

UNIVERSITY OF CAPE COAST

DECISION MAKING PROCESS OF FEMALES SEEKING
ABORTION AT ASHIAMAN

MERCY NANA AKUA OTSIN

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ASHIAMAN

BY

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Thesis submitted to the Department of Population and Health, Faculty of Social Sciences, University Of Cape Coast in partial fulfilment of the requirements for award of Master of Philosophy Degree in Population and Health

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DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original work and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Name:

Signature:..... Date:.....

Supervisors' Declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Principal Supervisor's Name:.....

Signature: Date:.....

Co-Supervisor's Name:.....

Signature: Date:.....

ABSTRACT

Despite the amendment of Ghana's abortion laws in 1985, aimed at increasing access to safe abortion services, abortion has consistently been an important contributor to maternal morbidity and mortality in the country. Within the current context, this study explored the decision making process of females seeking abortion.

The study was undertaken in Ashiaman, located in the Greater Accra region. It was based on 28 in-depth interviews among females between the ages of 15 and 30 years. The data were analysed manually using Miles and Huberman's framework and the social ecological model as guides.

Among the factors influencing the decision to abort a pregnancy were economic difficulties, child spacing, fear of parental reaction, meeting career and educational objectives, attitude of partner, impregnated by someone other than the regular partner and health concerns. Only 7% of the participants were aware of Ghana's abortion law. Sixty four percent of the participants decided with partners to abort and in 18% of the cases friends and other family members were involved. On the choice of facility, friends, family members, partners and health workers played diverse roles in the process. Based on the findings the study concluded that the abortion decision making process was a complex one involving various stake holders and that for the design and implementation of appropriate interventions there was a need to draw on the voices of all the stakeholders.

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DEDICATION

This work is dedicated to all the study participants for sharing their stories with me.

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LIST OF ACRONYMS

BBC	British Broadcasting Corporation
D and C	Dilation and Curettage
FHI	Family Health International
GSS	Ghana Statistical Service
ICPD	International Conference on Population and Development
IMMPACT	Initiative for Maternal Mortality Programme Assessment
IPAS	International Projects Assistance Services
MSI	Marie Stopes International
NMMR	Noguchi Memorial Institute for Medical Research
NGO's	Non-governmental Organisations
NDPC	National Development Planning Commission
PNDC	Provisional National Defence Council
UN	United Nations
UNFPA	United Nations Population Fund
UNDP	United Nations Development Programme
R3M	Reducing Maternal Morbidity and Mortality
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

“Why is abortion, experienced by 81 women around the world every minute, silenced and ignored even by organisations dedicated to women’s health?”,

(Kumar, Hessini & Mitchell, 2009, p.2)

Background to the study

The challenge associated with abortions is reflected in the quote above. Induced abortions have been practised in human societies since time immemorial. The seminal work of Devereux (1976) points to its frequency across time and culture. It is known to have been practised by pre-historic people from all over the world. In ancient Rome, Greece and Africa there are evidences which attest to the fact that abortion was practised (Ogiamien, 1991; Morhee & Morhee, 2006). Abortion was achieved by various means during that era, some of which were the use of mercury as an abortifacient, in China some 5000 years ago (World Health Organisation, 2007). Other methods used in inducing abortion were the application of pressure outside the womb, the use of vigorous abdominal massage, lifting of heavy weights, insertion of chicken bone and drinking various herbal preparations (Grimes, et. al., 2006). Women used and are still using these methods to induce abortion despite the risk that they put their life and health to.

Although the past three decades have witnessed an increase in the worldwide use of contraceptives, unwanted and unplanned pregnancies still occur throughout the industrialised and the less industrialised world (World Health Organisation, 2003; Grimes, et. al., 2006). Every year an estimated 210 million pregnancies occur globally. Out of this number, 130 million end in live

births, and with the remaining 80 million, an estimated 40 to 50 million, end in abortions most of which are unsafe, and the remainder ends in either still birth or spontaneous abortion (World Health Organisation, 2007; 2008). The estimates further revealed that out of every five pregnancies which occur worldwide one ends in an abortion (Sedgh, Singh, Hensahw, Ahman & Shah, 2007). Additionally, unknown numbers of women attempt to abort their pregnancies but are unsuccessful (Karamae & Spender, 2000).

Abortion is defined as the termination of a pregnancy before the foetus is capable of extrauterine life, and could be induced or spontaneous (World Health Organisation, 1995; 2008). Induced abortion is the deliberate interference of a pregnancy, with the aim of terminating it, whereas spontaneous abortion occurs naturally without any deliberate means in ending the pregnancy (World Health Organisation, 1994; 2008). Induced abortion, can be for therapeutic reasons, it could also be for elective or voluntary reasons and could be legal or illegal (Macpherson, 2002; World Health Organisation, 2008). Therapeutic abortions often refer to legally sanctioned abortions carried in instances of rape, foetal abnormalities and to protect the mental and physical health of the woman. Voluntary or elective abortion is the interruption of a pregnancy for reasons other than foetal abnormalities or maternal risk (World Health Organisation, 1995; MacPherson, 2002).

Legal abortion is an abortion performed by a licensed physician or someone acting under the supervision of a licensed physician. Illegal abortion is the one that is either self-induced or induced by someone who is not a physician or not acting under the supervision of a physician. An abortion is also said to be illegal, even if it is induced by a physician but violates the laws

of the state governing abortions (MacPherson, 2002; World Health Organisation, 2008).

Unsafe abortion is defined by the World Health Organisation (WHO) as a procedure for terminating an unintended pregnancy either by individuals without the necessary skills or in an environment that does not conform to minimal medical standards or both (World Health Organisation, 1995; 2007; 2008). Unsafe abortion is a global public health problem and has been a major cause of morbidity and mortality among women (Berer, 2000). In 1976, the World Health Assembly recognised unsafe abortion as a serious public health problem and in 1987, the Safe Motherhood Conference in Kenya, stressed the need to put measures in place to reduce maternal morbidity and mortality from abortions (World Health Organisation, 1998). In addition, the 1994 International Conference on Population and Development (ICPD) and its follow-up Conference in 1999, urged governments, intergovernmental agencies and non-governmental organisations to increase their commitment towards preventing the death of women through abortions (World Health Organisation, 2007). Moreover, the Millennium Development Goal (MDG) five, focusing on reducing maternal mortality stressed that it cannot be achieved without a reduction in unsafe abortions (United Nations, 2007 a).

Despite the efforts of international organisations aimed at reducing morbidity and mortality from unsafe abortions, the incidence of unsafe abortions is still high: close to 20 million women risk their lives and health yearly by undergoing unsafe abortion procedures (Sedgh et. al., 2007). It is also estimated to account for at least thirteen percent (13%) of all maternal deaths worldwide (World Health Organisation, 1998; Berer, 2000; World

Health Organisation, 2008). In the less industrialised world only one in three legal abortions are safe, as against ninety eight percent (98%) unsafe (World Health Organisation, 2003). Moreover, one in eight maternal deaths occurring globally is attributed to unsafe abortions (World Health Organisation, 2007).

Other estimates indicate that unsafe abortions claim the lives of approximately 80,000 women yearly, ninety five percent (95%) of whom are in the less industrialised world (Guttmacher Institute, 2008; World Health Organisation, 2008). The estimates further revealed that every hour seven women, mostly from the less industrialised world die from the complications of unsafe abortions (World Health Organisation, 2007). In spite of the contribution of unsafe abortion to maternal morbidity and mortality in many countries, issues about abortion is contentious with arguments either for or against abortion on moral, ethical, religious, political, human rights and public health grounds (Guttmacher Institute, 1999).

In a bid to end the preventable deaths of women through abortions, some countries have liberalised their abortion laws. Between 1950 and 1985, for example, there was a rapid liberalisation of abortion laws in some industrialised and less industrialised countries. Countries such as Britain, France, India, China and Tunisia liberalised abortion (World Health Organisation, 1996; Guttmacher Institute, 1999; Sai, 2004; Guttmacher Institute, 2008). By 1990, it was estimated that seventy five percent (75%) of the world's population lived in countries that allowed induced abortions on medical, social and economic grounds, whilst the remaining twenty five percent (25%) lived in countries that had restrictive laws on abortion (World Health Organisation, 1996). Besides, the 2007 estimates established that

abortion was permitted on the grounds of saving a woman's life in ninety seven percent (97%) of countries and in 5 countries it was totally restricted. The estimates further revealed the fact that, the industrialised world generally allowed abortions on broader grounds than the less industrialised world (United Nations, 2007 b).

In Africa, current estimates establish the annual incidence of induced abortions occurring on the continent to have risen from 5 million in 1995 to 5.6 million in 2003 (Singh, et. al, 2009). This situation coupled with poor access to health services, often results in some women using clandestine and unsafe means in inducing abortions, thereby significantly increasing their risk of dying through complications (Svanemyr & Sundby, 2007). For example, out of the 5.6 million abortions which occurred in 2003 only 100,000 procedures were done under safe conditions (Guttmacher Institute, 2009).

Although only fifteen percent (15%) of females in Ghana reported having had an abortion before, safe abortion services on medico-social grounds is not readily available (Ahiadeke, 2001; Morhee & Morhee, 2006; Ghana Statistical Service, Ghana Health Service & Macro International Inc., 2009). A recent study undertaken in some health facilities in some districts across the country reported fewer than one in seven public health facilities admitting to offering induced abortions (Aboagye, et. al., 2007).

Observers blame the secrecy surrounding abortions on the stigma and the laws pertaining to abortions. For instance, in earlier studies, it was realised that the participants generally found it difficult talking about abortion. Therefore, subsequent researchers decided to remove abortion components from their study (Caldwell, 1968 as cited in Bleek, 1978). In Caldwell's (1968

as cited in Bleek, 1978; Anarfi, 2003) study, he decided at the last minute to remove questions on abortions from his work since he feared that participants would not respond to his questions, thereby jeopardising his entire study. Similarly, in past fertility surveys participants were not asked questions on abortion (Caldwell, 1968 as cited in Bleek, 1978; Blanc and Gray, 2000; Anarfi, 2003). Nabila and Fayorsey (1996) argued that in instances where information exists it tended to give credence to the notion that induced abortion is a growing problem in the country, particularly in our cities. Findings from other studies suggest that most abortions in Ghana occur outside health institutions (Lasseby, 1995). Yeboah and Kom (2003) on the other hand, reported that at the Korle Bu Teaching hospital a total of 1,935 abortion cases were handled in the year 2000 and 1,838 in 2001.

Statement of the problem

Abortion is believed to be a major cause of morbidity and mortality among women in Africa. In 2000, for instance, it was estimated to have claimed the lives of 30,000 women (World Health Organisation, 2004). Other estimates report that averagely about 4.2 million women in Africa undergo unsafe abortion procedures yearly and out of this number 38,000 of them die from complications associated with the procedure. In the West African sub-region it was also estimated that out of every 100,000 unsafe abortion procedures which occurred, 90 women died from it (World Health Organisation, 2004). For 2003, the estimates established that every 100,000 unsafe abortion procedures occurring in Africa is likely to result in 650 deaths (Singh et. al., 2009).

Some of the women who escape death from unsafe abortions have to live with various debilitating and often irreversible health conditions such as uterine perforation, chronic pelvic pains and infertility. Women who have experienced abortion complications just do not suffer damage to their physical health, their mental and social wellbeing is also affected through stigmatisation by family and friends (Hords, Benson, Potts & Billings, 2006). The stigma surrounding abortion is so pervasive that even in Vietnam, a country which at one time had the world's highest abortion rate and currently has a relatively easy access to abortion services, persons who induced abortions often experience stigma and feelings of regret which leads to keeping their abortions a secret (Gammeltoft, 2003). From the African perspective, Koster-Oyekan (1998) reports on the "shame, fear of ridicule and taboos associated with abortion" (p.3).

Before 1985, abortion was illegal on all grounds in Ghana except to save the life of the woman. This law was however, amended in 1985, abortion is now legal if the continuation of the pregnancy involves risk to the life or injury to the physical or mental health of the pregnant woman, if there is substantial risk that the child, might suffer from or later develop a serious physical abnormality or disease and if the pregnancy results from rape, incest or the defilement of a mentally challenged woman (Morhee & Morhee, 2006). Despite the amendment of the abortion laws, aimed at increasing access to safe legal abortion services, some women still resort to unsafe means in the termination of pregnancy, thereby significantly endangering their lives and health (Ahiadeke, 2001).

Abortion, especially unsafe abortion, is estimated to be the second leading cause of maternal deaths in Ghana (Henaku, Akiko & Horuich, 2007; Ghana statistical service, Ghana Health Service & Macro International, 2009). Studies of women on admission at the gynaecological and obstetrics wards of various hospitals in the country revealed a high proportion of cases due to abortion related complications (Srofenyoh & Lassey, 2003; Nyarko et. al., 2003; Yeboah & Kom, 2003). Moreover, the numbers of women who attempt to abort their pregnancies but are unsuccessful and those who experience abortion complications but do not seek for treatment in health facilities is not known (Ahiadeke, 2001; Anarfi, 2003).

Even though laws on abortion are expected to be in operation in medical centres, a recent study identified fewer than one in seven admitting to offering abortion services (Ghana Statistical Service et. al., 2009). Observers blame the low level of knowledge and poor interpretation of the law on the lack of publicity and debate about abortion laws in the public domain (Lithur, 2004 b). Others attribute it to the stigma attached to the procedure (Harris, Orner, Gabriel & Mitchell, 2007). Notwithstanding the current context surrounding abortions in Ghana, at the Marie Stopes Centre in Ashiaman, an average of about 200 females are estimated to induce abortions monthly (Marie Stopes International, 2009). Within this context, this study, sought to explore the various factors influencing the decision to abort a pregnancy among females using the facility at Ashiaman. The focus was on pregnancy termination, knowledge about abortion legislation, persons with whom the abortion intentions were discussed with and the reasons for the choice of facility.

Objectives of the study

The general objective of the study was to explore the decision making process of females who sought abortion at the Marie Stopes facility in Ashiaman. Specifically it sought to:

1. Examine women's level of knowledge about laws governing abortion in the country;
2. Examine the various factors influencing the abortion decision making process;
3. Analyse women's perspectives on the processes involved in the termination of pregnancy; and
4. Assess the challenges associated with pregnancy termination.

Assumptions of the study

The following assumptions governed the study:

1. Abortion seekers are generally not aware of the laws governing abortions in Ghana.
2. Ghanaian women mainly induce abortions due to financial difficulties.
3. The abortion decision is often taken by only the female and her partner.
4. Women with abortion intentions prefer inducing abortions in private than in public health facilities.

Significance of the study

This study contributes to an understanding of some factors which influence the abortion decision making of females within Ashiaman, an area in

the country with high maternal morbidity and mortality rates (Ghana Statistical Service et. al., 2009). In addition, research on induced abortion is considered a high priority area due to its impact on the lives and health of women. Globally it is estimated to claim the lives of 80,000 women and in Ghana it is the second leading cause of maternal deaths (Anarfi, 2003; Guttmacher Institute, 2006; Ghana Statistical Service et. al., 2009).

Also, despite the fact that Ashiaman is located in one of the three Reducing Maternal Morbidity and Mortality regions (RM3), it has a 10.4% maternal death rate from induced abortions compared to 11.1% to the regional average. Studies on abortions (Yeboah & Kom, 2003; Senah, 2003; Srofenyoh & Lassey, 2003; Ghana Statistical Service et. al., 2009) were carried out at the Korle-bu and the Komfo Anokye teaching hospitals in Accra and Kumasi respectively. This study presents the views of females who underwent their abortion in a non-governmental health facility.

Finally, the study adds to the use of qualitative approach in social science research (See for example Bleek, 1978).

Limitations of the study

The small sample size involved in the study was a limitation. Owing to the sample size the findings and interpretations of the data are subjective and hence cannot be used for generalisation. The sensitivity of the study was another limitation; had it not been for the study being very sensitive it could have been carried out in more than one site, which would have allowed the issue to be presented from various contexts. Another limitation was financial, limited financial resources affected the duration of stay in the field. During the

course of the fieldwork; I had to pay for accommodation, general maintenance, other logistics and transportation, from my own resources. This led to the fieldwork being carried out for only three weeks, had it not been for financial reasons the study could have involved more people.

Structure of the thesis

The thesis was organised in six chapters. In chapter one, which is the introduction to the research, the context of induced abortion from the world, African and Ghanaian perspectives are presented. This is followed by the statement of the problem, objectives of the study, assumptions of the study, the significance of the study and the structure of the thesis. Chapter Two reviewed literature related to the study. Chapter Three was on the design of the research and the methods of data collection and analysis. Chapter Four focused on the background characteristics, knowledge of abortion laws and reasons for abortion. Chapter Five identified the actions taken to end pregnancy, choice of facility and abortion decision making. Chapter Six, the last chapter, presents a summary of findings and conclusions.

CHAPTER TWO

LITERATURE REVIEW

Introduction

In ideal situations pregnancy is an event that is supposed to be a happy experience for women, their partners and families (Guttmacher Institute, 1999). However, this is not always the case. Many women, the world over, become pregnant unintentionally, due to varying reasons, including lack of or inadequate access to birth control services, contraceptive failure and sexual assault (Crane & Hord-Smith, 2006). While some of these women try to terminate their pregnancies through safe means, if possible, others may terminate their pregnancies by whatever means available to them, even if it is against the law, unsafe and might result in complications or death (Henshaw et. al., 1998; Crane & Hord-Smith, 2006). This chapter presents a review of literature on abortion from the global, African and Ghanaian perspectives.

The global context of abortion

Some women have relied on abortion as a means to terminate unintended pregnancies both in the past and in present times (Singh, 2007; Simon, 1998). Induced abortions are believed to occur one-third as frequently as births and just as frequently as deaths. Yet, in spite of the frequency of its occurrence, some researchers shy away from studying it. Caldwell and Caldwell (2003) assert that this phenomenon might be due to the controversy surrounding the termination of pregnancies. Issues, about whether a woman have the right to terminate a pregnancy intentionally have been a source of

intense controversy for over a generation and is still an intractable dispute whose resolution is not eminent (Wilcox & Jelen, 2003).

Induced abortion, whether under safe or unsafe conditions has been surrounded by controversy the world over for various reasons including ethics. The biggest source of this controversy is around when a foetus can be considered human. While some argue that the foetus becomes a human being at the time of conception, hence it is morally wrong to destroy it, others claim that the foetus only becomes a human being upon birth, and therefore can be destroyed (Head, 2006). The proponents of the 'human upon birth' view argue that societies which force women to carry their pregnancies to term against their will, violate their human rights, deny them of their human dignity and abuse their reproductive capacities (Hord & Wolf, 2004; Alexander, Larosa, Bader & Garfield, 2007).

The controversies surrounding abortion have generated several thought provoking debates, with the two main schools of thought being the pro-choice or those in support of the legalisation of abortion and the pro-life or those against its legalisation. The pro-choice view is premised on the fact that women have the right to choose an abortion, if they so wish. Thus, they support the notion that abortion must be legalised and do consider abortion as an expression of a woman's right. They claim that since it is a woman's body that is used in carrying the foetus, she has a right to do whatever she wants with her body. They further argue that unwanted children should not be born into the world.

The pro-life view opposes the idea that abortion must be legalised on the grounds that it is wrong. They argue that the foetus has a right to life and

abortion denies it of that privilege (Alexander et. al., 2007). Monteiro (2005) points out that it is impossible to hold a neutral position in the abortion debate and argues that no matter what one's beliefs or experiences in life are that person might either be in support of or against the termination of pregnancies. The abortion issue has been what Fried (2006, p.10) termed "a condensational symbol involving questions of moral theology, human rights, gender roles and sexual morality".

Abortion has also been a source of intense political discourse in many western liberal democracies. In the United States of America (USA), though the landmark Roe versus Wade case legalised abortion, as far back as 1973, it is still a big issue on their political landscape. It has inspired matches, murders and led to the formation of many interest groups, with the aim of influencing public opinion and voting behaviour (Kulczycki, 2003; Wilcox & Jelen, 2003). Wilcox and Jelen (2003) further contended that abortion seems to consistently influence voting behaviour at all levels of government in America.

In Africa, while some argue that the termination of unwanted pregnancies has long been an accepted practice in some cultures, others argue that it is alien to the African culture and must be abhorred. Sai (2004) has drawn attention to the fact that anecdotal evidence indicates that abortion was regarded as vital in many traditional African societies for the maintenance of law and order. He indicated that among the Masai of Kenya, pregnancies involving young unmarried women or those who had been raped were considered socially unacceptable so must be terminated. Rattray (1927 as cited in Bleek, 1978) also argued that among the Akans of Ghana abortion was

permitted to save the life of a woman when it was the only alternative. On their part, Bram and Hessini (2004) indicate that anthropological and historical studies from pre-colonial Africa show that abortion was tolerated. Egyptians, for instance, are accredited with being among the first group of people to have created abortion techniques.

On the other hand, to Lithur (2004 a) traditional Ghanaian cultural practices stigmatise abortion and considers it as murder. Rattray (1927 as cited in Bleek 1978) also reported of the belief among the Akans that abortion was an evil occurrence brought on by witches and other supernatural forces on their enemies. Gyekye (1996) and Mbiti (1969) maintain that Africans in general consider children as their most priceless possession. Bleek (1978) also reported that among the Akans of Ghana, traditionally the concept of induced abortions did not exist, because the idea of illegitimacy was non-existent and the desired family size was also unlimited. However, the study indicated that in rare instances where induced abortions occurred the perpetrators, if found out, were sent to the chief's palace for punishment.

Globally, due to the stigma attached to abortions, women who undergo the procedure fear disclosure (Kumar, et. al., 2009; Caldwell & Caldwell, 2003). Even in some highly industrialised countries like England where abortion was legalised as far back as 1967, issues regarding abortion is cloaked in a veil of secrecy (Marie Stopes International, 2002). In sub-Saharan Africa the fear of disclosure is greatest among married women, because African societies abhor women who are in a position to give birth but fail to do so. This perhaps might be due to the fact that in the traditional African context abortion among married couples is considered an abomination to the

gods and ancestors, due to its interference with the return of the ancestors (Caldwell & Caldwell, 2003; Yeboah & Kom, 2003). The society is however, a little more tolerant of single women in difficult circumstances who abort pregnancies.

The case is reversed in some Asian societies, where it is the unmarried who are rather terrified of admitting to an abortion than their married counterparts. For example, in countries like China and Korea, due to the strong social stigma attached to out of wedlock pregnancies, abortion is seen as a better option than carrying an unwanted pregnancy to term (Mundigo, 2006; Caldwell & Caldwell, 2003).

However, in spite of the controversy and the stigma surrounding induced abortions and the universality of the practice, it has not been given the necessary public attention that it deserves (Rabindranathan, 2003). For centuries abortion has been a practice that is kept in the back alleys of society and considered by many as a subject not worthy of mention. In fact, even many of the women who practiced it did not generally express themselves to be in favour of the procedure (Caldwell & Caldwell, 2003). This unacceptable attitude of the public towards induced abortions make many women resort to clandestine and unsafe means in the termination of pregnancy even at the peril of their lives (Rabindranathan, 2003).

Singh, et. al., (2009), indicated that there was a general worldwide decline in the number of induced abortions between the year 1995 and 2003: from 46 million to approximately 42 million, with the decline being greater in the industrialised world where most of the abortions performed are safe and legal than in the less industrialised world where almost all the incidences of

unsafe abortions are believed to occur. The estimate further indicated that 35 million abortions occur in developing countries annually as against 6.6 million in the developed world (Table 1).

Table 1: Induced abortion cases for 1995 and 2003

Region	Number of cases (millions)	
	1995	2003
World	45.6	41.6
Industrialised countries	10.0	6.6
Less industrialised countries	35.5	35.0

Source: Guttmacher Institute, 2007 a

According to estimates from the Guttmacher Institute (1999), by the age of 45 years, 95 percent of women would have had at least one induced abortion. Marie Stopes International (2002) also estimated that there is the probability of every one in three women between the ages of 16 and 45 inducing an abortion. This connotes that some women at a point in their lives will experience an unwanted pregnancy and might resort to induced abortion (Guttmacher Institute, 1999).

Experts from the WHO reporting on the incidence of worldwide abortions also showed that the background of women terminating a pregnancy varies from society to society. In parts of Sub-Saharan Africa, while it is mostly the young and unmarried who undergo abortion, in Eastern Europe, Latin America and most of Asia it is the married who often terminate pregnancies (Caldwell & Caldwell, 2003).

Of the 35 million abortions estimated to occur in the less industrialised world, women in Eastern and Western Africa are perceived to have the highest likelihood of inducing an abortion, most of which are done under either illegal or unsafe conditions (Berer, 2000). Hessini, et. al., (2006) also drew attention to the fact that Sub-Saharan African women have the highest risk of injury and death from abortion related complications in the world. They further estimated that 60 percent of the worldwide incidence of unsafe abortions occurs among Sub-Saharan African women who also account for 43 percent of the global incidence of deaths due to unsafe abortions.

Although this figure is accepted internationally it is considered to be a gross underestimation, partly due to the fact that, globally, data on the exact incidences of induced abortions is difficult to estimate, especially abortion related deaths (World Health Organisation, 1992; Hord & Wolf, 2004). Jaganathan (2001) blames this on the stigma associated with abortions which often leads to underreporting of actual abortion incidences; and that about only 36 percent of actual abortions are reported in surveys.

The anguish and shame that women go through in order to have abortions were finally recognised and given a public hearing at the Cairo and Beijing conferences in 1994 and 1995 respectively. These conferences sought to expand the conditions under which women and girls could have access to safe sexual and reproductive health services. In addition, it recognised abortion as a public health issue. This acknowledgment paved the way for debates on the rights of women to safe abortion services to be held. It further led to an increased global attention and awareness about the negative

implications of abortions on the lives and the health of women, especially those in the less industrialised world (Singh, Cabigon, Kamal & Perez, 1997).

However, in many countries whether induced abortion is legal or not it is usually stigmatised and frequently censured by religious and political leaders thereby causing a general underreporting of its occurrence which hinders the design of effective policies in addressing the issue (Singh et. al, 1997; Guttmacher Institute, 1999; Grimes, et. al., 2006). In some countries where abortion services are ostensibly available, they may not be accessible to the women who need it due to cost and the location of the facilities (World Health Organisation, 1992). There is therefore a need for concerted efforts by all stakeholders in addressing the problem of unsafe abortion and its consequences.

Unsafe abortion

Unsafe abortion is an area in reproductive health that is often neglected. Banerjee and Clark (2009) attribute this phenomenon to the fact that maternal morbidity and mortality from unsafe abortions can easily be prevented by paying more attention to women's health care needs. Unsafe abortions affect the development of the society in general and is a major cause of death and sickness to millions of women, especially in places where it is illegal or severely restricted (Singh, et. al., 2006). Unsafe abortion is believed to be one of the five leading causes of maternal deaths in the less industrialised world (Grimes, 2003).

Unsafe abortion procedures are usually characterised by illegality, lack or inadequacy of the skills of the provider, hazardous techniques, unsanitary

facilities and complications (Centre for Reproductive Rights, 2008). More often than not, some of these abortions are either self induced by the woman, or take place in clandestine venues like pharmacy shops, offices or homes of health workers and untrained abortionist sheds (Okonofua, 1991; Ghana Statistical Service, et. al., 2009). About one-third of women who have abortions under these conditions experience complications that pose a major threat to their lives and health (Centre for Reproductive Rights, 2008). Moreover, some women who undergo unsafe abortions are usually exploited financially by providers through exorbitant charges (Marie Stopes International, 2007).

Several factors influence women in resorting to an unsafe abortion (Singh, Prada & Kestler, 2006). They include a lack of knowledge about the provision of safe abortion services at health facilities, inaccessibility of health facilities due to cost and distance and reluctance of women to be seen obtaining abortions in well known facilities (Singh, et. al., 2006). Bram and Hessini (2004) argued that a key determinant of unsafe abortion is poverty and that in most countries, even in instances where abortion is highly restricted by the law; women with economic resources can obtain safe abortions, while poor women are less likely to access safe abortion even when abortion is legal. They claimed that in Africa, women choose to terminate their pregnancies, mainly because of economic difficulties. In furtherance to that argument Nyanzi, et. al., (2005) have argued that, it might even be economic hardships which brought about the pregnancy in the first place. Their discourse showed instances where some girls and women had been forced to sell themselves for some basic necessities of life like school fees, textbooks, clothes and food.

Although the authors' argument appears to be true, there is more to unsafe abortions than poverty. Studies conducted elsewhere revealed instances where women underwent abortions to protect their moral integrity, because the pregnancy resulted from a pre or an extramarital sexual encounter (Bleek, 1981; Agadjania, 1998; Schuster, 2005; Lie, Robson & May, 2008). Other studies have also reported instances where the fear of parental reaction to pregnancy and the likely interference of pregnancy in career and educational ambitions have led to abortions (Agadjania, 1998; Guttmacher Institute, 2003; Lie et. al., 2008).

Even though almost all unsafe abortions are believed to occur in the less industrialised world, issues involving unsafe abortion have been a matter of low priority for some of its policy makers. Some deny the existence of the problem, others may not have the political will to implement laws that can help to either reduce or prevent the occurrence of unsafe abortions, or fear losing political and social support from their countries and communities (Okonofua, 2004; Grimes et. al., 2006).

In spite of the generally restrictive laws governing abortions in Africa, there are a wide range of persons who provide this service. They include medical practitioners in the private and public sector, pharmacist, chemist, nurses, midwives, laboratory technicians, professional abortionists and traditional practitioners (Etuk, Ebong & Okonofua, 2003). Surveys conducted in Uganda showed that 56 percent of women depended on doctors and nurses, 23 percent went to traditional practitioners, 7 percent relied on pharmacists and other drug peddlers and 15 percent self induced their abortions (Singh et. al., 2006). Similar studies in Nigeria also established the dependence on

trained health professionals in the performance of abortions as commonplace. The study noted that out of every 10 abortions performed 6 are carried out by trained health professionals in medical facilities, that is 55 percent in private health facilities and 3 percent in public health facilities. The remainder are done using less safe methods like medication by chemist, 22 percent; 14 percent by traditional practitioners and 6 percent by the woman herself or a friend (Singh et. al., 2009).

These studies have pointed out that the type of abortion provider a woman relied on depended on her economic and residential status. Forty four percent of poor women compared with 66 percent of non-poor women had their abortions performed by a health professional, while 30 percent of poor women against 14 percent of non poor women sought the services of a traditional healer or self induced their abortions. With regards to their residential statuses the study found out that 42 percent of urban against 16 percent of rural women are more likely to terminate their pregnancies in health institutions (Singh et. al., 2009). More often than not the conditions under which some of these procedures are done heighten the likelihood of the clients experiencing complications which need specialised medical care.

Barriers to care in treatment of abortion complications

A number of factors have over the years influenced the health seeking behaviour of women who experience abortion complications. Among these is the socio-cultural environment (Kumar et. al., 2009; Ojengbede, 1991). For example in some cultures, in the Northern part of Ghana, where women are often not the final decision makers in the event of their experiencing an

abortion complication those desiring to attend hospitals have to seek permission from their mother in-laws, husbands and other extended family relations which sometimes delays the onset on treatment (Ngom, Debpuur, Akweongo, Adongo & Binka, 2003). In other instances where induced abortion is restricted, Hords et. al. (2006) points out that some women who report to health facilities with abortion complications rarely receive prompt treatment. They argued that more often than not, these women have to visit quite a number of health facilities before finally receiving care. They reported further that in Kenya and Senegal abortion complication patients have to visit an average of two health facilities before care. They reiterated, finally that “the keys to the survival of a woman who experiences an obstetric complication depends on the time it takes before she seeks care and the length of stay in a health facility before receiving treatment”(p. 20).

Another significant issue in this discourse is the role of alternative treatment. In cultures which encourage the use of alternative treatment, sometimes women grappling with the consequences of abortion complication, resort to traditional herbalist and spiritual healers instead of going directly to health facilities. They more often than not report at health facilities when their condition worsens and not much can be done for them (Ngom et. al., 2003) Besides, the uneven distribution of health facilities affects the quality of care given to women with complications of abortion. In most of the less industrialised world particularly Africa, health facilities are unevenly distributed. They are mainly located in the urban areas, a situation leading to rural women who experience abortion complications finding it difficult to access health facility (Ojengbede, 1991).

The judgmental attitude of some health workers towards women seeking care for abortion complications, sometimes acts as a barrier. More often than not there is the tendency for health workers particularly nurses to treat patients with abortion complications very harshly. In some instances their attitude makes some of these patients feel very guilty such that if they are able to receive care they do not come back to the health facility for a review (Koster-Oyekan, 1998).

One other area that needs consideration is the stigma attached to abortions. The abortion stigma is so pervasive that, in women's desire to avoid it they sometimes resort to clandestine abortions which often end in complications. The social stigma further impedes adequate medical care through their desire to keep their abortions a secret. For example participants in a study on abortion in Ghana identified the social stigma attached to abortions as hindering their desire to seek for medical care in the event of an abortion complication (Kumar et. al., 2009; Guttmacher, 2009; Schuster, 2005).

Finally, the lack of knowledge concerning the legality of abortions also sometimes acts as a barrier to treatment in the event of an abortion complication. Because of this ignorance in the event of an abortion complication some women fear going to health facilities for treatment because of fear of prosecution by the law enforcement agencies (Banerjee & Clark, 2009). Studies in Cameroun, Ghana, Uganda and Zambia cited the fear of legal consequences as hindering women from seeking care (Guttmacher Institute, 2009).

Consequences of abortion complications

Abortion is both a social and a medical problem whose implications affect every aspect of the lives of the persons involved and in some cases, other family members (World Health Organisation, 1990; Guttmacher Institute, 2007 a). For individuals it affects them physically, mentally, socially and economically. Sometimes it even results in their deaths. The World Health Organisation (2007) for example estimated that one out of every seven maternal deaths in Africa is due to complications associated with abortions. Other studies carried out in Africa found that deaths from abortion ranged between 28 percent in Zimbabwe, 54 percent in Ethiopia and 51 percent in Nigeria (Henaku, et. al., 2007).

Some women who undergo unsafe abortion suffer from various forms of incapacitating health conditions like excessive haemorrhage, uterine perforation, infection of the uterus, tearing of the cervix, blood poisoning and infection which sometimes leads to pelvic inflammatory disease and partial or total infertility. It is approximated that between 10 and 50 percent of these women will need medical attention (Hord & Wolf, 2004; Guttmacher Institute, 2007 b).

Worldwide, an estimated five million women are hospitalised each year due to complications associated with abortion. Out of this number, 1.7 million are believed to be Africans (Guttmacher Institute, 2007 b). Also, in some parts of the less industrialised world up to 50 percent of hospital budgets for obstetrics and gynaecology is spent treating complications of abortion (Grimes et. al., 2006).

It is, however, not only women who experience abortions that are affected by its impact, their families, societies and nations are as well affected in diverse ways (Guttmacher Institute, 2007 b). When a woman dies, children lose their primary care giver, families lose her nurturing and productivity, communities are denied of her paid and unpaid labour and countries forego her contributions to economic and social development (Grimes et. al., 2006).

Unsafe abortion impacts greatly on health systems, particularly in the developing world. In a study carried out at the Kenyatta National Hospital in Kenya, it was revealed that 60 percent of the beds in the gynaecological wards were occupied by patients with abortion related complications (Aggarwal & Mati, 1982). Studies by Baker and Khasiani (1992 as cited in Banerjee & Clark, 2009) estimated more than 10,000 patients being treated for abortion complications yearly in Kenya. Similarly, in Uganda 85,000 women were reported to have received care for abortion related complications. In Ghana, Yeboah and Kom (2003) and Ampofo and Collison (1993) as cited in Nabila, Fayorsey and Pappoe, (1997) mentioned that at the gynaecological wards of most hospitals, health staff are overburdened with numbers of women seeking treatment because of abortion related complications.

Economically, the complications which result from unsafe abortions drains the financial resources of individuals and nations. For example, the average Nigerian women reported having spent 10,933 naira in treating abortion related complications (Bankole, et. al., 2006). Whereas, nationally 11.7 million dollars and 19 million dollars was spent in treating abortion related complications in 2002 and 2005 respectively in Nigeria (Guttmacher Institute, 2008). The next section reviews abortion and the law, it argues that

the legal environment surrounding abortion is important in women's ability to end an unwanted pregnancy (Guttmacher Institute, 1999).

Abortion and the law

Though history abounds with societies having laws and regulations governing abortions, with the intent of restricting it, women have always had and will continue to have abortions despite these regulations (Morhee & Morhee, 2006; Singh et. al., 2009). More often than not these regulations are a product of the legal heritage as well as the social, political, economic and religious values of the society (Simon, 1998). Before the dawn of the 19th Century, there were no civil laws regulating the conduct of induced abortions (Womenonwaves Foundation, 2009).

The first adopted statute concerning abortion was the Napoleonic code of 1810. Contained in this code were laws criminalising and prescribing harsh sentences for providers and seekers of induced abortions. In places like England, issues concerning abortion began appearing in the law statutes in the 13th century. Following the enactment of the first laws, various laws meant to restrict women from accessing abortions were introduced and enforced in the English penal codes until 1967 when abortion was legalised (Ogiamein, 1991; Simon, 1998; Abortion Rights Centre, 2009)

Access to safe abortion services is in many ways influenced by laws pertaining to abortion in one's country of residence (Rahman, Katzive & Henshaw, 1998). Though the legal status of induced abortions is not the only factor which affects the availability of safe abortion services, it remains a key determinant. For example, in places where access to induced abortion is either

prohibited or restricted, medically trained practitioners are more often than not unwilling to provide the service, thereby leaving it in the hands of quacks and private medical personnel who charge exorbitant fees (Etuk, et. al., 2003).

Globally, a trend towards the liberalisation of abortion laws began in the 1950s in Eastern Europe and gradually spread to the rest of the world (Kulczycki, 2003). In spite of this gradual removal of worldwide legal restrictions placed on abortion, accessibility of safe abortion services still remains largely unavailable to many women, especially those in developing countries (Singh, et. al., 2009). Laws governing abortions can be broadly categorised into five main groups. These are countries where there is total prohibition of abortion on all grounds in countries such as Malta and Andorra. In the next category are Ireland and Mali which allow abortions only on the grounds of saving the life of the woman. The next group of countries allow abortion to protect the physical and mental health of the woman. In the fourth group are countries where abortion is allowed on socio-economic grounds and finally countries that allow abortion without restriction as to reason like China and Norway (Singh et. al., 2009).

In the first group are 32 countries containing 6% of the global number of women within the reproductive ages. In the second and third categories are 59 countries containing 14 percent of the global number of women within the childbearing ages. Lastly, the countries in the fourth and fifth categories who allow abortion on socio-economic grounds and without restriction as to reason are mainly in the developed world and account for 60% of the total global number of women within the reproductive ages (Sai, 2004; Singh et. al., 2009).

Since the early 1990s, some African countries have initiated moves towards the liberalisation of abortion laws. Nonetheless, the laws governing abortion on the continent are still generally strict; it is only in Cape Verde, Tunisia and South Africa that abortion is available on request (Sai, 2004). However, despite these restrictions placed on the procedure, African women still undergo induced abortions, most of which are through clandestine and unsafe means. This situation might be attributed to the fact that legal restrictions placed on abortions, normally do not prevent its occurrence, it rather causes it to be driven underground, which becomes more dangerous to the lives and health of persons involved.

Although the legalisation of abortion does not totally obliterate a woman's recourse to abortion, it is an essential prerequisite for making it safe, because when abortions are legal it normally reduces a woman's recourse to unsafe abortions (Berer, 2000). In South Africa for instance, the legalisation of abortion in 1997 led to a 90 percent reduction in abortion related deaths. In Romania when abortion was legalised in 1990 it led to a dramatic decline in maternal mortality. The study, further identified that, the legalisation of abortion is a necessary but insufficient step towards wide spread access to safe abortion services and that for women to have access to safe abortion services there is a need for them to know the laws pertaining to abortions in their countries (Grimes, et. al., 2006; Sai, 2004; Hord & Wolf, 2004). Koster (2003) has also argued that a woman's ability to obtain safe abortion services is affected not just by the law in a particular country, but also by how these laws are interpreted, enforced and the attitude of the medical community towards abortion.

A publication by Guttmacher Institute titled “Abortion worldwide: A decade of uneven progress” found the review period 1990 to 2008, witnessing some moderate legal reforms concerning abortions. It saw some countries broadening the grounds under which legal abortion services could be accessed, while a few tightened their laws on abortions (Singh, et. al., 2009). Countries such as Cambodia, Swaziland, Benin, Togo and Portugal broadened the grounds on which legal abortion services could be obtained, while Nicaragua, El Salvador and Poland made their abortion laws more restrictive. However, in Sub-Saharan Africa and Latin America there was not much legal reforms concerning abortion during the period under review (Singh et. al., 2009).

Law on abortion in Ghana

Abortion is a criminal offence in Ghana. It is governed by Act 29, section 58 of the Criminal Code of 1960, amended by the Provisional National Defence Council (PNDC) Law 102 of 1985. Under, the law any person administering any poison or other noxious substance to a woman or using any instruments or other means with the intent to cause an abortion is guilty of an offence and is liable to imprisonment for a term not exceeding five years, regardless of whether the woman is pregnant or has given her consent. It further, states that, any person inducing a woman to cause or consent to an abortion, assisting a woman to cause an abortion or attempting to cause an abortion may also be imprisoned for a term not exceeding five years. A person who supplies or procures any poison, drug or instrument or any other thing knowing that it will be used to perform an abortion is also subject to the same punishment (Morhee & Morhee, 2006).

The only exception to the law is if the continuation of the pregnancy involves risk to the life or injury to the physical or mental health of the pregnant woman, if there is substantial risk that the child, might suffer from or later develop a serious physical abnormality or disease and if the pregnancy results from rape, incest or the defilement of a mentally challenged woman. It must however be performed by a registered medical practitioner, in a government hospital, private hospital or clinic registered under the Private Hospital and Maternity Home Act 1985 (No. 9) or in a place approved for that purpose by the law. The law further stipulates that the consent of the pregnant woman in question must be sought and in the case where she lacks the capacity to give her own consent, the consent of her next of kin or guardian is required before the performance of the procedure (Morhee & Morhee, 2006).

Attitude of health care providers towards abortion seekers

The attitude of the medical community towards abortion, in many ways, influences a woman's ability to obtain abortion services. Koster (2003) has argued that some health workers share society's general negative attitude towards women undergoing abortion. She further alleged that more often than not health staff "abuse, mock and reprimand women seeking abortion for their immoral and foolish behaviour" (p.124). Other studies reiterate that this behaviour by health workers is often meant to discourage women from seeking abortion (Lie, et. al., 2008).

In Nigeria, an assessment of health care provider's attitude towards abortion indicated that they can be broadly classified as being either conservatives or liberals. The conservatives are those who do not support

abortion irrespective of the circumstances under which it is being demanded. They base their argument on medical ethics and the Hippocratic Oath; which states the need to uphold the sanctity of human life from conception. The liberals, on the other hand, are further grouped into two; that is the radical liberals and the conservative liberals. The radical liberals support abortion on demand, whilst the conservative liberals support selective abortions. They also premise their argument on the grounds that it is more important to protect the life of the mother than the unborn child (Ojengbede, 1991). Other studies in South Africa, introduced a third category of conscientious objection (Lie et. al., 2008). Conscientious objection allows medical personnel the right to either perform or refuse a woman an abortion, but obliges him or her to inform the patient of her reproductive right and also refer her to a facility where the service can be accessed. Studies elsewhere found out that religious beliefs, gestational age and the reasons for seeking abortion often affected the attitude of health workers towards the provision of abortion (Harris et. al., 2009).

Abortion and religion

Religion plays a very important role in the life of humans and touches on every aspect of our lives (Brodsky, 2000). From an African perspective, Mbiti (1969) describes religion as revolving around the totality of the individual. Carmody and Brink (2002) also emphasised the strong hold of religion on its adherents. Ghana's population and housing census (2000) recorded 68.8 percent Christians, 15.9 percent Muslims, and 8.5 percent Traditionalists, with other religions occupying 0.7 percent and 6.1 percent

being non-adherents. This section explores the views of Christianity and Islam, the two main religions in Ghana regarding abortion.

In Christianity, the Bible does not condemn abortion and Church tradition rarely addresses it. Early Church theologians generally allowed abortion before the first three months after which it was believed the soul entered the foetus hence it was morally wrong to destroy (Simon, 1998; Kulczycki, 2003). The earliest attempt to organise an ecclesiastical legislation on abortion was by the Catholic Church. The Church decreed that if abortion was done before the movement of the foetus, assumed to take place within forty days of conception for males and eighty days for females then it was acceptable but if afterwards then it was murder. This view point was adhered to by the followers of the church till it was annulled by Pope Pius IX in 1930. He decreed that abortion was illegal on all grounds since ensoulment or movement of the foetus occurred at conception. He further stressed that persons found to be engaging in it would be excommunicated from the church (Simon, 1998; Kulczycki, 2003; Abortion Rights Centre, 2009). Some authors have argued that this standpoint forms the basis of the formulation of laws regarding abortions worldwide.

Within the protestant circles there is no single protestant position on abortion. While some denominations do not have any official stand on abortions, others consider it as necessary in instances where the life of the mother is at risk (Head, 2006). For example, while some churches such as the Assemblies of God, the Salvation Army and Lutheran Church take a prolife stand on abortion, they do not have a common stance on when abortion is appropriate in cases of rape, incest and to save the life of the woman. Also in

the United Methodist Church, the church's standpoint is that the parties involved should decide on their own as to what to do with the pregnancy, after they had been counselled by medical and pastoral personnel. Among the Southern Baptist churches abortion is opposed outright (Women's Right World, 2008). For the seventh Day Adventists, abortion is allowed in instances, of significant threat to the life and health of the woman, severe congenital deformities have been detected in the foetus and if the pregnancy resulted from rape or incest. On the part of the Presbyterian Church abortion is condemned on the grounds that the foetus is an unborn child whom God is creating.

Islamic scholars differ in their interpretation of the religion's stand concerning abortion (Simon, 1998; Kulczycki, 2003; British Broadcasting Corporation, 2009). While some argue that it is permissible before movement of the foetus if there are very good grounds for it, others indicate that it should be allowed in instances where the pregnancy endangers the life of the woman regardless of the period of gestation (Simon, 1998; Kulczycki, 2003; British Broadcasting Corporation, 2009). These religious prescriptions in many ways influence the decisions taken by some of its adherents in the event of unwanted pregnancies.

Reasons for pregnancy termination

Women the world over cite various reasons for obtaining abortion. These range from socio-economic to psychological and health. Bankole, et. al., (1998) in a study involving women from 27 countries discovered that the most commonly cited reason for having abortion was to postpone or stop

childbearing. Other important categories identified by the study were socio-economic influences such as disruption of education or employment, lack of support from partner, desire to provide schooling for existing children, poverty, not wanting to stay with the person who made them pregnant and unemployment (Bankole, et. al., 1998). In addition, relationship problems with a husband or partner, pregnancy occurring out of wedlock and a woman's perception that she is too young to be a mother constituted another category of reasons identified by another study (Henry & Fayorsey, 2002; Guttmacher Institute, 2006). In Nigeria and Uganda, it was stigmatisation associated with out of wedlock births and the denial of the pregnancy by partners which often resulted in women terminating their pregnancies (Hord & Wolf, 2004; Singh, et. al., 2005)

Likewise, Henry and Fayorsey (2002) identified that in Ghana, young women especially those in schools cited their desire to continue their education as the main reason for terminating a pregnancy. Economic constraints, the fear of community sanctions and the shame of premarital childbirth were some other reasons causing women to have abortion.

Abortion procedures

Clinical abortion, though contentious in some countries, has become a normalised component of women's health care over the past 40 years in most developed and a few developing countries (Lie, et. al., 2008). Clinical terminations of pregnancies are often carried out through two main ways, namely the surgical and the non-surgical method which is also sometimes termed medical abortion (Karamae & Spender, 2000).

The surgical method of terminating pregnancy is usually carried out from the first trimester and beyond while medical abortion is restricted to the first trimester. For surgical methods of abortion, manual vacuum aspiration is usually used during the first trimester, while dilation and evacuation, labour induction is used in aborting advanced pregnancies. The manual vacuum aspiration is a five to ten minute procedure, in which the cervix is dilated and the products of conception together with the lining of the uterus is expelled through suction. This method of inducing abortion is a modern method that has replaced the more dangerous and risky dilation and curettage (D&C). In the dilation and evacuation, the uterus is dilated and its content scraped with a sharp instrument called the curette. Induction of labour is normally used for late term abortions, here the amniotic fluid is removed from the uterus after which injections are given to the woman to bring about contractions (Karamae & Spender, 2000; Grimes, et. al., 2006; Population Reference Bureau, 2006; Svanemyr & Sundby, 2007).

Mifepristone and Misoprostol are the most common medicines used in medical abortion. These medicines work by causing the uterus to contract and expel its contents, in a manner similar to miscarriage (Karamae & Spender, 2000). However, some studies report that majority of abortionist in Africa still rely on the outmoded and dangerous method of Dilation and Curettage (D&C) in inducing abortions (Svanemyr & Sundby, 2007; Grimes et. al., 2006).

The Ghanaian context of abortion

In Ghana, induced abortion evokes a great deal of controversy and passion based on religious, cultural, ethical and moral dimension (Senah,

2003). Some ethnic groups in the country equate it to murder and hence persons found to have been involved in it are looked upon with disdain (Lithur, 2004 a). It is, therefore, resorted to in secrecy and considered as “the most clandestine method” (Bleek, 1978).

Although the abortion law in Ghana is comparatively more liberal than many countries in the sub-region, the translation of the law into effective services has been limited (Nyarko et. al., 2008). Among health workers who are supposed to be the main implementers of the law only 20 percent of them are aware of the circumstances under which it is permitted (Nyarko, et. al., 2008).

Other studies found that among women within the reproductive ages only 4 percent think abortion is legal in Ghana and in this category 17 percent do not know the circumstances under which abortion is legally permissible (Ghana Statistical Service et. al., 2009). The general ignorance of some women about their legal rights to abortions sometimes results in women and girls seeking abortion services they are legally entitled to being turned over to the police (Ghana Statistical Service et. al., 2009; Awusabo-Asare, Anarfi & Agyeman, 1993 as cited in Kwankye, 2007).

Until 2003, safe abortion service was not integrated into the national health policy. However, in 2006 the Ghana Health Service together with other stakeholders released new standards and protocols for safe abortion services (Ghana Statistical Service, et. al., 2009; Ipas, 2009). Despite these changes, in many cases persons responsible for the interpretation of the law still tend to interpret it as prohibitive thereby leading to safe abortion services not being

practiced to the full extent of the law (Ghana Statistical Service, et. al., 2009; Nyarko, et. al., 2008).

In the view of Ahiadeke (2001), the law on abortion in Ghana is still restrictive. He argued further that this restrictive nature of the law, results in quite a number of women resorting to unsafe means in the termination of pregnancy. Empirical evidence, attests to the fact that when a woman wants to end an unintended pregnancy she will go to extreme lengths to end it regardless of whether the procedure is safe or illegal (Morhee & Morhee, 2006).

Despite statistical data on the magnitude of morbidity and mortality from induced abortions being limited, thereby making it almost impossible to determine the number of abortions occurring yearly in the country, current observations peg Ghana as having an abortion rate of 0.4 abortions per woman. In addition, 11 percent of all maternal deaths in the country is abortion related (Anarfi, 2003; Ghana Statistical Service, et. al., 2009). Besides, other studies estimate that one out of seven Ghanaian women has the likelihood of inducing an abortion in her lifetime (Ghana Statistical Service, et. al., 2009).

Moreover, hospital-based studies also confirm that complications of abortion are a leading cause of gynaecological admissions in the country (Srofenyoh & Lassey, 2003). In a study conducted at the Korle-bu Teaching Hospital in 2000, complications of abortion was identified as resulting in 41 percent of hospital admissions. The study further established that 14 percent of the maternal deaths recorded during that same period were due to abortion complications (Srofenyoh & Lassey, 2003).

In a review of hospital data from the Kassena-Nankana district, between January 2000 and December 2003, 24 maternal deaths occurred in the district and seven out of these deaths were due to complications of abortion (Nyarko, et. al., 2008). Likewise, in a hospital based study undertaken in a rural hospital in the southern part of the country between 1990 and 1992, out of a total of 2,228 admissions at the maternity unit, 335 were abortion complication related (Anarfi, 2003). Records from the same health facility during the period of the study showed that 451 evacuation of uterus procedures were done (Anarfi, 2003). This is apart from those done successfully outside health institutions.

Research evidence indicates that both married and unmarried women induce abortion in the country; however, it was identified that Ghanaian women often used abortions to space than limit births. Moreover, females less than 20 years were identified as having the highest probability of inducing abortion (Lamprey, Janowitz, Smith & Klufio, 1985; Ghana Statistical Service, et. al., 2009). Nevertheless, abortion has been noted not only among the young and unmarried, also 15 percent of the divorced, separated and the widowed have been found to indulge in it (Ghana Statistical Service, et. al., 2009).

Women induce abortions for several reasons. Financial considerations have been found to be the main reason cited by most Ghanaian women as having made them undergo abortions (Ghana Statistical Service, et.al, 2009). Ghana Statistical Service, et. al., (2009) indicates that out of every five women who have caused abortions one reported financial difficulties as being the main reason for their decision. Other reasons mentioned were the desire to

postpone birth, continue education and job, not being in love with the partner and the denying of responsibility by partner (Ghana Statistical Service, et. al., 2009).

While some of these women go to health facilities to induce abortions, others self induce or use unorthodox means in ending their pregnancies. Available data over the past five years revealed that 38 percent of all abortions occurred in private health institutions, while 15 percent happened in public health institutions (Lassey, 1995; Ghana Statistical Service, et. al., 2009). For abortions outside health facilities, the study found one third occurring in the home of the woman and 30 percent performed by a pharmacist, traditional practitioner, relative, or a friend (Blanc & Gray, 2000; Ghana Statistical Service, et. al., 2009).

Females self induced abortions by drinking various herbal concoctions and inserting twigs of certain plants like the *jatropha* and *commelina* into their vaginas with the intent of rupturing the uterus. Others also relied on methods termed miscellaneous such as ingesting milk mixed with lots of sugar, mixing sugar with coffee, taking Guinness and other strong alcoholic beverages like brandy (Ghana Statistical Service, et. al., 2009).

Framing the study

This section seeks to embed an understanding of the abortion decision making process in an informed sense of the context in which such decisions are made. First it sets out to understand the concept of decision making. Second, it reviews research on abortion decision making as a way of entering into debate about the various influences on the process. It then considers some

decision making models and its applicability to the study. Finally, it draws on them to construct a conceptual frame for the design of the study.

Conceptualising decision making

The effective operation of the human society is based on decisions. As humans we are constantly called upon to make decisions. We decide what to eat, wear and do at a particular time. Decision is defined as what one intends to do or a choice between alternatives (www.merriamwebsterdictionary.com). On his part Zeleny (1979) defines decision as an act of selecting the most desirable alternative. Decision making, on the other hand, is said to be the process of making a choice between or among various alternatives after a consideration of the cost and benefits (Cliffs, 2008). It is, however, important to note that the process often involves more than one person and is influenced by circumstances. Also at times it is an extremely short process, while at other times it can drag on for months, and even years (Beer, 1975; Cliffs, 2008). Zeleny (1979) argues that decision making is a dynamic process involving a complex search for information. He further stated that it is full of detours and enriched by feedback from the various stakeholders. Within the context of this study, decision making is the processes involved in the termination of pregnancy with or without the consideration of the suggestions of intimate partner and significant others.

The abortion decision

Some people believe that because a woman bears the greatest burden in pregnancy it is her sole prerogative in deciding what to do with it. Yet from

a sociological point of view, this notion might be misleading in that there are various stakeholders in the pregnancy and the abortion decision making process. Cotroneo and Krasner (1977), for example reported of the influence of one's social network on the process. Similarly, Lee, Klienbach, Hu, Peng, Chen (1996) have indicated that even the national culture that an individual belongs to plays a role in the decision making process. Their research, a comparative study of the attitudes of the youth in America and China on abortion, reported the Chinese as having a favourable attitude towards abortion as compared to their American counterparts. The study indicated further that the findings were in line with the cultural orientation in America which saw fetuses as sacred, unlike the Chinese culture which did not. In another study on abortion decision making, Trent and Hoskin (1999) reported of the influences of religious orientation on the process.

In contrast, Fielding and Schaff (2004) notes that although there are social, historical and cultural influences on the abortion decision making process some women act contrary to it. For example, in a pilot study in the United States of America, Allanson and Astbury (1995) found that the majority of women sampled made the decision to have an abortion based on pragmatic and practical concerns like a belief in their right to control their fertility and the lack of someone to support them financially. The study reported further that issues concerning morality and social expectations were of secondary importance to the participants.

Renne (1996 as cited in Caldwell & Caldwell, 2003) argues that for married women in West Africa the decision to abort a pregnancy is purely a man's business. On the surface, Renne's assertion might appear true in

practice, but it is doubtful if it applies to all societies in West Africa. In Ghana, for instance there are instances where women resort to abortions without the consent of either their male partners or husbands because of socio-economic pressures. These pressures may result from preference for continuing schooling, the cost of raising a child, fear of job loss and many others. Therefore this assertion cannot be wholly relied upon.

On their part, Svanemyr and Sundby (2007) claim that parents and family members play quite a significant role in the abortion decision making process. They argued that in some instances the fear of parental reaction to pregnancy leads to some people inducing abortions. They reported further that in other instances parents were found to have actually forced and threatened their children into aborting their pregnancies or risk being sanctioned by them. A study by Fayorsey and Henry (2002) in Ghana found that most parents opt for abortions if they become involved in deciding the fate of a pregnancy. The study further reported that couples often involved their families in the pregnancy termination process when there was a misunderstanding between them.

Fielding and Schaff's (2004) study in the United States of America involving women with unwanted pregnancies found out that those whom women talked to before an abortion was important in shaping their decisions. The study involving 50 participants indicated that half of the sample who continued with their pregnancies talked to health, social workers and Reverend Ministers about their abortion intentions. While those who went ahead with the abortions talked with families and friends about their intentions. Bankole, et. al. (2006) revealed that male involvement in abortion decision making was

high: about 6 out of 10 women who had obtained abortions did so with the approval of their partners. The study further revealed that people intending to abort their pregnancies mainly discussed their decision with their partners and friends than their mothers or sisters. In contrast, Friedlander, Kaul and Stimel (1984) notes that the involvement of the male partner in the abortion decision often made it less likely that it would be carried out.

Decision making theories

This section reviews some decision making theories and considers its suitability or otherwise to the study. It starts with a review of the theory of planned behaviour, followed by the transtheoretical model, the information-motivation-behavioural model, the health belief model, the Vroom- Jago decision making model and then the social ecological model.

Theory of planned behaviour

The theory of planned behaviour, is a behavioural prediction theory representing a social-psychological approach to understanding, predicting and examining the determinants of human action and decision making. It was developed by Ajzen in 1985 as an extension of his and Fishbein's earlier theory of reasoned action (Redding, Rossi, Rossi, Velicer & Prochaska, 2000). According to the theory, behavioural intentions are formed with the contribution of three sets of factors: attitudes, subjective norms and perceived behavioural control. It posits that individual behaviour is driven by behavioural intentions where behavioural intentions are a function of the individual's attitude towards the behaviour, the subjective norms surrounding

the performance of the behaviour and the individual's perception of the ease with which the behaviour can be performed (Eagly & Chaiken, 1993; Dommermuth, Klobas & Lappegard, 2009). From the perspective of the theory, people behave in a certain way because they choose to do so and use rational decision making processes in choosing and planning actions (Redding, et. al., 2000)

Attitude, the first variable proposed by the theory as influencing behavioural intention, can be conceptualised in terms of values. That is an individual develops particular values about certain behaviours. The second, subjective norms, considers an individual's estimation of whether people important to the individual think the behaviour should be performed. Here, a behavioural intention is influenced by the judgment of significant others like parents, spouse, friends etc. and their beliefs about whether the behaviour should or should not be performed. However, the opinion of any referent group is weighted against the motivation that an individual has to comply with the wishes of that referent (Eagly & Chaiken, 1993). The last, perceived behavioural control, means an individual's perception of his or her ability to perform the behaviour. It is assumed that this concept is determined by an individual's beliefs about the presence of factors that may facilitate or impede the performance of that behaviour. The theory posits further that only specific attitudes towards the behaviour in question can be expected to predict that behaviour and that in addition to measuring attitudes towards the behaviour there is also the need for the measurement of the subjective norms. It notes, further that the more favourable the attitude and the subjective norm, the greater the tendency for the individual to perform the behaviour. The theory is

criticised as focusing more on the cognitive processes involved in decision making thereby giving little attention to the affective.

Transtheoretical model

The transtheoretical model formulated by Prochaska and DiClemente in 1983 is a behavioural change model that explains or predicts behavioural change as being intentional and occurring in stages (Povey, Conner, James, Sparks & Shepherd, 1999). The model, which is currently the most popular stage model used in the explanation and prediction of the success or failure of an individual's attempt at achieving a behavioural change was developed initially to aid in the explanation of smoking cessation but has now become well established in research and practice pertaining to health behaviours (Prochaska, DiClemente & Norcross, 1992). For instance Howarth (1999) applied the transtheoretical model to her study of eating behaviours. What distinguishes this model from the rest is the idea that behavioural change occurs over time and in stages.

The model proposes that the changing of negative health behaviours and the adoption of positive ones involves a progression through five distinct stages. The first three of these stages are motivational, whilst the remaining two are actional. These stages are the pre-contemplation, contemplation, preparation, action and maintenance (Povey, et. al., 1999).

At the first stage, which is the pre-contemplation stage there is no intent on the part of the individual to change his or her behaviour in the foreseeable future. Persons within this stage tend not to see the need for a change in their behaviour because they do not realise that they have a problem.

This non-realisation of the existence of a problem is usually due to the fact that they more often than not are either unaware or uninformed about the existence of a problem and the consequences of their behaviour or may have tried to change to positive health behaviours a number of times but were unsuccessful so have become demoralised, and resigned themselves to their fate. More often than not, people within this stage tend to avoid reading, thinking or talking about their current undesired state of health (Prochaska & Velicer, 1997; Lach, Everard, Highstein, & Brownson, 2004).

In the second stage called the contemplation stage, persons within it, become aware that they have a problem and start gathering the necessary information that is likely to help them adopt the intended positive health behaviour. However at this stage they have not as yet made a commitment to take action, due to the fact that the pros and the cons of the intended action is considered which makes them remain at this stage for quite a while, a process termed by Prochaska and Velicer (1997) as chronic procrastination. The model proposes that individuals within this stage normally move to the next stage if upon the consideration of the pros and cons they realise that the expected benefits from the change in behaviour is likely to be more than the cost.

The third stage is called the preparation stage. Persons, within this stage have the intention to change behaviour. A characteristic of most persons in this stage is that they have unsuccessfully taken some action to change their behaviour, but are still involved in the undesired health related behaviour. The model proposes that due to the failure of most persons here, to change their behaviour, they are usually nervous and might not know what to do in order to

achieve the change that they desire in their health (Povey, et. al., 1999; Lach, et. al., 2004).

In the fourth stage, which is the action stage, individuals make the effort to modify their behaviour or environment in order to overcome their problems. This stage requires the commitment of a lot of time and energy on the part of the individual in order to bring about the desired change. It is also a stage where the individual receives a lot of recognition by others due to the fact that a visible change in behaviour is seen. In the maintenance stage, which is the fifth and final stage of the model, persons within this stage work to prevent relapse and consolidate the gains attained in the action stage (Povey, et. al., 1999; Lach, et. al., 2004).

Notwithstanding, the strengths of the transtheoretical model it has some weakness. The major criticism levelled against this model is the classification of the process of behavioural change into arbitrarily defined stages (Sutton, 2001). Whitelaw, et. al., (2000) for instance have indicated that the classifying of the behavioural change process into stages brings about have several problems, with one of them being how the model can be applied to people who move through all the stages in a matter of minutes. De Nooijer, et.al., (2005) has also questioned the stability of the stages. West (2005) thinks that the model 'does little more than stating the obvious'. Another criticism levelled against this model is that human functioning is too versatile and multidimensional to be categorised into discrete stages (Bandura, 1997).

Information-motivation-behavioural model

The information- motivation- behavioural model (IMB), developed by Fisher and Fisher (1992) is a theory that was specifically formulated to understand HIV risk and prevention, but has now been broadened and is being used as a general theory in the study of health behaviours (Rew, 2005). The theory, argues that the information a person has about a certain situation or health condition affects how he or she will engage in preventive behaviours in order to avoid getting into the undesired condition of health. That is, the fundamental skills for practising preventive behaviour effectively is information which is directly relevant to the state of health the individual does not want to get into, motivation to practice prevention and behavioural skills for practising prevention effectively (Rew, 2005).

The theory further suggests that, most persons at risk of getting into a particular health condition possess inadequate information about the personal practice of preventive behaviour. Besides, they also possess insufficient personal and social motivation to practice prevention, and inadequate behavioural skills for practising prevention effectively. On the basis of this analysis, the theory designates information, motivation, and behavioural skills as critical factors to target for change in intervention efforts to promote preventive behaviour (Fisher & Fisher, 1992).

Health belief model

The health belief model developed in the 1950's is currently one of the most popular theories in health education and promotion (Turner, Hunt, DiBrezza, & Jones, 2004). The model postulates that an individual's health

seeking behaviour is based on the person's awareness of the threat posed by a health condition and the importance that that individual attaches to actions aimed at reducing the threat. This model tries to explain the relationship between an individual's philosophy and his or her actions. The key dimensions or the main constructs of the model are perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action and self efficacy (Al-Ali & Haddad, 2004; Parker, et. al., 2004; Winfield & Whaley, 2002).

Perceived susceptibility looks at an individual's beliefs about chances of contracting a certain health condition. Whereas, the concept of perceived severity; considers an individual's belief about the seriousness or severity of a disease or health condition. With the concept of perceived benefits, emphasis is placed on an individual's belief in the effectiveness of a course of action in either reducing the risk or preventing the undesirable health condition. Under the concept of perceived barriers, the barriers to the intended course of action are considered, here the individual considers both the concrete and the psychological cost of the intended course of action. The construct of cues to action, on the other hand, study's personal, interpersonal and environmental factors motivating a person to take a health related action. It can also be said to be events which activates a person's readiness to act and stimulate an observable behaviour. Finally, the construct of self efficacy looks at the ability of the individual to successfully perform the intended course of action (Al-Ali & Haddad, 2004; Parker et. al., 2004; Winfield & Whaley, 2002).

Despite the strengths of the health belief model it is criticised as not specifying how the variables within the model combine to influence behaviour. Another criticism levelled against this model is the lack of

operational definitions for the variables (Champion, 1984 cited in Quine & Rutter 2002).

The Vroom-Jago decision model

The model is a decision tree model used by leaders to determine whether they should make a decision alone or involve a group and to what extent the group should be involved. It was developed by Vroom and Yetton in 1973 and later modified by Vroom and Jago (Vroom & Jago, 1988). The model operates by emphasising the need for an individual intending to take a decision, to first pose a series of questions about the nature of the problem at hand, the decision he or she should take and the likely consequences of that decision. After, the series of questions had been posed about the decision to be taken, the individual arrives at a conclusion whether to take the decision alone or to involve others and just how much involvement the others should have in the decision (Vroom & Jago, 1988).

The model identifies five styles of decision making ranging from autocratic to consultative to group based. In the Autocratic Type I (AI), which is the first type of decision making process, the individual decides alone using the information that he or she has gathered about how to solve the problem. The second, Autocratic Type II (AII) the individual seeks for information from his or her significant others about a problem but may or may not tell them why that particular information is being sought. Here the final decision is taken by the individual alone.

The significant others involvement is just limited to the provision of information. In the Consultative Type I (CI), the third style of decision

making, the individual shares the problem with significant others individually and seeks their suggestions and ideas about how to solve the problem, but makes the decision alone. Under this style the role played by the significant others is the provision of alternative solutions to the problem individually. Fourthly, in the Consultative Type II (CII) the problem is shared with all the significant others in a group, the individual facing the problem seeks their ideas and suggestions about the problem but makes the decision alone. The role of the significant others is to meet together as a group to try and find out various alternatives to the problem. However, under this style of decision making the final decision on how to solve the problem lies with the individual and the decision may or may not reflect the suggestions of the significant others. In the Group-base Type II (GII) which is the final style of decision making under the model the individual discusses the problem with the significant others as a group and seeks their ideas and suggestions through brainstorming. Here whatever decision is taken by the group is accepted and implemented by the individual (Vroom & Jago, 1988).

Social ecological model

The social ecological model, also known as the social ecological perspective is a comprehensive public health approach. This model does not only address individual level influences on behaviour and decision making but also considers the influence of friends, family, society and even public policy on behaviour and decision making (Bauer, et. al., 2003). Social ecology is said to be the study of people in an environment and the influences they have on each other (Hawley, 1950). Feltson and Carlson (2001) defined it as the nested

arrangement of family, school, community and public policy on behaviour. It is essentially an approach that recognises the interdependence of multiple systems (Swartz, 2007). It was propounded by Bronfenbrenner in 1979 in response to the focus of most theorists on a dichotomous perspective of behavioural change that is either from an individual or a societal level perspective. Bronfenbrenner, argued that these two levels interacted continuously and evolved into various interrelated components (Swartz, 2007). He conceptualised the interplay of the influences on behaviour at four main levels, they are individual, relationship, community and societal factors. At the individual level, the model focuses on individual characteristics that influence behaviour and decisions. Some factors such as knowledge, attitude, beliefs, skills, age, and educational level are considered. The second factor, relationship level influences; considers the importance of relationship with family, intimate partners, peers and the immediate social circle of an individual on his or her decisions. At the community level, the model explores the influences of settings in which social relationships occur like schools, workplaces, and neighbourhoods on an individual. Lastly, societal level factors focus on broad societal factors that either create or inhibit an individual from undertaking certain behaviours. These factors include the influence of social norms, public policies, religious and cultural belief systems on behaviour and decisions (Campbell, 2010; Feltson & Carlson, 2001; Dahlberg & Krug, 2002). This theory has been employed in the explanation of human behaviour in diverse fields like public health, education, disability and child development (Swartz, 2007). The model is usually represented in concentric circles; figure 1 provides a graphic description of the model.

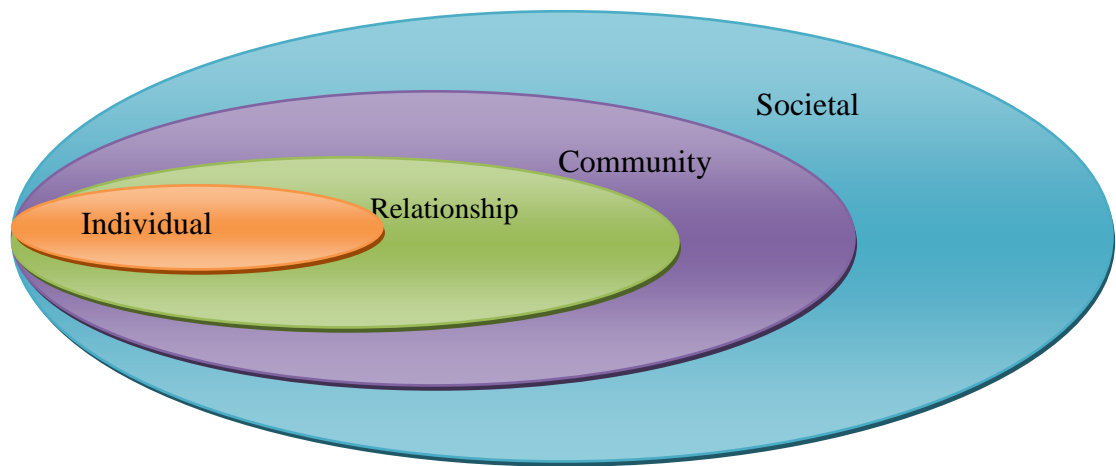


Figure 1: Social ecological model (Source: Dahlberg & Krug, 2002).

Conceptual framework for the study

Analysis of the abortion decision making process requires a conceptual approach that can reveal the multiple influences on the process. In designing the study, therefore, this research draws on the social ecological model because it provides a focus for analysis by looking for varying influences on the abortion decision making process instead of just the individual level influences. Moreover, unlike the theory of planned behaviour, the transtheoretical model, the information-motivation-behavioural model, the health belief model, and the Vroom-Jago decision making theories which focus on intra and interpersonal factors, the social ecological model moves beyond it. It forces us to consider the abortion decision making beyond the narrow confines of individual choice or even the influence of intimate partners, family and friends. It recognises the broader sociocultural influences on the process. Also, the abortion decision making process is a multifaceted behaviour in which influence is drawn from various sources, therefore a social ecological approach in this context may be the most appropriate. As noted by

Bauer and colleagues (2003) theories which focus on only one level underestimates the effects of other context on behaviour. The socio-ecological model has also been argued to be an effective framework when exploring complex health issues, as revealed by the literature there are diverse influences on the abortion decision making process. This theory, has also been noted to help in the identification of determinants at the different levels of influences and suggest the relationship between and among them, for example determinants such as abortion policies may influence the place in which an abortion is sought. Finally, it is primarily a qualitative research framework.

Within the context of this study, three levels of influences on decision making were considered, namely the individual, relationship and societal level factors. Due to the sensitive nature of the study the community level factors were not considered. At the individual level the study examined the role of the study participant in terminating pregnancy; here consideration is made of how participant's knowledge about abortion may affect her decision. As reiterated by Feltson and Carlson (2001) interpersonal relationships are extremely influential to behaviour change. At the interpersonal level the influence of intimate partner, family, friends and health workers on the abortion is considered. Lastly, at the societal level, the influence of abortion laws on pregnancy termination is considered.

Conclusion

Thus, far this review has offered a broad range of issues on pregnancy termination. The review started with the global scenario on abortion with examples from the Western, African and Ghanaian context. It further showed

the consequences and implications of abortion on individual, societal and national economies. The chapter further examined the legal and religious regimes surrounding abortions. Also the discourse on health workers attitude to women seeking abortion and reasons why women sought for abortions was explored. Besides, the chapter attempted a conceptualisation of decision making and the divergent influences on the process. The chapter ended with a discussion of some decision making theories. It then drew on the social ecological model to design the conceptual frame for the study.

CHAPTER THREE

RESEARCH METHODOLOGY

Introduction

This chapter describes the methodological perspective which informed the design of the study, study population, study area and sampling procedures. It also discusses ethical issues associated with the research methodology, instrument of data collection, pre-testing of instrument, data collection, challenges faced during data collection and data analysis.

Research approach adopted

Research designs are tools which offer perspectives on certain aspects of reality (Neuman, 1997). This study was located within the interpretivist research design; because it was deemed more suitable in helping to achieve the intended research aims and objectives. Interpretivism emphasises qualitative research methodologies and seeks to answer questions about the experiences and meanings people give to various aspects of their lives and social worlds. It attempts to explain those experiences, behaviours, interactions and social context (Fossey, Harvey, McDermott & Davidson, 2002). Qualitative research has as its central focus, the processes and meanings arrived at through human interaction without any independent existence outside the social context (Creswell, 1994).

The World Health Organisation (1996), for example, has suggested the use of qualitative methodologies in researching induced abortion and other sensitive issues as particularly valuable due to their sensitivity and often clandestine nature. This assertion influenced the adoption of this perspective.

Moreover, using this approach gives the opportunity to gain a descriptive understanding of the values, actions and concerns of the participants under study (Denzin & Lincoln, 2000).

The qualitative standpoint is represented by three major schools of thought namely ethnomethodology, symbolic interactionism and phenomenology (Cohen & Manion, 1994). Ethnomethodology, is a school of thought that focuses on the way people make sense of their everyday world. It argues that people are rational actors but employ practical reasoning rather than formal logic to achieve, display understanding and function in the society. Symbolic interactionism, describes how humans act towards things based on the meanings ascribed to those things or how people act in a particular way based on their definition of the situation (Cohen & Manion, 1994).

Phenomenology urges researchers to ‘set aside all previous habits of thought, see through and break down the mental barriers which these habits have set along the horizons of our thinking..... to learn to see what stands before our eyes’ (Crotty, 2005, p. 80). It also promotes the meanings and understandings of a phenomenon as experienced by the participants under study. Phenomenology was considered an appropriate qualitative tradition to borrow from because it emphasises on the subjective understanding of an experience from the perspective of those who have experienced it as well as engaging and making sense of the phenomenon under study directly (Oduro, 2007). Another feature of phenomenology, which was deemed useful for the study, is the priority that it gives to the voices of the researched. Danaher and

Briod (2005) posit that data gathered through language aids in projecting the words of the researched in their own voices.

Despite the strengths of phenomenology it has some weakness. A major weakness associated with this method is the concept of 'bracketing' or issue of setting aside all presuppositions such as previous beliefs and assumptions before going to the field. In practical terms, one wonders how feasible it is for one to go to the field without any assumptions. As, Moustakas (1994) argues, going to the field without any assumption is itself an assumption because, all questions intended for the study are based on some assumptions. Ashworth (1999) also, argues that even the introduction of the research project to participants relies on assumptions therefore totally setting aside all assumptions before undertaking a study is impossible, nevertheless it appears to be the most suitable option for this study.

Profile of the study area: Ashiaman

The area for the study is Ashiaman. It was founded by Nii Ashia in the 17th century and is the second largest settlement within the Greater Accra Region of Ghana. It is a heterogeneous community with diverse ethnic and religious population. The township is dominated by four main ethnic groups namely the Ga-Dangbe, Ewes, Dagomba and Akan. Besides, there are people from all the 10 regions of Ghana and other African countries, residing within the municipality (National Development Planning Commission & United Nations Development Program, 2005; Nunoo, 2008).

Ashiaman is located about four kilometres to the north of Tema and about 30 kilometres from Accra. It shares boundaries on the north and east

with the Katamanso Zonal Council. The municipality is bounded on the south by the Tema Township and on the west with Adjei Kojo, a community which is part of Tema Zonal Council (Ghana Statistical Service, 2005; Nunoo, 2008; Awumbila & Agyei-Mensah, 2009). Ashiaman lies within the coastal savannah zone and has a vegetation of grassland and shrub (National Development Planning Commission & United Nations Development Program, 2005). The township, which was originally under the control of the Tema Municipal Assembly, gained its municipal and autonomous status on the 29th of February 2008 (Ministry of Local Government, 2009).

Ghana's 2000 Population and Housing Census report estimated the population of Ashiaman to be 150,312 with an annual growth rate of 4.6 per cent, which was higher than the 2.6 per cent national growth rate. Of the number, 75,183 of the population were males and 75,129 were females (Ghana Statistical Service, 2005; Awumbila & Agyei-Mensah, 2009). Ashiaman is said to accommodate about two thirds of the entire workforce of Tema municipality, with about 75% of women within the township being self employed (Awumbila & Agyei-Mensah, 2009; National Development Planning Commission & United Nations Development Programme, 2005).

Ashiaman is a largely deprived, underdeveloped and marginalised settlement compared to some of its surrounding towns like Accra and Tema. For instance the town has only (1) one public health centre, (14) fourteen private clinics and (1) one private maternity home. It also has 17 public basic schools, 286 private basic schools, one public senior high school and seven private senior high schools (Nunoo, 2008).

The Ashiaman municipality was selected mainly because of issues of access. Marie Stopes International has a facility for reproductive health and permission was granted for the facility to be used for the study. Figure 2 shows a map of the study area.

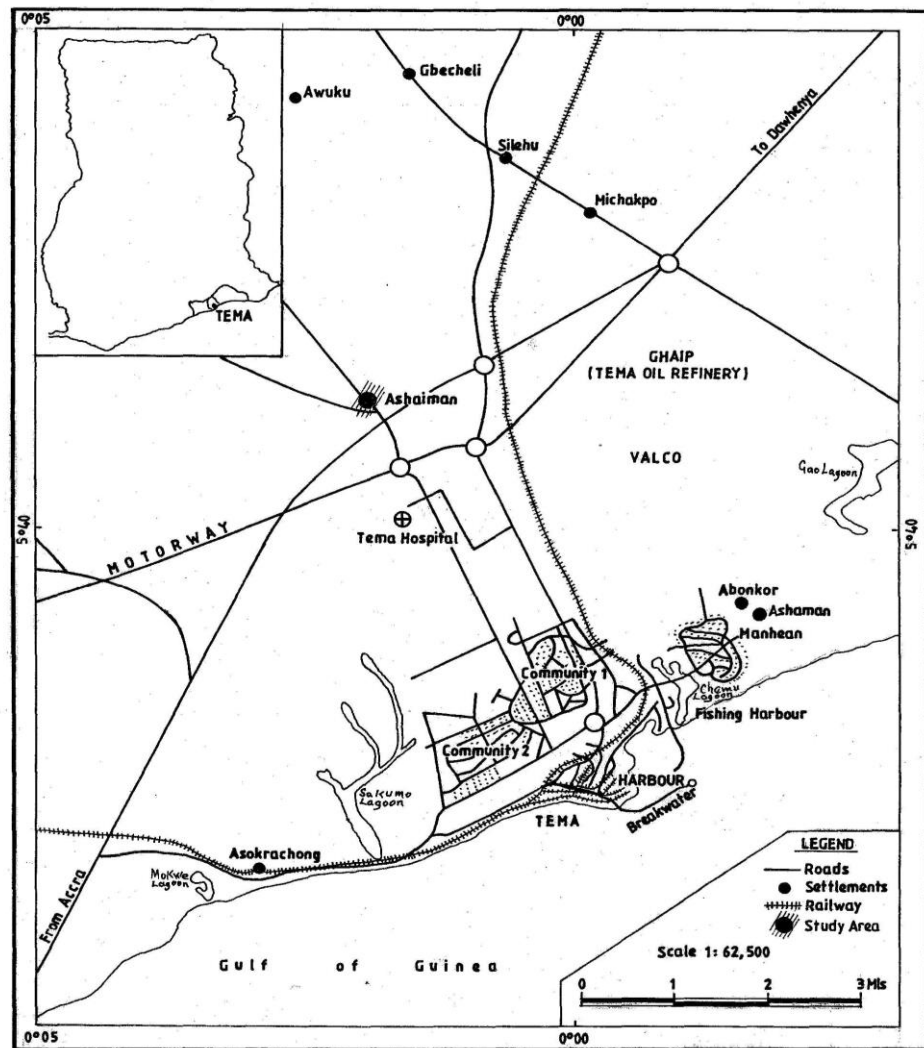


Figure 2: Map of Tema showing the study area

Source: Department of Geography and Regional Planning, UCC: 2009

Background information about the Marie Stopes Centre

Marie Stopes International is an international non-governmental organisation which provides reproductive health services for women,

especially the disadvantaged. The Ashiaman centre is the second Marie Stopes Centre to be set up in Ghana. It was officially launched on the 4th of May 2007 in response to the Reducing Maternal Mortality and Morbidity (R3M) Project of four consortia (Ipas, Engender Health, Population Council and Marie Stopes International). By the Project design, the R3M partners were to work in the Greater Accra, the Ashanti and the Eastern Regions, three regions in the country with well noted maternal ill health problems. Being a densely populated town with over 10 thousand people and high incidence of abortion related problems, it became a suitable venue for setting up a Marie Stopes Centre (Marie Stopes International, 2009).

Data gathering instrument

An interview guide for in-depth interviews was used in the collection of data. The interview guide contained 28 open ended items which guided the discussion. The discussion bothered on issues surrounding the background characteristics of participants, their heterosexual relationships and sexual experiences, abortion decision making and the processes involved in the termination of pregnancy (See appendix, 1).

Pre-testing of instrument

The instrument for data collection was pre-tested at the Cape Coast Metropolitan Hospital after permission had been sought and granted by the various gatekeepers. The nature of the study was also explained to the authorities concerned as well the participants. Furthermore, the participants were made aware of their right to take part or withdraw from the study. This

was in line with O'Connell, Davidson and Layer's (1994 cited in Oduro, 2007) suggestion that participation in research should be based on informed consent.

The pre-testing took place in the month of April 2009, at the Cape Coast Metropolitan Hospital. During the pre-testing, the hospital was visited weekly to find out whether there had been any admissions due to induced abortions. In all five women were reported as being on admission because of abortion related complications. Subsequently the nurse in charge explained the purpose of the study to them and they all agreed to participate. However, after the nurse left and we went to the scheduled place of interview, which was one of the empty rooms in the ward, three out of the five women indicated that they did not in any way interfere in ending their pregnancy despite their medical records indicating otherwise; therefore only two women were involved in the pre-testing. This occurrence was worrisome in the sense that it led to concerns about how easy it would be to recruit participants for the main study and the reliability of the information provided.

The pre-testing helped in knowing ways of relaxing the participants before delving into the substantive issues, their reaction to some of the questions and the duration that the interviews were likely to take.

Ethical considerations

Permission for this study was granted by the University of Cape Coast after a proposal outlining the aims and the objectives of the study had been presented and approved. In addition, permission was sought and granted by the metropolitan health director for Cape Coast, the country director, clinical services manager and centre manager of Marie Stopes International Ashiaman

facility before the start of data collection. The study was also explained to participants and their informed verbal and written consent was obtained before interviews (see appendix 2).

Participants were also promised confidentiality and anonymity. This was to ensure that the study does not expose them to any form of ridicule or stigmatisation. Moreover, the interviews were conducted in private. In addition, pseudonyms were used for all the participants and after each interview participants were debriefed in order to reduce any possible anxieties that might have occurred during the course of the interview. Counsellors were also identified and informed that participants needing counseling would be referred to them.

Participants for the main study

For the main study, the population were 28 women, aged 15-30 years who reported at the Marie Stopes International facility seeking to induce abortion. The literature (Henry & Fayorsey, 2002; Hords & Wolf, 2004; Olukoya, 2004; WHO, 2004) suggests females within this age group as being the most vulnerable to induced abortion.

Selection of participants

At the Marie Stopes clinic, before an abortion is performed a client first has to undergo a one on one counselling session. After which they are taken to the surgery room for the abortion, then to the recovery room to rest a while before discharge. The participants for the study were recruited with the help of the health workers after discharge. The purposive and the accidental

sampling techniques were employed in their selection. At the start of fieldwork, I joined all counselling sessions, during which the reason for my presence was explained to the clients, particularly those who met the age requirement of the study which was between 15 and 30 years. Upon recovery of the clients the health workers reminded them about the study and I initiated discussion with those willing to take part.

Data collection

Data were collected through fieldwork which lasted three weeks, that is 11th to 30th May, 2009. Interviews were the sole means of data collection and they were all done at the Ashiaman Marie Stopes Centre. All the interviews were conducted at one of the offices in the facility. This was to ensure that the privacy of the participants was not compromised. Before the start of interview the purpose and the objectives of the study were explained to the study participants. They were also assured of anonymity and confidentiality. In addition, permission was sought from them to record the interviews. Upon hearing the use of a tape recorder for the interviews, some of the participants expressed some misgivings and indicated what if their interviews were aired on the radio. Their apprehension was calmed by reassurance that the information solicited was solely for academic purposes.

Before delving into the main issues, the participants were asked questions on general everyday issues about the weather, news headlines and other subjects. This was meant to relax them and stimulate discussion, in a friendly and relaxed environment. On average each of the interviews lasted for

35 minutes to an hour. Within the period 28 women aged 15 to 30 years were interviewed.

Member checking

Member checking was employed in enhancing the trustworthiness or validity of the study. To Creswell (1994) member checking is a situation where analysed reports are taken back to research participants for their validation. However, because of the sensitivity and difficulty in accessing participants, the interviews were played back to each study participant after an interview session. This was to enable participants listen and delete portions of the interview they felt should not be retained. Such feedbacks helped to maintain the exchange feature of interview relationships (Daly, 1992 as cited in Sword, 1999).

Data Analysis

The analysis of the data began with the 'listening phase'. All the tape recordings were transcribed. After the transcription, the transcripts were read and compared with what was on the tape recording to ensure that nothing had been left out. From the transcripts, emerging themes, patterns and categories were identified.

This was done using Miles and Huberman's, (1994) framework for qualitative analysis as a guide. According to Miles and Huberman (1994) there are four main steps in qualitative data analysis, these are data reduction, data display, conclusion drawing and verification. In data reduction, data that are relevant to the study is identified and organised. After the organisation

emerging patterns and themes are identified and then the data are coded. The third step, which is conclusion drawing, involves a consideration of the larger meanings and implications of the data as they relate to the objectives of the study. The final stage involved a verification of the data that is revisiting the data to search for alternative explanations and meanings to it.

Challenges to data collection

This study started with an introductory letter from the University of Cape Coast (UCC) to the Cape Coast Regional Hospital. However, access to the facility for the study was denied due to the perceived negative implications of the study. Interactions and consultations with some members of Department and colleagues, resulted in the decision to inform the Cape Coast Metropolitan Director of Health and the clinical services manager of Marie Stopes about the difficulties in obtaining study sites. A meeting was later scheduled and the research aims and objectives were explained to them. They in turn asked for time to contact the various gatekeepers at the proposed facilities. After clearance had been sought from the gatekeepers, they personally went and introduced me to the persons in charge of the study sites.

Due to the highly sensitive nature of the study, it would have been very essential to spend time building rapport with the study participants before starting data collection, but because of the difficulty in accessing participants and time limitation, this was not done. Nevertheless, to ensure that the limited time for rapport building did not affect the quality of data, the study participants were talked to about general issues, till they became very relaxed

before venturing into issues regarding their sexual behaviour, which is considered private and sensitive (Lee, 1993).

Another challenge faced during data collection was the reaction of some participants to the recording of the interviews. This was solved by assuring study participants that the data being collected was purely for academic purposes. The emotional outburst expressed by some study participants during the course of the interviewing was challenging. This was however resolved by referring them to counsellors at the centre. In addition some study participants used the interviews as a forum to talk about their marital problems. This provided an opportunity to empathise with the participants.

Finally, limited time was another challenge, during the course of the interviews some study participants indicated that the interviews were too long and that they were in a hurry. This led to cutting short the introductory sections and going straight into addressing the important issues such as the background characteristics of the participants, the reasons for the abortion and the abortion decision making process.

Conclusion

This chapter has offered an account of the methodological perspective underpinning the design of the study. It started with a presentation on qualitative research and some of its associated schools of thought. It also stated the importance of qualitative research methodologies in interrogating the study. The characteristics of the study area and some background information about the facility for the study were explored. In addition, issues

associated with the collection and the analysis of data were presented. The chapter ended with some of the difficulties encountered in the collection of data and how they were handled. The following chapters four and five begin to disclose how the various experiences of participants shape their abortion decision making.

CHAPTER FOUR

BACKGROUND CHARACTERISTICS, KNOWLEDGE OF ABORTION LAWS AND REASONS FOR ABORTION

Introduction

Public discussion about abortion has mainly centred on unsafe abortions and its associated complications. Receiving less attention has been the characteristics of women who induce abortions, the influence of the abortions laws on the decision to cause abortion and the reasons for the abortion (Finer, Frohwirth, Dauphinee, Singh & Moore, 2005). Building on the methodological perspective explored in the previous chapter, this chapter presents some of the findings of the study. It begins with a presentation of the background of study participants, followed by a detailed discussion of participant's knowledge of Ghana's abortion laws and the reasons which influenced their decision to abort their pregnancies. For ethical purposes, all the names used in the study are pseudonyms.

Background characteristics of participants

The age of the 28 participants in the study ranged from 15 to 30 years. Seventeen of the participants were between 20 and 29 years. In addition there were six participants aged less than 20 years and five participants aged 30. With respect to residence, 13 of the participants interviewed indicated that they lived at Ashiaman. Also interviewed were six participants living at Tema, five at Michel Camp, two in Accra and two outside the Greater Accra Region. Regarding religion, 22 of the participants identified themselves as Christians. They were made up of nine Catholics and 13 belonging to various protestant

Christian denominations. In addition six Muslims were interviewed. Thus two of the major religions in Ghana were represented.

The data indicated that most of the study participants had had some education. Thirteen of the participants interviewed were Junior High School (JHS) graduates. Three did not complete basic education and seven had Senior High School education: two completed and five did not complete. Two had attended vocational school. There was only one person sampled who had no formal education. In terms of occupation, 18 of the participants were self employed: they were involved in activities such as the selling of fruits and petty items like biscuits, toffees, fruits and safety matches. Four persons worked for others: two were working in restaurants as waitresses, one was a teacher and the other worked with a private waste collection agency. Also interviewed were two in apprenticeship training, two students and two unemployed. The marital statuses of the participants indicated that 16 of them were never married. Seven were married and five were in co-habiting relationships.

Knowledge of abortion legislation

The laws governing abortion in Ghana articulate that abortion is not an offence if the pregnancy is the result of rape, incest or the defilement of a female idiot; when the 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 a substantial risk that if the pregnancy is carried to term the child would suffer from or later develop a serious physical abnormality or disease (Morhee & Morhee, 2006). Within the current context surrounding abortions,

this section aimed at eliciting from participants their knowledge about the abortion legislation in Ghana.

There was a general ignorance by almost all the study participants about the law surrounding abortion in Ghana. Out of the total sample only two participants, with secondary school education, demonstrated some knowledge about the abortion legislation in Ghana. This is what they said:

The law allows it if the pregnancy resulted from rape, incest or if it can lead to the woman's death (Monica, 22 years).

It is a criminal offence and when caught you can be imprisoned. But if it is done in a health facility by someone who has been trained then it is okay (May, 24 years).

Asked, where they got the information from, sources such as books, radio, friends, school and television were mentioned. Sixteen of the participants mentioned that they did not know anything about the abortion legislation. This was exemplified in comments such as:

I have no knowledge about it (Matilda, 29 years).

I don't know that such a law exist (Nina, 24 years).

That one I don't know (Fuseina, 20 years).

Reasons such as issues bordering on abortion not being discussed often in the public domain were mentioned by the participants for their lack of knowledge. Another person said that though she did not know anything about abortion laws in Ghana, in her opinion abortion was not very popular nowadays. This standpoint might perhaps be influenced by the fact that abortion is a subject that is rarely discussed, hence her perception that it is rare. A participant stated that due to the free maternal health policy, women who would have had their

pregnancies terminated now gave birth. The free maternal health policy of exempting users from delivery fees, was introduced in the four most deprived areas of the country in September, 2003. In April 2005 the policy was extended to the remaining six regions in the country. The policy aimed at reducing the financial barriers in using maternity services (Immpact, 2005).

These are excerpts from the interview:

I do not know about it but I think nowadays abortion is not very popular. Due to the free maternal health policy everywhere you pass you see small small children pregnant. For a two month pregnancy the cost of abortion is 600 thousand at other hospitals it is not everyone who can afford (Sophia, 30 years).

As to what they knew about the laws governing abortion in Ghana, six participants said that abortion was illegal. An enquiry on what informed their view revealed friends, the print and electronic media.

It is illegal (Jemila, 30 years).

I know that it is illegal (Paulina, 24 years).

Two other participants said that:

What I know about the laws in Ghana concerning abortion is that if you give birth and you put it in a polythene bag and you are caught you will be put in prison. But if you have your own body and you use it for abortion, I do not believe the Ghanaian law will do you anything (Melissa, 30 years).

Nineteen year-old Rukiyatu added:

I think it is your own body so there is nothing wrong with it in my opinion; the police can arrest you only if you give birth and throw it away (Rukiyatu, 19 years).

Yet still, one participant argued that Ghana does not have any laws on abortion. This is reflected in her statement:

Ghana does not have any laws about abortion (Mavis, 19 years).

From the voices of the participants, it is clear that people are ignorant about the laws governing abortion in the country.

Reasons for abortion

Women terminate their pregnancies for diverse reasons, ranging from social, cultural, medical, economic, relationship problems to career and educational ambitions. This section discusses the various reasons mentioned by participants as having influenced their decision to abort the pregnancy.

Economic reasons

Economic difficulties featured prominently among the reasons assigned by participants for pregnancy terminations: nine of the participants mentioned that economic challenges led to their abortions. Mary's account, for instance captures the difficulty faced by some of these women:

Things are very difficult I am not doing any meaningful work
(Mary, 28 years).

Sixteen year old Aisha added that:

Right now I am not doing anything.....the boy is also not working so if I give birth now we cannot look after it (Aisha, 16 years).

Sybil mentioned:

.....in Ghana nowadays things are hard it is difficult taking care of children so having many children always makes you hard up (Sybil, 29 years).

Another said:

I am not financially sound and I already have a daughter who is with my mother (Lawrencia, 30 years).

Naomi argued:

I already have two children that I am struggling to take care of it is not easy (Naomi, 30 years).

It can be seen from the data that unemployment and lack of a regular source of income influenced some participants to terminate their pregnancies.

Child spacing

Child spacing was one of the issues which emerged from the interviews. Four of the participants, all married or in stable union, said they aborted because their children were too young. Some of the responses given by the participants were:

My child is still young I will want her to grow a little before giving birth again (Joyce, 21 years).

My child is very young she is just 11 months old (Louisa, 24 years).

My last child is young he is just 2 years old (Anatu, 28 years).

The voices of the participants showed that instead of couples relying on contraceptives to delay and space child birth, some are resorting to abortion as an alternative. Considering Joyce's statement it could be rationalised that she was using abortion to space birth, while Louisa and Anatu were using it to delay birth.

Fear of parental reaction

The fear of the reaction of parents to pregnancy also came up during the interviews. Juanita and Sandra, both single and residing with grandmother

and parents respectively said they went in for abortion to avoid any negative reaction from them.

Seventeen year old Juanita an orphan said:

I do not want my grandmother to find out; she will be angry with me (Juanita, 17 years).

While Sandra an apprentice seamstress said:

If I do not remove it and my mother finds out she will worry me (Sandra, 18 years).

Evidence shows that in some instances where parents may not be aware of their children's pregnancy the fear of their reaction causes some females to resort to abortion (Bankole, et. al., 1998; Svanemyr & Sundry, 2007).

Career and educational ambitions

Bankole, et. al.'s (1998) study in 27 countries on reasons why women have abortions identified career and educational ambitions as important reasons for abortions. In contrast, this study sampled only three females who mentioned that they terminated their pregnancies to prevent a disruption in career and education. Mariama a twenty three year old woman rationalised her abortion in terms of allowing her to continue working she said:

It is because of my job, if I keep the pregnancy I cannot do the job and I will lose it (Mariama, 23 years).

Grace on the other hand saw the abortion as giving her the opportunity to implement her career and educational goals:

I will want to achieve something in life. I have a lot of plans I will want to go to a computer training school....do some courses in catering that will add more value to my life.....If I give birth now I cannot do all those things (Grace, 22 years).

Whereas Lydia argued:

I am still in school I want to do something meaningful with my life. If I become a mother right now I cannot have any good future (Lydia, 15 years).

Twenty three year-old Mariama's fear of being sacked from her job caused her to terminate her pregnancy whereas Grace's (22 years) desire for a better future also influenced her abortion decision. Lydia on other hand saw herself as being in school and not ready for parenthood. It is clear that all the three participants were not ready for childbirth.

Partner's attitude

Some of the participants blamed their partners for the abortion. They attributed the abortion to their partner's denial of the pregnancy, womanising, non-fulfillment of promise and anger. Sylvia and Elizabeth for instance mentioned they aborted because the pregnancy was denied by their partners:

He said that he is not responsible and that I should go and look for whoever made me pregnant. So I decided to come and remove it for peace (Sylvia, 24 years).

The man beats me on the least provocation. When I realised that I was pregnant and I told him he became angry, he then beat me and told me that I should remove it since he is not responsible (Elizabeth, 22 years).

For Patricia, a twenty one year old SHS dropout, the non-fulfillment of her partner's promise of marriage and education was mentioned as influencing her decision to abort:

With my last pregnancy, I was in the final year of SHS when it occurred. The man accepted responsibility for the pregnancy and promised to take care of me till I deliver. He also promised send me back to school and marry me. I delivered two years

ago but he has not fulfilled the rest of his promise. I therefore decided to remove this one (Patricia, 21 years).

Ethel also spoke of how the sexual behaviour of her partner influenced her decision to terminate the pregnancy.

My man, he is not correct. He likes women too much I want to leave him (Ethel, 22 years).

Nina on the other hand argued:

My husband was angry with me when I told him I was pregnant. He told me that I should have protected myself (Nina, 24 years).

The experiences of participants highlight the role played by men in influencing women to abort pregnancies. Whereas pregnancy is the result of sexual action between a man and a woman, the experiences of Sylvia and Elizabeth show how some men tend to shy away from their actions or responsibilities. From a gender perspective, Elizabeth even experienced violence in the form of beatings from the very man who impregnated her. The men did not take responsibility for their action and also did not respect the women, even at the vulnerable period of pregnancy. Ethel, on the other hand, though not happy about the partner's behaviour, continued having non-protected sex with him and became pregnant. For Nina, her experience points to the fact that men expect women to take responsibility for safer sex practices and the prevention of pregnancy. Though her partner did not tell her to abort the pregnancy directly, his attitude indirectly influenced her to terminate the pregnancy.

Impregnated by someone other than regular partner

Mavis and Fuseina described how they decided to terminate their pregnancies because they were impregnated by someone other than their regular partners. These were their voices:

When my boy hears of it he will leave me because he is not responsible for it (Mavis, 19 years).

The father of my son..... he is gone overseas and will be coming in 2011; it will not be good if he comes to see me carrying another man's child (Fuseina, 20 years).

Mavis and Fuseina's actions might have been influenced by the fact that, in the African and Ghanaian society, though it is culturally acceptable for a man to be unfaithful to his partner, it is highly stigmatised among women. As reiterated by Oduyoye (1995), while society approves of multiple and extra-marital relations for men, the same is not expected of women. Participants' therefore carried out the abortions to prevent the consequences associated extra-marital relations.

Health reasons

Sophia a thirty year old woman mentioned aborting twice due to health reasons:

Pregnancy really makes me suffer. I will be sick throughout I cannot eat even this one since it happened I can't eat normally all that I am able to take is porridge and even when I buy porridge thousand I can't even drink all (Sophia, 30 years).

Sophia's experience illustrates how women are sometimes forced to terminate their pregnancies on health grounds.

Discussion

As reflected in the discussion, factors influencing women to terminate their pregnancies are many and complex. Relating the study to the social ecological model it could be argued that participants were affected by a broad range of intra, interpersonal and societal level influences. While certain factors like the knowledge of the participant about abortion could be related to the intrapersonal level of the social ecological model. Other factors like termination the pregnancy to prevent negative reaction from the parents and economic difficulties could be related to the interpersonal and the societal level influences of the model. At the start of the interviews participants were asked questions about their background characteristics as part of the rapport building process. They were asked to recount their age, residence, educational background, occupation, religion and marital status. From the results it was observed that 60 percent of the participants sampled were between the ages 20 and 29 years old, in contrast to other studies which reported women less than 20 years as having the highest probability of inducing abortions (Lamptey, Janowitz, Smith & Klufio, 1985; Ghana Statistical Service, et. al., 2009). In terms of residence 89 percent of the participants lived in and around the environs of Ashiaman, emphasising the benefits of citing health facilities within communities. With regards to knowledge about abortion legislation, an important issue that has received attention in abortion discourse is the influence of abortion laws on access to services (Rahman, et. al., 1998), in this study however participants were ignorant about the abortion laws. Situating this within the social ecological perspective even though knowledge about public legislation is supposed to influence behaviour, in this case it was not so.

This situation might be attributed to the fact that because there are multiple levels of influences on the abortion decision, knowledge about the abortion legislation was not enough to influence study participants.

The reasons women give for undertaking abortions are often far more complex than simply not intending to carry the pregnancy to term. While some of the participants mentioned terminating their pregnancies because of difficult economic circumstances others relied on abortion to delay and space births. For some especially, those living with their parents the fear of their reaction to the pregnancy made them resort to abortion. Some participants also cited career and educational ambitions, impregnated by someone other than their regular partners, the attitude of their partners and health reasons as their reasons for the abortion. The findings give an indication of how women are sometimes compelled by circumstances to terminate pregnancies.

Conclusion

This chapter has presented an overview of the background characteristics of study participants, their knowledge about abortion legislation and reasons for terminations. It showed that women from various backgrounds resort to abortions when faced with an unwanted pregnancy. Regarding the knowledge of participants about the abortion legislation, participants expressed ignorance about the abortion laws. The narratives, further highlighted that, although, numerous reasons influenced participants in terminating their pregnancies, financial considerations were the most important. Also it was established that participants' abortion decisions were affected by intrapersonal, interpersonal and societal level factors of the social

ecological model. It can be concluded that pragmatic and practical concerns override all other issues when a woman wants to terminate a pregnancy.

CHAPTER FIVE

DECISION MAKING AND ACTIONS TAKEN TO END PREGNANCY

Introduction

The previous chapter introduced the background characteristics of study participants, followed by a discussion of their knowledge about abortion legislation and their reasons for the abortion. This chapter describes how participants made the abortion decision and the actions they took to end the pregnancy.

Abortion decision making

Decision making often centres on whether to keep or not to keep a pregnancy, the choice of method and facility. While women sometimes decide alone to terminate their pregnancies, more often than not the abortion decision is a shared one. This section discusses the abortion decision making process. It attempts to look at how the individual and relationship levels of the social ecological model may have influenced participants.

Role of the study participant

Five of the participants mentioned taking the final decision to terminate the pregnancy because of differences between them and their partners. Some of them blamed their actions on partner's indifference, economic difficulties, non-readiness for motherhood and irresponsibility. Elizabeth and Patricia, for example mentioned that after discussing with their partners on what to do about the pregnancy the indifference shown by them influenced their decision to abort.

I took the final decision alone. When I told him about it he wasn't very happy and we quarreled. Though we are still together he has not asked anything about it (Elizabeth, 22 years).

I decided alone, he knows that I am pregnant but he has not said anything about it (Patricia, 21 years).

The narratives showed that participants often took the final decision to terminate the pregnancy when there was a disagreement between them and their partners. From a social ecological perspective it could be argued that since there are multiple level influences on the study participants although their partners disagreed with the abortion they still went ahead with it by considering other factors. From the narratives it can be deduced that because Elizabeth and Patricia's partners did not want the child and knew they would object to an abortion; they indirectly influenced them to abort by adopting an indifferent attitude.

On the other hand Sybil, Jemila and Paulina whose partners did not consent to the abortion assigned economic difficulties, irresponsibility of partner and non readiness for motherhood as influencing their actions.

He said that I should keep it; God will help us take care of it but I said that no we already have two we should rather use the resources in taking very good care of them although he stood his grounds I have removed it (Sybil, 29 years).

He said that I should keep it; but I can't see him well nowadays. He has not been acting responsibly towards me.... I know that if I do not remove it he will not help look after the child (Jemila, 30 years).

He said that I should keep it; when he asks about it I will tell him I miscarried it (Paulina, 24 years).

From the quotes it could be realised that pragmatic concerns often influenced the abortion decision. While Sybil's partner argued that God will help them take care of the child, Sybil on the other hand saw an additional child as more pressure on their economic resources. For Jemila the inconsistency between her partner's words and actions influenced her choice. Paulina on the other hand aborted because she was not ready for motherhood.

Role of partners

An analysis of the data revealed a high involvement of males in the abortion decision making process. Sixteen year old Aisha mentioned having been influenced by her partner to abort the pregnancy:

My boyfriend said that we should remove it because he is still in school and I agreed with him (Aisha, 16 years).

Aisha's words reinforce the reliance on abortion sometimes to prevent a disruption in educational pursuit. Aisha's partner knew that if it became public knowledge that he had impregnated someone, he might have to stop school and start working to take care of the woman and the unborn child.

Similarly, 17 participants said the abortion decision was a joint one. They mentioned having discussed the issue with their partners to terminate the pregnancy. The following statements expressed their views:

It was only my husband and I who decided (Anatu, 28 years).

I am a married person who understands myself, so it is only my husband and I who decided. He even gave me the money for it.....this thing if you go and tell your parents they will think you are not mature as for married people there is a need to keep everything within (Mary, 28 years).

He asked me what we should do with it.... he wanted to find out whether I have given my mind to him because if I say I would not do he cannot do it alone (May, 24 years).

When I told him he asked me what I want to do about the pregnancy I said I wanted to remove it and he supported me (Melissa, 30 years).

From Mary and Anatu's situation, it could be deduced that they felt that discussing their abortion intentions with only their partners was the best option. It could also be argued that as married people their partners were their immediate contact. In contrast, May and Melissa's partners allowed them to decide and then supported their decision.

Monica, on the other hand mentioned, deciding with only her partner to prevent stigmatisation.

It is only the man and I who decided because if you tell someone they will also in turn go and tell another person and then with time everyone will know that you have done an abortion it can be used against you (Monica, 22 years).

Monica's statement points to the fact that due to her desire to avoid the negative consequences associated with disclosure she did not involve other people in the decision to abort the pregnancy.

Nineteen year old Rukiyatu and her partner jointly decided to terminate their pregnancy in order to avoid being given conflicting advice. According to her:

With the exception of my boy nobody knows. We decided alone because if we tell somebody what we want to do some might say do it others might say don't do it and they will confuse us (Rukiyatu, 19 years).

Rukiyatu and her partner discussed their abortion intentions without influence; this was perhaps to avoid the controversy which often emerges whenever the

topic is broached. As noted by Monteiro (2005) people often take entrenched positions on issues regarding abortion.

Role of family and friends

Within the context of this study family refers to both the nuclear and the extended family. Five of the participants mentioned family and friends playing various roles in the abortion decision making process. Twenty nine year old Matilda, for instance, indicated that her mother became involved in the decision to terminate the pregnancy due to a misunderstanding that ensued between her and the partner. This gave credence to Henry and Fayorsey's (2002) claim that parents often became involved in abortions when there was a misunderstanding between the couple. This is what she said:

The man wanted me to give birth but I told him that I want to remove ...he told my mother that I was pregnant and want to remove it.... she said yes I should remove it ...he has not asked for my hand in marriage (Matilda, 29 year).

Juanita, a 17 year old, orphan living with the grandmother had this to say:

My aunt, she said that I do not learn my lessons why didn't I use condom. She asked me what I wanted to do and I told her the boy said I should remove it. She asked whether I was in agreement, I told her that I do not know what to do I am going to think about it. I later told her that I wanted to abort and she brought me here (Juanita, 17 years).

One participant had no say in the abortion. She indicated that her father decided on the abortion to enable her continue her education, though her partner's parents wanted her to give birth:

My father told them that I am too young to give birth I have to remove it. When he told me that I really cried I never imagined that I would find myself in such a situation. I always thought

such things happen to other people but not me (Lydia, 15 years).

The context within which the families of Matilda, Juanita, and Lydia became involved in the abortion decision making was different. Had it not been for the misunderstanding that ensued between Matilda and her partner probably none of her family members would have become involved in the decision to terminate the pregnancy. Juanita on the other hand, depended on her aunt for support and direction to a place where the abortion could be done safely. In Lydia's case it can be concluded that her young age and the interference of the pregnancy in her education influenced her father's decision to terminate the pregnancy.

Mavis' behaviour contrasts with some of the other participants who involved their partners and family in the abortion decision. She chose to decide with a friend. This is her voice:

I decided with only the friend who brought me here. She is my best friend and I trust her. I did not tell the man I know he would not have allowed the abortion (Mavis, 19 years).

From Mavis' statement it could be inferred that because she knew her partner would not consent to the abortion, she chose to rely on a friend.

Choice of facility

After asking participants how they decided to end the pregnancy, questions were asked on some of the actions they took to implement the decision. This section is on the various factors considered by participants in choosing a health facility for the abortion. It utilises, the social ecological model (Dahlberg & Krug, 2002). Specifically, individual, relationship and

societal level factors are considered. Within this context, individual level factors considers the role played by the participant in the choice of facility, while at the relationship level the role of partners, friends, family members and health workers, is discussed. Finally, at the societal level the influence of abortion laws on the choice of facility is discussed.

Participant and choice of facility

Fuseina, Louisa and Ethel living in Ashiaman mentioned selecting the Marie Stopes clinic for the abortion based on their knowledge that the clinic performs abortion. When probed on how they got to know about it, twenty year old Fuseina mentioned that it was through accompanying a friend to the clinic. The following quote is her voice:

I was once here with a friend who came to abort (Fuseina, 20 years)

The mentioning of friendship was not unique to Fuseina. Twenty four year old Louisa also cited a friend:

I got to know about the clinic through a friend who used to work here she has now been transferred to their branch in Accra (Louisa, 24 years).

Ethel on the other hand argued that it was though rumours:

I heard that this clinic is an abortion clinic. So when I wanted to abort I decided to come here to find out. Luckily when I got here I met someone I knew and she confirmed it and also told me how much they charged so I did it (Ethel, 22 years).

Fuseina, Louisa and Ethel's account depicts the importance of social networks in the spread of information. While Fuseina and Louisa mentioned hearing about the clinic through friends, Ethel reiterated that she selected the clinic

based on rumours. It can therefore be concluded that social networks, are are very important agents in the dissemination of sexual and reproductive health information.

Partner and choice of facility

There were instances where participants were not consulted regarding the choice of facility. Anatu (28 years) for example mentioned playing no role in the choice of facility:

It was my husband who chose this place (Anatu, 28 years)

Sixteen year old, Aisha similarly stated:

I did not select this place it was my boyfriend who did (Aisha, 16 years).

Nineteen year old Rukiyatu on the other hand argued:

Unless you ask the man, he brought me here (19 years).

The narratives of Anatu, Rukiyatu and Aisha, shows the patriarchal nature of the Ghanaian society, because the men were paying for the services they felt they had the prerogative to choose the facility.

Friends and choice of facility

Recommendations from friends emerged as an important factor in the choice of facility. Participants discussed how friends influenced them in selecting the Marie Stopes clinic by highlighting on their good services and low price. Four of the participants felt the good services mentioned by their friends made them select the Marie Stopes clinic for their abortions.

Nina, a 24 year old woman rationalised her selection of the facility by claiming that:

It was because of my friend; she said here they do it well (Nina, 24 years).

Jemila (30, years), on the other hand mentioned the services provided by private institutions behind her choice:

I am here due to the recommendation from my friend; but I know that generally private hospitals are better than the government ones; even schools, the private ones do better than those of the government (Jemila, 30 years).

Sophia similarly mentioned:

I am here because of my friend, but even if she had suggested a government run health facility, it I would not have gone. At government hospitals even if you are sick the nurses treat you anyhow, how much more if you go there and tell them you want to 'remove stomach' (Sophia, 30 years).

Sandra (18 years) and Mavis (19 years) on the other hand explained how their friends attracted them to the Marie Stopes clinic by describing the good services and the low prices charged.

My friend told me here they do it well and the price is low. That is why I came here (Sandra, 18 years).

I came here because of a friend. She said, here the place is fine and they take their time to explain everything to you (Mavis, 19 years).

The narratives of participants depicts that although friends played an important role in the choice of facility participants often considered other factors before adhering to their advice. From a social ecological perspective participants' narratives shows that behavior is affected by multiple levels of influence.

Family and choice of facility

Family members did not have a strong influence on the choice of health facility for abortion. Juanita (17 years) and Lydia (15 years) were the only participants who mentioned family members influencing selection and accompanying them to the clinic.

Juanita an orphan, who mentioned living with a very strict grandmother, said her aunt helped her in the choice of facility:

My aunt, the one I discussed the abortion with, helped me select this place. She even accompanied me here and is waiting outside (Juanita, 17 years)

Lydia a JHS student on the other hand mentioned that her father selected the clinic and told her sister to accompany her:

My father told my sister to bring me here (Lydia, 15 years).

From the quotes it is clear that women often relied on family members with whom they had a close relationship with for support. Juanita, for instance, chose to rely on her aunt instead of her grandmother, because she found her more approachable and friendly. Similarly, Lydia's father played a very important role in the choice of facility.

Health workers and choice of facility

Elizabeth and Naomi explained that they were directed to the Marie Stopes clinic by health workers. Elizabeth a twenty two year old woman whose pregnancy resulted from her inconsistent use of family planning services explained that:

The nurse, that I have been doing family planning with directed me here (Elizabeth, 22 years).

Naomi (30 years) on the other hand said:

When the pregnancy was confirmed I told the doctor that I wanted to remove it and he showed me here (Naomi, 30 years).

The quotes indicate that medical practitioners can be a very important source of knowledge on where to access safe services. It also highlights, the need to educate more health workers about the legal regime surrounding abortions, as reported by Nyarko, et. al., (2008) only 20 percent of them are aware of the circumstances under which abortion is legally permissible in Ghana.

Legal status of abortion and choice of facility

The narratives of Joyce, Melissa and Patricia established that their choice of the Marie Stopes clinic was based on the perception that abortion was illegal. Relating this to the social ecological model, participants' behaviour could be situated within the societal level influences of the model.

Joyce (21 years) for example mentioned that:

For the government hospitals because it is illegal I have heard you need to know someone who will lead you to see a doctor; then the doctor will arrange with you and do it at his house that is why I came here (Joyce, 21 years).

Melissa (30 years) also recounted:

The government hospital I have heard that you can only go there if maybe you do it and there is a problem so people send you. So I came here instead (Melissa, 30 years).

Similarly, Patricia (21 years) mentioned:

I do not think that when you go there they will do it for you because it is illegal. That is why I opted for this place (Patricia, 30 years).

The stories of the participants suggested that though they perceived abortion to be illegal, they still found a safe place for the procedure, thereby contrasting social ecological perspective's influence on the role of public policy on behaviour.

Method and cost of abortion

As discussed in chapter two, clinical terminations of pregnancies are often carried out through two main ways, namely surgical and medical. Surgical abortion is often carried out using manual vacuum aspiration. Manual vacuum aspiration is a five to ten minute procedure in which the cervix is dilated and its products expelled through suction. In medical abortion Mifepristone and Misoprostol are ingested by the woman to bring about the abortion. Both types of abortions are undertaken by the Marie Stopes clinic. All the study participants mentioned using the surgical method. Reasons they cited for the choice was that it was fast and also gave them the assurance that all the products of conception had been expelled. With regards to the cost, participants mentioned having been charged GH¢ 35. This price was on the low side compared to other facilities which charged between GH¢ 50 to 200.

Discussion

There were diverse influences on the abortion decision making process. While some of the participants mentioned taking the final decision alone to terminate the pregnancy based on their partners' indifference, others mentioned terminating the pregnancy despite the objection of partners because of economic difficulties, irresponsibility and their non readiness for

motherhood. Also emerging from the study was a high level of male involvement in the abortion decision making: seventeen of the participants mentioned that the decision was a joint one, between them and their partners, giving credence to Bankole, et. al's (2006) claims of a high level of partner involvement in the abortion decision. While some of them saw their act as a sign of maturity, others mentioned deciding with only their partners to avoid the stigma and confusion that often resulted from being advised by many people. Only one participant mentioned having been influenced by her partner to decide on the abortion. On the role of family and friends in the abortion decision it emerged from the data that, participants often involved family members whom they had a close relationship with. It also confirmed Fayorsey and Henry's (2002) claim that family members often became involved in abortions when there was a misunderstanding between the couples.

Regarding the choice of facility, the strong influence of social networks on the process was apparent, confirming Cotronoe and Krasner's (1977) and the social ecological model's claim of the influence of social networks on the process. The interviews highlighted that while some of the participants chose the Marie Stopes clinic due to a previous experience of having accompanied a friend there, others cited selecting the clinic based on the recommendation of friends. Yet still some argued that rumours regarding the activities of the clinic influenced their choice. The influence of participants' intimate partners on the process was also established. Three of the participants mentioned that their partner selected the clinic. On the role of family members in the choice of facility, two participants less than eighteen years, mentioned that the clinic was selected for them by their aunt and father.

Two of the participants mentioned selecting the Marie Stopes clinic based on the recommendation of their health service providers. Contrasting Rabindranathan's (2003) claim that women often resorted to clandestine unsafe abortions in order to avoid public scrutiny, it was not so for some of the study participants. Although they thought abortion was illegal, hence would not be done for them in a government run health institution, they found a safe private clinic to abort. Also, all the participants mentioned using surgical abortions due to the assurance it gave them that the abortion had occurred. Participants further mentioned paying thirty five Ghana cedis for the abortion, which was on the low side compared to other facilities which charged between fifty and two hundred Ghana cedis.

Conclusion

This chapter has argued that participants' social networks that is (partners, friends, family members and health personnel) and the legal circumstances play a major role in decision making. However, the role of family members and friends was not decisive with regards to abortion decision making. Partners, on the other hand were found to not only play a major role in the decision itself, but were also involved in helping to locate a place for the abortion. In some situations women, took the final decision to terminate the pregnancy alone when there was a lack of consensus with their partners. Health service providers also played an important role in directing participants to service providers. Women's perception about abortion laws played a role in the choice of facility. The findings revealed the need to target the various stakeholders in reproductive health, pregnancy prevention campaigns and

education against unsafe abortions so that they will be able to provide the needed support if need be.

CHAPTER SIX

SUMMARY OF FINDINGS AND CONCLUSIONS

Introduction

Issues concerning abortion and its associated consequences have been a prominent feature in international conferences on reproductive and sexual health and women's rights (Guillaume & Desgrees du Lou, 2002). Besides, the reduction of unsafe abortion has been identified by the United Nations Millennium Development Goal 5 as a key issue in achieving its aim of reducing maternal mortality. This initiative, among others, has led to the recognition of unsafe abortion as a major public health concern (WHO, 2003). This notwithstanding, due to a combination of religious, social and economic factors, countless women from the developing world, especially Africa continue to bear the brunt of unsafe abortions (Warriner & Shah, 2006). In Ghana, despite legal reforms aimed at increasing access to safe abortion, the literature is replete with the impact of unsafe abortions on the lives and health of women (Srofenyoh & Lassey, 2003; Yeboah & Kom, 2003). Within the current context surrounding abortions in Ghana this study sought to explore the decision making process of females seeking abortion at Ashiaman. It was guided by the following assumptions:

1. Abortion seekers are generally not aware of the laws governing abortions in Ghana.
2. Ghanaian women mainly induce abortions due to financial difficulties
3. The abortion decision is often taken by only the female and her partner
4. Women with abortion intentions prefer inducing abortions in private than in public health facilities.

In addressing these assumptions, this study was designed employing a phenomenological methodology using individual in-depth interviews. Also, the social ecological model and the Miles and Huberman framework informed the work. This final chapter provides a summary and conclusion of the key findings of the study.

Summary of findings

Based on the assumptions governing the study, this section presents a summary of the key findings of the study.

Knowledge of abortion legislation

Almost all the study participants demonstrated ignorance about the law on abortion, with the exception of two who rightly pointed out instances where the law permits it. Six of the participants argued that abortion was illegal, while one said Ghana did not have any laws on abortion. A further sixteen mentioned not knowing anything about the abortion laws. A participant also mentioned that in her opinion the free antenatal care had led to a reduction in the incidence of abortion. Two of the participants contended that they could only be reprehended by the law if they gave birth and abandoned their babies but not for undergoing abortions. Probing participants on what informed their views, it emerged that the print, electronic media and friends were the source. Some also contended that issues concerning abortion was rarely discussed in the public domain hence their lack of knowledge about the abortion laws. Situating the findings within the social ecological model, it could be argued that although most of the study participants were ignorant about the laws

regarding abortions in Ghana they still went ahead to seek for a safe place to terminate their pregnancies. This could be attributed to that fact that the study participants were influenced by factors beyond the individual level of the social ecological model like friends, school, the print and the electronic media.

Reasons for abortion

Among the reasons were economic difficulties due to a lack of regular source of income and the general difficult economic conditions in the country, also emerging from the study was the use of abortions to space and limit births. Other participants cited terminating their pregnancies because they were not impregnated by their regular partners. Besides, some participants mentioned resorting to abortions in instances where the pregnancy was likely to result in either a disruption of their career or educational ambition. Some were compelled to terminate their pregnancies because their partners denied responsibility for the pregnancy, behaved irresponsibly and blamed them for not taking action to prevent the pregnancy in the first place. For instance, in the case of Elizabeth, undergoing abortion was not just because of her partner denying the pregnancy but also suffering physical abuse at his hands.

Abortion decision making

The process of deciding to abort the pregnancy was found to be a shared one. The data established that none of the participants terminated the pregnancy without consulting someone such as partner and friends. Besides, there was a high level of male involvement in the process. Males were found to have played a direct role by jointly deciding with the participants to

terminate the pregnancy. At other times their roles were indirect, such as indifference displayed by them. The data also found females sometimes terminating pregnancies without the approval of their partners. They contended wanting to use the available resources in taking very good care of their children and not being ready for motherhood. On the role of family and friends in the abortion decision making, it was observed that they did not have a strong influence on the process. Participants cited depending on family members with whom they had a close relationship with first to help them decide and also support them. For instance one participant mentioned involving her mother when there was a misunderstanding between her and her partner, while another's aunt became involved due to the close relationship that existed between them. The only participant who reported deciding with only her friend argued that she chose not to involve the man because of her fear that he might not allow her to terminate the pregnancy. From a socio-ecological perspective it could be argued that the relationship level influences was found play an important role in the process.

Choice of facility

On the choice of facility, friends were observed to play a key role in the process. Seventeen of the participants mentioned choosing the Marie Stopes clinic based on the influence of friends. Fifteen out of the seventeen participants said they selected the Marie Stopes clinic due to the assertion of friends about the good services provided and low prices charged at the clinic. Of the remaining two; one stated selecting the clinic because of a friend who works in the institution and the other a previous experience of accompanying a

friend to the clinic for an abortion. On the role of men the study found that when they became involved in choosing the facility for the abortion they often did not consult their partners. Although their influence was not strong family members and health workers were also found to have played a role in the choice of facility. Participants further pointed out choosing the facility based on rumours and their perception that since abortion was illegal it would not be performed for them in government health facilities. On the choice of facility for abortions although relationship level influences were the most dominant, societal level influences were also found to have played a role.

Implications of the study

The findings which emerged on the knowledge of participants about Ghana's abortion legislation implies that the knowledge of the law has been negligible. Although the study participants sought safe abortions despite their lack of knowledge about the laws governing their action, there is a need for the abortion laws to be publicised. Like issues on domestic violence, girl child education and child trafficking that receive enormous amount of coverage in the print and the electronic media there is a similar need for publicity regarding issues on abortion. This will enable more people know about it and also allow them to freely access safe abortion services if need be from both government and private health institutions without fear of being turned away. This will in the long run, lead to a reduction in morbidity and mortality associated with unsafe abortions.

The reliance of some participants on abortions for birth spacing shows the need for more education on family planning to encourage couples to rely

on contraceptives instead of abortion. There is also the need for effective post abortion family planning as this will help to prevent repeat abortions and increase contraceptive use. In a study carried out in Turkey on the effect of post abortion family planning counselling, Ceylan, et. al. (2009) reported that 75.9 percent of women used contraceptives consistently to prevent repeat abortions after being counselled. Also some men denying pregnancy, blaming women for pregnancy and sometimes abusing women physically shows the need for gender sensitive health education. Health educational campaigns should include information on the need for both men and women to take responsibility for preventing unwanted births.

The important role played by friends throughout the pregnancy termination process implies the important role they can play as peer educators. Existing evidence indicates that peer led educational campaigns tend to be very effective (Family Health International, 2009). In Thailand, a study which compared peer and adult led educational campaigns found out that persons who underwent peer led education demonstrated the most significant improvements in both knowledge and negotiation skills in issues regarding the use of contraceptives, sexual negotiation and responsible sexual behaviour (Family Health International, 2009)

Conclusion

Although the study involved only 28 persons one can draw some conclusions. First there were various influences and actors in the process. Majority of participants informed or discussed with at least one person before carrying out the abortion. Most participants also cited terminating the

pregnancy because of some pragmatic concerns like economic difficulties, child spacing, attitude of partners, career and educational ambitions, reaction of parents, and being impregnated by someone other than their regular partners. Although it emerged that family members, health workers and friends played various roles in the pregnancy termination process, friends were found to have the most influence on the process.

Situating the findings within the social ecological model relationship level factors were found to have the strongest effect on the abortion decision making process. There is, therefore the need to involve all various stakeholders in the design of appropriate interventions aimed at reducing the need for abortions.

Suggestions for future research

This study, looked at the abortion decision making process at an NGO run clinic in the Greater Accra Region, it can be replicated in government and private health institutions within and outside the region. This will enable a presentation of the issue from various contexts. Also the study did not delve into what the participants did in the event of a complication. It is an area that can be explored by future researchers. The WHO has stipulated that the manual vacuum aspiration should be used in aborting pregnancies because it is safer than the dilation and curettage which is often used in abortions (Grimes, et. al., 2006). A study can be carried out by other researchers to investigate the methods often used in aborting pregnancies. In addition, though questions were asked on the cost of the abortion it was rudimentary; future researchers

can carry out a study on the cost incurred by women during pregnancy terminations.

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APPENDICES

APPENDIX 1: INDIVIDUAL INTERVIEW GUIDE

Topic: 'Decision making process of females seeking abortion at Ashiaman'

Warming up questions: The interview will start with an introduction and explanation of the purpose of study to participants. In addition participants will be made aware that their participation is voluntary and they can opt out at anytime. Also anonymity and confidentiality issues as well as the purpose for the information being solicited from the participants will be explained to them. Furthermore, participant's consent will be solicited for the interview including permission to record. Participants will also be encouraged to use the local language if they are more comfortable with it.

Background Information:

1. Please tell me about yourself?

Probe: Age, place of residence, length of stay at residence, if a teenager find out person living with, marital status (single, married, cohabiting with partner or currently in a relationship, number of children).

2. Please tell me about the family you grew up in?

Probe: Job of parents, Number of siblings, some happy and sad childhood memories.

3. What about the community or communities you have lived in, tell me about it?

4. Please tell me about your educational background?

Heterosexual relationship and sexual experiences

Now I will like to ask you some questions about your sexual relationships and experiences. I know that some of these questions are quite sensitive, and might make you uncomfortable, but be as frank as possible. I will like to assure you that your responses will be kept in strict confidence.

5. A) If you can recollect, at what age did you start dating?

B) What can you remember about your first sexual experience? **Probe:** The circumstance that lead to it, if it was it consensual, coercion or forced. If consensual find out if any protection was used.

6. Now, let us talk about the present. Please tell me about your current partner?

Probe: If not currently in a relationship, how was your previous relationship?

7. Reflecting on your pregnancy. When did you realise you were pregnant and how did you react towards it? **Prompt:** Missed or delayed period, pregnancy test or went to see a doctor

8. What led to the pregnancy?

Probe: Number of weeks pregnant before finding out

9. Whom did you tell about the pregnancy and why? What was their reaction?

10. Was this your first pregnancy or have been pregnant before? **Probe:** number of pregnancies experienced. Ones that ended in life birth and miscarriage.

Abortion decision making

11. Why did you decide to abort your pregnancy?

Probe: For various reasons

12. When did you decide to abort it?

13. Did you discuss it with anybody before terminating the pregnancy? If yes whom did you discuss it with any why? If no why didn't you discuss with anybody

14. Was your partner aware and in support of the abortion? If yes what were his reasons for supporting it? If partner was not aware, why was he not informed?

15. Who took the final decision to terminate the pregnancy?

Probe: How old was the pregnancy when you had the abortion, is this your first abortion or you have had previous abortions.

Processes involved in the termination of pregnancy

Women do many things when they want to induce an abortion, can you recall some of the things you did when you decided to terminate this pregnancy.

16. Did you do anything on your own to terminate the pregnancy, such as taking some herbs, home-made remedies, medicines or inserting something into yourself?

Probe: Find out what was used and the results, if bleeding etc. resulted what was done to remedy it.

17. What about friends and family, what assistance did they give you during the pregnancy? Did anybody assist in any form in the termination of pregnancy? If yes who and why that person?

18. What made you finally decide to terminate the pregnancy in a health facility

19. How did you locate this facility?

Probe: For various reasons

20. Why did you choose this clinic instead of a government run health institution?

21. Did anybody accompany you here? If yes why and who that person? If no why?

22. Were you counselled before the abortion?

23. What were some of the things discussed during the counselling session?

24. What method was used in terminating the pregnancy?

25. Why did you choose that method?

26. How much did it cost?

27. Who paid the bills?

28. Were you given any advice on family planning after the abortion?

29. What about medication?

30. What does the abortion experience mean to you? (what lessons have you learnt from this experience)

31. What positive and negative effects did the abortion have on you?

32. What do you know about the laws governing abortion in the country?

33. Finally, what is your religious affiliation?

We have reached the end of the interview. Thanks very much for participating I once again assure you that your information will be kept very confidential and there will be no clues to trace the responses to you.

Closure and Debriefing

Tell me what it was like talking to me about these things? What was difficult, what was easy? What would make it easier?

Is there anything else you would like to tell me? Is there anything you'd like to ask me?

APPENDIX 2: INFORMED CONSENT FORM

C/o Department of Population and Health

University of Cape Coast

Cape Coast

E-mail: aotsin@yahoo.co.uk

Tel: 0243-612076

10th May, 2009

Dear participant

Abortion research project

I wish to invite you to participate in a research project involving women who have induced abortions. This research forms part of my studies at the University of Cape Coast, on the topic: Decision making process of females seeking abortion at Ashiaman. In this regard, I wish to obtain your permission to participate in this study:

- Your real name will not be used in the report and all names of people and places you may mention will be disguised and given pseudonyms.
- You will be free to withdraw from the study and discontinue participation at anytime if you so wish without any penalty
- If you do not wish to answer any of the questions posed during the interview, you may say so and I will move to the next question

- There will be no direct benefit to you but your participation in this study is likely to help me learn more about the pregnancy termination process
- Your participation should be totally voluntary.
- The information given out by you will be used for purely academic purpose.
- Should you experience a level of stress that requires professional help, referral services can be recommended.

Please sign the attached forms if you are interested in participating. I shall be glad to answer any questions or clarify any issues regarding the study. Please contact me through the above e-mail address or phone number if need be.

Yours sincerely

Mercy Otsin (M. Phil Student)

Consent Form: To be completed by the participant

I understand that participation is voluntary; I have also been assured of confidentiality and anonymity. I have read/have had read to me and explained to me the sensitive nature of the study and understand that I am free to withdraw as and when I wish. I also understand that the researcher will answer any queries during the course of the research.

Signature:.....

Date:.....

Section to be filled by Researcher

I have discussed and explained to
the above procedures pointing out potential risks or discomforts. I have also
made provision for further clarification on any questions that remain to be
answered.

Signature:

Date:

*If you have any complaints or problems concerning this research project you
may contact any of the following who serve as supervisors for this study:*

Prof. Kofi Awusabo- Asare

DR. Barima Antwi

Dept. of Population and Health

Dept. of Geog.& Reg.Planning

UCC

UCC

APPENDIX 3: INTRODUCTORY LETTER

UNIVERSITY OF CAPE COAST
FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF POPULATION AND HEALTH

Telephone: 042-32440/4 & 32480.3 Direct: 34072
028-5276587
028-9538048
Fax: 233-34072, UCC, GH.
Telex: 2552, UCC, GH.
Telegrams & Cables: University, Cape Coast



UNIVERSITY POST OFFICE
CAPE COAST, GHANA

Our Ref:
Your Ref:

2nd April, 2009

The Country Director
Marie Stopes International
PMB 267
Accra Nation

Dear Sir/Madam,

The bearer, Miss Mercy Otsin, is an M.Phil student of the Department of Population and Health, Faculty of Social Sciences, University of Cape Coast. She is researching into: "*A study on unsafe abortions at Ashaiman*" as part of the requirements for the award of an M.Phil Degree.

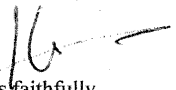
Her work will involve women who have experienced complications from induced abortion and are receiving treatment at health facilities. Given the nature of your activities, your facility has been identified as a possible site for such a research.

I shall be most grateful if you would facilitate her work at your facility and/or give her the necessary assistance to enable her undertake her research work.

The information provided will solely be used for academic purposes and will not be divulged to anybody not related to the study.

We hope that this contact will be the beginning of collaboration between Marie Stopes International (Ghana) and the Department of Population and Health of the University of Cape Coast.

For further information please feel free to contact Prof. Kofi Awusabo-Asare (0244704605) the Head of Department.


Yours faithfully,

Kofi Awusabo-Asare (Prof.)
[Head of Department]

Attention:
The Clinical Services Manager