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# THE CONUNDRUM OF UNSAFE ABORTION AMONG THE YOUTH IN GHANA: A CASE STUDY OF AWUTU SENYA EAST MUNICIPAL ASSEMBLY.

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**ABSTRACT**

The United Nations sustainable development goal 5 focused on achieving Gender Equality and Empowering Women and Girls. This empowerment requires that women have channels through which sexual, reproductive, economic and legal aspects of their lives are largely within their power and /or control. There is a long way to go in seeing this become reality in Ghana. Reduced maternal death is one such area. Achieving sustainable development goal 5 requires tackling the issue of unsafe abortion among youth and women because approximately 287, 000 women's lives are lost from pregnancy-related causes. Abortion has been a major contributor to the loss of life of pregnant women. It accounts for more than 16 percent of such deaths. Unsafe abortion has been described as a public health threat especially in less developed countries where even safe abortion is frowned upon by religious beliefs and teaching, cultural norms, and values as well as societal structures. People therefore resort to unsafe means to terminate a pregnancy.

Ghana over more than two decades has implemented legal provisions where unsafe abortion is regarded as illegal and attracts criminal sanctions for both women and the unprofessional attempting the abortion. An unsafe abortion carried out by an unprofessional, compromises the procedure, uses unhygienic instruments and unaccredited and unapproved drugs that threaten the life and health of the pregnant woman. Abortion accounts for more than 19% of maternal deaths in Ghana and is most prevalent in the Northern, Upper East and Upper West district hospitals. Despite high abortion-related deaths in Ghana (higher than global figures), unsafe abortion is the most preventable cause of maternal morbidity and mortality.

Ghana as a country is a signatory to the Maputo protocols that regarded abortion as a human right for women in Africa but the inadequate and lack of health facilities has made it difficult to enforce the Maputo protocols creating space for unsafe abortions to be carried out by unprofessional and unqualified persons. The lagging health facilities to carry out safe abortions and ensure that women's right to abortion is enforced requires awareness creation on safe and unsafe abortion among Ghanaians, especially the youth. It is on the back of this that the study explores the conundrum of unsafe abortion among the youth in Ghana.

Using a case study research design, data on unsafe abortion was gathered from 160 sampled females with age boundaries of 19 years to 40 years through questionnaire

administration and key informant and focus group discussions. The study was geographically limited to the Awutu Senya District in the Central Region of Ghana

Findings from the study revealed that (female) youth had knowledge of safe and unsafe abortion in relation to abortion practitioners, substances used and source of those abortifacients as well as the methods used in terminating the unwanted pregnancy. Furthermore, pregnant youth or a young woman's decision to engage in unsafe abortion can be influenced by economic factors (financial difficulty in securing a safe procedure), social and societal factors (unpreparedness to bear a child, desire to continue with education), health factors (fear of surgery, contraceptive failure) and religious and cultural factors (fear of parents, stigmatization from community members, partner denial). Again, access to safe abortion was challenged by way of the cost involved in safe abortion, religious and cultural beliefs, fear of death and complications through surgery, poor public health education and inadequate health facilities carrying out safe abortion. Based on findings the study recommends the government to cover the cost of safe abortion on the national health insurance system (NHIS) for at least females less than 25 years, operationalize abortion units in all district hospitals and community sensitization on the relevance of safe abortion to the girl child development.

In conclusion, addressing the challenges of unsafe abortion by way of highlighting safe abortion will contribute to curbing the rising maternal mortality rate and hence achieve targets of the SDG Goal 5.

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# CHAPTER ONE

# GENERAL OVERVIEW ON THE CONUNDRUM OF UNSAFE ABORTION

## 1.1 Introduction

The Center for Reproductive Rights (2018) report shows that in the years 1995, 2003 and 2008 every abortion in West Africa was found unsafe. Klutsey and Ankomah (2014) confirm the claim made by the Center for Reproductive Rights and further note that Africa is currently burdened with many unsafe abortions, and that unsafe abortion is a public health concern and contributes significantly to maternal morbidity and mortality. Ghana's maternal mortality rate is estimated to be low at 319 per 100,000 live births (World Bank 2015).

The World Health Organisation (WHO) describes unsafe abortion as a procedure for termination of pregnancy undertaken by people who lack the requisite qualifications or are not in accordance with basic professional requirements or both (Ganatra et al. 2014).

At the present time in Ghana, the criminal offense of abortion is regulated by Act 29, Section 58 of the 1960 Criminal Code, as amended by the 1985 PNDC Law 102. The amendment does not allow a healthy mother with a healthy pregnancy to get an abortion on the grounds that she does not wish to have a pregnancy but instead opens the door for the following provisions: (1) Abortion is illegal unless it is performed by a registered medical practitioner or gynecologist in a hospital or designated clinic; (2) abortion is permitted where the continuation of the pregnancy poses a serious risk to the life of the pregnant woman or to her physical or mental health; 3) Abortion is often permitted where rape or defilement of the female idiot or incest leads to pregnancy, and where there is a considerable risk of severe physical abnormality or fetal disease (PNDC, 1985).

Most Ghanaians have been pressured by the clear existence of the Law on Abortion to believe that abortion is unlawful in Ghana. This situation has led to an increase in unjustified maternal deaths and morbidities for women seeking unsafe abortion procedures. The Ghana Statistical Service estimated that 15 percent of women in the reproductive age group (15-49 years) have performed illegal abortions, given the presence of a regulation on abortion and a legal abortion policy.

Ipas, an international non-governmental organization, reported by Jehu-Appiah (2009), has discovered that the high fees charged for the service is a major reason for unsafe abortion in Ghana. The financial cost of abortion in government facilities varies from $30 to $40 depending on the gestational age of the pregnancy. However, the cost is not stipulated by the Ministry of Health or Ghana Health Services and as a result gives room for professionals in the government facility to charge by discretion thereby leading to a rise in cost of accessing an abortion service. Ipas states that abortion treatment in Ghana does not have any official cost. Jehu-Appiah (2009) observes that high costs result in poor women and adolescents not being able to access the service. The high costs of abortion is also due to the fact that just a few doctors offer abortion services, says Jehu-Appiah (2009). Jehu-Appiah (2009) observes that the consequence of the high cost makes the service inaccessible for poor women and especially adolescents. Lithur (2004) also suggested that the high prevalence of unsafe abortions, particularly in Ghana is attributed to the extreme stigmatization and humiliation associated with criminalizing abortion-related procedures by social, legal and religious beliefs

In Africa, there are significantly higher adverse consequences of unsafe abortions (Shah and Ahman, 2009; WHO, 2011). The above assertion is backed by Singh (2003), which further stated that in West Africa, the admission rate is projected to be 6 in 1000 women between the ages of 15 and 44 years per year for complications resulting from unsafe abortions. Unsafe abortion is the major cause of maternal mortality in Ghana (Mills et al., 2008). Singh (2003) reports that more than 5 million (or around 1 in 4) women have a chance of serious risks like death, with 1.7 million women currently experiencing secondary infertility. However, most deaths and long-term complications of unsafe abortion can only be avoided by: i) increasing access to reliable forms of family planning and contraceptives to decrease the occurrence of unintended birth. (ii) Providing quality health care service to women after abortion and (iii) healthy abortion provision.

The Ghana Government has taken measures to reduce the growing tendency toward unsafe abortions through a safe abortion program, but the expected decrease in maternal deaths is still uncertain (Rominski and Lori 2014). Given the lack of reliable knowledge on unsafe abortion practices in Ghana and its accompanied result of an increase in maternal death, the study seeks to assess the prevalence of unsafe abortion

among the youth, especially at the Awutu Senya East Municipal Assembly in the Central Region of Ghana.

### 1.2 Problem Statement

The UN Millennium Development Goal (MDG) 5 seeks to reduce maternal deaths in the developing world by three quarters. Nevertheless, MDG 5 cannot be met without tackling the issues of unsafe abortion. That is because, according to the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), UNFPA and the World Bank, 287,000 women die from pregnancy-related causes worldwide each year (WHO, 2012). World Health Organization reports that 47,000 of these deaths each year are due to illegal abortion, rendering abortion the leading cause of maternal mortality (WHO, 2012). Unsafe abortion is a significant public health issue in developing countries where abortion is restricted by laws, religions, culture and beliefs.

Notwithstanding the clear liberalization of the law on abortion for over two decades, unsafe abortions remain a significant public health issue in Ghana and this is because, despite the fact that the existing legislation on abortion makes it impossible for untrained professionals and people to carry out unsafe abortion procedures, morbidity and mortality linked to unreliable abortion has been established in the literature to be largely dependent on the procedure, the provision's ability and the cleanliness of the instruments and environment, together with the stage of the woman's pregnancy and the woman's overall health. Increasing maternal death and morbidity thus continue to have significant public health implications (Ghana Statistical Service 2016)

Assessing Ghana's institutional maternal deaths, abortion complications were estimated at 19% in Northern, Upper East and Upper West district hospitals (Jehu-Appiah, 2009). However, the World Health Organisation report (2011) discloses that unsafe abortion which causes maternal morbidity and mortality is one of the most preventable factors. Although the Maputo protocol which says that abortion is a human right for women in Africa, was signed by the Government of Ghana (Banda, 2008), measures such as legal abortion services in Ghana are yet to be fully enforced in the health facilities. This further calls for research and related activism in Ghana to create awareness on the conundrum of unsafe abortion among the youth.

In order to minimize the adverse effects of unsafe abortion, Ghana's Government has taken significant initial moves to eliminate regulatory obstacles to safe abortion care

and also improve training for professional workers. However, complications arising from unsafe abortions are still a significant contributor to mortality and morbidity among women. This work therefore has its main focus on exploring this dreaded problem of unsafe abortion prevalent among the Ghanaian youth.

### 1.3 Research Questions

The study will help answer the following question:

1. What is the perception of Ghanaian youth about unsafe abortion?
2. What are the factors contributing to the prevalent rate of unsafe abortions in Ghana?
3. What are the challenges confronting access to legal and safe abortion practices in Ghana?
4. In what ways can access to safe abortion care in Ghana be improved?

### 1.4 Research Objectives

This research is aimed at analyzing the difficult problem of unsafe abortion among Ghanaian youth. To ensure the realization of the study's goal, the research seeks to achieve these specific objectives:

- To identify the causes of the patronage of unsafe abortion in the study area.
- To analyze the perception of social acceptance of abortion in Ghanaian society.
- To examine the challenges that confront access to legal and safe abortion procedures in Ghana
- To propose recommendations to mitigate the challenges that confront safe abortion care to Ghanaian youth.

### 1.5 Scope

Geographically, Ghana is the scope of the research. Ghana, a nation in West Africa, had an estimated population of 28.83 million in 2017. The annual per capita income is roughly $181015, putting Ghana in the middle-income bracket. Ghana has a similar trend of health as other countries in the region; marked by a pervasive burden of infectious diseases among the impoverished and rural population, and increasing non-communicable diseases among the urban middle class. Specifically, the Awutu Senya East Municipality situated in the Central Region of Ghana will be chosen for

the study. This is because the municipality is one of the fastest-growing municipalities in the sub-region of West Africa.

Contextually, the paper seeks to study the conundrum of unsafe abortions among Ghanaian youth. The study further will review literature on unsafe abortion and its implication on the society and victims. The study further makes recommendations to improve access to legal and safe abortion procedures among the youth in Ghana.

### 1.6 Significance of the Study

First, this research adds to the existing literature as part of concerted efforts toward addressing the problem of unsafe abortion among the youth in Ghana. The findings of this study would awaken and sensitize academicians and health practitioners in Ghana to appreciate the health implications as well as the socio-economic effects of unsafe abortions on the youth. Such findings and recommendations would contribute to fashioning out strategies and programs to improve on the existing law to also include women of all categories who may have the desire at a point in their lives to get an abortion for an unplanned pregnancy.

Second, a study on the conundrum of unsafe abortions among the youth in Ghana has the potential to underpin future studies on de-stigmatizing the health practitioners and citizens who patronize abortion procedures, particularly among the youth in Ghana. The present study would also invigorate debates among key stakeholders in the health sector on how to make abortion procedures legally accessible to the citizens and devoid of the stigmatization attached to the abortion procedures across similar geographical localities. The study also provides a new door to understanding safe abortion procedures.

Since the duty of every government is to protect the lives of its citizens, at the national level, the outcome of this research would make valuable contributions to wider policy implications on the health delivery of the nation. The findings of the study would contain reliable data which would seek to inform health policy makers on sound health policies aimed at mitigating the challenges to access of safe abortion care. It is expected that the findings of this present study would be compelling enough to lead policy makers and management of public and private health facilities to commit the necessary resources and funding to improve access to safe abortion procedures.

## 1.7 Limitation of Study

There will be a lot of challenges and limitations to conducting any research of this nature. The first restriction is time limits. Keeping in mind, in the sense of the study, the importance of finishing this project on schedule before graduation means that there is not much time left to carry out this project. Nevertheless, the researcher must make use of the minimal resources available to ensure that this study is done on schedule. Timelines have been planned by the study as to when each chapter will be completed. This personal deadline will make it easier for the researcher to work and complete the project on schedule.

The proximity of the researcher to the selected region for data collection is another drawback. In order to resolve this restriction, a compilation of these data was rendered by individuals residing in Ghana on behalf of the researcher.

Given the expense to conduct such a project and the fact that this project is self-financed, the researcher may fund it from her own personal funding. In all, arrangements by the researcher will resolve all obstacles.

## 1.8 Organization of Work

The study is organized into five chapters. Chapter one focuses on the overview and the key issues concerned with the conundrum of unsafe abortion among the youth. It contains the problem statement, research questions and the objectives, scope, limitation and organization of the study.

Chapter two discusses relevant literature on unsafe abortions among the youth with particular focus on the developing countries. This provided a conceptual understanding and framework for the study.

Chapter three focuses on the methodology used in this study and the profile of Awutu Senya East Municipal Assembly.

Chapter four presents the analysis of issues gathered from the data collection. It presents an analysis on the conundrum of unsafe abortion among the youth in the study area.

Chapter five presents a summary of the key findings resulting from the analysis of data. It also provides recommendations to mitigate the challenges to access safe and legal access to abortion procedures in Ghana. The chapter also presents the conclusion of the study.

# CHAPTER TWO

# LITERATURE REVIEW ON UNSAFE ABORTION

## 2.1 Introduction

The universal nature and reality of abortion are well documented throughout history. Abortion is a matter of interest to persons and families in recent times. Just as attempts were made to recognize technology and ways to address childlessness in socially appropriate ways, efforts have been made toward avoiding unintended births through abortion and contraception (World Health Organisation, 1998; 2003; 2012).

Unsafe abortion in reproductive health is an issue that is commonly overlooked. Nevertheless, millions of developed countries are facing a major health crisis in women's reproductive life. Complications caused by unsafe abortion remain the root cause of maternal death and morbidity.

The previous chapter provided the background to the study, problem statement, study objectives, the scope, justification and organisation of study. This chapter examines the relevant literature as a follow-up to this study and creates a framework for theory.

## 2.2 Global Perspective on Unsafe Abortion

Abortion is the termination of a uterus embryo or fetus until it is mature enough to survive (Insel & Roth, 2004) or 'the loss of pregnancy before the foetus is viable' (GHS, 2003). Abortion also constitutes pregnancy loss, expulsion or termination before 28 weeks of gestation (Deganus et. al., 2002). An approximate 210 million women around the world become pregnant each year, and around one in five have abortions.

It is estimated that 19 million of 46 million abortions done worldwide are unsafe (WHO,1997). World Health Organisation (2015) report disclosed that there is an annual voluntary termination of about 42 million pregnancies worldwide, 22 million within and 20 million outside the national legal system, which is deemed to be unsafe. There are likely to be severe complications in more than 5 million (or about 1 in 4) women who have an unsafe abortion; death is also involved. Abortion-related deaths are primarily caused by unsafe abortion procedures. The World Health Organization describes unsafe abortion as an abortion procedure that is either done by individuals who do not possess the requisite expertise to perform an abortion or done in an

environment that does not comply with the medical standards required to perform an abortion, or both (WHO 2015).

Approximately 97 percent of all global abortions occurred in low income countries between 2010 and 2014 (Ganatra et al, 2010). In countries with extremely restrictive abortion laws, the proportion of unsafe abortions is higher compared to more liberal countries (Ganatra et al. 2014). Ganatra et al (2002) indicate that in India where abortion is legal and provided free of charge in government authorized clinics, there are still significant numbers of abortions that continue to take place in uncertified settings; a large proportion of which are unsafe. This situation of high levels of unsafe abortion in India is largely caused by factors relating to the quality of abortion care services offered and the access to the said services including a limited number of government-certified abortion clinics in rural areas as a result women are compelled to seek out for other providers (Ganatra and Johnson, 2002).

In regions where abortion is highly restricted, the private sector plays an important role in provision of safe abortions for women who can afford it. Although costly and therefore only accessible to women with the means to pay, clandestine abortion providers (such as well-trained doctors and midwives) may offer a safe abortion service, including post-abortion care if there should be complications.

Unsafe abortion occurrence is predominant in developing countries. Arowojolu (2002 ) notes that many studies have consistently shown that girls in Africa have elevated rates of illegal abortion. Arowojolu (2002) further states that surveys of adolescents in Cameroon and Nigeria across various communities have shown that some 20 per cent of teenagers have reported having at least one abortion and that complications are normal. An empirical study of Abortion in Uganda (Mbonye, 2000 ) showed that 55% of abortions occurred in females aged 17 to 20 years of age in health facilities. 23% of the abortion of these pregnancies resulted in procedural accidents leading to a loss of ability to control complications. While some women seeking abortion are married or in stable relationships and already have several children, a growing proportion of those seeking an abortion, especially in urban areas, are single adolescents.

However, many women in the developing world are denied access to safe abortion services due to a variety of social, cultural, religious and social reasons. Although a number of developed countries have liberalized abortion laws. In 1995, 2003 and 2008, all abortions in West Africa were reported as unsafe (WHO 2002). Africa has encountered many complications relating to abortion (Klutsey and

Ankomah, 2014). Maternal death is a problem in less-resourced nations (Rominiski and Lori, 2014) Deaths from unsafe abortions were estimated to account for 14% of all maternal deaths in Africa (Ganatra et al. 2014). Among the effects of unsafe abortions on maternal mortality, unsafe abortion procedures often contribute to many health implications. An additional 5million people are admitted worldwide from less developing nations for unsafe abortion risks such as hemorrhages, infections and perforations (Sign, 2006).

The adverse implications of unsafe abortions in Africa are unreasonably higher (WHO 2018). Across the globe, community research indicates a higher incidence of unsafe abortion than safe abortion estimates (Shah and Ahman, 2012).

In Zambia, maternal deaths caused by unsafe abortion are generally not recorded in health reports because of the secrecy that covers abortion procedures. A survey interviewing women in Zambia indicates that 69% of respondents had one or more women who had died as a result of unsafe abortion (Koster, 1998). It is clear that women are more likely to have unprotected abortions in South America, East Africa and West Africa than women in other nations. The south-central and south-eastern regions of Asia have comparable rates of unsafe abortion (22 and 21 per 1,000 women, respectively ) compared to around half (12 per 1,000) in western Asia and slightly in eastern Asia (where abortion is lawful and readily available on request)

Unsafe abortions vary widely across age groups and regions: Of all unsafe abortions in Africa, teenagers between 15 and 19 years of age account for 25% of it. The figures are much smaller in Asia, Latin America and the Caribbean. Women between 30 and 44 years of age account for 23% percent in Africa as compared to 42% in Asia and 33% in Latin America of all unsafe abortions(Shah and Ahman, 2004). According to WHO estimates, women would have had an excess of about one unsafe abortion at 45 years of age if current rates of women's reproductive lives prevail (Shah & Ahman, 2004).

In many countries, adolescents make up a significant proportion of abortion-seekers. Where abortion is against the law, adolescents are most likely to experience unsafe abortion and its consequences. For example, 59 % of all unsafe abortions in Africa are estimated to occur in women aged less than 25 years (WHO, 2004).

The motives for seeking abortion are different: socio-economic issues (including poverty, lack of partner support, dysfunctional families, lack of healthy sexual education, unemployment); family desires ( the need to plan when to have children);

marital or spousal problems; maternal or fetal health risks; and unusual pregnancy arising from rape or incest (Bankole et al.1998).

### 2.3. Unsafe abortion in Ghana

Numerous factors account for unsafe abortion procedures in Ghana. These factors include: lack of information about legal abortion procedures, socio-economic challenges, cultural and religious values, unplanned pregnancies, stigma, wanting to bear children only after marriage, desires to avert parental/guardian dissatisfaction or sorrow, and the desire to pursue schooling. Ghana has different abortion rates in each region. A survey in the Volta Region by Mote et al. (2010) reported 21.3% and a further survey in the Brong Ahafo region reported 22.6% (Geelhoed et al. 2002), respectively. The prevalence of unsafe abortions has major implications for Ghana's general health as it raises infant death and morbidity (GSS, 2008).

While many cases of unsafe abortions in Ghana remain largely unreported, the rate of unsafe abortion in the published studies has dramatically increased. The highest reporting statistic comes from Agyei et al. (2000), who found an illegal abortion by a total of 47 percent of female respondents who registered at least one birth. Morhe et al. (2012) estimated in their report that 36.7 percent of females had experienced illegal abortion outside of Kumasi. Ahiadeke (2012), who makes use of data from the Maternal Survey Program, estimates an unsafe abortions rate of 27 per 100 live births. Krakowiak-Reed et al. (2011) in their seminal work found that 20% of women have had at least one abortion before. In their research, Oliveras et al. (2009) found that there was an involuntary abortion at conception between 10 and 17.6 % of women. Geelhoed et al (2002), in their work also found out that there is a prevalent usage of induced abortion by 22.6 percent of the respondents who took part in the work. Glover et al (2003 ) found that 70 percent of pregnant young women had attempted an abortion in their sample. In the 2007 Maternal Health Survey, five years prior to the survey, Sundaram et al (2012 ) reported abortion in around 10 percent of the population. Nevertheless, the authors note that the figure is undoubtedly, significantly understated.

Over the years, Ghana's Reproductive Health Policy on Secure Abortion Regulation has focused mainly on encouraging family planning, contraception and post-abortion treatment. In Ghana, manual vacuum aspiration (MVA), surgical

abortions, dilatation and curettage (D&C), and dilation and evacuation (D&E) are performed. Only physicians and research staff do follow D&C and D&E methods.

Abortion is usually not permissible in public health facilities for punitive reasons but is carried out clandestinely and is often deemed "incomplete" (spontaneous abortions).

Many medical workers, including health care professionals (especially male nurses) and certain doctors perform abortions clandestinely on private grounds and in their capacity.

Such abortions are contrary to law and are liable to litigation, though cases are rare and irregular. Ghanaian abortion seekers purchase a chemical called misoprostol from pharmacies when they were not officially approved but were subject to country trials at the time of the study, they also find these drugs from private hospitals, other public hospitals and other locations such as 'suppliers' (MOH, 2008). The International NGO (Ipas) Comprehensive reports on the cost of abortion in Ghana's public health facilities put the range between US$ 30 to US$ 40. These rates are high primarily because there are few practitioners offering the service.

A new study by Sarah et al (2019) showed that, among young people interviewed, the majority (87% of women and 64% of men) find abortion unlawful, or may not know the law.

**2.4. Medical Abortion**

Nearly all the deaths and injuries caused by unsafe abortion are preventable. Early induced abortion procedures and therapies are simple and safe. Abortion is best performed by qualified health care providers with appropriate facilities, proper training, and sanitary conditions. In countries where women have access to safe care, their risk of dying as a result of an abortion done using modern methods is no more than one operation per 100,000 (Alan Guttmacher Institute 1999).

By using mifepristone in combination with an appropriate prostaglandin such as misoprostol or a prostaglandin analogue, medical termination of abortion can be done. Safe abortion is increasingly available internationally, but for countries where abortion is legal, misoprostol may boost abortion care where it is not accessible to qualified providers and sterile surgical equipment is not available. Misoprostol is affordable, easy to prescribe and easy to transport, making it especially appealing to clinics in developed countries and women pursuing clandestine abortions.

Safe abortion has a success rate of about 95 percent when given under controlled medical supervision (Suhuneon et. al, 2002). Nonetheless, concerns remain regarding the implementation of surgical abortion in contexts where sufficient medical oversight is unavailable, especially where women rely on social networks for dosage information and where access to professional follow-up treatment is limited.

The opinion so far is that surgical abortion is more likely to be healthier than other forms of self-induced abortion using actual objects or caustic chemicals, and is likely to decrease morbidity and mortality associated with illegal abortion (Berer, 2000). Women who take wrong dosages, however, could be at risk of potentially serious complications such as prolonged bleeding if they do not receive prompt medical attention.

**2.5. Causes of Unsafe Abortion**

Common reasons for unsafe abortions include accidental or unintended conception and the absence of legal regimes to provide abortion services of all kinds for women.

Social expectations, economic conditions, regulatory restrictions and other systemic factors may have a significant impact on abortion, particularly unsafe abortions. For example, the fact that women consider the financial burden of accidental pregnancy in decisions regarding abortion is an important factor.

The main cause of women seeking an abortion is the prevalence of unplanned pregnancies, suggesting a failure of their family planning systems (Ahiadeke, 2001). Given the increasing number of women who want to control their fertility and have fewer children, better contraceptive measures for women and men of reproductive age are required. Nonetheless, obstacles, such as; difficulty in accessing desired contraceptive treatments, the misuse or non-use of contraceptive methods, and the potential inability of contraceptive measures to work, among other things may contribute to unwanted pregnancy.

Some women continue to rely on unsafe abortion due to external challenges such as costs of the procedure, waiting periods and a lack of parental consent. (Jelinska, 2017). In countries where abortion is heavily limited, substantial numbers of beds in obstetric wards are mostly filled by women who have endured complications from illegal abortion, attesting to the fact that women try abortion irrespective of abortion care prohibition laws. Whatever the legitimacy of the

operation, social inequalities are an important determinant of access to safe abortion care. However, few studies have shown the causes and consequences of differential access to safe abortion.

A survey of women's health care providers in Nigeria (Makinwa, 2002), where abortion is strongly limited, showed that women of all socioeconomic classes were pursuing abortion but that about half of women received abortions from traditional providers without professional training, or self-induced abortion using a range of substances. unlike poor residents, affluent residents have greater access to health care in the abortion market. Likewise, a survey by health care professionals in South and South East Asia (Singh,2002) reported that about one-third to one-half of vulnerable women in both rural and urban areas turn to uncertified abortion services or cause abortion themselves.

**2.6. Effects of Unsafe Abortion**

Conversely, ensuring that women have access to safe services for abortion reduces health system medical costs. Close to 50% of the healthcare expenses of obstetrics and gynecological care for risks of unsafe abortion was expended in some low income and medium income countries. A review of medical reports in 569 public hospitals in Egypt for a span of 1 month revealed the diagnosis of unsafe abortion in close 20 percent of the 22656 admissions to obstetrics and gynaecology departments (Huntington,1998).

In Tanzania, the rate for abortion treatment systems per woman is more than seven times the overall expenditure of the Ministry of Health per population head (Mpangile, 1997). The total rate per person for health care for abortion complications is more than seven times the average in Tanzania (Mpangile, 1997). Uganda statistics in relation to the cost of providing safe, legal abortion and complex patient care indicate potential reductions in financing health services. The average cost of outpatient care in tertiary hospitals delivered by physicians is 10 times the cost of the relatively average surgical abortion provided by primary care physicians. (Heidi Johnston, 2003; Ipas, Chapel Hill, NC). In the 1997 survey in South Africa the average total cost of the treatment of illegal abortion morbidity in public hospitals was ZAR 9.74 million (around US$ 1.4 million) (KAY et al. 1997). A 2002 Nigerian study reported that the national direct health care (Adewole 2002) of NGN 140 million ($11.7 million) was sufficient for the care of complicated abortions. Nigeria puts the

overall cost of treating risks of illegal abortions in a second study at $19 million in 2005 (Akinrinola Bankole).

About five million (or around 1 in 4) pregnant women who engage themselves in abortion are vulnerable to major dangers, including mortality and secondary infertility which affects about 1.7 million women worldwide (WHO,2002). Death associated with abortion is mostly a result of unsafe abortion as spontaneous abortion (miscarriage) typically does not result in death. It is estimated that 6 in 1,000 women aged 15 to 44 years a year are subjected to problematic unsafe abortions in West Africa (WHO 2002).

Mortality is also the greatest in teens because they are unable to accept the pregnancy, are least likely to provide adequate treatment, and are more vulnerable to inadequate quality treatment and unsuccessful procedures. The longer it takes for a woman to locate and access an abortion service, the older the gestational period the greater likelihood of complications.

Maternal morbidity and death were substantially affected by unsafe abortion in Ghana, especially among young people (Aboagye et al . 2007). Ghana has a small maternal mortality rate of 319 per 100,000 live births (WHO, 2015). In Ghana, up to 30% of all maternal deaths can be due to unsafe abortions while it is estimated that globally unsafe abortions account for only 8 and 12% of mother's deaths (GHS, 2008). The morbidity and mortality of unsafe abortion depend on the procedure used, provider expertise, cleanliness of instruments and the environment, pregnancy rates of women and healthcare (WHO, 2004).

Abortion-related stigmas hit young and single women especially hard. It is marked by severe stigma and embarrassment related to the criminal law and social and religious opposition (Payne et al. 2013). Stigma is a characteristic that distinguishes or obscures an individual, a person that is profoundly discreditable (Goffman, 1963). Stigma is a flexible mechanism that works on several levels (Link & Phelan, 2001).

Stigma includes parents, family, friends and physicians who are ignored simply because of their association with a person who is stigmatized (Phillips, 2012). Persons who have had an abortion, administered or are involved in an abortion issue are susceptible to stigma. Such views will affect physicians, health providers and even researchers who are committed to improving abortion seekers' well-being and protection.

Ohene et al (2011) found that most maternal deaths of adolescents at Korle Bu Teaching Hospital in Accra were due to complications from unsafe abortion. Abortion complications were the leading cause of death for younger women in the Tamale Teaching Hospital maternal mortality survey and the fourth leading general cause (Ohene et al. 2011). Abortion complications were the second leading cause of maternal mortality after postpartum bleeding between 2004 and 2009. Lee et al (2012) stated that the most frequent case fatality of all causes of maternal mortality in their study was the sepsis of the vagina, mainly due to abortion. Geelhoed et al (2002) in Brong Ahafo found that abortion complications are the key cause of maternal mortality in Berekum District Hospital.

### 2.7. Abortion Laws in Ghana

Until the latter half of the twentieth century abortion was unlawfully performed by the majority of the countries in the world and was mostly illegal and unsafe. This resulted in a high degree of maternal morbidity and mortality (WHO, 2002). That, along with a stronger and more universal marketing and usage of contraception, has led to a significant decrease in the incidence of unsafe abortion and its related mortality in the developed world. However, it has been found that safe abortion facilities are not available to the maximum degree allowed by law in many developing countries.

> In Ghana, an amendment to the Criminal Code on abortion was proposed by a group of doctors in 1985. This led to a change to the law, with provisions as follows. Although Ghana's law on induced abortion is arguably among the most advanced in Sub-Saharan Africa and its unknown law and taboos, the actual practice has largely gone on "underground'.

Abortion in Ghana is a criminal offence protected by Act 29, Article 58 of the 1960 criminal code revised by the 1985 PNDCL 102. It is stated:

1. Subject to the provisions of subsection (2) of this section
    a) any woman who with intent to cause abortion or miscarriage administers to herself or consent to be administered to her any poison, drug or other noxious thing or uses any instrument or other means whatsoever; or
    b) any person who
        i. administers to a woman any poison, drug or other noxious thing or uses any instrument or other means whatsoever with intent to cause

abortion or miscarriage, whether or not the woman who is pregnant has given her consent

ii. induces a woman to cause or consent to causing abortion or miscarriage;

iii. aids and abets a woman to cause abortion or miscarriage;

iv. attempts to cause abortion or miscarriage; or

v. supplies or procures any poison, drug, instrument or other thing knowing that it is intended to be used or employed to cause abortion or miscarriage; shall be guilty of an offence and liable on conviction to imprisonment for a term not exceeding five years.

2. It is not an offence under section (1) if an abortion or miscarriage is caused in any of the following circumstances by a registered medical practitioner specializing in Gynaecology or any other registered medical practitioner in a government hospital or a private hospital or clinic registered under the Private Hospital and Maternity Home Act, 1958 (No. 9) or in a place approved for the purpose by legislative instrument made by the Secretary:

a. where pregnancy is the result of rape or defilement of a female idiot or incest and the abortion or miscarriage is requested by the victim or her next of kin or the person in loco parentis, if she lacks the capacity to make such request;

b. where the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health and such a woman consents to it or if she lacks the capacity to give such consent it is given on her behalf by her next of kin or the person in loco parentis;

c. where there is substantial risk that if the child were born it may suffer from or later develop a serious physical abnormality or disease.

3. For the purposes of this section Abortion or miscarriage means premature expulsion or removal of conception from the uterus or womb before the period of gestation is completed.

The concept of abortion or miscarriage as set forth in the Act appears to differ from the commonly recognized scientific meaning of abortion as 'termination of pregnancy before viability,' that is, the gestational period in which the fetus becomes capable of survival as an autonomous person. While the ambiguous definition of the World Health Organization has defined viability at 24 weeks gestation, it has been adopted by most developing countries where abortion is allowed on wider grounds,

including socio-economic purposes, or upon request. The West African sub-region puts the gestational age at 28 weeks after the last menstrual era.

Consequently, terminating a pregnancy in West African countries, including Ghana, before 28 weeks is known as abortion. Nevertheless, it is important to remember that the description given is meant to include fetal protection for purposes of Section 58 of the criminal code before labour ends. During labour, the child fetus is safeguarded by Sections 60 and 61 of the Criminal Code.

The criminal code thus seems to have not given the fetus a person's right, trying to suggest that a crime continues until the child has been completely delivered from the mother's body. This however, cannot be applied when the gestational age is less than six months whether the baby is born alive or dead.

It could be an attempt by the Criminal Code to increase profitability by six months. The body of babies born at the gestational age of below six months can also be disposed of without committing an offense of concealment of the womb or birth of a child under Sections 62 and 63 (PNDC Code, 195). Yet the good nursing practice is that these babies will be introduced to their parents if they so wish. In order to be correct, it is necessary to update the definition of 'death or miscarriage' in the Act in order to bring it into line with the agreed definition of Obstetrics.

This Operational Document explained that medical practitioners (doctors), midwives nurse obstetricians, community health officers and physician assistants are permitted to administer medical or surgical abortions at various levels of the health care system (community, district-level, state, regional and national). Nurse / Midwives and community health staff can perform abortions at fewer than nine (9) weeks of pregnancy. If pregnancy lasts longer than nine ( 9) weeks, these officers can administer surgical abortions only at the level where doctors are available ( e.g. at the district level) to supervise them.

The Government of Ghana has taken significant steps to minimize the effects of unsafe abortion mostly through the various laws provided. It should be noted that the conversion of law into action involves the creation and execution of policies that are largely dependent on legal clarification. The point, however, is that the existing law on abortion in Ghana makes compliance impossible and allows untrained staff, space to participate in unsafe abortion procedures; and that a revision of the legislation is desperately required.

## 2.8. Conceptual framework

The goal of this research is to shed light on the conundrum of illegal abortion. Abortion is pregnancy termination before the foetus becomes viable (WHO, 2004). Unsafe abortion is a procedure for termination of unintended pregnancy performed either by people lacking the requisite qualifications or in a setting lacking the appropriate professional requirements or by both (WHO 1997). When women have strong motives to choose not to be pregnant, they would risk their lives to prevent premature births. There are many reasons for choosing to terminate a pregnancy, such as consideration for their own health, the wellbeing of the children they already have, relationship rejection and the desire to continue working or schooling. (WHO 2004). Unsafe abortion comes with its corresponding issues. It may be uterine perforation or diseases that eventually contribute to infertility. Unsafe abortion could lead to death. Unsafe abortion also leads millions of women to suffer from chronic illnesses and disabilities.

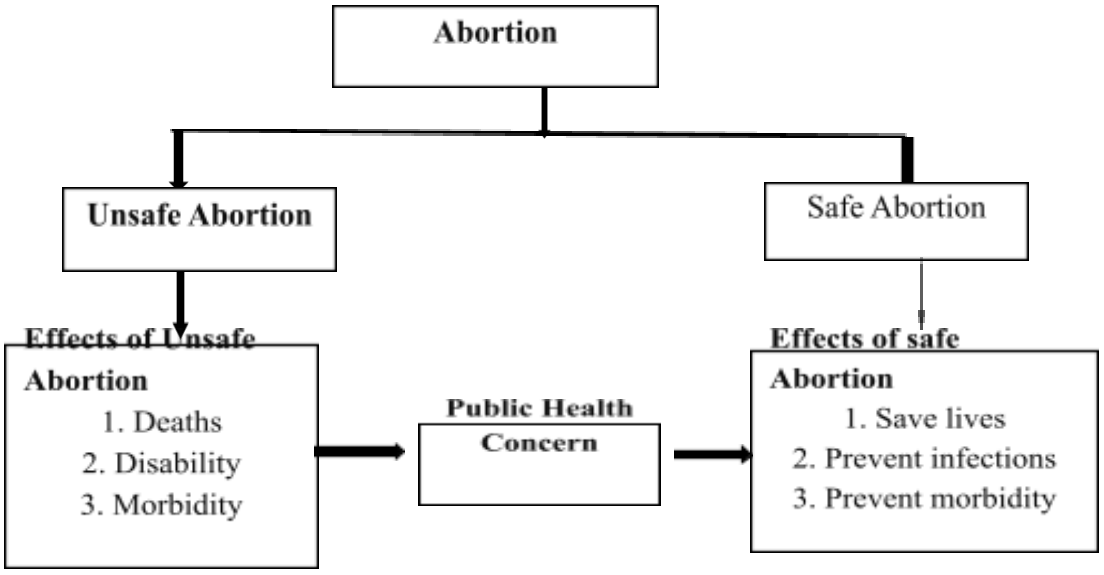


*Figure 2.1*: Conceptual Framework

Source: Authors Construct, April 2022

## 2.6. Summary

This chapter discusses pertinent studies concerning unsafe abortion in Ghana. Efforts were made to recognize the prevalence of, and the effects of unsafe abortion. Knowing the effects of unsafe abortion**,** the government of Ghana has made the important initial steps to reduce legal barriers to safe abortion services, provide health facilities as well as increasing the training of qualified personnel in order to reduce the

burden of disease attributable to unsafe abortion. However, complications from unsafe abortion are still a large contributor to women's mortality and morbidity.

This chapter also examined the literature on the obstacles to women's access to safe abortion and ensuring that the law permits women in Ghana access to safe abortion. The next chapter will concentrate on the research design and method that was employed to aid this work. The chapter provides the framework for the research to be conducted.

# CHAPTER THREE

# RESEARCH APPROACH AND METHODOLOGY

## 3.1 Introduction

Research method is the practice of systematically seeking solutions to research problems. Babbie (2008) points out that a research methodology for a study is relevant as it helps to explain the theory of different techniques and processes that relate to certain issues. The research methodology covered the research method, research design, sampling, methods and techniques for data collection, data analysis and ethical problems.

## 3.2 Research Method

According to Bryman (2012), research method means a direction to efficiently and systematically solve a research problem. The research method has various ranges and so does not only concentrate on the methods used in the research but also justifies the reasons researchers used the methods in the circumstances of their study and gives reasons they are adopting a particular method in order that the researcher or other researchers can measure the findings (Kothari, 2004). The use of this research approach requires a lot of scientific cautions and principles that when violated could distort findings (Creswell et al. 2011).

The study adopts the mixed method. The integrated approach has been selected to help collect scientific evidence so that unsafe abortions can be understood and clarified. It also helps to gather hard data and create a link between unsafe abortions in the form of numbers. Within the analysis, descriptive work was also utilized. The definition of the conditions (Fraenkel & Wallen, 2009) is based on a concise study design. This uses methods for defining, documenting, evaluating and understanding current conditions. A concise nature of the analysis often requires compromise or comparison and seeks to define connections between different variables (Neuman, 2011).

The primary approach to the processing and interpretation of data is the qualitative and quantitative research approach. This method is adopted because the mixed research approach was a type of research approach focused on techniques to explain the problems of analysis in the form of descriptive and inferential statistics (Johnson and Onubegbuzie, 2004). The technique was often used to provide clear

responses to research questions and to help the researcher remain neutral and independent of what is being examined. Furthermore, such an approach does not intervene or engage in the study from the researchers' perspective.

It was conceived as a descriptive study to gather appropriate and reliable information on the issue of unsafe abortion in Ghana's youth.

Finally, it is possible to use statistical methods for calculating factors by numbers and evaluating the problems. The approach will thus mitigate the question of generalization of the study outcome since the views are more analytical than subjective.

Semi-structured face-to-face interviews were taken at the institutional level while gathering data. This has led to the awareness and familiarity of the problems facing organizations in their dealing with the increase in unsafe abortions among the youth. The Semi-Structured interview is thus valuable in addressing research questions two and three since its nature is compatible with the interpretive or constructive research paradigm which aims at providing a detailed understanding of a social phenomenon.

### 3.3 Research design

A research design sets the tone for data gathering and exploration (Bryman 2012). Thus, the selection of a specific research design has to be contingent upon the situation under study. It is a necessary blueprint for the study as the aforementioned offers a “method decision” and “conditions' ' the researcher must make during the studies. It also determines the rationality by which results and conclusions will be presented. Consequently, the study design acts as a stimulus for the practical method used in obtaining, determining and scrutinizing primary and secondary data (Bazely, 2013).

David and Sutton (2004) suggest that the case study approach offers an explanatory mechanism that makes it easy to ask and explore solutions for the relevant questions relating to research ('how,' 'when' and 'why'). Any causes that make the case unique can also be analyzed in detail (Babbie, 2007). As Yin (2002) points out, the case study approach is a technique for analysis that helps you to learn about a complex problem. This is achieved not only through a thorough explanation and contextual analysis, but also by analyzing why problems emerge as they have, and what can be predicted and are relevant for further study in any similar situation (Yin 2002).

The proposed study adopted the case study design to obtain the necessary and required information and/or data. The case study design was chosen due to its ability to provide an in-depth insight into the unit to be studied. The research question starts with the "how" type of phrase. It is widely accepted that "why" and "how" questions can best be answered by the use of case study methods, as this method allows careful and complete observation of the social unit (Korthary,1990). Again, this research sought to carry out intensive analysis of the district situation regarding people's participation in project planning and implementation.

This design also is focused on producing a concise insight of a phenomenon that is within the wider course of the interpretive research viewpoint (Given, 2008). According to Mills et al. (2010) the features of the case study are:

- It focuses on the link with the context of the study entity (such as group, occasion, action or persons);
- It analyses the connection that exists between background issues and the unit of study;
- It uses data from diverse sources to explain problems and add on to existing theories.

The case study approach is used in this research because current problems with a significant effect on the reproductive rights of young people in Ghana emerge out of the problem being studied (the influence of unsafe abortion). The study case design therefore provides a way to increase understanding of the situation and encourages the evaluation of public health agencies' responses to research questions (Kumekpor, 2002). In relation to case studies, triangulation can also be used to validate findings. Yin (1994 ) points out that triangulation is important for ethical reasons to confirm that the findings are not only accurate but also that the processes which yield those results are appropriate. Concerning case studies, triangulation can be carried out when data is collected from multiple sources.

### 3.4 Research Context

Ghana, formerly known as the Gold Coast, is a republic in western Africa. Located between the Ivory Coast and Togo and bordered by Burkina Faso in the north and the Gulf of Guinea (Atlantic Ocean) in the south. The property occupies an area of 238,533 km2.

Ghana's land presents mainly flat plains with some isolated hills cut by rivers and lakes. Lake Volta is the biggest artificial lake in the world.

Mount Afadja (or Mount Afadjato) is Ghana's highest mountain at 885 m (2.904 ft). The hill is situated in the region of Agumatsa. The major rivers are the Black Volta, the Red Volta and the White Volta. They converge into one of the Volta rivers, which was dammed at Akosombo to create Lake Volta, the world's largest artificial lake.

Ghana is divided into some 75 ethnic groups and has a population of nearly 30.8 million according to the Ghana Statistical Service 2021 census report on housing and population. The report clearly shows that there is a young population in the country.

Complications arising from abortion are a major contributor to motherhood and mortality in Ghana. As established in the literature review of the present study, abortion is the leading cause of mortality in women, comprising 15-30% of maternal deaths, according to the Ghana Medical Association. The study also reports that 15 women experience short-term and long-term morbidities in each woman who dies from unsafe abortions.

Abortion is officially a felony in Ghana regulated by Law 29, section 58 of the 1960 Criminal Code amended by PNDCL 102 of 1985. Nevertheless, section 2 of this Act states that an abortion can be performed if the pregnancy is due to rape or incest, to protect a mother's mental or physical health, or if the fetus is endangered. As part of the Reproductive Health Policy since 2003, a licensed health care provider may perform a safe abortion.

### 3.5. Data Requirements and Sources

Both primary and secondary data sources are used to perform this analysis. The secondary data cover a wide range of local and international abortion topics. The secondary information will be obtained from different sources, such as articles, books, studies and conference proceedings. The secondary information will be gathered through a literature review focusing on specific unsafe abortion related issues. The literature review was useful for identifying and analyzing key unsafe practices of abortion in developing countries in particular. The documents offered valuable information on the nature of unsafe abortion, which was made accessible by the institutions.

The primary data centered on the reasons for unsafe abortions and the effects on public health. Another aspect of the key data collection was the institutional role,

collaboration and approaches to managing unsafe abortion. The offices of the institutions participating in the provision of safe abortion for the public were the key data sources. Tables outline the data collection process 3.1.

**Table 3.1 Data Requirements and Sources**

| Source of Data | Data Required | Data Collection Technique |
|---|---|---|
| Ministry of Health | To propose recommendations to mitigate the challenges that confront safe abortion care to Ghanaian youth. | Semi-structured interviews, secondary data analysis |
| Ghana Health Service | To examine the challenges that confront access to legal and safe abortion procedures in Ghana | Semi-structured interviews, secondary data analysis |
| Pharmacist, And Health professionals | To identify the causes for the patronage of unsafe abortion in the study area | Semi-structured interviews, field observations |
| Sampled size | To analyze the perception of social acceptance of abortion in the Ghanaian society. | Questionnaires |

Source: Author's Construct, April 2022.

### 3.6. Sampling Procedures

A sample is a small part of something that is supposed to reflect the whole. The sampling aspect of the statistical approach relates to the use of an impartial or random subdivision of individual observations within a population of individuals, in particular for the purpose of preparing predictions based on the sample context, to provide information on the populations concerned. The sampling method provides a basis for choosing a smaller number of participants from a large population segment (Kemper et al., 2003). The present research used a mixed-method approach that proposed a combination of qualitative and quantitative sampling methods. It was then implemented to demonstrate the possibility of a mixed-method analysis. The mixed approach is called the combination of qualitative and quantitative technologies to answer research issues in a way that ensures a real-life contextual understanding (Johnson et al., 2007). The research therefore uses both systematic and purposive methods for sampling.

### 3.6.1 Institutional Level Sampling

In selecting institutions, the study uses a purposive sampling procedure. This is based on the fact that it helps to choose respondents with full knowledge about the subject being studied. The advantage therefore promotes the reason for the adoption of a case study approach (Mills et al., 2010; Yin, 2003). Hence, the choice for; the Health Ministry, Ghana Health Service, Healthcare professionals and pharmacists

The Health Ministry is included in the study as it plays a key role in designing and implementing policies to address the health problems of the country. Health employees were recruited from a range of public and private institutions and it included staff in charge of the units (institutions heads). The two major hospitals in Ghana (Korle Bu teaching Hospitals and Komfo Anokye Teaching hospitals) have been selected for the study since a large number of cases from all over the country are referred to these two institutions.

Midwives are included rather than nurses because they are the people with the most contact with the women in need of reproductive health care and this is because their core function is the provision of the pre-natal, post-natal and family planning services. Three private-sector institutions have also been included to provide an overview of private sector activities.

The research includes pharmacists because studies have shown that pharmacists are the first point of call in community-based pharmacies when women have an unwanted pregnancy that they wish to terminate. This is because abortion facilities are not readily accessible in public hospitals or private clinics. Many drug stores are also known to sell abortifacient drugs to women (e.g. Cytotec or Misoprostol).

### 3.6.2 Household Sample Size Determination

There are usually two different opinions on the number of respondents needed in mixed-method research: The qualitative aspect demands smaller samples, whereas the quantitative aspect calls for large samples (Creswell, 2009). In this study, which has to do with the mixed approaches, there is no consensus on the precise number of respondents needed to undertake a research of this nature. Creswell (2002) reports that at least three (3) and at most five (5) respondents are appropriate to conduct the analysis. That is to say, descriptive details about an event is most required. On the quantitative aspect, a sample size of at least 30 respondents is the adequate number needed to be involved in survey before reasonable conclusions could be drawn.

In this research, purposive sampling will be used to administer 160 questionnaires to the women and men between the ages of 19- 49 years across the 16 regions in Ghana. It is therefore assumed that 10 questionnaires will be administered to each region.

### 3.7 Data Collection Methods

Both primary and secondary data were collected from the relevant sources in an effort to meet the objectives of the study.

#### 3.7.1 Primary data

Directly, the data observed from first-hand experience was collected, organized and analyzed in order to be interpreted. The following approaches have been used for collecting qualitative as well as quantitative data using various data collection methods:

##### 3.7.1.1 Interviews

In order to get information and ideas from respondents, structured questionnaires were used. Interviewees at one point in a different region were gathered. The researcher asked the respondents questions and completed questionnaires. In order to get more details and the experiences of participants, the researcher often asked open-ended questions. They are largely qualitative and cannot be used in the formal questionnaire. These methods were used to obtain responses from key stakeholders such as the Ministry of Health, the Ghana Health Service, the Nurses and Midwife Council, the Teaching Hospital, etc. Interview guidelines and checklists have been used to guide the collection of data. The interviews will be tape-recorded and transcribed later, with an average interview time of between 45 and 60 minutes.

##### 3.6.1.2 Questionnaire

The instrument used to collect the data was a self-governing questionnaire, which was distributed to the target population and collected after one week. A questionnaire is a set of questions for a specific purpose, designed for the target group of people to be administered on their own within a specific timeframe. According to Abdelzaher et al . (2010), the questionnaire guarantees high efficiency in data collection and a high generalization of results over more intensive research designs. However, Creswell et al . ( 2011) point out that the questionnaire lacks flexibility in

that once the questionnaire has been designed and distributed, it becomes difficult to change the categories of data collection. The questionnaire was selected for this kind of study because it is a self-reported measure that guarantees confidentiality and therefore it is more likely to elicit truthful responses with regard to the information required from the respondents.

To prevent confusion, the questionnaire was written in a brief and precise language. (It is attached as an appendix). The questionnaire consisted of a variety of questions. Information on the demographic data of the participants was gathered from multiple-choice (closed) questions, which simply required the correct answers to be checked by the respondents. The main part of the questionnaire concerned the objectives of the thesis.

#### 3.7.1.3 Focus Group Discussions

Focus groups have their roots in sociology (a tool used in market research) but have now gained popularity in social science research (Templeton 1987). A focus group guide is structured to facilitate effective discussions. Focus Group Discussions (FDGs) are done in a group of 6-10 people in a serene setting that is noise-free. Ideally, the seating arrangement for a focus group discussion should be in a semi-circle to ensure audibility of recorded voices (; Krueger & Casey, 2000). It also enables the researcher to validate the findings on the household survey questionnaire by asking discussants questions on the effects of unsafe abortions and what contributes to them.

However, FGD has the challenges of getting representative samples to form a group and the likelihood of discouraging those who are not confident from participating, and others from giving out sensitive or personal information (Gibbs, 2007).

### 3.8 Data analysis

Before coding, every questionnaire is numerated, cleaned and edited. Raw data is loaded on the computer and analyzed with software version 22.0 of the Statistical Service Package (SPSS) In order to interpret the results, concise statistics such as frequencies, tables and percentages are used.

The data analysis uses both qualitative and quantitative approaches. Qualitatively, problems are defined and interpreted on the basis of data collected.

### 3.9 Pretesting

Validity and reliability demonstrate how best to calculate the parameters used in the study and how to assess their accuracy in terms of the results of the test (Cook, Campbell & Day, 1979). In this research, a pre-test for the investigative questionnaire will be done at the Mother and Child Hospital at Kasoa.

This method aims to test the accuracy and strength of the questionnaire in order to obtain the necessary details for the analysis. In other words, this allows the respondents to assess the specificity of our questions and to increase their comprehension of the answers to questions. The questionnaires are administered and reviewed in order to address abnormalities after they are received.

### 3.10 Reliability and Validity

Research validity means to what degree to which the tools to be used for the research (questionnaires or standardized interview schedules), will indeed test what it was intended to test. Several approaches were taken in conjunction with this analysis in order for the questionnaire to be checked and refined. To fix the authenticity of the picture, the experts read the questionnaires carefully and made the right corrections in advance. But of great significance was the peer review. The validity of the content was further improved by asking for the questionnaire to be examined by experienced experts before being administered.

In quantitative studies, researchers should seek to use instruments that are accurate as well as appropriate, according to Neuman (2011). That is, if a system produces the same result each time it has been given to the same respondents, then it is considered reliable. The reliability of the instrument depends, however, on whether the question can be answered constantly in the same direction taking into consideration the attitudes of the respondents when answering the questions. The quality of the questions posed in the instrument also applies to the ability of the respondents to answer them. In order to ensure the use of correct terms and questions' clarity and relevance, a pilot study was conducted.

### 3.11 Ethical Consideration

Bless and Higson-Smith (2000) note that the key data collection principles are: (a) voluntary participation (b) privacy protection (c) freedom (d) anonymity and (e) confidentiality. For this research report, all these ethical principles were complied

with. General agreements between researchers on ethical research issues need to be achieved. This section discusses briefly some of the generally accepted ethical research principles. It discusses the key facets of ethical research and how they have been applied and taken into account in this paper. Research participation must be voluntary and participants must be able to refuse to reveal such details. Search often allows participants to reveal personal details that their friends and colleagues may not be aware of (Babbie and Mouton, 2001). The research intention and what goal it aimed to accomplish were told to the participants. They were encouraged to be free to express their opinions as objectively as possible and to decide whether or not to participate. They also were able, without any adverse effects, to withdraw their consent at all times.

Some ethical problems are considered by the researcher. To obtain institutional approval before conducting the data collection, the researcher first introduced themselves to the institutional head and the purpose of the research which is mainly for academic purposes was made known to them. Secondly, before obtaining information, the researcher must obtain the consent of the respondents. The respondents were eager without any pressure or dissatisfaction to take part in data collection. You will also know what questions to expect, the purpose of the information you have been asked and how directly or indirectly the information provided would affect them. Lastly, anonymity and confidentiality were guaranteed and the researcher did not cause harm or mental stress to those who chose to participate. This research and its associated methodology adhere to all of these ethical considerations.

### 3.12 Summary

The purpose of this chapter is to explain how the analysis was carried out. It has thus far been noted that a mixed method involving interviews and structured questionnaires will be used for data collection and analysis. Essential background information on the study environment of Ghana including how the collection and analysis of the data were to be done has been given. The study has also shown integrity in ethical consideration. The approval of all institutional heads involved was sought prior to the initiation of the data collection. Anonymity and confidentiality for those taking part in the survey will also be guaranteed.

# CHAPTER FOUR

# DATA PRESENTATION AND ANALYSIS

## 4.1 Introduction

Chapter four of the study presents an analysis of data gathered from sampled respondents. The analysis and presentation were sectioned according to the specific research objectives and variables defining the contextual scope of the study. Data on the problem of unsafe abortion among Ghanaian youth were presented in tables, frequencies and percentages. Chapter four covered the demographics and characteristics of respondents, perception of Ghanaian youth about unsafe abortion, factors contributing to the prevalent rate of unsafe abortion in Ghana, and challenges confronting access to legal and safe abortion practices.

## 4.2 Characteristics of respondents

This section of the study examines the characteristics of household respondents engaged in the study. The characteristics were presented in two parts, that is: demographic characteristics such as age group, location, religion and marital status of respondents and socio-economic characteristics that included main employment of respondents, employment of partners and partner's highest level of education.

### 4.2.1 Demographic characteristics

The demographic characteristics were relevant for the study in understanding variables that may determine and influence respondents' understanding and appreciation of unsafe abortion, especially among young Ghanaians. The study had a minimum age of 19 years participating in it. The data gathered revealed that the majority of respondents (approximately 41%) were in the age category of 25 to 29 years, while approximately 29% were of ages 30 to 34 years (Table 4.1). The two age categories that are considered the period where males and females are sexually active constituted approximately 70% of the household respondents engaged in the study. Among the various age groups covered in the study, two educational level attainments stood out. Tertiary level education and vocational/ technical education. The study indicated that approximately 94 percent of household respondents had attained tertiary level education while approximately 6 percent had attained vocational or technical education (Table 4.1).

In the Ghanaian society, sex is largely considered to be exclusive to married couples and adults. This belief often results in shaming females who are not traditionally married but go ahead to engage in sex and ultimately get pregnant. Data from the study showed that approximately 53 percent and 43 percent of household respondents engaged in the study were single (not married) and married respectively (Table 4.1). The greater proportion of household respondents not married indicates the high likelihood of such females engaging in abortion in the event of pregnancy in order to avoid societal disdain, disapproval, and condemnation. Other marital statuses recorded in the study were cohabiting and separated (approximately 2 percent). Cohabiting couples are couples who live together but are not legitimately married and therefore are not expected by society to be in the business of procreation.

Religion and ethnicity play critical roles in the behaviours and culture of society. The two major religions in Ghana are Christianity which constitutes 70 percent of Ghanaians and Islamic religion which constitute 25 percent of Ghanaians. The two dominant religions in Ghana frown upon birth before marriage and therefore put to shame members who engage in such action. Similarly, ethnic groups in Ghana recognises married couples through traditional marriage in order to be reckoned appropriate for childbirth. Hence, religious and ethnicity norms and values influence females' decision to undertake abortion during pregnancy especially when they have not been legally and/or customarily married. The study revealed that a greater proportion of approximately 84 percent and 16 percent were Christians and Muslims respectively. The household respondents were again dominated by the Akan (the largest ethnic group in Ghana) which constituted approximately 68 percent of the total household respondents engaged in the study.

**Table 4.1: Demographic characteristics of female household respondents**

| Demographic variables | Frequency | Percentage (%) |
|---|---|---|
| **Age** | | |
| 19-24 | 26 | 16.3 |
| 25-29 | 66 | 41.3 |
| 30-34 | 46 | 28.8 |
| 35-39 | 16 | 10.0 |
| 40+ | 6 | 3.8 |
| **Total** | **160** | **100.0** |
| **Marital status** | | |
| Married | 69 | 43.1 |
| Single | 85 | 53.1 |
| Separated | 3 | 1.9 |
| Co-habiting | 3 | 1.9 |
| **Total** | **160** | **100.0** |
| **Highest level of education** | | |
| Technical/Vocational | 9 | 5.6 |
| Tertiary | 151 | 94.4 |
| **Total** | **160** | **100.0** |
| **Religion** | | |
| Christian | 135 | 84.4 |
| Islam | 25 | 15.6 |
| **Total** | **160** | **100.0** |
| **Ethnicity** | | |
| Ga/Dangme | 9 | 4.7 |
| Akan | 108 | 67.5 |
| Hausa | 10 | 6.3 |
| Ewe | 23 | 14.4 |
| Others | 10 | 6.3 |
| **Total** | **160** | **100.0** |

Source: Field Survey, 2022

### 4.2.2 Social and economic characteristics

The socio-economic characteristics of respondents covered their main employment, employment of partners, educational level of partners and whether or not they were currently living with a partner. The study considered the female respondents who live under a common shed with their partners. The data revealed that approximately 41 percent of household respondents lived together with their partners while approximately 59 percent of respondents lived in separate housing units with their partners (Table 4.2). The proportion was consistent with the proportion of

respondents who were married at the time of the study. Unlike the educational level attainment of female household respondents that were either tertiary or technical (vocational), partners of the household respondents had diverse upper-level educational attainment. The data indicated that the majority of the respondents were employed in the formal sector in various professional works (approximately 37 percent) while approximately 23 percent were students of higher education (Table 4.2). Household respondents were also engaged in informal activities such as artisans (approximately 2 percent), housework (approximately 4 percent) and trading (approximately 14 percent).

**Table 4.2: Socio-economic characteristics of female household respondents**

| Socio-economic variables | Frequency | Percentage (%) |
|---|---|---|
| **Currently living with partner** | | |
| Yes | 66 | 41.3 |
| No | 94 | 58.8 |
| **Total** | **160** | **100.0** |
| **Main employment** | | |
| Artisan | 3 | 1.9 |
| Trader | 22 | 13.8 |
| Professional | 59 | 36.9 |
| House Work | 7 | 4.4 |
| Students | 36 | 22.5 |
| Other (Specify) | 33 | 20.6 |
| **Total** | **160** | **100.0** |
| **Partner's highest level of education** | | |
| Junior High school/Middle school | 7 | 10.1 |
| Senior High School | 4 | 5.8 |
| Technical/Vocational | 10 | 14.4 |
| Tertiary | 51 | 73.9 |
| **Total** | **69** | **100.0** |
| **Partner's current occupation** | | |
| Professional | 29 | 42.2 |
| Farmer | 11 | 15.9 |
| Trader/Businessman | 13 | 18.8 |
| Factory work | 3 | 4.3 |
| Student | 7 | 10.1 |
| Other (specify) | 6 | 8.7 |
| **Total** | **69** | **100.0** |

Source: Field Survey, 2022

### 4.3 Knowledge of Ghanaian youth about unsafe abortion

The knowledge of Ghanaian youth about unsafe abortion was examined based on whether the female respondent had been pregnant before, their means of preventing pregnancy, knowledge on abortion, health practitioners who perform the abortion, methods of abortion, the reason behind abortion decision, the outcome of unsafe abortion and means of eradicating unsafe abortion complications

#### 4.3.1 Incidence of pregnancy among females

Incidence of pregnancy among respondents was highest as approximately 54 percent of household respondents had been pregnant before (Table 4.3). The high level of females engaged being pregnant before was due to the age range the study considered in the selection of respondents. Also, the high level of married respondents and those cohabiting also puts female respondents in a high probability of being pregnant. However, approximately 46 percent of the female respondents also indicated not being ever pregnant (Table 4.3). Among females engaged in the study who had been pregnant before, approximately 67 percent delivered the babies while approximately 19 percent could not carry unborn babies to term, but had had a miscarriage along the way. A significant proportion of 14 percent of females who had been pregnant before at the time of the study indicated that their pregnancies were terminated through unsafe abortion procedures (Table 4.3). This indicates that out of every 100 women in Ghana who had been pregnant before, approximately 14 terminated the pregnancy through unsafe abortion. Unsafe abortion has been described to have dire health consequences on the reproductive system of females.

**Table 4.3: Incidence of pregnancy among respondents**

| **Response** | **Frequency** | **Percentage (%)** |
|---|---|---|
| **Ever being pregnant** | | |
| Yes | 86 | 53.8 |
| No | 74 | 46.3 |
| **Total** | **160** | **100.0** |
| **Status of pregnancy** | | |
| Delivered | 58 | 67.4 |
| Spontaneous Abortion (miscarriage) | 16 | 18.6 |
| Unsafe Abortion Procedures | 12 | 14.0 |
| **Total** | **86** | **100.0** |

Source: Field Survey

### 4.3.2 Prevention of pregnancy

Prevention of unsafe abortion requires that females who are not ready to give birth abstained from sex or institute measures to prevent pregnancy. The study examined preventive measures females used in order to prevent pregnancy from happening. The data revealed that the use of condoms during sex was the dominant means of preventing pregnancy among household respondents. Approximately 41 percent of females indicated the use of condoms during sex to prevent not only pregnancy but also sexually transmitted diseases (Table 4.4). A considerable proportion of approximately 27 percent of females indicated the use of menstrual cycle to prevent pregnancy (Table 4.4). According to these respondents', a free period in the menstrual cycle presents an opportunity for sex without the risk of pregnancy. Pregnancy prevention is 100 percent assured through abstinence from sex. Approximately 24 percent of females indicated their total abstinence from sex as a means of preventing pregnancy (Table 4.4). This method was common among single females and students who were not married. Methods used for preventing pregnancy that were not common among females were natural methods (approximately 6 percent) and medication (approximately 2 percent) (Table 4.4). The natural means also known as coitus interruptus is where male partners totally withdraw and ejaculate outside other than reproductive system of female partner during sexual intercourse.

**Table 4.4: Prevention of pregnancy**

| Response | Frequency | Percentage (%) |
|---|---|---|
| Menstrual Cycle | 43 | 26.9 |
| Natural Method | 10 | 6.3 |
| Condom | 66 | 41.3 |
| Abstinence | 38 | 23.8 |
| Medication | 3 | 1.9 |
| **Total** | **160** | **100.0** |

Source: Field Survey, 2022

### 4.3.3 Household knowledge on abortion

The study in examining household respondents' knowledge on unsafe abortion considered females knowledge on abortion, whether females had engaged in abortion, and if so, the number of times. Data gathered from the study indicated that approximately 94 percent of females have a considerable knowledge about abortion

(Table 4.5). The knowledge on abortion was centered on persons who had prior knowledge through the actual practice of abortion, methods and substances used for abortion, sources for obtaining abortifacients and the outcome of unsafe abortion. The data gathered further showed that abortion practice was not common among respondents irrespective of the high knowledge of respondents on the practice among females. Approximately 79 percent of respondents covered in the study has never undertaken abortion while approximately 21 percent had undergone abortion (Table 4.5). According to institutional health professionals engaged in the study, reasons, why pregnant women undertake abortion, included teenage pregnancy, the incidence of pregnancy abnormality to foetus, inadequate financial strength, preventing discrimination among friends and families and societal ridicule, unwanted pregnancy and unpreparedness to be a parent, and desire to pursue other life activities such as education. Among females who had undergone abortion before, a greater proportion of approximately 74 percent had abortion once, while approximately 18 percent and 9 percent had engaged in abortion twice and thrice respectively. In general, the study can deduce that females after their first practice of abortion made conscious efforts to prevent having a subsequent abortion.

**Table 4.5: Household knowledge on abortion**

| **Response** | **Frequency** | **Percentage (%)** |
|---|---|---|
| **Knowledge on abortion** | | |
| Yes | 150 | 93.8 |
| No | 10 | 6.3 |
| **Total** | **160** | **100.0** |
| **Ever practiced abortion** | | |
| Yes | 34 | 21.3 |
| No | 126 | 78.8 |
| **Total** | **160** | **100.0** |
| **Number of times of unsafe abortion** | | |
| Once | 25 | 73.5 |
| Twice | 6 | 17.7 |
| Thrice | 3 | 8.8 |
| **Total** | **34** | **100.0** |

Source: Field Survey, 2022

### 4.3.4 Respondents knowledge on abortion practitioners

Practice of abortion can be legal or illegal. Legal abortion is carried out by health professionals with the requisite knowledge and skills to conduct abortion. Abortion under the guidance of legal practitioners or professionals is considered as safe abortion while illegal abortion is undertaken by unqualified personnel without any knowledge and skills in the health profession. The study revealed that approximately 6 percent of female households covered in the study had no idea about practitioners that carried out abortions whether legally or not. (Table 4.6). However, a considerable cumulative proportion of approximately 94 percent of female household respondents had knowledge on both legal and illegal abortion practitioners in Ghana. A greater proportion of the respondents (Approximately 94 percent) indicated that abortion was carried out by doctors and nurses in the various health facilities (Table 4.6). Doctors and nurses provide legal abortion under strict health guidance that makes the process safe and less risky to the reproductive health of pregnant women. According to health professionals engaged in the study, accessing safe abortion ensures that, patients do not suffer bad complications, and possible infections, less risky and prevent chronic damage to reproductive health. Pharmacists were adjudged the second most commonly known abortion practitioners among female household respondents. A proportion of approximately 78 percent (Table 4.6) indicated that pharmacists provided abortion services mostly not through surgical or instrumentation but rather by swallowing pills or inserting pills into the cervix through the vagina. Health professionals including doctors, nurses and pharmacists recorded in the study as abortion practitioners are categorised as legal and safe abortion practitioners.

Beyond the legal abortion practitioners, the study recorded abortion practitioners who are illegal to carry out abortion due to their unqualified knowledge and skills in the health profession. The data indicated illegal abortion practitioners included friends (approximately 36 percent), traditional herbalists (approximately 31 percent) and relatives or family members (approximately 23 percent) (Table 4.6). Illegal abortion practitioners use various means and substances for abortion purposes, posing high reproductive health risk and life-threatening activity.

**Table 4.6: Knowledge on practitioners of abortion**

| Response | Frequency | Percentage (%) |
|---|---|---|
| **Abortion practitioners** | | |
| Friends | 58 | 36.3 |
| Relatives | 37 | 23.1 |
| Herbalist | 49 | 30.6 |
| Doctor/Nurses | 150 | 93.8 |
| Pharmacist | 124 | 77.5 |
| No idea | 10 | 6.3 |
| Multiple responses* | | |
| **Specific abortion practitioner used during abortion** | | |
| Self | 4 | 11.8 |
| Doctor/Nurses | 13 | 38.2 |
| Pharmacist | 14 | 41.2 |
| Herbalist | 3 | 8.8 |
| **Total** | **34** | **100.0** |

Source: Field Survey, 2022

Among the approximately 21 percent of female respondents who had had the procedure before, the study showed greater preference for legal abortion practitioners. Again, considering abortion practitioners, a greater proportion of approximately 41 percent engaged pharmacists for abortion purposes while approximately 38 percent had their abortion through doctors or nurses' guidance (Table 4.6). Access to safe abortion in hospitals according to health professionals covered in this study was challenged by factors such as, relatively high cost, religious and cultural beliefs, poor education on safe abortion, inadequate safe abortion facilities and the fear of surgery. This indicates that more than 79 percent of female household respondents who had had abortion used legal practitioners in the abortion process. Pharmacists who are classified as legal abortion practitioners use pills other than surgery or instrumentation in conducting abortion procedures. Females who resorted to pharmacists were of the view that, abortion by way of swallowing or inserting pills was less risky than abortion through instrumentation or surgery. Illegal abortion was revealed to have happened by the respondents who had had an abortion before and that included self-abortion (approximately 12 percent) and abortion aided by herbalists

(approximately 9 percent) (Table 4.6). Even though illegal abortion practitioners constituted the least among the respondents who admitted to having done abortion before, their patronizing of unqualified personnel to aid them through the abortion procedure, is a threat to the life and reproductive health of females and as such cannot be overlooked.

### 4.3.5 Respondents' knowledge of methods of abortion

The kind of abortion options chosen by respondents presents varied methods of abortion among the Ghanaian youth. The study therefore examined the female household respondent's knowledge of methods used during abortion processes. Female household respondents had much knowledge on legal methods of abortion relative to illegal abortion methods. The common method of legal abortion known by female household respondents were surgery or instrumentation (approximately 97 percent), injections (approximately 84 percent) and Cytotec or abortion pills (75 percent) (Table 4.7). This finding was consistent with females' knowledge on abortion practitioners presented in Table 4.6 above. Furthermore, a significant section of approximately 31 percent and 9 percent indicated that abortion was carried out through the use of crude and unsafe methods such as herbal medicine and insertion of broken bottles in the genitals(Table 4.7). This finding was also consistent with females who indicated that illegal abortions happen with practitioners such as herbalists, friends and relatives. These illegal practitioners use illegal and harmful substances and methods during the abortion process. According to health professionals interviewed in the study, substances used by pregnant women for terminating pregnancy included: concoctions of coca-cola mixed with sugar, Guinness mixed with sugar, local herbs (ginger, garlic and salt), Cytotec, piriton, misoprostol and mifepristone. These are high concentration substances in their poor proportion making them harmful to the health and reproductive system of users.

` In understanding methods that females who had undergone abortion used, the data gathered from the study showed diverse methods. Female household respondents of approximately 41 percent indicated that abortion substances were inserted into their genitals during the abortion process (Table 4.7). Again, approximately 38 percent of females who had had an abortion before, indicated that the method of abortion that involved the usage of instruments was used during the abortion process (Table 4.7), while approximately 12 percent and 9 percent swallowed substances respectively.

Methods such as insertion of pills, drinking and swallowing of abortion substances introduces medicine into the female reproductive system and body. Ensuring safety and avoiding casualties requires that abortion, just like any medication, should be guided by health professionals. However, approximately 6 percent of female household respondents had no idea on the subject of inquiry.

**Table 4.7: Knowledge of female respondents on substances used for abortion**

| Response | Frequency | Percentage (%) |
|---|---|---|
| **Substance used for abortion** | | |
| Broken Bottles | 15 | 9.4 |
| Herbal medicine | 49 | 30.6 |
| Abortion pills or Cytotec | 120 | 75.0 |
| Injections | 134 | 83.8 |
| Surgery or instrumentation | 155 | 96.9 |
| No idea | 10 | 6.3 |
| Multiple response* | | |
| **Specific abortion method used** | | |
| Swallowing of substances | 4 | 11.8 |
| Drinking | 3 | 8.8 |
| Inserting into the vagina | 14 | 41.2 |
| Instrumentation | 13 | 38.2 |
| **Total** | **34** | **100.0** |

Source: Field Survey, 2022

### 4.3.6 Sources for obtaining abortion substances

The final element under the knowledge of abortion among females was examined based on "sources" or where individuals obtained or acquired abortive substances. Based on the various substances made known by female respondents for undertaking abortion, the study further considered the sources of such substances. The study showed that a greater proportion of females knew sources of abortion substances from legal practitioners including doctors or nurses (approximately 94 percent) and pharmacists (approximately 84) (Table 4.8). However, illegal sources expressed by female respondents for obtaining abortion substances included friends and relatives (approximately 36 percent), drug peddlers (approximately 33 percent) and herbalists or herbal shops (approximately 31 percent) (Table 4.8). The illegal sources of abortion substances are unqualified, unlicensed and unregulated.

**Table 4.8: Source of obtaining substances for abortion**

| Response | Frequency | Percentage (%) |
|---|---|---|
| Friends and relatives | 58 | 36.3 |
| Doctor/Nurses | 150 | 93.8 |
| Pharmacist | 135 | 84.4 |
| Drug peddlers | 52 | 32.5 |
| Herbalist and herbal shops | 49 | 30.6 |
| No idea | 10 | 6.3 |
| **Total** | **160** | **100.0** |

Source: Field Survey, 2022

### 4.4 Factors contributing to prevalent rate of unsafe abortion in Ghana

Factors contributing to continuous practice of unsafe abortion were grouped into four key themes. Economic factors, health factors, social factors and cultural and religious factors. Female household respondents were presented with elements under each theme to rate such challenges by indicating their strong agreement, agreement, neutral, disagreement and strong disagreement.

#### 4.4.1 Economic factors underpinning unsafe abortion

The economic factor for accessing unsafe abortion among women describes the living conditions of such women in terms of their livelihood, wellbeing and living standards as t the time of getting pregnant and onward termination of the pregnancy. Based on data gathered, approximately 50 percent and 44 percent of female household respondents indicated strong agreement and agreement respectively to the assertion that financial difficulty was a key factor that pushed pregnant women into having unsafe abortions (Table 4.9). This indicates that the financial difficulty that women and their partners suffer during pregnancy or anticipate to suffer in future mostly after giving birth pushes women into having an unsafe abortion. Less than 10 percent of the female household respondents indicated disagreement (approximately 4 percent) and strong disagreement (approximately 2 percent) to the assertion that financial difficulty was a cause of unsafe abortion among pregnant women (Table 4.9).

Again, economic factors as the cause of unsafe abortion among women considered the cost of undertaking safe abortion relative to unsafe abortion. The study revealed that approximately 33 percent of female household respondents (Table 4.9) indicated

their agreement to the assertion that relatively lower cost of unsafe abortion to safe abortion was the cause of unsafe abortion among women. A further proportion of approximately 19 percent of female household respondents indicated strong agreement to the assertion that relatively high cost of safe abortion to unsafe abortion was the cause of prevalent unsafe abortion among pregnant women. According to health professionals engaged in the study, the reason for the patronage of unsafe abortion had to do with the high costs and charges involved in accessing safe abortion in health facilities, push pregnant women to access unsafe abortion. The health professionals described unsafe abortion as less expensive which makes it accessible to lower and middle income and even extremely poor in society.

In spite of a greater proportion agreeing to cost of unsafe abortion being factor to prevalent unsafe abortion, approximately 18 percent of female households engaged in the study expressed their neutrality to the assertion (Table 4.9). However, approximately 24 percent and 6 percent of female household respondents disagreed and strongly disagreed respectively with the assertion.

**Table 4.9: Economic factors underpinning unsafe abortion**

| **Response** | **Frequency** | **Percentage (%)** |
|---|---|---|
| **Financial difficulty** | | |
| Strongly agree | 80 | 50.0 |
| Agree | 71 | 44.4 |
| Neutral | 0 | - |
| Disagree | 6 | 3.8 |
| Strongly disagree | 3 | 1.9 |
| **Total** | **160** | **100.0** |
| **Cost of unsafe abortion** | | |
| Strongly agree | 30 | 18.8 |
| Agree | 53 | 33.1 |
| Neutral | 29 | 18.1 |
| Disagree | 39 | 24.4 |
| Strongly disagree | 9 | 5.6 |
| **Total** | **160** | **100.0** |

Source: Field Survey, 2022

### 4.4.2 Health factors underpinning unsafe abortion

Fear of undergoing surgery at the health facility as means of safe abortion, and contraceptive failure were the health factors discovered through this research as drivers in the increase of unsafe abortion among women. The data gathered from female household respondents indicated that a greater proportion of approximately 39 percent disagreed that pregnant women's fear of clinical surgery was the cause of prevalent unsafe abortion. (Table 4.10). Again, a proportion of approximately 8 percent further strongly disagree with the assertion of fear of surgery being the cause of the prevalent rate of unsafe abortion among women. Notwithstanding, a significant proportion of approximately 22 percent and 13 percent of female household respondents indicated agreement and strong agreement with the claim that fear of clinical surgery was a factor for which females engaged in unsafe abortion (Table 4.10). The greater proportion disagree and strongly disagreeing with the assertion on fear of surgery as a cause of increasing unsafe abortion among females may not be a reality.

**Table 4.10: Health factors underpinning unsafe abortion**

| **Response** | **Frequency** | **Percentage (%)** |
|---|---|---|
| **Fear of surgery** | | |
| Strongly agree | 21 | 13.1 |
| Agree | 35 | 21.9 |
| Neutral | 28 | 17.5 |
| Disagree | 63 | 39.4 |
| Strongly disagree | 13 | 8.1 |
| **Total** | **160** | **100.0** |
| **Contraceptive failure** | | |
| Strongly agree | 26 | 16.3 |
| Agree | 81 | 50.6 |
| Neutral | 22 | 13.8 |
| Disagree | 18 | 11.3 |
| Strongly disagree | 13 | 8.1 |
| **Total** | **160** | **100.0** |

Source: Field Survey, 2022

The other cause of rising unsafe abortion among women in Ghana considered under health factor was failure of contraceptive use after sex. As discussed above, the use of contraceptives was a major factor adopted to prevent pregnancy among women. The study revealed that more than 60 percent strongly agreed (approximately 16 percent) and agreed (approximately 51 percent) that contraceptive failure was a cause of increasing unsafe abortion among pregnant women (Table 4.10). The high agreement to the assertion indicates that women were willing to have unprotected sex (sex without condom) but not ready to carry pregnancy. In such instances, women take emergency contraception (morning after/post-pills) or other contraceptives to prevent pregnancy after sex. However, some contraceptives fail as contraceptive usage is related to time and period that sexual intercourse occurred. The unpreparedness to carry pregnancy pushes pregnant women who relied on contraceptives to prevent pregnancy into undergoing unsafe abortion. Notwithstanding, approximately 11 percent disagreed and approximately 8 percent strongly disagreed (Table 4.10) that contraceptive failure was a cause for rising levels of unsafe abortion among youth and women in Ghana.

### 4.4.3 Social factors underpinning unsafe abortion

The social factors that respondents expressed their views on their level of agreement or disagreement as factors contributing to the increasing incidence of unsafe abortion among youth and women included: negative attitude of health workers, pregnant women not being ready for a child and desire to continue with education. Data gathered from the study revealed that more than 60 percent of female household respondents agreed and strongly agreed that pregnant women not being ready for a child and the desire to continue education as the predominant causes for the increasing levels of unsafe abortion among women and females. Specifically, approximately 46 percent and 37 percent who strongly agreed and agreed respectively asserted that pregnant women's lack of preparedness for bearing a child was a cause of increasing unsafe abortion (Table 4.11). Lack of readiness and preparedness to bear children was mostly associated with unmarried youth and cohabiting couples who were yet to marry. Societal ridicule that unmarried women suffer pushes them into aborting pregnancies before marriage irrespective of the safety of the abortion process. Similarly, approximately 25 percent and 48 percent of female household

respondents strongly agreed and agreed respectively to the assertion that, desire or decision to continue with their education was a cause of the increasing rate of unsafe abortion among female youth (Table 4.11). Pregnancy during basic and senior high school levels and at times, first-degree education, disrupts the education process of female youth who get pregnant. Beyond the nine months pregnancy journey, new mothers require close to two years to cater for their baby. Young ladies who give birth along their educational journey tend to feel ashamed to return to school because their mates will have been promoted into a higher grade than them, upon their return to school. In order to circumvent this, they may turn to abortion by any means; safe or unsafe.

**Table 4.11: Social factors underpinning unsafe abortion**

| **Response** | **Frequency** | **Percentage (%)** |
|---|---|---|
| **Negative attitude of health workers** | | |
| Strongly agree | 22 | 13.8 |
| Agree | 21 | 13.1 |
| Neutral | 20 | 12.5 |
| Disagree | 58 | 36.3 |
| Strongly disagree | 39 | 24.4 |
| **Total** | **160** | **100.0** |
| **Not ready for a child** | | |
| Strongly agree | 73 | 45.6 |
| Agree | 59 | 36.9 |
| Neutral | 9 | 5.6 |
| Disagree | 13 | 8.1 |
| Strongly disagree | 6 | 3.8 |
| **Total** | **160** | **100.0** |
| **Desire to continue with education** | | |
| Strongly agree | 40 | 25.0 |
| Agree | 76 | 47.5 |
| Neutral | 28 | 17.5 |
| Disagree | 10 | 6.3 |
| Strongly disagree | 6 | 3.8 |

| | | |
|---|---|---|
| **Total** | **160** | **100.0** |

Source: Field Survey, 2022

Negative attitude of health workers towards pregnant women who have safe abortion at health facilities as a cause of increased incidence of abortion was highly disagreed by female household respondents. The data showed that, approximately 36 percent and 24 percent (cumulative 60 percent) disagreed and strongly disagreed to the view that negative attitudes expressed by health workers towards pregnant women wanting to use safe means to abort pregnancy was the cause of rising cases of unsafe abortion among female youth and women (Table 4.11). The majority disagreeing with the assertion indicates that health directives to conduct safe abortion in health facilities were being undermined by health professionals and as a result pregnant women had no desire to visit health facilities and instead resort to unsafe abortion practitioners.

### 4.4.4 Religious and cultural factors underpinning unsafe abortion

The final factor underpinning the increasing rate of unsafe abortion among youth and women were religious and cultural factors. Religious and cultural factors are centered on the norms, values, beliefs and way of life among religious groups such as Christians and Muslims and the culture of various ethnic groups and communities. Religious and cultural factors account for the resultant fear of parents, stigmatization from society and in some cases, partner denial. Data gathered revealed that greater proportion of female household respondents agreed and strongly agreed with all the causes under the religious and cultural factors underpinning unsafe abortion among youth and women. The data showed that approximately 45 percent and 35 percent strongly agreed and agreed to the assertion that fear of parents was a cause of increasing unsafe abortion among female youth (Table 4.12). In Ghanaian society, unmarried young ladies getting pregnant brings a lot of societal ridicule. Responsible and respected parents are expected to guide their children into marriage before they give birth. Therefore, parents get furious in the event that their unmarried child gets pregnant, especially at a young age. In worse cases, such parents may kick out the lady and/ or shun them. This situation puts some level of fear into female youth and will therefore avail to any means of pregnancy termination; even unsafe abortion.

**Table 4.12: Religious and cultural factors underpinning unsafe abortion**

| Response | Frequency | Percentage (%) |
|---|---|---|
| **Fear of parents** | | |
| Strongly agree | 72 | 45.0 |
| Agree | 56 | 35.0 |
| Neutral | 12 | 7.5 |
| Disagree | 17 | 10.6 |
| Strongly disagree | 3 | 1.9 |
| **Total** | **160** | **100.0** |
| **Stigmatisation from society** | | |
| Strongly agree | 75 | 46.9 |
| Agree | 49 | 30.6 |
| Neutral | 10 | 6.3 |
| Disagree | 20 | 12.5 |
| Strongly disagree | 6 | 3.8 |
| **Total** | **160** | **100.0** |
| **Partner denial** | | |
| Strongly agree | 70 | 43.8 |
| Agree | 49 | 30.6 |
| Neutral | 24 | 15.0 |
| Disagree | 14 | 8.8 |
| Strongly disagree | 3 | 1.9 |
| **Total** | **160** | **100.0** |

Source: Field Survey, 2022

Furthermore, stigmatisation from society to young female and unmarried women who get pregnant as a cause of the increasing numbers of unsafe abortions is discussed below.

A greater proportion of respondents expressed agreement as the data revealed that approximately 47 percent and 31 percent of female household respondents strongly agreed and agreed respectively (Table 4.12) to stigmatization by society as a cause of unsafe abortion. The stigmatization from society to female youth and unmarried women who get pregnant can be generational and affect other relatives. Society may

describe a family as irresponsible and may not be interested to marry from such a family if a young lady in the family bears a child out of wedlock.

However, a significant cumulative proportion of more than 15 percent expressed disagreement (approximately 13 percent) and strong disagreement (approximately 4 percent) to assertion that stigmatisation was a cause of increasing abortion among female youth and women (Table 4.12).

Finally, partner denial under religious and cultural factors as a cause of increasing rate of unsafe abortion was agreed on by greater proportion of the respondents. Data indicated that approximately 44 percent and 31 percent respectively who strongly agreed and agreed were of the view that partner denial was a cause of increasing unsafe abortion (Table 4.12). Often, male partners who impregnate young ladies tend to deny being responsible for the pregnancy. The denial of pregnancy is mostly associated with stigmatisation that he may suffer, fear of parents and at times, compulsory marriage of the pregnant lady. Preventing such unwanted circumstances pushes male partners to deny being responsible for such pregnancy if the female partner refuses to terminate. In summary, accessing unsafe abortion is caused by various factors and therefore promoting safe abortion practices among women must inculcate economic factors, social factors, religious and cultural factors and health factors to ensure comprehensive and sustainable advocacy and access to safe abortion.

### 4.5 Challenges confronting access to legal and safe abortion practice in Ghana

The final section under the Chapter focuses on challenges and ways of enhancing access to safe abortion among youth in Ghana. The section covers female respondent views on subjects such as: seeking medical attention after unsafe abortion, reasons for, and outcomes of unsafe abortion, barriers to safe abortion, roles of health professionals towards safe abortion and means of eradicating unsafe abortion.

#### 4.5.1 Reasons and outcomes of unsafe abortion

Addressing the challenges of unsafe abortion and instituting measures to enhance safe abortion habits required the researcher to understand from female household respondent perspective, the reason and outcome of unsafe abortion and the need to seek medical attention after undergoing unsafe abortion. The study revealed approximately 96 out of 100 respondents were of the view that pregnant women who undergo unsafe abortion must seek medical attention from professional health

facilities (Table 4.13). The view expressed was based on reasons including: preventing unsafe abortion-related death (approximately 28 percent) and abortion-related complications (approximately 73 percent) (Table 4.13). Pregnant women undergo unsafe abortions without practitioners of unsafe abortion checking and understanding patients' vitals such as blood pressure and blood quantity. This poses high health risk that may cause death after unsafe abortion. Again, the illegal substances used in unsafe abortion poses risk to reproductive health and system of women who undergo an unsafe abortion. Unsafe abortion may cause complications that may result in barrenness and infections. Failing to seek professional medical attention may lead to several unwanted outcomes that unsafe abortion victims may suffer in future. Female household respondents indicated that unsafe abortion may result in unwanted and preventable outcomes such as death (approximately 33 percent), infertility in women (approximately 33 percent), infections (approximately 18 percent), excessive bleeding (approximately 9 percent) and chronic disease (approximately 8 percent) (Table 4.13). Although unsafe abortion is not advised, it however encouraged that women seek medical attention after the procedure.

**Table 4.13: Reasons and outcomes of unsafe abortion**

| Response | Frequency | Percentage (%) |
|---|---|---|
| **Need for seeking medical attention after unsafe abortion** | | |
| Yes | 153 | 95.6 |
| No | 7 | 4.4 |
| **Total** | **160** | **100.0** |
| **Reason to seek medical attention after unsafe abortion** | | |
| To prevent death | 44 | 27.5 |
| To prevent further complications | 109 | 72.5 |
| **Total** | **153** | **100.0** |
| **Outcomes of unsafe abortion** | | |
| Bleeding | 15 | 9.4 |
| Chronic disease | 12 | 7.5 |
| Infertility | 52 | 32.5 |
| Infections | 29 | 18.1 |
| Death | 52 | 32.5 |
| **Total** | **160** | **100.0** |

Source: Field Survey, 2022

### 4.5.2 Challenges impeding access to safe abortion

The challenges hindering access to safe abortion in health facilities were gathered from the viewpoint of health practitioners. According to the data gathered at the institutional level, access to safe abortion was challenged because of factors such as: cost involved in safe abortion, religious and cultural beliefs, fear of death and complications through clinical surgery, poor public health education and inadequate health facilities carrying out safe abortion. Safe abortion in health facilities also requires strict measures to be put in place to ensure success to the surgery. The situation makes safe abortion relatively expensive and therefore not accessible to persons who lack the financial strength to pay for such service. In Ghana, the national insurance scheme does not cover cost of surgery and therefore abortion is not treated as medical condition covered under insurance. Hence, patients bear full cost of abortion surgery.

Religious and cultural beliefs were among the challenges impeding access to safe abortion. Religious beliefs that frown on aborting pregnancy prevent pregnant women from accessing safe abortion. In effect, pregnant women wanting to abort pregnancy will consume substances to terminate the pregnancy other than through surgical abortion. Again, there is the general fear of dying and suffering complications after undergoing safe abortion through surgery. Safe abortion also known as instrumentation involves using sharp objects to terminate the pregnancy in the womb of pregnant woman. The process sounds terrifying to most young ladies. Ironically they also fear that the sharp objects used in safe abortion process may cause damage to their reproductive system.

Abortion is not a popular act in Ghana and therefore many resources have not been channeled into educating the general public on the need for safe abortion and investment in safe abortion facilities. The act of getting pregnant before marriage is frowned upon by society in Ghana. Educating the public on safe abortion especially among youth will not be welcoming as society may deduce that, sex before marriage is being encouraged. Sex education in Ghana at basic and high school level education is silent on safe abortion after pregnancy.

Finally, mere access to health facilities is a problem. The number of facilities undertaking safe abortions is limited. Abortion becomes complicated as the foetus grows and months pass by therefore, pregnancy termination is preferred at the early

stages. With the limited facilities for safe abortion, pregnant women tend to access unsafe procedures to avoid pregnancy from growing beyond a month or two.

### 4.5.3 Roles of health professionals in access to safe abortion

Health professionals who are the frontline advocates for safe abortion and actual practitioners indicated some key roles that they played to enhance access to safe abortion. According to health professionals engaged in the study, their outfit educates and sensitizes the public on the criminality element of unsafe abortion and its associated effects. Again, health professionals over the years have advocated for reduction in cost of safe abortion or a policy that covers safe abortive procedures for youth females (say, below 25 years) under the health insurance. Again, enhancing access to safe abortion requires specialised doctors and referring cases to solely specialised medical practitioners. Finally, safe abortion should be made legal in Ghana to dilute the societal backlashed attached to abortion. Irrespective of the roles performed by health professionals to enhance access to safe abortion, professionals indicated that, the public should seek medical attention before undergoing any unsafe abortion, abstain from sex if possible or only engage in safe sex. There should also be nationwide sensitization on healthy sexual practices. Criminalization of unsafe abortion as well as prosecuting perpetrators are welcome changes.

# CHAPTER FIVE

# SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATION

## 5.1 Introduction

The aim of the study was to examine the problem of unsafe abortion especially among Ghanaian youth. Based on the broad objective, key themes that guided the study included perception of Ghanaian youth on unsafe abortion, factors contributing to prevalent rates of unsafe abortion in Ghana, challenges undermining safe abortion and enhancing access safe abortion in Ghana. This section of the study presents general findings emanating from the analysis and discussion of the research variables, conclusions made based on the research findings and recommendation towards addressing and enhancing the findings of the study. Findings of the study were presented based on the research objectives that guided the contextual scope of the study.

## 5.2 Summary of key findings

The summary of findings was presented based on the specific research objectives that guided the study and they include: perception of Ghanaian youth about unsafe abortion, factors contributing to prevalent rate of unsafe abortion, challenges confronting access to safe abortion and enhancing access to safe abortion. The general characteristics of the respondents was such that more than half of females engaged fell within the age range of 19 to 29 years, single without any partner or not living partner, either Christian or Muslim and ethnic identity (Akan). The characteristics such as age, marital status, religion and ethnicity had several elements that define a person's perspectives on sex, pregnancy and abortion.

### 5.2.1 Knowledge of Ghanaian youth about unsafe abortion

The study showed that a greater proportion of females engaged in the study had been pregnant before irrespective of the fact that the greater proportion of females covered in the study were single as of the time of the study. This gives an indication of the prevalence of females sexual engagement outside the confines of marriage. Among females who had been pregnant before as of the time of the study, a greater proportion carried to term. However, a significant proportion aborted or had spontaneous abortion. In preventing pregnancy from occurring, the study revealed that

various methods of pregnancy prevention were employed by females. Common among the means of pregnancy prevention were condom use, 'safe period' in female menstrual cycle and total abstinence from sex. Pregnancy preventive measures that were not mostly used by females included natural methods (withdrawal) and use of post-pills (medication).

In terms of knowledge on abortion, the study revealed that a greater section of the females engaged in the study had knowledge on abortion. Despite majority of females having knowledge on abortion, approximately 8 out of 10 had never practiced abortion. Among females who had practiced abortion before, majority had done abortion once. This indicates a low incidence of abortion irrespective of knowledge on abortion among females. The study further showed that the female youth had knowledge on practitioners of abortion services and this includes doctors, nurses, pharmacist, herbalist, friends and relatives. Knowledge on abortion practitioners showed both legal and illegal abortion practitioners. The abortion practitioners; both legal and illegal adopted various methods and substances in abortion procedures. Among legal abortion practitioners, which are the doctors, pharmacists and nurses, substances used for abortion process included Cytotec, injections and instrumentation. On the part of illegal abortion practitioners, substances used for abortion process were broken bottles, herbal medicine and strong concoctions with high concentration of sugar and salt.

Females who had undergone abortion before as at the time of the study revealed unsafe methods such as swallowing pills, drinking herbal teas, inserting pills into genitalia and instrumentation. Substances expressed by female respondents for purposes abortion were obtained from various sources. A common source of obtaining abortion substances were doctors, nurses and pharmacists that were regarded as legal abortion practitioners. Illegal abortion substances were sourced from drug peddlers, herbalists and close friends and relatives.

### 5.2.2 Factors affecting prevalent rate of unsafe abortion

Factors contributing to prevalent rate of unsafe abortion among youth were classified under four main groups that were, health factors, economic factors, social factors and religious and cultural factors. Under various factors, female respondents rated their level of agreement or disagreement with causes under each theme.

#### 5.2.2.1 Economic factors contributing to unsafe abortion

Unsafe abortion was prevalent based on economic factors and these factores were including financial difficulty on the part of spouse and family as well as the high cost associated with unsafe abortion. Findings from the study on economic factors revealed that a greater proportion of more than 90 percent of female respondents either agreed or strongly agreed that financial difficulty that confronted pregnant women and female youth and their households or families was a cause of increasing levels of unsafe abortion. The second element under economic factors also showed greater proportion of more than 50 percent female respondents either agreeing or strongly agreeing to the assertion that relatively lower cost involved in unsafe abortion of safe abortion. The low cost of unsafe abortion relative to safe abortion influenced pregnant women and youth to choose unsafe abortion.

#### 5.2.2.2 Health factors contributing unsafe abortion

Causes of rising rate of unsafe abortion under the health factor included pregnant women fear of surgical abortion as well as contraceptive failure. Findings from the study revealed, majority of female respondents disagreed or strongly disagreed to the assertion that fear of surgery contributed to rising levels of unsafe abortion among females. Pregnant women accessing abortion services have preference for illegal practitioners other than legal practitioners. Therefore, fear of abortion cannot be a strong case for the rising levels of unsafe abortion. In terms of contraceptive failure, a greater proportion of female respondents revealed either strong agreement or agreement to the assertion. Females who were sexually active used contraceptives as a method for preventing pregnancy after sex. However, using contraceptives may not necessarily prevent pregnancy resulting in unexpected pregnancy. The frustration emanating from such instance pushes pregnant women and youth into unsafe abortion.

#### 5.2.2.3 Social factors contributing unsafe abortion

The social factor leading to increasing unsafe methods, included negative attitudes of some health workers toward pregnant women seeking options after pregnancy. Some people were just not ready to have a child because they want to continue their education or train for an artisanal career. Findings from the study showed that negative attitudes of health workers towards pregnant women undergoing

abortion was disagreed and strongly disagreed. The unpreparedness of young women together with their partners to bear a child was revealed to be another factor of rising cause of unsafe abortion. The study showed that approximately 8 out 10 females either agreed or strongly agreed that, lack of readiness of pregnant women to bear a child pushes such women and youth into unsafe abortion. The final assertion under social factor was desire to pursue education on the part of pregnant women and partners was the cause of rising unsafe abortion among women and youth. The study showed that approximately 7 out 10 females either agreeing or strongly agreeing to the assertion that desire to continue with education was a cause of prevalent rate of unsafe abortion.

#### 5.2.2.4. Religious and cultural factors contributing unsafe abortion

Religious and cultural factors contributing to unsafe abortion were as follows: pregnant women and their partner's fear of their parents, stigmatization from society and partner denial. All the elements under religious and cultural factors contributing to unsafe abortion were strongly agreed and agreed on by female respondents. Fear of parents abandoning the child, dismissing the child from household or stigma towards pregnant women and their partner saw approximately 8 out of 10 respondents strongly agreeing and agreeing to the assertion. This indicates that fear of parents was a cause of prevalent unsafe abortion among women and youth and as such women would do anything to prevent that, hence unsafe abortion.

Again, the study revealed that more than 70 percent of female respondents agreed and strongly agreed that the stigmatization that unmarried women faced from society extended to immediate family was also a cause. Similarly, a greater section of female respondents further indicated that partner denial of being responsible for pregnancy causes rising levels of unsafe abortion among women and youth.

### 5.2.3 Challenges affecting access to safe abortion

Irrespective of barriers to safe procedures, a greater proportion of more than 95 percent of females indicated that pregnant women who terminate their pregnancy through unsafe or illegal means were to proceed to health facilities to seek expert and professional attention. Seeking medical attention was for the benefit of women as such medical attention could prevent death or further complications (excessive bleeding, chronic disease and infertility, infections.)

The findings revealed that from the point of view of health professionals access to safe abortion was challenged by:

- Cost involved in safe abortion
- Religious and cultural beliefs
- Fear of death and complications through surgery
- Poor public health education
- Inadequate health facilities carrying out safe abortion.

Some religious teachings and practices frown upon abortion and therefore do not encourage the practice of abortion. In the event that such religious organisation owned and operated health facilities, safe abortion was not practiced in such facilities. High cost of safe abortion was also due to lack of health insurance covering part or full cost of abortion making it inaccessible to low income earners and youth. Abortion which has no legal legislation makes it difficult to conduct public education and society sensitization on healthy sexual choices.

### 5.2.4 Enhancing access to safe abortion

From the perspective of health professionals, access to safe abortion could be enhanced through: Education and sensitization on safe abortion to eliminate criminality associated with safe abortion and rather elevate criminality on unsafe abortion. Again, access to safe abortion can be enhanced through reduction in cost of abortion through health insurance to cover youth aged 16 to 25 years. Establishment of abortion units under the maternity department will improve physical access to safe abortion across the country. Safe abortion should be legalised to ensure that health professionals are mandated to undertake the process upon demand or request from a patient.

## 5.3 Conclusion

The focus of the study was to examine unsafe abortion among youth in Ghanaian societies. The high-level knowledge of youth on abortion both safe and unsafe in terms of practitioners, methods and outcomes indicated that abortion was not a grey area among Ghanaian youth. However, accessing safe abortion is affected by various factors such as economic, social, health, religious and cultural norms and values. Without conscious efforts to address causes such high cost of safe abortion, financial difficulty, social stigmatization, limited health facilities undertaking safe

abortion and the fear of parents, unsafe abortion will continue to rise among youth in Ghana. In, conclusion eliminating unsafe or illegal abortion among youth in Ghana and other developing countries requires a collaborative effort and co-production of ideas among government, opinion leaders, civil society, parents, educational sector and health sector. This will ensure that all elements contributing and influencing access to unsafe abortion are holistically removed completely to ensure that abortion are conducted in safe and professional ways.

### 5.4 Recommendation

Knowledge on safe and unsafe abortion procedure or methods, practitioners and substances were common among female respondents. Such knowledge provides the potential and opportunity for the authorities to embark on an education and public sensitization drive to drum home the relevance of safe abortion and the consequences of unsafe abortion. The general population will accept and understand effectively the education on safe abortion, procedures for safe abortion and benefits associated with safe abortion.

Since financial difficulty coupled with lower cost of unsafe abortion has been established in this work as contributing factors for high level of unsafe abortion, it is recommended that Government takes practical steps and strategies to remove financial or cost barriers to safe abortion by way of covering abortion under national health insurance. This will ensure that safe abortion becomes relatively cheaper and economically accessible.

The ministry of social welfare, gender and children protection must collaborate with health agencies and NGOs to sensitize and remove the stigma attached to unmarried women who gets pregnant. Professional counselling and education should be organised for women who suffer stigma and temporary homes provided for such women for at least two years to cover the period of pregnancy and early months of giving birth.

Finally, all government health facilities owned fully by government and joint ownership with religious organisations and private health facilities must be mandated to operate an abortion unit. Operationalisation of abortion unit under the maternity department will improve physical access to safe abortion by health professionals and therefore discourage accessing unsafe and illegal abortion.

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## Appendix 1

### Interview Guide for Institutions

The objective of this research technique is to gather empirical data for academic research thus, ***"the conundrum of unsafe abortions on the youth in Ghana.*** The information gathered will be handled with complete confidentiality. Thank you.

**Background Information**

Location …….....

Name ……

Post……

**Unsafe Abortion**

1. What are the functions of your institution in relation to public reproductive health?

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2. What is your understanding of abortion?

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3. What are your roles in improving safe abortion in Ghana?

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4. What are some of the reasons for accessing abortion services?

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5. What is the perception about people who offer safe abortion services in the hospital?

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6. What are challenges obstructing access to safe abortion

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**7.** Can you tell me some of the various substances women procure for unsafe abortion?

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**Reasons for unsafe Abortion**

8. What are the reasons for procuring unsafe abortion procedures to safe abortion?

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9. How do women procure some of these substances used by the youth in unsafe abortion?

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10. What are the reasons behind the use of these substances for unsafe abortion?

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11. Which people do you think influence or help the women to cause unsafe abortion?

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**Sources of Substances**

12. Can you tell me where the youth obtain the substances they use in unsafe abortion?

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13. Among the sources you mentioned, which one is mostly a source?

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14. What is the rate of youth involvement in the use of unsafe abortion procedures?

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**Effects of unsafe abortions**

15. What are the complication(s) associated with unsafe abortion?

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16. What are the impacts of these complications on the management of these health facilities?

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17. What are the problems your institution encounter in your efforts to resolve the prevalence of unsafe abortion?

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18. In what ways can these challenges be resolved?

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*Thank you!*

## Appendix 2

### Questionnaires for Respondents

The objective of this research technique is to gather empirical data for academic research thus, ***"the conundrum of unsafe abortions on the youth in Ghana***. The information gathered will be handled with complete confidentiality. Thank you.

**Socio-Demographic/Economic characteristics of respondents.**

1. Age of respondents [ ]
2. Where do you live? .....
3. Religion a. Christian [ ] b. Islam [ ] c. Traditional [ ] d. Other (specify) _____
4. Ethnicity?

a. Ga/Dangme [ ] b. Akan [ ] c. Hausa [ ] d. Ewe [ ] e. Other (specify) _____

5. Marital status

a. Married [ ] b. Single (never married) [ ] c. Divorced [ ] d. Separated [ ] e. Widowed [ ] f. Co-habiting [ ]

6. Highest level of Education?

a. No Education [ ] b. Primary [ ] c. JSS/ middle school [ ] d. SSS/Secondary school [ ] e. Technical/Vocational [ ] f. Tertiary [ ]

7. What is the main work that you do for a living?

a. Apprentice [ ] b. Artisan [ ] c. Trader [ ] d. Professional [ ] e. House Work [ ] f. Students [ ] g. Other (specify) _____

8. Are you currently living with a partner? a. Yes [ ] b. No [ ] **IF NO, go to Q 17**
9. What is your husband/Partner's highest level of education?

a. No Education [ ] b. Primary [ ] c. JSS/ middle school [ ] d. SSS/Secondary school [ ] e. Technical/Vocational [ ] f. Tertiary [ ]

10. What is your husband/partner's main occupation?

a. Professional [ ] b. Farmer [ ] c. Trader/Businessman [ ] d. Artisan [ ] e. Factory work [ ] f. Student [ ] g. Other (specify)…….

**Abortion**

11. Have you ever been pregnant? a. Yes [ ] b. No [ ] **if NO go to Q19**
12. If yes, what happened to the pregnancy?

a. Delivered [ ] b. Spontaneous Abortion (miscarriage) [ ] c. unsafe Abortion Procedures [ ]

13. How many children do you have? [ ]

14. What is the age of your last child (in years)? ……..

15. What exactly do you use to prevent pregnancy?

……

16. Do you know what is meant by abortion? a. Yes [ ] b. No [ ]

17. Have you ever practiced abortion before? **If NO go to Q34**

a. Yes [ ] b. No [ ]

18. If yes, which method have you ever used? _____

**Methods of abortion procedure**

19. Which people do you know aid/help in the termination of abortion?

a. Friends [ ] b. Relatives [ ] c. Herbalist [ ] d. Doctor/Nurses [ ] e. Pharmacist [ ] f. Drug peddlers [ ] g. Other (specify) _____

20. Who aided the termination of your pregnancy? a. Self [ ] b. Relatives [ ] c. Friends [ ] d. Doctor/Nurses [ ] e. Pharmacist [ ] f. Drug peddlers [ ] g. Herbalist h. Other (specify) _____

21. How many times have you had an unsafe abortion? None [ ] Once [ ] Twice [ ] Thrice [ ] >Four [ ] Other( specify)……

22. How was the method(s) applied? a. Swallowing [ ] b. Drinking [ ] c. Injecting [ ] d. Inserting into the vagina [ ] e. Enema [ ] f. Instrumentation [ ] g. Abdominal massage [ ] h. Other (specify) _____

23. What are some of the substances that you know/heard are generally used in the abortion/termination of pregnancy?

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24. In your opinion, where do they normally obtain these substances used in the abortion/termination of pregnancy?

a. Self [ ] b. Relatives [ ] c. Friends [ ] d. Doctor/Nurses [ ] e. Pharmacist [ ] f. Drug peddlers [ ] g. Herbalist h. Other (specify) _____

**Reasons for Self Induced Abortion**

25. If you have ever procured an unsafe abortion, what were the reasons?

Please rate the reasons 1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly Disagree

| **Reasons for Unsafe Abortion** | **Strongly Agree** | **Agree** | **Neutral** | **Disagree** | **Strongly Disagree** |
|---|---|---|---|---|---|
| Financial difficulty | | | | | |
| Negative attitude of health workers | | | | | |
| Stigmatization from the society | | | | | |
| Not ready for a child | | | | | |
| Want to continue education | | | | | |
| Partner denial | | | | | |
| Cost of safe abortion | | | | | |
| Fear of surgery | | | | | |
| Contraceptive failure | | | | | |
| Fear of parent | | | | | |

26. In your opinion, why do women generally resort to unsafe abortion?

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27. Did you seek help at the health facility (hospital) after unsafe abortions?

a. Yes [ ] b. No [ ]

28. Please give reasons why you sought for medical attention at the hospital after procuring unsafe abortions?

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……

29. Generally, what has been the outcome of unsafe abortion?

a. Bleeding [ ] b. Chronic disease [ ] c. Infertility [ ] d. Infections [ ] e. Death [ ] f. Other (specify) _____

30. What in your view, are the ways of eradicating the complication(s) associated with unsafe abortion?

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THANK YOU