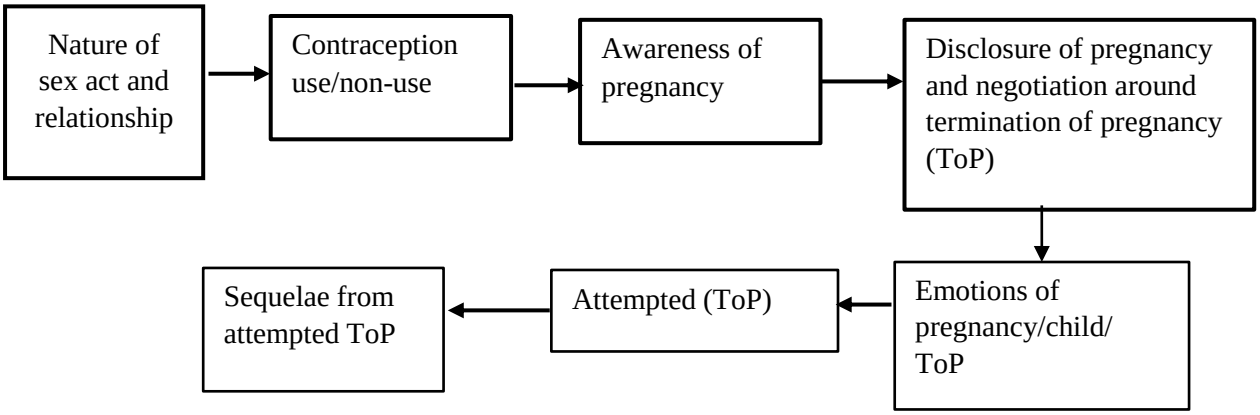
Prior to coding, reading the transcripts and listening to audio recordings was done thoroughly and concurrently to increase familiarity with all the interview responses by study participants. Both activities were repeated twice to see whether it compared and matched with the translated English transcripts.

Coding was manually done on hard copies of transcripts. At the initial stage of coding, a coding frame was developed. During the development of the coding frame, themes and sub-themes were inductively and deductively generated. The coding process began with identification of deductive codes which were pre-selected and derived from the specific research questions. The deductive structure and format of the guides made it easier for further generation of new codes. This was followed by generating inductive codes, informed by empirical data. Attention was given to areas of consensus and conflict in study participants' narratives.

An analytical framework was developed to highlight the pathways leading to male partners' involvement in the abortion process. The analytical framework also sheds insights on important predictors which are likely to predict male participation in the abortion, likelihood of support during the time of abortion, and possible uptake of post-abortion contraception. The framework was adapted from WHO (2007).

The conceptual model by WHO (as depicted in Figure 3.1) was developed to help in the study of women's trajectories to seeking an induced abortion or abortion-related care (Coast et al., 2014). It provides a wider lens than previous models in understanding key issues and relationships between variables and elements in trajectories of abortion-related behaviour and care. The framework considers a diverse range of social and legal contexts, and has three components: (1) international, national and sub-national contexts (2) individual contexts and (3) an individual's pregnancy termination-related experiences, ordered as a time sequence from sex to abortion sequelae.

FIGURE 3. 1 TRAJECTORY TO ABORTION AND ABORTION-RELATED CARE: INDIVIDUAL'S TERMINATION OF PREGNANCY (TOP) RELATED EXPERIENCES



For the purposes of this study, the third component of the conceptual model which focuses on individual's pregnancy termination experiences was adapted and modified. The model was re-formulated with the addition of new variables derived from the qualitative analysis results to produce an analytical framework for this study.

3.4 Quantitative phase

3.4.1 Study design

The quantitative phase of the research design was the second part of the study. It involved the survey design as the method of data collection after qualitative data analysis was completed.

The essence of the survey was to investigate whether a relationship exists between male partners' support in abortion and uptake of post-abortion contraception. Variables which were included in the survey questionnaire were generated and derived from the themes in the qualitative analysis. The qualitative phase, therefore, formed the basis for the implementation of the second phase of the study.

The rationale behind using the survey design to conduct the second phase of this study was to maximize the value in obtaining data from a large number of responses for the purpose of conducting a robust statistical analysis. Using the survey strategy is also economical and facilitates identification and reporting on a large population (Babbie, 2007; Fowler, 2009).

3.4.2 Study sites

Five government hospitals located in the GAR were sampled purposively from a sample frame of hospitals providing comprehensive abortion care (CAC). The sample frame was obtained from the GHS. Out of the sample frame, hospitals reporting induced and elective abortions with a caseload of 100 and above were selected. Five hospitals that met the selection criteria became the study sites. The participating health facilities were Korle-Bu Teaching Hospital (KBTH), Tema General Hospital (TGH), Ga West Municipal and Maamobi General Hospitals. Data were not collected from the fifth hospital, namely Ada East District Hospital because of the difficulty in obtaining usable data[10] within the study period.

3.4.2.1 Korle-Bu Teaching hospital (KBTH)

Korle-Bu Teaching Hospital is a tertiary health facility that primarily provides a wide range of medical services to the health insured and uninsured population. It was formerly the regional

[10] Usable data in this context refers to meaningful data obtained from the survey questionnaires and can be used for statistical analysis to address the study objectives.

hospital in the nation's capital until its status was ceded to Ridge Hospital. The hospital is also a major referral facility, and a teaching hospital for training medical health professionals.

Korle-Bu Teaching Hospital houses a wide range of special clinics and centres for specific medical conditions. One of such facilities is the Reproductive Health Centre (RHC). The RHC was commissioned in 2008 to provide sexual and reproductive health care services such as family planning, comprehensive abortion care, cervical cancer screening and other services to the general population.

3.4.2.2 Tema General hospital

Tema General Hospital (TGH) is the biggest public health institution located in the Light Industrial Area of the Tema Metropolis. Tema is one of the sixteen districts in the GAR and located eastwards, about 30km from Accra. The TGH was established in 1954 to provide health care services to staff of the Tema Port. Now, the hospital offers a 24-hour general and specialist services to the entire populace of Tema and surrounding communities. The hospital is also the main referral health facility for all other clinics/hospitals in the Metropolis. Apart from the 24-hour general medical services, a variety of health services are provided and available: in-patient and out-patient departments, internal medicine, obstetrics and gynaecology, as well as specialist and support services.

3.4.2.3 Ga West Municipal hospital

Ga West Municipal Hospital (GWMH) was established as a health centre in 1984 to provide health services to the inhabitants in that area. However, its status was converted to a Municipal hospital in 2008 to serve the high level of health care demands of the growing population in that catchment area. Ga West Municipal Hospital is the only public health facility located between Nsawam Government Hospital and Achimota Hospital.

The hospital offers a number of out-patient and in-patient services. The out-patient services include emergency recovery, dental, ear, nose and throat (ENT), reproductive and child health, laboratory, pharmacy, obstetrics and gynaecology, and eye care. The in-patient services provided include medical and emergency care, and gynaecological care. A number of private maternity clinics within the Municipality are affiliated with the Ga West Municipal Hospital. It also monitors and supervises some Community-based Health Planning and services (CHPS) compounds under its jurisdiction.

3.4.2.4 Maamobi General hospital

Maamobi General Hospital, formerly Maamobi Polyclinic is a secondary level medical care facility located in the Ayawaso Sub-Metro of the Greater Accra Region. It is the biggest publicly owned health institution in the Sub-Metro. The hospital was upgraded from a polyclinic to a general hospital in 2011 in response to the high demand for services and increasing population in the Sub-Metro. A wide variety of health services are offered in the hospital: obstetrics and gynaecology, internal medicine, reproductive and child health services, dental, disease control, pharmacy, and laboratory services. Specialist Clinics including chest clinic, ENT and ultra-scan services are part of the range of services provided.

3.4.3 Study population

All women visiting the health facility for an elective/induced abortion, post-abortion care, post-abortion follow-up, and post-abortion contraception uptake were eligible to participate in the study. Potential study participants were identified with assistance from the CAC provider who usually directed this category of women to the researcher and research assistants. Women visiting the health facility for a post-abortion family planning method were also identified with the assistance of the family planning providers. The health care providers in both instances

were very instrumental in recognizing, identifying, and recruiting the study participants. However, women visiting the hospital with a spontaneous or missed abortion, rape victims, and adolescents below age 15 were not eligible to participate in the study.

3.4.4 Sample size determination

A sample size estimation technique was used to estimate the sample size in this study due to the absence of finite figures for the target population in all the study sites. Although few abortion-related studies conducted in other contexts have used the sample size determination technique proposed by Lwanga and Lemeshow (1991) and Fisher et al. (1991, 1998) where N= (the proportion of the target population estimated to have a particular characteristic is unknown), this study adopted and utilized a different formula as N was already known. The formula for determining the sample size was: **$n= N/1+N\ (e)^2$**

Where n = the desired sample size; N= population size of elective/induced abortions in all hospitals for 2015; e = 0.05

Substituting N into the equation, the desired sample size yielded:

$$n = 1{,}598/1+1{,}598\ (0.05)^2 = 319.9 \text{ (rounded to 320)}$$

A ten percent non-response rate was calculated on the final value (10/100 *320) to yield 350. The desired sample size for the study was 350. From this value, the sample size estimations for the five hospitals were computed.

3.4.5 Sampling technique

A two-stage approach was used in selecting the study facilities in the study. First, a list of health facilities providing CAC services in the Greater Accra Region was obtained from the Ghana Health Service (GHS). Within the list, health facilities which recorded a high number of elective/induced abortions (above 100 cases) during 2015 were selected.

Second, the selected health facilities were placed into their respective district zones to which they belonged. The zonal placement was to avoid overlapping of facilities located within the same zone and providing similar services. It was also to ensure that the high patient caseload being recorded was a reflection of patronage of CAC services at that specific facility and not a result of other similar competing medical facilities providing the same level of abortion-related care. In a few cases where two hospitals were located in the same zone, simple randomization was done. Selection was irrespective of the type of health facility, or level of care, or whether it is publicly or privately owned.

The selection criteria (described in the preceding paragraph) was important for two main reasons: first, to increase the probability of obtaining large data across the selected facilities within the data collection period and second, to generate large sample size estimates in each of the selected health facility. After these two procedures were completed, the final list of facilities represented the chosen study facilities.

3.4.6 Data collection instrument

An eight-page questionnaire in English was developed from the themes derived from the qualitative data analysis (Appendix 3). Additional statements were included in the instrument to measure variables in the conceptual framework. The questions were mostly closed-ended.

The first section covered participants' socio-demographic characteristics. It included age, highest educational attainment, current schooling status, employment status, occupation, religious affiliation, ethnicity, place of residence, living arrangement, current marital status, duration of union, and number of living or surviving children.

The second section focused on participants' contraceptive practices in their lifetime. Questions were asked on level of knowledge of FP/contraceptives, attitude towards

FP/contraceptive use, contraceptive use before index pregnancy, and duration of contraceptive use prior to index pregnancy. Statements on the perception of benefits and barriers of contraceptive use were also included in this section. Statements were measured on a five-point Likert scale and participants were requested to strongly disagree (SD), disagree (D), neutral (N), agree (A), or strongly agree (SA) with these statements.

In the third section, questions on participants' reproductive history were captured. The reproductive health questions comprised of the following: pregnancy history, for instance, the number of pregnancies in their lifetime (including index pregnancy), number of induced abortions in lifetime (including index abortion), children ever born and children dead, stillbirths, number of miscarriages or spontaneous abortion, and gestational age of the index pregnancy. Additional questions included pregnancy intention and reasons for pregnancy termination.

Section four comprised of partnership characteristics which were segmented into two parts. The first part focussed on the socio-demographic characteristics of the male partner responsible for the pregnancy. The questions included age, educational level, current schooling, employment status, occupation, religious affiliation, ethnicity, marital status, duration of union, number of living/surviving children and living arrangement. The second part pertained to the nature of relationship between the couple. The various relationship dynamics consisted of: relationship stability, duration and type of relationship, current relationship status, partner's level of knowledge about contraceptives/FP, attitude towards contraceptive use, communication with partner on contraceptive use, and finally, male partner's knowledge of the pregnancy.

In the fifth section, study participants were asked to provide information on their partners' involvement in the abortion. The questions related to the partners' knowledge about

the abortion, the decision-maker on abortion, partners' support for the abortion and attitude toward the abortion. In addition, the partners' provision of various forms of support, and whether the partners' support in the abortion will influence uptake of an FP method after the abortion were included.

Perception statements concerning the severity of abortion and negative health outcomes, and self-efficacy of post-abortion contraceptive use were contained in the sixth section of the questionnaire. Participants were requested to strongly disagree (SD), disagree (D), neutral (N), agree (A), or strongly agree (SA) on these statements.

The final part of the questionnaire was on post-abortion contraception uptake. This section aimed to examine study participants' adoption of an FP method immediately after the abortion, and/or future intentions to use post-abortion contraception. Also, reasons for immediate FP uptake, type of FP method chosen and reasons for choice of method, and the decision-maker on post-abortion contraception initiation were explored. Other questions included whether the male partners' involvement in the abortion will influence post-abortion FP uptake.

3.4.6.1 Data collection procedure

Primary data collection began concurrently in two hospitals, KBTH and TGH from January 30th, to March 30th, 2017. This was after approval from the hospital's management. Prior to the data collection, a reconnaissance survey was undertaken in each hospital in order to develop a recruitment strategy to collect data, establish rapport with the main abortion service providers, and determine the feasibility and duration of accessing data.

Three research assistants were trained to administer the questionnaires in three hospitals. The research assistants were three female health workers: a nurse assistant,

laboratory technologist and a research field assistant. They were all less than 27 years with tertiary education except the nurse assistant who had secondary level of education. She had, however, previously worked in a hospital for two years as a nurse assistant and attended short courses in health management. The three research assistants were fluent in English, Akan and Ga except one. Training was organised on one-to-one basis and lasted for three days. It focused on: (i) the ethics of the study (with emphasis on voluntary participation, informed consent, risk, confidential and privacy of interview, and freedom to withdraw from study); (ii) familiarity with the questionnaire (iii) knowledge of subject matter (iv) pre-test session with researcher and (v) translation of questionnaires into Akan and 'Ga' to ensure familiarity and clarity of the questions with the aim of obtaining accurate responses from study participants. The questionnaires were pre-tested in the presence of the researcher.

The strategy or approach for questionnaire administration differed in each hospital according to how CAC services were organized and provided in the facility. For instance, in KBTH, and TGH, abortion-related care was more structured and organized compared to GWMH and Maamobi Hospital. At KBTH, elective abortions were carried out at the Reproductive Health Centre (RHC), and post-abortion care for incomplete abortions was performed at a different ward (CHENARD). In both TGH and Maamobi, pregnancy terminations were done at the obstetrics and gynaecology[11] wards; and in GWMH, abortions were done in three places: scan room, labour ward, and maternity ward/unit.

Elective abortions were also performed by different medical health professionals in each facility. For example, whilst professionally trained midwives performed abortions in GWMH and Maamobi, only gynaecologists and medical doctors performed the procedure in KBTH and TGH. At TGH, clients undergoing an evacuation of uterus (EOU)[12] had a reserved

[11] Used interchangeably with maternity ward.
[12] Also synonymous with manual vacuum aspiration for pregnancy termination

seating area. The nurses usually informed and introduced clients waiting at the reserved seating area to interact with the female research assistant. At other times, the research assistant was ushered into the ward at the bedside of a woman who had undergone an abortion. Screening questions were used to confirm whether it was an elective abortion, or miscarriage before the interview started. Arrival at the facility was 9 am from Monday to Friday in order to avoid missing out on women who came for an abortion very early in the morning. Data collection lasted for a period of 37 days. The average number of interviews conducted daily was two (2).

Comprehensive abortion care at KBTH was provided at the RHC. The centre offers other reproductive health services like cervical cancer screening, family planning services, and pelvic scan services. The building has three private counselling rooms, two procedure rooms, a conference room and offices, a store room, a kitchenette and washrooms. The centre has professionally trained three abortion care providers (all females) and a male gynaecologist. On entry at the centre, clients are asked the reason for their visit. They are then ushered into a waiting room area to have their vital statistics checked. Thereafter, they are directed into one of the private counselling rooms for a more detailed assessment and purpose of their visit and also, for further counselling. Women visiting the centre for an elective abortion are offered pre-abortion counselling by one of three nurses who offer abortion care services.

Potential participants were introduced to the researcher immediately after the end of pre-abortion counselling, and consenting participants were ushered into a private seating area to be interviewed. Sometimes, interviews were interrupted on the arrival of the gynaecologist. On few occasions, the nurse requested an exemption of some women undergoing an abortion due to circumstances surrounding the abortion, and on psychological grounds. An average of three (3) interviews were conducted within the first week.

Questionnaire administration at Maamobi General Hospital began in mid-February, 2017. The head of nursing services and in-service coordinator enquired about the objective of the study, respondents involved, and procedure for administering questionnaires. The CAC provider was later introduced to the researcher and research assistant. Two midwives performed induced/elective abortions to women on request at the maternity unit. After being informed about the procedure for accessing abortion care services, it was agreed that recruitment of potential participants and administration of questionnaires would be done at the gynaecology unit. The research assistant was to log in and sign in a book which was in the custody of the nurse in-charge. She was also to report at 9 am from Monday to Friday.

The total number of questionnaires administered after the first 25 days spent at Maamobi Hospital was six (6). During this period, one health worker revealed to the research assistant that some women visiting the hospital for elective abortions were redirected to another private hospital which was a few meters from the study site. Further explanation for this low response rate was sought from the CAC providers who reported that the number of women reporting for elective abortion was very low at that time of the year, and high numbers were recorded from June through September. In view of the low response rate obtained and little usable data within that period, data collection was abrogated.

Fieldwork at GWMH began on March 14th and ended on September, 6th 2017. Since prior in-depth interviews had already been conducted at the site, navigating the questionnaire administration was flexible, except when client attendance or caseload was high (five or six at a time), and when the procedure was performed in succession. Other exceptions were when the abortion care provider performed the abortions very early in the mornings before 9 am, and at the labour ward without the researcher's knowledge. Four (4) questionnaires were administered daily.

3.4.7 Measures

3.4.7.1 Independent variable

The key independent variable in the study was male partners' involvement in abortion. Twelve types of partner involvement components were measured (Table 3.1). The dimensions which measured partner involvement were extracted from the qualitative results and from similar studies (Clark et al., 2008).

The internal consistency for the 12 male involvement measures was done using Cronbach alpha (α). This yielded an alpha value of 0.87. The internal consistency for communication, emotional and instrumental support were separately done and the alpha values obtained were 0.94, 0.80 and 0.69. No internal consistency analysis was performed for informational support because it had only one component.

A simple linear regression was computed to determine the degree of relationship between the predictor and outcome variables to measure if the data was a good fit for the statistical modelling. A correlation coefficient value of 0.24 was obtained which indicated a weak relationship between the variables. The test of multicollinearity based on variance inflation score (VIF) was computed for the explanatory variables. High VIF scores (3.6-6.2) were obtained for all communicative support items and one item on emotional support. The high VIF scores indicated multicollinearity between communicative support variables. The KMO coefficient of sampling adequacy was computed and a value of 0.8 was obtained. This value indicated that the sampling is adequate for factor analysis. However, factor analysis was not done because the variable components were already too few to be reduced.

A composite categorisation measure of male partner involvement was developed as: 'No involvement', 'Partial involvement' and 'High involvement'. No involvement indicated no receipt of support from the male partner and was scored "0". Partial involvement indicated

the receipt of some support (either 1 or 2) on a partner involvement dimension; and high involvement indicated the receipt of all support (either 3 or 4). A composite categorisation of the male partner involvement measure was developed. This approach has been used in similar studies (Kavanaugh et al., 2012).

TABLE 3. 1 SUMMARY MEASURES OF PARTNERS' INVOLVEMENT IN ABORTION AND CORRESPONDING DIMENSIONS

Instrumental
Payment of abortion fee
Purchased drugs for home abortion
Provided money for transportation to hospital for abortion
Partner accompanied woman to hospital for abortion
Informational
Partner provided information on place for abortion
Emotional
Partner encouragement not to be worried about abortion
Partner expressed concern about abortion
Partner expressed concern about health prior to abortion
Partner expressed concern about sexual abstinence after abortion
Communication
Partner discussed post-abortion FP uptake
Partner agreed on post-abortion FP uptake
Partner approved post-abortion FP initiation

3.4.7.2 Dependent variable

The dependent variable of interest was post-abortion family planning uptake or non-uptake. It was measured as: "Yes"=1 (immediate adoption or uptake of a FP method at the health facility); "No"=2 (non-uptake of a post-abortion FP method immediately). These were dichotomized as (Yes=1, No=0) during the analysis.

3.5 Data management

All the survey questionnaires were sorted by checking for their completeness. Incompletely answered questionnaires were discarded while completed questionnaires were organised and entered into SPSS version 20. Only the researcher had access to the questionnaires. Data entry

and cleaning lasted for five weeks. Recoding of variables was done iteratively and was based on statistical reasons.

3.5.1 Coding and recoding of variables

The intermediate and control variables used in the regression analysis and corresponding coding are described in Table 3.2. Recoding of response categories for the socio-demographic and psychosocial variables was done prior to their inclusion in the models for analysis. Variables which were recoded were premised on statistical reasons with consideration on the counts in each category. In some instances, the response categories were condensed or collapsed into new response categories due to the few counts reported. Other response categories were merged and recoded.

The self-perception statements were checked for unidimensionality and reverse coding was done where necessary. Reliability analysis was done using Cronbach's alpha to check the internal consistency of the items prior to analysis. The statements on the perceived benefits of contraception yielded an alpha value of 0.8. Statements on the perceived barriers of contraceptives and perceived severity of abortion also yielded alpha values of 0.8 and 0.7 respectively. With the statements on self-efficacy, an alpha value of 0.6 was obtained.

All the self-perception statements were treated as continuous variables and scoring ranged from 1 to the highest score of 30 and above.

TABLE 3. 2 CODED AND RECODED VARIABLES

Variables	Measurement	Recoded categories
Age	Age was treated as a continuous variable	--
Highest educational level	1= No Education, 2= Preschool, 3= Primary, 4= Middle/JHS 5= Secondary/SHS, 6= Higher/ Tertiary, 7= Vocational, 8= Other (Specify)	1= Other[13] education; 2= Primary, 3= Middle/JHS; 4= Secondary/SHS/Higher
Occupation/ Employment	1= No Occupation/Not Working 2=Clerical, 3= Sales, 4= Self-Employed, 5= Unskilled Manual, 6= Managerial, 7= Household and Domestic, 8= Skilled Manual 9= Other [Specify]	1= Unemployed 2= Employed
Religious affiliation	1= No Religion, 2= Catholic 3= Presbyterian, 4= Methodist, 5= Pentecost/ Charismatic, 6= Traditional/Spiritualist, 7= Muslim, 8= Deeper Life 9= SDA, 10= Jehovah Witness 11= Anglican, 12= Other [Specify]	1= No Religion; 2= Orthodox; 3= Pentecostal/ Charismatic; 4= Muslim
Ethnicity	1= Akan, 2= Ga-Dangme, 3= Ewe, 4= Grusi, 5= Guan, 6= Gruma, 7= Mole-Dagbani, 8= Hausa, 9= Other [Specify]	1= Akan; 2= Ga-Dangme; 3= Ewe; 4= Northern ethnic groups
Marital status	1= Never Married, 2= Currently Married, 3= Cohabiting, 4= Divorced, 5= Widowed, 6= Separated	1= Never Married; 2= Currently Married; 3= Cohabiting; 4= Formerly married
Contraceptive knowledge	1= Very Knowledgeable, 2= Knowledgeable, 3= Somewhat Knowledgeable, 4= Don't care, 5= Not Knowledgeable, 6= Not Knowledgeable at all	1= Knowledgeable; 2= Somewhat Knowledgeable; 3= Don't care; 4= Not Knowledgeable
Attitudes towards contraceptive use	1= Very Favourable, 2= Favourable, 3= Somewhat Favourable, 4= Don't care, 5= Not Favourable, 6= Not Favourable at all	1= Favourable; 2= Somewhat Favourable; 3= Don't care; 4= Not Favourable

[13] The 'Other education' category comprised of pre-school, primary, no education and 'Don't know'. These categories were merged because of the few counts in each category.

3.6 Data Analysis

Analysis of data was performed at the univariate, bivariate, and multivariate levels. Univariate analysis was mainly descriptive statistics and expressed in frequencies, percentages and mean distribution. Bivariate analysis with cross-tabulations and chi-square tests were used to examine the association between the socio-demographic variables, reproductive and attitudinal factors with the outcome variable (uptake or non-uptake of PAFP). Binary logistic regression analysis was performed to determine the relationship between the predictor variables and outcome variable. Since the predictor variables was a mixed set of continuous and categorical variables whilst the outcome variable was dichotomous (either yes or no), the binary logistic model suited the analysis.

Five regression models were computed in this study to determine interactive and joint effects between the independent and dependent variables. In the first model, the four dimensions of partner involvement in abortion (instrumental, informational, emotional, communication) were regressed on the outcome variable controlling for all other variables in the study. The second model comprised of the dependent variable, women's socio-demographic characteristics, and partner involvement variables. Model three examined the dependent variable, male partner socio-demographic characteristics and partner involvement variables. The fourth model examined the joint effects of all the socio-demographic characteristics and partner involvement variables on the outcome variable. The net model was the final regression modelling which included all the variables in the study.

3.7 Ethical consideration

Ethical clearance was obtained from the Ghana Health Service Ethical Review Committee (GHS-ERC) on 12th April, 2016 with GHS-ERC number GM 02/02/16 (Appendix 4). The GHS-ERC is an institutional body which provides ethical approval for all social science

research that are conducted in all Ghana Health Service facilities. Ethical approval ensures respect for the rights of all voluntary participants in the study; access to information from health facilities, and adherence to standard ethical guidelines and regulations in the conduct of scientific research.

Permission was also sought from the Regional Director of Health Services within the Greater Accra Region since the selected health facilities were located in the region. An introductory letter from the researcher's institute (Regional Institute for Population Studies) included as part of administrative procedures. Written informed consent of all study participants was obtained prior to commencing each interview (Appendix 5). Study participants either appended their signature or thumbprinted as proof of consent. Some ethical issues encountered during the qualitative interview phase revolved around emotional discomfort, informed consent and willingness to participate in the study, confidentiality, anonymity, and detailed or full disclosure of the study and benefits.

No study participant was coerced to participate in the study. Unique identification numbers to conceal participants' names and identity were also provided. In addition, study participants were assured that their responses to questions as well as their names will not be disclosed to the public or any other third party. An information sheet detailing participants' rights was explained comprehensively and made available to them to keep (where necessary). Study respondents were informed on their rights to choose whether to respond to some questions or not and leave the interview without any reason.

The nature of research questions caused emotional discomfort to a few study participants especially when participants had to recount past experiences and events that led to the decision-making process prior to the abortion, and also as they managed to balance their personal views on abortions, religious and social beliefs. In order to minimize respondents'

emotional discomfort, questions were asked in soft low tone; 'abortion' was exchanged with 'pregnancy termination', 'get rid of it', 'remove it' or 'take it out'. Empathetic words were proffered (where necessary) to encourage responsiveness to the questions.

In two separate situations where respondents' emotional discomfort yielded no response after five minutes, the interview was discontinued.

3.8 Study limitations

Some limitations were encountered during the study which are worth stating. First, results of the study cannot be generalised to the entire population due to unrepresentativeness of the sample and non-random selection of the study sites. Second, the cross-sectional focus of the study prevents causality inferences to be made and inability to follow-up on women who had future intentions of using PAFP. Third, only individual-level factors from the Theory of Planned Behaviour and Health Belief Models were included in the regression modelling. Fourth, although participants were interviewed following the cessation of pain from the abortion procedure, their responses could potentially affect the validity of data. Thus, influencing the quality of data collected.

CHAPTER FOUR

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

4.1 Introduction

The socio-demographic characteristics of women and their partners have been found to be associated with contraceptive use. This chapter presents the socio-demographic characteristics of all respondents who participated in both phases of the study. The results from the data collection are also featured in this section.

4.2 Results from data collection

A total of thirty-eight (38) women and three (3) male partners participated in the in-depth interviews during the qualitative phase of the study whilst three hundred and fifty-six (356) questionnaires were obtained during the survey data collection during the quantitative stage. Out of the 356 questionnaires, twenty-nine (29), representing eight percent were excluded due to incomplete demographic data (about themselves and/or their partners), and ineligibility of some participants. The remaining questionnaires, numbering 327 (92 percent) were included in the analysis. Table 4.1 depicts the sample size distribution in each hospital. The results in the table indicate that most (64 percent) questionnaires were administered at Ga West Municipal Hospital, followed by KBTH, TGH and Maamobi hospitals respectively.

TABLE 4. 1 PERCENTAGE DISTRIBUTION OF SAMPLE SIZES ACROSS STUDY FACILITIES

Hospital	**N=327**	**Percentage**
KBTH	65	19.9
TGH	47	14.4
Ga West Municipal	209	63.9
Maamobi	6	1.8
Total	**327**	**100.0**

Source: Field data, 2017

4.3 Incomplete interviews and refusals

There were incomplete interviews during both phases of the data collection process. For instance, some respondents became unresponsive to the questions a few minutes into the interview without any reason. After successive questions yielded no response, the researcher ended the conversation. Possible reasons for this non-response could be due to anxiety, lack of trust, contextual factors, or whether the line of questioning provoked guilt or regret for their actions. Others refused participation after a detailed description of the study was provided. Also, the interviews ended when some respondents complained of mild abdominal pains midway during the interview. In addition, others declined participation on grounds of attending to their personal business, family matters, exhaustion, pain, time constraints and to avoid further exposure to 'strangers'.

Furthermore, five respondents refused participation in the interviews after the provider introduced the researcher. These women on observation were between ages 20 and 29. Last but not the least, a woman who was accompanied by her partner declined consent and participation in the study when approached directly by the researcher. She wished to be left alone.

4.4 Socio-demographic characteristics of study participants

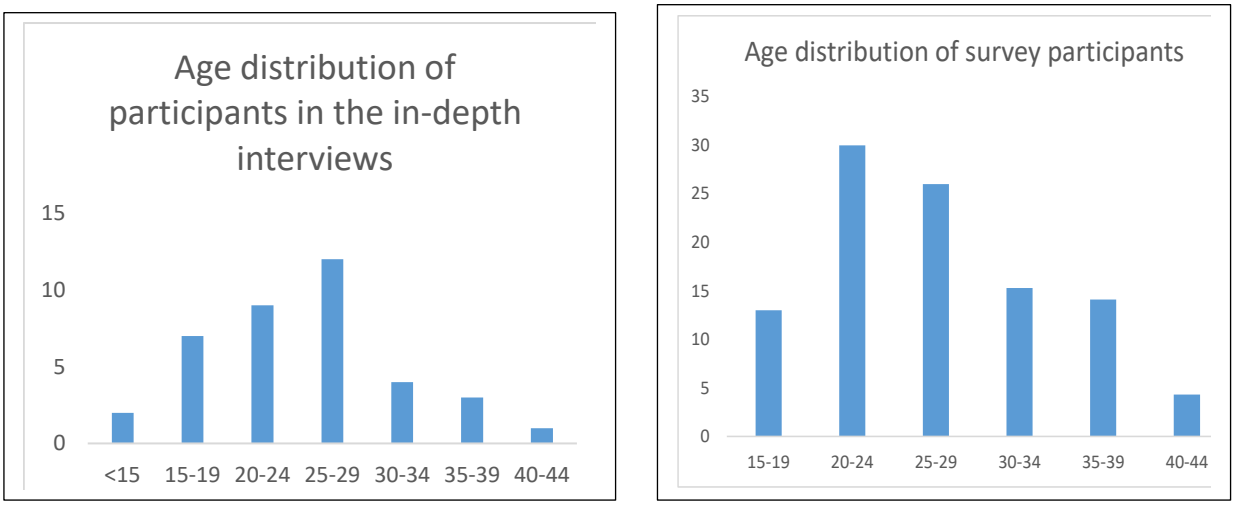
4.4.1 Age distribution of respondents

Of the total number of respondents who participated in the interviews, thirty-eight (38) were females and three (3) were male partners of three female participants. A little more than half of respondents were aged between 21 and 29 years. Twenty-four percent of respondents were less than 20 years and the youngest was 13 years. The proportion of participants between ages 30 and 39 years was 18 percent.

The age distribution of participants in the in-depth interviews and survey were comparable. The results in Figure 4.1 show that slightly more than half (53 percent) were between ages 20

and 29 years. The least age group of participants who reported for an abortion during the study were between 40 and 44 years old. The mean age of survey respondents was 27 years. The findings indicate that the incidence of abortion is highest for women aged 20 to 29 years compared to women in other age groups. The results also suggest that many women in their reproductive age are likely to consider pregnancy termination at a point in their lives irrespective of their age.

FIGURE 4. 1 AGE DISTRIBUTION OF STUDY RESPONDENTS

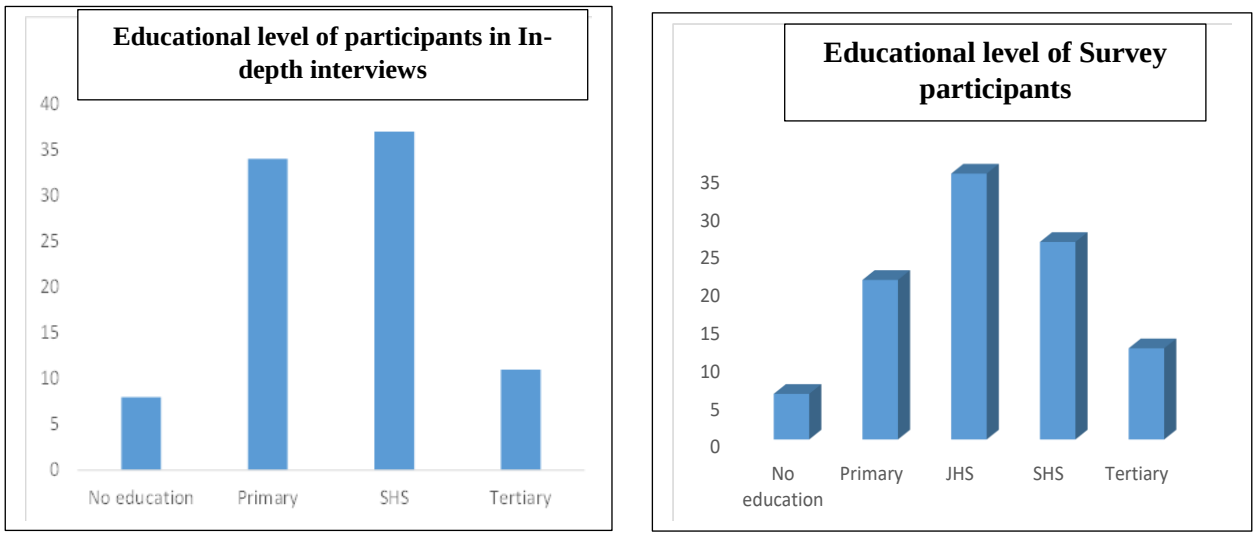


4.4.2 Educational status of respondents

Figure 4.2 illustrates the educational status of respondents in the study. The findings show that a greater proportion of respondents in the study had received some formal education. For instance, among those interviewed during the IDIs, 34 percent had completed primary school, 37 percent had had a secondary education and only 11 percent had completed tertiary education. Only eight percent had never attended school. For the surveyed respondents, however, the proportion of participants with no formal education was six percent; 21 percent had completed primary school, 35 percent had completed Junior High School (JHS) whilst 26 percent had completed secondary education. Twelve percent had completed a tertiary

education. In sum, the results indicate that education is nearly universal with at least, every study participant having some level of formal education.

FIGURE 4. 2 EDUCATIONAL LEVEL OF RESPONDENTS



4.4.3 Marital status of respondents

Table 4.2 shows the current marital status of study respondents. Of the participants in the qualitative interview, majority (76 percent) were not married but were currently 'dating' or in intimate sexual relationships, and twenty-four percent were married. Slightly similar results were observed for the marital status of the survey respondents. The data presented in Table 4.2 show that 51 percent of the surveyed respondents were never married; 30 percent were currently married; 17 percent were cohabiting and three percent had ever been married. The ever married respondents were either divorced, separated or widowed.

These findings indicate that many pregnancies and subsequent abortions occur outside of formalised unions. When unintended pregnancies occur outside marital unions, the tendency is that it exposes unmarried and young women to a high risk of future unplanned births and possible abortions increasing the lifetime pregnancies.

TABLE 4. 2 MARITAL STATUS OF RESPONDENTS

	In-depth interviews		Survey	
	Number	**Percentage**	**Number**	**Percentage**
Never married	29	76.3	165	50.5
Currently married	9	23.7	98	29.9
Cohabiting	--	--	55	16.8
Formerly married (Divorced/ separated or widowed)	--	--	9	2.7
Total	**38**	**100.0**	**327**	**100.0**

Source: Field data (2016-2017)

4.4.4 Employment and type of occupation

One-third of the participants in the in-depth interviews (Table 4.3) were not employed whilst the remaining were actively engaged in different income generating activities. Of the currently employed respondents, their occupations varied from sales, services, administrative/clerical and managerial, and domestic services. For instance, participants were traders, food vendors, and hairdressers. Thirteen percent were currently under apprenticeship.

On the other hand, the results from the survey showed that the leading occupation were sales (27 percent) and services (26 percent). One-third of participants were however, unemployed. Other occupations in which participants were engaged in included unskilled manual jobs, managerial and administrative work, and household/domestic work. Employment status and the type of work indicate that at least many respondents are economically empowered, and therefore, have the ability to purchase and access less expensive family planning methods. The type of occupation respondents are also engaged in may influence their choice of contraceptive method because of cost implications.

TABLE 4. 3 OCCUPATION TYPE OF RESPONDENTS

	In-depth interviews		Survey	
	Number	**Percentage**	**Number**	**Percentage**
No occupation	12	31.6	98	29.9
Sales	12	31.6	87	26.6
Services	4	10.5	85	25.9
Unskilled manual	---	--	15	4.6
Managerial/Clerical/Administrative	3	7.9	6	1.8
Household/domestic services	1	2.6	5	1.5
Other	---	---	31	9.5
Apprenticeship	5	13.2	--	--
Not stated	**1**	**2.6**	**--**	**--**
Total	**38**	**100.0**	**327**	**100.0**

Source: Field data (2016-2017)

4.4.5 Religious affiliation of respondents

The religious denominations which the study participants belonged to differed, but most belonged to the Christian Charismatic Faith. The data in Table 4.4 show that a greater proportion of respondents were Pentecostals or Charismatics compared to the Catholics, Anglican, Methodists, other Christians and Muslims.

TABLE 4. 4 RELIGIOUS AFFILIATION OF RESPONDENTS

	In-depth interviews		Survey	
	Number	**Percentage**	**Number**	**Percentage**
Catholic	1	2.6	10	3.1
Anglican/Methodist/Presbyterian	4	10.5	60	18.3
Pentecostal/Charismatic	18	47.4	214	65.5
Muslim	5	13.2	17	5.2
Other Christian	4	10.5	25	7.7
No religion	--	--	1	0.3
Not stated	6	15.7	--	--
Total	**32**	**100.0**	**327**	**100.0**

Source: Field data (2016-2017)
Other Christian include Jehovah Witness, Deeper life, and Seventh Day Adventists.

4.4.6 Ethnicity

With regard to the ethnic groups of respondents in the study, results in Table 4.5 show that the highest percentage of respondents belong to the Akan ethnic group. This is followed by Ewe,

Ga-Dangme, and other ethnic groups. The ethnic variation in the study is characteristic of the ethnic composition in Ghana as evidenced from the 2014 Demographic Health Survey.

TABLE 4. 5 ETHNICITY OF RESPONDENTS

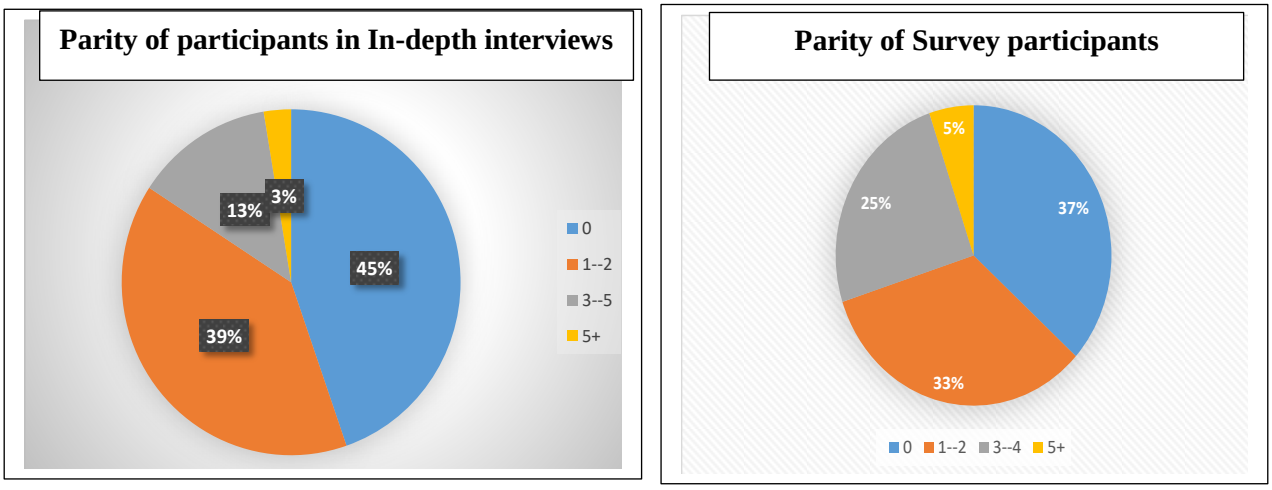
	In-depth interviews		Survey	
	Number	**Percentage**	**Number**	**Percentage**
Akan	19	50.0	136	41.6
Ga-Dangme	5	13.2	61	18.7
Ewe	9	23.7	76	23.2
Other northern ethnic groups	2	5.2	--	--
Other ethnic groups	1	2.6	54	16.6
Not stated	**2**	**5.2**		
Total	**38**	**100.0**	**327**	**100.0**

Source: Field data (2016-2017)

4.4.7 Number of living children

The number of living children that a couple has may influence their pregnancy intention, fertility desires, contraceptive behaviour and practice. Results from the study indicate that a high proportion of respondents have at least two children (Figure 4.3). Less than one-third of respondents had more than five children.

FIGURE 4. 3 NUMBER OF LIVING CHILDREN OF RESPONDENTS



4.4.8 Residential places of respondents

Nearly all study participants resided in the Greater Accra Region, precisely within close geographical proximity to the health facility. Few women, however, stayed outside the

catchment area of the health facilities and they accessed health care at the facility through recommendation from friends and family members. Some women were residents from an adjoining town in the Eastern Region. Respondents remarked that their decision to access health care at the participating health facility was on referral from a health provider, or recommendation from close neighbours, friends, family members and staff of the hospital. Some reported that fear of being stigmatized by neighbours in their place of residence prevented them from accessing health care in their locality. The detailed sample characteristics of the In-depth interviewees are presented in Appendix 6.

4.5 Socio- demographic characteristics of male partners

With respect to the age distribution of respondents' male partners, five percent reported having no knowledge of their partners' age. The results showed that a greater proportion of male partners were between age 30 and 39 years (Table 4.6). The mean age was 33 years.

TABLE 4. 6 AGE DISTRIBUTION OF MALE PARTNERS

Characteristic	Number	Percentage
Age		
18-24	39	11.9
25-29	69	21.1
30-34	64	19.6
35-39	65	19.9
40-44	44	13.5
45+	31	9.5
*Not stated	15	4.6
Total	**327**	**100.0**

Source: Field data 2017

There were slight variations in the educational status of male partners. For instance, a third had completed secondary school, whilst 24 and 25 percent had completed Middle/Junior High School (JHS) and tertiary education respectively. However, 11 percent of the respondents reported that they had no knowledge of the educational status of their partners.

Participants reported that nearly all (92 percent) of their partners were currently employed and engaged in different types of occupation. Twenty-two percent were employed in the service sector, whilst 39 percent were employed in skilled manual jobs such as drivers, painters, and construction workers. Less than 20 percent were working as professional and administrative personnel. Eight percent were, however, not working at the time of the study.

The ethnic groups to which the male partners belonged to was almost similar to their female partners. Similar to the female respondents, a little less than half (47 percent) of male partners were Akan. This was followed by the Ewes, Ga-Dangme and other ethnic groups. The other ethnic groups consisted of Dagomba, Gruma, Kotokoli, Guan and Hausa.

With respect to the religious denominations, most male partners belonged to the Pentecostal or Charismatic religious denomination. Sixteen percent were other Christians like Deeper Life, Jehovah Witness, and SDA, and only seven percent were Muslims. Study participants reported that 43 percent of their partners had never been married compared to 39 percent of respondents whose partners were married. Other respondents had male partners who had ever married and 14 percent were cohabiting. Only one percent reported not knowing the marital status of their partners. The detailed socio-demographic characteristics are shown in Appendix 7.

In summary, the sociodemographic characteristics of both female and male partners show a similar pattern except for slight variations in the age distribution. A high proportion of all the study respondents had received some basic formal education and higher, and more than half were currently engaged in some income generating activity. The proportion of unmarried male partners and female respondents are quite similar.

Similar results regarding respondents' ethnicity and religious affiliation compares favourably with the 2014 Demographic and Health Survey report. Compared to the male partners, the onset of sexual activity which resulted in the abortion begins early for the female partners. The results

also show that, for females, the onset of sexual activity begins early from age 20-29 and gradually reduces from age 30 to 39. In sum, the slight differentials in the age distribution of these female respondents with their male partners in informal unions is suggestive of the risky sexual practices of this group of women which raises concern about the likelihood of subsequent future pregnancies that may lead to abortions.

CHAPTER FIVE

SEXUAL AND REPRODUCTIVE HEALTH BEHAVIOUR AND PARTNERSHIP CHARACTERISTICS OF RESPONDENTS

5.1 Introduction

This chapter presents the sexual and reproductive health behaviour and partnership characteristics of study respondents. The sexual and reproductive health profile which was examined in the study were reproductive history, contraceptive practices and pregnancy intention. The partnership characteristics focused on the nature of sexual relationship, relationship stability, and level of commitment to the relationship.

5.2 Sexual and reproductive health behaviour

5.2.1 Reproductive history

The reproductive history of participants examined in the study include pregnancy history, abortion history, birth history and gestational age of pregnancy.

5.2.1.1 Pregnancy history

Participants were asked to report on all the pregnancies they had had in their lifetime since becoming sexually active including the current or index pregnancy. From Table 5.1, the results indicate that a greater proportion of study participants had more than two children compared to less than one-third of all participants who reported the pregnancy as the first.

TABLE 5. 1 PREGNANCY HISTORY OF RESPONDENTS

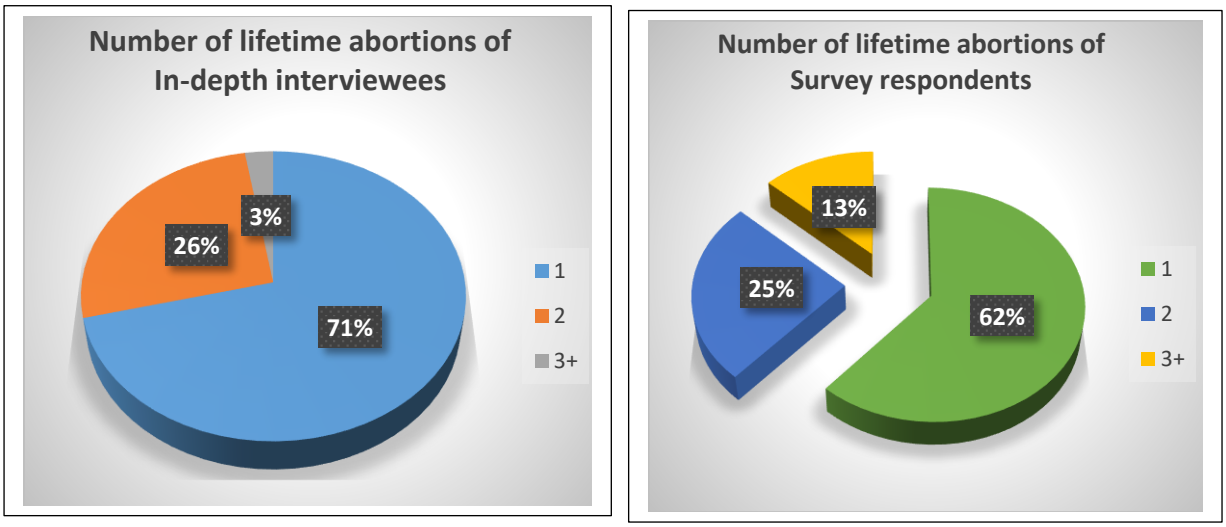
Number of lifetime pregnancies	In-depth interviews		Survey	
	N	%	N	%
1	11	28.9	89	27.2
2-3	17	44.7	98	30.0
4-5	8	21.1	75	23.0
6+	2	5.3	65	19.8
Total	**38**	**100.0**	**327**	**100.0**

Source: Field data, 2016-2017

5.2.1.2 Abortion history of respondents

Figure 5.1 shows the abortion history of participants in the study. Respondents were asked to report the number of pregnancies they had terminated in their lifetime by themselves at home or elsewhere, or by someone else since they became sexually active. From Figure 5.1, the proportion of respondents having their index abortion was higher (71 percent) among the in-depth interviewees compared to the survey respondents (62 percent). It was the first time of terminating a pregnancy in their lifetime.

FIGURE 5. 1 ABORTION HISTORY OF PARTICIPANTS



The number of pregnancies and induced abortions is an important reproductive feature of women in their reproductive age. These results suggest that at least, every sexually active woman is potentially at risk of having an intended or unintended pregnancy in her lifetime. Unintended pregnancies are likely to end in an abortion than planned pregnancies. Several possible explanations ranging from personal and non-personal factors may account for having an abortion. For instance, the narratives confirmed that some participants terminated the pregnancy because of lack of readiness for the pregnancy, educational aspirations, financial constraints, young age and partner-related problems. In addition, poor contraceptive behaviour, lack of contraceptive knowledge and practice, lack of contraceptive use, inconsistent

contraceptive use, and using traditional methods of pregnancy prevention may have resulted in the pregnancies and subsequent abortion.

5.2.1.3 Gestational age of pregnancy

Table 5.2 presents the gestational age of pregnancy of study participants. The data presented in the table indicate that nearly all the pregnancies reported by participants were first trimester pregnancies. This means that most respondents visited the hospital to terminate their pregnancies within twelve weeks of the pregnancy. Compared to second trimester abortions, the proportion of participants whose pregnancies were terminated during the second trimester was small.

TABLE 5. 2 GESTATIONAL AGE OF PREGNANCY OF PARTICIPANTS

Number of weeks of pregnancy	In-depth interviews		Survey	
	N	%	N	%
4 weeks	--	--	71	21.7
5-8 weeks	30	78.9	178	54.4
9- 12 weeks	5	13.2	49	15.0
>12 weeks	1	2.6	24	7.3
Not stated	2	5.3	5	1.5
Total	**38**	**100.0**	**327**	**100.0**

Source: Field data, 2016-2017

The results suggest that a large number of abortions are done within the first trimester, specifically, eight weeks of pregnancy. A possible explanation could be that the timing and receipt of the abortion-related care coincide with the end of the abortion decision-making process. The findings suggest that there is no limit to having an induced abortion irrespective of the gestational age of the pregnancy.

5.3 Contraceptive practices before abortion

A combination of modern family planning, natural family planning methods, alternative herbal medicines and emergency contraceptive pills were used by participants to prevent pregnancy

in the study. The types of contraception used by respondents are discussed in the subsequent paragraphs.

5.3.1 Use of emergency contraceptive pills

Results from the study indicate that almost all the participants were using a contraceptive method prior to the abortion. The analysis showed that 36 percent of the survey respondents were using emergency contraceptive (EC) pills, while almost one-third of the in-depth interviewees were also currently using emergency contraceptives as their main method of pregnancy prevention. Respondents were asked to mention the name of the EC pills they ingested as a way to assess their knowledge of these pills[14]. The branded types of EC reportedly used by participants were 'Postinor 2', 'Leno', 'N-tablet', 'Lydia' and 'Potex'. The mode of contraceptive administration and timing of contraceptive use differed among respondents. One respondent reported in the following words:

> *"Yes I took medicine but still got pregnant. I took an antibiotic which had only one tablet. The only one I know is what I have told you and I have forgotten the name. It is only one tablet in a small box. When you take it this week you take another one the following week"* (27 year-old woman with one child).

Some respondents experienced contraceptive failure after ingesting the emergency contraceptive pills before 72 hours after sexual intercourse whilst others took it prior to sex. Two participants narrated their past experience with the emergency pills and how it had failed them. They said:

> *"We were using medicine called postinor 2, but it failed me; that was how I had my first born. I took this same postinor 2 and I got pregnant this time again. I took two tablets the first and second day." (*22 year-old woman with one child).

> *"I was using leno. Because he is usually not around, when he comes around and we have sex, I use leno. I take it after sex before 72 hours. But this time, it failed me. I*

[14] Some of the respondents could not mention and remember the name of the medicines they ingested to prevent pregnancy. It was quite worrying to find out that they lacked knowledge of these things because it had been recommended to them by their peers. This has far reaching implications for their reproductive health.

> *didn't take it on time. I took it after more than two days. We went out of town to the village and it was more than 48 hours. So because it was less than 72 hours I thought it will work"* (31 year-old woman with one child).

However, a few of the participants reportedly failed to take a birth control method leading to the pregnancy and abortion. Although participants displayed some knowledge about contraceptives, the reason for not using a contraceptive method was because of rumours about the side-effects. One participant explained as follows:

> *"I didn't take a post-pill. I have heard that taking too much of it is bad. [Pause]. When we had sex, I didn't think it was going to end up this way even though I should have taken the necessary precaution* (21 year-old girl).

Another respondent also reported:

> *"I know this natural method where you read your cycle to know your safe period. And when you have sex in your safe period, you won't get pregnant. But I have heard of postinor from friends at school. I know of postinor. Sometimes friends even ask you to buy it for them and mostly it works out. But this time round in my case, come what may, I was prepared to face anything"* (26 year- old girl).

These contraceptive practices by respondents indicate that a greater proportion of respondents are aware of emergency pills. Awareness of and subsequent use of emergency pills may be due to its acceptability, knowledge and preference as some studies have suggested (Goulard et al., 2006). These revelations also suggest that although measures were taken to prevent conception, participants' contraception methods did not provide the maximum protection against unintended pregnancy. It is also plausible that respondents may not have had accurate and comprehensive information about emergency contraceptives and for that matter, they may have substituted emergency pills with oral contraceptive pills which they used regularly as birth prevention methods. However, regular use of emergency pills might result in failure and expose respondents to the risk of unintended pregnancy when the mode of prescription and administration is incorrect or untimely.

5.3.2 Use of modern contraceptive methods

The oral contraceptive pills (OCP), male condoms and injectables were the only modern types of contraceptives being practised by participants in the study. The proportion of survey respondents who used oral contraceptive pills was 22 percent and two percent used injectable before becoming pregnant. There was no respondent who mentioned ingesting oral contraceptive pills and injectable during the in-depth interview. The male condom was also mentioned by some respondents as their method of contraception prior to conception and the abortion. Furthermore, the findings showed that there was a slightly high number of male condom users in the in-depth interviews than in the survey (18 percent versus 11 percent). Some in-depth interviewees reported that they experienced a burst condom during sex while others were inconsistent condom users. A 26 year-old woman reported that:

> *"We were using a condom and it got burst. I felt that something had gone inside of me. But he said it hadn't burst but I felt that something had gone inside of me. But when we finished we realized it had burst".*

Another participant reported that her partner preferred to use male condoms but because of the discomfort she experienced during sex, she suggested to the partner not to use it. She stated:

> *"He uses the condom but when he uses it, then he removes it. He removes it himself then continues. It is because I said I don't like it that's why"* (21 year-old girl).

Two of the male respondents who were interviewed also shared their contraceptive experiences. One of them reported that they used condoms inconsistently and they combined with the calendar/rhythm method occasionally. He narrated in the following words:

> *"We use to buy a condom. Actually, we haven't had fun all the time and it was only once I didn't use a condom. She confirmed that I didn't use a condom the last time"* (23 year-old male partner).

Another male partner also reported his dislike for using the condoms. He and his partner therefore switched to use emergency pills. He averred that:

> *"Talking about contraceptives doesn't really come up when we chat. However, during intercourse, I tried using the condom but I just don't like it. I have gone to buy some from the drug store. I used it and removed it later on. I just don't like it. I don't feel anything"* (23 year-old male partner).

From the narratives, it appears that inconsistent condom use resulted in participants becoming pregnant. Other factors which can be adduced from respondents' contraceptive behaviour relate to personal characteristics such as attitudes, partner influences and sexual satisfaction (Raine, Minnis and Padian, 2003; Sayegh et al., 2006). This finding is consistent with other studies which found that dislike for a particular contraceptive method was associated with condom use (Sayegh et al., 2006; Frost and Darroch, 2008). While sexual satisfaction is important in fostering sexual intimacy in a sexual dyad, the risk of unintended pregnancy is high when condoms are inconsistently used. Method failure could also result when condoms are incorrectly used, increasing the risk of unplanned pregnancy.

5.3.3 Use of traditional or natural family planning method (NFP)

The proportion of participants using traditional methods to prevent pregnancy in the study was nearly the same when compared to participants using all the other forms of modern contraception except the emergency pill. Eleven percent of all the study respondents relied on the rhythm or calendar method which is a natural family planning method (NFP). Participants who relied on the rhythm/calendar NFP method to avoid pregnancy shared their knowledge about their fertile and infertile days when they were asked. They reported avoiding sex during "fertile" or unsafe days. They reported that their choice of family planning method was based on previous use and knowledge. One of them said:

> *"I know this natural method where you read your cycle to know your safe period. So when you have sex during your safe period, you won't become pregnant. The last time I had my menses was 16th of July and my menstrual cycle is 28 days. My safe period will start from 16th to 25th but with this very one, the day I had sex, I knew I was going to get pregnant"* (26 year-old girl).

Results from the survey showed that 22 percent of respondents practised the 'withdrawal' method compared with only eight percent of those who participated in the in-depth interviews. A 23 year-old woman commented:

> *"He didn't release the sperm inside me, all came out. But I don't know how it happened. A lot of sperms came out".*

Furthermore, less than five percent of the participants in the study were currently using lactational amenorrhea method (LAM) as a birth control method. During the narratives, it was found that respondents did not anticipate getting pregnant because of past experience with the LAM method, and also because their children were very young. Joyce's second child was less than eight months old when she discovered that she was pregnant. She averred that:

> *"After the birth of the first born, I did not have my menses for 6 months. Then with this second child too, after delivery for about 6 months, I didn't experience my menses. I waited but no menses came. So I went to buy pregnancy test. When I tested, I was pregnant"* (27 year-old woman with two children).

Catherine also had a one-year old child and she combined breastfeeding and withdrawal method. She expressed fears of adopting an intrauterine device compared to other hormonal family planning methods. She admitted being shocked at the news of the pregnancy. She narrated:

> *"When we have sex, he doesn't put the sperms inside me [laughs]. He withdraws. When I stopped the family planning some years ago, that was what he was doing before we had this child. Every day, I say I will come and do family planning but I have not been able to do so"* (32 year old woman with three children).

Some respondents combined traditional methods and modern family planning methods, for example, withdrawal and condoms, whilst others used condoms and EC. Besides using these ineffective pregnancy prevention methods, respondents admitted having unprotected sex occasionally. Rita, an 18 year-old girl was unknowingly combining methods because of her lack of knowledge about conception. She said:

> *"I know I don't have much education on pregnancy but I thought everything will go on well. So I didn't take anything to protect myself.*

In another vein, she said:

> *"I have been taking pills for some months when I intend to have sex. After sex, I take the pills for some three days' and everything will be okay"*

In another situation, a respondent relied on the rhythm method and withdrawal because of her perceived fear of infertility which could result through using emergency pills.

> *"I check my safe days and the unsafe days, but this time it failed. There are some days he does withdrawal"* --- 21 year-old student

Study participants practising NFP can be described as having an unmet need for modern contraception. This is because their current contraceptive practices place them at high risk for unintended pregnancies. It is possible that participants who practised LAM had misconceptions about their return to fertility after breast feeding (Kouyate et al., 2015), or they unknowingly delayed transitioning to adopt modern family planning methods (Bongiovanni et al., 2005). Furthermore, these revelations raise questions about inconsistent, and a possibly incorrect pattern of pregnancy preventive behaviours which might consequently lead to more unintended pregnancies in the future.

5.3.4 No contraceptive use

Although most respondents in the study were practising some method of pregnancy prevention prior to the abortion, others were not practising any contraception. Of the participants who were surveyed, 17 percent had had unprotected sex during their last sexual encounter. Similarly, a few of the in-depth interviewees disclosed their lack of contraceptive use during their last sex. The lack of contraceptive use was due to infrequent sexual intercourse and irregular availability of the male partner. A 28 year-old mother of four children narrated:

> *"As for me I wasn't using anything to prevent pregnancy. I didn't know I could become pregnant because he doesn't stay here. He goes away for a long time before he returns".*

Another respondent also mentioned her dislike for modern contraception because of the side-effects associated with its use. In her view, she and her partner were willing to be parents if a pregnancy occurred. She narrated:

> *"Contraception are something I have never wanted to use because of what people say about it especially the side effects. I had always told myself that whatever happens, I was going to give birth. He doesn't like using a condom. He said [pause] he doesn't like it, and we were okay because I knew I was the only lady he has, and I knew he was my only man. We talk about kids and marriage. So why then should we protect ourselves? At least, he is 32 and I'm 26 and we are old enough to give birth so there was no need"* (26 year-old girl).

Lack of contraceptive use in intimate sexual relationships most often increases a woman's risk of having an unintended pregnancy. Non-contraceptive users may also be termed as sexual risk takers since their sexual activities are unprotected. What these results seem to suggest is that, contraceptive behaviours of individuals are complex and influenced by several factors. Consistent with the literature on determinants of contraceptive use, individual factors, interpersonal, socio-cultural belief systems, myths and misconception, attributes of contraceptive types, as well as health system factors account for contraceptive use (Madden et al., 2015; Sundstrom, Baker-Whitcomb and DeMaria, 2015; Pritt, Norris and Berlan, 2017).

The results also suggest that respondents' contraceptive choices are motivated by their current partnership arrangements and coital frequency. For instance, some studies have found that the presence of male partners, frequency of sexual activity, personal preference for a specific type of contraceptive method, and knowledge of pregnancy prevention methods may influence contraceptive method choice and use in sexual relationships (Frost and Darroch, 2008). In addition, the perception of potential side-effects such as infertility or delayed fertility, fear of partner finding out about contraceptive use, partner disapproval of contraceptive use, lack of economic resources to purchase contraceptives and inability to correctly use contraception may work as barriers to using contraception. Consequently, a high unmet need for modern contraception may perpetuate leading to a cycle of unintended pregnancies and abortion.

These findings lend support to other studies which have found a high unmet need for contraception among women of reproductive ages (Sedgh and Hussain, 2014). The findings can also be explained in light of the theory of Planned Behaviour (TPB) and the HBM. For instance, the TPB posits that an individual's attitude, subjective norm, perceived behavioural control and behavioural intention culminate to influence the performance of specific positive behaviours. In this regard, it is likely that study respondents who failed to use contraception prior to the abortion, as well as those who practised ineffective contraceptive methods did so because of their undesirable or unfavourable attitude towards modern contraception, and lack of personal autonomy in contraceptive decision-making.

In the Ghanaian context where pro-natalist ideologies are upheld, individuals are likely to value societal misconceptions, myths and beliefs which demonize modern birth regulation methods. The implication is that with several of these factors regulating, shaping and influencing the reproductive behaviours and practices of respondents, they will begin to adopt

ambivalent attitudes, or negative attitudes to birth control methods which are effective in preventing pregnancies and abortions.

5.4 Partnership characteristics

5.4.1 Nature of relationship with sexual partner

Pregnancy (intended or unintended) and abortion usually occur between a man and a woman in the context of an ongoing relationship. The quality and dimensions of the dyadic relationship might determine a pregnancy outcome. Relationship quality, with reference to relationship length, stability, commitment and satisfaction potentially increases the likelihood of male involvement and support during an unintended pregnancy. In this study, dimensions of the dyadic relationship explored were: type and duration of the relationship, relationship stability, and level of commitment to the relationship. The indicators which constitute the various dimensions of the nature of the relationship are organized and diagrammatically presented in the ensuing sections.

5.4.1.1 Relationship type and duration of the partnership

Two-thirds of the in-depth interviewees were in intimate sexual relationships or ‘dating’ at the time of the study; less than a third were married and few were cohabiting. Of the interviewees who were dating, they described their partners as their boyfriends, whilst others reported that their partners were their ‘husbands to be’ or fiancé. Three couples were interviewed during the in-depth interviews; one was married, while the other two were unmarried. One couple admitted cohabiting occasionally. The shortest duration of the relationship participants were involved in was three months, and the longest was 16 years.

Compared to the survey participants, exactly half (50 percent) described their partners as their boyfriends; 34 percent said that their partners were their husbands and nine percent had

fiancés. Less than five percent described their partners as their friends, casual acquaintance, relative or just any other person. The results of bivariate analysis showed a high variation between relationship type and duration among the surveyed respondents (Table 5.3).

From Table 5.3, type of relationship differed with the length of years in the relationship. For instance, a higher proportion of respondents who had boyfriends were in unions of less than a year compared to those who had been in a relationship for more than six years and above (48 percent versus 4 percent). For respondents whose partners were their husbands, a greater proportion of them had been in longer unions of six years and above (60 percent) than fewer of them. So duration of the union or relationship increases depending on whether the respondent had a husband compared to when respondents had boyfriends.

TABLE 5. 3 ASSOCIATION BETWEEN TYPE OF RELATIONSHIP AND DURATION OF RELATIONSHIP

	Duration of relationship				
	Less than a year	1- 2 years	3- 5 years	6 years and above	Total
Relationship type					
Boyfriend	47.9%	27%	20.9%	4.3%	100%
Husband	3.6%	8.9%	20.5%	60%	100%
Fiancé	24.1%	41.4%	31%	3.4%	100%
Others	47.8%	13%	4.3%	34.8%	100%

Source: Field data, 2016-2017; N=327; X^2 =167.340** degrees of freedom = 9; **p <0.001

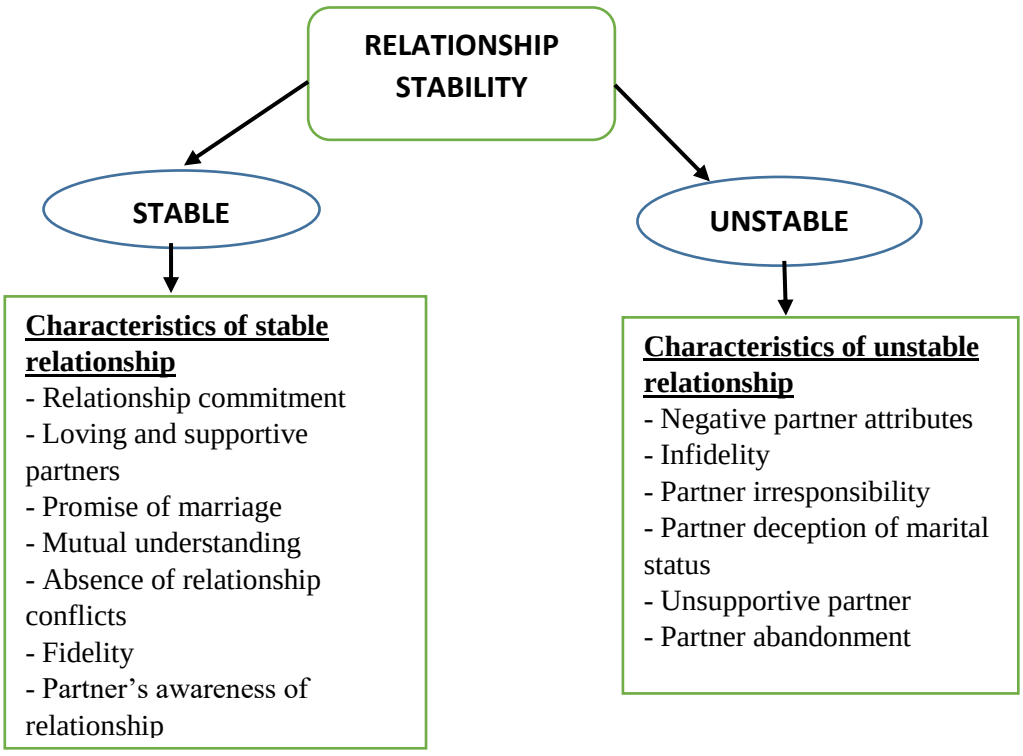
The results in Table 5.3 indicate that many respondents in the study were unmarried and involved in romantic sexual relationships. The findings also reveal that heterogeneity exists among sexual relationships and this varies with the length or duration of the unions. A number of studies have found that the type, stage and duration of sexual partnerships have several implications for contraceptive decision-making, contraceptive method choice and pregnancy outcomes (Kusunoki and Upchurch, 2011; Manlove et al., 2014; Osei et al., 2014). Depending on the stage and duration of the relationship, the motivation to terminate an unintended

pregnancy may be weighed as high or low if both partners are not ready, or financially constrained. Partners who for example consider their relationships to be casual or transient or short-term or as a means to an end may be more likely to end a pregnancy than couples who have higher expectations of continuing their relationship.

5.4.1.2 Relationship stability

Respondents were asked to describe the stability of their relationship and whether it was stable or unstable. The results showed that a high proportion of those interviewed in the study reported that they were in what they characterised as stable relationships. On the other hand, 71 percent of the surveyed respondents reported that their current partnership was stable, whilst 13 percent said that they were in somewhat stable relationships. Sixteen percent were however not in stable relationships as at the time of the study. The factors or themes which constitute relationship stability is presented in Figure 5.2.

FIGURE 5.2 DIAGRAM DEPICTING INDICATORS OF RELATIONSHIP STABILITY



Participants were asked the reasons for describing their relationship as stable and attributes like commitment, loving, understanding and supportive partners were mentioned as indicators of relationship stability. A 39 year-old woman simply responded that *"we love each other, we understand each other, and we do things together"*. Other respondents viewed their relationships as stable because of the promise of marriage. Two of them stated:

> *"I say it's stable because he told me that he will marry me. He is a Moslem and my dad says I should find a man who is a Moslem to marry me. So when it happened like that I told my parents. So my parents know about the pregnancy and my partner said he wants me to finish learning my trade first before giving birth so that in future when he needs support, I can assist him"* (21 year-old girl).

> *"It is because sometimes he says he will buy the items for the marriage that's why I think he is serious"* (23 year-old girl).

Still on relationship stability, other respondents mentioned the absence of relationship conflicts, provision of financial support, and jointly engaging in activities to be primary indicators of their stable relationship. Some of them opined as follows:

> *"Our relationship is stable. It is stable because he is not someone who is haphazard, he isn't a liar, he is committed to his promise and he assists me. For instance, when I'm in need of finances. I also assist him"* (26 year-old woman with one child).

> *"Our relationship is stable because he doesn't quarrel with me, even if I want anything he gives it to me"* (39 year-old woman with four children).

Others commented that their partners' fidelity to the relationship overtime was a positive indicator of a stable relationship. One respondent averred by saying:

> *"He is not a womanizer although he travels a lot. If it were to be some other men, they will lose interest. But I have come to realize in so many things that he cares for me"* (31 year-old woman with one child).

In addition, some respondents including two married women found it difficult to identify characteristics they considered as indicators of their stable relationship. They averred that everything in their relationship was 'normal' or 'fine'. They averred:

> *"Our relationship is stable, hmm. We don't fight ... Nothing. I don't know what to even say* (21 year-old girl).

> *"Hmm, I don't know how to describe it but then it's stable. I don't know how you want me to explain it"* (29 year-old mother with two children).

During the narratives, two of the three male partners interviewed stated that partner fidelity, and parental awareness of the relationship were fundamental attributes of their stable relationship. Two of them reported:

> *"Our relationship is stable in the sense that talking from my perspective, I don't cheat on her"* (23 year-old male partner).

> *"The relationship is stable. First of all when I met her, I didn't hesitate to go to her parents. I took her to my family too, my house. So in anything that we do, both families are aware that we are living together* --- 23 year-old male partner

On the other hand, nearly one-third of participants in the in-depth interviews and 16 percent of the respondents in the survey reported being in unstable relationships at the time of having the abortion. The participants narrated that their relationship became unstable from the time of pregnancy discovery until the abortion decision-making. Half of the in-depth interviewees in unstable relationships intended to end the relationship after the abortion whilst few of them actually mentioned that their relationship was over. Other respondents had communicated their intention to quit the relationship, but their partners disagreed.

A few of these respondents in unstable relationships based their decision to end the relationship on partner-related grounds, specifically their partners' negative attributes and behaviour, infidelity, and irresponsibility. Three respondents had this to say:

> *"For now our relationship is not stable, [laughing]. He is crazy! I don't like the way he behaves. I just don't like him; the way he behaves. That is why I want to terminate it"* (26 year-old woman with two children).

> *"It was stable. Actually I knew things were working, everything was going to be alright until the pregnancy happened. I didn't know he had kids"* (26 year-old woman).

> *"I'm not sure the relationship is stable. I planned that after this abortion, I will stop the relationship because, from the beginning he did not tell me that he is married. I came to find out"* (23 year-old woman with one child).

Suzie[15] (not her real name), a 19 year-old girl reported that she would end the relationship with her partner after the abortion because of her partner's threat of denying responsibility for the pregnancy. In her frustration, she purchased some medicine for a home abortion but failed. She narrated saying:

> *"As for me I was ready to give birth. When this pregnancy happened, he was joking with me that's why I took that medicine. Sometimes, he will say that if I fool, he will deny responsibility of the pregnancy. So I think that he was not serious of taking responsibility for the pregnancy. That's why I took the medicine"* (19 year-old girl).

Others based their decision to end the relationship on grounds of deception of their partners' marital status. In their view, the 'law of karma' or the universal 'neighbour' principle[16] were guiding principles to end the union. They further wanted to avoid the situation of becoming a second marriage partner, hence their decision to quit the relationship after the abortion. A participant explained:

> *"I didn't know at first. I came to know later that he has a wife and children, and I can't have children with him. So after this abortion, I'm going to end it with him"* (23 year-old woman with one child).

> *"I told him to end the relationship so if he gives me money now I don't take it. I told him that I cannot continue with him. The painful thing is that he hasn't performed her marriage rites but wants to perform mine. He is part of the reason why I'm terminating this pregnancy. He wants to have my list for the engagement. I told him that we should end it because my family doesn't accept second marriages. He can get another woman to marry if he wants one but I have stopped the relationship with him"* (27 year-old woman with three children).

[15] All names used to report the narratives are pseudonyms.
[16] 'Do unto others what you want others to do unto you'

Others reported that their partners' sudden disappearance after the pregnancy disclosure, abandonment, and lack of support during the pregnancy resolution process influenced their decisions to terminate the pregnancy. In their view, the relationship was over. One of them said:

> *"Right now, we are no more in a relationship. I aborted it because I don't hear from him, I don't see him. I have been to his house but haven't heard from him"* (27 year-old woman with one child).

Furthermore, the narratives revealed that the male partners' non-provision of funds for the cost of abortion created the condition for an unstable relationship. In two different instances, some respondents reported that their relationship was unstable because their partners failed to provide funds for the cost of the abortion. For one participant, her partners' request for an abortion without her consent fuelled his decision to withhold financial support towards the abortion. She narrated:

> *"I was expecting him to tell me something. Any time I mention this pregnancy, he won't get money for me but when I stop complaining about the pregnancy, he will get money for me. At least if you don't have money for the pregnancy, just find half of it and give it to me; but nothing at all. I was really hurt. I really don't want him to see me. Three days now I have not seen him and don't want him to see me again"* (22 year-old girl).

In Matilda's case, she opposed the decision to continue the pregnancy against her partner's wishes. She also had to use her personal money for the abortion without the knowledge of her partner since he initially refused to provide funds for the abortion. She stated:

> *"When he came I told him of the problem and asked him what we are going to do. He told me to keep it. I said nothing. He wanted me to keep it but I didn't want to keep it. So I asked him to give me money to have an abortion but he refused to give me money. I persisted but he refused to give me money for the abortion"* (31 year-old with one child).

The foregoing indicate that, unstable relationships contribute to pregnancy termination in dyadic relationships. This finding is corroborated by other studies which found that beside the

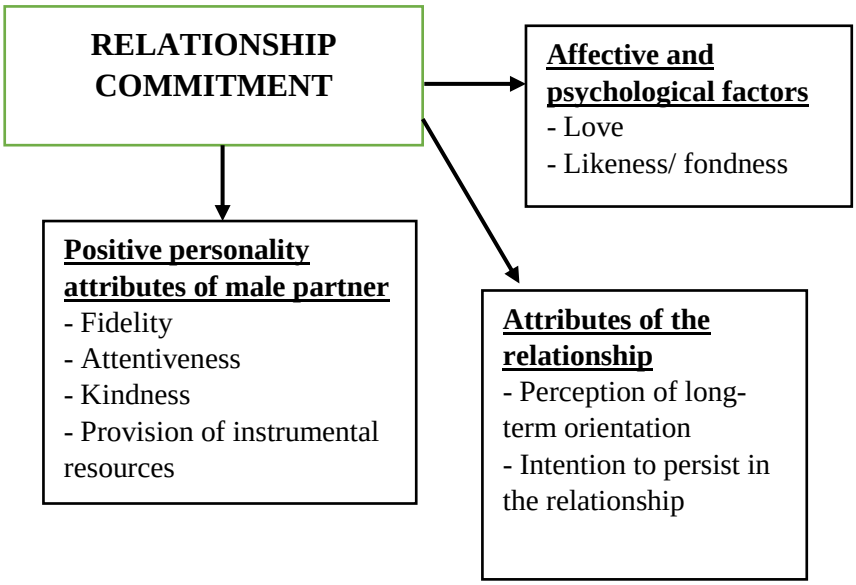
sexual dyad, partner characteristics were associated with intentions to end a pregnancy (Kusunoki and Upchurch, 2011; Manlove et al., 2014; Osei et al., 2014). From the study, respondents considered the undesirable attitudes of their partners, mistrust and infidelity, inability to obtain financial resources and support from their partner as critical to end their pregnancies. For such women, the desire to have a child or continue a pregnancy in unstable unions may impose burden of childcare, financial constraints and other hardships which is unplanned for. They may also consider societal normative expectations of childbearing outside of wedlock and decide to terminate the pregnancy.

However, in the context of stable dyadic unions, the desire to end an unintended pregnancy may be ascribed to other socio-economic factors, and social desirability determinants other than partner attributes. Pregnancy resolutions in stable unions are more likely to have mutual basis and shared/joint responsibility than in unstable relationships.

5.4.1.3 Level of relationship commitment

The level of couples' commitment in a dyadic relationship is a strong component of a stable relationship. Most theorists have demonstrated through several studies that relationship commitment is a multidimensional construct with three main components: affective, cognitive, and conative (Arriaga and Agnew, 2001). In this study, relationship commitment was described as a strong personal intention to continue a sexual relationship. The various themes which characterised level of commitment is diagrammatically presented in figure 5.2.

Figure 5.2: Figure showing thematic areas of Relationship commitment



During the narratives, study participants were asked to describe factors or attributes which characterized relationship commitment as well as provide examples where necessary. The main indicator of relationship commitment reported by more than one-third of respondents was positive personality attributes of their male partners. Positive personality attributes included caring, attentiveness, kind, good, responsible, and fidelity. Some respondents reported as follows:

> *"Both of us are committed to the relationship. He is attentive and cares about me. He doesn't joke with his church. Even though I have a child which is not his, he caters for the child. He is good"* (31 year old with one child).

Some respondents also reported that the partners' provision of instrumental resources, especially financial resources indicated commitment to the relationship. Two respondents commented:

> *"The two of us are committed. He supports me financially as I learn the trade. He was even the one who put me in the trade. Whenever I don't have money, he gives me. He always calls me. There is no day that he doesn't call me"* (21 year-old girl).

> *"Because he looks after me. I'm jobless and I'm an apprentice so I have no money to look after myself so he is the one who is more committed"* (25 year-old woman with one child).

In a different circumstance, few respondents stated that performance of household duties or chores such as cooking, washing, and cleaning were evidence of their commitment level. A 28 year-old woman said:

> *"I am more committed in the relationship. I wash, cook and tidy up his room. I also do petty things for him. He even brought his child here and I was the one who took care of his child"* (28 year-old woman with two children).

In addition, less than one-third of study participants mentioned psychological attachment as attributes of relationship commitment. Psychological attachment related to feelings of love and likeness, fondness and understanding. When a 22 year-old girl was asked to provide reasons for why she thought both of them were committed to the relationship, she simply said: *"because I like him, he too he likes me"*. A similar response was also proffered by a 23 year-old girl. She said: *"We are both committed to the relationship because we love each other. He's also gone to see my parents"*.

For some other participants, the perception of a long-term orientation regarding the relationship indicated the level of commitment in the relationship. These women had expectations of getting married to their partner in the long-term future. They viewed themselves as more committed to

the relationship than their partners and for that reason, felt committed to continuing the relationship until the pregnancy happened. One of the respondents averred:

> *"As for me I thought that I would be married to him. I didn't know he was married. I thought I had gotten a guy who will marry me. He also says it that he will marry me"* (34 year-old woman with two children).

The intention to persist in the relationship by two women was a sign of their commitment to the relationship. One of them felt morally obligated to continue the relationship because of the children, whilst the other said that she and her partner played their respective roles to continue with the relationship. She reported:

> *"I am the more committed one in the relationship because of the kids I have with him"* (25 year-old woman, 2 children)

In two separate accounts, two women mentioned that their partners' personal devotion or dedication to the family showed commitment to their marital union, and long-term relationship. In their view, however, they considered themselves to be more committed to the relationship than their partners. Two of them reported:

> *"Both of us are committed. You know, women are more committed than men. He's been kind to the family and caring. When he goes to work, he comes home on time and wherever he is, he ensures that I know. He lets me know his whereabouts every time. He sends and picks his children from school. Now that I am not in Accra, he takes care of the children until I come during the weekends"* (29 year-old woman with two children).

> *"The two of us can sit down and chat. When I'm cooking and he is around, he will sit with me. If I say I want to wash and he is in the house, he will help me"* (39 year-old woman with four children).

Contrary to the level of commitment characteristics reported by participants, other participants could neither explain nor describe what it meant to be in a committed relationship although they could tell who was more committed in the relationship. They had difficulties in describing

what constituted as marks of commitment in the relationship. Two of their responses are captured in the following statements:

> *"He is more committed to the relationship. I can't tell but he is more committed. He wants the relationship to go on"* (18 year-old girl).

A 21 year-old student also reported saying:

> *"Both of us are committed to the relationship. For me I see myself to be committed and if he were to be the one, he would have said the same thing. [Laughs]. I don't even know what indicators to give. It should be like that".*

The level of commitment as a relationship component has been viewed as an important determinant in the overall quality of a relationship. The multidimensionality of commitment level is also evident in the results of the study. The affective component which focuses on psychological attachment to the relationship was mentioned by some respondents; whilst the intention to persist in the relationship equates with the conative component. The cognitive component emphasizes long-term orientation regarding the relationship (Arriaga and Agnew, 2001). These subjective understandings and interpretations reflect the current experiences of participants' dyad.

Beside the three level of commitment components reported differently by participants, other respondents reported that provision of financial resources and performance of household duties was a function of their commitment to the relationship. It is possible that respondents considered these to be normative expectations in partnership arrangements where the male partner assumes financial obligation whilst the woman performs household tasks. So whilst some women perceive that commitment is tied to or dependent on ability to maintain and perform household chores, a lack of it may suggest otherwise.

In summary, the results from the sexual and reproductive behaviour of study participants has implications for their future fertility goals, reproductive behaviour and

contraction of sexually transmitted infections. The results of the study suggest that this group of women are potentially at risk of future unintended pregnancies sometime in their lifetime. The likelihood of multiple abortions among this sub-population of women during their lifetime is also high because of their poor contraceptive behaviour and practices. The study found that a majority of the participants practised contraception ineffectively and inconsistently while others used natural FP methods which failed them. By far, the nature of the sexual dyad, partner characteristics, partner's preference for contraceptive type, knowledge and attitude towards contraception, and fear of the side-effects of FP dictated contraceptive use and non-use prior to the unintended pregnancy and subsequent abortion.

The partnership characteristics that was examined in this study pertained to the relationship type, duration of the partnership, relationship stability and level of commitment. The results showed that more than half of the respondents were unmarried but involved in intimate sexual partnerships whilst few were in marital unions. This suggests that sexual activity is prevalent in male-female dyads and not only confined to legalized partnership arrangements. It is plausible, therefore, to assume that sexual debut may begin early for young women who indulge in sexual intimate relationships with their male counterparts.

Furthermore, respondents ascribed the level of commitment to the relationship to positive personality attributes of their male partners, psychological attachment, perception of long term attachment to the relationship and supportive partners. The results imply that, such attributes are important in sustaining the sexual relationship especially, being in stable unions where male partners are committed is vital in facilitating fertility and reproductive decision-making, as well as improving communication for effective contraceptive use. Essentially, relationship stability and commitment are important determinants of the quality of relationships which may underpin male support and involvement in reproductive decisions.

CHAPTER 6

MALE PARTNERS' INVOLVEMENT IN ABORTION AND POST-ABORTION FAMILY PLANNING (PAFP) UPTAKE

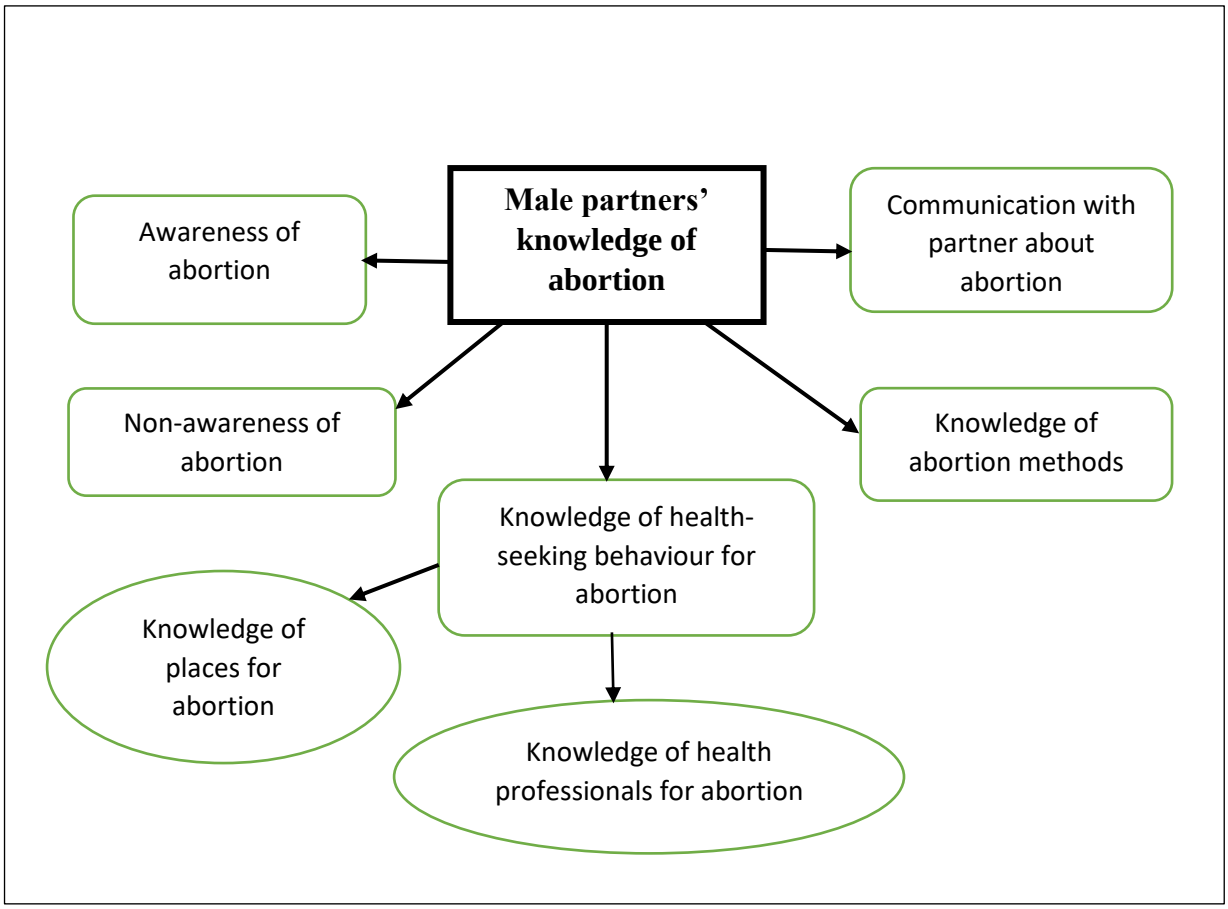
6.1 Introduction

This chapter presents the findings from women's narratives about their partners' involvement in abortion and family planning methods adopted thereafter. Narratives from male partners who were interviewed are also included in the results. Three main themes characterised male partners' involvement in women's abortion experiences. These are: partners' knowledge of abortion; role of male partners in the abortion decision-making process, and male partners' support in the abortion. The sub-themes under these core themes are presented in the ensuing sections with accompanying diagrammatic presentations.

6.2. Male partners' knowledge of abortion

This theme describes male partners' knowledge of their female partners' abortion. Under this broad theme, five sub-themes emerged: awareness of abortion, communication with partner about abortion, knowledge of health-seeking behaviour for abortion, knowledge of abortion methods, and non-awareness of the abortion. Figure 5.1 illustrates the thematic areas under this theme.

FIGURE 6. 1 DIAGRAM DEPICTING MALE PARTNERS' KNOWLEDGE OF ABORTION AND ASSOCIATED SUB-THEMES



6.2.1 Awareness of abortion

Most women informed their male partners about the abortion and decision to terminate the pregnancy. Disclosure of the pregnancy termination was preceded by confirmation of the pregnancy. In few instances, pregnancy test kits were purchased by the couple, or woman alone or man alone to confirm the pregnancy before decision-making. A 27 year-old woman reported her partner's knowledge of the pregnancy and his enquiry about the status of her condition. She reported:

> *"Yes, he knows I'm coming to terminate the pregnancy. He even called just a while ago and asked whether I'm finished. I told him that I'm now going to do family planning".*

Two other participants reported about their partners' knowledge of the pregnancy termination. From their narration, it appeared that their partners were disinterested about the abortion decision. One of them, a 25 year-old woman said: "*I told him before about the abortion and he said he doesn't care if I do that".* Another respondent also remarked:

> *"He didn't say anything about the abortion. He said I can remove it. He said there may be nothing so I should go to the hospital and check again. It is poverty that makes us reject child birth"* (36 year-old woman with six children).

From the interviews, it was found that, the timing of abortion was not immediately performed after pregnancy confirmation. A period from three days to two weeks elapsed before abortion-related care was sought. Results of the analysis of data from the survey also showed similar results whereby an overwhelming majority (94 percent) of women informed their partners about the abortion. Only six percent said that their partners were not aware of the pregnancy.

6.2.2 Communication with male partner about abortion

From the women's self-reports, their partners were the first to be informed about the pregnancy because they had had sexual relations with them and were responsible. Discussions on whether to continue or terminate the pregnancy followed pregnancy disclosure until a consensus was reached between the couple. During the interviews, many of the women stated that after talking with their partners concerning the pregnancy, both agreed to terminate it. Communication between the couple on the abortion decision was iterative. It usually involved negotiations and rationalisation and was initiated by either the man or woman. Three respondents shared their experiences in the following words:

> *"I only told my partner. He said if it's not because of something, he should have made me give birth but I don't want to. He asked me about my plan and I told him that I don't want to give birth with somebody who is married. Then he said he will give me money to terminate the pregnancy"*--- (23 year-old woman with one child).

> *"I told him first. Initially, he said I should give birth but later on, he was scared because he is now schooling and we have no money"* (25 year-old woman with one child).

> *"He asked me what I will do; whether to give birth or terminate it. I told him that I don't want to give birth"* **(**26 year old woman with two children).

In contrast, some women reported that their partners refused their personal decision to end the pregnancy after disclosing it to them. One-third of the participants provided valid reasons to have the abortion. Some valid reasons included; financial constraints, desire to continue education or schooling, not ready for a pregnancy, partner infidelity, fear of disrupting work and life trajectory, partner-related behaviour and to avoid giving birth to a child with foetal abnormalities. On the other hand, very few offered intangible explanations to keep the pregnancy without their partner's support. The intangible reason pertained to the fact that females under 18 years in the community had a child. One respondent stated:

> *"He said I should keep the pregnancy. But keeping the pregnancy will also create some problems for me at home. So I told him that, I am not ready and I don't want to have any problems at home with my parents, especially, my dad. So I begged him to consider this pregnancy as a mistake and allow me to terminate it so that, next time I will take precaution in order that it doesn't become a problem again"* (21 year-old woman).

> *"I was very determined to give birth because when you come to my home, even 16 year-old girls have a child how much more 22. I can give birth you see. So I told him I want to give birth and he didn't bother about it"* (22 year-old woman)

In Miriam's case, her partner requested for an abortion on the promise of providing some material gifts. She lamented her partner's irresponsiveness about her decision to keep the pregnancy. She said:

> *"He said I should abort it so that he can build a house for me. So I told him that I won't"* (22 year-old woman).

On the other hand, some participants were not able to communicate the news of the abortion to their partners because they had no knowledge about the whereabouts of their partners. A participant narrated that:

> *"When I told him about the pregnancy, I didn't hear from him. So I even went to his house. When I went, I didn't find anyone there. That is why I have come to abort it. He doesn't know I am coming to terminate the pregnancy, because I don't see him or hear from him"* (27 year-old woman with one child).

6.2.3 Knowledge of health-seeking behaviour

This theme describes male partners' knowledge of places and people to contact for an abortion. Two sub-themes emerged from the analysis: knowledge of health professionals required to perform the abortion, and places for abortion care services.

The narratives indicate that, only one woman reported that her partner knew of a medical professional who could provide abortion care services. Her partner therefore obtained medication abortion (MA), prescribed by the doctor and guided her on how to administer the medication at home. However, after an unsuccessful home abortion with the medication, he brought her to the hospital for post-abortion care. The respondent, a 21 year-old woman said:

> *"When he bought the pills for me, I told him that the pregnancy didn't terminate and he said it's because I didn't take the pills well. He said that he bought the pills from a medical doctor. He asked me to take the pills but if I take it and the pregnancy doesn't terminate, we will go to the doctor. I told him I don't want to go to a doctor around our area".*

Another theme that emerged from the narratives was related to male partners' knowledge of abortion places. The narratives showed that five respondents' partners had prior knowledge of where to have an abortion. Two of these interviewees had their partners fully responsible for seeking abortion care. They mentioned that their partners knew that abortion services could be obtained from the hospital. In that vein, they were directed and accompanied to the hospital. One participant reported:

> *"We have a friend at the hospital administration. So yesterday, my husband came to him and he introduced the health provider to him. The health provider asked us to come today"* (32 year-old woman with 3 children).

Another respondent commented:

> *"There is a hospital where I stay but I don't like it. My partner stays around this place [Amasaman] and he said he will bring me to Amasaman"* (21 year-old girl).

In the case of three other participants, their partners instructed and directed them to visit the pharmacy, drug store or hospital for an abortion. They were not accompanied by their partners during the time of seeking abortion care. For instance, two participants reported that, after discussing the pregnancy outcome and decision to have an abortion with their partners, their partners explicitly instructed them to go to the hospital. They narrated in the following words:

> *"He told me not to do anything to terminate the pregnancy but I should come to the hospital. He showed me that the abortion can be done here. He said that they had to terminate the wife's pregnancy in order to save her life, so they came here"* (23 year-old woman).

> *"My husband told me to come to this place where pregnant women are looked after but they will attend to me. And so I came to this hospital"* (27 year-old woman with two children).

The rest of the respondents revealed that they were directed to the hospital by their peers, siblings, and relations. On the other hand, 60 percent of the surveyed respondents reported that other people other than their partners gave them information on where to go for the abortion.

6.2.4 Knowledge of abortion methods

Knowledge of abortion methods was the fourth theme that emerged from the narratives. Participants' reports showed that although male partners knew that abortions could be terminated in a hospital, they had little knowledge of the procedure by which the pregnancies could be terminated. One out of the three men interviewed had foreknowledge about how the

pregnancy could be terminated, both surgically and with medication. He knew of both methods of abortion based on prior experience. He reported that it was the second time he and the partner were having an abortion from the same provider and health facility. During the first home abortion, he directed his girlfriend to purchase a medication drug called 'cytotec' which he had heard about from a friend. Unfortunately, it ended in an incomplete abortion which compelled them to seek post-abortion care at the hospital. With this background knowledge and experience, it wasn't difficult seeking abortion care from the hospital again. He narrated in these words:

> *"She was mounting pressure on me so I had to give her money to terminate the pregnancy. Initially, I told her to go to the hospital but from the way she was speaking, I could tell that she didn't go. She was still disturbing me so I gave her money to go to the hospital. I asked her if there was a good pharmacy around to buy the cytotec which I had heard off."* (23 year-old male partner).

On the other hand, the other two men obtained knowledge of the abortion method from health providers at a health facility. Whilst one came directly to the hospital to seek information on the abortion from a FP health provider, the other was referred from another health facility following his partner's desire for antenatal health services. According to one male partner, he and the girlfriend went to a nearby clinic to access maternal health care services. They were, however, redirected to another health facility for further maternal health care services and any other information pertaining to safe abortion. He said:

> *"Earlier this morning, she told me that she is not feeling fine. So I told her to go to ante-natal clinic. So when we got there, the lady said it was a new place so they don't provide maternal care. So the woman told her that if she wants ante-natal services, then she should come to Amasaman hospital"* (23 year-old male partner).

During the interview, it also emerged that some respondents' partners knew that an abortion could be done biomedically and surgically at the hospital. Respondents had the option to decide on the abortion method before the actual care was sought. One of them asserted:

> *"Hmmm, he asked me what I will do, either take medicine or go to the hospital. I told him I will go to the hospital"* (26 year-old woman with two children).

6.2.5 Non-awareness of the abortion

This theme describes male partners' lack of awareness and knowledge of the abortion. Almost one-third of the female respondents mentioned several reasons for not disclosing the abortion to their partners. In addition, the circumstances under which the abortion occurred varied, causing some of these women to withhold the news of the abortion from their partners. One woman narrated that her partner disappeared after she informed him about the pregnancy and had no opportunity to inform him of the abortion. According to her, his absence made her ambivalent, causing delay in seeking abortion care. She said:

> *"Since I got pregnant I have not heard from him. Although I decided to give birth, I have not heard from him since then. Even when I call, I don't hear from him. When I told him about the pregnancy, I didn't hear from him. So I even went to his house but I didn't find anyone there. That is why I have come to abort it* (27 year-old with one child).

Of these respondents, four mentioned that despite their partners' knowledge of the pregnancy, they had no intention of ever disclosing the abortion to them because of infidelity, negative partner attributes, and poor quality of the relationship. All of them expressed their intention to discontinue the relationship after the abortion. Annie, a 27 year-old woman of three recounted:

> *"I told him my menses has come again so I am not pregnant, otherwise, he will tell his friends that I was pregnant and I have come to remove it. I decided to give birth but I changed my mind because the man already has a wife and children. The woman can even go and do something to you. So I will come and abort. I will never tell him of the abortion".*

Another woman reported that she would not disclose the abortion to her partner because his knowledge of it would create family conflicts. She admitted though that he knew of the pregnancy and wished to have a child. She averred:

> *"I told him I can't keep the pregnancy. He just doesn't understand. If he finds out that I had this abortion, it will be a whole thing. I'm not going to tell him. He doesn't agree and there is no way he's going to agree with me and he is going to make a big deal about it"* (21 year-old woman).

In two other distinct cases, the abortion decision was made by parents and caregivers. One respondent said that her partner was ambivalent about the pregnancy, so this forced her caregivers to terminate the pregnancy without her consent. She remarked:

> *"My aunty asked me to tell the guy that I was pregnant. But when I called him, he didn't pick my call. I went to his house and told him of the pregnancy and he said he doesn't know what to do now because of my current work. So he asked me whether I want to terminate the pregnancy or keep it. I also don't know what to do and my sister brought me here"* (19 year-old woman).

In a similar vein, parents brought their 14 year-old daughter to the CAC provider for an abortion. They were directed by a staff in the same facility. During the interview, the young girl reported being oblivious of her pregnancy after being questioned by her parents severally. She mentioned that her boyfriend was not aware of the pregnancy and the abortion. She also had no knowledge about what it meant to have an abortion. She narrated:

> *"I didn't do anything about the pregnancy. My mother asked me and I said I am not pregnant. I haven't menstruated this month and she said I'm pregnant and I said no. I disagreed with her that I'm not pregnant but she said I'm lying. My parents went to buy pregnancy test and showed it to me before I knew that I was pregnant. I will call and tell the boy about what has happened".*

Another young girl who visited the facility for post-abortion care reported that the pregnancy was unknown to her and the boyfriend. Neither did they decide nor intend to terminate it. She narrated ingesting some herbal mixtures to cure stomach pains but started experiencing abdominal pains and bleeding a few hours later. It was at the health facility that the pregnancy was detected and upon further interrogation, the health personnel confirmed an incomplete abortion as a result of a self-induced abortion. She recounted in the following words:

> *"I didn't know that I was pregnant. If I had known, I would have told my partner and he would have accepted it. The nurses asked me whether I had taken any medicine and*

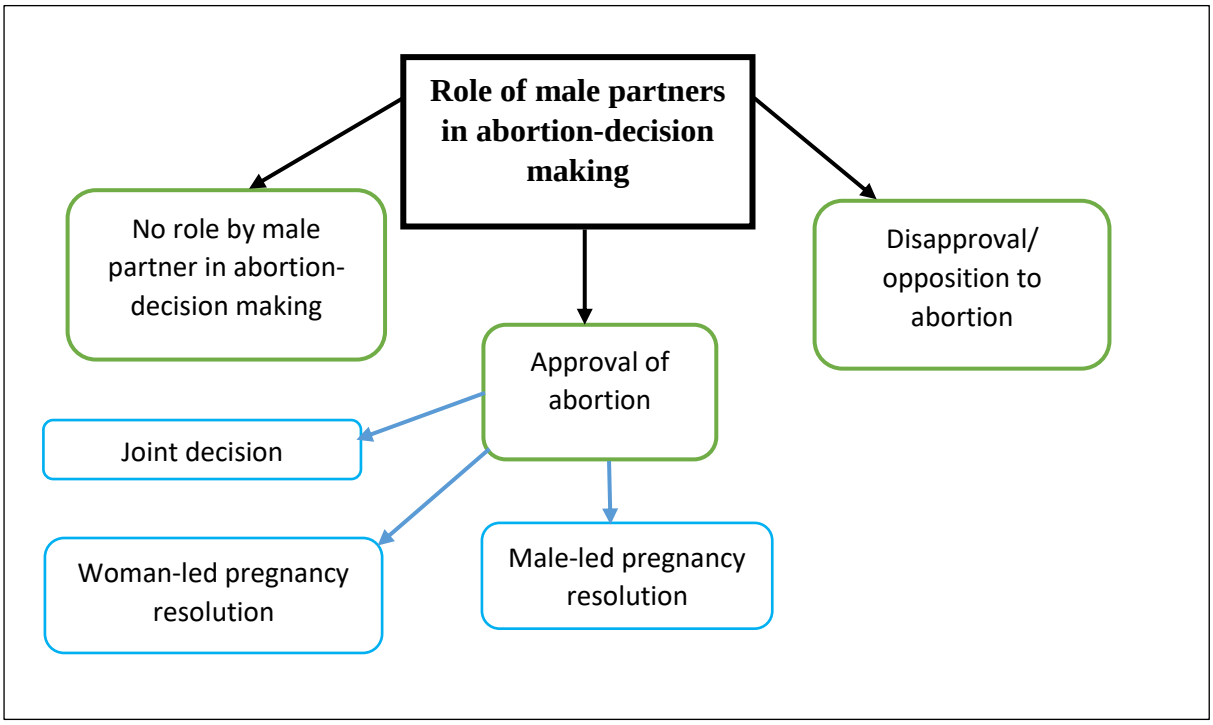
> *I said no I hadn't. I don't know the type of medicines. But if my partner knew of the pregnancy, he wouldn't have told me to abort it. He has ever asked me that if I get pregnant, will I abort it. I said no, I won't abort it. My partner asked me how the pregnancy got spoilt. I told him it started on Saturday. It was really worrying me. So my brother's wife gave me medicine and I don't know whether that spoilt the pregnancy. That was what I told him"* (18 year-old girl).

From these narrative accounts, it can be deduced that respondents were determined at all cost to end the pregnancy, although a few were ambivalent about the pregnancy decision. It is also evident from their responses that the pregnancy was unintended or unplanned, hence the desire to terminate it with or without their partners' consent or approval. These accounts reflect a strong sense of self-determination and confidence in seeking abortion care with the goal of avoiding any possible disruptions in their life trajectory.

6.3 Role of male partners in abortion decision-making

This theme describes the various roles played by male partners during the abortion decision-making process. The sub-themes that emerged portray that the pregnancy resolution process is complex and involves multifaceted factors prior to the final decision to have an abortion. Three sub-themes emerged from the analysis of transcripts and include the following: male partners' approval of the abortion, disapproval or opposition to the abortion, and lack of partners' participation in the abortion decision-making process. A graphical presentation of the thematic areas and sub-themes is shown in Figure 6.2.

FIGURE 6. 2 GRAPHICAL PRESENTATION OF THE ROLE OF MALE PARTNERS IN ABORTION DECISION-MAKING



Source: Author's construct

6.3.1 Approval of abortion

The results from the study showed that majority of the female's partners approved of the abortion and were involved in decisions leading to the abortion by initiating the pregnancy resolution process. Approval for the abortion was initiated through direct requests, orders, negotiations, and discussions. Indirect approval was given after seeking the woman's opinion about the pregnancy before the final decision was made jointly, or by the male partner. From the narrative accounts, the male partners played active roles in seeking abortion care. Two sub-themes emerged from the analysis of the responses. These were the male partners as initiators of the abortion decision and the woman-led pregnancy resolution.

6.3.1.1 Male partner as initiator of abortion decision

When the women were asked to describe who initiated the discussion on ending the pregnancy as well as their partners' reaction to the pregnancy disclosure, seven of them reported saying:

"he said I should abort it". From the women's accounts, male partners approved of and supported the decision to end the pregnancy. They were usually the first to initiate the decision to abort the pregnancy through direct orders and requests. Further, pregnancy negotiation was directed by the men and involved suggestions, discussions, rationalisation, questioning, costs of childbearing and child care, and financial burden. The negotiations were underpinned by two main considerations: first, on current circumstances within the relationship context; and second, on possible disruption in their life trajectory.

For instance, one male partner reported that he was very influential in the decision-making process. According to him, he was the first to initiate a discussion surrounding the pregnancy because of the negative consequences that might affect his partner (i.e. dropping out of school). He subtly rationalised the situation and decided to discuss with the girlfriend to have the pregnancy terminated. After discussing with his girlfriend about the need to complete her education, she agreed to have the abortion before they finally sought abortion care at the hospital. He reported:

> *"I suggested in the first place that the pregnancy should be terminated. I told her about her education. I was very concerned about her school. I know that if the pregnancy is developing, school authorities will not allow her so I told her about it and she understood that we have to terminate it. I don't like a situation where I will be an obstacle to her education. Also, because of the pregnancy, I told her that we have to terminate it and she agreed. I didn't force her. I had to speak to her. We talk together. So we decided that we have to terminate it"* (23 year-old male partner).

Another finding that emerged was that only one male partner who directly requested an end to the pregnancy attached conditional clauses to the abortion decision. The respondent narrated that her partner out-rightly demanded an abortion on hearing of the pregnancy so he could assist her to complete her building. However, when she refused his request for an abortion, he withheld all financial support and failed to pay any expenses related to the abortion. She asserted:

> *"I became pregnant and when I told him, he said I should abort it. Yeah, I should abort it so that he can build a house for me. He asked me to abort it and I said no because I was very determined to give birth. I told him I want to give birth and he didn't bother about it. It came to a time that even when I ask for money, he doesn't want to give me. But I know that when he has, he will give me. But now when I ask him for money, he doesn't have money. So I decided to abort it"* (22 year-old woman).

Further analysis of the transcripts showed that indirect requests by male partners for an abortion were often made through negotiations, suggestions, rationalisation, and cost-benefit analysis. Whilst some men resorted to providing realistic justifications for the woman to rationalise with, others suggested an abortion without plausible reasons. In most of these cases, the woman's consent was sought first before the process of seeking abortion-related care began. For instance, one woman stated that she wished to keep the pregnancy although her partner was not in support of that. They dialogued about the need for the termination and he offered reasonable justifications especially, completing her apprenticeship, and to bring honour to herself by not having a child out of wedlock. She narrated:

> *"He enquired whether I will give birth or terminate the pregnancy. I told him that I wish to keep the pregnancy. His reason for not wanting me to give birth is to allow me concentrate on learning the trade. He said: "if you impregnate a woman, you have to take her to your house. She doesn't have to continue staying in her mother's house". So he asked me that when I give birth, would I still stay with my mum? I said no. Then he said he will bring me to come and terminate it"* (21 year-old woman).

According to another respondent, her partner proposed that the pregnancy should be terminated without tangible reasons. However, the decision was arrived at after she also expressed no interest to continue with the pregnancy because she wasn't ready to cater for a child with a married man. She commented:

> *"He said if it's not because of something, he should have made me give birth but I don't want to. I did not say anything. He asked me of my plan and I said I don't want to give birth with somebody who is married and he said then he will give me money"* (23 year-old woman with one child).

The circumstances for two other women differed as their partners neither requested for an abortion nor proposed it, but their actions implied or was suggestive of pregnancy unwantedness. Judging by their partners' behaviour at the time of pregnancy disclosure, they decided to seek abortion care. Their partners' roles in the decision-making process was limited because of their non-committal behaviour. The participants averred:

> *"As for my partner, he hasn't made up his mind to have children and I am also not married. I can't do that while I am at the mission house. He is not ready to have a child. So I told him I was pregnant. The first time, he gave me money to buy a drug and I inserted it, but it didn't work"* (23 year-old woman).

> *"He said he is not aware that he is responsible, so I have to do something about it because I don't want to end my marriage. So yesterday when he returned from work, he told me that he cannot take care of the pregnancy. So I have to do something. I have to come to the hospital"* (39 year-old woman with four children).

6.3.1.2 Woman-led pregnancy resolution

From the narratives, 10 women reported that they initiated the decision to end the pregnancy and were more influential in the abortion decision-making process compared to their partners. They stated substantive reasons to justify their decisions for an abortion. Consequently, their partners who hitherto disapproved of the abortion, now supported them. The reasons the women gave for wanting to terminate their pregnancy were mainly health-related reasons, and financial/ economic constraints. What was also evident from these narratives was that these women autonomously decided on the abortion before asking for their partners' views. Only two study respondents made the decision to terminate the pregnancy for health-related reasons. They mentioned ingesting some drugs prior to detecting the pregnancy, hence the fear of giving birth to an abnormal child made them decide to abort the pregnancy. Two of them remarked:

> *"Actually, I never knew I was pregnant. I was taking this 442 medicine and I have heard that it is not good for pregnancy. I have taken this medicine thrice already. Considering the way my stomach is and the pains I'm experiencing, I told my partner that I cannot have a baby because I have already ingested this medicine and I don't know what will happen."* (39 year-old woman with two children).

> *"The reason for terminating the pregnancy is because it will worry me. If I don't terminate it, it will worry me because I have already taken a drug. I don't want to deliver something"* (31 year-old woman with one child).

Some other four participants had the final say as to whether to keep the pregnancy or terminate it. The decision-making power rested on them even after communicating with their partners on the outcome of the pregnancy. They asserted:

> *"When I found out about the pregnancy, I didn't know what to do. I was thinking whether to keep it and I remembered what I will go through with this pregnancy and this baby. So even before I told my husband, I had doubts whether to keep it or remove it, I don't know. So when I told him, he told me, when I'm pregnant I know what I go through and this baby is small. So what are we going to do? So I told him I've been thinking about it and I don't want to keep it"* (32 year-old woman with children).

> *"He asked me what I will do, whether to give birth or not. I told him that I don't want to give birth. He asked me if I will take medicine or go to the hospital. I told him I will go to the hospital" (*26 year-old woman with two children).

6.3.1.3 Joint abortion decision

Another theme derived from the narratives was joint decision-making on the pregnancy. One couple said that they both agreed to terminate the pregnancy. When they were asked separately, each stated that the decision was jointly made because of their young child. When the male partner was asked to report on who decided to terminate the pregnancy, he said: *"the two of us"*. The woman also similarly reported that: *"the two of us decided because the child we have now is young"*.

6.3.2 Disapproval of abortion

The second theme which emerged from the narratives was disapproval of the pregnancy termination. Seven women stated that their partners disapproved of the abortion and wished to keep the pregnancy. For the most part, they significantly influenced their partners to consent

with the decision for an abortion and navigated the decision-making process by offering tangible reasons to justify their demand. The responses showed a strong insistence to terminate the pregnancy at all cost with or without their partners' support. Two participants narrated how insistent they had to be in order to convince their partners to agree with their decision. One of them said:

> *"When he came I told him of the problem and asked him what we are going to do. He told me to keep it. I said nothing. He wanted me to keep it but I didn't want to keep it. So I asked him to give me money to do abortion but he refused to give me money. I persisted but he refused to give me money for the abortion. So since I had already decided not to keep it, I won't let it keep long at all. When I realized I was pregnant on Wednesday, he said we shouldn't abort it but I insisted and he said okay he will give me money to take it out. So I thought of it though I was very afraid"* (32 year-old woman with one child).

The other respondent also narrated:

> *"He is a student. He was a little bit scared because maybe he will stop schooling that's why I said we should abort it. At first, he said I should give birth but later on, he was scared because he is now schooling and we have no money. Hmm, I think I was the one pressuring him to do the abortion"* (25 year-old woman with one child).

In another case, a participant stated her partner's readiness to have a child but she decided to terminate the pregnancy without his knowledge in order to avoid family problems with her parents. She narrated saying:

> *"He doesn't know about the abortion. I am not going to tell him. He doesn't agree and there is no way he's going to agree with me and he is going to make a big deal about it. He was threatening to call my daddy about the whole thing and I tried to calm him by telling him that I will be busy this week so that, by next week, I will find time so that we can go together to do a blood test to see whether its positive. I don't trust the urine test"* (21 year-old woman).

For another woman, the fear of psychological disruption, work-related reasons and future schooling aspirations motivated her to terminate the pregnancy despite her partner's decision to keep the pregnancy. She averred:

> *"He said I should give birth and I said no. He wasn't happy with it. I told him that I will be going to school and because of my work it will worry me"* (26 year-old woman with one child).

The reasons some other women gave for wanting to terminate the pregnancy were made in the context of avoiding disruptions to their current life trajectory. Two respondents remarked in the following words:

> *"The guy who made me pregnant told me to deliver the baby, but I said no because when I signed the contract, we were told that when you get pregnant, all your money will be wasted, about 7 million. I will be done next year February. So I told him that he should give me money to do it and I told him that it will never happen again"* (23 year-old woman).

> *"He says I should give birth with him, but I said I can't. No I won't. I want to travel and my time is nearly up, next month I will be leaving". He told me that as for him, he doesn't do those things but I should give birth. And I told him I cannot give birth. It will prevent me from doing something. And if I'm unable to do what I want to do, you and your children will enjoy, and I will be disgraced"* (34 year-old woman with two children).

6.3.4 Lack of male partners' role in abortion decision-making

Male partners' lack of participation in the abortion decision-making was the final theme which emerged during the interviews. Of the total number of thirty-eight (38) female participants interviewed, nearly one-third did not have their partners playing any role in the abortion decision-making process. The main reason for male partners' non-involvement in the abortion decision was because the women chose not to disclose the abortion to their partners. Although few women disclosed their pregnancy status to their partners, they terminated the pregnancy without their partners' knowledge, approval and support. They independently made the decision and were not expectant of any support during the abortion decision-making process. One of the participants simply reported that: *"I won't tell him about the abortion. I just want him to bring his family"*.

Another participant, a 40 year-old woman lamented about her partner's irresponsible behaviour towards the family and her firm resolution to prevent anymore unintended pregnancies. She commented:

> *"As for me, I just want the pregnancy to be terminated so that I will be free of any worries/problems and run my business. The children I had in this latter part, can you imagine that I pay their school fees and everything they need. He doesn't look after the two children I had after he told me not to give birth again. Bearing in mind that he doesn't want any more children, I cannot have this child because it will worry me. So I have to do something to terminate this pregnancy. I haven't even told him about the pregnancy because he won't do anything about it".*

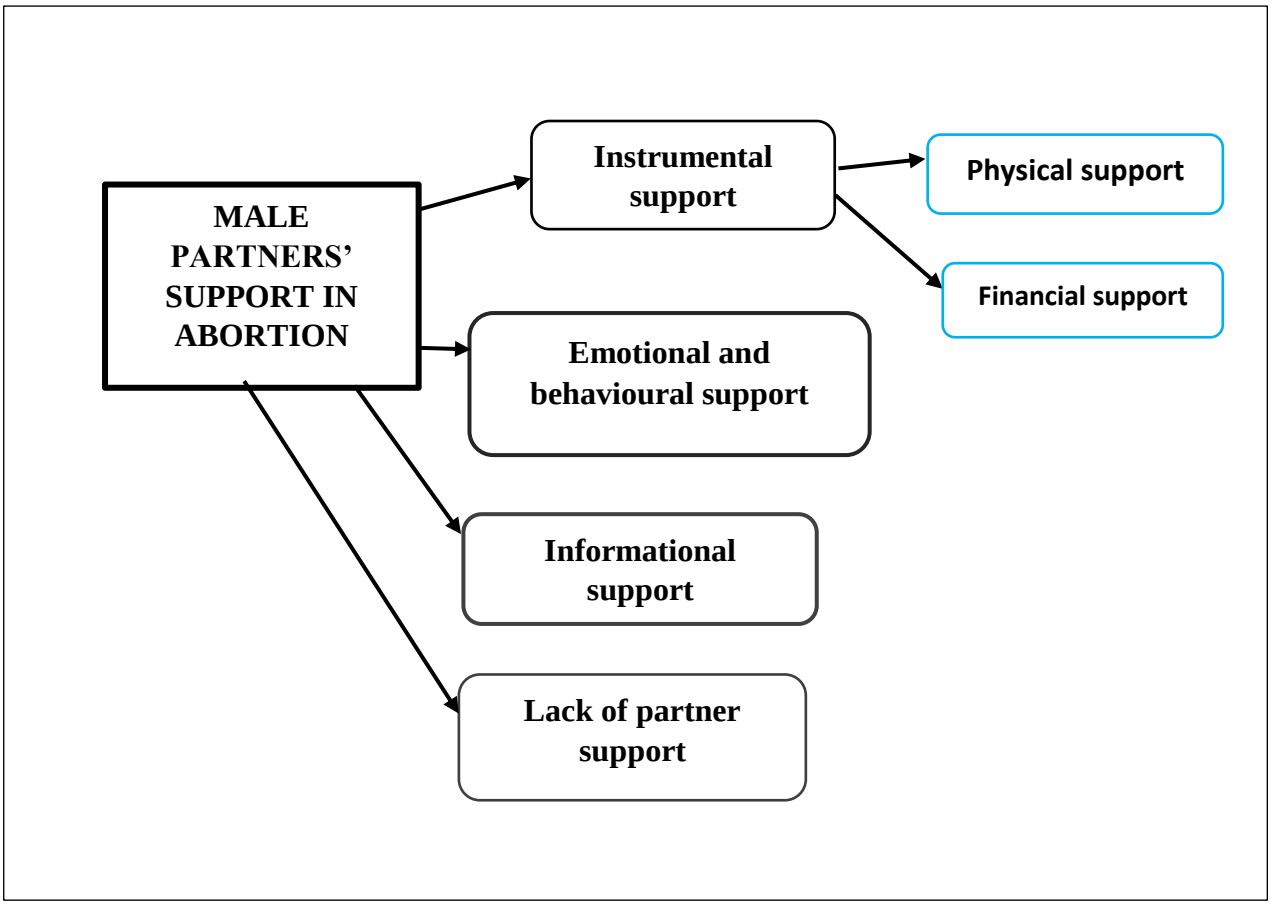
Also, the circumstances under which the pregnancy termination occurred were without the knowledge of the man responsible for the pregnancy; especially when the decision was made by parents and guardians. In one case of abandonment of the woman by the male partner, the respondent had expected her partner to participate in the pregnancy decision-making. She independently decided to keep the pregnancy. However, when she realized she had been abandoned after several weeks passed, she made the decision to terminate the pregnancy. She stated that:

> *"When I told him about the pregnancy, I didn't hear from him. So I even went to his house. When I went there, I didn't find anyone there. That is why I have come to abort it"* (27 year-old woman with one child).

6.4 Male partners' support in abortion

Partners' support during the abortion was the third broad theme that emerged from the results of the analysis. This theme sheds insights on the different dimensions of support received by participants from their male partners prior to and at the time of the abortion. Three types of partner support emerged from the analysis. These are: instrumental, informational, and emotional. Figure 6.3 shows a graphical presentation of the themes and sub-themes derived from this broad theme.

FIGURE 6. 3 DIAGRAMMATIC PRESENTATION OF MALE PARTNERS' SUPPORT IN ABORTION



Source: Author's construct

6.4.1 Instrumental support

Instrumental support is used in this context to make reference to tangible and intangible aid and service. For example, aid in labour, for instance, housekeeping or childcare; provision of transportation or financial assistance, and time provided by an individual.

6.4.1.1 Payment for abortion

From the interviews, instrumental support was mainly characterized by the provision of funds and other expenses related to the abortion care. Out of the 38 women interviewed, nearly half of them reported that they received financial support from their male partners to pay for the cost of the abortion whilst a greater proportion (77 percent) of the surveyed respondents reportedly received funds from their male partners for the same purpose. Besides receiving

funds to cover the entire costs of the abortion, other participants reported receiving only part of the money for the abortion. Three women, during the in-depth interviews, reported that the cost of abortion was shared with their partners. They received insufficient money to cover the expenses of the abortion so they supplemented with their personal funds. A 39 year-old woman commented that: "*My husband gave me some and I also added mine".* Another participant also reported that:

> *"He gave me GH150 but I was told to have GH200. So I added my own GH30 to become GH180"* (23 year-old woman).

However, eleven women personally paid the cost of the abortion without any financial aid or support from their partners. The circumstances under which the women paid for the abortion expenses themselves varied. Whilst some paid because their partners were not around to provide the money, others wanted to avoid delay in seeking abortion care. One woman for instance, paid herself because her partner had absconded and she was ambivalent about the pregnancy outcome. She said:

> *"I used my money for this abortion. I have been to his home several times and I don't meet him. I don't hear from him too and there is no one in his house. The main reason I came to terminate this pregnancy is because I don't hear from him"* (27 year-old girl with one child).

Another woman also used her personal finances as she didn't want the pregnancy to be detected early by her older siblings and house owner. Although her partner had initially provided money for a home abortion, she urgently decided to seek abortion care from the hospital following a failed home abortion. She reported that her partner was not aware of this second abortion at the hospital. She narrated:

> *"I used my money for this abortion. I was going to buy something with it but I will collect it from him. The first time I did the abortion, he gave me money to buy a drug and I inserted it, but it didn't work. I don't know the name of the first drug I bought. Then I took money again and I went to buy cytotec. With the second attempt, I took cytotec but it didn't also come"* (23 year-old woman).

Only one participant said that her partner refused to give her money for the abortion when she asked him. She, therefore, used her personal funds but planned to recoup the money from him afterwards. She explained:

> *"Seriously, he said he doesn't have money. I know when he has, he will give me. But now when I ask him money he doesn't have. Oh so I was there and I was thinking, it became a burden, seriously. He didn't pay but I know he will pay because he was having money. I know that he will and he is going to pay the money"* (22 year-old woman).

6.4.1.2. Accompaniment to the hospital

Being accompanied by the male partner to the hospital for the abortion was the second instrumental support mentioned by respondents. From the observations and narratives, 14 women were accompanied by either their husbands or boyfriends, whilst 33 percent of the survey respondents were also accompanied by their partners. Of this, only three male partners were interviewed. During the interviews, the male partners were not in close proximity to the women. Instead, they were somewhere within the precincts of the hospital.

For instance, during the in-depth interview, one participant said that she and her partner thought men were not allowed in the counselling room and family planning clinic. For that reason, he decided to wait for her outside the hospital. The following observation (Box 1) was made:

Box 1: Field extract, DAY 16, 07/07/2016

I introduce myself to a second young girl seated at the family planning unit. She reveals during the interview that she is a Moslem accompanied by the man who impregnated her. She reports that her partner is sitting outside. Asked why he didn't join her inside the family planning unit, she says it appears men are not allowed inside. In the middle of the interview, a ward assistant comes to call her that the healthcare provider is waiting to do the procedure. I observe that she proceeds towards the entrance of the hospital gate. When I ask, she said she's going to collect money from the man to pay the health provider before the procedure. I miss out on speaking to her partner.//

Two out of the three male partners sat closely to where the abortion procedure was being performed. In one instance, the husband accompanied his wife to the family planning room for post-abortion family planning counselling. The observation accompanying the interview is provided below in Box 2:

Box 2: Field extract, DAY 19, 15/07/2016

I see a woman and her husband being accompanied by a ward assistant of the abortion provider going to the family planning Unit. I enquire from the abortion provider whether the couple came for an abortion. She responds in the affirmative. I follow-up to the family planning unit. The couple enter the family planning Unit and sit together while the man carries their young child. I ask the nurse to direct them to speak with me. I introduce myself and the man asks me to speak to his wife but I tell him that I need his responses as well. Woman says she isn't well so is unable to chat with me but the family planning nurse encourages her to speak with me. A few minutes into the interview, I realize that my recorder is full so I proceed to interview the couple together. //

In the second instance, the male partner waited outside the procedure room and after the procedure, accompanied his partner to the family planning unit. He sat in the FP Unit while his partner was counselled. The observation following the interview is provided in the extract in Box 3.

Box 3: Field extract, DAY 27, 06/9/2016

While waiting at the counselling room beside the abortion procedure room, the ward assistant informs me about a young girl coming for abortion. I seek her consent in the counselling room. I enquire whether she came alone but she tells me that her boyfriend is around. She is shy at first; sometimes, not willing to talk. After the abortion procedure, her partner emerges from the waiting area outside the abortion procedure room and walks with her towards the family planning Unit. We sit at the Family Planning clinic not far from her boyfriend. She gives short brief answers and looks away the whole time of the interview. The nurse interrupts and calls the respondent for counselling. I approach her partner and tell him about my study. He is receptive and gives his consent to be interviewed.//

However, with the third couple, the male partner was not beside his partner. He was waiting outside at the patient waiting area. The woman mentioned that he was shy and wouldn't want to be interviewed. But upon invitation to be interviewed, he consented.

The three male partners were asked to state the reasons for accompanying their partners to the hospital for the abortion. The reasons given pertained to psychological attachment especially of love, emotional support, sense of obligation, and concern for satisfaction of service delivery. One of them stated: *"She's my wife and I love her that's why"*. The other two also reported:

> *"Oh I couldn't allow her to come alone, because I told her in every circumstance I'm behind her so that it will even boost her. At first I wasn't in support, I didn't agree with her to come and abort. But she sat with me and explained to me that we have to do it for the mean time. So I decided to come with her"* (23 year-old male partner).

> *"Oh, I came just to be sure that everything is well done for her. I just have to get involved because leaving her alone is not the best. I came with her the first time. I also prefer to come with her. I can't leave her to come alone. I would have, I insisted to come"* (23 year-old male partner).

Eleven women mentioned that their partners wished to accompany them to the hospital but could not do so because of work demands and change in plans. The frequently stated reason for the male partners' absence at the hospital was mainly work-related. A 26 year-old woman said: *"I wanted him to come and escort me but he said he will not be able to come because of work"*.

Some respondents narrated that personal commitments unrelated to work prevented their partners from being present at the hospital at the time of the abortion. A 28 year-old mother with four children explained: *"he knows I have come to the hospital and he also left for town"*.

Only one woman reported that her partner had travelled. She said *"he is my fiancé'; he has gone to Italy"*. On the contrary, one woman reported that the fear of abortion deterred her partner from accompanying her to the health facility for the abortion. She narrated:

> *"When I told him to bring me here, he told me that he's going to work. He is very scared. Even when I got pregnant and I was coming to deliver, he didn't come along. It was his sister and mother. He was afraid. He is always calling me to find out if it has been done for me, and I told him to wait but not yet. But after it's done, I will call him. As for him, he is afraid"* (27 year-old woman with two children).

Two others did not want to be accompanied by their partners to the hospital at the time of seeking abortion care without any reason. One of them stated:

> *"He is a steel bender so he was going to work for someone. But he made up his mind to accompany me but I told him its nothing, but I will come alone. I don't want it"* (23 year-old woman).

6.4.2 Informational support

Informational support relates to the acquisition and provision of relevant information pertaining to where the pregnancy can be terminated, by whom, and how it can be terminated. During the narratives, respondents revealed that some of their partners were knowledgeable of where an abortion could be performed and they facilitated the process of seeking abortion-care. For the survey respondents, 40 percent of them reported that their partners provided information on where to go for the pregnancy to be terminated. Those who reported that their partners knew of the places for the abortion stated:

> *"The man [referring to partner] showed me this place that it can be done. He is around. He is the one who brought me here"* (21 year-old girl).

> *"You see, we have a friend at the administration. So yesterday my husband came to see him and he introduced us to the lady. So he came here yesterday around 4:30 so she asked that we come today"* (32 year-old woman with three children).

One male partner had previously accompanied his partner to the same health facility for an abortion so it was easy for him to navigate the process of seeking abortion care. He also mentioned that he directed his partner to purchase a medication pill for a home abortion but

she was reluctant. Hence, his decision to accompany her to the hospital for the termination to be done.

> *"We terminated it the first time here in this hospital. For that one it was very young by then. We came here. We went to the scan room then just like the same procedure. Initially, I told her to go to the hospital but from the way she was speaking I, could see that she didn't go."* (23 year-old male partner).

Two women were also directed by their partners to seek abortion-care from the hospital but they were unaccompanied. A 27 year-old woman commented:

> *"My husband told me to come to this place where pregnant women are looked after, but they will attend to me and so I came here".*

Another respondent also mentioned that *"he told me not to do anything to terminate it but I should come to the hospital".*

In another vein, a 19 year-old girl reported that her partner brought her to the hospital on the behest of her mother for the abortion. But at the time of the interview, her partner had returned home. She explained: *"It is the boy who brought me here. My mother told him to bring me here [to the hospital]".*

6.4.3 Emotional or behavioural support

Emotional/behavioural support is used in this context to describe the care, concern, and expressions of empathy and encouragement expressed by the male partner before and after the abortion. Participants were asked to describe and report on the verbal, and non-verbal emotional and affective acts expressed by their male partners which helped to alleviate distress at the time of having the abortion. When asked, most of them could not explicitly describe how affectionate their partners had been towards the pregnancy termination.

From the narratives, it was evident that emotional and behavioural support was expressed in different ways, especially through concern about the health of the woman. Three

women stated that their partners showed concern for them prior to the abortion by advising them to seek abortion care from the hospital since they didn't want any complications, and also because it was safer. A 23 year-old woman simply said: *"He told me not to do anything to terminate it but I should come to the hospital".*

Emotional support for the abortion was also expressed through concern for the welfare of the woman after the abortion through phone calls. It was observed during the interviews that some respondents received phone calls intermittently from their partners. Whilst some women's partners called to enquire about the procedure, others enquired whether the procedure had ended, and had set off home, whether they were in good health and other issues. One woman commented:

> *"He even called just a while ago and asked whether I'm finished. I told him that I'm now going to do family planning. He is always calling me to find out if it has been done for me, and I told him to wait but not yet. But after it's done, I will call him"* (27 year-old woman with two children).

Three interviewees reported receiving encouragement from their partners to adopt a family planning method after the abortion. One of them narrated how insistent the partner had been for her to adopt a family planning method prior to the abortion. She said:

> *"He has told me to go and do family planning but I told him that I'm afraid. It's about 5 months now when he told me to go and do family planning. But I'm also afraid because I was told that it kills people. And I was also there the whole time and now I'm pregnant again"* (27 year-old woman with two children).

On the other hand, 44 percent of the survey respondents reported that their partners expressed concern about their health, whilst 50 percent said their partners were concerned about the abortion.

6.5 Lack of partner support for the abortion

Eleven (11) women did not receive any form of support from their male partners when they sought abortion care. The context under which these participants did not receive support from their partners at the time of having the abortion varied. Abandonment, partner-related problems, relationship-related conflicts, and parental responsibility were reported as grounds for non-involvement of partners. However, the main reason stemmed from the male partners' lack of knowledge of their female partners' personal decision to end the pregnancy, although a few of them were aware of the pregnancy. Thus, lack of partner support directly resulted in or contributed to partners' non-involvement during the abortion. In one circumstance, an interviewee mentioned that she chose to keep the pregnancy a secret because her partner wouldn't provide any financial support. She simply retorted: *"I haven't even told him about the pregnancy because he won't do anything about it".*

For some others, the abortion decision was made by their parents and guardians without recourse to the man responsible for the pregnancy. Hence, there was no anticipation of involvement of the partner. For instance, a young girl narrated that her eldest sister was the final decision maker on the abortion. Her sister accompanied her to the health facility, and made all payments and other expenses for the abortion. She averred:

> *"My sister paid for the abortion. We were asked to pay 200 cedis, then it was reduced to 150 but she said she couldn't pay for it. She had only 80 cedis so that is what we paid"* (19 year-old girl).

6.7 Male partners' involvement in post-abortion family planning uptake

The results from the study showed that nearly two-thirds of the in-depth interview participants and 72 percent of the survey respondents adopted a family planning method immediately after the abortion and even before leaving the health facility. Compared to the in-depth interviewees, the proportion of survey respondents who had future intentions of using post-abortion family

planning was slightly higher (24% and 28%). Fewer than 15 percent of all study respondents had no future intentions of adopting a contraceptive method after the abortion. However, for three participants in the in-depth interviews, it was not clear whether they adopted a family planning method after the abortion because of their sudden 'disappearance' immediately after the abortion procedure.

A greater proportion of the study respondents took up long-acting reversible contraception (LARC) immediately post-abortion. Among those interviewed during the in-depth interviews, for example, 15 of them chose a LARC, specifically implants. Similarly, majority (72%) of the survey respondents also preferred LARC, mainly implants (38%) and intrauterine device (9%). The remaining respondents opted for short-term contraception with the injectable, oral contraceptive pills and male condoms. For the interviewees, less than one-third preferred the injectable compared to 17 percent of the surveyed respondents. Six percent opted for the oral contraceptive pills and two percent chose the male condoms.

From the narratives, immediate post-abortion contraception uptake was not a result of male partners' involvement. Multiple reasons were provided for the immediate adoption of the contraceptive method after the abortion including: healthcare provider's counselling and suggestion, and sometimes 'indirect compulsion'; availability of contraceptive method upon request; and low cost of family planning. One participant reported that:

> *"The family planning nurse asked me which one I preferred. Then I told her I wanted the five year type. The abortion care provider said I should use the 5 year type. I would have chosen the 3-year family planning type but because of what she [referring to abortion provider] said that's why. She called the family planning nurses to tell them"* (27 year-old woman with one child).

Another respondent also narrated that her preference for a particular family planning method was influenced by the health provider. She said:

> *"The nurse counselled me a lot on family planning. She said, there is one month, three months and three years, and one year. And after she finished speaking, I told her that I*

> *will do the 3 months type. And she said as for that one, I can easily get pregnant again. So I should do the 3 years type because that one has a longer duration before I get pregnant. And I thought about it and made up my mind to do the three years type"* (27 year-old woman with two children).

Other participants also said that the decision to adopt a post-abortion family planning method was made by their caregivers. One of them stated:

> *"I was given the five year family planning type. My sister asked them to do it for me. As for me I don't know which types are available. My sister is the one who knows. When we got there, she asked them to give me the five years type"* (19 year-old girl).

From the observations, most women who decided to terminate the pregnancy were offered pre-abortion counselling by the abortion provider prior to the abortion. Sometimes, the abortion provider deferred post-abortion counselling to the family planning nurses. Post-abortion counselling focused on long-term contraception.

During post-abortion counselling, it was observed that the abortion care provider strongly cautioned the post-abortion women to initiate FP immediately to prevent another unplanned pregnancy which could occur within two-weeks after the abortion. However, FP uptake was met with disaffection, unwillingness and resistance by the respondents. The general concerns reported against FP use related to the side-effects of FP such as cessation of menses, dizziness, weight gain, fast heartbeat, and loss of weight. Some of the women expressed fears of future infertility with FP use. The respondents who mentioned negative experiences and side-effects with using FP were asked whether they had experienced these symptoms themselves, and to which they responded in the negative. Many reported knowledge of the experiences of FP use from friends, and relatives as well as through hearsays by other people. Some women who were still sceptical about the hormonal side-effects of FP, however, adopted an FP method for fear of a subsequent unintended pregnancy and abortion.

Occasionally, family planning uptake before the pregnancy termination was 'conditional' particularly for those women who opposed its use but wanted a pregnancy termination. It was observed that though some women were reluctant to adopt a FP method, they had no option than to accept the conditional clause being offered by the abortion care provider. In a few circumstances, some women requested for a short-term FP method instead of a LARC which the abortion care provider proposed. Their reason was to test for compatibility with their body. Yet still, those women who did not desire to initiate a post-abortion contraceptive method were not coerced. Neither were they refused abortion care. However, severe admonishment accompanied the performance of the abortion procedure.

6.8 Discussion

This chapter sought to explore male partners' participation in abortion and the extent of participation in women's abortion experiences and post-abortion family planning uptake. The study found that male partners are mostly involved in their female partners' abortion experiences through three main ways: knowledge of the abortion, role in the abortion decision-making process and provision of support. Partners' involvement in the abortion begins from the time of pregnancy awareness and disclosure and trajects until the termination of pregnancy. This entire period can be described as a continuum of stages with the partner being involved at marked points in the process of the pregnancy resolution.

Partner knowledge of the abortion is integral to the initiation of the pregnancy resolution process and subsequent pregnancy outcome. It also heralds a chain of other positive or negative outcomes. This finding is corroborated by other studies which also found that male partners are knowledgeable of their female partners' abortion and play active supportive roles during the pregnancy resolution process (Becker, 1996; Beenhakker et al., 2004; Schwandt et al., 2013). The results of the study demonstrate that averagely, male partners who are informed

of the abortion participated fully, partially or did not participate at all during the abortion decision-making process. In addition, whilst some partners played active roles after being informed of the pregnancy, others were ambivalent, passive or indifferent.

The knowledge factor is an important determinant of and precursor to male participation in the pregnancy resolution process because it admonishes the man to assume responsibility for the pregnancy outcome. It also enables inter-spousal or couple communication about the final decision to be made about the pregnancy. It is interesting to note from the women's narratives that few men had limited knowledge about where to seek abortion care following the abortion decision, reinforcing the belief that abortion is a woman's responsibility as suggested by some researchers (Papworth, 2011). Socio-culturally, because men are primary decision makers in sexual and reproductive health issues, most women in the study deferred to their partners immediately for a decision to be made. However, there are exceptions when the partners' whereabouts were unknown, and where the decision was independently made by the woman without involvement of the partner.

The study also found that male partners participate in women's abortion experiences through their roles during the abortion decision-making process. Multiple studies lend support to this finding (Schwandt et al., 2013; Freeman, Coast and Murray, 2017; Nguyen et al., 2018). For instance, Johansson et al. (1998) report that male partners approved of the abortion and were actually involved in the abortion decision. Although contrary results have been found in other studies (Leshabari et al., 1994; Norris et al., 2011), the results of this study provide evidence that male partners actually participated in their female partners' abortion decision, either partially or fully.

Further, the narratives showed that male partners either act as facilitators or initiators to end the pregnancy. Partners' greater influence regarding the abortion during the decision-making

process was tied to the provision of support for abortion-seeking care. On the other hand, negotiations characterised the discussions surrounding the pregnancy resolution in circumstances where the male partner disapproved of the pregnancy termination. These revelations highlight the existing knowledge that responsibility and final decision-making on fertility (or childbearing) lies with men.

Because some male partners may be absent during the pregnancy resolution process, participation may be expressed differently through expressions of support such as: through presence at the health facility at the time of abortion; providing money for transportation, and provision of finances for the abortion expenses. From the study results, partners' support for the abortion signified participation in the abortion. Provision of support ranged from payment for the costs of abortion, accompanying to the hospital for the abortion, provision of information on where to seek abortion-related care, and emotional support in terms of showing concern for the abortion. This finding corroborate other findings which indicate that male partners provided different forms of instrumental support during the time of the female partners' abortion (Cozzarelli et al., 1994; Becker et al., 2008; Kero et al., 2010; Kalyanwala et al., 2010; Makenzius et al., 2012).

Financial support to cover the abortion expenses was the most dominant type of partner support expressed by male partners. Even partners who opposed the decision to end the pregnancy paid the cost of abortion. However, women whose partners were not aware of and informed about the pregnancy termination received no support from their partners, neither did they receive any other material support. Perhaps, a common responsibility that men feel obligated to is financial responsibility for the cost of an elective abortion they are responsible for. This finding gives credence to the assertion that because men have control over the sexual rights of women, and are involved in the reproductive decision-making, the cost of reproductive health services must be borne by them.

Provision of financial support even becomes highly expectant of men if they were strongly influential in the abortion decision-making process and also where the pregnancy is considered as unwanted. Further, financial burden will lie on the male partner if the couple are in a stable and committed relationship. It follows that, women whose partners are supportive of the abortion decision are generally more likely to provide money for the abortion.

Several plausible explanations can be advanced for male participation in women's abortion experiences. Some studies have found that unstable partnerships serve as grounds for an abortion (Sihvo et al., 2003); which this study found in the narratives. These include relationship stability, commitment level of the couple, relationship satisfaction and partner suitability and attributes. Women in stable relationships and committed to future long-term partnership with their male partners are more likely to receive greater support from their partners during pregnancy termination than women in unstable relationships, or women with intentions to end their relationship. Also, women in short-term relationships may receive little or no support compared to women in relatively long-term relationships depending on circumstances surrounding the pregnancy wantedness, psychological or emotional attachment, and commitment to continue the relationship.

There were some women who reported of their partners' non-participation during the time of the abortion. Reasons why the male partners were not involved in the abortion pertained to the women's self-autonomy and efficacy to terminate the pregnancy without their partners' knowledge, abandonment by the male partner, partner infidelity, and parental/caregiver decision on the abortion. Women's autonomy during the abortion decision-making without partner involvement has been reported elsewhere (Oduro and Otsin, 2014). These authors found that economically empowered women rationalized their decision to have an abortion because it was their "body" and could, therefore, do anything to their body as they wished.

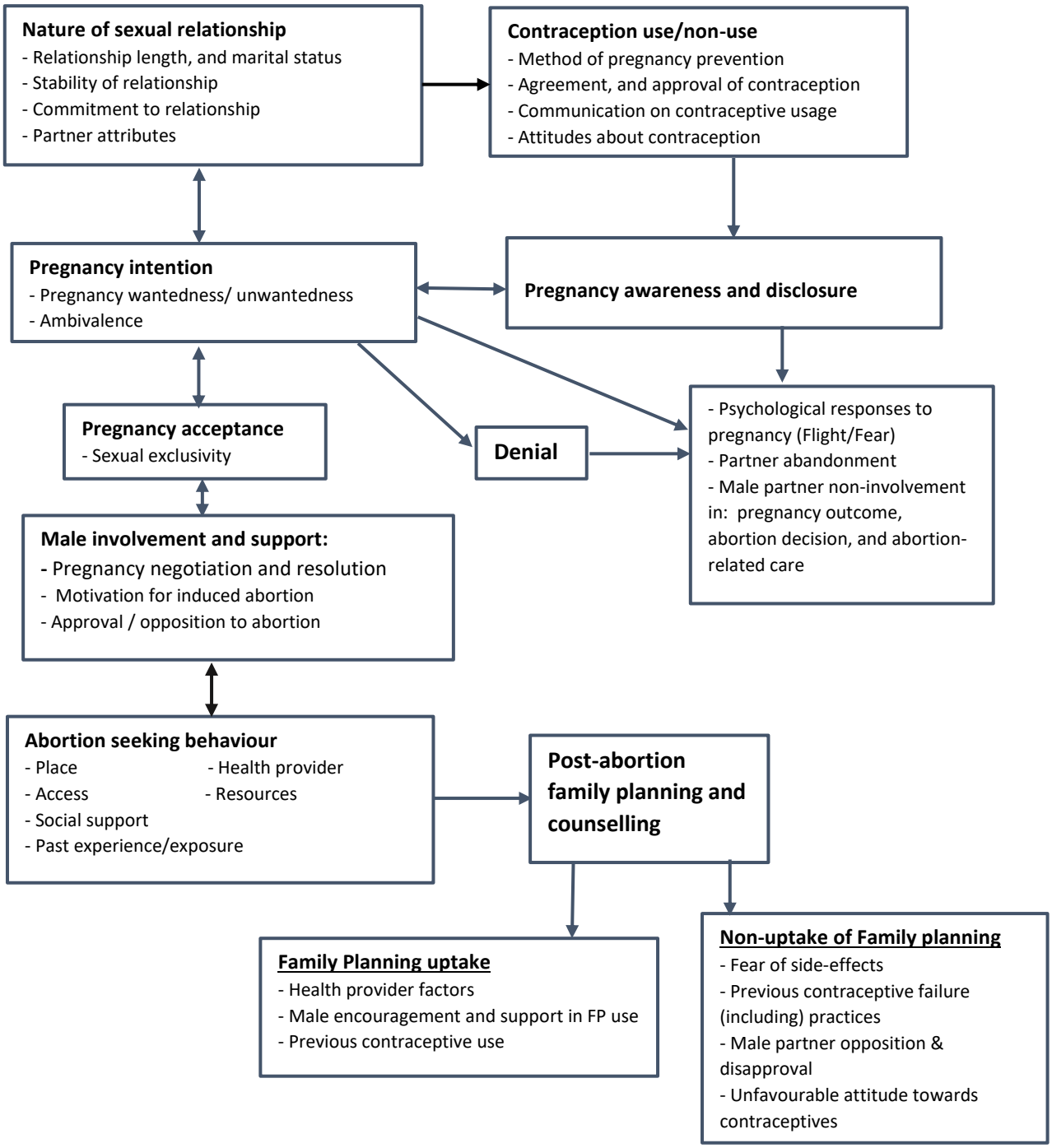
Another reason underlying male non-involvement in the abortion was premised on participants' reports of their unstable relationships with their partners. Succinctly put, the quality of their current relationship accounted for their personal decision to keep the abortion a secret from their partner. Some mentioned partner infidelity, negative partner behaviour and personality, irresponsibility, perception of partner disapproval of the abortion decision, and avoidance of relationship conflicts as contributing to their self-autonomous decision-making on the abortion. Nearly all these women considered terminating the relationship after the abortion. This finding corroborates other similar studies (Barnett, Freudenberg and Wille, 1992; Rue et al., 2004) which found that the abortion indirectly contributed to the breakdown of the relationship by creating emotional distance or disagreements.

6.8.1 Discussion of analytic framework

An analytic framework in Figure 6.4 was developed during the qualitative analysis to summarise the multiple factors that depict the pathways to male partners' involvement in the abortion. The framework highlights several factors as well as events preceding male partners' involvement in the abortion, and uptake of post-abortion contraception. It also helps to explain the dynamics of male partner involvement in women's abortion experiences and subsequent post-abortion contraception uptake. The components in the framework include:

- Nature of sexual relationship
- Contraceptive use/non-use
- Pregnancy awareness and disclosure
- Pregnancy intention and acceptance
- Partner involvement and support
- Abortion seeking-behaviour and
- Post-abortion family planning and counselling

FIGURE 6. 4 AN ANALYTIC FRAMEWORK TO UNDERSTAND MALE PARTNER INVOLVEMENT AND SUPPORT IN WOMEN'S ABORTION, AND LIKELIHOOD OF POST-ABORTION FAMILY PLANNING UPTAKE



Source: Author's construct, 2017

The sexual relationship provided the context for pregnancy to take place. It is a fundamental component in the framework because both partners' perception of the relationship stability, level of commitment, duration of the relationship and suitability of partners set the precedent for decision-making on the abortion. Relationship stability and commitment was decisive in determining the outcome of the pregnancy. It also provided a basis to continue with the relationship or quit. As was found in the narratives, negative partner attributes, relationship dissatisfaction, low relationship commitment level, and unstable dyads contributed to the decision to terminate the pregnancy and which also accounted for the lack of partners' involvement in the abortion.

Evidence from the women's narrative accounts showed that, the type of contraception used (or non-use) before the abortion depended on several factors: nature of the sexual relationship, knowledge of contraceptive, partner attitudes towards contraception, and agreement between the couple on the preferred method of contraception. Contraceptive use or non-use was dictated by the level of relationship commitment, stability and satisfaction level of the couple. Dyads where contraception was inconsistently practised resulted in unintended pregnancies leading to the abortion. Lack of contraceptive use may inversely affect the nature of the relationship. For instance, women in unstable and or erratic relationships may be less likely than others to plan sexual intimacy, resulting in unplanned pregnancy (Glei, 1999). It is also possible that women who decide to end the relationship prior to, or after the abortion may discontinue contraceptive usage since the relationship is unstable.

Pregnancy disclosure and awareness occurred after confirmation of the pregnancy. Disclosure to the male partner was central to initiating negotiations leading to the abortion decision-making process. The disclosure of the news of the pregnancy depended on the presence of the male partner within the context of the ongoing sexual relationship. Male partners' knowledge and awareness of an unintended pregnancy may trigger a positive or

negative psychological response in the form of fear, fright or flight. Negative psychological responses may inadvertently lead to ambivalence about the pregnancy and which may cause abandonment. However, disclosure to other close persons was due to the absence of the male partner and parental responsibility for the pregnancy. Male partners who accepted responsibility for the pregnancy participated actively or passively in the abortion decision irrespective of whether the pregnancy was intended or unintended. However, some male partners were ambivalent whilst others exhibited psychological responses (such as fear or flight, abandonment) upon hearing of the pregnancy.

In addition, knowledge of an unintended pregnancy triggered some positive and negative psychological or emotional responses from the male partner leading to abandonment, denial, and non-involvement in the abortion decision. A positive reaction formed the basis for pregnancy negotiation, decision-making and resolution. It was also characterised by willingness and involvement to seek abortion-related care. On the other hand, a negative response after pregnancy disclosure was characterised by directly observable behaviours such as fear, anxiety, and irresponsible behaviour towards the pregnancy. A negative attitude exhibited after knowledge of a pregnancy was suggestive of couple discordance in the pregnancy negotiation process, lack of desire for the pregnancy, unwillingness to continue the pregnancy and ambivalence.

Pregnancy intention influenced the women's (or couples') decision to keep or terminate the pregnancy. It also led to the occurrence of series of multiple reactions; starting off from the male partners' acceptance of the pregnancy, decision-making on the pregnancy outcome, involvement and support in seeking abortion-related care.

The involvement of a male partner in his female partner's abortion was dependent on several factors such as: stability and commitment to the relationship, responsibility for contraceptive use in the relationship, knowledge and acceptance of pregnancy, and whether the

pregnancy was wanted or not. Negotiating or deciding on a pregnancy resolution were often made on the backdrop of mixed reasons, mostly personal, by the women (or couple). In other situations, the motivation for an abortion occurred under circumstances beyond the woman's will; for example, when the woman is still under parental control.

Abortion care is an important part of abortion-seeking behaviour. Choosing to have a safe induced abortion is dependent on the couple's knowledge of place of abortion, knowledge of provider, access to information on how to terminate a pregnancy, availability of resources, access to place of abortion care, and past experience of an induced abortion. Other individuals like peers, family members, and close confidants and trusted persons may also be relied upon for information on seeking abortion.

Depending on the place of abortion seeking care, the woman (or couple) was counselled to use contraception to prevent a subsequent abortion. Per the model of safe abortion practices in a facility, non-judgemental counselling was offered after the abortion. Women and/or their partners, therefore, decided to adopt a contraceptive method immediately or at another time. The reasons for using post-abortion contraception was based on male support and encouragement for contraceptive use, woman's confidence in contraceptive decision-making, previous contraceptive use, positive predisposition towards contraceptive usage, availability of preferred contraception, health provider factors, and ability to afford contraceptive type.

Contrary to using post-abortion contraception, the decision not to adopt post-abortion contraception were hinged on male partner opposition/disapproval of contraceptive use, fear of side-effects, unfavourable attitude, and previous contraceptive practices. Women who perceived that their male partners are responsible for contraceptive decision-making were reluctant, and not likely to use contraception compared to women who have the power to decide on fertility and contraceptive issues.

CHAPTER SEVEN

WOMEN'S EXPECTATION OF PARTNERS' ROLE IN ABORTION

7.1 Introduction

The expectation of receiving support from a partner during difficult times is relatively high for individuals in dyadic partnerships. Abortion can be considered as a difficult period for women because of the interplay of individual, interpersonal and societal characteristics involved in the decision-making process, and the psychological, and sociological costs associated with the pregnancy resolution process. This chapter explored women's expectation of their partners' roles during the abortion and whether their expectations were met. The emerging themes are presented and discussed in the subsequent sections.

7.2 Perceived expectation of partner support pre-abortion

The first main theme which emerged from the analysis was the women's perceived expectation of receiving support from their male partners prior to the abortion decision and actual abortion. These women expected to receive different kinds of support from their partners prior to, and during the time of the abortion. Two sub-themes that emerged from the interviewees' perceived expectation of support are instrumental and affective or emotional support.

7.2.1 Instrumental support

7.2.1.1 Payment of abortion expenses

About two-thirds of those interviewed were expectant of their partners' provision of funds for the cost of the abortion. Some reported that the provision of funds by their partners was not prompted; it was given without them not having to demand after a consensus was reached during the decision-making process. However, a few demanded money from their partners to pay the abortion expenses. Some participants said that their expectations of their partners'

financial obligation towards payment of the abortion cost was met because they did not have to pay for the abortion services. One respondent, 39 year-old woman simply stated: "*Oh yes, he was aware and he gave me the money".*

Another respondent cited her partner as the 'breadwinner' of the house and for that matter, all her financial needs were dependent on him. She narrated that:

> *"As for financial support, he is the one providing everything in the house because I am not working. So even if I have money, he is the one who will give me the money"* (32 year-old woman with three children).

Another woman who was highly expectant of being financially supported by her partner during the abortion period did not receive any financial support for the cost of her abortion care and other related expenses. She felt disappointed and hurt at her partner's failure to provide any money. She reported:

> *"I was expecting him to bring me the money but he asked someone to bring it. Yesterday, I was there and he called me to let my little cousin come and take something for me. So I thought he was going to send me some money through my cousin to bring to me. My cousin returned with meat. I was expecting him to tell me something. At least if you don't have money for the abortion, just find half of it and give it to me, but nothing at all. I was really hurt"* (22 year-old woman).

7.2.1.2 Accompaniment by male partner to the hospital

Some of the interviewees were expecting to be accompanied to the health facility by their partners at the time of the abortion. However, they came to the health facility unaccompanied because their partners were absent due to work demands or travelled. They anticipated that after the abortion, they might not be physically strong enough to go home by themselves, hence the expectation of being accompanied. One interviewee, a 26 year-old woman of one child stated: *"I wanted him to come and escort me but he said he will not be able to come".*

Another interviewee also commented that, the nature of her partner's work schedule prevented him from accompanying her to the hospital for the abortion although he had planned to be present. She explained that:

> *"He wanted to come with me and he asked for permission from the boss. The boss told him today is the meeting day so he can't absent himself"* (39 year-old woman with two children).

7.2.1.3. Emotional/ affective support

Beside the expectation of financial support and aid to the hospital for an abortion, some respondents also expected to receive affection and emotional support from their partners. Whilst the receipt of emotional support was latent for some respondents, it was highly anticipated and explicit for others. For instance, Abigail, did not expect her partner to be caring or show concern about her until after the abortion decision was made. She explained:

> *"Yes that's what I thought; that he will give me some support. But I thought maybe he will change his mind. I was afraid. When I told him I was pregnant, he got [more] closer to me than before. He called me every morning and night to ask of me"* (23 year-old woman with one child).

Unlike Abigail, Sarah expressed disappointment when her hopes of receiving some affection from her partner did not actualise. She narrated:

> *"The day my partner brought me the money for the abortion, I had already done the abortion. He didn't know. After giving me the money, he didn't even ask me how the abortion went and that is what annoys me most. At least, even after giving me the money for the abortion he didn't call me the whole day to ask about how things went and so on. He didn't call. That makes him annoying*" (32 year-old woman with one child).

7.3 Expectation of partner involvement in the abortion decision-making process

The interviewees' expectation of receiving support from their partners during the decision-making process was the second broad theme that emerged during the narratives. A few of the respondents reported that their partners' participation was decisive in determining the outcome

of the pregnancy. They explained that because their partners were not forthcoming with any conclusive directive on the pregnancy, they were psychologically restless. Their partners' passivity on the pregnancy outcome resulted in delays in seeking abortion care.

For example, Delilah expected to have her partner participate in determining the pregnancy outcome since she could not independently decide to continue or terminate the pregnancy. She was also expecting a promise of marriage, reassurance to be cared for during the pregnancy and affection from her partner. However, all her perceived expectations were not enacted as her partner abandoned her. After a long period of absence from the partner, she decided to have an abortion. She reported:

> *"I was expecting him to say that we should have a child, I will take care of you, or I will marry you something like that. But none of these things happened. I didn't see him nor hear from him. Like I said, I'm looking for someone who can take care of me, but he can't cater for me so..."* (27 year-old woman with one child).

Still regarding the expectation of partner involvement in the pregnancy outcome and decision making process, another respondent said:

> *"I was expecting him to tell me something. Yeah. Something like keep it or don't keep it, get money and go to the hospital and let's see what we can do, yeah"* (39 year-old woman with four children).

7.4 Perceived expectation of partner support post-abortion

The third theme that characterised participants' responses pertained to the expectation of support from their partners after the abortion. Three types of post-abortion support emerged during the analysis: emotional, instrumental and material support.

7.4.1 Affective/emotional support

One-third of the participants stated that they expected their partners to express concern for their health after the abortion; enquire about the abortion procedure, and be empathetic. Some said

their partner would ask how "everything" went at the hospital. For instance, one woman was confident that her partner would express concern about the pain she experienced during the abortion. She averred: *"he is going to ask about everything that happened, like even the pain I went through"*.

Another woman also reported: "*He will come closer to me and ask how I'm doing and things"*. In the case of a 21 year-old woman, she expected to receive the same kind of treatment from her partner prior to the abortion. She stated:

> *"Hmm, with that one, we will be there normally like how everything was. Everything will just be the same. That is it. If he used to give me money, it will continue, if he used to give me emotional support, it will continue. So everything will be normal".*

In contrast, another participant highly expected her partner to express concern about her, enquire about the abortion procedure and all other things related to the abortion. However, the partner's lack of emotional support and concern for her health after the abortion angered her. In her view, the partner's disapproval of the abortion accounted for the lack of any emotional support. She narrated:

> *"He didn't ask me anything because I annoy him. Yeah, I think he doesn't have a male child. The day he brought me the money for the abortion, I had done the abortion already. He didn't know. After giving me the money, he didn't even ask me how the abortion went. That is what annoys me most. At least, even after giving me the money for the abortion he didn't call me the whole day to ask about how things went and so on. He didn't call. That makes him annoying"* (32 year-old woman with one child).

Two of the three male partners expressed continued emotional support for their partners' health after the abortion. One of them reported that he would support the partner's decision to adopt a family planning method to prevent any future unintended pregnancies. He commented:

> *"What things will I do for her? Just the normal chatting. How are you feeling and those stuff. I will ask her about her health and buy her drugs to aid her recovery. From the education I just received from the nurses, I will support her to use family planning. The final decision will come from her if she will like to do it"* (23 year-old male partner).

7.4.2 Material support

Some participants were certain of receiving some material rewards or gifts from their partners after the abortion. They likened the pregnancy termination to having a safe birth delivery, hence the expectation of a reward. Their expectations were based on past experiences. Two of them explained:

> *"Oh yes, he is going to ask about everything that happened. Even my provisions will be double today and a different shopping for tomorrow. As for that one, he will do it for me, he will ask me what I want. It can be compared to giving birth. So today will be my special day"* (39 year-old woman with two children).

> *"He will do it, he will do it. If he knows that I'm ok, then he's ok. He knows I will not give him any problem. For example, he will say: today, take this; tomorrow, take that, when I give birth he will say congratulations! He gives me money, he bought fowl for me, he does a lot"* (39 year-old woman with four children).

Two others also expected continued provision of basic needs from their partners after the abortion. One of them said:

> *"Hmm, he will do what he used to do at first. He is the one who feeds and clothe me because I have no one except him. I want him to continue doing that. My dad is there but he is not around"* (25 year-old woman with one child).

7.4.3 Instrumental support

With regard to the expectation of receiving support, some participants who paid for the abortion expenses themselves hoped to reclaim the money from their partners later. One of them said:

> *"He didn't pay for the abortion but I know he will pay because he had money. I know that he will and he is going to pay the money"* (22 year-old girl).

Only one participant was very certain that her partner would assist with household chores at home after the abortion. In her narrative, she expected this support because her partner had been assisting with household chores anytime she was unwell. She commented:

> *"From here, I'm going to sleep. My husband will do the cooking and everything until I tell him that I'm ok before he will stop doing it"* (39 year-old woman with two children).

7.5 No expectation of partner support

No expectation of partner support was the last theme that emerged when participants were asked to report on their role expectations from their partners at the time of the abortion. About a third expressed uncertainty about receiving any support or assistance from their partners. One participant said: *"this is my first time of doing it so I don't know how he will help me. I can't tell"*. Others could not articulate what kind of roles to expect especially in circumstances where the partner did not participate in the decision-making and abortion care. Few respondents were unresponsive to the question when interviewed.

7.6 Discussion

This chapter aimed to investigate women's expectations of their partners' roles at the time of having an abortion. The results showed that women had perceived expectations of receiving mainly instrumental and emotional support from their partners prior to and after the abortion. These findings are expected and consistent with other studies which found that most women want their male partners to provide support when having an abortion (Major, 1992; Johansson et al., 1998; Evans, 2001; Becker, Bazant and Meyers, 2008; Jones, Moore and Frohwirth, 2011). The sociocultural norms which prescribe males as breadwinners, co-creators and decision-makers may have reinforced the women's expectancy of receiving instrumental support from their male partners. Another plausible explanation could be that these women wanted to avoid the negative stereotyping when accessing abortion care (Ganle et al., 2016).

The results can also be explained in light of the theoretical perspectives of the gendered role expectation models of social support and social support activation model. The gendered

role model emphasizes the role of gendered differences on giving and receiving of social support in dyads (McMullen and Gross, 1983; Sarasan et al., 1985; Belle, 1987; Barbee et al., 1993). The effect of gender is accentuated in intimate partner arrangements or relationships where socio-cultural norms prescribe and sanction the behaviour of males and females. For example, females are more likely than males to seek and receive the needed support than males (Belle, 1987; Shumaker and Hill, 1991). According to Sarason et al. (1985), females have "higher levels of perceived social support than males". The results are therefore, corroborated, on the basis of these theoretical assumptions.

Having an abortion is a difficult and emotionally distressing time for many women (including men) considering the dynamic interplay of personal, social (or community beliefs), religious doctrines, and cultural factors surrounding the decision-making process and the actual abortion. Under such circumstances, the tendency for women to expect emotional support through reassurance, care, concern, and advice from their male partners is high given the type of partnership arrangement. In addition, women's anticipation of receiving instrumental and emotional support could be underpinned on who the main decision-maker for the abortion was. For instance, if the woman was pressured by her partner to terminate the pregnancy, then there is greater likelihood for such a woman to expect support for the abortion compared to a woman who had full autonomy for the abortion decision.

Gender role expectations may also influence how women activate and seek support from their social networks (including sexual partners). The female role which emphasizes "nurturance and emotional expressiveness" allows females to activate the needed social support from their social network (McMullen and Gross, 1983; Belle, 1987; Shumaker and Hill, 1991; Barbee et al., 1993). It is not out of place then for these women to have anticipated support from their partners during the time of having the abortion. The results indicate that women's expectation of receiving financial resources to pay the abortion expenses may be underpinned

by socially accepted norms and roles of men as breadwinners of the household, and as primary decision-makers in the sexual dyad. In this regard, financial obligation of men towards the pregnancy outcome is highly anticipated.

Furthermore, participants expected their partners' involvement during the decision-making process. The perceived anticipation of support during the pregnancy resolution process has been reported in other studies (Johansson et al., 1998; Costescu and Lamont, 2013). A probable explanation for this result is rooted in culturally-constructed prescriptions that cede women's sexual and reproductive rights to men (Ezeh, 1993; Dodoo, 1993, 1998). Such normative prescriptions may, therefore, make it difficult for women to independently decide to keep or terminate a pregnancy without the male partner's knowledge. It is also plausible for women to think that the burden of pregnancy is a shared responsibility, given the type of partnership arrangement, and for that matter, the male partner must contribute to the pregnancy outcome decision. The expectation of receiving support from their partners is, therefore not far-fetched.

However, the narrative accounts from the participants showed that one-third of them had no role expectations from their partners at the time of having the abortion. This finding is supported by other studies which found that women had no perception and expectation of support from their male partners when having an abortion (Moore et al., 2010). These women did not rely on their male partners nor anticipate to receive any support for possible reasons that their partners may prevent them from accessing abortion care, and fear of physical abuse. Also, avoidance of relationship conflicts, unstable union, unsuitability of the male partner and intention to end the relationship may have influenced nondisclosure of the abortion to the partner with implications for no perception of support. More so, the absence of the male partner participation in the abortion decision may have contributed to the women's lack of anticipation of partner support.

This finding reveals several things about women who are capable of exercising their agency at the time of undergoing an abortion without the expectation of partner support. A woman's desire to exercise her reproductive freedom as suggested by Mackinnon (2010), may increase her autonomy in reproductive decision-making and make her less dependent on her partner when faced with future unintended pregnancy. It also shows that such women are self-confident in seeking abortion-related care, thereby, exercising their reproductive choice without any barriers. Further, women with high self-aspirations and personal goals may have lower desire to burden their partners with any responsibility, especially when their partners are ambivalent of an unwanted pregnancy.

Involvement of parents or care-givers in their children's abortion experiences has been found in other studies (Henshaw and Kost, 1992) and this lends support to the results in this study. Few women reported that the decision to terminate the pregnancy was made by their care-givers without regard to their partners' involvement. In a patriarchal context like Ghana, parents are viewed as having primary responsibility and control of the reproductive freedom and choices of their children who are still economically and socially dependent on them. Parental decisions in this regard are, therefore, paramount in order to prevent the burden of childcare problems and for continued parental support for the child/children. Thus, parents and primary care-givers have a 'big' say in abortion decisions without recourse to the male partner.

CHAPTER EIGHT

RELATIONSHIP BETWEEN PARTNERS' INVOLVEMENT IN ABORTION AND POST-ABORTION FAMILY PLANNING UPTAKE

8.1 Introduction

This chapter examines the relationship between partners' involvement in women's abortion and post-abortion family planning uptake. The data were analysed at the bivariate and multivariate levels. At the bivariate level of analysis, cross-tabulation and chi-square tests were used to determine the association between the explanatory and outcome variable of interest. Multiple logistic regression models were used to examine the relationship between male partners' involvement in abortion and post-abortion family planning use.

8.2 Results of bivariate analyses

8.2.1 Relationship between socio-demographic characteristics and post-abortion family planning uptake (PAFP)

The variables included in the analysis are socio-demographic, psychosocial variables, reproductive history, and partnership characteristics. The socio-demographic variables included are age, highest educational level attained, employment, ethnicity, number of living children, religious affiliation, and marital status. Table 8.1 presents the results from the chi-square tests (X^2) of association between respondents' and male partners' socio-demographic characteristics and PAFP uptake.

The results from Table 8.1 indicate that PAFP uptake varies by women's employment and number of surviving children. The data show that family planning use after an abortion is higher among women who were employed compared to other women who were not employed. Also, a higher proportion of women with two, four and five children adopted post-abortion contraception compared to women who had no child. The results, however, show no

statistically significant association between women's age, educational level, marital status, ethnicity and religious affiliation and post-abortion family planning uptake.

TABLE 8. 1 RELATIONSHIP BETWEEN WOMEN'S AND MALE PARTNERS' SOCIO-DEMOGRAPHIC CHARACTERISTICS AND PAFP UPTAKE

Characteristics	Women			Male partners		
	Yes	No	X^2	Yes	No	X^2
Age			0.6			6.201
< 20	72.1	29.9				
< 24	--	--		64.1	35.9	
20-24	70.5	29.5		72.5	27.5	
25-29	70.6	29.4		70.3	29.7	
30-34	76.0	24.0		76.9	23.1	
35+	70.0	30.0		79.5	20.5	
45+				58.1	41.9	
Educational level			5.615			1.985
No education	73.7	26.3		66.7	33.3	
Primary	80.0	20.0		--	--	
Middle/JHS	75.2	24.8		77.2	22.8	
Secondary/Higher+	64.5	35.5		70.7	29.3	
Employment			4.730*			0.001
Not employed	63.3	36.7		72.0	28.0	
Employed	75.1	24.9		71.7	28.3	
Ethnicity			3.071			6.345
Akan	68.4	31.6		65.4	34.6	
Ga-Dangme	78.7	21.3		81.8	18.2	
Ewe	68.4	31.6		74.6	25.4	
Other ethnic groups	75.9	24.1		75.0	25.0	
Religious affiliation			7.870			1.624
No religion	--	--		78.9	21.1	
Christians	69.7	30.3		71.2	28.8	
Other Christian	80.8	19.2		66.7	33.3	
Muslim	88.2	11.8		78.3	21.7	
Number of living children			16.032*			
0	64.2	35.8				
1	70.4	29.6				
2	78.2	21.8				
3	77.1	22.9				
4	81.8	18.2				
5	83.3	16.7				
6	0.00	100.0				
Marital status			1.823			3.007
Never married	69.1	30.9		70.5	29.5	
Currently married	72.4	27.6		69.3	30.7	
Cohabiting	78.2	21.8		80.4	19.6	
Formerly married	66.7	33.3		69.2	30.8	

Source: Computed from survey data 2017; N=327; *p<0.05;
(--) indicates not applicable

The socio-demographic factors of the male partners' were also examined in Table 8.1 but, the results show that none of the variables is statistically significant in its association with PAFP uptake. There is also no clear pattern or variation that can be observed from the results.

8.2.2 Relationship between psychosocial variables and PAFP uptake

Three psychosocial variables were included in the analysis to determine their relatedness to PAFP uptake. These psychosocial variables are: (i) attitude towards contraceptive use (ii) level of knowledge about contraception/FP and (iii) self-perception statements on the barriers, benefits, self-efficacy of contraceptive use and severity of abortion.

The results from Table 8.2 show that women's attitude towards contraceptive use and their level of knowledge about FP are associated with post-abortion contraception uptake at a statistically significant level of $p<.05$. The results indicate that women with favourable attitudes towards using contraception were associated with PAFP use than women with unfavourable attitudes towards contraceptive use. A high percentage of women with favourable attitudes towards contraception adopted a contraceptive method after an abortion compared to women with moderate and unfavourable attitudes towards contraception. In addition, level of family planning knowledge varied with PAFP uptake at statistically significant level of $p<.05$. A high proportion of women with a moderate level of FP knowledge adopted a family planning method after the abortion compared to their counterparts with no knowledge of family planning. On the other hand, male partners' attitude towards FP and level of FP knowledge do not appear to be statistically significant in relation to post-abortion contraception uptake.

TABLE 8. 2 RELATIONSHIP BETWEEN PSYCHOSOCIAL VARIABLES AND PAFP UPTAKE

	Women			Male partner		
Variables	**Yes**	**No**	**X^2**	**Yes**	**No**	**X^2**
Attitude towards contraceptive use			6.062*			4.254
Favourable	77.6	22.4		74.4	25.6	
Moderately favourable	64.5	35.5		75.9	24.1	
Not favourable	67.3	32.7		63.4	36.6	
Level of family planning knowledge			14.173*			3.776
Knowledgeable	74.0	26.0		68.4	31.6	
Moderately knowledgeable	78.2	21.8		79.2	20.8	
Not knowledgeable	54.7	45.3		67.5	32.5	
Don't know				70.4	29.6	

Source: Computed from survey data, 2017; *p<0.05
Notes: 'Don't know' category applies to Male partner

8.2.3 Relationship between partnership dynamics and PAFP uptake

Table 8.3 presents the results of the partnership dynamics (relationship stability, type of relationship, and duration of the relationship) with PAFP uptake as the outcome variable. The results show no statistically significant variation in PAFP uptake by relationship dynamics. All the three measures of the partnership dimensions are not associated with PAFP uptake.

TABLE 8. 3 RELATIONSHIP BETWEEN PARTNERSHIP DYNAMICS AND PAFP UPTAKE

Characteristics	**Yes**	**No**	**X^2**
Relationship stability			2.646
Stable	70.1	29.9	
Somewhat stable	81.8	18.2	
Not stable	69.2	30.8	
Relationship type			1.298
Boyfriend	70.6	29.4	
Husband	75.0	25.0	
Fiancé	65.5	34.5	
Other partnership	69.6	30.4	
Duration of relationship			5.233
< 1 year	68.0	32.0	
1 – 2 years	63.8	36.2	
3 – 5 years	76.1	23.9	
6+	78.0	22.0	

Source: Computed from survey data, 2017

8.2.4 Relationship between reproductive variables and PAFP uptake

Four reproductive variables were included as independent factors: number of lifetime pregnancies, number of previous abortions, contraceptive use at index pregnancy and pregnancy intention. The results show no statistically significant relationship between the reproductive variables and PAFP uptake (Table 8.4). Although there are variations with the outcome variable, they are not statistically significant at $p<0.05$.

TABLE 8. 4 RELATIONSHIP BETWEEN REPRODUCTIVE VARIABLES AND PAFP UPTAKE

Variables	Yes	No	X^2
Number of lifetime pregnancies			5.396
1- 3	66.8	33.2	
4- 6	79.8	20.2	
7+	73.2	26.8	
Number of previous induced abortions			0.407
0- 2	71.5	28.5	
3- 4	69.7	30.3	
5+	80.0	20.0	
Contraceptive use at index pregnancy			0.499
Yes	70.6	29.4	
No	74.7	25.3	
Pregnancy intention			0.391
Yes	76.5	23.5	
No	71.4	28.6	

Source: Computed from survey data, 2017

8.3 Results of multiple logistic regression analysis

8.3.1 Model 1: Partner involvement and PAFP uptake

Model 1 shows the relationship between the partner involvement variables and PAFP uptake controlling for all the other variables. The results from Table 8.5 show a statistically significant relationship between communicative support and uptake of post-abortion contraception. Women who receive a high communicative support from their partners are 2.66 times as likely to use contraception after the abortion as women who did not receive any communicative support from their partners at $p<0.01$. The results further indicate that women who receive

some (partial) communicative support from their partners are 2.52 times as likely to use PAFP as women who did not receive any communicative support ($p<0.05$). However, physical support, financial support and emotional support did not show any statistically significant relationship with PAFP uptake. The model explains seven percent of the variation of the outcome variable. The analysis, thus, shows that communicative support from male partners is an important factor affecting post-abortion contraceptive use among women.

TABLE 8. 5 LOGISTIC REGRESSION BETWEEN PARTNER INVOLVEMENT AND PAFP UPTAKE

	Post-abortion family planning uptake		
Characteristics	**Odds ratio (OR)**	**Standard error (S.E.)**	**95% Confidence Interval (CI)**
Physical support			
No support (RC)	1.00		
Partial support	1.28	0.38	0.608 – 2.698
High support	0.76	0.38	0.362 – 1.629
Financial support			
No support (RC)	1.00		
Partial support	0.97	0.36	0.484 – 1.980
High support	0.76	0.51	0.279 – 2.072
Communicative support			
No support (RC)	1.00		
Partial support	2.52*	0.47	0.998 – 6.399
High support	2.66**	0.30	1.451 – 4.873
Emotional support			
No support (RC)	1.00		
Partial support	0.58	0.32	0.311 – 1.112
High support	0.69	0.58	0.223 – 2.145

Notes: N= 327; Adjusted R^2 =0.069; X^2= 16.163; Asterisks indicate significance at *p<0.05, **p<0.01; (RC) - Reference category

The results indicating that communicative support from male partners at the time of an abortion has a statistically significant effect on women's uptake of post-abortion contraception is consistent with other studies which also found that spousal communication, and/or spousal discussion is a strong factor influencing women's family planning use (Bawah et al., 1999; Bawah, 2002; Sharan and Valente, 2002; Kaggwa, Diop and Storey, 2008; Yue, O'Donnell and Sparks, 2010; Eliason et al., 2014; Ezeanolue et al., 2015). The hypothesis that women

who receive communicative support are more likely to use family planning after an abortion compared to women who do not receive any communicative support is, therefore supported by the findings of this study. However, the second hypothesis which stated that women who are financially supported by their partners are more likely to adopt a PAFP method is not supported by the results of the analysis at $p<0.05$.

The first hypothesis which was supported is expected because, when couples discuss, agree and approve of FP during the abortion decision-making process, women are encouraged to accept and adopt a contraceptive method to prevent future unintended pregnancies. Women also come to believe that by communicating with their partners on ways of preventing unintended pregnancies, their partners become more receptive to contraceptive use, and may support their actions to avoid future unintended pregnancies. Discussions surrounding limiting childbirth tend to assume a joint character and a shared responsibility between the couple, thereby minimising the woman's discreet use of contraceptives. Some studies have found that discussions on family planning increase contraceptive use, and corrects women's erroneous perception that their partners disapprove of contraceptive use (Bongaarts and Bruce, 1995; Berhane et al., 2011). Through effective dialogue on family planning, couples are able to select appropriate birth control methods with encouragement and support from each other. Consistent contraceptive use, therefore, becomes possible over time. Communicative involvement from the male partner is, therefore, instrumental in changing attitudes on contraceptive method use (DeRose et al., 2004).

8.3.2 Partner involvement, socio-demographic variables and PAFP uptake

Table 8.6 presents the results from three Models which examined the relationship between the partner involvement variables, socio-demographic characteristics and PAFP uptake. Model 2 shows the effect of women's socio-demographic characteristics and partner involvement factors on PAFP uptake. In Model 3, the male partners' socio-demographic characteristics and

partner involvement variables were regressed on PAFP uptake. The fourth model combined both the women and male partners socio-demographic factors, and partner involvement variables on the outcome variable.

In Table 8.6, the results from Model 2 indicate that communicative and emotional support strongly influenced women's adoption of PAFP. Similar to the results in Model 1, women who received a high communicative support from their male partners were 2.32 times as likely to use family planning after the abortion as women who did not receive any communicative support from their partners at $p<0.05$. However, emotional support was inversely related to PAFP uptake. Compared to women who did not receive any emotional support, women who received some (partial) emotional support were 0.53 times less likely to adopt a contraceptive method after abortion at $p<0.05$. There was however no observed statistically significant relationship between physical and financial support and PAFP uptake.

Among the socio-demographic variables, a woman's age, number of living children and employment were statistically significant factors influencing PAFP uptake (Table 8.6). The results show a positive relationship between number of surviving children, employment and PAFP uptake, but, age was inversely related with PAFP use. Women with two children were 4.13 times as likely to uptake PAFP as women with no children. Also, employed women were 2.17 times as likely to use post-abortion contraception as unemployed women. The results further indicate that women who were aged 35-39 years were 0.79 times less likely to adopt a family planning method after an abortion compared to women who were less than 20 years at $p<0.05$. The model explains 18 percent of the variation in the outcome variable.

The results in Model 3 (Columns 4 and 5) indicate that women's receipt of communicative support still strongly influenced their use of a PAFP method. The results show that compared to women who did not receive any communicative support from their partners,

women who received high communicative support from their partners were 2.54 times as likely to uptake PAFP at $p<0.05$. Physical, financial and emotional support, however, had no statistically significant effect on PAFP uptake.

Male partners' age and ethnicity were found to be statistically significant predictors of women's use of post-abortion contraception (Model 3). Women whose partners are aged 35-39 years, and 40-44 years were 3.44 and 4.12 times respectively as likely to uptake PAFP as their counterparts whose partners were below 24 years. Additionally, the results show that women whose partners are Ga-Dangme are 2.38 times as likely to adopt a post-abortion contraceptive method as those women whose partners were Akan. The model results illustrate that 17 percent of the variation in the model is explained by the predictor variables.

The fourth model includes females and male partners' socio-demographic[17] characteristics, the partner involvement variables and PAFP uptake. The results as depicted in Table 8.6 (Column 6 and 7) show that communicative support still significantly predicted women's use of a family planning method after an abortion with significantly higher odds for women who received high communicative support from their partners. The woman's employment and number of surviving children, and the male partners' educational level showed a strong positive relationship with PAFP uptake at $p<0.05$.

[17] Religious affiliation variables for both women and male partners were excluded in Model 4 because of the few counts in some cells which produced insignificant values and large confidence intervals.

TABLE 8. 6 LOGISTIC REGRESSION OF SOCIO-DEMOGRAPHIC VARIABLES AND PAFP UPTAKE

Variables	Model 2		Model 3		Model 4	
	OR (s.e.)	95% CI	OR (s.e.)	95% CI	OR (s.e.)	95% CI
Physical support						
No support (RC)	1.00		1.00		1.00	
Partial support	1.52 (.40)	.687- 3.353	1.34 (.42)	.595-3.0261	1.03 (.45)	.699-4.133
High support	.86 (.41)	.386- 1.920	.79 (.43)	.340-1.8421	1.03 (.46)	.419-2.514
Financial support						
No support (RC)	1.00		1.00		1.00	
Partial support	1.09 (.39)	.508-2.350	1.08 (.40)	.487-2.372	1.28 (.45)	.527- 3.109
High support	.68 (.55)	.243-1.994	.83 (.56)	.273-2.497	.82 (.60)	.255 -2.660
Communicative support						
No support (RC)	1.00		1.00		1.00	
Partial support	2.56 (.53)	.908- 7.254	2.68 (.51)	.982-7.296	2.52 (.54)	.866-7.315
High support	2.32* (.34)	1.196- 4.512	2.54* (.34)	1.310-4.918	2.16*(.37)	1.052-4.429
Emotional support						
No support (RC)	1.00		1.00		1.00	
Partial support	0.47* (.36)	.230-.9560	.90 (.69)	.231-3.488	.88 (.74)	.208-3.738
High support	0.84 (.63)	.244- 2.871	.60 (.63)	.177-2.056	.47 (.66)	.130-1.730
Woman's characteristics						
Education						
No education (RC)	1.00				1.00	
Primary	1.80 (.57)	.603- 5.612			2.28 (.64)	.652-7.968
Middle/JHS	1.30 (.48)	.521- 3.472			2.02 (.59)	.642 -6.370
Secondary+	.94 (.47)	.374- 2.379			1.51 (.63)	.437- 5.244
Age						
< 20 years (RC)	1.00				1.00	
20 - 24	.80 (0.46)	.323 – 1.987			.73 (.65)	.207-2.606
25 – 29	.49 (0.54)	.173 – 1.440			.44 (.80)	.092-2.109
30 – 34	.68 (0.61)	.208 – 2.225			.45 (.87)	.082-2.435
35 – 39	.21* (0.7)	.055 – .832				
40 – 44						
Employment						
No employment (RC)	1.00				1.00	
Employed	2.17* (.36)	1.080 – 4.356			2.17* (0.39)	1.022-4.621
Religious affiliation						
Christians (RC)	1.00					
Other Christians	1.74 (0.55)	.596 – 5.088				
Muslim	3.91 (0.85)	.739 – 20.672				
Ethnicity						
Akan **(RC)**	1.00				1.00	
Ga-Dangme	1.95 (.67)	.857- 4.416			1.3 (.47)	.523-3.241
Ewe	.96 (-.03)	.500- 1.860			.69 (.40)	.315-1.510
Other ethnic groups	1.27 (.24)	.545- 2.975			1.52 (.50)	.574-4.011

Asterisks indicate significance at *p<0.05

Model 2: Adjusted R^2 =.175; X^2 =42.067; N= 324; df= 28

Model 3: Adjusted R^2=.172, X^2= 39.583; N= 309; df = 26

Model 4: R^2 = 0.23 X^2 =53.840; N= 308; df = 41

Table 8.6 continued

Variables	Model 2		Model 3		Model 4	
	OR (s.e.)	95% CI	OR (s.e.)	95% CI	OR (s.e.)	95% CI
Parity						
0 (RC)	1.00				1.00	
1	1.53 (.45)	.638-3.690			1.15 (.50)	.434-3.048
2	4.13* (.6)	1.261-13.495			4.4* (.65)	1.236-15.692
3	2.95 (.65)	.826-10.499			3.14 (.73)	.749-13.180
4	3.26 (.69)	.835-12.703			3.00 (.78)	.646-13.883
Male partner characteristics						
Age						
< 24 (RC)						
25 – 29			2.37 (.51)	.871-6.456	2.53 (.63)	.740-8.657
30 – 34			2.31 (.55)	.787-6.764	2.01 (.75)	.465-8.716
35 – 39			3.44 * (.61)	1.035-11.170	3.09 (.79)	.651-14.707
40 – 44			4.12* (.67)	1.12-15.275	3.25 (.9)	.557-18.925
45+			1.18 (.65)	.332-4.185	1.13 (.88)	.201-6.360
Employment						
No employment (RC)			1.00		1.00	
Employed			.58 (.58)	.186-1.813	.76 (.60)	.233-2.491
Religious affiliation						
No religion (RC)			1.00			
Christians			.93 (.66)	.255-3.399		
Muslim			2.23 (.99)	.322-15.493		
Other Christians			.77 (.72)	.190 -3.153		
Ethnicity						
Akan (RC)						
Ga-Dangme			2.38* (.42)	1.043-5.449	2.1 (.46)	.858-5.146
Ewe			1.48 (.37)	.711-3.067	1.6 (.43)	.694-3.668
Other ethnic groups			1.64 (.50)	.615-4.369	2.44 (.51)	.894-6.635
Education						
Other education (RC)			1.00		1.00	
Middle/JHS			1.95 (.45)	.803-4.752	2.22 (.49)	.856-5.804
Secondary			2.21 (.44)	.940-5.214	3.0 (.49)	1.144-7.794
Higher/tertiary			.90 (.45)	.371-2.173	2.99*(.49)	1.144-7.794
Marital Status						
Never married (RC)						
Currently married			.74 (.39)	.340-1.589	.48 (.57)	.158-1.474
Formerly married			.68 (.73)	.164-2.859	.49 (.83)	.097-2.516
Cohabiting			1.2 (.48)	.464-3.098	.99 (.70)	.249-3.901

Asterisks indicate significance at *p<0.05

Women who were employed were 2.17 times as likely to use post-abortion contraception as unemployed women. Compared to women without a child (or children), women with two children were 4.13 times more likely to use post-abortion contraception. The results further indicate that women were more likely to adopt a PAFP method if their partners had a secondary or higher education compared to their counterparts whose partners had 'Other' education. Model 4 explains 23 percent of the variation in PAFP uptake.

The results from Models 2, 3 and 4 show that communicative support provided by male partners at the time of an abortion significantly influences women's uptake of post-abortion contraception. These findings are consistent with earlier studies conducted in Ghana and other settings which found that spousal discussion, and/or communication about contraception influenced women's use of a modern family planning method (Bawah, 2002; Kaggwa, Diop and Storey, 2008; Yue, O'Donnell and Sparks, 2010; Mekonnen and Worku, 2011; Eliason et al., 2014; Ezeanolue et al., 2015). The results suggest that male partners are central to contraceptive decision-making and contribute to women's acceptance, adoption and initiation of contraception after an abortion. Male partners who desire to limit their family size are more likely to be supportive of their female partners' decision to adopt a modern FP method after an abortion to reduce future unintended pregnancies. On the other hand, women who perceive that their partners want no more children may be encouraged to implement their fertility goals with their partners' implied consent.

In furtherance to the results from Model 2, women who received some emotional support from their partners at the time of the abortion were less likely to adopt a contraceptive method after the abortion compared to women who did not receive any emotional support. A plausible explanation for this unexpected finding could be that, the lack of affection, reassurance and concern for the abortion from the male partner may be negatively reinforcing for these women, hence, their decision to protect themselves from another future abortion.

Women who do not receive any emotional support from their sexual partners tend to bear the burden of the psychological pain and distress alone and this can intrinsically be a 'push factor' for some of them to avoid a future unplanned pregnancy. It is possible that adopting a post-abortion contraception may be a coping mechanism to dealing with the loss of pregnancy.

Additionally, the results from Models 2 and 4 also found that women's age, number of surviving children and employment status had a significant effect on the uptake of a PAFP method although age was negatively correlated with PAFP uptake. These findings corroborate other studies conducted by Adanu et al. (2009), Bbaale and Mpuga (2011), Jabeen et al. (2011), Sharma et al. (2012) and Buyinza and Hisali (2014). These studies found that women's socio-demographic characteristics such as age, educational status, and parity influence contraceptive use. However, studies with contrasting results have been reported elsewhere where women with no child (or children) reported higher likelihood of contraceptive use (Frost and Lindberg, 2013).

Couples or women with at least two surviving children who do not intend to continue childbearing or who want to space childbearing have a higher likelihood of using birth control to regulate their desired family size than other women without any children. The motivation may be dependent on financial constraints, changing nature of the family system and a desire to avoid disruption in life goals which may compel women or couples to limit their family size. These reasons may account for why the results showed that women with no children were less likely to adopt a family planning method after the abortion compared to women with two surviving children.

Among women who do not have a child, plausible explanations for non-use of a PAFP method may stem from the fear of side-effects of modern family planning methods especially, concerns about infertility as some studies have found (Ross and Agwanda, 2012; Ochako et

al., 2015). Thus, for this group of women, the tendency to accept or initiate a modern family planning method even after the abortion will be low. It is also possible that women whose relationships ended prior to the abortion may be unwilling to initiate a contraceptive method immediately after the abortion since they are no longer in sexual partnerships.

Consistent with other studies in the literature, women with a high socio-economic status, and/or women with a higher wealth quintile are more likely to use contraception than women with lower socio-economic status (Jabeen et al., 2011; Lakew et al., 2013). Women who are economically empowered are more likely to use family planning because they have financial power to access and purchase contraceptive methods which are available to them. It is also plausible that women's greater autonomy in economic matters gives them a say in contraceptive decision-making with or without their partners' consent for contraceptive use after an abortion.

The results from Model 3 showed that women whose male partners were Ga-Dangme were more likely to use PAFP compared to women whose partners were Akan. This finding is inconsistent with earlier studies conducted by Dodoo and Takyi (2005), Addai (1999a, 1999b), Addai and Trovato (1999). They found that ethnic and kinship identity regulates the fertility goals of women in patrilineal arrangements. For instance, among the Akan, women enjoy autonomy in childbearing and reproductive decision-making than non-Akan women. So, whilst Akan women may enjoy the freedom to use modern contraception to reduce unintended pregnancies, non-Akan women, like the Ewe and Ga-Dangme, may be unable to implement their reproductive goals.

Several plausible reasons can be adduced for this unexpected result which found that women with Ga-Dangme partners are more likely to adopt a post-abortion contraception. According to Fayorsey and Fayorsey (1992, 1993), the commoditization of childbirth is one of

the several factors that affect fertility. Among the Ga people who live in Central Accra, pregnancy, childbirth and marriage are commoditized. In Fayorsey and Fayorsey's study among the Ga people, commoditization is an economic strategy employed by women to obtain capital from their Ga male partners from conception until childbirth. It is a socially accepted custom for Ga men to provide for their female partners pregnancy until childbirth. Ga men take pride in their paternal responsibility from conception until birth and a woman's matrikin is likely to approve such partnership arrangements. However, a woman will be more likely to adopt post-abortion contraception on realizing that her Ga male partner is financially incapable of providing her needs during pregnancy. Also, such women may wish to regulate the pregnancies they want, avoid the liability of unwanted children, and the associated economic burden of childcare. In addition, women in partnership arrangements with Ga partners are likely to initiate contraception after an abortion if the economic burden of large family affects their economic activity.

Another explanation which can be proffered for this finding can be linked to women's economic autonomy in the household, shifting gender power relations in sexual dyads in response to normative expectations, and women's ability to negotiate reproductive and fertility choices. Considering the growing awareness and availability of maternal healthcare services, it is possible that women who wield large economic resources in the household may discreetly decide to implement their fertility preferences so as to be able to continue with their work. It is likely that economically empowered women with Ga partners may have strong negotiating skills and power to influence their partners to accept their decision to regulate their fertility if their financial support to the household is significant. An evaluation of the trade-offs between expected benefits of large number of children and costs associated with high parity may compel latent use of contraception without their partners' knowledge. Consequentially, women in such patrilineal heterosexual relationships may be motivated to use post-abortion contraception if

they perceive significant costs of pregnancy, their health, and employment especially in informal unions.

Furthermore, the decision regarding post-abortion contraception uptake among this category of women may be reinforced by the availability of contraceptive services at the time of the abortion as some studies have found (Goodman et al., 2008; McDougall et al., 2009; Zhu et al., 2009). Some studies have found that women in patrilineal contexts are able to stop childbearing only if their partners wish to stop childbearing (DeRose, Dodoo and Patil, 2002). Thus, in such circumstances, women who perceive that their partners wish to control their fertility will be more likely to implement their partners' reproductive intentions with that perceived support.

8.3.3 Partner involvement, socio-demographics, intermediate variables and PAFP uptake

In Model 5, all the variables in the study were introduced into the model and regressed on PAFP uptake. However, marital status variables (for both partners) were excluded from the model due to multicollinearity. The results in Table 8.7 are only shown for the characteristics which were statistically significant at $p<0.05$.

From Table 8.7, women's employment, level of family planning knowledge, and self-efficacy positively predicted use of post-abortion contraception at $p<0.05$. Compared to unemployed women, employed women were 3.23 times as likely to use a PAFP method. With reference to level of FP knowledge, women who were not knowledgeable about family planning were significantly less likely (0.78 times) to use a PAFP method compared to women who were knowledgeable about FP at $p<0.05$. Self-efficacy significantly predicted women's initiation and use of post-abortion contraception at $p<0.05$. The results show that an increase in self-efficacy is associated with an increased likelihood of PAFP use.

The male partners' characteristics which showed a statistically significant relationship with PAFP uptake include ethnicity, educational level and level of FP knowledge. All the other socio-demographic factors were not significantly related to PAFP uptake. As it was found in the results, women with Ga-Dangme partners were 3.38 times as likely to adopt post-abortion contraception as women whose partners were Akan. Women whose partners have Middle/Junior High School and secondary education were also respectively 3.21 times and 4.26 times as likely to use PAFP as women whose partners had 'Other' education. The results further showed that, women who reported their partners to have 'moderate knowledge' of family planning were 4.21 times more likely to use a post-abortion contraceptive method than women who reported their partners to have knowledge of family planning. Communicative support, physical, emotional and financial support, however, did not predict PAFP use. Compared to Models 1, 2, 3 and 4, model 5 explains 38 percent variation in the outcome variable.

TABLE 8. 7 LOGISTIC REGRESSION RESULTS OF ALL STUDY VARIABLES AND PAFP UPTAKE

Variables	OR (s.e.)	95%CI
Woman		
Employment		
Unemployed (RC)	1.00	
Employed	3.23*(.45)	1.342-7.819
Level of family planning knowledge		
Knowledgeable (RC)	1.00	
Moderately knowledgeable	.92 (.44)	.391-2.183
Not knowledgeable	0.22*(.56)	.072- 0.654
Self-efficacy	1.10	1.008-1.210
Male partner characteristics		
Ethnicity		
Akan (RC)	1.00	
Ga-Dangme	3.38* (.53)	1.199- 9.551
Ewe	1.66 (.47)	.655-4.216
Other Northern groups	2.10 (.61)	.637-6.870
Educational level		
Other education (RC)	1.00	
Middle/JHS	3.21*(.56)	1.062- 9.668
Secondary	4.26*(.56)	1.412-12.849
Higher	1.87 (.63)	0.543-6.424
Level of family planning knowledge		
Knowledgeable (RC)	1.00	
Moderately knowledgeable	4.21*(.47)	1.689- 10.485
Not knowledgeable	1.55(.55)	0.522-4.572
Don't know	.98 (.58)	3.16

Asterisks indicate significance at *p<0.05; Model 5: X^2 =94.916; Adjusted R^2 = 0.383; df= 54; N= 307

The results from Models 2 to 5 consistently showed that woman's employment still remained statistically significant in predicting PAFP uptake. The level of contraception knowledge was a significant correlate of post-abortion contraception use. Whilst women who were not knowledgeable about family planning had reduced odds of PAFP use, women whose partners had a moderate knowledge of contraception had higher odds of using PAFP. This finding is consistent with Biney's (2011) study which showed that among women receiving abortion in some hospitals, they had no knowledge of contraceptive methods prior to the abortion. Beside this finding, scholars have attributed a high unmet need for contraception as a function of the lack of effective contraception knowledge (Casterline and Sinding, 2000) and poor uptake (Wafula, Obare and Bellows, 2014). Although contraceptive knowledge is universal in Ghana, the result suggests that knowledge on birth control alone may not translate into attitudes, practice and behaviour.

Additionally, the study found that post-abortion family planning uptake was influenced by women's self-efficacy. This finding is congruent with previous research which found perceived self-efficacy to be strongly associated with contraceptive use and intentions to use contraception (Peyman and Oakley, 2009; Peyman et al., 2009; Kahsay et al., 2018). Among the six constructs of the HBM, various studies have demonstrated that self-efficacy is the single strongest predictor of contraceptive use than the other constructs (Terry and O'Leary, 1995; Babalola, John and Ajao, 2015; Muhindo et al., 2015). Self-efficacy to use post-abortion contraception as demonstrated by the results reflect women's strong desire to prevent future unintended pregnancies. It is also suggestive of a strong sense of personal responsibility, self-dependency or autonomy which is pivotal in explaining intentions for engaging in health promotive behaviours. By far, contraceptive self-efficacy indicates women's agentic freedom in contraceptive decision-making.

CHAPTER 9

SUMMARY, CONCLUSION AND RECOMMENDATION

9.1 Introduction

Increasing men's involvement in sexual and reproductive issues is instrumental to reducing unintended pregnancies and unmet need for contraception which may result in induced abortions. Considerable evidence from various settings indicate that male participation in women's reproduction (specifically, contraceptive use) is linked to contraceptive continuity and consistency. Limited data, however, exist on whether male partners' involvement in abortion can influence women's use of post-abortion contraception. Although few studies have investigated male partners' roles in abortion in Ghana, there is scarce literature examining the link between male involvement in women's abortion experiences and post-abortion contraception uptake.

This thesis examined the relationship between male partners' involvement in abortion and post-abortion family planning (PAFP) uptake in the Greater Accra Region. Specifically, this study explored the extent of male partners' involvement in their female partners' abortion and use of PAFP; women's expectations of their partners' roles in abortion and identified the barriers to partners' inclusion and participation in the abortion process. The mixed methods approach guided the collection of primary data through in-depth interviews, participant observations and survey. The data were obtained from four purposively selected health facilities within the Greater Accra Region. Forty-one interviewees participated in the in-depth interviews and 356 women participated in the survey. Coding and thematic analysis of qualitative data were done with the Nvivo software and multiple logistic regression analysis were done with the SPSS to examine the relationship between partner involvement and PAFP uptake in respect of the quantitative data.

The main findings of the study, theoretical implications and recommendations for future research are presented in the subsequent sections.

9.2 Summary of findings

The study found that the male partners are involved in women's abortion experiences in three main ways: through their knowledge of the abortion, role in the abortion decision-making process, and provision of support for the abortion. Male partners' knowledge of the abortion pertained to their awareness of abortion, communication with partners about the abortion, knowledge of health-seeking behaviour for abortion-related care; knowledge of abortion methods, and non-awareness of abortion.

The male partners' roles in the decision-making process was three-fold: they were either active facilitators or initiators in the abortion decision-making process, passive actors during the pregnancy resolution process, or played no role during the abortion decision. Regarding male partners' support for the abortion, different types were identified. These include: instrumental support (mainly payment of abortion expenses and accompaniment to the hospital); emotional support (expressions of empathy, and concern for female partners' health after the abortion); informational support (relevant direction and guidance on place of abortion-seeking care); and communicative support (discussions and negotiation surrounding the abortion decision).

The results also showed that nearly all the study participants initiated and adopted a contraceptive method, mainly, long-acting reversible contraception (LARC) such as implants immediately after the abortion without the involvement of their partners. The narratives indicated that immediate post-abortion family planning uptake was influenced by the abortion provider's characteristics, access to and availability of family planning consumables.

Results from the study further showed that women's expectation of receiving financial support for the abortion was mostly anticipated and prioritised over the expectation of partner participation in the pregnancy resolution process, and perceived support after the abortion. Some of the women had no expectations of their partners' support at the time of the abortion. Lack of male partners' awareness and knowledge of the pregnancy and abortion mainly inhibited their inclusion and participation in the abortion. Other factors that served as barriers to involvement in the abortion related to secrecy surrounding the abortion, partner abandonment, work-related demands, ambivalence about the pregnancy outcome, and parental responsibility for the pregnancy.

The results from the multiple logistic regression analysis showed that communicative support provided by the male partners has a statistically significant positive effect on the women's use of post-abortion family planning. Women's receipt of emotional support from their male partners was, however, not predictive of PAFP uptake. The hypothesis that women who received high communicative support from their male partners were more likely to use post-abortion contraception than women who did not receive any communicative support from their partners was supported. The second hypothesis that women who are financially supported by their partners during the abortion are more likely to use a PAFP method was, however, not supported by the results from the study.

The study also found that women who were knowledgeable of family planning, were employed, and had a high self-efficacy in using contraception were more likely to adopt a post-abortion contraceptive method compared to women who had no knowledge of FP, or who were unemployed or had a low self-efficacy. The male partner characteristics which predicted women's PAFP uptake were educational level, ethnicity and level of FP knowledge. Women were significantly more likely to adopt a post-abortion family planning method if their partners had a Middle/JHS and secondary level of education, and if the partner was Ga-Dangme.

Furthermore, women were more likely to use PAFP if their partners had a 'moderate' level of knowledge of family planning.

9.3 Conclusion

The male partners' are involved in women's abortion experiences in different ways. The study has established that communicative support from male partners during an abortion is crucial in positively reinforcing women's adoption and initiation of a family planning method after an abortion. This finding corroborates earlier studies conducted in other settings. However, male partners' lack of involvement during the abortion was a result of the secrecy and partners' lack of knowledge surrounding the pregnancy and abortion, work-related demands, parental responsibility and partner unavailability. Furthermore, self-efficacy remained the only significant predictor of PAFP use compared to the other HBM constructs. This result shows that women are capable of exercising autonomy over their reproductive choices and goals in preventing pregnancies either with or without their partners' participation in the abortion, and irrespective of socio-cultural myths, beliefs and perceptions regarding contraception.

In sum, the women's use of post-abortion contraception is a net result from individual factors (of both partners), partner involvement in abortion variables (communicative and emotional support), and HBM factors (self-efficacy). Generalizability of the results is limited to participating health facilities and sample characteristics. Caution should be exercised in extrapolating the study findings to other contexts although replication may yield additional interesting revelations.

9.4 Recommendations

The results obtained in this study reveal relevant issues which have implications for improving CAC and post-abortion family planning services. The study recommends intensive

comprehensive contraceptive counselling for women and couples during abortion care delivery. The goal of contraceptive counselling should aim at improving women's self-efficacy in contraceptive decision-making, and encourage continuous and sustained contraceptive adherence. Comprehensive investigations into couples' (or the woman's) contraceptive history prior to the abortion will serve as a pedestal for the acceptance and uptake of effective contraceptive methods after the abortion.

From a programmatic perspective, sexual and reproductive health practitioners should design strategies that promote men's sexual health by emphasizing on the use of male contraceptive methods to prevented unintended pregnancies, sexually transmitted infections and abortion. Public health interventions should also apply social media communication strategies to advocate men's important role in improving the sexual health of their female partners.

9.5 Theoretical implications of study findings

In this thesis, the Theory of Planned Behaviour (TPB) and Health Belief Models (HBM) were applied to explain and possibly predict women's use of PAFP. The results indicate to an extent, the utility of these theories in predicting PAFP use. The study found that self-efficacy was the only significant predictor of PAFP uptake compared to the other HBM constructs. Other studies lend support to this finding (Peyman and Oakley, 2009; Peyman et al., 2009) where self-efficacy influenced women's contraceptive use. This result suggests that women are capable of exercising autonomy over their reproductive choices and goals when it comes to preventing pregnancies either with or without their partners' participation in the abortion, and irrespective of socio-cultural myths, beliefs and perceptions regarding contraception. The ability of women to determine what happens to their 'body' is also indicative that women value their confidence to prevent future unintended pregnancies. In effect, even with male partners' participation in

abortion, women with a high self-efficacy are more likely to adopt post-abortion contraception than women with a low self-efficacy.

With Ajzen's theory of Planned Behaviour (TPB), it is predicted that individual behavioural intention(s) are influenced by the individual's attitude, perceived behavioural control and subjective norms. Linked to self-efficacy, women with a high self-efficacy have a relatively higher chance of exercising control of and making decisions on specific behaviours to engage in to prevent future unintended pregnancies and abortions compared to women with a low self-efficacy. The joint effect of perceived behavioural control and behavioural intention potentially reinforces an individual's confidence to use contraception discounting the negative attitude towards FP. Though subjective norm may negatively affect women's post-abortion contraceptive use, the results indicate that the intention and actual performance of a behaviour (uptake of PAFP) are strongly hinged on a strong sense of agency and self-determination discounting all other factors.

9.6 Future research

This study provides first-hand exploratory results which provide opportunities for further research agenda. First, future researchers may consider expanding the scope of this study to include private health facilities in other regions of the country since this study was limited to only public health facilities within the Greater Accra Region of Ghana. Interesting results may be found in these settings owing to the diversity of facility-level and provider characteristics which might influence or inhibit the delivery of post-abortion family planning services.

Another area for future research relates to the research design modification. Future studies can consider undertaking longitudinal investigation instead of a cross-sectional one. This will enable causality inferences and assumptions to be drawn and follow-ups on post-abortion contraception use can be investigated. Also, other researchers may wish to replicate

this topic in the wider community context as the present study was hospital-based. As the research was limited to only women who visited the participating hospitals, the perspectives of other women who might have had an abortion elsewhere were missed. There is a possibility that their abortion trajectories, and abortion-seeking behaviour experiences would differ from the current study respondents.

This study has shown that male partners participate in women's abortions in different ways. In future research endeavours, researchers may wish to collect primary data directly from male partners who accompany their female partners to the hospital for an abortion in order to obtain detailed insights into the social and psychological experiences of male involvement in women's abortion experiences. Couple studies to investigate the patterns of communication on post-abortion contraceptive use can be worth investigating. It will be insightful and interesting to tap into the worldview and perspectives of male partners who are involved in women's abortion experiences as this would enrich the paucity of abortion data from men, while contributing to a broader understanding of male involvement in abortion.

In the current study, individual-level characteristics of the Health Belief Model and Theory of Planned Behaviour were factored into the conceptual model to examine its effect on PAFP uptake. There is existing literature which suggest that health facility variables account for increased post-abortion contraceptive acceptance and prevalence (Banerjee et al., 2009; Navin et al., 2011b). In this regard, it will be useful for future studies to explore these health facility characteristics, and community-level factors which might moderate the relationship between male involvement and PAFP uptake.

Furthermore, although the study specifically sought to investigate male partners' involvement in pregnancy termination and PAFP uptake, the available literature demonstrates that social networks influence post-abortion contraception use. Since such studies are

understudied in the Ghanaian context, researchers may wish to consider conducting exploratory studies to examine the influence of social networks in alleviating women's emotional distress and coping mechanisms after an abortion.

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APPENDICES

Appendix 1: Interview Guide for Women

Title of study: Male Partners' Involvement in Abortion and Uptake of Post-abortion Family Planning Services.

Section A: Socio-demographic data

1. Age:
2. Highest educational level (in completed years):
3. Present occupation:
4. Employment status:
5. Religious affiliation:
6. Number of living children:
7. Living arrangement with partner:
8. Number of months/years living with partner:
9. Place of residence

Section B: Relationship Characteristics

i. How are you involved with the man responsible for your pregnancy?

Probe: - Duration of relationship/union, Relationship stability/instability; indicators of stable/unstable relationship, Status of relationship at time of pregnancy, Status of relationship at time of abortion

- Level of commitment to relationship/union; and indicators of commitment

Section C: Pregnancy History

i. In your lifetime, how many pregnancies have you had?

Probe: Age of sexual activity; sexual debut, outcome of pregnancies (birth, deaths, miscarriage, abortion); reasons for previous abortion (if any); pre-and post-abortion counselling during previous abortion

Section D: Contraceptive use before abortion

i. Before the abortion, were you or your partner doing something to prevent pregnancy?

Probe: - Method used to prevent pregnancy, and reason for method
- Duration of protection against pregnancy
- Partner approval/agreement of using contraceptive method, and Reasons
- Discussion with partner to use contraception

ii. How will you describe your attitude towards contraception? (Favourable/Unfavourable/Neutral)

iii. How will you describe your partner's attitude towards contraception?

Section E: Pregnancy disclosure and Intention

i. How did you come to know/find out that you were pregnant?

Probe: - When did you find out about the pregnancy?

- Gestational age of pregnancy when first discovered

ii. Who was the first person you told when you discovered you were pregnant?

Probe: If partner first, or others first, give reasons.

- Partner's immediate reaction to news of pregnancy. Describe
- Partner's acceptance/denial of pregnancy. Describe things he did to suggest denial
- Awareness of partner's pregnancy intention

iii. How did you feel about the pregnancy when you found out? Give reasons

iv. What was your immediate reaction to the pregnancy?

v. Has this pregnancy come too soon, right time, later in future, or you didn't care? Why?

vi. Did you want/desire to become pregnant? Why? (Pregnancy wantedness)

vii. Did you think you could become pregnant? Why? (Perceived risk of pregnancy)

Section F: Abortion history

i. Before the last time (at the clinic), have you ever terminated a pregnancy in your lifetime?

Probe: Number of times aborted pregnancy

Age of pregnancy (months/weeks) at time of abortion

First thing to end pregnancy (whether self-induced); and Reasons

Person who terminated pregnancy (if not self-induced)

Knowledge of where to seek help for pregnancy termination

Procedure for abortion; Reason for abortion procedure; Health complications after abortion; describe the kind of complication [bleeding, pain, fever, etc.]; Place of treatment for complication of abortion

ii. Who paid for the abortion? Give reasons

iii. How much was paid for the cost of abortion?

Section G: Abortion decision

i. What decision did you make independently when you discovered you were pregnant?

ii. Who made the decision to terminate the pregnancy?

Probe: Was your partner involved in the decision to terminate the pregnancy? Give reasons; Involvement of other people; Partner's reaction to abortion; First person to suggest/demand for abortion; most influential in decision to terminate pregnancy

iii. Before you became pregnant, did you ever discuss with your partner what you will do in the event of a pregnancy?

iv. In your view, who do you think has the right to decide on abortion or not? State reasons

Probe: - Final decision maker. Give reasons

Reasons for pregnancy termination:

i. What were the main reasons that influenced your decision to terminate the pregnancy?

Probe: - Other factors that influenced decision to terminate pregnancy
- Health grounds, Partner attributes, actual time abortion was performed after first discovered

Section H: Expectations of Male partner support in abortion

i. Did you think that you could depend on your partner for any form of support when you found out about the pregnancy?

ii. Did you think that you could depend on your partner for any form of support when you decided to have an abortion?

iv. When u decided to terminate the pregnancy, did you expect your partner to provide some support for you?

Probe: Describe various ways in which your partner provided some form of support to you before the abortion (financial, emotional, instrumental, family planning/contraception)

- Whether expectations were met
- Reasons that accounted for unmet expectations

v. After the abortion, do you expect to receive support from your partner? Give examples & reasons

Probe: [financially, emotionally, materially/instrumentally, & informationally]

**What are some of the things you expect your partner to do for you after the abortion?

- Reasons for male partner non-support in the abortion

Section K: Post-abortion Family Planning/Contraception

i. Are you using a contraceptive method now after the abortion? Give reasons

Probe: If Yes,- Reasons for type of contraceptive method

- Whether contraceptive type chosen depended on partner's preference; partner's influence; & partner's involvement/support

- Time of contraceptive uptake

- Whose responsibility for use of contraception in relationship

ii. Will your partner's support for the abortion influence you to use a family planning method after the abortion?

iii. If No, was there anything to prevent you from using contraception after the abortion? Give reasons

Probe: - Partner disapproval, Contraception issues (side- effects, cost, and access)

- Future intentions to use contraception

iv. Were you (and your partner) encouraged to use contraception by health professional before or after the abortion?

Probe: - Describe events before and after abortion procedure

- Contraception/FP methods discussed
- Whether felt pressured to accept a contraceptive method
- Partner knowledge of contraception use

iii. What roles and responsibilities were you expecting from your partner from the time of the pregnancy until the abortion?

Appendix 2: Interview guide for Male Partner

Title of study: Male partner involvement in abortion and uptake of post-abortion family planning (PAFP) services.

Section A: Socio-demographic data

1. Age
2. Highest educational level
3. Present occupation
4. Employment status
5. Religious affiliation
6. Number of living children
7. Living arrangement with partner
8. Place of residence

Section A1: Relationship Characteristics

i. Can you describe the nature of the relationship between you and the woman who got pregnant for you and which you assisted to terminate?

Probe: - Duration of relationship/union

- **Relationship stability/instability, and reasons
- Level of commitment to relationship/union, and reasons
- Level of communication on sexual matters

Section B: Abortion history

i. In the past, have you and your partner terminated a pregnancy for which you were responsible for?

Probe: Number of times pregnancy has been terminated
Age of pregnancy (months/weeks) at time of termination
First thing to end pregnancy (whether self-induced); and Reasons
Person who terminated pregnancy (if not self-induced)
Knowledge of where to seek help for pregnancy termination
Procedure for pregnancy termination

Health complications after pregnancy termination

Probe: Describe the kind of complication [bleeding, pain, fever, etc.]

Place of treatment for complication of abortion

ii. Who paid for the abortion? Give reasons

iii. How much was paid for the cost of abortion?

Section C: Pre-abortion stage

Contraceptive use before abortion

i. Were you or your partner doing something to avoid pregnancy? Reasons if Yes/No.

Probe: - Method used to prevent pregnancy, and Reason for method

- Duration of protection against pregnancy

- Partner approval/agreement of using contraceptive method, and Reasons

- Discussion with partner to use contraception

ii. Can you describe your attitude towards contraception? (Favourable/Unfavourable/Neutral)

iii. How will you describe your partner's attitude towards contraception?

Pregnancy disclosure and Intention:

i. How did you come to know that your partner was pregnant?

Probe: Gestational age of pregnancy

ii. Can you describe your immediate reaction when you found out about the pregnancy?

Probe: - Describe feeling about pregnancy

- Timing of pregnancy (too soon, later [future], didn't care). Reasons

- Responsibility for pregnancy. Reasons

Abortion decision

i. What did you plan to do when your partner informed you about the pregnancy?

ii. Who made the decision to terminate the pregnancy?

Probe: - Woman's decision, joint decision, decision of other people

- First person to demand for abortion

- Most influential in decision to terminate pregnancy

- Attitude of woman to abortion

- Intentions to provide support after abortion decision

iii. Before the pregnancy, had you previously discussed what you will do in the event of a pregnancy?

iv. In your view, who do you think has the right to decide on abortion or not? State reasons

Probe: - Final decision maker. Give reasons

Reasons for pregnancy termination:

i. What were the main reasons that influenced your decision to terminate the pregnancy?

Probe: - Other factors that influenced decision to terminate pregnancy

** Actual time abortion was performed after first discovered

Section D: Involvement and support in abortion

i. Can you describe the ways in which you supported your partner at the time of abortion?

Probe: - Reasons for non-support in the abortion

Financial support: – Payment of cost of abortion

- Payments for other expenses related to abortion
- Payment of transportation cost

Physical/material/instrumental support

- Accompany woman to facility. Give reasons.
- Seek information on place to have the abortion performed. Give reasons.
- Encourage rest/sleep after abortion.
- Purchase nutritious food/drinks/drugs to aid recovery after abortion

- Perform any house chores/cater for the children after abortion

Emotional support

- Empathetic, - Reassurance about health

- Concern to accompany woman to facility or stay home with her after the termination

- Encourage follow-up visit to the health facility after abortion

- Concern about postponing sexual intercourse after the abortion

Family Planning/Contraception support
- Encourage/Influence contraceptive use after the abortion
- Discuss contraceptive use
- Approved of/agreed to contraception use after the abortion

ii. What things or factors prevent men from involving and supporting themselves in their partner's abortion?

Section D1: Post-abortion decision stage

i. After the abortion, did you and your partner adopt a contraceptive method?

Probe: If Yes,
- Reasons for type of contraceptive method
-Whether contraceptive type chosen depended on your preference; influence; & involvement/support
- Time of contraceptive uptake

- Future fertility intentions

ii. If NO, was there anything to prevent you and your partner from using contraception after the abortion? Give reasons

Probe: - Contraception issues (side- effects, cost, and access); other issues (religion)

- Future intentions to use contraception

iii. Were you (and your partner) encouraged to use contraception by a health professional before or after the abortion?

Probe: - Narrate events before and after abortion procedure

- Contraception/FP methods discussed

- Whether felt pressured to accept a contraceptive method

- Partner knowledge of contraception use

APPENDIX 3: QUESTIONNAIRE

Location of Interview: **Date of interview:** **Start time:**		**Respondent Unique ID:**
SECTION 1: RESPONDENT BACKGROUND INFORMATION		
	I would like to ask you some information about yourself.	
Q NO	**QUESTION**	
1.	How old were you on your last birthday? __ __	
2.	On what day, month and year were you born? DAY __ __ MONTH _____ YEAR__ __ __ __	
3.	What is the highest level of school you have attended and completed? 1= NO EDUCATION 2= PRE-SCHOOL 3= PRIMARY 4= MIDDLE/JHS 5= SECONDARY/SHS 6= HIGHER/TERTIARY 7= VOCATIONAL 8= OTHER (SPECIFY)	
4.	Are you currently attending school? 1= YES 2= NO	
5.	What work are you currently engaged in for money/income for the past 6 months? 1= NO OCCUPATION/NOT WORKING 2=CLERICAL 3= SALES 4= SELF-EMPLOYED 5= UNSKILLED MANUAL 6= MANAGERIAL 7= HOUSEHOLD AND DOMESTIC 8= SKILLED MANUAL 9= OTHER [SPECIFY]	
6.	What is your religion? 1= NO RELIGION 2= CATHOLIC 3= PRESBYTARIAN 4= METHODIST 5= PENTECOST/ CHARISMATIC 6= TRADITIONAL/SPIRITUALIST 7= MUSLIM/ISLAM 8= DEEPER LIFE 9= SDA 10= JEHOVAH WITNESS 11= ANGLICAN 12= OTHER [SPECIFY]	
7.	What is your ethnic group? 1= AKAN 2= GA-DANGME 3= EWE 4= GRUSI 5= GUAN 6= GRUMA 7= MOLE-DAGBANI 8= HAUSA 9= OTHER [SPECIFY]	
8.	Where is your usual place of residence (for the last six months)?	
9.	Who are you currently living with? 1= LIVING ALONE 2= PARTNER/SPOUSE 3= BOTH PARENTS 4= ONE PARENT 5= SIBLINGS [SISTERS/BROTHERS] 6= FRIEND 7= GRANDPARENTS 8= GUARDIAN/CARE-GIVER 9=OTHER [SPECIFY]	
10.	What is your marital status now? 1= SINGLE (NEVER MARRIED) 2= CURRENTLY MARRIED 3= COHABITING 4= DIVORCED 5= WIDOWED 6= SEPARATED	
11.	If **currently married** or **Cohabiting**, for how long? _____	
12.	How many children do you have?	
	SECTION 2a: CONTRACEPTIVE KNOWLEDGE	
	Now I would like to ask you some questions about the various ways or methods that men and women use to delay or avoid pregnancy.	
13.	Which family planning methods or contraceptive methods have you **EVER** heard of? 1= EMERGENCY PILLS [E.G. POSTINOR, N-TABLET, PROTEX] 2= ORAL CONTRACEPTIVE PILLS [E.G. SECURE] 3= INJECTABLES 4= MALE CONDOM 5= FEMALE CONDOM 6= WITHDRAWAL 7= IMPLANTS 8= IUD 9= LACTATIONAL AMENORRHOEA METHOD [LAM] 10= FEMALE STERILIZATION (TUBAL LIGATION) 11= MALE STERILIZATION (VASECTOMY)	**ALLOW respondent to mention spontaneously.** **Circle as many options mentioned.**

	12= DIAPHRAGM 13= FOAM/JELLY 14= RHYTHM/CALENDAR 15= OTHER METHOD [specify]				
14.	Which contraceptive methods do you know of? (**Probe: allow respondent to describe how contraceptive is used, past experience)** 1= EMERGENCY PILLS [E.G. POSTINOR, N-TABLET, PROTEX] 2= ORAL CONTRACEPTIVE PILLS [E.G. SECURE] 3= INJECTABLES 4= MALE CONDOM 5= FEMALE CONDOM 6= WITHDRAWAL 7= IMPLANTS 8= IUD 9= LACTATIONAL AMENORRHEA METHOD [LAM] 10= FEMALE STERILIZATION (TUBAL LIGATION) 11= MALE STERILIZATION (VASECTOMY) 12= DIAPHRAGM 13= FOAM/JELLY 14= RHYTHM/CALENDAR 15= OTHER METHOD [specify]				**Circle as many options described by Respondent.**
15.	How will you describe your level of knowledge about family planning/contraceptives? 1= VERY KNOWLEDGEABLE 2= KNOWLEDGEABLE 3= SOMEWHAT KNOWLEDGEABLE 4= NOT KNOWLEDGEABLE 5= NOT KNOWLEDGEABLE AT ALL 6= DON'T CARE				
16.	What is your attitude towards contraceptive use? 1= VERY FAVOURABLE 2= FAVOURABLE 3= SOMEWHAT FAVOURABLE 4= NOT FAVOURABLE 5= NOT FAVOURABLE AT ALL 6= DON'T CARE				
	Instructions: In this section, I will read some statements to you. FOR EACH STATEMENT, TELL ME WHETHER YOU: **1-STRONGLY DISAGREE 2- DISAGREE 3- AGREE 4- STRONGLY AGREE**				**5- DON'T KNOW**
	Perceived Benefits Of Contraceptives	**SD**	**D**	**A**	**SA**
a.	Using contraceptives would help me avoid unwanted or unexpected pregnancy	**1**	**2**	**3**	**4**
b.	I would have saved the money I used to pay for the abortion if I used contraceptives	**1**	**2**	**3**	**4**
c.	Using contraceptives is effective and easy to use	**1**	**2**	**3**	**4**
d.	I do not have to worry about becoming pregnant when I use contraceptives	**1**	**2**	**3**	**4**
e.	I am not ready to have children now so I have to protect myself with contraceptives	**1**	**2**	**3**	**4**
f.	Using contraceptives will prevent me from having an abortion	**1**	**2**	**3**	**4**
g.	The cost of abortion is more expensive than the cost of contraceptives	**1**	**2**	**3**	**4**
	PERCEIVED BARRIERS TO CONTRACEPTIVE USE				
a.	I know that using contraceptives might cause side-effects	**1**	**2**	**3**	**4**
b.	I believe when I use contraceptives, I might not be able to have children in future	**1**	**2**	**3**	**4**
c.	I think that when I use contraceptives, it might cause health problems in future	**1**	**2**	**3**	**4**
d.	I am too young to use contraceptives to protect against pregnancy	**1**	**2**	**3**	**4**
e.	My partner does not agree that I use contraceptives	**1**	**2**	**3**	**4**
f.	It will be difficult to go to a hospital/clinic for a contraceptive/family planning	**1**	**2**	**3**	**4**
g.	It is an inconvenience to use contraceptives/family planning	**1**	**2**	**3**	**4**
h.	Buying contraceptives is expensive	**1**	**2**	**3**	**4**
j.	The side-effects that people have said about contraceptives prevents me from using it.	**1**	**2**	**3**	**4**
17.	Before you became pregnant, were you and/ OR your partner doing something to prevent yourself from becoming pregnant? 1= YES, WE WERE USING EMERGENCY CONTRACEPTIVE PILLS 2= YES, WE WERE USING ORAL CONTRACEPTIVE PILLS 3= YES, WE WERE USING MALE CONDOMS 4= YES, WE WERE USING FEMALE CONDOMS				**IF NO, Skip to Q19**

	5= YES, I WAS USING WITHDRAWAL 6= YES, WE WERE USING IMPLANTS 7= YES, I WAS USING IUD 8= YES, I WAS USING INJECTABLES 9= YES, I WAS USING MY SAFE PERIOD/CALENDAR METHOD/ RHYTHM METHOD 10= YES, I WAS BREASTFEEDING (LACTATIONAL AMENORRHEA [LAM] 11= NO, WE WERE NOT DOING ANYTHING TO PREVENT PREGNANCY 12= OTHER (SPECIFY)	
18.	How long have you been using this method to prevent pregnancy from occurring? 1= LESS THAN SIX MONTHS AGO 2= ONE YEAR AGO 3= TWO YEARS AGO 4= MORE THAN TWO YEARS AGO	
19.	In your whole lifetime, which contraceptives /family planning types have you ever used before? a. NO METHOD b. EMERGENCY PILLS [E.G. POSTINOR, N-TABLET, PROTEX] c. ORAL CONTRACEPTIVE PILLS [E.G. SECURE] d. INJECTABLES e. MALE CONDOM f. FEMALE CONDOM g. WITHDRAWAL h. IMPLANTS j. IUD k. LACTATIONAL AMENORRHEA METHOD l. DIAPHRAGM m. FOAM/JELLY n. RHYTHM/CALENDAR O. OTHER METHOD [specify]	
	PREGNANCY HISTORY SECTION	
20.	In your whole lifetime, how many times have you become pregnant (including this last pregnancy)? _____	
21.	Out of this (these) pregnancy/pregnancies, how many ended in live births? _____	
22.	**How many ended in stillbirths?**	
22a.	How many ended in deaths? _____	
23.	How many ended in induced abortion? _____	
23a.	So how many of the pregnancies were miscarriages/spontaneous abortions?	
23b.	So how many months/weeks are you pregnant?	
24.	Before this current pregnancy, did you want/wish to become pregnant? **1= YES 2= NO 3= DIDN'T CARE**	
25.	So how would you consider the timing of your pregnancy? 1= TOO SOON (UNEXPECTED) 2= AT THE RIGHT TIME 3= LATER (IN FUTURE) 4= DIDN'T CARE	
26.	If **LATER (IN FUTURE)**, when did you want to become pregnant? 1= IN 12MONTHS TIME 2= IN 2YEARS TIME 3= IN 3YEARS TIME 4= IN 4YEARS TIME 5= IN 5YEARS TIME 6= OTHER [SPECIFY]	
27.	Which of the following best describes how you felt when you found out you were pregnant. 1= VERY UNHAPPY 2= UNHAPPY 3= NORMAL (NEITHER HAPPY OR UNHAPPY) 4= HAPPY 5= VERY HAPPY	
28.	What are the **main** reasons why you don't want to have a child now or keep this pregnancy?	

	SECTION 3: MALE PARTNER BACKGROUND INFORMATION	
	In this section, I would like to ask you a few questions about your male partner who is responsible for your pregnancy.	
29.	How old is your male partner (age as at last birthday)? ____	
30.	What is the highest level of education your partner has **completed?** 1= NO EDUCATION 2= PRE-SCHOOL 3= PRIMARY 4= MIDDLE/JHS 5= SECONDARY/SHS 6= HIGHER/TERTIARY 7= DON'T KNOW 8= OTHER (SPECIFY)	
31.	What kind of work/job is your partner currently engaged in or doing for income/money? 1= NOT WORKING/NO OCCUPATION 2= CLERICAL 3= SALES 4= SELF-EMPLOYED 5= UNSKILLED MANUAL 6= MANAGERIAL 7= HOUSEHOLD AND DOMESTIC 8= OTHER [SPECIFY]	
31a.	Is your partner currently attending school? **1= YES 2= NO**	
32.	What religion does your partner belong to? 1= NO RELIGION 2= CATHOLIC 3= PRESBYTARIAN 4=METHODIST 5= PENTECOST/CHARISMATIC 6=TRADITIONAL/SPIRITUALIST 7= MUSLIM/ISLAM 8= DEEPER LIFE 9= SDA 10= JEHOVAH WITNESS 11= ANGLICAN 12= OTHER [SPECIFY]	
33.	What is your partners' ethnic group? 1= AKAN 2= GA-DANGME 3= EWE 4= GUAN 5= GRUMA 6= MOLE-DAGBANI 7= GRUSI 8= HAUSA 9=OTHER [SPECIFY]	
34.	What is your partner's current marital status? 1= SINGLE (NEVER MARRIED) 2= CURRENTLY MARRIED 3= DIVORCED 4= WIDOWED 5= SEPARATED 6= DON'T KNOW 7= OTHER [SPECIFY]	
35.	Who is your partner currently living/ staying with? 1= ALONE 2= ME/SPOUSE 3= ANOTHER WOMAN 4= BOTH PARENTS 5= ONE PARENT 6= FRIEND 7= SIBLINGS [SISTERS/BROTHERS] 8= GRANDPARENTS 9= OTHER [SPECIFY]	
	SECTION 3b: NATURE OF RELATIONSHIP WITH MALE PARTNER	
36.	What is your relationship with the man who is responsible for your pregnancy? 1= BOYFRIEND 2= HUSBAND 3= FIANCÉ 4= RELATIVE 5= FRIEND 6= CASUAL ACQUAINTANCE 7= RELIGIOUS LEADER/PASTOR 8= OTHER [SPECIFY]	
37.	How long have you been in a relationship with the man responsible for the pregnancy? 1=LESS THAN 6MONTHS 2= 6 MONTHS TO 1 YEAR 3= 1-2YEARS 4= 3-5YEARS 5= 6YEARS- 11YEARS 6= MORE THAN 11YEARS	
38.	How stable is your relationship with the man responsible for the pregnancy? 1= VERY STABLE 2= STABLE 3= SOMEWHAT STABLE 4= NOT STABLE 5= NOT STABLE AT ALL	
39.	Right now, are you in a relationship with this man? 1= YES 2= NO 3= NOT SURE 4= I INTEND TO END THE RELATIONSHIP WITH HIM	**IF YES, go to Q41**
40.	If **NOT SURE**, OR **INTEND TO END THE RELATIONSHIP,** what are the reasons?	
41.	How will you describe your partner's level of knowledge about family planning/ contraceptives? 1= VERY KNOWLEDGEABLE 2= KNOWLEDGEABLE 3= SOMEWHAT KNOWLEDGEABLE 4= NOT KNOWLEDGEABLE 5= NOT KNOWLEDGEABLE AT ALL 6= DON'T KNOW	
42.	Have you and your partner ever talked about or discussed using contraceptives in your relationship? 1= YES, VERY OFTEN 2= YES, SOMETIMES 3= NEVER	
43.	Before this pregnancy, did your partner agree that you will use contraceptives in your relationship? 1= YES 2= NO	

44.	If **NO**, why didn't your partner agree to using contraceptives?	
45.	What is your partner's attitude towards contraceptive use? 1= VERY FAVOURABLE 2= FAVOURABLE 3= NOT FAVOURABLE 4= NOT FAVOURABLE AT ALL 5= HE DOESN'T CARE	
46.	Before this pregnancy, did you know when your partner wanted to have a child? 1= YES, HE WANTED A CHILD NOW/IMMEDIATELY 2= YES, HE WANTED A CHILD LATER (IN THE FUTURE) 3= NOT SURE WHEN HE WANTED A CHILD 4= NO, I DON'T KNOW 5= HE DOES NOT WANT ANY MORE CHILDREN	**If NOT SURE or DON'T KNOW, go to Q48**
47.	If **YES,** how many children does your partner want to have in future? _____	
48.	If **NO**, why don't you know when your partner wants to have children? 1= WE HAVE NEVER TALKED ABOUT IT 2= ITS NOT IMPORTANT 3= HE HAS NEVER TOLD ME ABOUT WHEN HE WANTS TO HAVE CHILDREN 4= I HAVE NEVER ASKED HIM WHEN HE WANTS TO HAVE CHILDREN 5= OTHER [SPECIFY]	
49.	Does your partner know that you are pregnant for him? **1= YES 2= NO**	**If YES, continue at Q50**
	If **NO,** why doesn't your partner know of the pregnancy?	
	SECTION 5a: MALE PARTNER INVOLVEMENT IN ABORTION **I am going to ask you a few questions about how your partner is involved in the decision to have an abortion.**	
50.	Before you became pregnant, did you discuss or talk with your partner about what you will do in the event of an unintended pregnancy? 1=YES 2=NO	**IF NO, go to Q52**
51.	If **YES**, what did the two of you decide to do in the event of an unintended pregnancy? 1= TO GIVE BIRTH/KEEP THE PREGNANCY 2= TO TERMINATE THE PREGNANCY 3= UNDECIDED/ NOT SURE 4= OTHER [specify]	
52.	If **NO**, why did you not discuss with your partner what you will do during an unintended pregnancy earlier before the pregnancy? 1. WE DIDN'T THINK THE PREGNANCY COULD HAPPEN 2. NOT NECESSARY OR IMPORTANT 3. I WAS USING CONTRACEPTION [PILLS] 4.WE WERE DOING SOMETHING TO PREVENT PREGNANCY [E.G. USING WITHDRAWAL, SAFE PERIOD, LAM] 5. NO REASON 6. OTHER [SPECIFY]	
53.	Does the man who got you pregnant know that you are choosing to have an abortion? **1=** YES 2= NO	**IF YES, go to Q55**
54.	If **NO,** why doesn't he know that you are terminating the pregnancy or choosing to have an abortion? a. HE IS NOT AROUND/TRAVELLED b. I DON'T KNOW HIS WHEREABOUTS c. I DON'T WANT TO TELL HIM d. HE IS NOT FAITHFUL e. WE ARE NO LONGER IN A RELATIONSHIP f. I WANT IT TO BE A SECRET g. I WANT TO AVOID CONFLICTS OR PROBLEMS h. AFRAID HE WILL DISCLOSE IT TO HIS FAMILY OR FRIENDS OR CHURCH MEMBERS j. OTHER [SPECIFY]	

55.	Who made the decision to terminate the pregnancy? 1= MYSELF 2= MY PARTNER 3= BOTH OF US 4= MY PARENTS [MOTHER, FATHER, OR MOTHER ALONE, OR FATHER ALONE] 5= MY OLDER SIBLING [SISTER, OR BROTHER] 6= MY GUARDIAN/CAREGIVER 7= OTHER [SPECIFY]	**If MY PARTNER=2continue at Q57.**
56.	If **YOU (woman)** made the decision, is your partner supportive of your decision to have the abortion? 1= YES, HE IS SUPPORTIVE 2= NO, HE IS NOT SUPPORTIVE 3= OTHER [SPECIFY]	
57.	How supportive or to what extent is your partner of your decision to have the abortion? 1= VERY SUPPORTIVE 2= SUPPORTIVE 3= SOMEWHAT SUPPORTIVE 4= NOT SUPPORTIVE 5= NOT SUPPORTIVE AT ALL	
58.	How will you describe your partner's attitude toward the abortion? 1= FAVOURABLE 2= NOT FAVOURABLE AT ALL 3= DOESN'T CARE 4= NOT AWARE OF ABORTION	
59.	Between you and your partner, who was the **FIRST** person to initiate or suggest the abortion? 1= MY PARTNER 2= MYSELF 3= BOTH OF US	
60.	Who was the MOST INFLUENTIAL person in the decision to terminate the pregnancy? 1= MY PARTNER 2= MYSELF 3= BOTH OF US 4= MY PARENTS 5= MY OLDER SIBLINGS 6= GUARDIAN/CARE-GIVER 7= MEDICAL DOCTOR 8= QUALIFIED NURSE 9= OTHER [SPECIFY]	

		Y	N
	SECTION 5b: MALE PARTNER SUPPORT IN THE ABORTION **In the following questions, I will like to know how your partner provided some support for you before and during the time of the abortion.** **Please tick YES [√] or NO [X].**		
	What are some of the things your partner did for you when you or (both of you) decided to terminate the pregnancy?		
a.	Pay for the abortion		
b.	Bought me some drugs to terminate the pregnancy before I came to the hospital		
c.	Accompanied me to the clinic/hospital		
d.	Provided me with information on where I could go for the abortion		
e.	Gave me money for transportation to the hospital		
f.	Encouraged me not to be worried about the abortion		
g.	Expressed concern about the abortion		
h.	Expressed concern about my health		
j.	Talked to me about using contraceptives/family planning after the abortion		
k.	He agreed that we will use contraceptives to prevent another pregnancy		
l.	Expressed concern that we should abstain from sexual intercourse after the abortion		
m.	Approved that we will use contraceptives after the abortion		
n.	**OTHER [Specify]**		

61.	Will your partner's support in the abortion influence you to use family planning after the abortion? 1= YES 2= NO 3= I DON'T KNOW
62.	To what extent will your partner's support during the abortion influence you to use contraception after the abortion? 1= VERY MUCH/GREATLY 2= MUCH/ GREATLY 3= LITTLE 4= VERY LITTLE 5= NEVER/NOT AT ALL

		SD	D	A	SA
	SECTION 6: SELF-PERCEIVED QUESTIONS I am going to ask you the following questions about your perceptions of severity of abortion. I will also ask you about whether you have the ability to prevent another pregnancy and abortion from occurring in future. FOR EACH STATEMENT, TELL ME WHETHER YOU: **1-STRONGLY DISAGREE 2- DISAGREE 3- AGREE 4- STRONGLY AGREE**				
	Perceived Severity Of Abortion And Negative Health Outcomes	**SD**	**D**	**A**	**SA**
1.	It is possible for some people to die as a result of abortion	**1**	**2**	**3**	**4**

2.	The thought of having an abortion again in my life scares me	**1**	**2**	**3**	**4**
3.	Having an abortion is a painful experience so I will not want to have another abortion	**1**	**2**	**3**	**4**
4.	I will not want another abortion in my life because I might not be able to bear children in future	**1**	**2**	**3**	**4**
5.	This abortion might cause some complications for me in future	**1**	**2**	**3**	**4**
6.	I will never have my peace of mind because of this abortion	**1**	**2**	**3**	**4**
7.	It is expensive to have an abortion than to buy contraceptives	**1**	**2**	**3**	**4**
	SELF-EFFICACY				
1.	I am confident that I can use FP to protect myself from becoming pregnant	**1**	**2**	**3**	**4**
2.	I can confidently go to a nurse or hospital for family planning	**1**	**2**	**3**	**4**
3.	I don't need to depend on anyone to use FP after the abortion	**1**	**2**	**3**	**4**
4.	On my own, I can make a decision to use family planning	**1**	**2**	**3**	**4**
5.	I have to take responsibility for using contraception/family planning after the abortion	**1**	**2**	**3**	**4**
6.	My partner doesn't need to be involved in the contraception/family planning I use after the abortion	**1**	**2**	**3**	**4**
7.	It is the responsibility of men to use contraceptives in a relationship	**1**	**2**	**3**	**4**
8.	My partner does not need to know about the family planning method I use after the abortion	**1**	**2**	**3**	**4**
9.	I am confident that I have enough knowledge on how I can prevent an unwanted pregnancy	**1**	**2**	**3**	**4**
10.	I am sure that I can protect myself from having an unwanted pregnancy even if I don't use contraceptives/ family planning	**1**	**2**	**3**	**4**

	SECTION 7: POST-ABORTION FAMILY PLANNING/ CONTRACEPTION UPTAKE	
*****	**What will influence you to use FP/contraception after this abortion?**	
63.	Will your partner's involvement in the abortion influence you to use FP after this abortion? **1= YES** **2= NO** **3= I DON'T KNOW**	
64.	How likely or **<u>to what extent</u>** will your partner's involvement in the abortion influence your decision to use contraception/FP after the abortion? 1= VERY MUCH/GREATLY 2= MUCH/ GREATLY 3= LITTLE 4= VERY LITTLE 5= NEVER/ NOT AT ALL	
65.	If **NEVER,** why won't your partner's involvement in the abortion influence your decision to use contraception/FP after the abortion? 1= BECAUSE HE WASN'T INVOLVED IN THE ABORTION 2= NO REASON 3= OTHER [SPECIFY]	
66.	**Have you adopted any family planning method after the abortion?** 1= YES 2= NO	**IF NO, SKIP TO Q71**
67.	If **YES**, what is (are) the reasons for your choice of FP method now after the abortion? 1. TO PREVENT UNWANTED PREGNANCY 2. TO PREVENT ANOTHER ABORTION 3. BECAUSE I HAVE EVER USED IT BEFORE 4. BECAUSE OF ENCOURAGEMENT/COUNSELLING/SUGGESTION FROM NURSE/ DOCTOR 5. BECAUSE OF PARTNERS' APPROVAL TO USE FP/CONTRACEPTION 6. BECAUSE OF PARTNERS' ENCOURAGEMENT & SUPPORT TO USE CONTRACEPTIVE/FP 7. BECAUSE MY PARTNER AND I DECIDED TO USE A MORE EFFECTIVE CONTRACEPTION/FP METHOD 8. BECAUSE MY PARTNER SUPPORTS MY DECISION TO USE CONTRACEPTION/FP 9. BECAUSE MY PARTNER WAS INVOLVED IN THE DECISION TO TERMINATE THE PREGNANCY 10. OTHER [SPECIFY]	
68.	What FP method are you using now after the abortion? 1= IMPLANTS 2= IUD 3= INJECTABLES 4= ORAL CONTRACEPTIVE PILLS 5= MALE CONDOMS 6= FEMALE CONDOMS	

	7= OTHER [SPECIFY]	
69.	Why did you choose to use this type of FP type? **(Multiple Choice)** 1. BECAUSE OF MY KNOWLEDGE ABOUT IT 2. I HAVE USED IT BEFORE 3. PARTNER'S PREFERENCE FOR CONTRACEPTIVE TYPE 4. BECAUSE MY FRIENDS HAVE ENCOURAGED ME TO USE IT 5. BECAUSE THE NURSE SUGGESTED AND COUNSELLED ME TO USE IT 6. OTHER [SPECIFY]	
70.	Who made the decision to use the FP after the abortion? 1= MY PARTNER 2= MYSELF 3= NURSE 4= MEDICAL DOCTOR 5= PARENTS 6= OLDER SIBLING [SISTER/BROTHER] 7= OTHER [SPECIFY]	
71.	Before you came for the abortion, had you already made up your mind to use FP after the abortion is done? 1= YES 2= NO 3= I DON'T KNOW	
72.	If **NO**, what contraceptive method/FP method do you intend to use after the abortion? 1= IMPLANT 2=IUD 3= INJECTABLES 4= PERIODIC ABSTINENCE 5=ORAL CONTRACEPTIVE PILLS 6= RHYTHM/CALENDAR METHOD **7= NO METHOD** 8= UNDECIDED 9= OTHER (SPECIFY)	
73.	What will be your reason/reasons for choosing to use this type of FP in future? 1. TO PREVENT UNWANTED PREGNANCY 2. TO PREVENT ANOTHER ABORTION 3. BECAUSE OF ENCOURAGEMENT FROM NURSE/DOCTOR 4. BECAUSE OF PARTNER'S APPROVAL TO USE FP/CONTRACEPTION 5. BECAUSE OF PARTNER'S ENCOURAGEMENT AND ADVICE TO USE CONTRACEPTION/FP 6. BECAUSE MY PARTNER AND I DECIDED TO USE A MORE EFFECTIVE CONTRACEPTION/FP METHOD 7. BECAUSE PARTNER SUPPORTS MY DECISION TO USE CONTRACEPTION/FP 8. BECAUSE MY PARTNER WAS INVOLVED IN THE DECISION TO TERMINATE THE PREGNANCY 9. OTHER [SPECIFY]	
74.	What is preventing you from using a FP method immediately after the abortion? 1. MALE PARTNER DISAPPROVAL TO USE CONTRACEPTIVE/FP 2. FEAR OF SIDE EFFECTS OF CONTRACEPTIVES 3. NEGATIVE PERCEPTION ABOUT USING CONTRACEPTIVES/FP 4. I WANT TO HAVE MY MENSES FIRST BEFORE I USE CONTRACEPTION 5. I WILL BE CAREFUL NEXT TIME SO THAT I DON'T GET PREGNANT 6. I HAVEN'T PLANNED OR DECIDED TO USE CONTRACEPTION/FP AFTER THE ABORTION 7. OTHER [SPECIFY]	
75.	What is/are the main reasons why you do not intend to use a contraceptive method at any time in the future?	

THANK YOU VERY MUCH FOR PARTICIPATING IN THIS SURVEY.

I will like to get in touch with you between two to 6 weeks just to find out whether you have decided to use a family planning method. IF YOU AGREE, KINDLY GIVE ME YOUR CONTACT NUMBER: _____

Appendix 4: Ethical Approval Letter

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Tel: +233-302-681109
Fax + 233-302-685424
Email: Hannah. Frimpong@ghsmail.org

My Ref. GHS/RDD/ERC/Admin/App/16/80
Your Ref. No.

Esinam Afi Kayi
Regional Institute for Population Studies
P. O. Box LG 96
University of Ghana
Legon

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	**GHS-ERC GM 02/02/16**
Project Title	"Male Partners' Involvement in Abortion Decision Making and Uptake of Post Abortion Family Planning Service"
Approval Date	12th April, 2016
Expiry Date	11th April, 2017
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report **after completion** of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....
DR. CYNTHIA BANNERMAN
(GHS-ERC CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

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Appendix 5: Consent Form

INFORMED CONSENT FORM

Principal Investigator: **Esinam Afi Kayi**
Regional Institute for Population Studies. University of Ghana, Legon

My name is _____. I am conducting a survey on ***'Male partners' involvement in abortion and uptake of post-abortion family planning services'*** in selected hospitals in Accra. I will ask you questions about you and your partner's background, contraceptive knowledge, involvement of your male partner during your pregnancy and abortion. The information you provide is solely for **academic purposes**. It will help me fulfil the requirements for the award of my academic degree.

There are no risks associated with participating in this study. You are free to decide if you want to be in this research. Your decision will not affect any service and benefits you would normally receive. Your participation is entirely voluntary.

All the information you provide in this interview is confidential and anonymous. Your name will not be linked to any responses. Neither will your name be mentioned in any report. No one will know that you participated in this study. Your information will be protected, and it will not be released to anyone. Only the researcher will have access to your information. If you agree to be interviewed, it will take 30-40minutes.

This study has been reviewed and approved by the Ghana Health Service Ethical Review Committee (GHS-ERC). After the interview, you may be contacted for some follow-up questions. If you have any concerns regarding the study, you may contact me on these numbers: 0543-567448/0265039701. If you have any questions about your rights as a research participant, you may contact [Hannah Frimpong, GHS-ERC Administrator on this number, 050-7041223].

CONSENT TO PARTICIPATE IN THE SURVEY

Please sign or thumbprint below if you agree to participate in the study.

I certify that I voluntarily agree to participate in the interviews. The nature of the research describing its benefits, risks, and procedures has been explained to me. I understand that my participation in this research is voluntary and I am free to withdraw from the study whenever I wish. All my questions have been answered satisfactorily. I agree to participate as a volunteer.

Respondent's Unique ID code: _____

Respondent's Signature/thumbprint ☐ Date: _____

Interviewer Signature _____ Date: _____

Appendix 6: Sample Characteristics of In-depth interviewees

Unique ID	Age	Educational status	Occupation	Employment status	Religious affiliation	Parity	Living arrangement
F1	27	Some primary school	Sells cooked food	Not working	Moslem	1	Stays alone
F2	27	No school	Sells doughnut	Employed	Baptist	2	Stays with partner for 4yrs, married
F3	26	Completed Senior high school	Teacher	Employed	Charismatic	1	Stay with parents
F4	19	Completed JSS	Apprentice seamstress	Unemployed	Pentecost	0	Stays with sister
F5	18	Currently in Senior high school	Not working (student)	Unemployed		0	Stays with mum
F6	31		Sells foodstuffs	Employed		1	Stays with partner
F7	32	Completed JSS	Hairdresser	Employed	Catholic	1	Stays alone
F8	23	Completed JSS	Apprentice hairdresser	Employed	Charismatic	0	Stays alone
F9	18	Currently in JSS 2	Not working (student)	Unemployed	Charismatic	0	Stays with parents
F10	22	Completed SSS	House help	Employed	Pentecost	1	Stays with mother
F11	39	Completed SSS	Fashion designer	Employed	Charismatic	2	Stays with partner, married
F12	13	Currently in class 6	Not working (student)	Unemployed		0	Resides with parents
F13	19	Currently in SS2	Not working (student)	Unemployed		0	Stays with parents
F14	28	No school	Sells charcoal	Employed	Moslem	4	Stays with partner, married
F15	18	Completed SSS	Not working	Unemployed	Presby	0	Stays with parents
F16	21	Currently in tertiary institution	Not working (student)	Unemployed	Charismatic	0	Stays with parents
F17	21	Completed JSS	Not working [apprentice seamstress]	Unemployed	Moslem	0	Stays with parents
F18	22	Completed SSS	Secretary	Employed	Charismatic	0	Stays with mother
F19	32	Completed SSS	Not working (house wife)	Unemployed	Charismatic	3	Stays with partner, married for 7years
F20	29	Completed tertiary	Assistant Budget analyst	Employed	Pentecost	2	Stay with partner, married for 7years
F21	23	No school	Apprentice	Unemployed	Methodist	1	Stays with extended family
F22	29	Completed SSS	Not working	Unemployed	Charismatic church	1	Stays with partner for 1 and half years, married
F23	34		Hairdresser	Employed	Moslem	2	Stays alone
F24	21	Completed SSS	Sells food	Unemployed	Charismatic	0	Cohabiting
F25	26	Tertiary	Accounts officer	Employed	Pentecost	0	Stays with parents

F26	36	Didn't complete SSS	Trader	Unemployed	Deeper life	6	Stays with partner for 6years, married
F27	23	Completed JSS	Shop keeper	Employed	Church of Christ	0	Stays with sibling
F28	26	Completed JSS	Hairdresser	Employed	Christ apostolic church	2	Stays alone
F29	39	No response	Fried fish seller	Employed	Baptist	4	Stays with partner for 14years since married,
F30	25	Completed JSS	Apprentice hairdresser	Unemployed	Pentecost	1	Stays with partner occasionally
F31	27	Did not complete	Fried fish seller	Employed	Pentecost	3	Stays with partner
F32	26	Completed SSS	Shop assistant	Employed	Pentecost	1	Stays alone
F33	21	Tertiary	Not working [student]	Unemployed	Charismatic	0	Stays with parents
F34	25	Completed SSS	Trader	Employed	Action faith	2	Stays with mother
F35	40		Trader	Employed	Moslem	4	Stays with partner, married
F36	19	Completed JSS	Not working	Unemployed		0	Stays with mother
F37	18	Currently in SSS	Not working [student]	Not employed	Christ Apostolic Church	0	Stays with parents
F38	14	Currently in JSS	Not working [student]	Not employed		0	Stays with parents

Appendix 7: Socio-demographic Characteristics of Male Partners

Characteristics	Number	Percentage
Employment status		
Unemployed	25	7.6
Employed	300	91.7
Missing	2	0.6
Educational status		
No education	6	1.8
Preschool	2	.6
Primary	9	2.8
Middle/JHS	79	24.2
Secondary	110	33.6
Tertiary	81	24.8
Don't know	36	11.0
Other	4	1.2
Ethnicity		
Akan	153	46.8
Ga-Dangme	55	16.8
Ewe	71	21.7
Other	47	14.3
Don't know	1	.3
Religion		
No religion	19	5.8
Catholic	14	4.3
Presbyterian	31	9.5
Methodist	14	4.3
Pentecostal/ Charismatic	171	52.2
Muslim	23	7.0
Anglican	3	.9
Other Christian (SDA, Deeper life, Jehovah's witness)	14	4.3
Other	21	6.4
Don't know	16	4.9
Missing	1	.3
Marital status		
Never married	139	42.5
Currently married	127	38.8
Formerly married	13	4.0
Cohabiting	46	14.1
Don't know	2	.6