SCHOOL OF PUBLIC HEALTH, COLLEGE OF HEALTH SCIENCES,

UNIVERSITY OF GHANA

ABORTION-RELATED HELP - SEEKING BEHAVIOURS AMONG FEMALES IN THE TEMA METROPOLIS

BY

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DECLERATION

I, Joel Jeffrey Idun – Acquah, declare that except for other works which have been duly acknowledged, this work is the result of my own original research, and that as far as I am aware, this dissertation, either in whole or in part, has not been presented elsewhere for another degree.

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DEDICATION

This piece of academic work is dedicated to the Almighty God, to whom I owe my existence. It is also dedicated to Emmanuel, Gertrude, Naana Egyiriba, Nancy and Felicia Idun-Acquah.

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ABSTRACT

Teenage pregnancies and abortion cases reported to health facilities in the Tema Metropolis have been increasing over the years. Anecdotally, community pharmacies are also reporting of increases in request for medicines that have abortifacient properties. It is against this background that this study seeks to identify abortion help-seeking behaviours of females in the metropolis when saddled with unwanted pregnancies. The study focuses on identifying where women in the metropolis go for abortion services and reasons for resorting to abortion. It also assesses the knowledge and perception of females on abortion. It also determines the extent of pharmaceutical use in inducing abortion, assesses knowledge of provisions of the Abortion Law in Ghana as well as knowledge of contraceptives among females.

The study was cross-sectional and involved interviewing three (3) key informants, three hundred (300) women and thirty (30) community pharmacists, chemical sellers, dispensing technicians and pharmacy counter assistants in the metropolis. Structured questionnaire and essay writing on abortion by sixty-five (65) senior high school students were some of the tools used for data collection.

Findings

- The majority of places within the metropolis where women seek abortion services did not guarantee safe abortion.
- An appreciable proportion of the population knew of a place where abortion services could be obtained and most of these facilities were privately-owned and were in Tema Township.

- Reasons for resorting to abortion were varied and included financial difficulties, unplanned pregnancy, the need to continue one's education, maintaining family reputation in society, immaturity, denial of responsibility for the pregnancy by the male partner and poor child spacing.
- The average number of abortion requests that pharmacies/chemical shops received per day was two and the most requested medicine was Cytotec.
- Many women knew of at least one modern method of contraception, with the condom being the most known contraceptive.
- The knowledge of the provision of the abortion law in Ghana is poor and many women are confused as to what regulates abortion in Ghana.

Recommendations

- The Health Promotion and the Adolescent and Reproductive Health Units of the Tema Metro Health Directorate need to step up education to encourage uptake of contraceptives, especially at the community level.
- The Adolescent and Reproductive Health Units of the various clinics in the metropolis need to be made friendlier and readily accessible. The units should also team up with the health promotion units to educate the populace, especially the youth, on the consequences of unsafe abortion and the provisions of the law on abortion.
- The Pharmacy Council and the Food and Drugs Board must step up the monitoring and enforcement of regulations on the supply of prescription-only medicines, especially those with abortifacient properties in the metropolis.

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LIST OF ABBREVIATION

DHMT: District Health Management Team

GHS: Ghana Health Service

OTC: Over-The-Counter Drug

TMHD: Tema Metropolitan Health Directorate

U.N: United Nations

WHO: World Health Organization

WIFA: Women in Fertility Age Group

DEFINITION OF TERMS

Abortifacient: An agent or drug which may induce abortion.

Abortion: An abortion is the premature exit of the products of conception (the foetus, foetal membranes, and placenta) from the uterus i.e. the loss of a pregnancy. It can be spontaneous (miscarriage) or induced.

Contraceptive: Any method, drug or device that helps prevents conception.

Illegal Abortion: Termination of pregnancy without legal justification

Induced Abortion: An abortion that is brought about intentionally. It is also called artificial or therapeutic abortion.

Legally Restricted Abortion: Abortion allowed only under a specific set of conditions and decreases access to services. As a result, women are more likely to seek illegal abortions. Legally restricted abortion is associated with a high incidence of unsafe abortions.

OTC: Medicines that can be obtained over-the-counter i.e. without prescription

Pharmaceutical: Drug or medicine that is prepared or dispensed in pharmacies and used in medical treatment.

Pharmacy Only Medicines: Medicines that can be obtained without prescription but based on the expertise of a qualified pharmacist.

Prescription Only Medicines: Medicines that can be obtained only upon a valid prescription by a qualified medical doctor.

Spontaneous Abortion (Miscarriage): Any pregnancy that is not viable (the foetus cannot survive) or in which the foetus is born before the 20th week of pregnancy. It occurs

in at least 15 – 20 % of all recognized pregnancies and usually takes place before the 13th week of pregnancy.

Unsafe Abortion: Abortion is unsafe when it is carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.

CHAPTER ONE

INTRODUCTION

1.0 Background

Maternal mortality and morbidity have been a global concern since 1967 after the World Health Assembly recognized unsafe abortion as a serious health problem (Ahman & Shah, 2004). Several decades down the line, it still remains a global challenge, especially in the developing world. It is estimated that globally, 13% of pregnancy-related deaths (or one in eight) are due to unsafe abortions while in many developing countries, one in every four maternal deaths is caused by unsafe abortions. It is also estimated that 98% of the world's 20 million unsafe abortions in the year 2003 occurred in developing countries (WHO, 2007).

Many women in Ghana, as in many African countries, are limited in choices when it comes to unwanted or unexpected pregnancy. A woman cannot freely request for abortion or termination of pregnancy, even at a government health facility because it is illegal. In Ghana, abortion is illegal except on three conditions: (a) when the pregnancy results from rape, defilement or incest; (b) when the pregnant woman's life is at risk because of the pregnancy; (c) where there is sufficient evidence to prove that the child would suffer from serious deformity after birth. Besides the law, the culture of the various ethnic groups and religions (Christianity, Islam and Traditional) in Ghana frown upon abortion. A woman found to have caused abortion faces stigmatization and condemnation by the society.

Recent increases in maternal deaths in Ghana have brought to the fore the various contributing factors which include abortions. Hospital-based studies indicate that 22% and

30% respectively, of maternal deaths in Komfo Anokye Teaching Hospital, Kumasi and Korle-Bu Teaching Hospital, Accra, are due to unsafe abortions (Lithur, 2004). Statistics on the incidence of induced abortions in Ghana are not accurate because most induced abortions are secretly done, with very few in hospitals. Even in the hospitals, data on the incidence of induced abortions is scanty as they are recorded under different conditions. The majority of abortions are undertaken by women below 30 years (Ahiadeke, 2001). The impression from various radio and television discussions on abortion is that Ghana has a high incidence of induced abortion due to breakdown in the extended family structure, the corruption of societal morals and the youthfulness of the population.

The study sets out to identify the options that are used by females in cases of unwanted pregnancies, the extent to which these options are resorted to and factors associated with the options used.

1.1 Problem Statement

Legal induced abortion is restricted throughout sub-Saharan Africa, with the exception of a few countries such as Ghana, which permit it only under clearly stated conditions. As a result, women who resort to abortion do it secretly and often use unsafe methods. Unsafe abortions remain a neglected healthcare problem in developing countries (Ahman & Shah, 2004) although 98% of the nearly twenty (20) million unsafe abortions worldwide in 2003 occurred in the developing countries. It has been described as a silent pandemic and an urgent public health issue with human rights dimensions. The incidence of induced abortions is estimated to be 14 and 16 per 1,000 WIFA in the world and developing countries, respectively. In Africa and West Africa, the incidence is 29 and 28, respectively (WHO, 2007).

There is the perception that the incidence of induced abortion in Ghana is very high, with the majority being obtained clandestinely (Awusabo-Asare, 2003). Although induced abortion is believed to be widespread in Ghana, there are no accurate data available due to the secretive nature of the practice. A study carried out in eight communities in Ghana by Clement Ahiadeke between 1997 and 1998 put the incidence of induced abortion at 17 abortions per 1,000 women of child bearing age. Sixty percent (60%) of the women who committed abortion were below 30 years. Abortion is also one of the leading causes of maternal deaths in Ghana (Ahiadeke, 2001).

Abortion is one of the issues that people hardly talk about openly in Ghana, yet many young women at one point or the other are faced with the challenge of making a decision

with regards to abortion. This serves as an impediment to seeking valid information from reliable sources.

Tema, as an industrial city, has teenage-pregnancy, prostitution and school dropouts as some of the challenges to overcome. Abortion was ranked as the sixth (6th) of the top 10 causes of admissions in 2007 in the metropolis. There were 442 cases of abortion in 2007 as against 297 cases of abortion in 2006 (TMHD, 2008). These were at the recognized facilities and did not include those that occurred in the communities and fell into the 'dark figure'. The proportions of early (10-14 yrs) and late (15-19 yrs) teenage pregnancies reported at the various antenatal clinics rose from 0.1 and 11.3% in 2006 to 0.2 and 12.6%, respectively (TMHD,2008). A pilot study and interaction of the investigator with community pharmacists and pharmacy counter assistants in the metropolis showed increasing numbers of young females requesting for medicines which have as their side effects, termination of pregnancy. Some boldly asked for medicines to terminate pregnancies with no concern for possible complications.

The Revised Ghana Reproductive Health Service Policy and Standards (2003) added legal induced abortion services as one of its components. Yet, five (5) years after the revision most of the population who stand to benefit from the policy seem not to be aware of the availability of such services (Lithur, 2004). There are no easily accessible and friendly facilities in the metropolis where information on reproductive health could be obtained. Questions that one will ask therefore are: Where do women in the reproductive age group in the metropolis obtain abortion and related services? Why do women engage in abortion

when contraceptive devices are available? What abortifacients are used and how safe are they?

1.2 Justification for the Study

Studies have been conducted on the incidence of induced abortion, to explain reasons women resort to abortion and the knowledge and use of contraceptives in Ghana (Bleek, 1981; Awusabo-Asare et al., 2003). There is the perception that the incidence of induced abortion is high in the country, especially among the youth and Tema cannot be an exception. However, very little has been done to document the situation in the Tema Metropolitan Area.

Tema, being an industrial and commercial city exposes its population to risky sexual behaviours which are likely to result in unwanted pregnancies. Induced abortions and complications arising from them are among the major health challenges in Tema (TMHD, 2008). Strategies and policies aimed at overcoming this challenge should factor in the perception and attitudes, help-seeking behaviour of females in relation to abortion and their knowledge on contraceptive use. It is, therefore, important to identify reasons for which females in the metropolis resort to abortion (legal or illegal), their sources of information on abortion practices and the places that these abortion services are obtained.

Community pharmacies and chemical shops are also points of call for procurement of medicines for induced abortions. Therefore, knowing their level of involvement and practices will also play an important role in designing strategies towards reducing self-

induced abortions. This study seeks to research into the above mentioned areas to serve as a guide for policy making in the metropolis and further the knowledge on abortions in Ghana.

1.3 Study Objectives

1.3.1 General Objective:

The general objective of the study is to identify the help – seeking behaviours among females in the Tema Metropolis when faced with unwanted pregnancy.

1.3.2 Specific Objectives

The specific objectives of the study are:

- To identify where women with unwanted pregnancies in the Tema Metropolis go for abortion services.
- To identify the reasons for resorting to abortion.
- To assess the knowledge and perception of females on abortion.
- To determine the extent of pharmaceutical use in inducing abortion.
- To assess knowledge of provisions of the Abortion Law in Ghana.
- To assess knowledge of contraceptives among females.

CHAPTER TWO

LITERATURE REVIEW

Induced abortion is highly restricted throughout the sub-Saharan African countries (Rasch et al., 2000) unlike in the United States where abortion services could be easily accessed. However, these services are restricted for minors in many states in the United States and parental consent or notification is a requirement for abortion. Also, Mandatory Waiting Periods require women to wait up to 24 hours between a state-mandated counselling appointment and their abortion (Haas-Wilson, 1996; Mueller S & Dudley S, 2003). For example, by October 1995, Twenty Seven (27) States had enacted and begun to enforce parental consent and notification laws for minors for abortion (Haas-Wilson, 1996).

Most WHO member states in Europe have law permitting abortion in order to save a woman's life. For the majority of other countries, abortion is permitted for the following reasons: on request, economic and social reasons, foetal impairment, rape and incest, to preserve mental health and to save a woman's life (Lazdane, 2005).

African countries are considered to have some of the most restrictive abortion laws in the world. In many sub-Saharan African countries, however, the restriction is not only to minors but also to women of all ages. National laws, stigmatization and religious prohibitions have served as barriers to access to abortion services. In countries where induced abortion is legal, factors such as cumbersome rules, discouraging attitudes of medical staff and low awareness of abortion services also serve as obstacles to accessing facilities (Ahman & Shah, 2004). A few countries though, permit induced abortions under

clearly stated conditions, violation of which becomes a criminal case. This is not restricted to only sub-Saharan African countries alone but some Asian countries like India also have restricted laws on abortion (Oye-Adeniran, 2004). In Zambia, the termination of pregnancy Act (1975) requires medical practitioners to recommend abortion "when the continued pregnancy would risk the mother's life or threaten her physical or mental health or there is evidence that the child would be seriously handicapped. This conclusion must be based on the recommendation of three medical officers, one being a registered psychiatrist" (Webb, 2000). In Ghana presently, abortion is not a criminal offence if it is caused by a medical practitioner specializing in gynaecology or other registered practitioner in a government hospital or registered private hospital or clinic when the pregnancy resulted from rape, defilement of a female idiot or incest; when continuation of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health; or where there is substantial risk that if the pregnancy were carried to term, the child would suffer from or later develop a serious abnormality or disease (Ahiadeke, 2001; Lithur, 2004; GHS, 2006). In Nigeria, abortion is illegal under the criminal law, unless the woman's life is threatened by the pregnancy (Otoide et al., 2001).

Worldwide, 42 million women are faced with an unplanned pregnancy annually and about 20 million out of this number are forced to resort to unsafe abortion, often self-induced or obtained clandestinely from untrained persons (WHO, 2007). Approximately 26 million legal and 20 million illegal abortions were performed in 1995, resulting in a worldwide abortion rate of 35 per 1,000 women aged 15 – 49 years (Henshaw et al., 1999). The estimated number of abortions in Europe varies from 500,000 to 800,000 annually, even though abortion is legal in most countries in the region (Lazdane, 2005). In Russia, although abortion is legalized, the abortion-related maternal mortality (ARMM) ratio is 6.3

per 100,000 known abortions and it is about 10 times higher than in Western Europe and North America. The causes of ARMM that have been identified include ignorance of the legal right to abortion, shortage of specialized second trimester abortion services, financial barriers and fear of seeking official permission from a committee for abortion (Ketting, 2005). Thus, having the law alone does not reduce ARMM but the proper application, together with practical measures is needed to reduce ARMM. According to the Office of Registrar General of India (RGI), abortion is a major cause of maternal death and contributes about 12 per cent of maternal deaths every year. Another study attributes about 20 per cent of the maternal deaths in India to septic abortions (Oye-Adeniran, 2004).

Over five million five hundred thousand of the world's unsafe abortions take place in Africa each year and approximately thirty six thousand women in Africa lose their lives as a result (WHO, 2007). The proportion of maternal deaths associated with unsafe abortions globally is estimated to be 13% with Central, Western and Eastern Africa being the regions with the worst record of maternal deaths due to unsafe abortions (WHO, 2007). Induced abortions account for 20,000 out of 50,000 maternal deaths that occur each year in Nigeria (Otoide, 2001) and in Ghana, abortion is one of the leading causes of maternal deaths and disability (Lithur, 2004; GHS 2006). In Ilala District in Tanzania, a study carried out between 1991 and 1993 showed that induced abortion was responsible for 15 % of maternal deaths (Rasch et al., 2000). According to the World Health Organization, the estimated number of deaths due to unsafe abortions in Ghana is about 85 per 100,000 live births (Lithur, 2003). These high maternal deaths could be attributed to the unsafe methods and materials used as well as the unhygienic conditions under which they are carried out, very often leading to complications and late arrival at the hospitals.

Complications arising from unsafe abortions include post-abortion sepsis, haemorrhage, genital trauma, temporary or permanent infertility and death. Treatment of complications arising from unsafe abortion has been identified to place extra demand on scarce resources available to the health sector in developing countries as well as financial and emotional cost on the women who undergo unsafe abortion. It is estimated that about five million women in developing countries are admitted to hospital yearly as a result of unsafe abortions (WHO, 2007).

Accurate measurement of induced abortion levels has proven difficult in many parts of the world although information on both legal and illegal induced abortions is needed by healthcare workers and policy makers to provide the needed services and to reduce the negative impact of unsafe abortions on women's health (Henshaw et al., 1999). Data on the incidence of induced abortion in sub-Saharan Africa are inconsistent and unreliable (Rasch et al., 2000; Ahiadeke, 2001). There is substantial under-reporting in many countries since most abortion services are obtained clandestinely for fear of stigmatization or prosecution. Hospital based surveys only report complications of induced abortions and is made worse by poor record-keeping practices. Community based surveys also tend to produce gross under-estimates because of the nature of the subject and the illegality of the procedure thereby discouraging accurate reporting. Despite all these limitations, research conducted so far all point to the fact that the incidence of induced abortion is high in countries in the sub-Saharan Africa region. A community based survey conducted among women of childbearing age in Nigeria found that 5.6 % of the women had ever had an induced abortion (Rasch et al., 2000). Another community-based survey in Ghana in 1997 showed

the rate of abortion to be 17 induced abortions per 1,000 women of child bearing age and 19 abortions per 100 pregnancies (Ahiadeke, 2001). In Nigeria, about 610,000 women induce abortions annually (Oye-Adeniran et al., 2004). W.H.O put the incidence of unsafe abortions in West Africa at 28 per 1,000 women aged 15 – 44 years (WHO, 2007).

It has been found that two-thirds of unsafe abortions occur among women aged between 15 and 30 years with almost 14% of all unsafe abortions in developing countries occurring in women below 20 years. In Africa, almost 60% of unsafe abortions are among women aged less than 25 years and almost 80% are among women below 30 (WHO, 2007). Studies have also shown that adolescents and single women are those who often resort to induced abortions. For example, hospital-based studies have shown that up to 80 % of patients with abortion-related complications in Nigeria are adolescents (Otoide et al., 2001) and in Kenya, two-thirds of hospitalized patients with incomplete abortion are adolescents between the ages of 11 and 19 years (Varga, 2002). Similar results have been obtained from studies in other countries like Liberia, Botswana, Zambia, South Africa and Sierra Leone (Varga, 2002). Most of these have been attributed to low uptake of contraceptives although there is an appreciable knowledge on contraceptives. Worldwide estimate of unplanned pregnancies is almost two (2) in every five (5) pregnancies and is mostly as a result of non-use of contraception or of ineffective contraceptive use or method failure (Ahman & Shah, 2004). Thus, expanding and improving family planning services can go a long way to decrease unintended pregnancy and induced abortion (UN, 1995). The challenge however, is the availability, accessibility and affordability of family planning services and its ability to meet demand (Ahman & Shah, 2004). Africa's abortion rate is said to be three times as high as that in Western Europe, where access to contraception and sexuality education are widely available. It also suffers the highest unmet need for

contraception than any region in the world, with only 13% of married women using contraceptives (Ipas, 2004).

Perceptions and attitudes of adolescents towards abortion are diverse. For example, close to half (46 %) of girls surveyed among urban Zulu schoolchildren in South Africa described abortion as an acceptable means of handling pregnancy (Varga, 2002). In another study involving pregnant Zulu teenagers, the respondents generally disapproved of pregnancy termination as an illegal, sinful, or immoral act. In Nigeria and Kenya, focus-group discussions among adolescents revealed their support of pregnancy termination for teenagers, provided it was conducted by a properly trained medical practitioner. In contrast, survey data collected among Kenyan teenagers showed overwhelming disapproval of abortion (Varga, 2002). Among the Akans in Ghana, abortion is considered as a major crime against society (Awusabo-Asare, 2003).

Many reasons have been assigned to why women, particularly adolescents, resort to abortion. Most of the reasons assigned are common to most countries. Unexpected / unplanned pregnancy, not having a stable partner, being too young to be a mother, the need to continue with studies, fear of parents' reaction and economic reasons were identified as some of the reasons why women resort to abortion (Ferrando, 2002). In South Africa, a study has shown that "adolescents' access to legal abortion is affected by at least three major factors: knowledge of its legal status, social stigma and conditional acceptability, and a complex, situation specific decision making process" (Varga, 2002). In another study in Nigeria, the major reasons assigned to why adolescents seek termination of pregnancy were " the need not to interfere with schooling; not being old enough to get married; fear

of family members knowing; not planning to marry the partner; being jilted by a fiancé; following rape or incest; and not knowing the actual father" (Otoide, 2001). Similar results were obtained in a study in Tanzania (Rasch et al., 2000) and Zambia (Webb, 2000) and many adolescents in Ghana may give one of the above reasons as why they will resort to abortion (Awusabo-Asare et al., 2003). Bleek identified three main factors that may influence the decision to have an abortion in Ghana: the need to continue the girl's education, pregnancy from premarital or extramarital relationships and rapid succession of pregnancy (Bleek, 1981). These factors, in addition to legal issues tend to influence the choice of abortion services. In a study by Ahiadeke in Ghana between 1997 and 1998, only 12 % of women who obtained abortion did so from a physician, 20 % from a nurse or midwife and 68 % from sources outside the health system (i.e. 38% from pharmacist, 11 % through self-medication, 16 % from a "quack doctor" and 3 % by some other means (Ahiadeke, 2001). In another study in South Africa, health professionals were identified to be involved in 68.2% of induced abortion cases and the induction process was initiated in the consulting rooms or in facilities not licensed for termination of pregnancies. The non-professionals involved included friends, relatives and consorts. In 39.6% of cases, the abortion process was initiated in health facilities whereas 60.5% of the cases occurred in the client's home or a boyfriend's house (Moodley and Akinsooto, 2003).

The decision to abort a pregnancy and the choice of abortion services does not lie solely with the pregnant woman. Boyfriends, friends or close peers, parents and grandparents, and health workers (outside the hospital setting) all play a role, provided they are trusted enough to be consulted and their advice counts a lot (Otoide et al., 2001; Varga, 2002). Whereas the partner may suggest abortion because he is either not ready for marriage or to accept the responsibility of being a father, or for economic reasons, parents or

grandparents may recommend abortion or in certain cases lead their wards to obtain the service, in order to maintain the family's social dignity and avoid public censure (Varga, 2002). "Nurses, presumably consider carrying out abortions as an additional, if clandestine, source of income" (Webb, 2000).

There are varied methods used to carry out unsafe abortion. It may be induced by insertion of a solid object (root, twig or catheter) into the uterus; an improperly performed dilatation and curettage procedure by an unskilled provider; ingestion of harmful substances; exertion of external force; or unauthorized use of modern pharmaceuticals, such as Misoprostol (Ahman & Shah, 2004). Untrained practitioners who are usually involved include traditional birth attendants, homeopaths, herbalists, religious healers, village doctors and relatives (Ahman & Shah, 2004; WHO, 2007). A study in Peru identified some of the methods used for inducing abortion as the introduction of solid objects (branches, knitting needles, catheters and wire) and liquids (soapy water, hydrogen peroxide, bleach, tar, infusions made from herbs, Coca-Cola and salty solutions). However, one of the commonest methods is the use of vaginal, oral and combined (vaginal and oral) application of prostaglandins (a pharmaceutical product used in gastroenterology and obstetrics during labour) in varied dosages depending on whether it was recommended by a medical practitioner, suggested by a pharmacist or pharmacist's assistant or self-prescribed. Other common methods identified were taking of oral medicines mainly aspirin and paracetamol in large quantities (i.e. about 20, 30 or 50 tablets at a go) and ingestion of extracts and infusions of herbal teas and native plants (Ferrando, 2002). In Zambia, chloroquine (8 to 20 tablets taken at a go), boiled roots, ashes, painkillers or antibiotics (e.g. Cafenol, Panadol, Ampicillin – 8 to 10 tablets at once), beverages (boiled beer, boiled Coca Cola, Fanta taken with an overdose of painkillers), crushed bottles (drinking ground glass with

any beverage), physical removal (using a stick or sharp object to 'prick foetus') and washing powder are some of the items used to induce abortion (Webb, 2000). A study in South Africa identified misoprostol, anti-malarial medicines, tetracycline, soap, traditional medicines and rupturing of the foetal membrane with metallic objects as some of the materials and methods used to induce abortion (Moodley & Akinsooto, 2003). Similar methods and materials have been identified to be in use in Ghana. Some of the materials identified include plants and trees (mango, pawpaw, pineapple, cotton, lemon, coconut and passion flower) and a variety of items e.g. washing blue mixed with water, extremely sweet drinks, alcoholic drinks and physical exhaustion (Bleek, 1981).

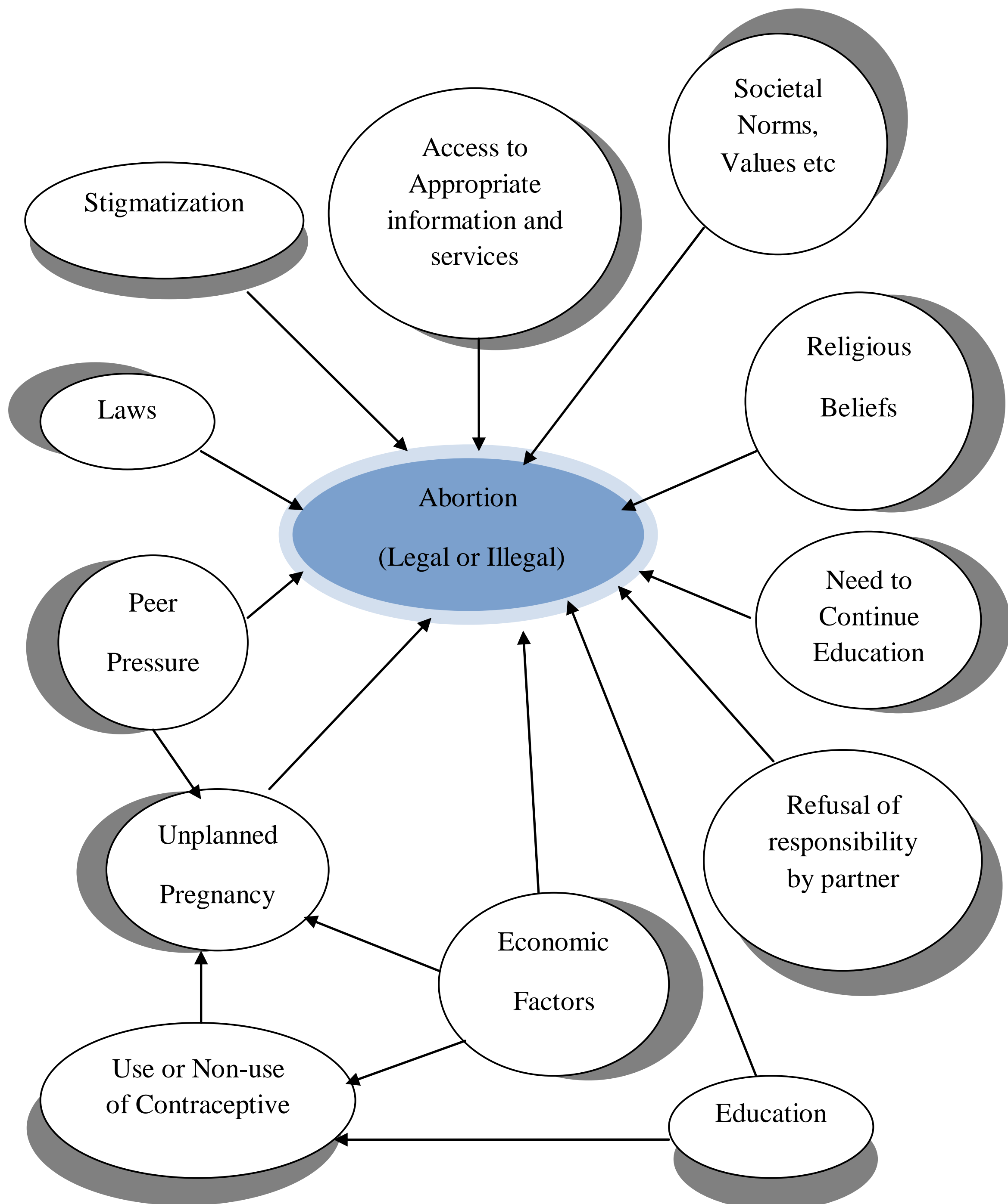
In Europe, although fewer women die from abortion-related causes, abortion-related deaths constitute over a quarter of maternal deaths in the region. In addressing the issues responsible for the abortion-related deaths, woman-centered comprehensive abortion care (CAC) has been adopted by a number of organizations in the region. The CAC approach comprises three key elements: Choice, Access and Quality. "Choice" implies that women have the right and opportunity to make choices about their bodies and health without interference from others. "Access" emphasizes the availability and accessibility of abortion services to women who need them while "Quality" requires giving attention to the factors that vary within the local contexts and according to available resources (Traci, 2005). These are aimed at ensuring the adoption and use of internationally recommended medical technologies to improve the quality of abortion care and towards safe abortion (Traci et al., 2005). Ghana has also adopted the CAC strategy and has developed a protocol for use in all public health facilities (GHS, 2006).

This study attempts to identify the situation as pertains in the Tema Metropolis to assess the differences and similarities between what is in available literature and what is actually happening on the ground. It will also add to existing literature on abortion by focusing on a vibrant port and cosmopolitan city in a developing country.

2.1 Conceptual Framework

A person's decision to abort a pregnancy is influenced by several factors (Otoide et al., 2001; Varga, 2002; Rasch et al., 2000; Awusabo-Asare, 2003). These include unplanned pregnancy (which may be due to non-use of contraceptive, peer pressure or soliciting for sex because of economic hardship), the need to continue with education, refusal of responsibility by the male partner and stigmatization in the society because of being pregnant without a husband. The choice of a particular abortion service, legal or illegal, is also influenced by access to appropriate information and services, societal norms and values, religious beliefs, peer pressure and laws regulating legal induced abortions. These are illustrated in Fig. 2.1.

Fig. 2.1 Diagrammatic presentation of the conceptual framework



CHAPTER THREE

METHOD OF DATA COLLECTION

3.0 Introduction

This chapter presents a description of the study area (Tema) and gives a picture of what pertains in the metropolis. This is to help the reader to appreciate the importance of this research against the background information given. It also presents the study design (with the various variables), study population, sampling procedures and data collection tools and methods as well as issues of quality control and ethics.

3.1 Study Area

The study was carried out in the Tema Metropolis in the Greater Accra Region. Tema is located in the south-eastern part of Ghana and is a vibrant commercial and industrial city with a large harbour which serves as the main seaport entry to Ghana. The Greenwich Meridian also passes through the metropolis. Tema Township is also considered to be the third largest urban settlement in Ghana after Accra and Kumasi.

The native Ga ethnic group is organized into two paramount chieftaincy traditional areas, each with its council of chiefs and elders. These are Tema Traditional Area (made up of the following sub-divisions: Ashamang, Awudum, Zenu, Ashaiman, Kubekro, Adjei Kojo, Adigon, Sasabi, Klangon and Sakumono) and the Kpone Traditional Council(made up of Gbetsile, Apolonia, Nsrehu, Kakasunanka, Okushibi and Kpone Bawaleshie divisions).

In addition to the indigenous Ga traditional leadership structures, many settler communities have installed their own chiefs especially in the Tema city and Ashaiman. These settler chiefs provide their people with varying degrees of organization and leadership.

Tema is endowed with a number of educational institutions and good road network and it enjoys regular electricity and water supply. The situation is, however, different for the semi-urban areas. Tema city is well planned with a well-laid out infrastructure although slums are springing up in some of the communities (TMHD, 2008).

WIFA (women between the ages of 15-49 years) form the largest proportion of the population (28.5%), with men (15-49 years) and children (5-14 years) constituting 27% and 22.08%, respectively (TMHD, 2008).

Tema has a vibrant social life. Most of the large industries have club houses and these are in addition to several hotels, guest houses, night clubs, drinking spots and restaurants. There are many expatriates working with the industries and fishing vessels as well as lots of truck drivers who transport transit goods from the habour to other parts of the country, Burkina Faso and Mali. Then there is the population of tanker drivers who lift petroleum products from the Tema Oil Refinery to all parts of the country and to Burkina Faso.

Sanitation in the metropolis is a major public health challenge due to delays in collection of refuse, increased pressure on underground sewage systems resulting in frequent bursting of pipes and general poor attitude towards sanitation and hygiene by residents.

Large industries such as VALCO, Tema Oil Refinery, Ghana Ports and Harbors Authority, Cocoa Processing Company, Ghana Textile Print (GTP), Unilever, Coca cola, Ghacem, Tema Steel, Nestle, Pioneer Food Cannery, Crocodile Machets and Aluworks dominate

economic activity in Tema. These industries serve as point of attraction for youth all over the country who migrate to Tema in search of non-existing jobs. Large scale fishing (canoe and trawler), medium and small scale manufacture, and commercial trading (wholesale and retail) are next in line. Small scale vegetable farming and animal husbandry are undertaken at the peripheral and rural areas.

The metropolis has over fifty (50) community pharmacies and over one hundred (100) licensed chemical shops duly registered by the Ghana Pharmacy Council. There are several herbal shops that sell herbal medicines. Functioning public health facilities in the metropolis include the Tema general Hospital (the referral centre in the metropolis), Tema Polyclinic and Manhean and Kpone Health Centres. These are in addition to several private health facilities including hospitals, clinics and maternity homes spread all over the metropolis.

Streetism, teenage pregnancy, prostitution and armed - robbery are some of the social vices of concern. Tema is also cosmopolitan with many ethnic groups in the population coupled with a large number of expatriates. As a port city, Tema is host to seafarers of various nationalities who compound the social problems of the city.

Community 7 is one of the twenty-six (26) well-planned urban communities in Tema. The population is very much diverse in terms of ethnic groups, socioeconomic characteristics, educational level and population distribution by age. It is also characterized by numerous drinking spots and ‘active’ night life similar to that of the other twenty five residential communities.

Tema New-Town has the Ga as the indigenous people. Other significant ethnic groups are the Ewe and the Akan. The main occupation among the various communities is fishing, both canoe and trawler fishing. The Tema Port and Fishing Harbour are within the boundaries of the town in addition to a Naval Base. The town also has active night life and has high rate of teenage pregnancy as one of the major challenges (TMHD, 2008).

These characteristics of Tema described above make the study of abortion-seeking behaviour very relevant so that appropriate strategies could be designed in addressing the issue, bearing in mind the relationship between induced abortion and maternal death. That is what this study seeks to achieve.

3.2 Study Design

3.2.1 Study Type

The study is cross-sectional and involves the use of both qualitative and quantitative methods to collect data on behaviours among WIFA in the Tema Metropolis in relation to abortion when faced with unwanted pregnancy.

3.2.2 Variables

3.2.2.1 Outcome Variable

Abortion

3.2.2.2 Explanatory Variable(s)

Help-Seeking Behaviour

- Places where abortion services are obtained

- Knowledge on abortion

- Pharmaceutical use
- Knowledge on the Abortion Law in Ghana
- Knowledge on contraceptives

3.2.2.3 Background / Confounding Variables

- Age
- Level of education
- Occupation
- Religion
- Marital status
- Number of children

3.2.2.4 Variable Definition

Age: – Age at last birthday

Knowledge on Abortion Law in Ghana: – Knowledge on:

- What abortion is
- Whether there is a law on abortion or not
- Conditions under which abortions are permitted

Knowledge on contraceptives: - Knowledge on:

- What types of contraceptives are available in Ghana
- Where contraceptives can be obtained
- Who can use contraceptives and who should not use contraceptive

Perception: - Perception on:

- Whether it is right or wrong for someone to commit abortion
- Conditions for which abortion should be permitted
- Who should pay for the cost of treatment of complications arising from unsafe abortions

3.3 Study Population

The study populations were female residents of Tema Metropolis Aged 15 – 49 years, Senior High School Students and Health Service Providers – Medical Doctors (public and private hospitals) and Pharmacists (Community Pharmacies).

3.4 Sampling

3.4.1 Sample Size Determination

With an induced abortion incidence of 17 abortions per 1000 WIFA in Ghana (Ahiadeke, 2001), a 5% margin of error and 95% confidence interval will give a sample size of two hundred and seventeen (217). Using the incidence in West Africa by the WHO in 2007 .i.e. 28 abortions per 1000 WIFA, a 5% margin of error and 95 % confidence interval will give a sample size of three hundred and ten (310). A sample size of three hundred (300) was chosen since it is closer to the WHO's figure which is more current but greater than the incidence in Ghana. (See Appendix 1 for the calculation)

3.4.2 Sampling Procedures

(i) Two communities, Community 7 and Tema New-Town, were purposively sampled to represent urban and semi-urban communities, respectively. Two hundred (200) and One Hundred (100) participants were sampled from Community 7 and Tema New-Town respectively representing a ratio of 2:1 because according to the Tema Metro Health Directorate 2007 Annual Report, the WIFA population of the urban areas is more than twice that of the semi-urban areas.

In Community 7, one household was randomly selected and subsequent ones selected at an interval of eleven (11) households (i.e. the calculated sample interval) from the previous one until the total number was reached. A participant was then selected randomly from the number of qualified participants in the household and interviewed.

In Tema New-Town, ten (10) participants each were selected from Abonkor, Bamkuman, Kpotame and Habour City while fifteen (15) participants each were selected from U-compound, Awudum, Ashamang and Manheam. The numbers were in proportion to the relative size of the population in these smaller communities / localities. For each of the communities, the centre of the community was located and a direction randomly chosen. A household was then chosen after every five (5) households in the chosen direction until the required number was obtained. In each household, a participant was randomly selected from the number of qualified participants in the household and interviewed.

(ii) Questionnaires were given to Community Pharmacies and some Chemical Shops in the Metropolis to answer. They were later collected and those that were filled used in the study.

(iii) Two (2) second year classes of a Senior High School were selected by convenience sampling.

(iv) The following were selected for the key informants' interviews

- A Medical Doctor at the Tema General Hospital
- A Private Medical Practitioner
- A Community Pharmacist

The following were excluded, although they play roles relevant to the issue, because of limited time for the study: herbalists, traditional healers, midwives and practitioners of alternative medicine (including faith-based healers).

3.5 Data Collection Tools and Methods

3.5.1 Tools

Tools employed in the study were structured questionnaires, essay writing, in-depth interview guide and tape recorder.

3.5.2 Data Collection Methods

Women in Fertility Age (WIFA) who were sampled from the various household were interviewed using a structured questionnaire by field assistants in a language that the

participants understood and could freely express themselves. The assistants recorded / circled responses as the respondents gave.

Thirty (30) respondents from the pharmacies and chemical shops were issued with self-administered questionnaires. Sixty five (65) students in the Senior High School were made to write an essay on the topic "What you know or have heard about abortion". The number represents students of the two classes that were available at the time of the study. The three (3) key informants were interviewed using different in-depth interview guides.

Table 3.1: Specific objectives and the question number that address it from the various tools

Specific Objective	Essay	Questionnaire (WIFA)	Questionnaire (pharmacies)	IDI- guide Medical practitioner	IDI- guide Community Pharmacist
- To identify where women with unwanted pregnancies in the Tema Metropolis go for abortion services	vi	21		1-5, 8-9	
- To identify the reasons for resorting to abortion	iii, iv	19		6-7	4
- To assess the knowledge and perception of females on abortion.	i, ii, v, viii	16, 17, 22-26		11-12	
- To determine the extent of pharmaceutical use in inducing abortion	vii	27	1 – 9, 15		1-5
- To assess		14,15,18	12-14	10	

knowledge of provisions of the Abortion Law in Ghana					
- To assess knowledge of contraceptives among females		9-13			

3.6 Quality Control

Data collected were checked for completeness and internal consistency on the field, during entry and during analysis before they were included in the study. The principal investigator also visited the field assistants daily to ensure that they were doing what was required of them.

3.7 Training of Fieldworkers

Fieldworkers were trained on how the participants were to be selected and questionnaires administered prior to the data collection exercise. They were made to translate the questions into the local language and back into English for an independent person to judge whether they meant the same thing. They were also required to respond to the questionnaire themselves and also undertake a trial administration among themselves for them to acquire the necessary administering skills.

3.8 Pretesting of Tools and Procedures

There was a pre-testing of ten questionnaires each in Community 8 and Ashaiman for WIFA and Pharmacies / Chemical Shops respectively. The necessary corrections and adjustments were then made and the lessons learnt incorporated into the actual field work.

3.9 Data Processing and Analysis

Data from the questionnaires (the females and pharmacies / chemical shops) were entered using Epi-Info (version 3.4.3) and analyzed using SPSS 16.

Open ended questions were coded for analysis while data from the essays and in-depth interviews with the key informants were summarized thematically and analyzed.

3.10 Ethical Issues

- Ethical clearance was sought from the Ghana Health Service while permission to proceed with data collection was sought from the DHMT.
- Permission and approval were sought from the Head of the Senior High School whose students wrote the essays.
- Informed Consents were obtained from all participants and only those who were willing to participate in the study were included. All study participants were assured of confidentiality of any information provided.

3.11 Study Limitations

- Other key informants such as herbalist and midwives were not interviewed due to limited time available for the study.
- The study was not set out to determine the incidence of abortion in the metropolis but to identify the various help-seeking behaviours in relation to abortion.
- Although the necessary measures were put in place to have accurate data, answers by some of the respondents to the questionnaires were quite suspicious. E.g. some of the females were given names and ages that were doubtful from observing their countenance.

- Only 26 pharmacies and 4 chemical shops participated in the study although there are over 150 pharmacies and chemical shops in the metropolis. Most of the facilities refused to participate for personal reasons although they were assured of confidentiality.

Notwithstanding the above limitations, the results of the study are reliable and reflect the situation pertaining in the metropolis as standard procedures were followed while avoiding preventable biases. The study would have, however, been enriched if the above limitations were not there since it would have added new dimensions to the study.

CHAPTER FOUR

RESULTS OF THE STUDY

4.1 Background Characteristics of Study Population

Respondents for the quantitative method were all females within WIFA, with the majority (70.3%) of them being below 30 years. The mean age of the respondents was 26.76 years. The proportion of respondents decreases as the highest level of educational attainment increases, with more than half of them (52.3%) attaining only basic education. There is, however, an appreciable proportion (5.3%) that has had no formal education. The majority were single/not married (62.7%), have no child (57%) and are Christians (96.7%). Other characteristics of the respondents are summarized in Table 4.1.

The Pharmacy / Licensed Chemical Shops study involved 26 Pharmacies and 4 Chemical Shops while the background of the respondents were Pharmacists (36.7%), Dispensing Technologist / Technologist (10.0%), Pharmacy Counter Assistants (43.3%) and Licensed Chemical Shop (10.0%). Half of the respondents were males with the other half being females.

The characteristics of the respondents for the essay writing are summarized in Table 4.2.

Table 4.1: Background characteristics of respondents to the questionnaire on abortion-related help-seeking behaviour among females in the Tema Metropolis

Community	Frequency	Percent
Community 7	200	66.7
Tema New-Town	100	33.3
Total	**300**	**100.0**
Age Group (yrs)		
15 – 19	58	19.3
20 – 24	75	25.0
25 – 29	78	26.0
30 – 34	33	11.0
35 – 39	31	10.3
40 – 44	12	4.0
45 – 49	13	4.3
Total	**300**	**100.0**
Level of Education		
Basic	157	52.3
Secondary	89	29.7
Tertiary	38	12.7
None	16	5.3
Total	**300**	**100.0**
Occupation		
Civil /Public Servant	31	10.3
Trader	81	27.0
Fish Monger	5	1.7
Artisan	60	20.0
Student	60	20.0
Unemployed	52	17.3
Others	11	3.7
Total	**300**	**100.0**

	Frequency	Percent
Marital Status		
Single	188	62.7
Married	93	31.0
Divorced	3	1.0
Widowed	11	3.7
Living Together	5	1.7
Total	**300**	**100.0**
Number of Children		
None	171	57.0
1 – 2	89	29.7
3 – 4	35	11.7
5 and above	5	1.7
Total	**300**	**100.0**
Religion		
Christian	290	96.7
Muslim	8	2.7
Traditional	1	0.3
Others	1	0.3
Total	**300**	**100.0**
Ethnicity		
Akan	158	52.7
Ga / Dangbe	84	28.0
Ewe	47	15.7
Mole - Dagomba	3	1.0
Hausa	2	0.7
Others	6	2.0
Total	**300**	**100.0**

(Source: Field Data, June 2008)

Table 4.2: Characteristics of the respondents to essay on abortion in the Tema Metropolis

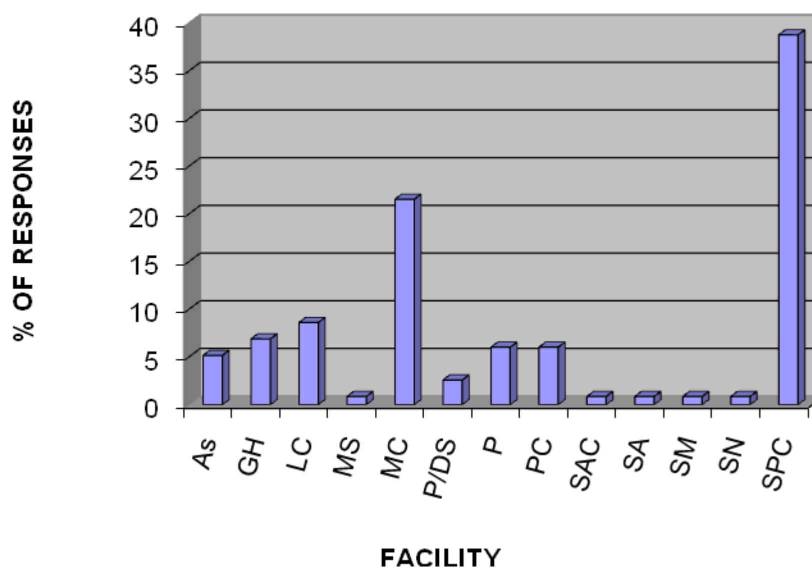
	Frequency	Percent
Age (yrs)		
15	5	7.8
16	14	21.9
17	25	39.1
18	17	26.6
19	3	4.7
Total	64	100.0
Sex		
Male	23	35.9
Female	41	64.1
Total	64	100.0

	Frequency	Percent
Religion		
1-Christian	61	95.3
2-Muslim	3	4.7
Total	64	100.0
Ethnicity		
Akan	28	43.8
Ewe	13	20.3
Ga/Dangbe	17	26.6
Hausa	3	4.7
Others	3	4.7
Total	64	100.0

4.2 Places Where Women Seek Abortion Services

About two-thirds of the female respondents (65.3%) did not know where abortion services are provided in the metropolis while one-third (34.7%) knew and identified places where abortion services are provided in the metropolis. The three most mentioned places were SPC, MC and LC (NB: Actual names coded for ethical reasons) and were identified by more than two-thirds (68.97%) of the respondents who knew places where abortion services are provided as seen in Fig. 4.1. There was a significant difference (p-value < 0.001) in the knowledge of places where abortion service can be obtained between the two communities (Table 4.3). However, there was no significant difference in the knowledge of such places among the various age groups, although higher proportions were in the 20 – 24 and 25 – 29 yrs age groups (Fig. 4.2).

Fig. 4.1: Facilities in the Tema Metropolis where women seek abortion services and the proportion of respondents who named the facility



NB: Actual names coded for ethical reasons

(Source: Field Interviews, June 2008)

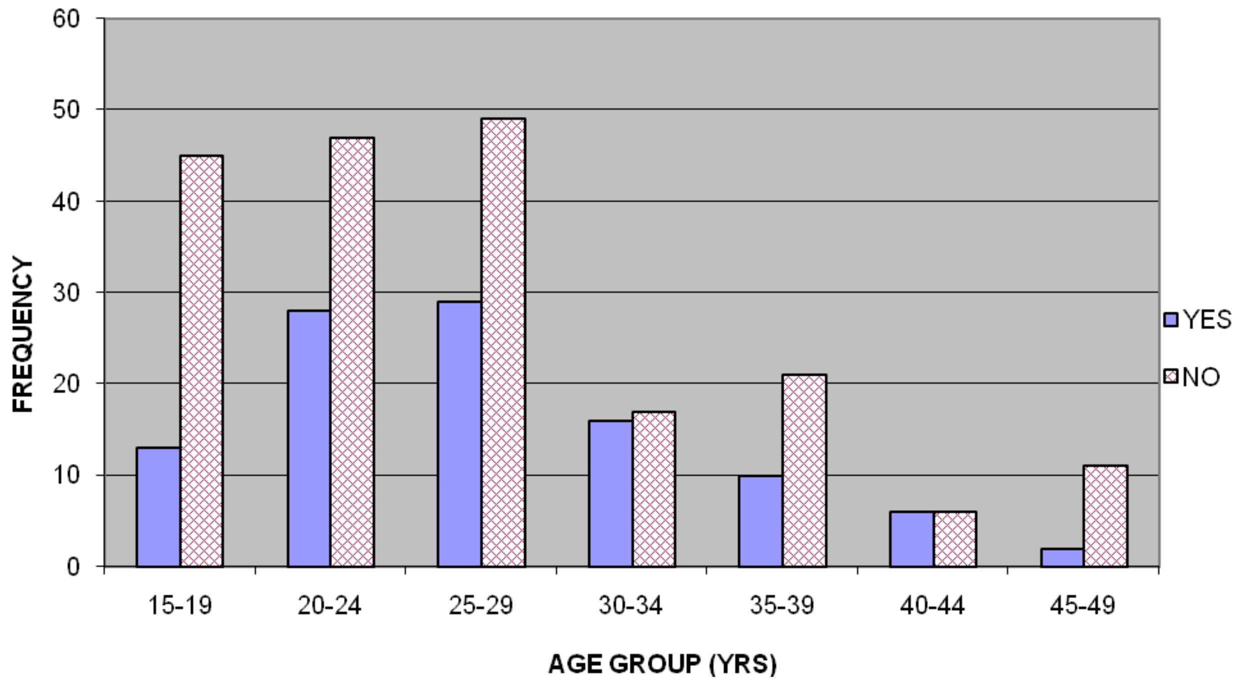
Table 4.3: Distribution of respondents' knowledge of abortion places in the Tema Metropolis by communities.

	Know A Place Where Abortion Is Done?				*p - value*
		YES	**NO**	**TOTAL**	
COMMUNITY 7	Freq.	**82**	**118**	**200**	**0.001***
	% within Community	41.0%	59.0%	100.0%	
TEMA NEW-TOWN	Freq.	**22**	**78**	**100**	
	% within Community	22.0%	78.0%	100.0%	
TOTAL	Freq.	**104**	**196**	**300**	

* *p- value* after controlling for education and occupation = 0.019 whiles the interaction between these variables were not significant.

(Source: Field Data, June 2008)

Fig. 4.2: Distribution of respondents' knowledge of abortion places in the Tema Metropolis by various age groups within WIFA.



(Source: Field Data, June 2008)

From the essays, places that were mentioned as places where abortions are performed were hospitals, homes, gutters, lavatory / public toilets, bush, boarding school, pharmacy shops, shrines, herbal centres, 'ghettos by fake doctors' and market places.

4.3 Reasons for Seeking Abortion Services

Reasons given by the various respondents on their thoughts as to why women in the metropolis seek abortion services are tabulated in (Table 4.4)

Table 4.4: Matrix of reasons women seek abortion: Perspectives of students and health practitioners.

Essays	In-depth interview : Public Medical Practitioner	In-depth interview : Practitioner	In-depth interview : Community Pharmacist
- Financial difficulty - Not ready for a child / unwanted pregnancy - To avoid being a school dropout/ the need to continue education -To save herself from embarrassment / disgrace - Pregnancy as a result of rape - Not knowing the man responsible for the pregnancy - To avoid being sacked from the house or rejected by parents - Parents not in support of the pregnancy - To save marriage - To look young and enjoy life - To maintain reputation in society	- Did not plan for the pregnancy - Not married and will want to be married before giving birth - She want to continue her education - The partner refused to accept responsibility for the pregnancy - Recently given birth or still breastfeeding another baby - Contraceptive failure	- Unplanned pregnancy - Recently delivered and still breastfeeding - Pregnancy as a result of rape - Partner did not accept responsibility for the pregnancy	- Nursing mother - Contraceptive failure - Missed Pill

(Source: Field Data, June 2008)

From the quantitative analysis of responses from the WIFA, the reason cited most was "when the woman considers her life to be at risk because of the pregnancy" (20.1%). The

other reasons in the top five reasons are "being too young to be a mother", "when there is a potential danger to the health of the foetus", "when the pregnancy was as a result of rape" and "the woman not ready for another child" (Table 4.5). The choices were however different within the communities, educational level and the age groups as seen Appendix 2 (Tables A, B and C).

Table 4.5: Reasons for seeking abortion and the frequency of responses from respondents within WIFA in the Tema Metropolis

Reason [a]	Responses	
	Freq.	**Percent**
Too young to be a mother	110	13.8%
The mother's life at risk	160	20.1%
Not ready for another child	72	9.0%
The need to continue education	61	7.6%
Pregnancy was as a result of rape	97	12.2%
Pregnancy was as a result of incest	49	6.1%
Boyfriend did not accept responsibility	42	5.3%
Pregnancy would interfere with career / job	33	4.1%
Potential danger to the health of the foetus	101	12.7%
Doesn't want people to know that she had sex or got pregnant	22	2.8%
Economic Reasons	41	5.1%
Others	1	0.1%
No Reason [b]	9	1.1%
Total	**798**	**100.0%**

a. Dichotomy group tabulated at value 1 b. Did not check any of the multiple responses

(Source: Field Data, June 2008)

4.4 Knowledge and Perceptions on Abortion

4.4.1 Sources of Information on Abortion

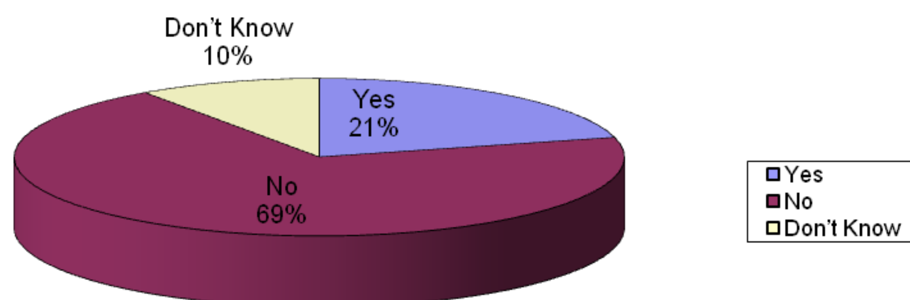
Sources of information on abortion services identified by the respondents to the essay were peers/friends, mass media, hospitals, herbalists, family relations/parents and men who are responsible for the pregnancies.

4.4.2 The Morality of Abortion

The majority of the respondents (69.3%) to the questionnaire for WIFA said it was wrong to have an abortion (Fig. 4.3). There was no significant difference (p-value > 0.05) between the communities as to whether it was right or wrong to have an abortion (Table 4.6). Those with secondary and tertiary education had the highest respondents (23.6 and 23.7% respectively) within their levels of education saying it was right to have an abortion (Table 4.7) while public / civil servants had the highest respondents within their category agreeing to abortion being right (Appendix 2, Table D).

Within the age groups, 21% of the respondents saw nothing wrong with having an abortion whiles 69.3% considered it as wrong , with the categories 30-34, 25-29 and 15-19 yrs having the highest proportions within their respective age group saying it was right to have an abortion (Appendix 2, Table E). 21.4% of Christians and 12.5% of Muslims said it was right to have an abortion (Appendix 2, Table F).

Fig. 4.3: Responses of WIFA in the Tema Metropolis to whether having abortion is right or not.



(Source: Field Data, June 2008)

Table 4.6: Distribution of respondents within WIFA in Tema Metropolis by community and morality of abortion

Community*	Is it Right to undergo Abortion?				Total
		Yes	No	Don't Know	
Community 7	Freq.	40	139	21	200
	% within community	20.0%	69.5%	10.5%	
Tema New-Town	Freq.	23	69	8	100
	% within community	23.0%	69.0%	8.0%	
Total	Freq.	63	208	29	300
	% of Total	**21.0%**	**69.3%**	**9.7%**	**100.0%**

* There was no significant difference between the communities (p-value > 0.05)

Table 4.7: Distribution of respondents within WIFA in Tema Metropolis by level of education and morality of abortion

Level of Education	Is it Right to undergo Abortion?				Total
		Yes	No	Don't Know	
Basic	Freq.	30	111	16	157
	% within Group	19.1%	70.7%	10.2%	
Secondary	Freq.	21	62	6	89
	% within Group	23.6%	69.7%	6.7%	
Tertiary	Freq.	9	24	5	38
	% within Group	23.7%	63.2%	13.2%	
None	Freq.	3	11	2	16
	% within Group	18.8%	68.8%	12.5%	
Total	Freq.	63	208	29	300
	% of Total	**21.0%**	**69.3%**	**9.7%**	**100.0%**

4.4.3 Definition of Abortion

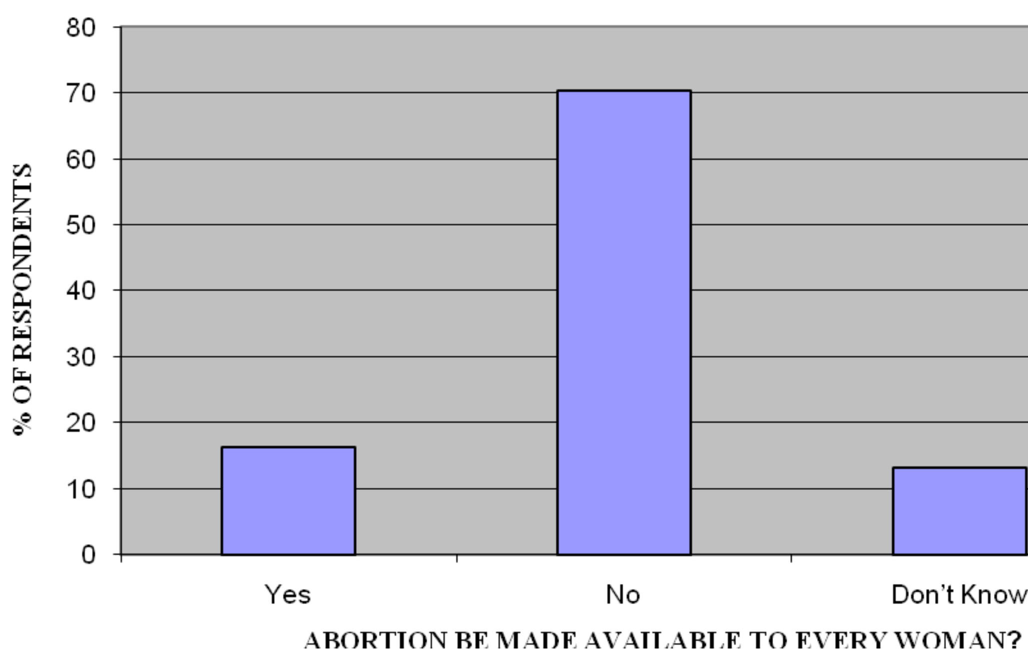
Respondents to the essay only knew of induced abortion and hardly talked about spontaneous abortion. Some of the definitions given for abortion were "the act of illegal termination of pregnancy that has been done without the recommendation of a qualified doctor", "the act of getting rid or doing harm to an unborn baby in the womb at an early state of pregnancy" and " the termination of wanted or unwanted pregnancy, naturally or illegally". The definition of the key informants' on what abortion is were " if the pregnancy is terminated or the developing baby is expelled before 28 completed weeks of

gestation" and " the expulsion or extraction from the woman of a foetus that is below age of viability i.e. 28 weeks(in Ghana)" from the in-depth interviews.

4.4.4 Access to Abortion Services

As to whether abortion services should be made available to every woman, 70% of the respondents to the female questionnaire responded in the negative (Fig.4.4) although the medical doctors in the in-depth interview think abortion service should be made available to every woman. From the questionnaire for Pharmacies / Chemical shops, 86.7% of respondents said No with 13.3% saying in the positive.

Fig. 4.4: Distribution of respondents in WIFA in the Tema Metropolis on degree of access to abortion services



There were statistically no significant differences (p-value > 0.05) between the two communities, the age groups, educational level attained, ethnic groups, occupation and

the religions as to whether abortion services should be made available to every woman (Table 4.8).

Table 4.8: Distribution of respondents according to whether abortion should be made available to every woman within the communities, age groups, levels of education and ethnic groups

Communities	Should Abortion Services Be made available to every woman?			
	Yes	**No**	**Don't Know**	**Total**
Community 7	17.0%	70.0%	13.0%	100%
Tema New-Town	15.0%	71.0%	14.0%	100%
% of Total	**16.3%**	**70.3%**	**13.3%**	**100%**
Age Group				
15-19	15.5%	70.7%	13.8%	100.0%
20-24	14.7%	68.0%	17.3%	100.0%
25-29	15.4%	69.2%	15.4%	100.0%
30-34	24.2%	69.7%	6.1%	100.0%
35-39	22.6%	67.7%	9.7%	100.0%
40-44	16.7%	83.3%	0.0%	100.0%
45-49	.0%	84.6%	15.4%	100.0%
% of Total	**16.3%**	**70.3%**	**13.3%**	**100.0%**
Level of Education				
Basic	16.6%	71.3%	12.1%	100.0%
Secondary	16.9%	69.7%	13.5%	100.0%
Tertiary	21.1%	63.2%	15.8%	100.0%
None	.0%	81.2%	18.8%	100.0%
% of Total	**16.3%**	**70.3%**	**13.3%**	**100.0%**
Ethnicity				
Akan	17.7%	69.0%	13.3%	100.0%
Ga / Dangbe	13.1%	76.2%	10.7%	100.0%
Ewe	21.3%	61.7%	17.0%	100.0%
Mole-Dagomba	0.0%	66.7%	33.3%	100.0%
Hausa	0.0%	100.0%	0.0%	100.0%
Others	0.0%	83.3%	16.7%	100.0%
% of Total	**16.3%**	**70.3%**	**13.3%**	**100.0%**

However, there was a significant difference between those who said abortion was either right or wrong when it came to whether abortion services should be made available to every woman (Table 4.9).

Table 4.9: Cross-tabulation of respondents within WIFA by whether it is right to have an abortion or not and whether abortion should be made available to every woman or not.

		Make Abortion Available to every Woman?			Total
		Yes	**No**	**Don't Know**	
Is it Right to have Abortio	**Yes**	33	27	3	63
	No	13	168	27	208
	Don't Know	3	16	10	29
Total		49	211	40	300

* p-value < 0.001

4.4.5 Contact person when considering abortion

The majority of the respondents said they will first contact either a friend or boyfriend (28.7% and 25.7% respectively) when considering abortion as an option for unwanted pregnancy as seen in Fig. 4.5.

Fig. 4.5: Distribution of respondents according to the person likely to be contacted by a woman when considering abortion.

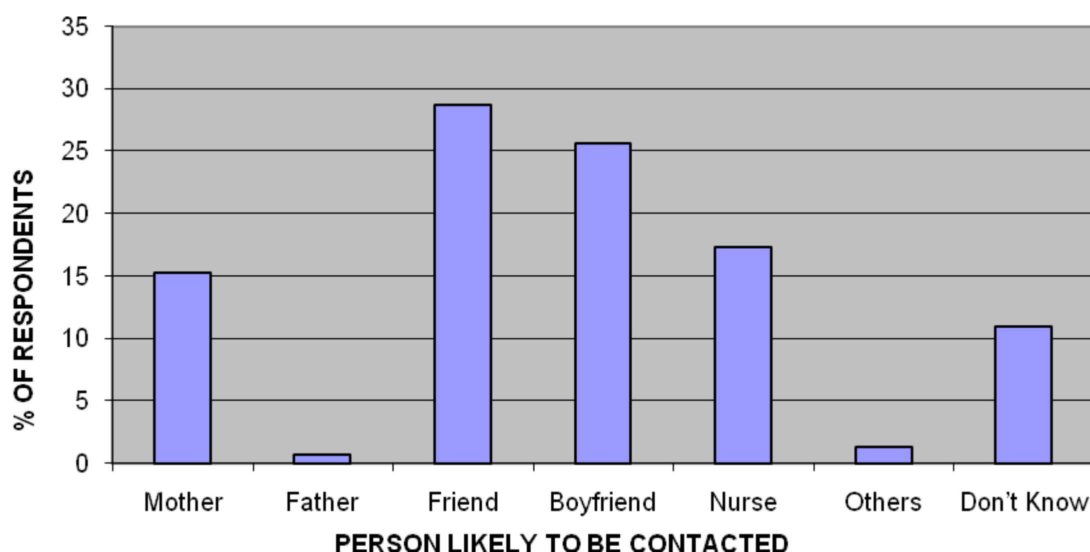
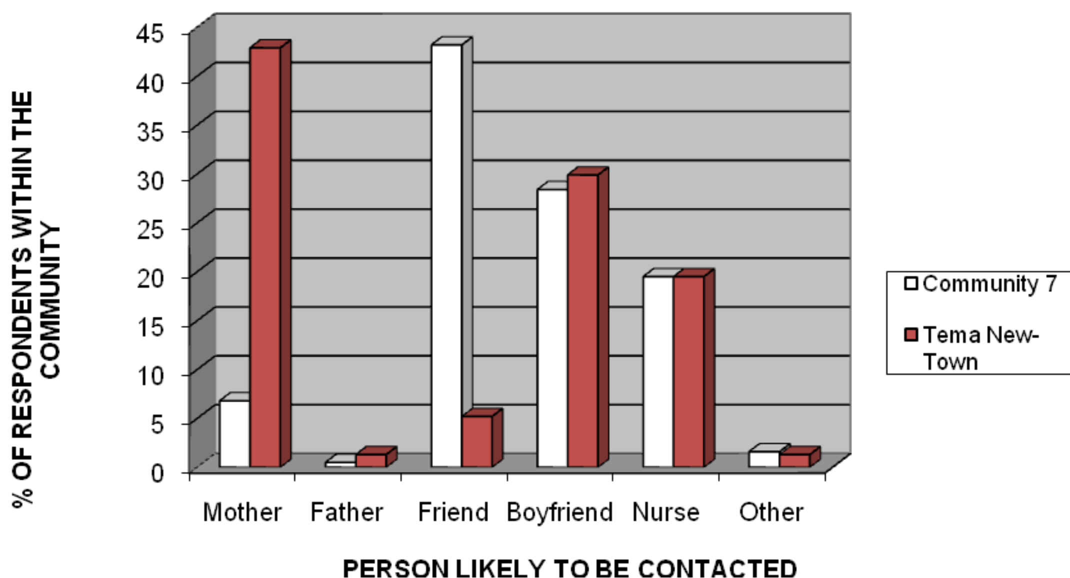


Fig. 4.6: Distribution of respondents within Community 7 and Tema-New Town by the person likely to be contacted by a woman when considering abortion.



There was however, statistically no significant difference between the two communities as to who will be contacted first when a woman is considering an abortion. The major difference was that whereas the majority of respondents in community 7 chose the mother, the majority of those in Tema New-Town chose a friend as the first person likely to be contacted (Fig. 4.6).

Below is an extract from the in-depth interview of one of the key informants which presents how health personnel treat the issue of abortion:

> "There is no setup to offer abortion on request at the facility. It is not open. From the reception to consulting room to theatre to ward, abortion is not acceptable. Staff will not even assist because they frown upon it. There is also the conflict between what is medically sound and what the society is offering. For example, in Korle-Bu, a medical doctor was stigmatised even by his own colleagues for offering abortion services. He only persevered because he is strong-willed. Others who wanted to offer the service were afraid to join him because of the stigmatization".

4.4.6 Materials/Substances for Abortion

Materials / substances that were mentioned as being used to induce abortion from the essay were

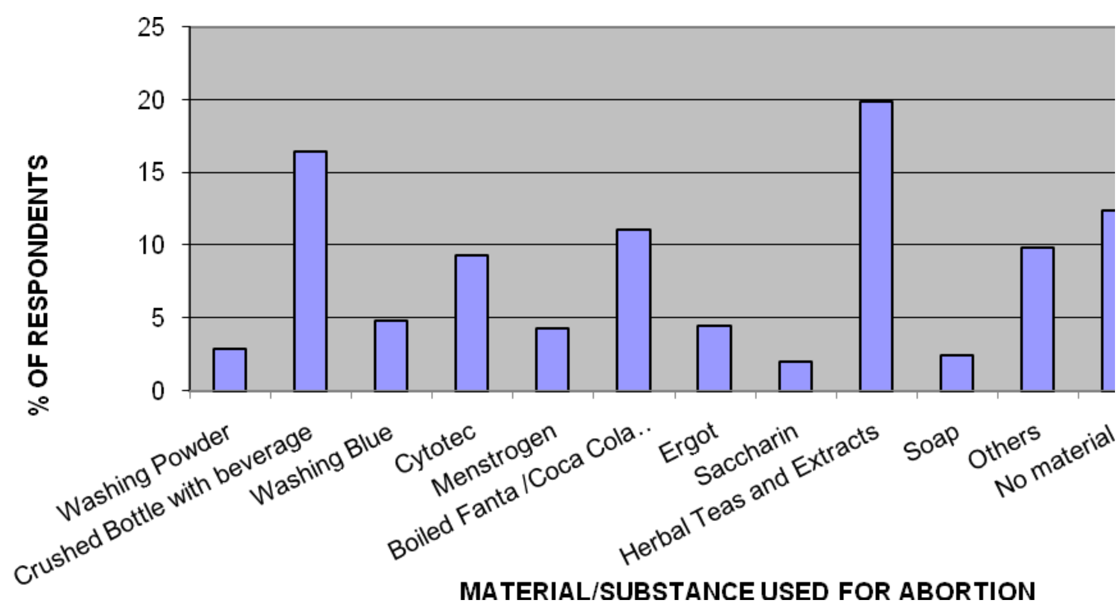
- Malta Guinness with “half margarine” (about 200g) of sugar
- Herbs / Herbal Extracts / Extracts from wild plants
- Ground or broken bottle with porridge or alcoholic beverages
- Groundnut soap which is not well cooked
- “Akasha”, a bleaching agent
- Small sticks
- Guinness or Coca Cola with plenty sugar
- Coffee with plenty sugar
- Medicines from the Pharmacy, including chloroquine
- Solution of cement and water
- Limestone in alcohol

Some also mentioned fighting and hitting the pregnancy unto a hard surface as some of the actions that some females take to abort their pregnancies.

From the in-depth interviews, all the key informants identified Cytotec® as the major substance / medicine being used now by women to induce abortion. The Community Pharmacist also mentioned Ergometrine, Gynaecosid, Primolut-N and Menstrogen as medicines that women who come to the facility request to carryout abortion.

From the quantitative study, crushed bottle with beverage, boiled Fanta / Coca Cola with overdose of painkillers and Herbal teas / extracts were the three most mentioned substances / materials for inducing abortion as seen in Fig. 4.7.

Fig. 4.7: Proportions of WIFA in the Tema Metropolis who know of a particular abortifacient.



The response according to the various communities and age groups are given in Tables 4.10 and G (Appendix 2) respectively.

4.4.7 Who should pay for the cost of Abortion Services?

When asked about who should pay for the cost of abortion services and the cost of complications that may arise from abortion, the majority of the respondents said the man responsible for the pregnancy should bear the cost although one-fourth of the respondents agree that both the man and woman should bear the cost of abortion services (Fig. 4.8).

Comparison of responses from the two communities as to who should pay for the cost of abortion services are given in Fig. 4.9.

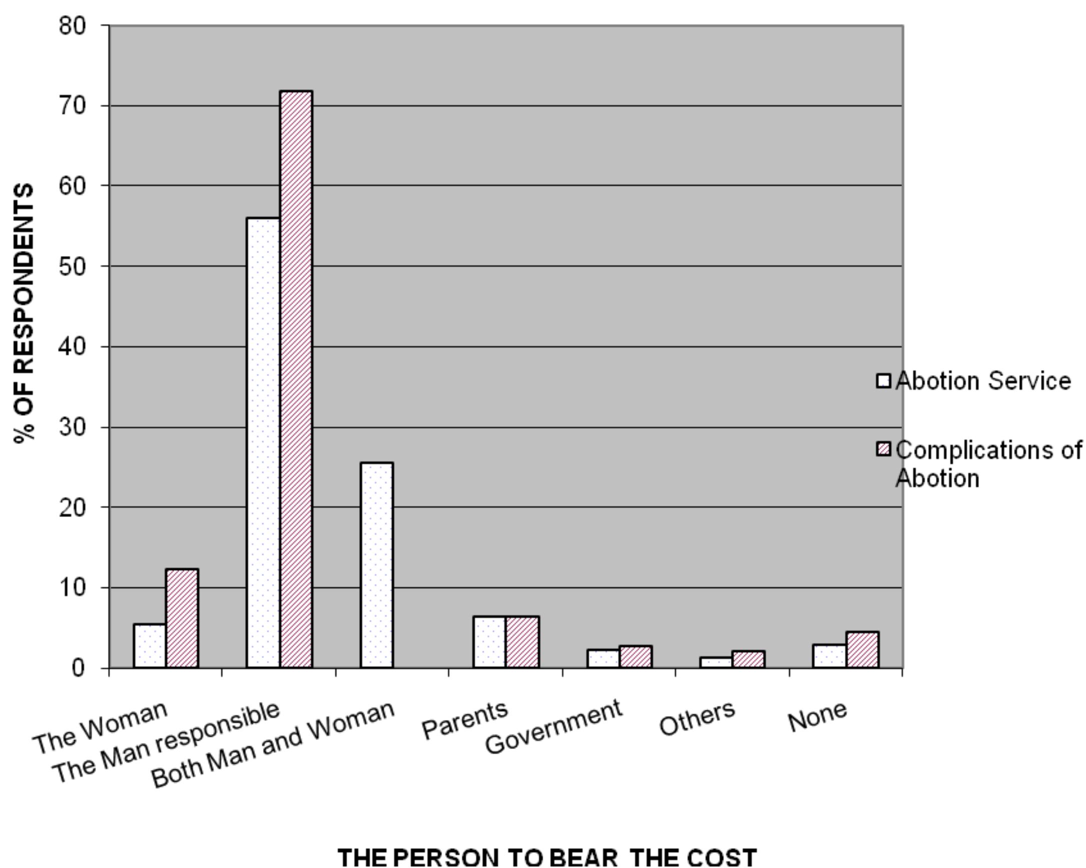
Table 4.10: Distribution of respondents within Community 7 and Tema New-Town by known abortifacient

Substance/ Material	CMNTY	
	Community 7	Tema New-Town
Washing Powder	3.0%	10.0%
Crushed Bottle with beverage	24.0%	44.0%
Washing Blue	10.0%	7.0%
Cytotec	11.5%	29.0%
Menstrogen	11.0%	2.0%
Boiled Fanta /Coca Cola with overdose of painkillers	22.0%	18.0%
Ergot	10.5%	4.0%
Saccharin	4.5%	2.0%
Herbal Teas and Extracts	34.0%	43.0%
Soap	2.5%	9.0%
Others	18.5%	18.0%
No material [b]	25.0%	19.0%

Percentages and totals are based on respondents.

a. Dichotomy group tabulated at value 1. b. Did not check any of the multiple responses

Fig 4.8: Distribution of respondents within WIFA in the Tema Metropolis according to who should pay for the cost of abortion services and complications that may arise from abortion



4.4.8 Views/ Thoughts on Abortion

The respondents to the essay writing were asked to write on what they think about abortion. This was to identify individual thoughts/perceptions on abortion. The various perceptions or views about abortion as expressed by the respondents to the essay are summarized in the following table:

Question	Views
Why would you encourage someone to have an abortion?	- So that she can continue her education - So as not to give birth to a fatherless child - It makes someone do away with difficulties - When there is a risk to the life of the pregnant woman - In order not to bring disgrace to herself
Why would you discourage someone from having an abortion?	- It can lead to death - It can cause barrenness or infertility - It is a sin - It brings emotional suffering - The baby may become an important person in the future
Why will someone not abort a pregnancy?	- She does not want to be barren - Fear of death - Fear of God and in order not to sin - Following advice from the elderly - Fear of complications such as perforated uterus and infections - Financial cost involved in having an abortion - Having wealthy parents or having support from parents
What do you think about abortion?	- Very serious and deadly act that must be stopped - Most wicked or sinful thing to do - It should be allowed if the woman wants it - Sinful but has to be committed one way or the other - It should not be legalized - It is safe if done between 1st to 3rd Month of pregnancy - A crime and should be punished according to law

Three of the essay writings by the senior high school students have been reproduced to show different views on abortion:

> "Abortion is the unlawful way and means of getting rid of unwanted pregnancies. People engage in this act for several reasons and mostly because peers or close relations advice them to go into it. People who engage in indiscriminate sex may end up getting pregnant and because she doesn't want to take up the responsibility of parenthood at that particular point in time, the

only thing she can do is to kill the unwanted child through abortion.

Also, parents or guardians advice their wards to go in for abortion because, if they keep the unwanted baby their education will be ruined and no man in the 21st Century will like to marry a woman who has already given birth, “born one” as it is commonly said. Sometimes, some boyfriends encourage their pregnant girlfriends to commit abortion in order for her to maintain her reputation in society.

Abortion is mostly carried out or done in hospitals, bathrooms, restrooms or hidden places. Most students in the second cycle institutions take in concoctions such as grinded glass which has been sieved and a whole lot. I will actually encourage one to commit abortion when she has tangible reasons for wanting to do it, even though it is very risky. To prevent complications, I would recommend a qualified doctor to do it.

Even though abortion is considered as a sin in the sight of God, abortion in one way or the other has to be committed because, as human as we are, we are bound to get pregnant when not ready for it.”

(16 years old female and a Christian)

“Abortion is the act of getting rid or doing harm to an unborn baby in the womb at the early state of pregnancy. People get information on abortion from their friends or boyfriends. Their friends or boyfriends may pressure them to do abortion when they get to know that they are pregnant.

People do abortion because they may or cannot cater for the child when the baby is born. Also they do it because they may want to continue their education. When people get to know that they are pregnant, they may be abandoned in the society. Their parents may reject them when they get to know that they are pregnant. Someone will not commit abortion because she knows that in future, it might bring problems in her getting pregnant or doesn’t want to harm an innocent child.

I will discourage abortion because when girls at their adolescent age involve themselves in abortion, they may face difficulties in getting pregnant again and also because the child in the womb is innocent of what might be happening to you.

Places where abortion may take place include hospital, home where friends may do it for you or at the boarding school.

Substances or materials for abortion are drugs, grinded bottle, knife, instruments from the hospital.

What I think about abortion is that it is a sinful thing for any girl / woman to do. It may also be a deadly thing for one to do. Women may also have difficulties with child bearing in the future. So I think abortion should be discouraged by girls.

Ghana doesn't have any law on abortion but I think there should be a law concerning abortion so that girls may not involve themselves in things that may get them pregnant and do abortion."

(18 years old female and a Christian)

"Abortion is the act of terminating a pregnancy without the permission of a qualified doctor. People get information about abortion from their peers, films and sometimes in books.

People do abortion or terminate pregnancies due to lack of education on abortion. Some also do it out of fear that they will be teased in the community because they are young and are pregnant while they are not married. Students who find themselves pregnant also do abortion so that they will not be dropped out of school. Married women do abortion when they are not ready to give birth and prostitutes do it when they want to continue with their prostitution.

Abortions are mostly done at the hospital, homes and convenience places. Some of the materials used in the termination of pregnancy are scissors, knife and other things (that is when terminating pregnancy in the hospital). In the home, people use malt and add a lot of sugar to it and drink. Some also use amoxicillin to terminate their pregnancies and others grind bottle and take it, just to terminate the pregnancy.

Abortion is something that may lead to so many things. These things are (i) one may become barren for the rest of her life (ii) one may die through it (iii) it may bring disgrace to you, your family and sometimes to the community. You may even contract deadly disease when you use unsterilized objects like knife and one may suffer emotionally.

I think that because abortion has much effect on the individual, we have to try very hard to stop it so that innocent children will not suffer from our stupidity."

(16 years old female and a Muslim)

4.5 Extent of Pharmaceutical Use in Inducing Abortion

The frequencies of request for medicines that are believed to be used in terminating pregnancy or preventing pregnancy are tabulated in Table 4.11.

Table 4.11: Average daily request for abortion services from pharmacies and chemical shops in the Tema Metropolis

Medicine	No. of Request (per day)			
	less than 2	**2 to 4**	**5 or more**	**No Response**
Menstrogen	60%	33.3%	0.0%	6.7%
Ergot	66.7%	20.0%	6.7%	6.7%
Cytotec	40%	33.3%	26.7%	0.0%
ECP	23.3%	26.7	46.7	0.0%

It was observed that most of the requests for these medicines were without prescription as seen in Table 4.12.

Table 4.12: Medicines and the form of request from various pharmacies and chemical shops in the Tema Metropolis

Medicine	No Prescription	Invalid Prescription	Valid Prescription
Menstrogen	90%	6.7%	3.3%
Ergot	73.3%	10.0%	16.7%
Cytotec	73.3%	20.0%	6.7%
ECP	96.7%	3.3%	0.0%

Most of the respondents classified the medicines as 'Prescription Only' medicines and suspected them to be used in terminating pregnancies. These medicines were also identified as medicines that have effects on pregnancy by the respondents.

The majority of the facilities received an average of one abortion request per day (33.3%) although quite a number (13.3%) received as many as five or more abortion requests per day. Those that were located in busy areas such as Community One received more request than those in less busy areas. It was also observed that in most of the facilities, abortion services are requested by both males and females (70%) whiles 26.7% said females are the ones who mostly request for abortion services.

The age groups that requested for abortion services were in the order (highest to lowest) 20-24 yrs, 25-29 yrs, 15-19 yrs, 30-34 yrs and 35 yrs and above. The majority of the facilities selected the age groups 20-24 yrs and 25-29 yrs as those that do request for abortion services.

4.6 Knowledge of the Provision of the Abortion Law

4.6.1 Legality of Abortion

While more than half (58.7%) of the respondents said abortion is illegal in Ghana, 24% said it is legal with 17.3% saying they do not know whether it is legal or illegal. There was a significant difference in the knowledge of legality of abortion between the two communities Table 4.13) but no significant difference between age groups and the level of education (Table 4.14).

Table 4.13: Distribution of responses on whether abortion is legal or not

Community	Is Abortion Legal in Ghana?				Total
		Yes	No	Don't Know	
Community 7	Freq.	34	131	35	200
	% within Community	17.0%	65.5%	17.5%	
Tema New-Town	Freq.	38	45	17	100
	% within community	38.0%	45.0%	17.0%	
Total	Freq.	72	176	52	300

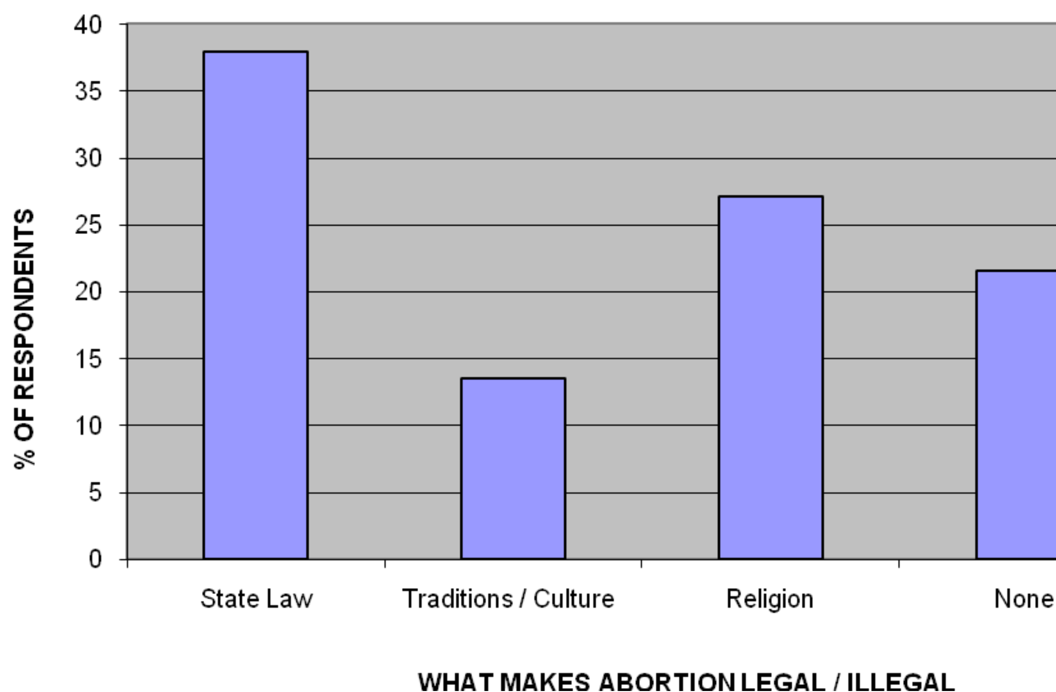
*p-value significant (p-value < 0.001)

Table 4.14: Distribution of women within age group and level of education by whether abortion is legal or not.

Age Group (yrs)	Is Abortion Legal?			% of Total
	Yes	No	Don't Know	
15-19	27.6%	53.4%	19.0%	19.3%
20-24	28.0%	50.7%	21.3%	25.0%
25-29	25.6%	59.0%	15.4%	26.0%
30-34	18.2%	66.7%	15.2%	11.0%
35-39	22.6%	71.0%	6.5%	10.3%
40-44	8.3%	83.3%	8.3%	4.0%
45-49	7.7%	53.8%	38.5%	4.3%
Level of Education				
Basic	24.8%	59.9%	15.3%	52.3%
Secondary	27.0%	53.9%	19.1%	29.7%
Tertiary	13.2%	68.4%	18.4%	12.7%
None	25.0%	50.0%	25.0%	5.3%

As to what makes abortion legal or illegal in Ghana, State Law (37.9%) and Religion (27.1%) were the most mentioned (Fig. 4.9). These two were also the most mentioned within the two communities, irrespective of age groups and educational differences.

Fig. 4.9: Distribution of WIFA in Tema Metropolis by what legalizes abortion in Ghana



Ninety percent (90%) of the respondents to the questionnaire for pharmacies / chemical shops said abortion is illegal with 10% saying it is legal in country. Most of the respondents (80%) also said it is State Law which makes abortion legal or illegal, with 10% and 3.3% saying Religion and Traditions/Customs respectively.

Only a small proportions of the participants in the essay said Ghana has a law that regulates abortion or do not know whether Ghana has a law or not. The majority said there is no law regulating abortion in the country. For those who said there is a law regulating abortion, some of the provisions that they mentioned as being in the law were abortion is permitted when the mother's life is at risk or the baby could suffer deformity and imprisonment for anyone who commits abortion.

4.6.2 Conditions for Abortion

The most identified condition under which abortion is permitted is when the mother's life is at risk because of the pregnancy (23%) as seen in Fig. 4.10. The trend within communities, age groups and level of education are shown in Table 4.15 and Appendix 2 (Tables H and I, respectively).

Fig. 4.10: Distribution of WIFA in Tema Metropolis by knowledge of Conditions under which abortion is permitted

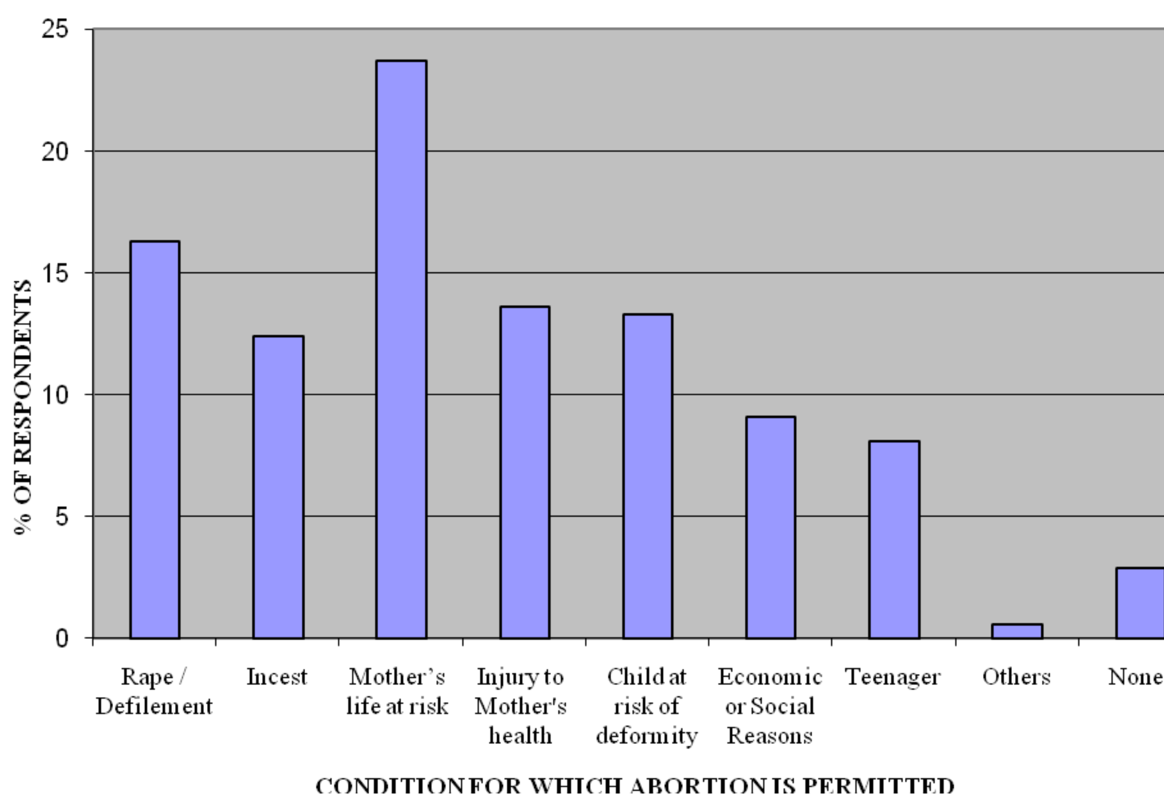


Table 4.15: Distribution of WIFA within Community 7 and Tema New-Town by knowledge of Conditions under which abortion is permitted

Condition for Abortion	Community		% of Total
	Community 7	Tema New-Town	
Pregnancy as a result of rape or defilement	36.5%	41.0%	38.0%
Pregnancy as a result of incest	32.0%	23.0%	29.0%
Mother's life at risk because of the pregnancy	53.0%	60.0%	55.3%
Possible injury to the physical and mental health of the mother	36.0%	23.0%	31.7%
Child at risk of developing serious deformity	33.5%	26.0%	31.0%
Economic or Social Reasons	20.5%	23.0%	21.3%
Teenager	14.5%	28.0%	19.0%
Others	2.0%	.0%	1.3%
None [a]	8.5%	3.0%	6.7%
Total			**100%**

Fig. 4.11: Proportion of respondents and contraceptives known

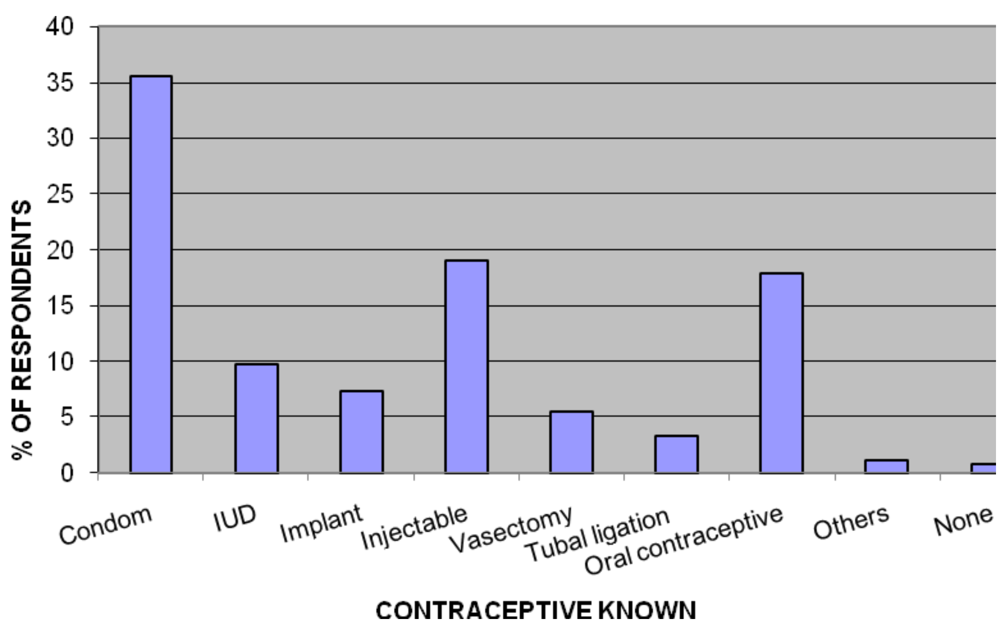
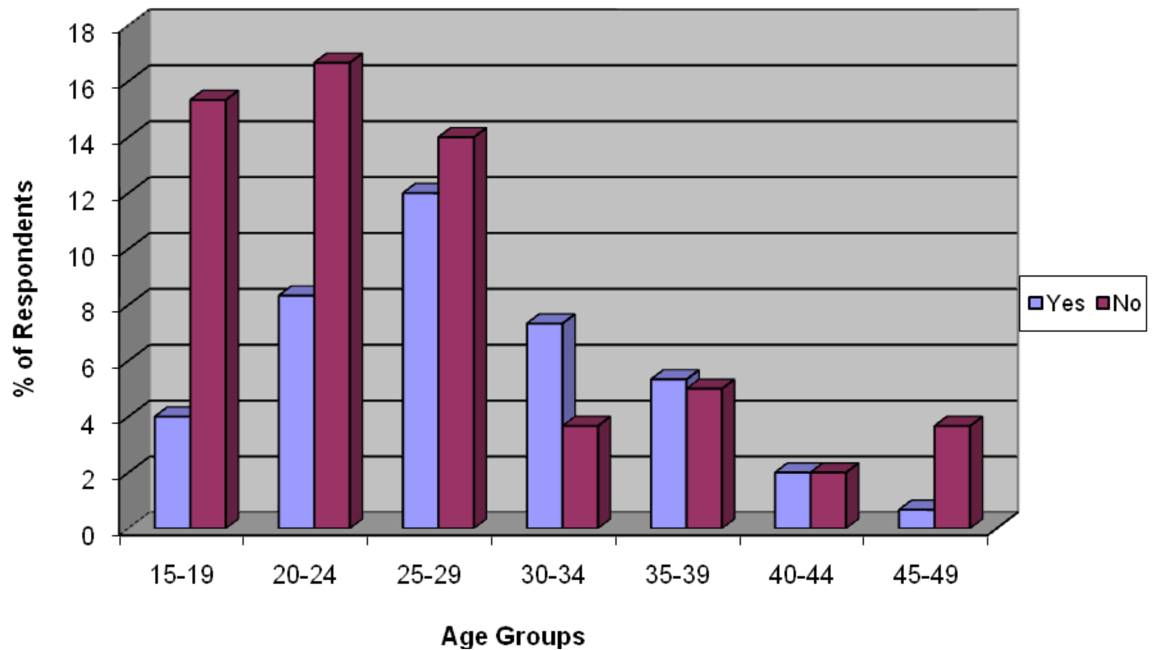


Fig. 4.12 The use of contraceptives among respondents



The responses to the types of contraceptives according to community and age group are given in Appendix 2 (Table J) and Table 4.16 respectively.

4.7 Knowledge of Contraceptives

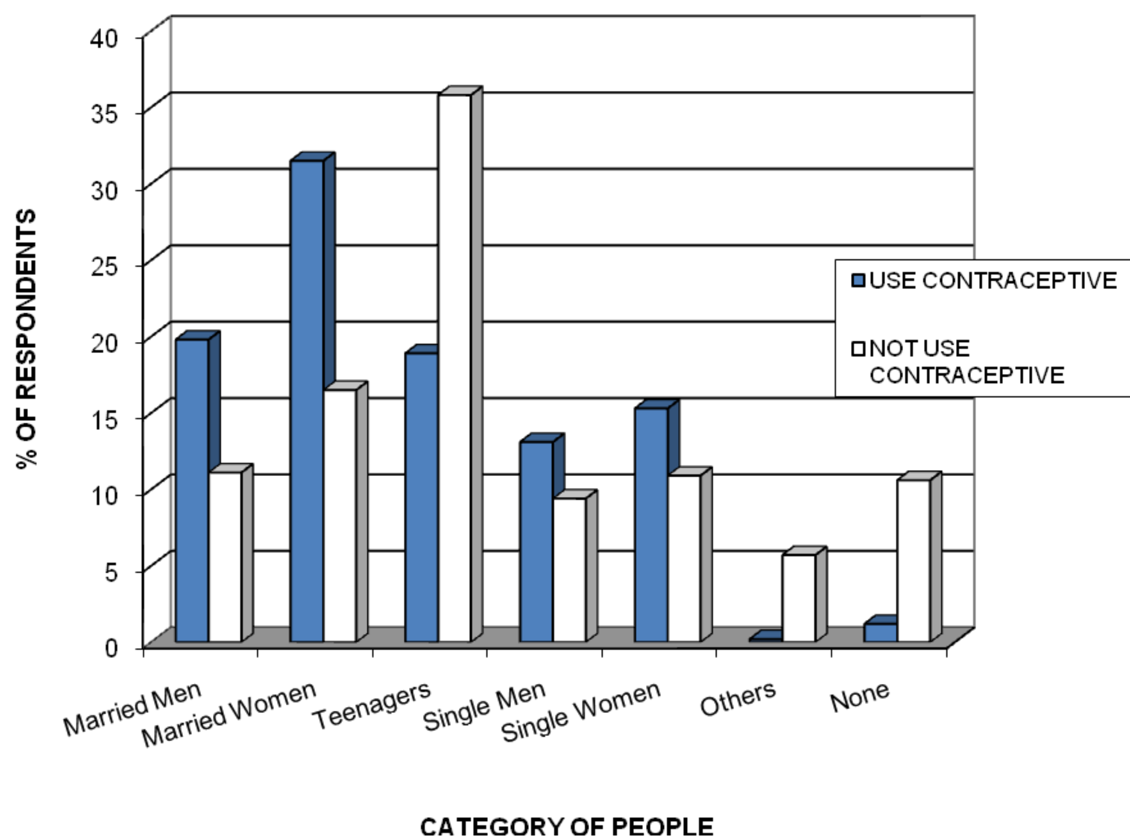
The three most known contraceptives among the respondents were condom, injectables and oral contraceptives (Fig. 4.11). However, only 39.7% of the respondents have ever used a contraceptive. The extent of contraceptive use among the various age groupings is illustrated in fig. 4.12.

Table 4.16: Distribution of respondents by age group and contraceptives known

Age Group		Known Contraceptive									Total
		Condom	IUD	Implant	Injectable	Vasectomy	Tubal ligation	Oral contracepti	Others	None	
15-19	Freq	48	4	6	13	3	1	16	2	1	58
	% of Total	16.0%	1.3%	2.0%	4.3%	1.0%	.3%	5.3%	.7%	.3%	19.3%
20-24	Freq	61	21	8	21	9	6	21	1	1	75
	% of Total	20.3%	7.0%	2.7%	7.0%	3.0%	2.0%	7.0%	.3%	.3%	25.0%
25-29	Freq	65	20	16	34	12	11	35	0	1	78
	% of Total	21.7%	6.7%	5.3%	11.3%	4.0%	3.7%	11.7%	.0%	.3%	26.0%
30-34	Freq	24	9	6	21	7	1	16	1	0	33
	% of Total	8.0%	3.0%	2.0%	7.0%	2.3%	.3%	5.3%	.3%	.0%	11.0%
35-39	Freq	18	7	6	20	2	0	19	2	0	31
	% of Total	6.0%	2.3%	2.0%	6.7%	.7%	.0%	6.3%	.7%	.0%	10.3%
40-44	Freq	8	2	4	9	2	2	7	1	1	12
	% of Total	2.7%	.7%	1.3%	3.0%	.7%	.7%	2.3%	.3%	.3%	4.0%
45-49	Freq	10	1	2	7	1	1	4	0	1	13
	% of Total	3.3%	.3%	.7%	2.3%	.3%	.3%	1.3%	.0%	.3%	4.3%
Total	Freq	234	64	48	125	36	22	118	7	5	300
	% of Total	78.0%	21.3%	16.0%	41.7%	12.0%	7.3%	39.3%	2.3%	1.7%	100.0%

Married women were the category that most respondents said are supposed to use contraceptives whiles teenagers were the group that are not supposed to use contraceptives as shown in Fig. 4.12.

Fig. 4.13: Distribution of respondents by views on who should and should not use contraceptives



4.8 Conclusion

This chapter has presented the results and analysis of both qualitative and quantitative methods used in the study i.e. interviews with questionnaires and IDI guides and essay writing. The next chapter discusses the results and analysis along the lines of the stated objectives of the study and available literature.

CHAPTER FIVE

DISCUSSION

5.1 Introduction

The previous chapter presented the results and analysis of data obtained from the study. In this chapter, the results and analysis obtained from the study are discussed in the context of the stated objectives and available literature on abortions, globally and nationally.

5.2 Places Where Women Seek Abortion Services

Due to the restrictive nature of the law on abortion, coupled with stigmatization, some women who resort to abortion do so secretly, under unsafe conditions and outside the formal health services structure (Lithur, 2004). A survey also showed that more than half of adolescents who were involved in an abortion had the last abortion at a hospital or clinic with one-third having abortion at home (Awusabo-Asare, 2003).

The results from this study indicate that places where women seek abortion services within the Metropolis are varied with most of them outside the formal health sector. Thus, there is likelihood that the abortion services being provided in these places are unsafe. Places identified include hospitals, homes, bush, pharmacies, herbal centers, boarding schools, ‘ghettos’ and public toilets. Although two-thirds of the respondents did not know of a place where abortion services are provided, one-third knew of such places and identified them. All the identified places are recognized healthcare providers within the Metropolis with most of them located in Tema Township (i.e. urban Tema). The three most mentioned facilities are St. Peter’s Clinic, Meridian Clinic and Lagoon Clinic.

Perhaps, that accounts for the significant difference (p-value < 0.001) between respondents in Community 7 and Tema New-Town with regard to known places for abortion since educational level and occupation had no significant effect on the knowledge of such places.

Most of the women who knew of such places were between the ages 20-29 years and this is along the lines of the assertion by the key informants that most of the people who seek abortion services or come with uncompleted abortion to their health facilities are women in their twenties.

5.3 Reasons for Seeking Abortion Services

Reasons cited by women in the Tema Metropolis for seeking abortion services were not different from those that were identified from other studies in Ghana (Bleek, 1981), Nigeria (Otoide, 2001), Tanzania (Rasch et al., 2000), Zambia (Webb, 2000) and Mexico (Gallen et al., 1981). These include financial difficulties, unplanned pregnancy, the need to continue ones education, to maintain family reputation in society, immaturity, rejection of responsibility for the pregnancy by male partner, poor spacing of children and contraceptive failure. For example, reasons given by a 16 year old female student and 17 year old male student in a senior high school as to why women resort to abortion in the Metropolis are given below:

> "… Parents or guardians advise their wards to go in for abortion because if they keep the unwanted baby, their education will be ruined and no man in the 21st century will like to marry a woman who has already given birth, "born one" as it is commonly said. Sometimes, some boyfriends encourage their pregnant girlfriends to commit abortion in order for her to maintain her reputation in the society". (16yrs old Senior High School female student)

> "Reasons for doing abortion come in different ways. One may be influenced to have an abortion due to the fact that she does not know the father of the baby or the one responsible for the pregnancy has denied it. It might also be that she wants to continue her education to the highest level. Maybe, the parents are not in support of her getting pregnant for that man, hence influencing her to have abortion". (17yrs old Senior High School male student)

The five most common reasons for having abortion from the interviews of WIFA are when the woman considers her life to be at risk because of the pregnancy, too young to be a mother, when there is a potential danger to the health of the foetus, when the pregnancy was as a result of rape and the woman not being ready for another child. These were also the top five reasons given within the communities, age groups and educational levels, although they rank differently within these categories.

It is worth noting that the reasons given in the essay writing were similar to reasons that women who sought abortion services or attempted terminating pregnancy gave to the key informants when they visit the health facility.

5.4 Knowledge and Perception on Abortion

Definitions given in the essay writing suggest that most of the respondents only consider induced abortions as "abortion". This is a reflection of the general perception that most women do not consider spontaneous abortion as abortion within the various Ghanaian cultural settings. It is also possible that the criminalization of induced abortions has shifted attention from spontaneous abortions.

Women who resort to abortion are believed to be very much aware of the possible complications that may arise from induced abortions. This opinion is shared by obstetrician / gynaecologist specialists (key informants) and some of the respondents who wrote essays. The following extracts give the details in this regard:

> "One observation I have made is that they fear side effects of contraception as against complications of induced abortions. That is why they will not use contraceptives but will want to have an abortion. Previously, most of these women were coming with more complications because they were using instruments that easily caused injury. Now most of them use Cytotec and often present with few complications. Mostly they bleed severely resulting in anaemia and require blood transfusion. Injuries are also minimized". (Obstetrician / gynaecologist specialist)

> "… They know the possible complications, just that they don't have a choice. They are pregnant. They have to get rid of it because they don't want it. So they will try something. At that material moment, they are not thinking about the complications. They just want to get rid of the pregnancy". (Obstetrician / gynaecologist specialist)

> "A person will not commit abortion because the person may be afraid of death and also being barren. Also, the person is afraid of having perforated uterus and the risk of having infections". (16 year old female senior high school student)

> "People may not commit abortion because abortion without seeing a qualified doctor may destroy your uterus and may result in barrenness/infertility and death" (17 year old male senior high school student)

The majority of the female respondents (69.3%) said it was wrong to have an abortion. This is similar to results obtained from studies among pregnant Zulu teenagers and Kenyan teenagers who showed overwhelming disapproval of abortion (Varga, 2002). Traditions, cultural and societal norms as well as religious beliefs could be responsible

for disapproval of abortion (Lithur, 2004; Bleek, 1981) as seen from the background characteristics of the respondents. It is also possible that respondents who disapproved did not want to be seen as "bad persons" since society considers abortion as a "bad practice".

There were no significant differences between the two communities, between the age groups and between the levels of education as to whether having abortion is right or not. It is worth noting, however, that appreciable proportions of respondents with secondary and tertiary education (23.6 and 23.7%, respectively) said it is right to have an abortion. Perhaps, their thought has been influenced by what they have learnt about abortion.

The majority of reasons advanced as to why it is not right to have an abortion were in line with religious beliefs, emphasizing the role of religion in issues of abortion. For example, most respondents considered abortion as a sin which is punishable according to God's word.

An overwhelming majority of respondents to the questionnaire for WIFA (70%) and pharmacies/chemical shops (86.7%) were against making abortion services available to every woman. Most of the reasons were in relation to the fact that it will promote promiscuity and the possible abuse of the facility. This position cut across the communities, levels of education, ethnicity and occupation. Of interest, however, is the fact that about 43% of the respondents who said it was right to have an abortion disapproved of making abortion services available to every woman. There was a

significant difference (p-value < 0.001) between the various positions on whether abortion is right or wrong and the provision of abortion services to every woman, emphasizing the variation in opinion among the groups.

Most respondents will contact either a friend (28.7%) or boyfriend (25.7%) when considering having an abortion, although an appreciable proportion said they will contact either a nurse (17.3%) or the mother (15.3%). Few respondents said they will contact their fathers. This is possibly due to the level of intimacy between females and these categories of people and the "amount" of their secret they are willing to share with them. The choice of a confidant is, however, different among respondents within the two communities, perhaps, indicating the different roles played by these categories of people in the different communities.

Materials/substances used to induce abortion that were mentioned in the study were similar to those that were identified in studies in Peru (Ferrando, 2002), Zambia (Webb, 2000) and South Africa (Moodley and Akinsooto, 2003). These include soap, various alcoholic and non-alcoholic beverages to which large quantities of sugar has been added, herbal extracts, ground bottle with porridge or alcoholic beverages and bleaching agents. Others are Cytotec, Primolut-N, Ergometrine, Gynaecosid and Menstrogen which are obtained mainly from pharmacies and chemical shops.

Crushed bottle with beverage, boiled Fanta/Coca Cola with overdose of painkillers and herbal teas/extracts were three most mentioned materials from the quantitative study. This may, perhaps, be due to the fact that they are cheap and readily available.

Views of respondents to the essay writing on abortion were diverse. While some will encourage a woman to have an abortion, others said they will discourage someone from having an abortion. The extracts below are typical of responses on what the respondents think about abortion:

> "Even though abortion is considered as a sin in the sight of God, abortion in one way or the other has to be committed because, as human as we are, we are bound to get pregnant unwontedly" (unplanned pregnancy) (16 year old female student)
>
> "If abortion is done between the first to third months, it is safe because the baby is not matured. The baby gets destroyed in the womb and comes out as blood". (17 years female student)
>
> " Abortion is the most wicked thing any proper human being could do apart from the situation whereby the baby's mother's life is at stake".(18 years female student)
>
> "I think abortion is a very serious and deadly act and should be stopped by all who practice it because it can end one up being barren for life and even going to the extent of losing one's life". (18 years male student)

5.5 Extent of Pharmaceutical Use

The majority of the facilities received an average of one abortion request per day (33.3%) although quite a number (13.3%) received as many as five or more abortion requests per

day. It was also observed that in most of the facilities, abortion services are requested by both males and females (70%) whiles 26.7% said females are the ones who mostly request for abortion services. This bring to the fore the situation on the ground with regard to abortion-seeking behaviour in the Metropolis. The majority of people who request for abortion services are below 30 years and this was confirmed by the key informants. It is also in line with WHO's report on global abortion (WHO, 2007) and a previous study in Ghana (Ahiadeke, 2001).

Although most of the medicines that are suspected to be used in inducing abortion are prescription only medicines, most of the request comes without prescription. How these people got to know of these drugs may possibly implicate some health professionals. For example, in the interview with the community pharmacist, it was obvious that a person may get these medicines from another facility if she/he is refused by a facility. They are so desperate to abort that nothing will convince them otherwise as expressed by the pharmacist

> "These days, the women are more daring and desperate. They no longer 'corner' you in the pharmacy and ask for such services in private but do so openly, very boldly and sometimes carry empty blisters or containers of the drug they want. This gives the worrisome impression that they are not first time users. The friends who accompany these women seem to have an in-depth knowledge of available options if they do not get the particular drug they asked for. Regular women customers who have asked for such services in time past confirm on subsequent visit that they got the drug that was refused them from other sources".

The most patronized medicine for abortion within the metropolis presently is Cytotec. It is the only medicine that had most facilities (26.7%) receiving five (5) or more request per day for abortion. This was also confirmed by the key informants.

5.6 Knowledge of the Provisions of the Abortion Law

Induced abortion in Ghana is illegal except when the pregnancy resulted from rape, defilement of a female idiot or incest; when continuation of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health; or where there is substantial risk that if the pregnancy were carried to term, the child would suffer from or later develop a serious abnormality or disease (Ahiadeke, 2001; Lithur, 2004; GHS, 2006). Most of the respondents are not aware of this. Although 58.7% of the respondents to the questionnaire for WIFA said abortion is illegal in Ghana, only a minority could give the conditions under which abortion is permitted under the law. There is also a conflict as to what makes abortion legal or illegal in Ghana. While the majority (37.9%) said it is state law that makes abortion illegal, appreciable proportions chose traditions/culture or religion (27.1 % and 13.5%, respectively) with 21.5% not knowing what makes abortion legal or illegal in Ghana.

Although there was a significant difference in the knowledge of legality of abortion between the two communities, observations made during the interviews pointed to the possibility that the WIFA respondents were doing more guess work than stating the fact. There was, however, no significant difference in the knowledge of legality of abortion between the age groups, educational levels and religion.

5.7 Knowledge of Contraceptives

Results from 1998 Ghana National Youth Reproductive Health Survey (GYRHS) indicates that awareness of young people about contraceptives and where to obtain them are high, with condom being the most known method (Awusabo-Asare, 2003). A similar result on the awareness of contraceptives was obtained in the 2003 Ghana Demographic

and Health Survey (Population Council, 2005). The results from this study showed a similar trend, with the condom being the most known method of contraception.

It is believed that availability, accessibility and affordability of family planning services and its ability to meet demand are sure ways of reducing unwanted pregnancies (Ahman & Shah, 2004) and, therefore, induced abortions. The results from the study show the misconception or misinformation about the use of contraceptives. Most of the respondents said married women (31.5%) and married men (19.8%) are supposed to use contraceptives and the most stated reason was to space child birth. On the other hand, teenagers are not supposed to use contraceptives (35.8%) because “they are not married, they can become barren and it is a sin for them to indulge in sex”. In the opinion of one key informant,

> “….the problem is cultural and religious. They teach the young not to have pre-marital sex. The young men and women are pretending of not having sex but a lot of sexual activities are going on. There is poor utilization of contraception, lots of negative perception on contraceptives. They don’t accept it”.

The view of another key informant is;

> “… You sometimes ask yourself whether they (women who abort) have not heard of HIV and how you can get it. Obviously they know it is sexually transmitted, so you ask them why condom was not used if they are not married to the person. Why wasn’t a condom used? To a large extent I will say it’s not ignorance, they just don’t care!”

5.8 Conclusion

This chapter has discussed the results obtained from the study and placed in the context of its stated specific objectives and available literature on studies in the area of abortion. Whereas women seek abortion services for varied reasons and from varied sources,

several substances (most of them dangerous) are used in terminating pregnancies. There are varied perceptions on abortion and the use of contraceptives. The next chapter gives a conclusion based on these results and analysis.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.0 Conclusions

It is a known fact that unsafe abortions and complications arising from them are major contributing factors to maternal deaths (WHO, 2007). Apart from the liberalization of abortion laws, there is the need to promote uptake of contraceptives focused on reducing unwanted pregnancies which may place a woman in a position to consider having an abortion.

The study has identified that women in the Tema Metropolis seek abortion services from a variety of sources. An appreciable proportion knows of specific places where abortion services could be obtained and these places are health facilities, the majority of which are privately owned facilities.

Women in the metropolis resort to abortions for various reasons that are comparable to those identified in studies in other developing countries. The five most stated reasons were: (a) when the woman considers her life to be at risk because of the pregnancy, (b) physical immaturity, (c) when there is a potential danger to the health of the foetus, (d) when the pregnancy was as a result of rape and (e) poor spacing of child birth.

Although women in the metropolis have knowledge on abortion and its complications, their knowledge is limited to induced abortions. The majority also perceives abortion as a

bad practice and that abortion services should not be made available to every woman because the services will be abused.

Several 'prescription only' medicines that are obtained from pharmacies are being requested for the purposes of terminating pregnancies. Chief among these medicines is Cytotec and it is also the medicine that most patients who reported to the health facilities with incomplete abortions reportedly took. Pharmacies and chemical shops are reporting an average of two abortion request per day with most of those making the request in their twenties.

Knowledge of the provisions of the abortion law in Ghana is poor. There is also a conflict as to what really regulates abortion in Ghana; state law, traditions/culture or religion.

The majority of women in the metropolis know of at least one modern method of contraception, with condom being the most known method.

6.1 Recommendations

- The Tema Metro Health Directorate need to monitor the activities of the facilities that were mentioned to be providing abortion services to ensure that the services

are being provided legally and under safe conditions in order to secure the safety of women who visit such facilities.

- The Health Promotion Unit of the Directorate need to step up its activities to promote use of contraceptives especially among the youth.
- M.O.H should consider setting up functional, friendly and easily accessible adolescent and reproductive units in the various public health facilities in the Metropolis to provide appropriate counselling services on reproductive health and abortion.
- Pharmacies/chemical shops need to be properly monitored to ensure that abortifacient medicines are not dispensed over-the-counter but only with valid prescription. Ghana Pharmacy Council and Food and Drugs Board should also regulate the activities of quacks who sell these medicines illegally.

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Appendix 1: Sample Size Calculation

The sample size is given by the formula

$$n = \frac{z^2pq}{d^2}$$

Where z = z –value for the confidence interval

p = proportion of women between 15 – 49 years who resort to abortion or the incidence of abortion in women aged 15 – 49 years

q = 1 – p

d = margin of error

n = sample size

At 95 % confidence interval and error margin of 5 %, with incidence of 17 abortions per 1000 WIFA (Incidence in Ghana: Ahiadeke, 2001), the minimum sample size is

$$n = \frac{(1.96^2)(0.17)(0.83)}{0.05^2} = 216.82 \approx 217$$

At 95 % confidence interval and error margin of 5 %, with incidence of 24 abortions per 1000 WIFA (Incidence in West Africa: WHO 2007), the minimum sample size is

$$n = \frac{(1.96^2)(0.28)(0.72)}{0.05^2} = 309.7 \approx 310$$

Three Hundred (300) participants (women aged between 15 and 49 years) were involved in the study.

Appendix 2: Additional Tables

Table A: Distribution of respondents by reason for seeking abortion and by community

Reason [a]		Community		Total (% of Total)
		Community 7	**Tema New-Town**	
Too young to be a mother	Freq.	67	43	110 (36.7%)
	% within community	**33.5%**	**43.0%**	
The mother's life at risk	Freq.	97	63	160 (53.3%)
	% within community	**48.5%**	**63.0%**	
Not ready for another child	Freq.	57	15	72 (24.0%)
	% within community	**28.5%**	**15.0%**	
The need to continue education	Freq.	39	22	61 (20.3%)
	% within community	**19.5%**	**22.0%**	
Pregnancy was as a result of rape	Freq.	80	17	97 (32.3%)
	% within community	**40.0%**	**17.0%**	
Pregnancy was as a result of incest	Freq.	44	5	49 (16.3%)
	% within community	**22.0%**	**5.0%**	
Boyfriend did not accept responsibility	Freq.	30	12	42 (14.0%)
	% within community	**15.0%**	**12.0%**	
Pregnancy would interfere with career / job	Freq.	21	12	33 (11.0%)
	% within community	**10.5%**	**12.0%**	
Potential danger to the health of the foetus	Freq.	78	23	101 (33.7%)
	% within community	**39.0%**	**23.0%**	
Doesn't want people to know that she had sex or got pregnant	Freq.	14	8	22 (7.3%)
	% within community	**7.0%**	**8.0%**	
Economic Reasons	Freq.	31	10	41 (13.7%)
	% within community	**15.5%**	**10.0%**	
Others	Freq.	0	1	1 (.3%)
	% within community	**0.0%**	**1.0%**	
No Reason [b]	Freq.	6	3	9 (3.0%)
	% within community	**3.0%**	**3.0%**	
Total	Freq.	200	100	300 (100.0%)

Percentages and totals are based on respondents.

a. Dichotomy group tabulated at value 1. b. Did not check any of the multiple responses

Table B: Distribution of respondents by reason for seeking abortion and by level of education

Reason [a]		Level of Education				Total *(% of Total)*
		Basic	**Secondary**	**Tertiary**	**None**	
Too young to be a mother	Freq.	57	27	16	10	110
	% of Group	**36.3**	**30.3**	**42.1**	**62.5**	*(36.7)*
The mother's life at risk	Freq.	81	44	27	8	160
	% of Group	**51.6**	**49.4**	**71.1**	**50.0**	*(53.3)*
Not ready for another child	Freq.	33	19	15	5	72
	% of Group	**21.0**	**21.3**	**39.5**	**31.2**	*(24.0)*
The need to continue education	Freq.	32	14	10	5	61
	% of Group	**20.4%**	**15.7%**	**26.3%**	**31.2%**	*(20.3)*
Pregnancy was as a result of rape	Freq.	54	28	14	1	97
	% of Group	**34.4%**	**31.5%**	**36.8%**	**6.2%**	*(32.3)*
Pregnancy was as a result of incest	Freq.	26	14	8	1	49
	% of Group	**16.6%**	**15.7%**	**21.1%**	**6.2%**	*(16.3)*
Boyfriend did not accept responsibility	Freq.	24	9	7	2	42
	% of Group	**15.3%**	**10.1%**	**18.4%**	**12.5%**	*(14.0)*
Pregnancy would interfere with career / job	Freq.	15	9	7	2	33
	% of Group	**9.6%**	**10.1%**	**18.4%**	**12.5%**	*(11.0)*
Potential danger to the health of the foetus	Freq.	44	33	20	4	101
	% of Group	**28.0%**	**37.1%**	**52.6%**	**25.0%**	*(33.7)*
Doesn't want people to know that she had sex or got pregnant	Freq.	10	5	5	2	22
	% of Group	**6.4%**	**5.6%**	**13.2%**	**12.5%**	*(7.3%)*
Economic Reasons	Freq.	22	14	3	2	41
	% of Group	**14.0%**	**15.7%**	**7.9%**	**12.5%**	*(13.7)*
Others	Freq.	0	1	0	0	1
	% of Group	**0.0%**	**1.1%**	**0.0%**	**0.0%**	*(.3%)*
No Reason [b]	Freq.	5	3	1	0	9
	% of Group	**3.2%**	**3.4%**	**2.6%**	**0.0%**	*(3.0)*

Total	**Freq.**	**157**	**89**	**38**	**16**	**300** *(100)*

Table C: Distribution of respondents by reason for seeking abortion and by age group

Reason [a]		**Age Group**							**Total** *(% of Total)*
		15-19	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	
Too young to be a mother	Freq.	24	30	31	7	11	4	3	110
	% within Group	41.4%	40.0%	39.7%	21.2%	35.5%	33.3%	23.1%	*(36.7)*
The mother's life at risk	Freq.	20	40	51	18	18	5	8	160
	% within Group	34.5%	53.3%	65.4%	54.5%	58.1%	41.7%	61.5%	*(53.3)*
Not ready for another child	Freq.	6	18	20	8	12	4	4	72
	% within Group	10.3%	24.0%	25.6%	24.2%	38.7%	33.3%	30.8%	*(24.0)*
The need to continue education	Freq.	15	15	15	4	6	3	3	61
	% within Group	25.9%	20.0%	19.2%	12.1%	19.4%	25.0%	23.1%	*(20.3)*
Pregnancy was as a result of rape	Freq.	16	22	25	16	10	4	4	97
	% within Group	27.6%	29.3%	32.1%	48.5%	32.3%	33.3%	30.8%	*(32.3)*
Pregnancy was as a result of incest	Freq.	6	13	15	7	4	1	3	49
	% within Group	10.3%	17.3%	19.2%	21.2%	12.9%	8.3%	23.1%	*(16.3)*
Boyfriend did not accept responsibility	Freq.	9	12	12	5	2	1	1	42
	% within Group	15.5%	16.0%	15.4%	15.2%	6.5%	8.3%	7.7%	*(14.0)*
Pregnancy would interfere with career / job	Freq.	10	8	10	1	1	2	1	33
	%	17.2%	10.7%	12.8%	3.0%	3.2%	16.7%	7.7%	*(11.0)*
Potential danger to the health of the foetus	Freq.	12	27	30	13	10	3	6	101
	% within Group	20.7%	36.0%	38.5%	39.4%	32.3%	25.0%	46.2%	*(33.7)*
Doesn't want people to know that she had sex or got pregnant	Freq.	9	4	6	1	0	0	2	22
	% within Group	15.5%	5.3%	7.7%	3.0%	.0%	.0%	15.4%	*(7.3)*
Economic	Freq.	9	10	10	5	4	1	2	41
	%	15.5%	13.3%	12.8%	15.2%	12.9%	8.3%	15.4%	*(13.7)*

Reasons	within Group								
Others	Freq.	0	0	1	0	0	0	0	1 (.3)
	% within Group	.0%	.0%	1.3%	.0%	.0%	.0%	.0%	
No Reason [b]	Freq.	1	2	2	2	0	1	1	9 (3.0)
	% within Group	1.7%	2.7%	2.6%	6.1%	.0%	8.3%	7.7%	
Total	Freq.	58	75	78	33	31	12	13	300 (100)

Percentages and totals are based on respondents.

a. Dichotomy group tabulated at value 1. b. Did not check any of the multiple responses

(Source: Field Data, June 2008)

Table D: Distribution of respondents within WIFA in Tema Metropolis by occupation and whether it is right to have an abortion or not.

Occupation	**Is it Right to undergo Abortion?**				**Total**
		Yes	**No**	**Don't Know**	
Civil /Public Servant	Freq.	11	15	5	31
	% within Group	35.5%	48.4%	16.1%	
Trader	Freq.	16	60	5	81
	% within Group	19.8%	74.1%	6.2%	
Fish Monger	Freq.	0	3	2	5
	% within Group	.0%	60.0%	40.0%	
Artisan	Freq.	10	41	9	60
	% within Group	16.7%	68.3%	15.0%	
Student	Freq.	14	42	4	60

	% within Group	23.3%	70.0%	6.7%	
Unemployed	Freq.	10	39	3	52
	% within Group	19.2%	75.0%	5.8%	
Others	Freq.	2	8	1	11
	% within Group	18.2%	72.7%	9.1%	
Total	Freq.	63	208	29	300
	% of Total	**21.0%**	**69.3%**	**9.7%**	**100.0%**

Table E: Distribution of respondents within WIFA in Tema Metropolis by age group and whether it is right to have an abortion or not.

Age Group	Is it Right to undergo Abortion?				Total
		Yes	**No**	**Don't Know**	
15-19	Freq.	13	41	4	58
	% within Group	22.4%	70.7%	6.9%	
20-24	Freq.	13	55	7	75
	% within Group	17.3%	73.3%	9.3%	
25-29	Freq.	20	51	7	78
	% within Group	25.6%	65.4%	9.0%	
30-34	Freq.	9	23	1	33
	% within Group	27.3%	69.7%	3.0%	
35-39	Freq.	6	17	8	31
	% within Group	19.4%	54.8%	25.8%	
40-44	Freq.	1	10	1	12
	% within Group	8.3%	83.3%	8.3%	
45-49	Freq.	1	11	1	13
	% within Group	7.7%	84.6%	7.7%	
Total	Freq.	63	208	29	300
	% of Total	21.0%	69.3%	9.7%	100.0%

Table F: Distribution of respondents within WIFA in Tema Metropolis by religion and whether it is right to have an abortion or not.

Religion	Is it Right to undergo Abortion?				Total
		Yes	No	Don't Know	
Christian	Freq.	62	200	28	290
	% within Religion	21.4%	69.0%	9.7%	
Muslim	Freq.	1	7	0	8
	% within Religion	12.5%	87.5%	.0%	
Traditional	Freq.	0	0	1	1
	% within Religion	0.0%	0.0%	100.0%	
Others	Freq.	0	1	0	1
	% within Religion	0.0%	100.0%	0.0%	
Total	Freq.	63	208	29	300
	% of Total	**21.0%**	**69.3%**	**9.7%**	**100.0%**

Table G: Distribution of respondents within the Age group of women in Tema Metropolis by known abortifacient

Substance/ Material	Age Group						
	15-19	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**
Washing Powder	5.2%	2.7%	10.3%	3.0%	.0%	8.3%	7.7%
Crushed Bottle with beverage	22.4%	34.7%	30.8%	30.3%	35.5%	33.3%	30.8%
Washing Blue	10.3%	4.0%	6.4%	15.2%	16.1%	8.3%	15.4%
Cytotec	10.3%	28.0%	16.7%	21.2%	9.7%	8.3%	7.7%
Menstrogen	6.9%	12.0%	6.4%	12.1%	.0%	.0%	15.4%
Boiled Fanta / Coca Cola with overdose of painkillers	13.8%	18.7%	29.5%	21.2%	22.6%	8.3%	15.4%
Ergot	5.2%	9.3%	9.0%	12.1%	9.7%	.0%	7.7%
Saccharin	5.2%	5.3%	2.6%	3.0%	.0%	.0%	7.7%
Herbal Teas and Extracts	22.4%	32.0%	42.3%	57.6%	48.4%	25.0%	30.8%
Soap	6.9%	4.0%	5.1%	3.0%	3.2%	.0%	7.7%

Others	25.9%	16.0%	17.9%	18.2%	22.6%	.0%	7.7%
No material [b]	31.0%	21.3%	16.7%	9.1%	22.6%	50.0%	46.2%

Percentages and totals are based on respondents.

a. Dichotomy group tabulated at value 1.b. Did not check any of the multiple responses

Table H: Distribution of WIFA within the various age groupings by knowledge of Conditions under which abortion is permitted

Condition under which abortion is permitted	Age Group						
	15-19	20-24	25-29	30-34	35-39	40-44	45-49
Pregnancy as a result of rape or defilement of a female idiot	39.7%	30.7%	41.0%	36.4%	48.4%	41.7%	30.8%
Pregnancy as a result of incest	19.0%	25.3%	34.6%	42.4%	38.7%	16.7%	15.4%
Mother's life at risk because of the pregnancy	39.7%	54.7%	61.5%	57.6%	61.3%	58.3%	69.2%
Possible injury to the physical and mental health of the mother	17.2%	25.3%	41.0%	45.5%	25.8%	50.0%	38.5%
Child at risk of developing serious deformity	19.0%	28.0%	33.3%	42.4%	38.7%	33.3%	38.5%
Economic or Social Reasons	31.0%	18.7%	19.2%	27.3%	22.6%	8.3%	.0%
Teenager	36.2%	17.3%	19.2%	9.1%	9.7%	.0%	15.4%
Others	.0%	.0%	3.8%	3.0%	.0%	.0%	.0%
None [b]	5.2%	12.0%	1.3%	6.1%	6.5%	.0%	23.1%

Table I: Distribution of WIFA within the various levels of education by knowledge of Conditions under which abortion is permitted

Condition under which abortion is permitted [a]	Level of Education			
	Basic	Secondary	Tertiary	None
Pregnancy as a result of rape or defilement of a female idiot	38.9%	40.4%	23.7%	50.0%
Pregnancy as a result of incest	30.6%	28.1%	23.7%	31.2%
Mother's life at risk because of the pregnancy	47.8%	60.7%	73.7%	56.2%
Possible injury to the physical and mental health of the mother	27.4%	31.5%	52.6%	25.0%
Child at risk of developing serious deformity	22.9%	37.1%	52.6%	25.0%
Economic or Social Reasons	28.0%	13.5%	13.2%	18.8%
Teenager	24.8%	11.2%	13.2%	18.8%
Others	1.9%	1.1%	.0%	.0%
None [b]	5.7%	6.7%	7.9%	12.5%

Percentages and totals are based on respondents.

a. Dichotomy group tabulated at value 1. b. Did not check any of the multiple responses

Table J: Distribution of respondents by Community and Contraceptives Known

Community		Known Contraceptive									Total
		Condom	IUD	Implant	Injectable	Vasectomy	Tubal ligation	Oral contraceptive	Others	None	
Community 7	Freq	154	34	22	87	27	16	88	7	3	200
	% of Total	51.3%	11.3%	7.3%	29.0%	9.0%	5.3%	29.3%	2.3%	1.0%	66.7%
Tema New-Town	Freq	80	30	26	38	9	6	30	0	2	100
	% of Total	26.7%	10.0%	8.7%	12.7%	3.0%	2.0%	10.0%	.0%	.7%	33.3%
Total	Freq	234	64	48	125	36	22	118	7	5	300

	% of Total	78.0%	21.3%	16.0%	41.7%	12.0%	7.3%	39.3%	2.3%	1.7%	100.0%

Appendix 3 – Questionnaire for WIFA

DEPARTMENT OF SOCIAL AND BEHAVIOURAL SCIENCES,

SCHOOL OF PUBLIC HEALTH,

COLLEGE OF HEALTH SCIENCES, UNIVERSITY OF GHANA

Questionnaire on Abortion – Related Help – Seeking Behaviour Among Females in the Tema Metropolis

Questionnaire #:_ _ _ **Community**: ………………… **House #**: ……………

Date: ……………….. **Interviewer**: ……………………………………………

Kindly fill in the blank spaces or tick appropriately

Part I: Background Information

1. Age (as at last birthday): ……………………………

2. Level of Education: Basic [ ], Secondary [ ], Tertiary [ ], None [ ]

3. Occupation: ………………………………………..

4. Marital Status: Single [ ], Married [ ], Divorced [ ], Widowed [ ], Living together [ ]

5. Number of children: None [ ], 1 - 2 [ ], 3 - 4 [ ], 5 and above [ ]

6. Religion: Christian [ ], Muslim [ ], Traditional [ ], others: (specify)..........................

7. Ethnicity: Akan [ ], Ga/Dangbe [ ], Ewe [ ], Guan [ ]
Mole-Dagomba [ ], Hausa [ ] others: (specify) ....

Part II:

9. Which contraceptives do you know? Condom [ ], IUD [ ], Implant [ ], Injectable [ ], Vasectomy [ ], Tubal Ligation [ ], Oral Contraceptives [ ], others (specify): ………………………………….

10. Where can contraceptives be obtained? Pharmacy [ ], Chemical shop [ ], Hospital [ ], Maternity homes [ ], others (specify): ……………………………

11. In your opinion, which category of people should use contraceptives? Married men [ ], Married Women [ ], Teenagers [ ], Single Men [ ], Single Women [ ]

Others (specify)………………………………………………………………………….

Reason: ………………………………………………………………………………

…………………………………………………………………………………………

12. Which group(s) of people are **NOT** supposed to use contraceptives? Married men [ ], Married women [ ], Teenagers [ ], Single Men [ ], Single Women [ ], others (specify)……...

Reason: ………………………………………………………………………………

……………………………………………………………………………………….

13. Have you used a contraceptive before? Yes [ ], No [ ]

If yes, which type(s): …………………………………….

14. Is abortion legal in Ghana? Yes [ ], No [ ], Don't Know [ ]

15. What makes abortion legal or illegal in Ghana?

State Law [ ] Traditions/ Culture [ ] Religion [ ] other [ ] (specify) …………………

16. Is it right to undergo abortion? Yes [ ], No [ ], Don't Know [ ]

Reason: ……………………………………………………………………………….

…………………………………………………………………………………………

17. Should abortion services be made available to every woman?

Yes [ ], No [ ], Don't know [ ]

Reason: ………………………………………………………………………………

………………………………………………………………………………………

18. Under what condition(s) do you think abortion should be permitted?

Pregnancy was as a result of rape or defilement of a female idiot [ ]

Pregnancy was as a result of incest [ ]

Mother's life at risk because of the pregnancy [ ]

Possible injury to the physical and mental health of the mother [ ]

Child at risk of developing serious physical abnormality or disease [ ]

Economic or social reasons [ ]

Teenager [ ]

Others (specify): ……………………………………………………………

19. Why would a woman resort to abortion?

Too young to be a mother [ ]

The mother's life at risk [ ]

Not ready for another child [ ]

The need to continue education [ ]

Pregnancy was as a result of rape [ ]

Pregnancy was as a result of incest [ ]

Boyfriend did not accept responsibility [ ]

Pregnancy would interfere with career / job [ ]

Potential danger to the health of the foetus [ ]

Doesn't want people to know that she had sex or got pregnant [ ]

Economic Reasons [ ]

Others (specify)…………………………………………………………………

20. Under what condition(s) should abortion not be permitted and why? …………………

……………………………………………………………………………………………

……………………………………………………………………………………………

21. Do you know any place where women go for abortion services in the Tema Metropolis?

Yes [ ], No [ ]

Name place(s) if Yes: ………………………………………………………………

22. Who is likely to be contacted first for advice / help when a woman considers an abortion as an option for unwanted pregnancy?

Mother [ ], Father [ ], Friend [ ], Boyfriend [ ], Nurse [ ], others (specify):

………………………………………………………………………………

23. Who should bear the cost of abortion service? The Woman [ ], the Man responsible [ ], Both Man and Woman [ ], Parents [ ], Government [ ], Others (specify): …………

Reason:

…………………………………………………………………………………………

…………………………………………………………………………………………

24. Who should pay for the cost of complications from abortion?

The Woman [ ], the Man responsible [ ], Parents [ ], Government [ ],

Others (specify): ……………………………………….

Reason: ………………………………………………………………………………

....

25. Do you know of any place in the metropolis where counsel or advice on reproductive health and abortion could be obtained? Yes [ ], No [ ]

If YES, name the place(s)………………………………………………………

26. Is it important to have a centre that provides counselling on reproductive health and abortion in the metropolis? Yes [ ], No [ ], Don't Know [ ]

Reason: ……………………………………………………………………………

……………………………………………………………………………………

27. What are some of the items / substances that are used to cause abortion?

Washing powder [ ]

Crushed bottle with beverage [ ]

Washing blue [ ]

Cytotec [ ]

Menstrogen [ ]

Ergot [ ]

Saccharine [ ]

Herbal teas and extracts [ ]

Soap [ ]

Boiled Fanta / Coca Cola with overdose of painkillers [ ]

Others (specify)...

28. Why would a woman choose the substances selected in Q.27 above? ....

....

Appendix 4 – Questionnaire for pharmacies/chemical shops

DEPARTMENT OF SOCIAL AND BEHAVIOURAL SCIENCES,

SCHOOL OF PUBLIC HEALTH, COLLEGE OF HEALTH SCIENCES,

UNIVERSITY OF GHANA

Abortion – Related Help – Seeking Behaviour among Females in the Tema Metropolis

Questionnaire for Pharmacies and Licensed Chemical Shops

Questionnaire #: _ _ _ **Date:** …………….

Facility: Pharmacy [ ], Chemical Shop [ ]

Kindly fill in the blank spaces or tick appropriately

Respondent:

Pharmacist [ ], Dispensing technician/technologist [ ],

Pharmacy Counter Assistant [ ], Licensed Chemical Seller [ ],

Others (specify): …………………………………………………………………………

Sex of Respondent: Male [ ], Female [ ]

PART I:

1. How often do people ask for the following medicines?

Menstrogen: <2 times per day [ ], 2-4 times per day [ ], 5 or more times per day [ ]

Ergot :< 2 times per day [ ], 2-4 times per day [ ], 5 or more times per day [ ]

Cytotec: <2 times per day [ ], 2-4 times per day [ ], 5 or more times per day [ ]

ECP: < 2 times per day [ ], 2-4 times per day [ ], 5 or more times per day [ ]

2. In what form do they mostly request for these medicines? (*Please tick appropriately*)

Name of Drug	No Prescription	Invalid Prescription	Valid Prescription
Menstrogen			
Ergot			
Cytotec			
ECP			

3. In your opinion, what do you think these medicines (i.e. Menstrogen, Ergot and Cytotec) are being used for? ....

....

4. What class of medicines do they belong to? (*Please tick appropriately*)

Name of Drug	Prescription Only	Pharmacy Only	OTC	Don't Know
Menstrogen				
Ergot				
Cytotec				
ECP				

5. Do these medicines have any effect on pregnancy?

Yes [ ], No [ ], Don't know [ ]

PART II

6. How often do people request for abortion services from your facility? (person*(s) per day*)

None [ ], 1(one) [ ], 2(two) [ ], 3(three) [ ], 4(four) [ ], 5 (five) or more [ ]

7. Which of these groups of people **mostly** request for abortion services from your facility?

Males [ ], Females [ ], Both Males and Females [ ]

8. Which age group normally request for abortion services?

(*Please rank them 1 – 5; 1=highest, 5=least)*

Age group	15 – 19yrs	20 – 24 yrs	25 – 29 yrs	30 – 34yrs	35 yrs and above
Rank					

9. What drugs do you know or suspect to be used in terminating pregnancy?

....

10. Is abortion legal in Ghana? Yes [ ] No [ ] Don't Know [ ]

11. What makes abortion legal or illegal in Ghana? State Law [ ] Traditions/Customs [ ] Religion [ ] others (specify)………………………………………………….

12. Under what condition(s) is (are) abortion permitted?

Pregnancy was as a result of rape or defilement of a female idiot [ ]

Pregnancy was as a result of incest [ ]

Mother's life at risk because of the pregnancy [ ]

Possible injury to the physical and mental health of the mother [ ]

Child at risk of developing serious physical abnormality or disease [ ]

Economic or social reasons [ ]

Teenager [ ]

13. Should abortion services be made available to every woman?

Yes [ ], No [ ], Don't know [ ]

14. What are your reasons for your answer in 13 above? ....

……………………………………………………………………………………………

15. Any comment / observation / other information on abortion seeking behaviours of females………………………………………………………………………………

……………………………………………………………………………………………

……………………………………………………………………………………………

……………………………………………………………………………………………

……………………………………………………………………………………………

……………………………………………………………………………………………

……………………………………………………………………………………………

……………………………………………………………………………………………

Appendix 5 – Essay Writing Format

<u>Write an essay on what you know or have heard about abortion.</u>

Be guided by the following in addition to whatever you know:

i. *What abortion is*

ii. *Where people get information on abortion*

iii. *Reasons people do abortion*

iv. *Why someone will / will not commit abortion*

v. *Why you would encourage/discourage someone from having an abortion*

vi. *Places where abortion is done*

vii. *Substances /materials that are used for abortion*

viii. *What you think about abortion*

ix. *Whether Ghana has a law that regulates abortion and what it says if there is any*

You can write as much as you can.

Age:

Sex:

Place of residence:

Religion:

Ethnicity:

Appendix 6 – IDI Guide for Medical Doctors

ABORTION – RELATED HELP – SEEKING BEHAVIOUR AMONG FEMALES IN THE TEMA METROPOLIS

Key Informants Interview Guide

Date: …………………   Interviewer: …………………………………………

Name of Interviewee: ………………………………………………………….

Position/ Rank: ………………………………………………………………

Institution: ……………………………………………………………………….

1. What do we mean when we say someone has had an abortion?
2. Is abortion an issue that should be of health concern? Why?

3. How often do women come to this facility to request for abortion services?
4. Do they come alone or with their partners or accompanied by someone else?
5. In your experience with women who request for abortion, can you give the age range that usually request for these services?
6. What are some of the reasons these women give for requesting for abortion services?
7. What do you do to such women?
8. How often do people present to this facility with abortion complications or incomplete abortions?
9. What are some of these complications?
10. What can you say about the knowledge of women in the metropolis on abortion? (Good / Wrong information / the consequences of their actions)
11. What can be done about it?
12. What are your comments on the provisions relating to abortion in the GHS protocol on CAC?
13. Should abortion services be made available to every woman?
14. What are your reasons?
15. Any other information or comment on the incidence of abortion in the metropolis, be it safe or unsafe?

Appendix 7- IDI Guide for Community Pharmacist

ABORTION – RELATED HELP – SEEKING BEHAVIOUR AMONG FEMALES IN THE TEMA METROPOLIS

Key Informants Interview Guide

Date: …………………   Interviewer: …………………………………………

Name of Interviewee: ………………………………………………………….

Position/ Rank: ……………………………………………………………………

Institution: ……………………………………………………………………….

1. Some of the community pharmacies are reporting of increasing number of women requesting for abortion services. What has been your own experience?
2. How serious is the situation, in terms of the number of people requesting for the service or drugs? (Rank age groups)
3. Do you think it should be of concern? What are your reasons?
4. What are some of the medicines that you suspect as being used to terminate pregnancies? In what form do they request for these drugs? Do they give reason(s) for asking these drugs?
5. What suggestions would you make as the way forward?

Appendix 8- Consent Form for WIFA

Consent Form I

ABORTION – RELATED HELP - SEEKING BEHAVIOURS AMONG FEMALES IN THE TEMA METROPOLIS

This study is seeking to identify the help – seeking behaviour of women with unwanted pregnancy in the metropolis in relation to abortion. It is the dissertation of JOEL J. IDUN – ACQUAH and is a requirement for the award of Master of Public Health at the School of Public Health, University of Ghana. The study results will help in planning and implementing policies on reproductive health in the metropolis, especially for women.

All information given by the respondent will be treated with confidentiality and his / her name or identity will not be disclosed to anyone. You are free to join or opt out of this study.

Append your signature or thumbprint if you willingly agree to take part in the study.

I (Name)…………………………………………………………………………… have read the foregoing information, or it has been read to me and I consent voluntarily to participate as a subject in this study.

Signature or Thumbprint:

Appendix 9 – Consent form for IDI

Consent Form II (In-depth Interview)

ABORTION – RELATED HELP - SEEKING BEHAVIOURS AMONG FEMALES IN THE TEMA METROPOLIS

This study is seeking to identify the help – seeking behaviour of women with unwanted pregnancy in the metropolis in relation to abortion. It is the dissertation of JOEL J. IDUN – ACQUAH and is a requirement for the award of Master of Public Health at the School of Public Health, University of Ghana. The study results will help in planning and implementing policies on reproductive health in the metropolis, especially for women.

All information given by the respondent will be treated with confidentiality and his / her name or identity will not be disclosed to anyone. This interview will be audio taped for transcription purposes and will be in the possession of only the principal investigator. You are free to join or opt out of this study.

Append your signature or thumbprint if you willingly agree to take part in the study.

I (Name)………………………………………………………………………………… have read the foregoing information, or it has been read to me and I consent voluntarily to participate as a subject in this study.

Signature or Thumbprint:

Appendix 10- Consent form for Essay Writing

Consent Form III

ABORTION – RELATED HELP - SEEKING BEHAVIOURS AMONG FEMALES IN THE TEMA METROPOLIS

This study is seeking to identify the help – seeking behaviour of women with unwanted pregnancy in the metropolis in relation to abortion. It is the dissertation of JOEL J. IDUN – ACQUAH and is a requirement for the award of Master of Public Health at the School of Public Health, University of Ghana. The study results will help in planning and implementing policies on reproductive health in the metropolis, especially for women.

All information given by the respondent will be treated with confidentiality and his / her name or identity will not be disclosed to anyone. You are free to join or opt out of this study.

Append your signature if you willingly agree to take part in the study.

I have read the foregoing information, or it has been read to me and I consent voluntarily to participate as a subject in this study.