COSTS OF UNSAFE ABORTIONS IN THE ABLEKUMA SOUTH DISTRICT OF THE ACCRA METROPOLIS

By
ELIZABETH ABU YEBOAH (Miss)
BA (Sociology and Social Work)

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DECLARATION

I declare that this is my personal work undertaken towards the award of M.A Degree in Sociology and to the best of my knowledge; it contains no material partially or wholly previously published by another person, which has been accepted for the award of any degree, diploma or its equivalent in any university. Where other people's views and ideas have been utilised, they have been duly acknowledged.

Abu Yeboah Elizabeth (PG 5696911)	……	……
Student Name & ID	Signature	Date
Certificated by:		
Dr. Francess Dufie Azumah	……	……
Supervisor's Name	Signature	Date
Dr. Martin Kweku Yeboah	……	..……
Supervisor's Name	Signature	Date
Dr. Kofi Osei Akuoko	……	……
Head of Department	Signature	Date

DEDICATION

This work is dedicated to two very important women in my life; Peggy my mother, and Juliana; my other mother, for all the love, prayers and support they have given me throughout the course of my study.

It is also dedicated to Kelvin, Raymond, Christian and Daniel; the _little‘ men in my life who always spur me on.

And to the strong and beautiful women out there who were courageous enough to share their stories with me.

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ABSTRACT

Women have resorted to abortions since times immemorial despite social norms and legal restriction that barred it. Today, restrictive abortion laws and inaccessibility to safe and affordable abortion services lead many girls and women of reproductive age to resort to unsafe abortion that result in costs: costs that are financial, social and health related. Costs which transcend the person of the woman; to her household and her community. The study assessed costs of unsafe abortions amongst forty-five (45) women who had gone through an unsafe abortion. It is came to light that the incidence of unsafe abortions is not limited to a homogenous group of woman, but cuts across women of different socio-demographic backgrounds of religious orientation and education for instance. The predominant age category was 19-28years, an indication that women in that age category are more predisposed to committing abortions than women in the other age categories.

This is in line with findings in the GMHS's (2007) report which indicated that women aged 20–29years are more likely to seek an abortion than those aged 30years and above. Many were unmarried and did not intend to get pregnant at the time pregnancy occurred, but, also did not use any form of modern contraceptive to prevent the risk of pregnancy. Most of the unsafe abortions were self-induced by taking a drug obtained from a pharmacy over the counter, or by drinking an herbal concoction which was self administered. The financial losses of the unsafe abortions affected both the individual women and their significant others. There were social costs or losses to children, as well as significant others in the household of study participants. The issue of unsafe abortions should and must be critically accesses and addressed if Ghana is to make head way its quest to meet the MDGs, and also because the losses or costs go beyond the women who commits the act, the Ghanaian society perhaps ought to lend more support, try to empathize with, as well as encourage young women and girls who find themselves saddled with unintended pregnancies instead of stigmatizing them, so that they will not resort to abortions, and unsafe abortions for that matter.

TABLE OF CONTENTS

Title **Page**

CHAPTER FIVE: SUMMARY OF FINDINGS, CONCLUSION, AREA OF

LIST OF TABLES

TABLE **PAGE**

LIST OF FIGURES

Figure **Page**

LIST OF ABBREVIATIONS

GDHS - Ghana Demographic and Health Survey

GHS - Ghana Health Service

GI - Guttmacher Institute

GMHS - Ghana Maternal Health Survey

ICPD - International Conference on Population and Development

KBTH - Korle Bu Teaching Hospital

KNUST - Kwame Nkrumah University of Science and Technology

MDG	**-**	**Millennium Development Goal**
UN	**-**	**United Nations**
WHO	**-**	**World Health Organisation**

CHAPTER ONE

1.0 Introduction

The incidence of abortion in itself is a problem to any developing nation robbing it of its future manpower and saddling its health systems with issues. Studies into the phenomenon has centered on the economic costs and or health costs to the women who undergo the procedure. Few have sought to address the issue of the financial, social as well as health costs to the both the individual and her significant others, particularly her house hold members. Each year, an estimated 210 million women throughout the world become pregnant and about one in five of them resort to abortion. Out of 46 million abortions performed annually, 19 million are estimated to be unsafe (Shah & Åhman, 2010). Induced abortion can be classified as one of the greatest human rights dilemmas of our time. The need for scientific and objective information on the matter is therefore imperative.

The present study for this reason sought to address this literature gap and document the financial, social and health costs of women who have gone through unsafe abortions in the Ablekuma South District in the Accra Metropolis.

This chapter whiles giving the background of the study, also incorporates the statement of the problem, research objectives, questions and assumptions which are based on the background information and problem statement of the study. Additionally, the chapter presents information on the scope and significance of the study, organisation of the study report as well as the operational definition of terms conceptualized for the study.

1.1 Background to the study

Every year, an estimated 78, 000 women die from complications of induced abortions and 95% of the deaths related to induced abortion occur in under-developed countries (Donnay, 2000). By contrast, legal abortion in industrialised nations has emerged as one of the safest procedures in contemporary medical practice, with minimum morbidity and a negligible risk of death (Hogberg & Joelsson, 1985). Unsafe abortion remains one of the most neglected sexual and reproductive health problems in the world today.

According to a study conducted by the Alan Guttmacher Institute in 2010, abortion is the second leading cause of death for women in Ghana, and more than one in ten maternal deaths are the result of unsafe abortion. Ghana is one of the few African countries where abortion is legal on some specified grounds; however, one of the major problems surrounding the law is the lack of awareness about it, consequently only 3% of pregnant women and 6% of women seeking an abortion are aware of Ghana‘s abortion laws (Sundaram, Juarez, Bankole, and Singh, 2012). These women seek unsafe abortions from pharmacists, midwives, or try to self-induce the abortion themselves, resulting in a staggeringly high number of abortion-related ill health and maternal deaths.

The World Health Organisation deems unsafe abortion one of the easiest preventable causes of maternal mortality. The available data on abortion suggest that overall worldwide abortion rate has declined, whereas the proportion of unsafe abortion has increased. Each year, an estimated 210 million women throughout the world become pregnant and about one in five of them resort to abortion. Out of 46 million abortions performed annually, 19 million are estimated to be unsafe (Ahman & Shah, 2004).

Sedgh, Singh, Henshaw, Bankole, Shah, and Ahman, (2012) found that the share of abortions worldwide that were unsafe has risen, from 44% in 1995 to 49% in 2008. Methods of unsafe abortion include drinking toxic fluids; inflicting injury to the uterus, cervix, or inflicting external injury to the abdomen. Complications also arise from unskilled providers causing uterine perforation and infections.

Abortion by definition refers to a termination of pregnancy before the foetus is capable of extra uterine life (WHO, 1996). Abortions are either induced or spontaneous. Induced abortions are those caused by deliberate interference whereas spontaneous abortions (also known as miscarriages) are those, which occur naturally without any deliberate interference (ibid).

Induced abortions may be further classified as legal abortions and illegal abortion. Abortions induced in accordance to law are legal abortions whereas abortions performed outside the legal sanctions are illegal abortions (WHO, 2004). However, both legal and illegal abortions may be safe or unsafe depending on the qualification and training of the provider, gestational age of the foetus, quality of the service provided and the environment in which it is performed (ibid)

The abortion subject has supporters on both side of the divide. Pro-abortionists who are also known as pro-choicers, are of the view that the mother has a right to do whatsoever she wants to do with her body, most prominently when her life is at stake from carrying a foetus inside her body and so she has the right to decided to have a baby or not when she gets pregnant. Anti-abortionists also referred to as pro-lifers, on the other hand assert that

the foetus is a human being from the point of conception and that the foetus has a right to life, consequently they oppose abortion.

Unsafe abortion is a persistent and often preventable pandemic which mainly endangers women in developing countries where abortion is highly restricted by law and countries where, although legally permitted under certain circumstances, safe abortion is not easily accessible. In these situations, women faced with an unintended pregnancy often selfinduce abortion, or obtain clandestine abortions from medical practitioners, paramedical workers, or traditional healers (Grimes, Benson, Singh, Romero, Ganatra, Okonofua, & Shah, 2006). WHO (2011) and Shah and Ahman (2010) assert that abortions done outside the bounds of law are likely to be unsafe even if they are done by people with medical training for several reasons. Such procedures are usually done outside facilities authorised to perform abortions, sometimes in unsanitary conditions; the woman might not receive appropriate post abortion care; medical back-up is unlikely to be immediately available should an emergency arise; and the woman might delay seeking care for complications because the abortion is clandestine.

World Health Organisation (WHO) defines unsafe abortion as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both (WHO, 2004). The burden of unsafe abortion lies primarily in the developing world; the highest rates are in Africa and in Latin America and the Caribbean, followed closely by South and South-East Asia.

At the extreme opposite, the rate of unsafe abortion in Europe and North America is low (WHO, 2004).

The root cause of women seeking an abortion is the persistence of unintended pregnancies, which in turn may be reflective of the failure of family planning programmes to meet the contraceptive needs of all women at risk of an unintended pregnancy (Okonofua, Shittu, Oronsaye, Ogunsakin, Ogbomwan, & Zayyan, 2005). For the growing number of women and men of reproductive age who wish to regulate their fertility and have fewer children, there is a need for correct and consistent use of effective contraceptive methods. However, problems such as difficulties in access to preferred methods of contraception, incorrect or inconsistent use of contraceptive methods, and potential contraceptive method failure are not easily resolved and may lead to unintended pregnancies (ibid).

Other reasons for unwanted pregnancies include forced or unwanted sexual intercourse and lack of women‘s empowerment over sexual and reproductive matters. Societal norms, economic conditions, legal obstacles and other systemic factors are likely to have a profound impact on women‘s recourse to abortion and especially unsafe abortion.

Singh, Sedgh and Hussain (2010) in a study ―unintended pregnancy: worldwide levels, trends, and outcomes‖ assert that poverty, for example, is an important determinant in the decision to seek an abortion when women consider the financial consequences of an unintended pregnancy.

Safe is defined by the Oxford Advanced Learned dictionary as ―protected from any danger or harm, not involving much or any risk; not likely to be wrong and doing an activity in a careful way‖. Consequently, unsafe will involve or cause danger or risk and is liable to hurt or harm and is not done in a careful way. Based on this assertion, unsafe abortions can be

said to be abortions not done in a careful way, involve risks, and will bring harm and cause loss.

Cost is also defined by wikitionary as ―the amount of money, time, etc. that is required or used or a negative consequence or loss that occurs or is required to occur‖. The MerriamWebster online dictionary defines costs as ―the outlay or expenditure (as of effort or sacrifice) made to achieve an object or loss or penalty incurred especially in gaining something‖.

The costs of unsafe abortions are subsequently the losses incurred by a person who undergoes an unsafe abortion procedure. The present study sought to identify losses that go beyond the individual‘s loss because when a woman undergoes an unsafe abortion and becomes ill and incapacitated, she falls on her household and community for help and support. The study specifically sought to determine the financial, social and health losses women incur when they go through an unsafe abortion in the Metropolis. Financial losses that include the monies the women who undergone the unsafe abortion lost, and monies a household member had lost on their account. The social costs looks at the strain in family relations such as women‘s relationships with their children during their period of hospitalisation when they were receiving treatment for the unsafe abortion, as well loss effect on a social group the women may have been involved in. Health costs looks at the morbidity or immediate ill-health condition that brought the woman to the health facility after the unsafe abortion procedure, long term consequences that may be present and if the women will access post-abortion care.

1.2 Statement of the problem

In Ghana, unlike in other countries where abortion is outright illegal, the problem is not with the law per se. Although the country‘s abortion law is relatively liberal in cases of rape, incest or the ―defilement of a female idiot.‖, and is also permitted if the life or health of the woman is in danger, or if there is risk of fetal abnormality, few women are knowledgeable about the law. Only 3% of pregnant women and 6% of women seeking an abortion are aware of Ghana‘s abortion law (Aboagye, 2012 cited in Aniteye, Mayhew, Kebede, Conteh, Steffen, Vandemaele & Casale, 2013). Also, some doctors arbitrarily choose to deny women abortions at a hospital even when the procedure should be allowed citing various reasons from religious to ethical thus forcing many women to undergo an unsafe procedure elsewhere albeit the consequential life and health problems that emanate from such.

In spite of the apparent liberalisation of the conditions under which abortion is legal, the law as it is written has several features that do not facilitate safe abortion. Most importantly, under the law, only medical officers are allowed to perform the procedure. This puts unclear and unrealistic limitation on who can perform safe and legal abortions.

Firstly, the term ―other registered medical practitioner‖ is indistinct. Who exactly is a medical practitioner? It could be referring to a nurse, nurse assistant, a physical therapist, a physician, or anyone in the medical profession.

In a country where the issue of law enforcement is a great challenge, this vagueness of the law allows untrained an unregulated ―medical practitioners,‖ on one hand, to engage in the practice of unsafe abortions (Morhee & Morhee, 2006). On the other hand, pending the

proper definition of ―medical practitioner‖, limiting the performance of abortions only to medical practitioners puts an unrealistic and impractical restriction on safe practice.

In a nation with a limited supply of highly trained physicians and other health professionals, and where a significant number of people live in rural towns and villages with limited access to the health services available, requiring that only physicians be allowed to perform the termination of pregnancy is gravely unrealistic and impractical; it consequently compels women to seek abortion services from untrained and unskilled abortion providers resulting often, in a lot of complications costly to both the victims and their families and the nation at large.

Research shows that making abortion illegal does not stop it from occurring, but rather just drives it underground, forcing women to obtain clandestine and often unsafe procedures (Morhee & Morhee, 2006). Until unsafe abortion is eliminated, women and public health systems will continue to suffer the consequences of abortions performed under unsafe conditions. In 2007, there were at least 15 induced abortions for every 1,000 women of reproductive age (between the ages of 15 and 44) in Ghana. However, since abortion is heavily stigmatized in Ghana, the actual incidence of the procedure is very likely underreported. While recent, reliable national abortion figures for Ghana are not available, the World Health Organization estimates that in Western Africa there are 28 procedures per 1,000 women each year. The accurate incidence in Ghana probably

approaches this rate.

Unfortunately, safe motherhood programmes generally do not address the causes and consequences of unsafe abortion. Consequently, as the other causes of maternal mortality decrease, deaths from complications of abortion increase as a proportion of all deaths. A 13-year retrospective study of the Safe Motherhood Initiative in Ghana found that as the relative contributions of other causes of maternal mortality decreased, complications of unsafe abortion increased significantly (Geelhoed, Visser, Asare, Schagen van Leeuwen, van Roosmalen, 2003). It is against this background that the present study was carried out to determine what propelled some women to undergo unsafe abortions and the financial, social and health costs it had on them and their significant others.

1.3 Research Objectives

Generally, the objective of this study was to look at unsafe abortions in the Ablekuma South District of Accra.

Specifically, the study sought to:

1. Examine the background characteristics of the women who underwent unsafe abortion.
2. Ascertain the pathways to unsafe abortions among who underwent unsafe abortion.
3. Determine the social, financial and health costs of unsafe abortions to the individual and her significant others.

1.4 Research questions

The pertinent research questions guiding this study are:

1. What are the background characteristics of women who undergo unsafe abortion?

2. What factors prompted them to consider the termination of their pregnancies?

3. What are the social, financial and health costs of unsafe abortions to the woman?

1.5 Assumptions

Upon the basis of the objectives and research questions, the researcher assumed that;

1. Women who have no or low level of formal education will have high incidence of unsafe abortion.

2. Women who are Christians will record low incidence of abortion.

3. Women of reproductive age below thirty eight years are likely to commit unsafe abortion.

4. Unmarried women are more likely to commit unsafe abortion than the married.

1.6 Significance of the Study

Despite gross under-reporting (due in part to deaths outside of hospital), unsafe abortion remains one of the five leading causes of maternal death in most developing countries (Grimes et al, 2006). For every woman who dies, many more are left wounded, some with life-long consequences, including infertility, chronic pelvic pain and genital trauma (ibid).

Factors associated with increased maternal mortality from unsafe abortion in developing countries include inadequate delivery systems for contraception needed to prevent unwanted pregnancies, restrictive abortion laws, pervading negative cultural and religious attitudes towards induced abortion, prevailing socio-cultural norms on sexual relations

outside of marriage and poor health infrastructures for the management of abortion complications (WHO, 2004).

Recalling in particular the goals set out in the United Nation‘s Millennium Declaration to have reduced, by the year 2015, maternal mortality by three-quarters, and under-five mortality by two-thirds, of their 1990 levers; Recognizing that increased access to goodquality primary health care information and services, including reproductive health, is critical for the attainment of the development goals contained in the United Nations Millennium Declaration, the costs of unsafe abortions in developing nations such as Ghana should be looked at carefully and accessed since it is a cause of maternal death that can be relatively easily reduced with the right interventions.

According to the Guttmacher Institute for example, providing access to contraceptives would result in about 14.5 million fewer unsafe abortions and 38,000 fewer deaths from unsafe abortion annually worldwide (G. I., 2010). The 1994 International Conference on Population and Development (ICPD) highlighted the pressing need for work on unsafe abortions, and, in its Programme of Action, it urged governments and other relevant organisations ―to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services‖ (Paragraph 8.25 of the Programme of Action).

Relatively few studies have examined unsafe abortions and its costs in the wake of the

ICPD's call for action. Consequently, there is a clear and pressing need to define a research agenda and identify advocacy strategies to reduce unsafe abortions and its attendant losses. Efforts to address these problems will contribute both to reducing maternal mortality associated with induced abortion and to achieving the Millennium Development Goals (MDG) in developing countries such as Ghana; especially goal five
(5) that seeks to improve maternal health.

1.7 Scope of the study

The study involved forty-five (45) women who have visited the gynaecology ward of the Korle Bu Teaching Hospital (KBTH) having undergone an unsafe abortion procedure prior to their visit to the facility between April – May 2013 to identify financial, social and health costs or losses they and their significant others had experienced since they went through the unsafe abortion procedure. The study identified whether the women intended to get pregnant at the time pregnancy occurred, and if they used contraceptives. The study also looked at reasons that informed the choice of an unsafe procedure, the method used and who suggested it to the women. Financial costs in this regard took account of money spent by the women or lost during the time of inability to do their income generating activity, as well as money lost by a significant other on their account. Social costs consisted of strain and burden on relationship with significant others of the woman whiles she received treatment in the hospital for the ill health resulting from the unsafe abortion procedure. Health costs comprised the immediate medical condition that compelled the women to go to the health facility after the unsafe abortion procedure. The study did not look at women who had gone through an unsafe abortion procedure but had not reported to the health

facility with any medical condition of ill health. The study limited itself to women who had reported to the health facility with some form of ill health because of an unsafe abortion procedure they had undergone.

The study did not identify if it was the first episode of unsafe abortion the woman participant had gone through. The study did not also look at how old the pregnancy was before it was aborted.

1.8 Operational definitions

The researcher operationalised the following terms in the study as follows:

Unsafe abortion: Termination of an unintended pregnancy, either by individuals without the necessary skills or in an environment that does not conform to minimum medical standards, or both.

Pathways to causes of unsafe procedure: The reasons why the woman opted for abortion, and what her choice of procedure to terminate the pregnancy was.

Costs of unsafe abortion: The losses incurred from unsafe abortions.

Financial costs: The monetary losses incurred by the woman when she was absent from her income generating activity, and monetary losses by significant others in her household.

Social costs: The loss of productivity from abortion-related morbidity and mortality on women and household members; Strain on relationship with children and effect on children's school attendance in the absence of the woman who is a mother.

Stigma: This includes feelings of shame and inferiority by the woman after, going through the unsafe abortion procedure, and the desire to keep the knowledge of her condition secret from members in her community.

Health costs: Immediate and long term morbidity or ill health suffered by the woman as a result of the unsafe abortion procedure, and accessibility of post abortion care.

1.9 Organisation of the study report

To ensure research report adheres to standard research, the study is organised into five chapters. Chapter one is the introductory chapter and deals with the background information, problem statement, research objectives and questions of the study. The significance, scope, conceptual and operational definition of key terms associated with the study is also discussed.

Chapter two deals with the thematic review of literature in existence on abortions in general and unsafe abortions in particular. These are discussed with reference to the existing body of literature on the subject matter, and the theoretical underpinnings.

Chapter three contains the methodology of the study. This includes the research design and population of the study. It also discusses the sampling technique and sample characteristics of study participants, data collection technique, data management ethical consideration of the study and limitations of the study.

Chapter four has the presentation and interpretation of the study results. It includes presentation of results on the characteristics of study participants, univariate analysis on thematic characteristics of the study participants.

Chapter five has a presentation on the summary and conclusions of the findings of the study, implication of the study for future research and recommendations for policy and practice.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter presents a review of related literature on the issue of abortion in general and unsafe abortions in particular. It presents the theories underpinning the present study namely the Theory of Reasoned Action developed by Fishbein and Ajzen (1975), Ethical Theory of Egoism and the Crisis Theory. It also presents some findings of studies on reasons why women may seek abortion, methods available for abortion, some

characteristics of unsafe abortions, the law on abortion in Ghana, the costs incurred in unsafe abortions and the conceptual framework of the present study.

More is known today about the epidemiology of legally induced abortion than any other operation. In contrast, a gap persists in our understanding of the incidence, morbidity and mortality of unsafe abortion. The distinction between safe and unsafe abortion is crucial because each has different public-health implications. Safe abortion has few consequences, whereas unsafe abortions are a threat to women's health and survival (Henshaw et al., 1999; Grimes, et al., 2006; WHO, 1996; WHO, 2004; Sedgh et al., 2007).

Unsafe abortion, an entirely preventable cause of maternal deaths and ill health, continues to account for 13% of maternal deaths and 20% of the overall burden of maternal death and long term disability as measured in disability adjusted life-years. Compared with developed countries, the burden per 1,000 unsafe abortions is more than six times as high in sub-Saharan Africa and four times as high in Asia (Shah & Ahman, 2009).

The WHO (2007) asserts that the relatively high risk associated with unsafe abortion in Africa is also manifested in Africa's estimated 650 deaths per 100,000 unsafe abortions in 2003, compared with 10 per 100,000 in developed regions. Other costs of unsafe abortion may include loss of productivity, financial burdens on households, stigma, and long-term health the women might not even be aware of till later in life.

This research sought to find out if the issues outlined by various researches in related work were the same issues concerning unsafe abortions amongst the women sampled. The study explored the financial, social and health costs or losses incurred by the women sampled in the health facility, as well as the losses their significant others had suffered on their account. Little is known about the losses significant others suffer when women who have had unsafe abortions go into hospital with some form of ill health; the researcher therefore tried to make assumptions from research already conducted in the area of unsafe abortions in some countries to see the similarities and diversities in the occurrences from these diverse backgrounds.

The UN Millennium Development Goals, adopted by 189 nations, Ghana included, embrace the target of improving maternal health and the explicit target of reducing the maternal mortality ratio by three-quarters between 1990 and 2015 (WHO, 2003). Unsafe abortion is a key cause of maternal mortality, and measuring its prevalence is important for monitoring progress on this goal. Unsafe abortion also has other consequences, including financial costs to health systems and families, stigmatisation, and social effects on women. A second look at the losses of unsafe abortions and the fact that it goes beyond the individual woman who goes through it will well inform society‘s view about the issue and be a guiding principle in programs and strategies to improving maternal health in general.

2.1 Theoretical framework underpinning the study

Research has endeavoured to use theories to establish the circumstances that lead to the choice of unsafe abortion by _victims‘ and whether or not they consider the possible consequences of the act in question. The theoretical framework for this study is built on

the Theory of Reasoned Action (rational action theory), the Ethical Theory of Egoism and Crisis theory.

2.1.1 Theory of Reasoned Action

The theory of reasoned action posits that a person's intention to a present behaviour serves as the immediate determinant of the action. The behavioral intention has two main determinants: attitude toward the behaviour and the subjective norm. The main concepts of the theory applicable to this study are the attitudes toward the behaviour (opinions with regards to abortion) and intention to perform: intention to go through an abortion procedure, safe or otherwise (Fishbein, & Ajzen, 1975).

Attitude toward the behaviour, which is the degree to which the performance of the behaviour is positively or negatively valued, will mean that a woman when pregnant will think of the consequences of carrying a pregnancy to full term and having a baby who will probably be denied by its father and her community at large and labeled a bastard. She will consider the negative comments her household and people in her community will make about her having gotten pregnant out of wedlock. The subjective norm is the individuals perception about the particular behaviour which is influenced by the judgment of significant others; if she is young and in school then she will be faced with the dilemma of dropping out of school to take her baby, her religion probably frowns on having children out of wed lock and she will be sanctioned, her peers will ridicule her as is often the case in teen pregnancies. Pregnancy outside marriage is not embraced in

Ghana.

Abortion is frown upon and so a woman or girl is expected to refrain from pre-marital sex. A woman who does not conform to these norms has therefore deviated and is subsequently sanctioned and this is mostly by stigmatisation and neglect by the community.

2.1.2 Ethical Theory of Egoism

According to Aristotle, man is a pleasure, selfish and self seeking animal, meaning that in whatever man does; his interest comes first. This conception forms the basis of the Ethical Theory of Egoism. Egoism is a theory which holds that ‗one ought to act so as to secure the greatest possible good for oneself‖ (Sanders, 1988). This theory in relating to this study, explains the driving force behind the commitment of an act by a person at any point in time. The driving force that would make a person abort a pregnancy is that she would think about her interest foremost before any other person. Consequently whatever action or decision the woman takes upon the realization that she has an unintended pregnancy must be in her favour.

Some of the most common reasons why a woman will contemplate an abortion are to postpone childbearing to a more suitable time or to focus energies and resources on existing children. Others include being unable to afford a child either in terms of the direct costs of raising a child or the loss of income while she is caring for the child, lack of support from the father of the child, inability to afford additional children, desire to provide schooling for existing children, disruption of one's own education, relationship problems with their partner, a perception of being too young to have a child, unemployment, and not being

willing to raise a child conceived as a result of rape or incest, among others (Bankole, Singh & Haas, 1999).

Based on the postulations of these outlined theories and reasons, a pregnant woman, probably unmarried, still in school, having enough children already, living with a partner who is not ready for a child consequently has just one thing on her mind; greatest possible good for herself in the midst of all these social and cultural factors. The pregnant woman has to take a decision and act in a manner that will make her fit and acceptable in her household and in the eyes of her community. Ghanaian society puts emphasis on communal values such as family, and the importance of dignity and proper social conduct (Nukunya, 2003). A young single and unmarried woman who gets pregnant will not be accepted and considered as having conducted herself in a socially proper way if members of her community find out she is pregnant, and so she may have to get rid of such a pregnancy.

Obtaining an abortion in a society that has norms and laws that generally prohibit it will mean that she must self induced the abortion quietly or go to another person clandestinely; thus many women who find themselves in such predicaments often end up with an unsafe abortion procedure. An unsafe abortion that brings in its wake costs such ill heath, burdening households with money spending, and time spent taking care of the women in cases of resultant ill-health when that money and time could have been used in taking care of other household needs.

2.1.3 The Crisis Theory

A Crisis may be viewed as the transitional period presenting an individual with; on the one hand, a prospect for personality growth or maturation and, on the other, a risk of adverse affect with increased vulnerability to ensuing stress. Caplan (1964) refers to crisis as an upset in the steady state. According to Caplan, people are in a state of crisis when they face an obstacle to important life goals—an obstacle that is, for a time, insurmountable by the use of customary methods of problem-solving. Accordingly, a period of disorganisation ensues, a period of upset, during which many abortive attempts at solution are made.

The study thus endeavoured to establish the circumstances that led to the choice of an unsafe abortion procedure by the _victims‘ and whether the risks factors and losses associated with the choice of an unsafe abortion procedure was taken into consideration by the women. Most especially within a society that adores and celebrates child birth since it is the basis of the family institution; thus celebrating it with rites of passages such as child outdooring and naming ceremonies, adolescent and puberty, marriage and funeral rites, all of which the family is the primary focus. It is norm in the Ghanaian society for a person, male or female to grow, marry and have children. For this reason a woman who gets the pregnant out of the bonds of marriage is looked down upon and considered promiscuous and has gone contrary to what is accepted in the society. Women who therefore find themselves with a pregnancy that will not be accepted in the society are faced with a crisis and have to take an action that will help them best in resolving the

crisis.

2.2 Unsafe abortions

Unsafe abortions carried out by individuals who lack the necessary skills and/or in unhygienic conditions, is a major global public health problem worth examining. The practice often occurs in places where abortion is legally restricted, and where access to safe abortion services is inadequate although the law may broadly permit the procedure.

2.2.1 Research on unsafe abortion

Unsafe abortion, from the body of research available so far, has been found to have a large impact on women‘s health and welfare; it causes death and ill health in women, saddles households and affect their financial well-being to a large extent. At the community and national levels, it can also consume scarce healthcare resources and burden health systems a great deal (Morhee & Morhee, 2006). Research on health costs and consequences is somewhat more developed than that on social and economic costs and consequences. Existing work on unsafe abortions costs and consequences have used quantitative and qualitative research approaches, and community-based as well as hospital-based designs to make estimations on the prevalence and occurrences of the phenomenon.

Evidence on the costs and consequences of unsafe abortion is critical for policymakers, providers and advocates seeking to mobilise resources to improve the situation. Reducing the public health problem of unsafe abortion is one of the most important goals of the Programme of Action of the International Conference on Population and Development (ICPD) held in Cairo in September 1994. Already, eighteen years of the twenty years in which to achieve that goal have already passed with relatively moderate progress.

An immense deal of vital information about unsafe abortions in developing countries comes from studies of women hospitalised for the management of complications. While helpful in documenting the health care burden of unsafe abortions, and in providing comprehensive information about the abortion experiences of women who seek post abortion care, these studies are limited in two important ways: They leave out the many women who have abortions in surreptitious circumstances but experience no complications, and they do not take account of women who experience complications but obtain no care. Finer and Henshaw (2006) assert that women who have had abortions are a heterogeneous group and their reasons for terminating their pregnancies also vary.

Data available indicate an association between unsafe abortion and restrictive abortion laws. The median rate of unsafe abortions in the 82 countries with the most restrictive abortion laws is up to 23 of 1000 women compared with 2 of 1000 in nations that allow abortions (Grimes et al, 2006). Where abortion laws are restricted or safe abortion services are not widely accessible or are of poor quality, women self-induce an abortion or resort to unskilled providers, risking serious consequences to their health and wellbeing.

Maternal mortality is the second most common cause of death among women in Ghana, and more than one in 10 maternal deaths (11%) are the result of unsafe induced abortions. In addition, a substantial proportion of women who survive an unsafe abortion experience complications from the procedure. According to the GDHS, 7% of all pregnancies end in abortion, and 15% of women aged 15–49 have ever had an abortion (GDHS, 2009: Sedge, 2010). About 15 abortions are performed for every 1,000 women of reproductive age (15–44years) each year.

According to a study conducted in the late 1990s in southern Ghana, 17 abortions were observed for every 1,000 women of reproductive age (ibid). The level of abortion in Ghana appears to be lower than in Western Africa as a whole, where the rate stands at 28 procedures per 1,000 women (Henry & Fayorsey, 2002).

2.2.2 Unsafe abortions characteristics

The World Health Organization defines unsafe abortion as a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both (WHO, 2004).

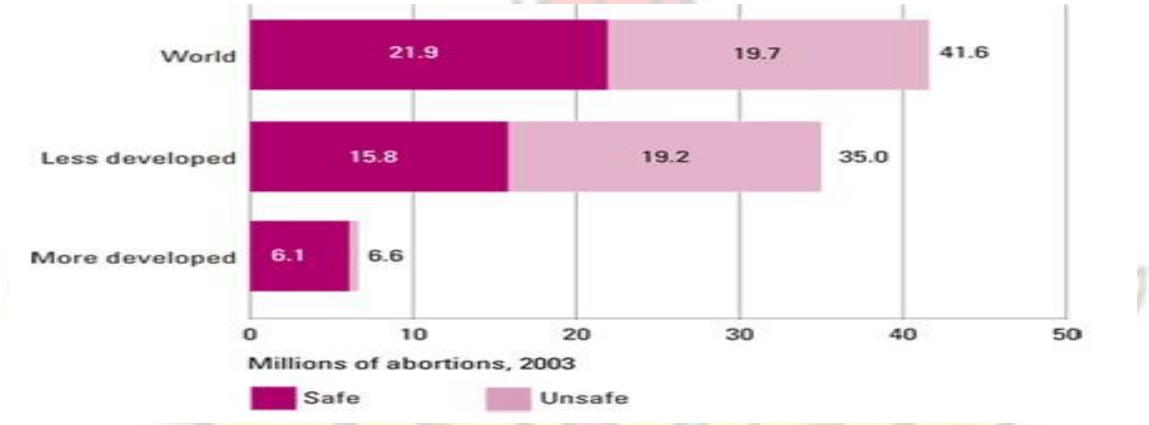
While the definition seems to be linked to the process, characteristics of an unsafe abortion touch on inappropriate circumstances before, during or after an abortion. The following conditions typically characterise an unsafe abortion, sometimes only a few conditions prevail, and sometimes all or most of them: no pre-abortion counselling and advice; abortion is induced by an unskilled provider, frequently in unhygienic conditions, or by a health practitioner outside official/adequate health facilities; abortion is selfinduced by ingestion of traditional medication or hazardous substances; abortion is provoked by insertion of an object into the uterus by the woman herself or by a traditional practitioner, or by a violent abdominal massage; a medical abortion is prescribed incorrectly or medication is issued by a pharmacist with no or incorrect instructions and no follow-up (Bankole et al, 1999).

Further features of unsafe abortion include the lack of immediate intervention if severe bleeding or other emergency develops during the procedure; failure to provide post

abortion check-up and care, including no contraceptive counselling to prevent repeat abortion; the reluctance of a woman to seek timely medical care in case of complications because of legal restrictions and social and cultural beliefs linked to induced abortion.

2.2.3 Information sheet

Of the almost 42 million abortions that take place around the world each year, about 20 million are unsafe and virtually all of those occur in developing countries.



Source: Guttmacher Institute, 2009

2.3 Pathways to unsafe abortion

Even safe abortion in developing nations carries risks that depend on the health facility, the skill of the provider, and the gestational age of the fetus. With unsafe abortion, the additional risks of maternal morbidity and mortality depend on what method of abortion is used, as well as on women‘s readiness to seek post-abortion care, the quality of the facility they reach, and the qualifications (and tolerance) of the health provider (Henry & Fayorsey, 2002).

The conditions surrounding the practice of unsafe abortion vary widely. The conditions in which women in countries with restrictive abortion laws terminate their pregnancies, or experience incomplete abortions, differ from one setting to another. A woman‘s choice of method or provider depends on the traditional methods known and used in her community, the types of untrained providers present in the community, the availability of trained doctors and nurses prepared to perform abortions despite legal restrictions and, in recent years, whether misoprostol can be easily obtained. Another factor, of course, is how much a woman can afford to pay to end a pregnancy (Mundigo, 2006).

2.3.1 Costs of abortion procedure

High costs prevent many poor women from obtaining safe abortions**.** In general, the less skilled an abortion provider is, the lower the cost of the abortion to the woman—and the greater the likelihood that the techniques the provider uses will be dangerous and will result in complications. In low-income countries with restrictive abortion laws, cost is often a major barrier preventing poor women from being able to end unwanted pregnancies safely. In a very real sense, then, the ability to pay can buy women a greater chance of safety (WHO, 2003).

In Ghana, some private clinics and organisations committed to safeguarding and promoting sexual and reproductive health such as the Marie Stopes centers dotted around the country do offer safe abortion services and care but, at a fee many of the women who need the services cannot afford readily. An enquiry in one of the centers in the metropolis showed that one would need about GH¢100.00 to have a pregnancy that is younger than 12weeks

old terminated; excluding pregnancy tests and ultra sound scans which often has to be taken elsewhere.

2.3.2 Methods available for abortion

Even safe abortion in developing nations carries risks that depend on the health facility, the skill of the provider, and the gestational age of the fetus. With unsafe abortion, the additional risks of maternal morbidity and mortality depend on what method of abortion is used, as well as on women‘s readiness to seek post-abortion care, the quality of the facility they reach, and the qualifications and often times the tolerance of the health provider. A woman who seeks a clandestine abortion, or the provider she consults, may try a number of traditional techniques of varying efficacy and harmfulness. Methods of unsafe abortion include drinking toxic fluids such as turpentine, bleach, or drinkable concoctions mixed with livestock manure such as cow dung (Mpangile, Leshabari and Kihwele, 1999).

Others are forceful manipulation of the abdomen, the insertion of sticks and other objects into the vagina, cervix or uterus. Many of these techniques pose serious threats to a woman‘s health, and sometimes even her life. If these methods fail to bring about a complete pregnancy termination, she may then go to pharmacists, nurses or doctors known to provide abortion services. Unskilled providers also improperly perform dilation and curettage in unhygienic settings, causing uterine perforations and infections. Methods of external injury are also used, such as jumping from the top of stairs or a roof, or inflicting blunt trauma to the abdomen such as massaging the abdomen (WHO, 2007;

Benson J, Singh S, et al. 2006 cited in Haddad and Nour, 2009).

2.3.3 Access to safe services

A wide range of barriers can make safe abortions difficult or nearly impossible to obtain, even where they are legal generally or in specified circumstances. In many countries, particularly those in the developing world, public information about the legal status of abortion and about women's right to a legal abortion are often lacking. Doctors may refuse to provide abortion services because of conscientious objection (WHO, 1992). Health care workers may fail to refer women seeking a pregnancy termination to an appropriate facility. Access to safe services might be geographically limited, or compromised by a shortage of trained providers or by requirements that the procedure be performed only by a doctor, or in a hospital or other accredited facility. Gestational age limits, the need for spousal or parental consent, and mandatory waiting periods or counseling may deter some women from obtaining services.

Financial barriers are also common: If abortion services are expensive, or are excluded from private and public health insurance plans, many adolescents (who usually have few resources of their own) and poor women may not be able to afford the procedure. Health systems may stigmatize women seeking reproductive health care, deny pain medication during an abortion or require the authorization of a spouse or third party (even if not required by law). Social values that stigmatize providers who offer safe abortion services constitute another barrier, because providers may stop offering the service (WHO, 2004).

2.3.4. Laws on abortion

Pregnancy termination is a universal practice: It occurs in all parts of the world, east and west, developed and developing, rich and poor and among women of all types, single and married, adolescent and older. However, in less developed regions that have restrictive abortion laws, many women, especially those who are poor and cannot pay for safe procedures end unwanted pregnancies themselves, or at the hands of unskilled personnel using unsafe methods. By doing so, they risk their health and even their lives (Morhee & Morhee, 2006).

Globally, 40% of women of childbearing age (15–44) live in countries with highly restrictive laws (those that prohibit abortion altogether, or allow the procedure only to save a woman‘s life, or protect her physical or mental health). Abortion-related deaths are more frequent in countries with more restrictive abortion laws (34 deaths per 100,000 childbirths) than in countries with less restrictive laws (1 or fewer per 100,000 childbirths) (WHO, 2007).

Although some countries have liberalised laws, abortion remains highly restricted in most countries. Since 1997, 22 countries or administrative areas within countries have changed their abortion laws; in 19 cases, the criteria under which abortion is permitted were broadened, and in three cases the criteria were narrowed. Nevertheless, especially in SubSaharan Africa and Latin America, abortion remains extremely restricted. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, make particular reference to sexual and reproductive health in article 14 (1,2) states that: States Parties shall ensure that the right to health of women, including sexual and

reproductive health is respected and promoted. This includes: the right to control their fertility; the right to decide whether to have children, the number of children and the spacing of children; the right to choose any method of contraception; . . . the right to have family planning education.

It also says that States Parties shall take all appropriate measures to: provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas; establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding; protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa in article 14 as stated, whiles enjoining state parties to ensure the reproductive rights and health of is peoples, makes no reference to abortion care. Virtually all countries with highly restrictive laws are developing countries. Excluding those in China and India (populous countries with liberal abortion laws), 86% of reproductive-age women in the developing world live under highly restrictive abortion laws. In some countries (e.g., India, South Africa and Ghana), abortion is available on broad grounds, but access to services provided by qualified personnel is uneven.

In Ghana, the Criminal Code of 1960 and its amendment in 1985 give grounds on which abortion may be permitted. Generally the law declares abortion illegal, stating that women involved or accomplices will be found guilty or a crime punishable by a prison sentence of up to five years. The law permits abortion only if it is performed by ―a registered medical practitioner specializing in Gynaecology or any other registered medical practitioner in a government hospital or a private hospital or clinic registered under the Private Hospital and Maternity Home Act, 1958 (No. 9) or in a place approved for the purpose by legislative instrument made by the Secretary: under the following circumstances: where pregnancy is the result of rape or defilement of a female idiot or incest and the abortion or miscarriage is requested by the victim or her next of kin or the person in loco parentis, if she lacks the capacity to make such request; where the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health and such a woman consents to it or if she lacks the capacity to give such consent it is given on her behalf by her next of kin or the person in loco parentis; where there is substantial risk that if the child were born it may suffer from or later develop a serious physical abnormality or disease. Albeit the provisions in these legislations that allow women to access abortion services on specified grounds, anecdotal data suggests that ignorance.

2.4 Financial costs

Vlassoff, Singh, Darroch, Carbone and Bernstein (2004) in assessing financial costs used a ―cost per case‖ approach and looked at patients‘ out-of-pocket expenses including treatment, transport and others; Patients‘ and carers‘ indirect cost due to loss of productivity during treatment and convalescence and indirect costs of orphanhood, psychological effects which he mentioned not but did not measure.

2.4.1 Loss of income by individuals and households

Unsafe abortions are financially costly for individuals, families and society. For the individual woman, the economic consequences of unsafe abortion involve not just the cost of obtaining treatment for complications, but also the loss of family income if she is unable to perform her income generating activity, or carry out her household chores. Women suffering from complications face costs in the form of lost productivity, which is often borne by the households affected and society more broadly. The costs that families incur if young children lose a mother are difficult to quantify, but should not be overlooked. Children from households experiencing long term maternal disability or a maternal death from unsafe abortion suffer in terms of their future health and education potential, with further economic implications for the household and society.

The financial and logistic impact of emergency care can overwhelm a health system and can prevent attention to be administered to other patients. In public health facilities, the costs may be shared between households and government if fees are charged. According to a Guttmacher Policy Review (2010), to provide care for the illness and disability associated with unsafe abortion, a government spends, on average, at least $114 per case in Africa and $130 in Latin America; in these regions, the total per capita spending on health care is $48 and $329, respectively.

The process of seeking care however do not include certain costs borne by households; for instance, medical costs such as buying of drugs or other supplies, the cost of the unsafe abortion procedure itself, nonmedical , costs such as transport to facilities, or the costs of lost productivity due to ill health or disability, all of which can be significant.

2.4.2 Loss of productivity

There is loss of productivity from abortion-related morbidity and mortality on women and household members when women have to be hospitalised for a period and household members have to devote time visiting them and taking care of their needs whiles they are recuperating culminating into los of various sums of household income. Studies indicate that the woman‘s occupation is an important predictor of days and earnings lost. Lost productive time was generally inversely correlated with wage earnings. Women reliant on daily wages, such as those in the informal sector, service industry, or factory workers, had to pay a heavier price in terms of each missed day of work than women who worked in the home or those who had seasonal incomes or low monthly wages, such as agricultural laborers (Norris, Bessett, Steinberg, Kavanaugh, De Zordo, & Becker, 2011).

Women in the informal sector, such as market vendors, reported the greatest amount of lost productive time (6.1 days) and lost earnings ($15.45). Women who did not work outside of the home or worked seasonally as agricultural laborers lost more time but little in household earnings. Yet the small number of women who were paraprofessionals reported losing the least amount of time and earnings than any other group, probably reflecting their purchasing power and their ability to pay more to access safe services from a private provider at their convenience (Sedgh et, al 2011).

More research is needed on the time and productivity losses associated with the abortion care-seeking process in order to fully understand the cost implications and the ramifications on women‘s households.

2.5 Social costs

There are negative social costs and consequences of unsafe abortion to children and other family members when women are sick or die from abortion complications.

2.5.1 Stigma

Stigma is a social process or related personal experience characterised by exclusion, rejection, blame or devaluation that results from experience or reasonable anticipation of an adverse social judgment about a person or group. In health related stigma, this judgment is based on an enduring feature of identity conferred by a health problem or health related condition (Weiss, Ramakrishna & Somma, 2006). Stigmatization is a deeply contextual, dynamic social process; it is related to the disgrace of an individual through a particular attribute he or she holds in violation of social expectations. Goffman (2009) described stigma as an attribute that is deeply discrediting, reducing the possessor from a whole and usual person to a tainted, discounted one.‖

Kumar, Hessini, and Mitchell, (2009) define abortion stigma as ―a negative attribute ascribed *to women* who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood‖. Kumar et al (2009) deftly assert that abortion violates two elemental ideals of womanhood: Nurturing motherhood and sexual purity. The desire to be a mother is essential to being a ―good woman‖ (Norris et al, 2011); notions that women should have sex only if they intend to procreate reinforce the idea that sex for pleasure is illicit for women (although it is acceptable for men). Abortion, therefore, is stigmatized because it is evidence that a woman has had

―nonprocreative‖ sex and is seeking to exert control over her own reproduction and sexuality, both of which threaten existing gender norms (Kumar et al., 2009). Social support that women receive from their immediate social networks, particularly their partners, mitigates the effects of abortion stigma. For this reason, women who perceive community support for the right to terminate a pregnancy are less likely to feel guilt and shame than those who do not (ibid).

There may be stigma related to the abortion itself: safe or unsafe, and stigma related to secondary infertility that may result from the unsafe abortion. The sources of stigma include the woman‘s family, community, health care providers who may give the postabortion care needed by the woman. Kumar et al (2009) posited that women who seek abortions challenge localized traditional social and cultural norms about the ―essential nature‖ of women and womanhood.

Women's attitudes such as fears and anxieties and opinions about unwanted pregnancy and having to go through or having gone through an unsafe abortion is also another social cost. There is also the impact of unsafe abortion on other life events, for instance parents' attitudes towards their adolescent children with unwanted pregnancy and wanting to have an abortion (WHO, 1993). As a result of stigma (Johnson-Hanks, 2002) or fear of legal reprisals, unsafe abortions are grossly under-reported, and the complications thereafter are often concealed or attributed to spontaneous miscarriage. For example, a recent hospital study from Ethiopia reported that 86% of abortions were spontaneous, yet the mean gestation age at admission was 15 weeks, an improbable

scenario (Yusuf & Zein, 2001). This is a likely indication that the real incidence and occurrence of unsafe abortion is not a true reflection of what it is.

Men as partners also often alleviate or contribute to social costs when they support or create barriers to women who want to end a pregnancy. Thus the power dynamics within relationships often tend to influence whether or not the woman may or may not end up with an unintended pregnancy; and when she does end up with an unintended pregnancy, whether she can resort to accessing an abortion through a safe procedure and not clandestinely. Conversely, stigma surrounding abortion may keep women from seeking or receiving social support (WHO, 1993).

Furthermore, often scarce medical resources are diverted for treatment of unsafe abortion complications such as secondary infertility in health institutions and other socio-psychological consequences such as treatment for Post Traumatic Stress Disorders (PTSD) for women who are not able to deal with the loss of their babies or come to terms with the decision they took earlier to end their pregnancy.

2.6 Health Costs

Worldwide, some 5 million women are hospitalised each year for treatment of abortionrelated complications such as hemorrhage and sepsis, and abortion-related deaths leave

220,000 children motherless (Grimes et al, 2006).

2.6.1 Morbidity

Morbidity is a much more common consequence of unsafe abortion than mortality, but is determined by the same risk factors. Complications include haemorrhage, sepsis, peritonitis, and trauma to the cervix, vagina, uterus, and abdominal organs. High proportions of women (20-50%) who have unsafe abortions are hospitalised for complications (Liskin, 1980).

The main causes of mortality from unsafe abortion are hemorrhage, infection, sepsis, genital trauma, and necrotic bowel (WHO, 2003). Data on nonfatal long-term health complications are poor, but those documented include poor wound healing, infertility, consequences of internal organ injury (urinary and stool incontinence from vesicovaginal or rectovaginal fistulas), and bowel resections. Other immeasurable consequences of unsafe abortion include loss of productivity and psychological damage (ibid).

National studies show that the rate of hospitalisation varies from a low of three per 1000 women per year (in Bangladesh, where menstrual regulation is legally permitted) to a high of 15 in Egypt and Uganda (Singh, 2006).

Unsafe abortions can also lead to longer-term health consequences. Long after their complications have occurred, many women continue to suffer serious and sometimes long lasting health effects. Anaemia and prolonged weakness are conditions that may persist long after a woman has had an unsafe abortion (Jeppsson et al., 1999, Bernstein & Rosenfield, 1998; Jamil & Fikree, 1998 cited in Singh, 2010).

Chronic pain, inflammation of the reproductive tract and pelvic inflammatory disease are other conditions that may continue indefinitely, severely compromising a woman‘s health. These conditions, as well as other post-abortion complications, may lead to one of the most pernicious of all long-term morbidities: secondary infertility. Estimates based on the limited available data suggest that around 1.7 million women develop secondary infertility each year as a consequence of unsafe abortions. The burden of unsafe abortion lies not only with the women and families, but also with the public health system. Every woman admitted for emergency post-abortion care may require blood products,

antibiotics, oxytocics, anesthesia, operating rooms, and surgical specialists. The financial and logistic impact of emergency care can overwhelm a health system and can prevent attention to be administered to other patients (WHO, 2003).

2.6.2 Longer-term health costs

Unsafe abortions can also lead to longer-term health consequences. Long after their complications have occurred, many women continue to suffer serious and sometimes long lasting health effects. Anaemia and prolonged weakness are conditions that may persist long after a woman has had an unsafe abortion (Singh, 2010).

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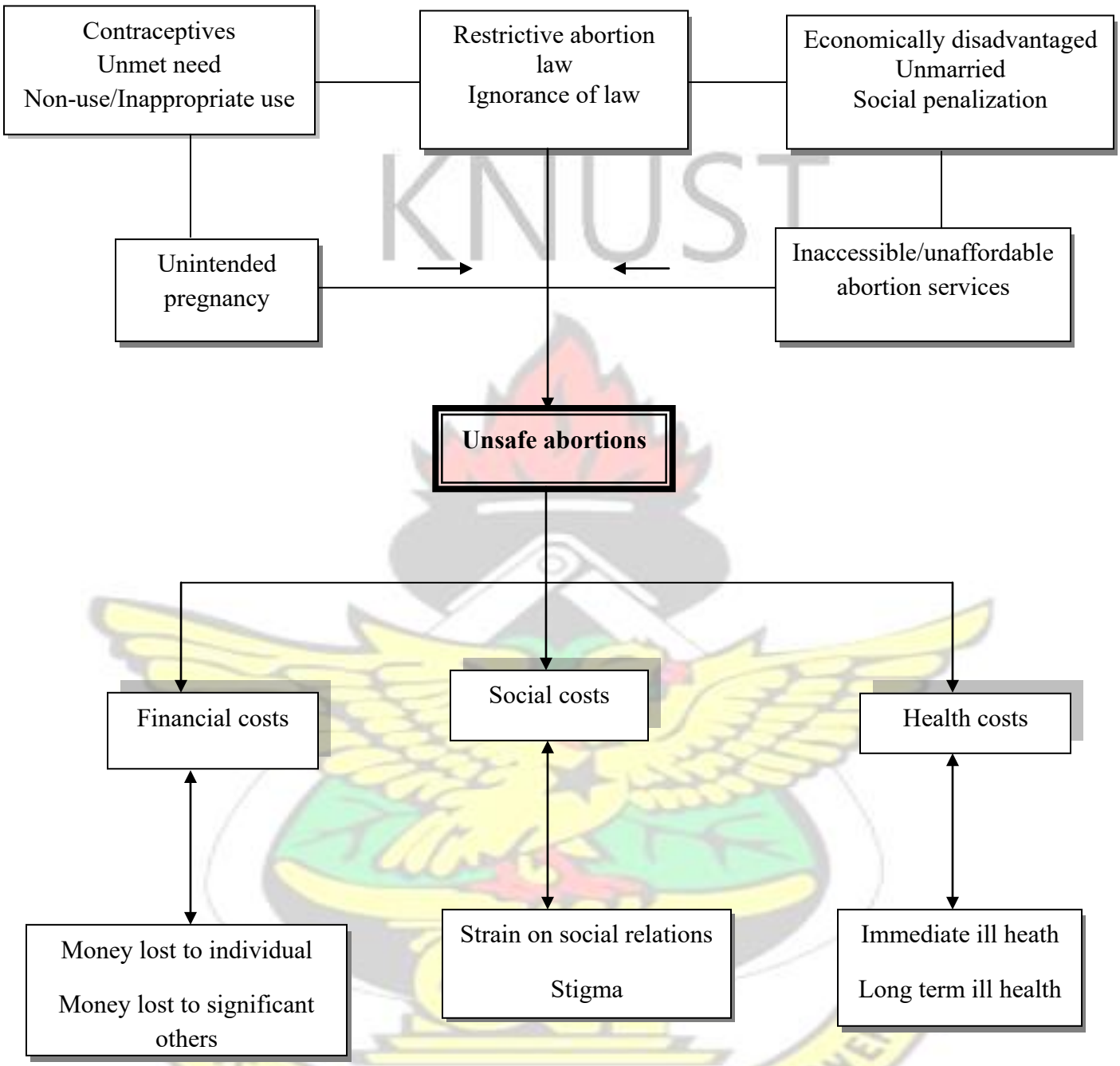
2.7 Conceptual framework on the costs of unsafe abortions

Table 2.1



Author's own construction, May 2013

Table 2.1 above presents the conceptual framework of unsafe abortions in the present study. As indicated in the table, in a milieu where there is an unmet need for contraceptive which culminates in non-use and inappropriate use of contraceptive, and there are restrictive

abortions laws as well as ignorance of the existing law on abortion; and there also economically disadvantaged and unmarried women coupled with the existence of social penalization where people are sanctioned for actions deemed as antisocial; then women who find themselves with unintended pregnancies outside the accepted means of procreation and cannot access or afford abortion services will invariably resort to unsafe abortions.

Unsafe abortions that will in turn result in financial costs where the individual who has undergone the unsafe abortion procedure as well as her significant others will lose money in a bid to get her healthy and whole again. Financial costs or losses because the monies spent buying her drugs, cooking and bringing food to her whilst she's been hospitalised and or paying her hospital bills may have come from her household income and could have been spent on some other household need.

In addition, the unsafe abortion procedure will result in social costs to the individual and her significant others since her absence from the home may affect her household members particularly her immediate nuclear family and most especially, her children who will have to cope with lacking her care whilst she is away. Then again in a society where one of the ideals of womanhood is child-bearing and child-nurturing, a woman who deliberately induces the loss of a pregnancy will undoubtedly have broken a social norm and consequently end up being stigmatized.

Unsafe abortions also results in health losses or costs mostly to the individual since she often ends up with one medical condition or another ranging from haemorrhage, vaginal

and abdominal injuries, shock and poisoning or infections from undergoing an unsafe medical procedure. Long term ill-health such as weakness, and perforations and lacerations in the womb that may hinder further conceptions may also occur from a botched abortion.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

The methodology chapter provides a description of the method used to collect data in the study and how it was analysed. It looked at the population, sample size, data collection method and ethical considerations in the study.

3.1 Research Design

The study was a clinic based survey which involved the self-administration of a specifically structured questionnaire for the collection of data. The purpose was to obtain information relevant to the phenomenon under study in this research.

3.2 Study Area and Population

The study was conducted in the Ablekuma South District of the Greater Accra Region. The target population was women who had undergone unsafe abortion procedures outside of the hospital facility and had ended up with one condition or another that needed medical attention. Ablekuma south district is saddled with many social issues ranging from high population, high rates of unemployment among the youth just to mention a few. Anecdotal data suggests that the district has a high prevalence of unintended pregnancies stemming from low usage of contraceptives, and consequently a high prevalence of unsafe abortions. Many of the women who undergo such unsafe abortions end up with complications which bring them to the Korle Bu Teaching hospital, one of the major hospitals in the Accra Metropolis.

3.3 Sample and Sampling Technique

The purposive sampling technique was employed by the researcher to obtain the sample of the study participants. The researcher purposively selected the study participants because they represent and have the characteristics of the variables in the study. All fortyfive (45) study participants were females of reproductive age who had reported to the health facility for care after having undergone an abortion procedure considered unsafe and had experienced some morbidity prior to or at the time this study was conducted.

3.4 Variables measured

The variables measured in the study were pathways to unsafe abortions which involved reasons why the unsafe abortion was considered by the women and the method used by the women to terminate the pregnancy. The other variables also included demographic characteristics such as the age, marital status, occupation, religion and level of education of the participants.

Social costs involved loss of productivity, strained relationships, and stigma. Financial costs included income lost because of subsequent inability to do income generating activity, and income lost to significant others.

Health costs included immediate morbidity such as hemorrhage, sepsis and abdominal pain, and other possible long term costs such secondary infertility.

3.5 Sources of data

The study employed both primary and secondary sources of data. The primary data for the study involved information directly obtained from the study participants in the field of study. Secondary data included a review of reports from the Social Welfare department of the KBTH on women who reported to the health facility with issues relating to unsafe abortions. Books related to the subject matter in the study and Journals were assessed: Overview of the Law and Availability of Abortion Services in Ghana. Ghana Medical Journal and Articles: ―Sharing responsibilities: women, society and abortion worldwide‖ (1999) were also used. Information obtained from web search: World Health Organization, *Unsafe abortion: global and regional estimates of the incidence of unsafe abortion* was also used.

3.6 Data collection

Data collection in this research consisted of self-administered questionnaire purposely constructed for the study. Researcher trained two research assistants who assisted in the collection of data. The two research assistants were staff of the social welfare unit of the KBTH and so were already familiar with the phenomenon under study. Questions were mostly asked in English and three main local languages; namely Twi, Ga and Ewe, and transcribed by the researcher and research assistants.

3.7 Data handling and analysis

Field information collected in any study must be coded, analyzed and interpreted to make it meaningful. To make meaning out of the data collected in the present study, the standard five steps involved in data analysis was employed duly. The researcher coded by developing meaning response categories to questions asked and assigning numbers to response categories in order to allow easy analysis.

Editing was also done by researcher to ensure that there were no discrepancy in the responses given by the study participants and answers to all questions asked were duly captured.

Data was entered into the Statistical Package for the Social Sciences (SPSS) software (Version 20) by the researcher. Variables were defined in the variable view phase of the SPSS programme while data was subsequently entered into the data view of the software programme to create a data file and analysed duly.

Data was checked again after entry to ensure there were no wild codes. A few wild codes were spotted and duly corrected. The study employed a thematic and univariate analysis of data using descriptive statistical tools such frequency distribution of tables.

3.8 Ethical Considerations

Before the commencement of the study, permission was sought from the participants to interact with them. An informed consent form which explained the purpose of the study which had been constructed by the researcher was made available to participants to seek their full consent before conducting the study. Participants were encouraged to withdraw from the study if they felt distressed at any point in the study.

The issue of abortion in the Ghanaian society is generally characterised by controversy and sensitivity, therefore to ensure the privacy of the participants, as well as ensure that no harm came to participants during and after the conduction of the study, the researcher did not require any form of personal identification, pseudonyms were therefore used by researcher to identify participants.

To ensure again that no harm came to participants, each participant was thoroughly debriefed at the end of interaction. Researcher gave participants a general idea of what the study was investigating and why, and their part in the research was explained to them. Participants were told if they have been deceived and given reasons why. They were asked if they had any questions and the researcher tried to answer their questions as honestly and as fully as possible.

3.9 Limitations of the study

This study like any other study was not devoid of impediments in the smooth realisation of the set objectives and purpose of study, few of which are enumerated below.

Some potential respondents refused to engage in the study due to the sensitive nature of the subject of abortion. For this reason the study had to make use of just forty-five respondents as a sample.

The study could not look at the experiences of women who had undergone unsafe abortion outside the health facility but had not reported to the health facility and so their experiences and that of their significant others could not be captured.

The study involved the use of questionnaires which were self-administered and for this reason responses are likely to be biased and so put the study at risk of gathering data which may not represent the true circumstances of the study participants.

CHAPTER FOUR

PRESENTATION AND ANALYSIS OF RESULTS

4.0 Introduction

The study reported here, was designed to assess the costs of unsafe abortion in a selected hospital in the Accra Metropolis. This chapter deals with the analysis, presentation and interpretation of the results of the study. It is divided into four sections. Section A presents the background characteristics of the forty-five (45) respondents who participated in the study. Section B examines the pathways to abortion; Section C, the financial cost of

abortion and Section D, social cost of abortion. Descriptive and Univariate analysis was conducted. Result of the analysis is presented in tables below.

4.1 Demographic background of respondents

This section presents the background characteristics of the forty-five (45) female respondents whose views were sought for the study. The background variables of respondents measured included: age, level of formal education, marital status and occupation of respondents. Following therefore is a presentation indicating the frequency distribution of the sample.

4.1.1 Age of Respondents

Table 4.1 below summarizes the age characteristics of patients/respondents sampled for the study. Respondents fell within the age ranges of below nineteen (19) and forty-eight (48). Of the forty-five respondents who participated in the study, all being females, nineteen (19) constituting 42.2% were between ages nineteen (19) and twenty-eight (28) years. Seventeen (17) constituting 37.8% were between ages 29years and 38years. Two (2) of the respondents comprising 4.4% were between ages 39years and 48years. Women aged 20–29years are more likely to seek an abortion than those aged 30years and above according to the GDHS (2008). The finding of this study confirms the findings made in the GDHS‘s report since the predominant age category of participants interviewed 19-28years. One question that comes to mind is: ―what propels women in this age category to resort to more abortions than the other age categories?‖ This could be that many women in this age category do not yet want to be saddled with the responsibility of child care.

Table 4.1: Age distribution of Respondents

Age range (years)	N	%
Below 19years	7	15.6
19 – 28	19	42.2
29 – 38	17	37.8
39 – 48	2	4.4
Total	**45**	**100.0**

Source: Author's field work, May 2013

4.1.2 Level of formal education completed

The variable in this section looked at the level of formal education of the respondents. As presented in Table 4.2 below, most of the respondents had attained some formal education. Details wise, nineteen (19) of the respondents making up 42.2% had completed Junior High School. Another thirteen (13) forming 28.9% of the participants sampled completed Primary School education. Three (3) respondents constituting 6.7% and two (2) constituting 4.4% had no formal education and had attained tertiary education respectively. Most of the women drawn by this study from the data have attained some level of formal education; an indication that they had the potential of being informed as far as the consequences associated with an unsafe abortion procedure was concerned. They had the potential and capability of seeking abortion care and service from better quarters so to speak.

Table 4.2: Level of formal Education

Level	N	%
No formal education	3	6.7

Primary	13	28.9
Junior High/Middle school	19	42.2
Senior High/Vocational/technical	8	17.8
Tertiary	2	4.4
Total	**45**	**100.0**

Source: Author's field work, May 2013

4.1.3 Occupation of respondents

Table 4.3 below also shows the occupational status of respondents. Respondents who indicated being self-employed at the time of the survey were the most represented (n=27, 60%). A considerable number of respondents (9, 20%), were students, another six (6) forming 13.3% were unemployed with the remaining three (3) constituting 6.7% of respondents being wage earners. A study by Aboagye (2012) cited in Aniteye et al, (2013) found that a woman's socioeconomic status largely determines how safe her abortion will be, with middle- and upper-income women in urban areas being more likely to obtain an abortion; and women who are young, poor or without the support of a partner at greater risk for obtaining an unsafe abortion. The data presented agrees with

Aboagye's findings since it can be inferred from the data that the idea of the socioeconomic status largely influencing how safe a woman's abortion will be, holds true, since most of the study participants were young and single or mostly wage earners involved in jobs like hairdressing and sowing of clothes.

Table 4.3: Occupation of Respondents

Status	N	%
Student	9	20.0
Unemployed	6	13.3
Self employed wage earner	27	60.0
Employee wage earner	3	6.7
Monthly salaried worker	1	2.2
Total	**45**	**100.0**

Source: Author's field work, May 2013

4.1.4 Marital status of Respondents

Table 4.4 below presents the marital statuses of respondents interviewed. Some literature already cited stress that stigma surrounding out-of-wedlock pregnancies prompt women to seek a termination of their pregnancy. To ascertain if this was a synonymous characteristics with the present study, participants were asked to indicate their marital status. Of the forty-five participants in the study, majority of them (86.7%) were unmarried and the remaining 13.3% were married. Of the thirty-nine (39, 86.7%) unmarried respondents, sixteen (16) forming 35.6% were single, another fifteen (15) thus

33.3% were co-habiting with their partners, six (6, 13.3%) were separated, and the remaining two (2, 4.4%) were divorced. Aside the fact that it agrees with literature already cited, the finding also agrees with the assumption of the researcher that unmarried women are more likely to commit unsafe abortion than married women. This is an indication that pregnancy out of wedlock is not very acceptable in the broad Ghanaian society and

consequently compelled these women to seek means of terminating the pregnancies resulting in unsafe abortions.

Table 4.4: Marital status of Respondents

Status	**N**	**%**
Single	16	35.6
Married	6	13.3
Divorced	2	4.4
Co-habiting	15	33.3
Separated	6	13.3
Total	**45**	**100.0**

Source: Author's field work, May 2013

4.1.5 Religion of respondents

The analysis of respondents self reported religious identification revealed that participants were predominantly Christians (n=20). Twelve (12) of the respondents constituting 26.7% were free thinkers, with nine (9, 20%) of the respondents belonging to the Islamic faith. The remaining four (4) respondents being 8.9% belonged to the African traditional religion. The import of this result is that, abortion is an act committed by women irrespective of their religious background or identity. The researcher assumed that less Christians will be involved in the abortion but per the data, more Christians are represented refuting the assumption made by the researcher. Though more Christians are represented, there is a fair representation of the other two major religious orientations in Ghana as well, though women from the African Traditional faith are the least

represented. Result of this analysis is depicted in table 4.5 below.

Table 4.5: Religion

Religious orientation	**N**	**%**
African Traditional Religion	4	8.9
Christian	20	44.4
Moslem	9	20.0
Free thinker	12	26.7
Total	**45**	**100.0**

Source: Author's field work, May 2013

4.2 Pathways to abortion

This section looks at the pathway to the commitment of the act of abortion, thus the trail that led to the participant deciding on abortion as a choice. It looks at whether the pregnancy was intended or not and the reason behind such, whether the individual was using a method to avoid the pregnancy, what the actual cause of loss was among others as presented below. Women younger than 30years it is estimated, may be more likely to be unmarried, working or in school, and therefore be more likely to have pregnancies that are unintended and accordingly resort to an abortion. The root cause of most abortions is unintended pregnancy, which occurs when women are unable to time or limit their childbearing. The need for a girl or woman to continue work or school has been shown in previous literature in studies by Adanu, Ntumy and Tweneboah (2005), and Mote, Otupiri and Hindin, (2010) cited in Sundaram et al (2012). Research findings by Aboagye (2007) as cited by Aniteye (2013) indicates the importance of partners in women's abortion seeking behaviour, stating that women who often have less support from their partners

often resort to abortion. The Ghana Demographic Health Survey (GDHS, 2008) mentions an unmet need for contraceptives as one of the reasons for unwanted or unintended pregnancies.

4.2.1 Respondents' pregnancy was intended

Data presented in Table 4.6 below indicate that of the total number of participants interviewed, forty-one (41) constituting 91.1% pointed out that their pregnancies were unintended. Four (4) participants constituting 8.9% indicated their pregnancies were intended and that they did want to get pregnant. This result implies that most pregnancies which lead to abortion are unintended.

Table 4.6: Pregnancy was intended

Answer	**Frequency**	**Percent**
Yes	4	8.9
No	41	91.1
Total	**45**	**100.0**

Source: Author's field work, 2013

4.2.2 Avoidance of Pregnancy and Methods Used

It is estimated that of the 210 million pregnancies that occur each year (Singh, 2009), some 80 million are unintended and 33 million of these are due to ineffective use of a contraceptive method mostly traditional methods (Sedgh et al., 2012). Participants were asked if they made a conscious effort to avoid pregnancy and the steps or methods they used to avoid a pregnancy. Data presented in Table 4.7 below indicates that majority (29, 64.4%) of the respondents did not take any steps to avoid a pregnancy. The remaining

(16, 35.6%) indicated that they took steps to avoid a pregnancy.

Table 4.7: Avoided pregnancy and method used

Respondent avoided getting pregnant	**N**	**%**
Yes	17	37.8
No	28	62.2
Total	**45**	**100.0**
Method used	**N**	**%**
Natural method (safe period)	10	22.2
Modern contraceptive	7	15.6
Did not avoid pregnancy	28	62.2
Total	**45**	**100.0**

Source: Author's field work, May 2013

When asked what steps they took to avoid a pregnancy, ten (10) constituting 22.2% of the 35.6% respondents who indicated they took steps to avoid a pregnancy mentioned they used the traditional method of avoiding pregnant otherwise known as the safe period. The remaining 15.6 % of the respondents who used some method to prevent pregnancy indicated they used some form of modern contraceptive mostly emergency contraceptive pill, in line with the 2008 GDHS's mention of an unmet need for contraceptives.

4.2.3 Respondent considered ending pregnancy and reason for such

The reason for unsafe abortions is the combination of poverty, moral condemnation of sex outside marriage and severe gender inequities in the labour market; this is the context in which the women and girls make their decisions (Grimes et al., 2006). Those who are most likely to need an abortion are often young or unmarried women, pursuing education or engaged in a low income earning job and either cannot afford a legal procedure or fear the stigma attached to going to a recognised clinic for care or cannot afford it. As a result, they end up having unsafe abortions. Respondents were asked if they considered stopping the pregnancy when they found out about it and the reason behind their decision to end the pregnancy. Data collected in this regard as presented in table 4.8 below indicate that of the forty-five respondents interviewed, majority of them (31, 68.9%) considered putting an end to the pregnancy themselves. The remaining fourteen (14) forming 31.1% of the respondents sampled said ending the pregnancy was not something they considered by themselves, it was suggested by a significant other such as a sister and a friend, and they obliged.

Table 4.8: Considered stopping the pregnancy and reason for that

Considered ending pregnancy	**N**	**%**
Yes	31	68.9
No	14	31.1
Total	**45**	**100**
Reason		
Husband/partner did not want a pregnancy at this time	5	11.2
Have enough children	6	13.3

Cost of raising children is too high	2	4.4
Would have to drop out of school	2	4.4
Would have to leave job	3	6.7
Too young	5	11.2
Too old	2	4.4
Not married	18	40.0
Extra-marital Affair	2	4.4
Total	**45**	**100.0**

Source: Author‘s field work, M ay 2013

Participants considered ending the pregnancy or agreed to do so when it was suggested to them by a significant other, eighteen (18) of the respondents constituting 40.0% said they considered ending the pregnancy because they were unmarried. Six (6) others attributed their decision to the fact that they had enough children and did not want any more. An equal number of five (5) constituting 11.1% each said their husbands or partners did not want a pregnancy as of that time, or that they were too young to have babies hence their decision to end it. Another (2, 4.4%) said the cost of raising children was too high, they would have to drop out of school if they kept the pregnancy, were too young to have a baby and other reasons such as having had extra-marital affair so couldn‘t keep the pregnancy.

4.2.4 Cause of loss of pregnancy

To ascertain the actual cause of the termination of the pregnancy, respondents were asked what caused the loss of their pregnancies. Data presented in table 4.9 below indicates that majority of respondents (26, 57.8%) said they took an abortifacient mainly cytotec which

they obtained from a pharmacy to end the pregnancy. Another thirteen (13) forming 28.9% of respondents interviewed also indicated having drunk some herbal concoction to end pregnancy. Two (2) respondents each being 4.4% of respondents either felt distressed and 4 had an accident. This is an indication that self-inducement of abortions is very common among women seeking to terminate a pregnancy. It also implies that abortifacients, which otherwise should be administered by a qualified health personnel and under observation, can be bought over the counter in some pharmacies in the metropolis. But as to whether the sale of such drugs over the counter is appropriate is another issue for the stakeholders in the health sector to take a look at and rectify.

Table 4.9: Cause of loss of pregnancy

Cause	**N**	**%**
Felt upset or distressed	2	4.4
Took medicine	26	57.8
Drank herbal concoction	13	28.9
Had an accident	4	8.9
Total	**45**	**100.0**

Source: Author‘s field work, May 2013

4.3 Financial costs of abortion

This section ascertained the financial costs of respondents stay in hospital after the unsafe abortion procedure, the money she lost as a result of her inability to do her income generating activity, as well as money her significant others lost on her account.

4.3.1 Engagement in income generating activities

As presented in Table 4.10 below respondents were asked if they had been unable to do their income generating activity. Majority (36, 80.0%) of respondents answered in the affirmative saying they had been unable to do their income generating activity since they had been in their condition. The remaining nine (9) constituting 20.0% of respondents interviewed said their condition and stay in the health facility has had no effect on their income generating activity.

Table 4.10: Engagement in income generating activities

Unable to do income generating activity	**N**	**%**
Yes	36	80.0
No	9	20.0
Total	**45**	**100.0**

Source: Author's field work, M ay 2013

4.3.2 Respondent lost income

Table 4.11 below presents data on whether or not the respondents lost income whiles in hospital. When asked if respondent lost income, thirty representing 66.7% of the respondents replied in the affirmative stating that indeed they lost income whiles in hospital. The remaining (15, 33.3%) said they did not lose income while in the hospital. The 30 respondents who indicated that they lost income while they were receiving treatment further indicated in figures the amount they lost. The minimum amount lost was GHc. 80.0, while the maximum was GHc. 450.00. Overall an average amount of GHc.

196.63 was lost by these 30 study participants. A detail of this analysis is also indicated in Table 4.12.

Table 4.11: Individual income or amount lost

Individual lost income	**N**	**%**
Yes	30	66.7
No	15	33.3
Total	**45**	**100.0**

Source: Author's field work, May 2013

Table 4.12: Income lost to Respondents

Amount lost (GHc.)	**N**	**%**
> 80	2	4.4
90 – 180	16	35.4
190 – 280	6	13.3
290 – 380	2	4.4
390 – 480	4	8.9
Total	**30**	**66.7**
Average amount lost (GHc.)	**196.63**	

Source: Author's field work, May 2013

4.3.2 Household member lost income

Table 4.13 below presents data on whether or not a household member of the respondents lost income whiles respondent was in hospital. When asked if household member lost income, thirty-nine representing 86.7% of the respondents replied in the affirmative stating that indeed another household member lost income on their account of being in hospital.

The remaining (6, 13.3%) said no household member lost income on their account. The 39 respondents who indicated that a household member lost income on their account while they were receiving treatment further indicated in figures the amount they lost. The minimum amount lost was GHc.50.0, while the maximum was GHc. 350.00. Overall an average amount of GHc.163.56 was lost by these 39 study participants. A detail of this analysis is also indicated in Table 4.14.

Table 4.13: Household member lost income

Household member lost income	**N**	**%**
Yes	39	86.7
No	6	13.3
Total	**45**	**100.0**

Source: Author's field work, May 2013

Table 4.14: Income lost to Household

Amount lost (GHc.)	**N**	**%**
≥ 60	2	4.4
70 – 160	22	48.7
170 – 260	6	13.2
270 – 360	9	20.0
Total	**39**	**86.3**
Average amount lost (GHc.)	**163.56**	

Source: Author's field work, May 2013

4.4 Social Costs

There are negative social costs and consequences of unsafe abortion to children and other family members when women are sick from abortion complications. There is stigma related to the abortion itself and stigma related to secondary infertility that may result from the unsafe procedure. The sources of stigma may include the woman‘s family, community, health care providers who may give the post-abortion care needed by the woman. This section looked at social costs of unsafe abortion with focus on possible strain on respondents‘ relationship with significant others and community as well as possible stigma associated with respondents‘ condition.

4.4.1 Relationship with children and significant others

Table 4.15 below shows data on person(s) respondents were living with at the time of the survey. A large number of respondents (n=17) making up 37.8% indicated they lived with their husbands or partners. Eleven of the respondents indicated they lived with their parents; seven (7) representing (15.6%) indicted living with their significant others (e.g. aunties, uncles, brothers and grandmothers), 5 of the respondents also indicated they lived with their children, three (3) of the respondents lived with their friends with only two indicating that they lived alone.

Table 4.15: Person respondent lives with

Person	**N**	**%**
Alone	2	4.4
Husband/partner	17	37.8

Parent(s)	11	24.4
Children	5	11.1
Friend	3	6.7
Other significant others	7	15.6
Total	**45**	**100.0**

Source: Author's field work, May 2013

4.4.2 Care giver from household

Respondents were asked who else cared for them when they were recuperating in hospital beside the hospital staff. When asked about their care giver from their household, sixteen (16) thus 35.6% of the respondents said their parents cared for them. Another thirteen (13) forming 28.9% said they were cared for by their husbands or co-habiting partners. Eight (8) others thus 17.8%, six (6) others making up 13.3% and another two (2) constituting 4.4% indicated they received care from their friends, from other significant others such as aunties and brothers and sisters, and from children respectively as presented in table 4.16 below.

Table 4.16: Care giver from household

Care giver from household	**N**	**%**
Husband/partner	13	28.9
Parent(s)	16	35.6

Children	2	4.4
Friend	8	17.8
Other significant others	6	13.3
Total	**45**	**100.0**

Source: Author's field work, May 2013

4.4.3 Type of care given by care giver

The search for information on the type of care given by care givers to respondents while receiving treatment or care at the hospital revealed two major types of care: bringing of food and other materials and paying of hospital bills.

Table 4.17: Type of care given

Type of care given	**N**	**%**
Bringing food and other materials	3	6.7
Paying hospital bills	4	8.9
All of the above	38	84.4
Total	**45**	**100.0**

Source: Author's field work, May 2013

Details wise, 3 of the respondents indicated that care givers only provided them with food and other materials, 4 of the patients also indicated that care givers only paid their hospital while 38, constituting the largest number of the sample indicated caregivers brought them food and also paid for their hospital bills as seen in Table 4.17 above.

4.4.4 Interruption of school

Table 4.18 below presents data on respondents‘ responses when asked if their absence from their homes affected their children‘s school attendances and the number of days missed. Thirteen (13), thus 28.9% of the respondents had no answers because the question did not apply to them. Nine (9) constituting 20.0% said their absence from home interrupted their children‘s school attendance. Six (6) of the respondents constituting 13.3% indicated that they did not know if their absence had an effect on their children, while six (6), constituting 13.3% indicated that they had no children enrolled in school.

When asked the number of days their children were absent from school, most respondents (7, 15.6%) said their children were absent for less than five (5) days. Two (2) respondents constituting 4.4% said their children were absent for about from five (5) days to about fifteen (15) days as shown below.

Table 4.18: Interruption of children‘s school

Child(ren) was absent from school	**N**	**%**
Yes	11	24.5
No	9	20.0
Do not know	6	13.3
No child enrolled in school	6	13.3
Do not have a child	13	28.9
Total	**45**	**100.0**
Days absent from school		
Less than 5	7	15.6
5 - 10	2	4.4
10 – 15	2	4.4

No child/child not in school	34	75.6
Total	**45**	**100.0**

Source: Author's field work, May 2013

4.4.5 Relationship with community

Respondents were asked to indicate if they belonged to and had an obligation to perform in a social group in their communities such as a neighborhood committee or religious group, and to indicate if their time spent away from their community had a strain on their relationship with their social group.

Data shown in table 4.19 below indicates that majority of the respondents (43, 95.6%) said they belonged to no social group. Two (2) others, thus 4.4% indicated they belonged to a social group. Of the two (2) thus 4.4% of respondents who belonged to a social group, 2.2% said they were uncertain about how their absence affected their social group,

2.2% indicated that they could not play their assigned role in their organisation.

Table 4.19: Respondent belong to social group

Belong to social group	**N**	**%**
Yes	2	4.4
No	43	95.6
Total	**45**	**100.0**
Effect of absence on social group		
Uncertain	1	2.2
Could not play assigned role	1	2.2

Do not belong to any group	43	95.6
Total	**45**	**100.0**

Source: Author's field work, May 2013

4.4.6 Stigma

People who commit certain acts in society such as abortion are often ostracized and stigmatized against. Women's attitudes such as fears and anxieties and opinions about unwanted pregnancy and having to go through or having gone through an unsafe abortion is also another social cost. Kumar et al, (2009) define abortion stigma as ―a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood‖. Research shows that two out of three women having abortions anticipate stigma if others were to learn about it; 58% felt they needed to keep their abortion secret from friends and family (Ellison, 2003).

The experience of stigma varies by individual characteristics, such as religious beliefs, cultural values, and economic status (Kumar et al., 2009). Major and Gramzow (1999) examined effects of individual-level abortion stigma, finding that the more a woman perceived others were looking down on her for having an abortion, the more she felt a need to keep the abortion secret. More than two thirds of women talked about their abortions ―only a little bit‖ or ―not at all.‖ To determine if the sample of women who participated in the present study at some point experienced stigma, they were asked to respond to items that measured if they felt inferior, felt ashamed and if their significant

others have less respect for them because of their condition. Result of this analysis is presented in Table 4.20. From the data presented in the table, twenty-one

(21) forming 46.7% of the women interviewed felt ashamed about the situation and 37.8% have not discussed the issue with the person closest to them giving credence to Ellison's assertion.

Table 4.20: Stigma

Felt Inferior	**N**	**%**
No	18	40.0
Uncertain	16	35.6
Possibly	3	6.7
Yes	8	17.8
Felt ashamed		
No	18	40.0
Uncertain	5	11.1
Possibly	1	2.2
Yes	21	46.7
Received less respect from colleagues No		
	1	2.2
Uncertain	35	17.8
Possibly	6	13.3
Yes	3	6.7
Have discussed problem with person closest		
No	26	57.8
Uncertain	1	2.2
Possibly	1	2.2
Yes	17	37.8

Source: Author's field work, May 2013

4.5 Health costs

The WHO asserts that morbidity is a much more common consequence of unsafe abortion than mortality, but is determined by the same risk factors. This section takes a look at some costs of unsafe abortion to respondents‘ health. It looks at variables like condition respondent reported to the health facility with, type of further treatment needed by respondent if necessary and respondents seeking or accessing post abortion care.

4.5.1 Condition respondents brought to health facility

Unsafe abortion also often results in maternal injury. The most common complications from unsafe abortion include hemorrhage and incomplete abortion, as well as more serious complications, such as shock, sepsis and injury to internal organs (WHO, 2011). To determine the actual reason that had the respondent report to a hospital, respondents were asked to indicate what condition they had reported to the health facility with. As shown in table 4.21, majority (26, 57.8%) of respondents reported to the health facility with vaginal bleeding. Sixteen (16) constituting 35.6% reported to the hospital as a result of abdominal pains. Another (2, 4.4%) and (1, 2.2%) reported with sepsis and uterine laceration accordingly.

Table 4.21: Condition respondent brought to hospital

Condition brought to hospital	**N**	**%**
Vaginal bleeding	26	57.8
Abdominal pain	16	35.6
Sepsis	2	4.4
Uterine laceration/perforation	1	2.2
Total	**45**	**100.0**

Source: Author's field work, May 2013

4.5.2 Further treatment

Data presented in table 4.22 below shows that majority of the respondents (25, 55.6%) indicated they do not have to return to the health facility for further treatment. The remaining (20, 44.4%) of the respondents had to return to the health facility for further treatment such as treatment of their wounds and general medical reviews.

Table 4.22: Further treatment

Seek further Treatment	**N**	**%**
Yes	20	44.4
No	25	55.6
Total	**45**	**100.0**

Source: Author's field work, 2013

4.5.3 Long term consequences of procedure

Studies have shown that persons who undergo unsafe abortions often end up with long term consequences such as chronic pain, inflammation of the reproductive tract and pelvic inflammatory disease are some conditions that may continue indefinitely, severely compromising a woman's health. These conditions, as well as other post-abortion complications, may lead to one of the most pernicious of all long-term morbidities: secondary infertility (WHO, 2005). To ascertain the veracity of this assertion, respondents were asked if they were aware of any long term consequences of the condition they had gone through and if they intended to visit the health facility in future for post abortion care

to see if everything was alright with them. As shown in table 4.23 below, forty (40) respondents constituting 88.9% indicated that they had no knowledge of any long term consequences of their condition. The remaining (5, 11.1%) said they were aware of some long term consequences citing difficulty in getting pregnant again and possible complications in subsequent pregnancies. A large number of respondents (36, 80.0%) had no intention of returning to the health facility for post abortion care. The remaining nine (9) constituting 20.0% had intentions of seeking post abortion care.

Table 4.23: Awareness of consequence and post abortion care

Aware of long term consequence	**N**	**%**
Yes	5	11.1
No	40	88.9
Seek post abortion care	**N**	**%**
Yes	9	20.0
No	36	80.0
Total	**45**	**100.00**

Source: Author's field work, May 2013

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION, AREA FOR FURTHER STUDIES AND RECOMMENDATIONS

5.0 Introduction

This chapter presents the summary of findings of the present study, the conclusions and recommendations made by the researcher. This study sought to generally find out about unsafe abortions in the Ablekuma South District of the Accra metropolis. The study focused on the resultant financial, social and health losses or consequences of unsafe abortions to

participants and their significant others, which it captured as ―A study of costs of unsafe abortions in a selected health facility in the Accra Metropolis‖.

The scope of the study focused on forty-five (45) women who had visited the gynaecology ward of the KBTH after undergoing an unsafe abortion outside of the health facility between April – May 2013. The study looked at the pathways to the unsafe abortion which sought to identify if the women intended to get pregnant at the time pregnancy occurred and if they used contraceptives, reasons that informed the choice of an unsafe procedure and the method used.

Financial costs in this study looked at money lost by the participants during the time of inability to do their income generating activity as well as money lost by a significant other on their account. Social costs consisted of strain and burden on relationship with significant others of the participants whiles she received treatment in the hospital for the ill health resulting from the unsafe procedure. Health costs looked at the immediate medical condition that compelled the women to go to the health facility after the unsafe abortion procedure outside of the facility. The study limited itself to women who had reported to the health facility with ill health from of an unsafe abortion procedure they had undergone. The study did not identify if it was the first episode of unsafe abortion the participant had gone through. The study did not look at the gestational age of the pregnancy before it was aborted.

5.1 Summary of findings

The study was guided by a general objective that sought to look at the phenomenon of unsafe abortions in the Accra Metropolis. Specifically, the study sought to examine the background characteristics of the women who underwent unsafe abortion, determine the social, financial and health costs of unsafe abortions to the individual and her household, determine social costs of unsafe abortion to the individual, her household and community.

The findings on the background characteristics of the participants indicate that the incidence of unsafe abortions is not limited to a homogenous group of women, but cuts across women of different socio-demographic backgrounds, religious orientations and educational levels for instance, in line with the findings made in the GDHS's (2008) report which indicated that women aged 20–29years are more likely to seek an abortion than those aged 30years and above. The predominant age category of participants interviewed was 19-28years, which forms 42.2% of the participants sampled. This is an indication that women in that age category are more predisposed to committing abortions than women in the other age categories. Majority, (n=27, 60%) of participants were selfemployed at the time of the survey. A considerable number (9, 20%), were students, another six (6) forming 13.3% were unemployed with the remaining three (3) constituting
6.7% of respondents being wage earners employed by other persons.

Findings on the marital statuses of the participants indicates that of the forty-five participants in the study, majority of them (39, 86.7%) were unmarried and (13.3%) were married. In the unmarried category of respondents, sixteen (16) constituting (35.6%) were single, another fifteen (15) who formed (33.3%) were co-habiting with their partners, six

(6, 13.3%) were separated, and the remaining two (2, 4.4%) were divorced. The findings indicate that most of the participants in the study who had been exposed to the risk and repercussions of unsafe abortions were unmarried; either single or co-habiting with their partners.

Participant's self-reported religious orientations revealed that participants were predominantly Christians (n=20) although the researcher had assumed otherwise, Twelve (12, 26.7%) were free thinkers, (9, 20%) belonged to the Islamic faith and the remaining four (4, 8.9%) belonged to the African traditional religion. The import is that abortion is an act committed by women irrespective of their religious background or identity. This finding also refutes the assumption by the researcher that women who are Christians will record low incidence of abortion. Results showed that only 13.3% of the women sampled were married with majority of the remaining being single and unmarried or co-habiting with a partner.

Pathways to unsafe abortions shows reasons for the abortion and this ranged from being unmarried, already having enough children, husbands or partners did not want a pregnancy at the time of pregnancy or being too young to have a baby, the cost of having to raise a child, having to drop out of school to have the baby and pregnancy resulting from an extra-marital affair in husband's absence were other reasons that accounted for the termination of pregnancies.

Participants mostly unmarried and did not intend to get pregnant at the time pregnancy occurred although they also did not use any form of modern contraceptive to prevent the

risk of pregnancy. Resultantly, 91.1% of the pregnancies were unintended, an indication that most pregnancies that end up being aborted are often unintended.

On the usage of contraceptive, only 35.6% of the participants used some form of contraceptives, namely the natural method or calendar calculation of safe periods: (22.2%), and the usage of emergency contraceptive pills: (15.6 %).

The choice to terminate the pregnancy was the choice of 68.9% of the participants, whereas it was suggested by a significant other to 31.1% and they imbibed the idea. Most of the unsafe abortions were self-induced by taking a drug obtained from a pharmacy over the counter, or by drinking an herbal concoction which was self administered.

Losses of the unsafe abortions which were financial in nature affected both the individual women who had gone through the procedure and their significant others. Majority (80.0%) of the participants were unable to do their income generating activity when they were receiving treatment after the unsafe procedure with the minimum amount lost being GHc. 50.0, while the maximum amount lost was GHc. 350.00. On the whole, an average amount of GHc. 163.56 was lost by participants. Significant others in the participant's households who lost monies on participants account lost monies ranging from a minimum amount of GHc. 50.0, to a maximum of GHc. 350.00. An overall average amount of GHc. 163.56 was lost by the significant others.

Participants lived with their husbands, co-habiting partners, parents, and other significant others such as aunties, uncles, brothers and grandmothers, while some lived with their

children or their friends, or lived alone. Participants indicated that they received some form of care from these persons they were living with when they reported to the health after the unsafe abortion procedure resulting in some social costs to these people as well. The type of care given by care givers to respondents while receiving treatment or care at the hospital brought two main types of care to light: bringing of food and other materials and paying of hospital bills. Specifically, 3 of the respondents indicated that care givers only provided them with food and other materials, 4 of the patients also indicated that give givers only paid their hospital, while 38, constituting the largest number of the sample indicated caregivers brought them food and also paid for their hospital bills.

When asked if their absence from their homes affected their children's school attendances, and the number of days their children missed, 13.3% of participants did not know if their absence had an effect on their children, another 13.3% indicated that they had no children enrolled in school, whereas 20.0% indicated that indeed their absence from home interrupted their children's school attendance. The number of days their children were absent from school ranged from less than five (5) days to about fifteen (15) days.

When asked if the time spent away from the community by the participants had a strain on their relationship with their communities, by virtue of them belonging to a social group in their communities such as a neighborhood committee or religious group shows that, majority of the respondents (95.6%) did not belong to any such group. Of the 4.4% of who belonged to a social group, 2.2% were uncertain about how their absence affected their

social group, whereas the other 2.2% indicated they could not play their assigned roles in their organisation.

Major and Gramzow (1999) examined effects of individual-level abortion stigma, finding that the more a woman perceived others were looking down on her for having an abortion, the more she felt a need to keep the abortion secret, consequently more than two thirds of women talk about their abortions ―only a little bit‖ or ―not at all.‖ Results on stigma indicate that 46.7% of the study participants felt ashamed about the situation and 37.8% have not discussed the issue with the person closest to them and wanted to keep people from knowing about it. The findings also show that though 40.0% of the women did not feel inferior, 17.8% of them felt inferior and thought their significant others had less respect for them because of their condition.

Women who undergo unsafe abortion procedures often lay themselves open to health complications or costs. The most common complications from unsafe abortion include hemorrhage and incomplete abortion, as well as more serious complications, such as shock, sepsis and injury to internal organs (WHO, 2011). Findings on health costs in the present study showed that majority (26, 57.8%) of the women sampled reported to the health facility with vaginal bleeding, some 35.6% with abdominal pains, 4.4% and 2.2% with sepsis and uterine laceration respectively.

Findings to ascertain if participants had to go through further treatments showed that 55.6% of the participants did not have to return to the health facility for further treatment whereas 44.4% of the respondents had to return to the health facility for further treatment such as

treatment of their wounds and general medical reviews. No long term health consequences was known of by forty (40) of the participants sampled constituting 88.9%.

However, difficulty in getting pregnant again and possible complications in subsequent pregnancies were some of the long term consequences cited by 11.1% of the participants who were aware of some long term consequences. A high proportion of participants (36, 80.0%) had no intention of returning to the health facility for post abortion care after leaving, the remaining 20.0% however had intentions of seeking post abortion care on their own accord.

5.2 Conclusion

The data drawn shows that, the losses from an unsafe abortion captured in this study as ―costs of unsafe abortion‖, go beyond the individual woman who goes through the experience. This is an important finding in and of itself, because it throws more light on the costs of unsafe abortions.

Singh et al (2009) assert that of the 210 million pregnancies that occur each year, some 80 million are unintended and 33 million of these are due to ineffective use of a contraceptive method; mostly traditional method. Accordingly, in countries where abortion remains unsafe it is the leading cause of maternal mortality, accounting for

78,000 of the 600,000 annual pregnancy-related deaths worldwide (WHO, 2009).

It is the researcher‘s view that incidence of unsafe abortion generally reflect the enormity of unwanted pregnancies in a community. Unsafe abortion is an important contributor to the high maternal rates in Ghana. The 2007 Ghana Maternal Health Survey (GMHS)

contained in the 2008 GDHS which was intended to serve as a source of data on maternal health and maternal death for policymakers and the research community, stipulated in its findings that maternal mortality ratio in Ghana remains high at 451 deaths per 100,000 live births (GDHS, 2008).

In addition, statistics from the Ghana Health Service (GHS) also indicates that 953 women died in 2008 from pregnancy and delivery complications in our health facilities. This figure, according to the GHS, did not include those women who died silently and never went into hospital. In order to achieve MDG 5 on Improving Maternal Health, it is vital that the issue of unsafe abortions and its attendant problems are addressed. Unwanted pregnancy has costs for women and their families or households, including: constrained opportunities for education or employment since women who end up with unwanted pregnancies who are either in school or work are usually confronted with the decision of keeping the pregnancies or leaving school or work.

There is associated social stigma for unmarried women or girls in communities. As the findings in the study indicated, unsafe abortion morbidity or ill health puts strain on household resources and children‘s education since it limit women‘s productivity inside and outside of the home and constrain their ability to care for their children. Unsafe abortion may also result in long-term illness, emotional distress. The UN‘s MDG has set goal 5 as ―Improve maternal health‖, and target 6 ―reduce by three quarters, between 1990 and 2015, the maternal mortality ratio‖. Ghana has just a year of the set time left to achieve this goal and target. The technical advisor of the National Development Planning

Commission (NDPC), when accessing Ghana‘s progress so far and estimating the likelihood of meeting the set targets in the MDGs‘ in a presentation titled ―Millennium Development Goals; Ghana's Performance, 2010‖, stipulated that though Ghana is working hard to meet all the goals set out, MDG 4 & 5 are unlikely to be met by the year 2015.

The issue of unsafe abortions should and must be critically accessed and addressed if Ghana is to make head way its quest to meet the UN‘s MDGs. Additionally, because the losses or costs go beyond the women who commits the act, the Ghanaian society perhaps ought to lend more support, try to empathize with, as well as encourage young women and girls who find themselves saddled with unintended pregnancies so that they will not resort to abortions, and unsafe abortions for that matter.

5.3 Area for further research

The results of every research has always not been expected since every research has some flaws which therefore provide the essence for further research into the phenomenon or an aspect of it.

The study did not look at the gestational ages of the fetuses that were aborted and so considers that area worth considering in another study.

The study did not also look at women who had gone through an unsafe abortion procedure but had not reported to the health facility with any medical condition of ill health as of the time of the study, it limited itself to women who had reported to the health facility with some form of ill health because of an unsafe abortion procedure they had undergone. A

study can be conducted into what happens to women who do go through unsafe abortions outside of the health facility who do not report for post abortion care either since it will widen the knowledge and literature on the incidence of unsafe abortions.

Furthermore, the study did not identify if it was the first episode of unsafe abortion the woman participant had gone through. The study did not also look at how old the pregnancy was before it was aborted.

5.4 Recommendations

Abortions take place where it is legally available with few or no restrictions, and where it is highly restricted. Where abortions are highly restricted, abortions are usually unsafe and carry high risk, causing serious costs or losses for the women and a major financial and service burden on the significant others and even on national health systems in general.

The key to the abortion issue in the researchers‘ view is that women gain control over their reproductive (and sexual) lives. Accordingly, reducing the unmet need for contraceptives and eliminating barriers to obtaining family planning services, providing greater access to comprehensive family planning services, including expanding the range of contraceptive options will go a long way to reduce the number of unintended pregnancies. This, in turn, will reduce the incidence of unsafe abortion and associated maternal deaths morbidity.

There is also the need to promote access to safe legal abortion services for all women, to the full scope of the law. The government and stakeholders in this regard must step up the effort to publicise the availability and accessibility of these services in public-sector facilities and ensure that services are indeed affordable to women of all status.

More campaigns to increase awareness of the legal status of abortion in Ghana ought to be added to the few awareness creation programmes already underway. Improving knowledge of the law may also help reduce stigma. Husbands and partners should also make it a matter of concern to encourage their women to use modern contraceptive measures to reduce if not eliminate out rightly, the risk of an unintended pregnancy, thereby reducing the likelihood of an unsafe abortion.

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APPENDIX A

CONSENT FORM

Thank you for agreeing to talk to me. All the information you will give will be used only for research purposes and will not identify you.

A. To learn more about the health problems women suffer and the treatment they receive, I would like your permission to get access to health information that is collected about you at this facility. The information will be linked to your interview by a number and not your name or other identifying information. Again, your participation is completely voluntary and you can refuse access to your information—it will not affect the care you receive here. May I have your permission to get your medical information from this facility and from you?

i. Yes [ ] ii. No [ ] [skip]

B. If you agree to permit me to get your information, please sign or write your initials here to show that you understand the information above and that your consent is given voluntarily.

_____ _____

(Respondent) (Date)

_____

If person is unable to read or sign:

I [the interviewer] will sign here indicating that the information above was read to you, that you permit me to get your medical information from this facility and that your consent is given voluntarily.

_____ _____

(Interviewer) (Date)

Study number: _____

C. Finally, I might want to talk to you again about any change in your health and how your life has been since you received treatment. May I contact you again?

i. Yes [ ] ii. No [ ] [Thank respondent again and end interaction]

If you agree to be contacted again, please sign or write your initials here to show that you understand the information above and that your consent is given voluntarily.

_____ _____

(Respondent) (Date)

_____

_____

If person is unwilling to initial or sign or unable to read or sign but agrees to be a participant:

I [the interviewer] will sign here indicating that the information above was read to you, that you agree to be contacted again and that your consent is given voluntarily.

_____ _____

(Interviewer) (Date)

a. Where do you want to meet again? At this health facility, your home or another place?

i. Health facility [ ] ii. Home [ ]

Other (specify):_____

b. Where is (your home/this place: other)?

Address/Directions:_____

_____

_____

_

_____

Phone number (if relevant):

_____

c. When would you like us to meet at (other)?

(Write agreed upon date and time)

APPENDIX B

A questionnaire on the costs of unsafe abortions

In partial fulfillment for the award of a degree of Master of Arts in Sociology in the faculty of Social Sciences, KNUST, this is a research into the costs of unsafe abortions in a selected health facility in the Accra metropolis of the Greater Accra region. This research is purely for academic purposes and any information given will be treated as confidential. Absolute sincerity is required in answering the questions outlined.

Please tick or write where appropriate. Thank you.

Section A: Socio demographic characteristics of respondents

1. How old are you?

a. 18years and below [ ] b. 19-28years [ ] c. 29-38years [ ]

d. 39-48years [ ] e. Above 49years [ ]

2. What is your level of formal education completed?

a. No education [ ] b. Primary/elementary [ ] c. Middle/Junior High [ ]

d. Secondary high/technical/vocational [ ] e. Tertiary [ ]

3. What is your occupation?

a. Student [ ] b. Unemployed [ ] c. Self employed wage earner [ ]

d. Employee wage earner [ ] e. Monthly salaried worker [ ]

4. Marital status

a. Single [ ] b. Married [ ] c. Divorced [ ] d. Widowed [ ]

e. Co-habiting [ ] f. Separated [ ]

5. What faith (religion) do you belong to?

a. African traditional religion [ ] b. Christian [ ] c. Moslem [ ] d. Free thinker [ ]

Section B:Pathways to/causes of unsafe procedure

6. Did the pregnancy occur because you wanted it? (Was it intended?)

a. Yes [ ] b. No [ ]

7. Were you using any method to avoid getting pregnant?

1. Yes [ ] 2. No [ ] {skip to q 11}

8. What method were you using?

_____

_____

_

9. Did you consider stopping this pregnancy yourself?

a. Yes [ ] b. No [ ]
If No, who did?

_____

10. Why did you consider stopping the pregnancy?

1. Husband/partner did not want a pregnancy this time [ ]
2. Have enough children [ ]
3. Cost of raising children is too high [ ]
4. Would have to drop out of school [ ]
5. Would have to leave job [ ]
6. Too young [ ]
7. Too old [ ]
8. Not married [ ]
10. Other (specify):_____

11. What caused the loss of this pregnancy?

[Do not read out-- circle all that apply]

1. Felt upset or distressed [ ]

2. Took medicine [ ]
3. Drank herbal concoction [ ] 4. Had an accident

[ ]

5. Other(specify): _____

Section 3: Financial costs

12. Have you been unable to do your normal income generating activities since you stopped the pregnancy?

a. Yes [ ] b. No [ ]

IF YES, how many days or weeks were you unable to do these activities?

_____

13. Did you lose any income during this time?

a. Yes [ ] b. No [ ]

14. If yes, how much income did you lose? _____ **[Probe for estimate]**

15. Did anyone else in your household lose income because of your illness?

a. Yes [ ] b. No [ ]

If YES, How much income did he/she lose? **[Probe for estimate]**
Amount _____

Section 4: Social costs

16. Who do you live with at home?

a. Alone [ ] b. Husband/partner [ ] c. Parent(s) [ ]

d. Children [ ] e. Friend [ ] f. Other (indicate) [ ]

17. Who cared for you whiles you were hospitalised?

a. Husband/partner [ ] b. Parent(s) [ ] c. Children [ ] d. Friend [ ]

e. Other [ ]

18. What exactly did the person(s) do?

a. Bringing food and other materials [ ]

b. Paying hospital bills [ ]

c. All of the above [ ]

d. Others (specify)

_____

19. Have any of your children been able to attend school since you have been ill?

i. Yes [ ] How many days missed?

_____

ii. No [ ]

iii. Do not know [ ]

iv. No children enrolled in school [ ]

v. Not applicable [ ]

20. Do you think your absence from home has had any effect on your children?

a. Yes [ ] If yes, how?

_____

b. No [ ] {skip to 22)

21. How did they cope?

_____

22. Are you involved in any social organisation/group?

a. Yes [ ] b. No [ ] {skip to 24}

If yes, what organisation?

i. Church group [ ] ii. Community group [ ] iii. Other (specify)

_____

23. How did your absence from the organisation's activities impact their activities?

_____

_____

Stigma

24. Do you feel inferior because of this problem?

a. Yes [ ] b. No [ ] c. Uncertain [ ] d. Possibly [ ]

25. Do you feel ashamed of this problem?

a. Yes [ ] b. No [ ] c. Uncertain [ ] d. Possibly [ ]

26. Do your neighbours, colleagues and others have less respect for you because of this problem?

a. Yes [ ] b. No [ ] c. Uncertain [ ] d. Possibly [ ]

27. Have you discussed this problem with the person closest to you?

a. Yes [ ] b. No [ ] c. Uncertain [ ] d. Possibly [ ]

Section 5: Health costs

28. What condition brought you to this health facility?

a. Vaginal Bleeding [ ]

b. Abdominal pain [ ]

c. Sepsis (infection) [ ]

c. Cervical/Vaginal lacerations [ ]

d. Uterine laceration/Perforation [ ]

29. Do you have to come back to this facility for further treatment?

a. Yes [ ] b. No [ ]

30. What further treatment will you be back at this facility for?

_____

_____

_

31. Are you aware of any long term consequences of your actions?

a. Yes [ ] b. No [ ]

If yes, what consequence?

_____

32. Do you intend to come back to the health facility in future for further examination to see if everything is alright with your reproductive system? (Post abortion care)

a. Yes [ ] b. No [ ]

Please indicate your reason for your answer.

_____

_____