"At that time, I didn't understand it!": Exploring the subject of contraceptive knowledge and use among women with induced abortion experiences in the Greater Accra Region, Ghana

Adriana A. E. Biney[1,2]

Corresponding Author's Information

[1]University of Ghana, Regional Institute for Population Studies (RIPS), P.O. Box LG96, Legon, Ghana. Email: aaeb212@gmail.com Tel: +233-21-500724 Fax: +233-21-500723

[2]Visiting Research Scholar at the Population Research Institute, Pennsylvania State University, 701 Oswald Tower, University Park, PA 16802. Email: aab18@psu.edu Tel: 1-814-863-0863

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ABSTRACT

Using a qualitative research methodology, twenty-four semi-structured individual interviews were conducted with women with induced abortion experiences at Korle Bu and Tema Hospitals in the Greater Accra Region, Ghana. Approximately 52 percent of the interviewed women were between ages 15-19 at the time of their first abortion. Results suggest that these women tended not to have knowledge of contraceptive methods prior to the abortion, while others were informed but failed to use because of a dislike for contraception. Some had since gained knowledge of methods and used at least one modern method. Others who had been informed on the available methods still chose not to utilize contraception due to rumors of side effects and personal negative experiences. Peer and reproductive health education must be reinforced in communities in Greater Accra to curb adolescents engaging in early sex as well as challenge rumors that exist regarding contraception in Ghana.

Key words: Induced Abortion; Contraception; Knowledge, Family Planning; Ghana

INTRODUCTION

Induced abortions occur worldwide. Some studies suggest that it is fast becoming a birth control method (Bongaarts and Westoff 2000; Geelhoed 2002; Weeks 1999). Most induced abortions occur as a result of unintended pregnancies. Estimates suggest that 79 million unintended pregnancies occur worldwide and of these 46 million are voluntarily aborted (Bongaarts and Westoff 2000). The stigma associated with abortions in developing nations coupled with laws that render abortions legal only under certain conditions (Morhee and Morhee 2006) results in the practice of clandestine, unsafe abortions even when legal and safe services are available (Grimes et. al. 2006).

Studies indicate that a sizable percentage of women in Ghana have at sometime in their lives resorted to the voluntary termination of an unwanted pregnancy (Adanu and Tweneboah 2005; Ahiadeke 2002; Henry and Fayorsey 2002; Yeboah and Kom 2003). Bleek (1990) also discovered that induced abortions were widely practiced in contemporary Ghana. He stated that among the Akan, "abortion is reprehensible unless it is successful and remains hidden" (Bleek 1981: 203). Hence, although Ghanaians approach the topic of induced abortion with the view that it goes against traditional ethics and values (Bleek 1981, 1990), the fact is that large numbers of maternal morbidity and mortality cases arise from unsafe abortions (Senah 2003). Although the abortion law in Ghana is said to be "broadly interpreted", abortion is illegal unless performed by a medical practitioner in a medical facility under circumstances involving rape or defilement of a female idiot, incest, fetal impairment, or when physical or mental risk could occur to harm the life of the woman. Hence, in Ghana, induced abortions are not legal if performed upon request or for social or financial purposes (Criminal Code of Ghana 1985; Morhee and Morhee 2006).

Using Bongaarts and Westoff's (2000) theory of unintended pregnancy and abortion as an explanatory framework, as well as the idea that women may be using contraception as a

means of birth control (Bongaarts and Westoff 2000; Geelhoed 2002; Weeks 1999), this exploratory study uses the qualitative research methodology to explore issues pertaining to the contraceptive practices of women with induced abortion experiences living in the Greater Accra region of Ghana.

Contraceptive Use in Ghana

The 2003 Ghana Demographic and Health Survey (GDHS) showed an increase in contraceptive use among currently married women in Ghana, from 13.0 percent in 1988 to 25.2 percent in 2003 (GSS and MI 2004). A decline has since taken place, as 23.5 percent of currently married women reported using a contraceptive method in 2008 (GSS et. al. 2009). However, an increase in the proportion of sexually active unmarried women using a contraceptive method was noted between 2003 and 2008, from 43.5 percent to 50.4 percent (GSS and MI 2004; GSS et. al. 2009). This increase in contraceptive use is encouraging; however, studies suggest that Ghana's contraceptive prevalence rate (CPR) is still too low to have solely contributed to reducing the fertility levels. Induced abortion is therefore one option that could explain this phenomenon (Ahiadeke 2005; Geelhoed 2002).

Among married Ghanaian women, the percentage of current contraceptive non-use is 76.5 percent while 50.4 percent of these women had ever used any method (GSS et. al. 2009). In gendered societies, where men make the decisions regarding the woman's reproductive health (Dodoo 1998), it becomes essential to know men's contraceptive use habits. About 57 percent of all men aged 15 to 59 stated they had used a male method at one time, the highest percentage being that of the male condom at 46.0 percent (GSS et. al. 2009). The GDHS informs us of the statistics on knowledge of contraceptive methods among men and women in Ghana. Among all men and married men, 98.9 percent and 99.5 percent are informed of a contraceptive method, respectively. In terms of women's knowledge, 97.8 percent of all

women and 97.9 percent of married women knew about any method of contraception. Therefore, knowledge about contraceptive methods, whether traditional or modern, among men and women in Ghana is high while use of any method is low (GSS et. al., 2009).

The Determinants of Unintended Pregnancy and Abortion Rates

Bongaarts and Westoff (2000) proposed a theory which states that there exist three direct determinants of unintended pregnancies and the abortion rate. The first is the fertility preference or desired number of children among couples or a population. In societies where fertility preference is high, such as those in sub-Saharan Africa, there are fewer unintended pregnancies than in settings where the ideal number of children is low. Once the fertility preference of a population declines, then the second determinant becomes important in predicting unintended pregnancies and the abortion rate. The second determinant, which underpins this study, is the prevalence and effectiveness of contraception. In communities where the proportion of women using contraception is low and methods being utilized are not effective or are used inconsistently, then unintended pregnancies will arise. The last determinant is the probability of seeking abortion due to contraceptive failure or non-use. The proportion who seek abortion after experiencing an unwanted pregnancy worldwide is 58 percent, and is higher in the developed world (73%) than in developing nations (54%). Higher abortion seeking rates indicate societies that "have a high propensity to rely on abortion" (Bongaarts and Westoff 2000: 194), while the opposite is true for those with low abortion seeking rates.

Therefore, among this unique group of women with induced abortion experiences, it is expected that prior to their abortions they did not use contraception or used it inconsistently. Thus these women experienced unintended pregnancies which they later aborted or attempted to abort.

DATA AND METHODS

Segmentation and settings

Sixteen* and eight semi-structured individual interviews were conducted with female respondents who had experienced or attempted an induced abortion at Tema General Hospital (TGH) and Korle Bu Teaching Hospital (KBTH), respectively. The settings for the study were selected mainly because of the researcher's access to the facilities; however, both hospitals are the major public health facilities in their metropolitan areas. KBTH, as the major teaching and referral hospital in the country, serves patients across Ghana and neighboring West African countries. Both facilities offer a variety of health services for women and men, including abortion services to those who experience incomplete abortions.

To supplement the information from the individual interviews, four focus group discussions were conducted to understand societal views on the issue of induced abortion. Two group interviews were held with female hairdressing apprentices in Ashongman Estates (a suburb of Accra). Abortion behavior is expected to be highest among young women in the 15 to 19 age group; hence the selected women would be expected to give insight into abortion experiences of their peers. The two hair salons selected tended to have many of these young girls working as apprentices. Nine female participants in total joined the two discussions in Ashongman Estates. Separate male and female group discussions were also conducted on the University of Ghana campus with Graduate students. These students varied in age but had all participated in a Gender and Reproductive Health course at the University. Hence, they had a variety of perspectives on abortion issues that differed from the hairdressing apprentices. The discussions consisted of five female and four male participants. These locations were also selected due to the researcher's access to the settings. In addition, interviews were held with

* Unfortunately, one of the interviews conducted at TGH could not be used since the taped conversation was inaudible and notes taken were not adequate for analysis

two experts at each hospital who had knowledge on abortion practices (gynecologists/obstetricians) and abortion counseling procedures at TGH and KBTH.

Participants for the individual interviews were selected using the purposive non-probability sampling technique. At TGH and KBTH, various heads of departments granted permission for the study to be conducted in their health facility. In these wards or departments, the women were approached and asked questions to determine their eligibility for the study. Respondents were deemed eligible for the study once they reported that they had ever attempted or experienced an induced abortion. Upon discovery of an induced abortion, or an attempt, at a point in time in their lives, she was offered a chance to participate in the study. Informed consent was then obtained from the respondents to demonstrate her voluntary participation. The semi-structured nature of the question guide resulted in each interview lasting for approximately 30 minutes. A major disadvantage of this data elicitation method was that participants were not able to discuss additional information that was not specifically listed on the question guide – information that could have been useful to the study. Thus, specific details about their abortion experiences went unexplored. However, this data elicitation method was deemed appropriate since the interviews were conducted in hospital wards and the conditions were not suitable for narratives and prolonged interviews. Eighteen interviews out of the twenty-three interviews were tape recorded and later transcribed. For five interviews, notes were taken of the participants' responses due to a malfunction of the tape-recorder. The interviews were conducted in either English or Twi, a local dialect of the Akan ethnic group, but is also spoken by a majority of Ghanaians living in Accra. The TGH interviews were conducted in February, 2008, while those at KBTH were conducted in July, 2008.

In terms of the group discussions, the 'Madams' (owners) of the salons granted permission for the interviews to be conducted on the premises with girls who were available

that day. The Graduate students were selected through the snowball sampling technique whereby the researcher informed a few of the participants, through word of mouth, about the study, and they in turn informed their friends about the group discussions. Each of the group interviews lasted between 30 to 45 minutes. The discussions were tape recorded and later transcribed for further analysis. Three discussions were conducted in English and one in Twi. Those in the latter group were the least educated of all the apprentices and found it easier to express themselves in Twi than in English. The group discussions with the hairdressing apprentices and the Graduate students were held in February and July, 2008, respectively[1].

Respondents' Background Characteristics

Table 1 displays the various background characteristics of the respondents for the individual interviews. Their current ages ranged between 16 and 57, with an average age of 28 years. The largest percentage (52.2%) of the respondents had their first abortion between ages 15 and 19. Their ages at first abortion ranged between 13 and 35, with an average age of 21 years. Table 1 also illustrates that 69.6 percent of the respondents had terminated only one pregnancy. The educational level of the 23 respondents suggests that 35 percent of the respondents were unable to complete Junior High School (JHS), while the same percentage completed JHS. Only one respondent had completed senior high school (SHS) and one other had gone on to obtain her teacher's certificate.

<<Table 1 about here>>

Also, the percent distribution of the respondents' current occupations revealed that a majority of the respondents (52.2%) described their occupation as traders since they sold a variety of goods. The remaining women were either unemployed (8.7%) or worked in the service industry as seamstresses (17.4%) and teachers (8.7%) or were food vendors (13.0%). The marital statuses of the respondents suggested that most of the women were not married

before the abortion (87.0%), while 52.2 percent were married at the time of the interview. Lastly, 65.2 percent of the women had no children prior to their first abortion, but currently 26.1 percent of the respondents both had one and two children.

These background characteristics correspond with those of abortion seekers in the literature. Studies suggest that young, never married, nulliparous women with some amount of education, who live in urban centers were the people more likely to undergo induced abortions (Adanu et. al. 2005; Adeokun 1991; Ahiadeke 2002).

Eighteen participants were engaged in four group discussions in Accra. Table 2 displays the background characteristics of these respondents, comprised of fourteen female and four male individuals. Respondents were evenly distributed between the 15 to 19, 20 to 24 and 25 to 29 age groups. The first two discussions comprised of nine hairdressers/ apprentices. The age range of this group was 18 to 33 with an average of 21.9. The other two discussions held on the University of Ghana, Legon campus, with nine Graduate students, comprised of ages ranging from 26 to 47 with an average age of 33.9. Seventy-two percent of the respondents had never been married. The discussants from the hairdressing salons were mostly graduates of JHS or SHS. All participants had completed some level of formal education. Discussants in the two sets of group interviews gave a good representation of societal views--from younger women seeking to enter the hairdressing profession and older Graduate students training to work in higher professional fields.

<< Table 2 about here >>

RESULTS

Data obtained from interviews with women who had induced an abortion at one time in their lives revealed that respondents could be placed in three categories: (1) those who knew about contraception and had used a modern method, but experienced contraceptive failure and hence became pregnant; (2) those who knew about a method prior to the abortion but failed to use any contraception; and (3) those who mentioned they had no knowledge of contraception and hence failed to use it prior to the termination of pregnancy. Each of these categories will be considered in turn[2].

Contraceptive knowledge and use:

Some participants had previous knowledge of a method and had used it prior to the abortion. However, they mentioned that these highly effective methods, the condom and the pill, failed them as they became pregnant and later sought abortions. An 18 year old mother of one and 22 year old seamstress mentioned the following respectively:

> *Interviewer: OK, so, at that time that you had the abortion, were you using family planning or anything?*
>
> *P8: No, only the protection.*
>
> *Interviewer: Which one?*
>
> *P8: Condom.*
>
> *Interviewer: But you were still able to get pregnant using the condom?*
>
> *P8: Mmm, it was a mistake, it was a mistake.* (Participant 8, TGH)

> *Interviewer: And [um] were you using, at the time you got pregnant, were you using contraception, any family planning or anything?*

P13: OK, I do use this [um], this tablet, Secure.

Interviewer: So, were you using it at that time?

P13: Yes, so, I was using it and you know these kinds of drugs they used to fail us sometimes… (Participant 13, TGH)

A few of the respondents had never heard of the term contraception (or family planning, as women refer to it as in this study), until they were admitted to the Chenard wards at KBTH, obstetrics and gynecology unit. One 22 year old, married respondent disclosed the following:

Interviewer: So, at that, that time you didn't know anything about it [contraception]. Right now what do you know about it?

PK3: They [the nurses] came here and told me something about abortions [contraception], but I don't know anything about it. They told me that when I'm going I should come and do it before I leave.

Interviewer: OK, so the family planning they told you about it

PK3: Yes

Interviewer: OK, [um] so what did they tell you about, what did they tell you?

PK3: They say they have [um] 3 months one there, they have what they put inside your body and they have some they put in (points to vagina)

(Participant 3, KBTH)

Regarding this issue, a sixteen year old respondent stated:

I didn't know about it so I didn't use it. I didn't know about family planning until I came to Korle Bu and the doctor told me about it. (Participant 4, KBTH)

It is important to note that a number of the respondents who had their first abortion earlier had since gained knowledge and utilized at least one method. However, some stated that they failed to use it consistently because of side-effects and for other personal reasons, to be discussed later. This subject of inconsistent contraceptive use was raised by a 27 year old Graduate student during a group interview.

> *I think [ah] the question about contraception, yeah, they are available, do people know about it, yeah, I think people know about it. But what I think is happening is that people are not using it consistently, so and that is the problem with the contraceptives. They, if it happens that I meet Akose and I use a condom the first time, the next time we meet again, I'm not using a condom, you know, doing my own thing and just once then somebody becomes pregnant or I mean when the person is within her ovulation period and you have sex with her and she'll become pregnant, but, you know, you don't know when she's in her ovulation period, so using it inconsistently you always stand the risk of becoming pregnant and that is the problem with I think that is what is going on. A lot of people know about it, they use it occasionally, sometimes, you know, but it's not every time.* (Male, Group 4, Discussant 3)

The calendar-based method of contraception was an absent topic in the interviews with the women. They failed to discuss the use of this method in preventing pregnancy or perhaps they did not realize that it was a contraceptive method. However, discussants at both hair salons mentioned that failing to know your ovulation period during the menstrual cycle could result in unwanted pregnancies. The discussant from the first group discussion was a 22-year-old SHS graduate, while the participant from the second discussant was a 20 year old who had failed to complete JHS.

Yeah, and it occurs too when you don't know your menstrual, like, you don't know your period. You have dangerous days and you have non dangerous days, so if you are in your dangerous period and you have sex without a condom you can get pregnant. (Female, Group 1, Discussant 1).

If you know your time isn't right to go to a guy don't go. You know if you go to the guy you will get pregnant and it will bring that problem….if you know that you will get your period today or tomorrow, you know your date and you go and make a mistake you could get pregnant. (Female, Group 2, Discussant 1)

In summary, concerning contraceptive knowledge and use, the results show that women with knowledge of a method prior to the abortion used a modern method (the condom and the pill) but experienced contraceptive failure, resulting in unintended pregnancies. Most respondents mentioned that prior to the abortion they had no knowledge of contraception but have since gained knowledge about family planning methods. Finally, those that knew of contraceptive methods prior to the abortion failed to use for a variety of reasons which are discussed next.

Reasons for contraceptive non-use:

Respondents were asked about their reasons for not using contraception prior to the termination of the pregnancy. The reasons they gave included: no knowledge of contraception prior to the abortion, fear of side effects, and a general dislike for it leading to the personal decision not to use it.

A major reason women cited for not using contraceptives prior to the abortion was they had not been informed about family planning services or they did not fully understand its usefulness at the time.

At that time I didn't know about it and I came from Togo and my friend told me about it and I started using it. (Participant 6, TGH – 26yrs)

At that time I didn't understand it. (Participant 2, KBTH – 38yrs)

Another reason for non-use was indicated by a participant whose first sexual encounter occurred when she was raped by her boyfriend and hence the issue of contraceptive use was not even considered. Such experiences were reported in other studies, such as Henry and Fayorsey's (2002), who discovered that many of the young girls interviewed were first introduced to sex when their current boyfriends or husbands raped them. The respondent described her experience as follows:

Interviewer: Were you using contraception at the time?

P4: No

Interviewer: Who in the relationship made the decision not to use contraception?

P4: It's a long story, but I'll say it. The thing is that he was my first boy, the one that breaked me [took my virginity]. So I decided to marry him, but the way he was doing things I decided to stop.

Interviewer: So, you both decided not to use?

P4: Even, it was a rape, he forced me, he forced me and I didn't want to, that was my first time. (Participant 4, TGH – 30 yrs)

A number of the respondents who had their first abortion many years ago had since gained knowledge and utilized at least one method. Whether they were informed about contraception prior to the abortion or after, some just still preferred not to use it. Some interviewees stated that they failed to use it at all or used it inconsistently because of experienced side-effects, negative rumors or a general dislike for contraception. A 26 year old mother of three who was in the hospital for inducing an incomplete abortion, a few days before the interview, reported:

P15: I got injected with some of the family planning but every week I got my period so I went to tell them and they said I should have patience with it so after the date passed [ahaa!].

Interviewer: So, you haven't done it again after you did it.... (Participant 15, TGH)

A conversation with a 35 year old widow of three years, and a mother of five, who was at the hospital for accidentally inducing an abortion, gave insight into two reasons why she chose not to use contraception. She mentioned side effects and a comment from a friend as deterrents to her contraceptive use.

Interviewer: Do you currently use or have you ever used family planning?

PK8: Yes, I used some last year, but I stopped because my heart was beating, it hurt my heart so I stopped.

Interviewer: Which methods were you using?

PK8: I was using Paninden injections for 3 months

Interviewer: Were you using it before you got pregnant and had the abortion?

PK8: No

Interviewer: What made you not use it before getting pregnant?

PK8: I had stopped because it hurt my heart, my heart was beating fast so I stopped using it.

Interviewer: Who in the relationship decided not to use it?

PK8: I used my own mind to go and do family planning, no one else told me to use the family planning. My mother told me to go back and use it but my friend said I shouldn't use it. (Participant 8, KBTH)

During an interview with a participant at KBTH, a 22 year old woman who had aborted her first pregnancy at the age of 19, she stated that she had never used contraception and did not intend to ever use it. She mentioned that she was scared to use contraception because someone had made negative comments about it and hence she believed it would affect here negatively. One respondent even speculated that the recent loss of her child could have been due to her use of a contraceptive method.

Interviewer: ...at the time you wanted to remove the pregnancy, did you use family planning or something like that?

P10: No I didn't use it.

Interviewer: Did you ever use family planning anytime after?

P10: The child that I lost right now, at the time after I had the first child he wasn't old enough so I went to use family planning, so I don't know if that is what affected me for my child to die. (Participant 10, TGH – 22 yrs)

A short dialogue with a thirty year old mother of two, who induced a safe abortion after the birth of her first child, brought insight into the issue of married women using both abortion and contraception as methods of spacing children.

Interviewer: ...you had your first born, then you had the abortion, before you gave birth to your second born...at that time, did you use family planning?

PK1: I've used family planning before; I gave birth to the second born before I started using family planning.

Interviewer: So, after the second born you used family planning, so right now do you use?

PK1: I used and stopped, and I got pregnant and had a miscarriage.

Interviewer: OK, why did you use family planning?

PK1: I used it so that my child would grow older a bit more, then I would give birth to the next.

Interviewer: OK, and what did you use?

PK1: I used Panitan, 3 months

Interviewer: Panitan, 3 months, OK and OK, what, OK, you said you wanted your child to grow older, OK and so, OK, who said use family planning?

PK1: I went to go and use it

Interviewer: Your husband didn't tell you…

PK1: I told my husband and he said I should go and do it.

Interviewer: OK, and the time you weren't using family planning, who told you not to use?

PK1: No one told me, after I gave birth to my second born then I said I would go and do family planning so that he will grow older and because after I gave birth to the first born, he was one year and I got pregnant the second time and when the pregnancy was 3 months I removed it and went to do family planning. So, after I gave birth to the second born I also went to do family planning.

Interviewer: OK and why, after you gave birth to the first born, why didn't you use family planning?

PK1: At that time (laughter) I didn't like it

Interviewer: You didn't like it, why didn't you like it?

PK1: They say when you're going to give birth it will bother you....so, I didn't like it and after the second born my husband said I should do it

Interviewer: So you changed your mind concerning the family planning? (Participant 1, KBTH)

This participant heard rumors of the negative side effects of modern contraceptives and so failed to use and hence got pregnant. She then used an induced abortion as a method of birth control to space her first two children. Later, after the birth of her second child, and with support from her husband, she started using a modern method of contraception. Unfortunately, after stopping contraception, in order to give birth, she suffered a miscarriage. Further on in the discussion, the participant mentioned the following about the miscarriage and her contraceptive use:

Interviewer: Did you think that something that is affecting you now is because of the abortion that you did?

PK1: No, nothing is happening to me now because of the abortion. What is happening to me now is because of the family planning that I was injected with... that is what is bothering me right now.

Interviewer: OK, so, now the family planning, you stopped and got pregnant and the child miscarried, OK, and did you ever think that I wish I hadn't done the abortion?

PK1: I wish I hadn't done the family planning

Interviewer: Oh, but have you ever regretted doing the abortion?

PK1: No, I have never regretted, no. (Participant 1, KBTH)

In summary, these women mentioned a variety of reasons for their contraceptive non-use leading to their unintended pregnancies. They reported no knowledge of contraception at the time, rumors they heard about side effects which were mentioned to them by people they knew, as well as a personal dislike for contraception. One respondent's unintended pregnancy was a result of rape and hence was unable to negotiate the use of contraception at the time. A few respondents also attributed certain unfortunate circumstances, including miscarriages and stillbirths that had occurred after their use of contraception, suggesting their reluctance to continue its use.

The issue of low contraceptive prevalence among women

An expert with knowledge on abortion practices at KBTH mentioned that women were granted abortions at the hospital after a method that had been prescribed to them failed. Therefore, women were able to resort to induced abortion after contraceptive failure. However, many women were still sexually active without using a method; some had even stated that they planned not to use any method of contraception. Thus, it seems as though they reverted to the abortion as the solution to dealing with the pregnancy.

One expert on abortion practices, interviewed at TGH, mentioned that contraceptive habits of his patients were poor. He also mentioned that women did seem to be using induced abortions as a form of birth control. He stated that:

[Um], usually for, as part of when a patient comes and you're taking his data, as part of it you ask about their contraception, so what methods they used.... and so it's part of the routine questioning that we question patients, so if the patient doesn't tell you then and I must say, many women are not using any contraceptive method and I think

many people think abortion is a form of contraception, so they don't prevent pregnancy but when the pregnancy comes they are very quick to go for an abortion. (Expert 1, TGH) – underlined for emphasis

When asked about the counseling procedures for patients at hospitals in Ghana, an expert in this field at TGH mentioned that in their facility they conducted both pre and post abortion counseling. However, the post abortion counseling usually involved informing the women about the various methods of contraception as well as dispelling the myths and rumors about contraception before placing them on a family planning regime.

E2: We just give them general counseling, you know. In abortion, prevention is always better than cure, so we ask the one why that abortion, if they have ever heard of a family planning method before, if not, if not then you counsel her on all the methods that we have. If they have heard of it before maybe because of all the misconceptions they do not want to do it, so you dispel all the misconceptions and you give her counseling on all the methods that we have and they choose from that. Yes, and then again you tell them of all the complications, the future effects, yes, what it could cause on them, blockage of the tubes and all that, we tell them. If the advantages dis-weigh the disadvantages then they pick a method and then carry it out.

Interviewer: So you don't force them to choose a method?

E2: No, we don't force them at all, we don't force them, in family planning you don't force, you counsel, then they choose the method themselves. (Expert 2, TGH) - underlined for emphasis

An abortion counseling expert working at KBTH mentioned that they also counseled abortion patients by encouraging them to adopt family planning methods.

Interviewer: What types of counseling services does your facility provide?

E3: We provide family planning counseling services and then when they choose a method we give it to them

Interviewer: How do you get the patients to counsel?

E3: We get the patients from the various wards, ante and post natal clinics etc. We go there (to the various wards) and motivate and recruit clients. Also, the nurses that assist in implementing the abortion later give the women free counseling and then they encourage them to come to the family planning clinic where we continue the counseling and provide them with the services. Not all the patients we get are abortion patients, however some are and some are young women who have regretted causing the abortion. (Expert 3, KBTH)

This information suggests that abortion counseling services in these two hospitals specifically offer family planning advice and services. They do not seem to offer any psychological counseling services to these women. Also, they do not force family planning methods on the women but inform them, refute any misconceptions, and warn them about risks that could incur while using the various contraceptive methods. One expert on abortion procedures at TGH mentioned that the country is making strides to undertake the issue of unsafe abortion in Ghana. The main solution the country has employed is to adopt a new policy targeted at ensuring women undergo safe abortions and more importantly adopt family planning methods.

Greater Accra, I think that I made [um] reference to the fact that we need to strengthen our family planning education. So that [um] young people do not get pregnant in the first place, so that they practice safe sex and use the various contraceptive methods that are available, so that they don't get [um] pregnant. But if

they get pregnant [um] and they do not want the pregnancy then the Ghana Health Service has a Safe Abortion Policy, which I must say is not fully being implemented in this hospital, where patients are counseled on the need for contraception after pregnancy, after terminating a pregnancy and then, and then the dangers of terminating a pregnancy are told them and then they are, the procedure is done for them. Then after the procedure, they accept family planning, so that they have family planning counseling and then they adopt a family planning method, so that they don't continue to use abortion as contraception. (Expert 1, TGH)

A family planning counselor at TGH also suggested that the youth be the targets of health education. This would make them recipients of information about safe abortion procedures and contraceptive methods.

Recommendations [ahh], maybe, the youth should be health educated about safe abortions and the prevention of abortions by going to schools, counseling them on the need for it. And then you should abstain, it's good, but if you can't abstain, you should come for a family planning method. Family planning is not meant for only married women and men, it is meant for everybody, because we are preventing pregnancies. So, if you are a youth and you cannot abstain, you'd better come here for it, than having it done and facing the consequences, than going through and inserting a while lot of things into your system, causing damage to your body. So the best is prevention, so when, if you are not ready for it, come for a family planning method. No matter your age, we don't, you know, whether you are young or old, we see everybody, provided you are in the reproductive stage. (Expert 2, TGH)

In summary, expert knowledge on the contraceptive practices of women in Ghana suggests that contraceptive use is low and hence women are using induced abortions to terminate unintended pregnancies that occur. These experts, made up of obstetricians/gynecologists and family planning counselors, who are also referred to as abortion counselors, implied that contraceptive use was the main solution in preventing unintended pregnancies, eliminating the need for abortions. They stated that abortion patients and women who attended the hospitals for ante and post natal visits, were approached with information about contraception and were encouraged, but not forced, to adopt family planning methods.

DISCUSSION

The information gathered from the interviews concerning contraceptive practices of women with induced abortion experiences seems to support Bleek's (1990: 127) observation, suggesting that women in Ghana are using induced abortions as a tool in "menstruation regulation". In his study, the vast amount of knowledge that women had about methods of aborting pregnancies revealed that the practice occurred widely in that culture. Information from this study shows that women are having sex, as early as age 13, and are doing so without using effective contraceptive methods. This implies that induced abortions could be the plausible solution in controlling births in the two cities of Accra and Tema.

Bongaarts and Westoff (2000) theorized that low contraceptive prevalence and effectiveness could lead to unintended pregnancies and induced abortion. Therefore, once there is no knowledge of, or a dislike for contraception, or use is inconsistent among sexually active women, the result will be an unintended pregnancy. The only other alternative in controlling births would be to terminate pregnancies as they occur. Results from the study

seem to suggest this, and also that some of the interviewed women may have used induced abortion as a form of birth control. Firstly, some participants had no knowledge of contraception prior to the abortion; hence abortion was the only means they knew through which to control births. Secondly, those who mentioned they had used contraception prior to the abortion may have used it inconsistently resulting in the unwanted or mistimed pregnancy. Thirdly, after suffering a miscarriage, child death or physical ailments, respondents mentioned they had no regrets in undergoing their abortions but rather regretted ever using contraception, which may have caused those conditions. This suggests that these women saw contraception as more harmful to their health than inducing abortions. Lastly, experts from the two hospitals mentioned that contraceptive use and effectiveness is an important means through which women can prevent unintended pregnancies, however, women that attended these hospitals failed to use these methods. A key informant at KBTH mentioned that the contraceptive prevalence rate of his patients at the obstetrics and gynecology unit resembled that of the information in the 2003 GDHS, suggesting low contraceptive prevalence. The instance of low contraceptive prevalence, mentioned in the 2003 GDHS, is also similarly reflected in this study.

Policy Implications

In the interviews, the major reason women failed to use contraception was because of lack of knowledge about it at the time. This reason would seem more plausible for those who performed the abortions years ago when family planning services were not widely available. However, a sixteen-year-old JHS graduate, who had recently terminated her pregnancy at home, stated that she had only been informed about family planning when a nurse discussed the subject with her the day before the interview. This implies that the present generation is

not receiving adequate education about contraception. This situation could have arisen because adults, or specifically parents and teachers, fear that reproductive health education could lead to their children becoming more promiscuous. The subject of sex also tends to cause embarrassment for many parents, creating a trend where parents fail to educate their wards on the subject. However, a study by Baumeister et. al. (1995) does indicate that Latina adolescents who received some type of sex education from their parents were less likely to become pregnant. Therefore, Ghanaian parents should be encouraged and equipped with the knowledge to properly educate their children on sexual matters. A longitudinal study similar to Baumeister et. al.'s (1995) could be carried out in two Ghanaian communities. However, this study could compare the sexual lifestyles of the youth in one community, who are informed about sexual issues from adults, at an early age, to the youth in another community, who are educated by their peers at later ages, which tends to be the case among youth in Ghana. In addition, non-governmental organizations, schools, religious bodies and a variety of other community-based organizations in Ghana could ensure reproductive health education is accessible to people in communities prone to unintended pregnancies and induced abortion. The fact that more than half of the interviewed women experienced their first abortion between ages 15 to 19 years, strongly suggests that adolescents must be targets of all forms of sex and reproductive health education.

In accordance with the recommendations from the experts' interviews, providing people with access to reproductive health education is a likely solution to increase the contraceptive prevalence rate in Ghana. This could also lead to a reduction in instances of unintended pregnancies and induced abortion cases. For the women who had heard of certain family planning methods, some chose not to use a method, or used in inconsistently. A few reasons were stated for this occurrence; the most important being past experiences of harmful side effects, along with negative rumors about the harmful effects of contraception on

women. Also, negative experiences such as child loss and miscarriage were also linked to past use of contraception rather than to a previous abortion. A solution to this issue involves women with experienced side effects being counseled to choose the best method for them. There are a variety of methods that exist and each must be explored to ensure they use the method that is best for their physiological make-up. Therefore, those who despise the hormonal (oral, injectable) and the IUD methods must be taught to use barrier and natural methods, which are better alternatives than failing to use contraception. Also, women who choose to abort children for child spacing purposes must find a way to breastfeed exclusively for a long period to avoid this predicament. The misconceived notions about contraception that plague women must be addressed, whereby they are re-educated on this issue from trained family planning counselors, thus dispelling rumors from their peers or any other sources of misinformation. Misconceptions about contraception must especially be seriously addressed among the youth who may spread rumors among their peers.

The effectiveness of contraception also determines whether women seek abortion or not. Two women in the study experienced contraceptive failure resulting in unintended pregnancies. One chose to abort it in order to continue with her educational aspirations. The other chose to keep it but ended up accidentally aborting the pregnancy after drinking an alcoholic beverage. The methods may have failed due to inconsistent or ineffective us on the part of the respondents. However, contraceptive methods are all not 100 percent effective and have differing effectiveness rates. In order to avoid unintended pregnancies, women and men who are determined to use contraception consistently must have access to effective contraception. Until methods are improved upon to become 100 percent effective, couples could be counseled to use two non-conflicting methods jointly. They must also be counseled to use methods consistently and effectively to prevent unintended pregnancies.

In their study, Baumeister et. al. (1995) also discovered that the reproductive health issue least discussed between Latina parents and their adolescents was birth control. Yet, family planning services are an essential component of reproductive health. Hence, couples must be counseled and encouraged to use the most appropriate method for them. The issue of couples receiving counseling was stated because this unit should also be addressed. The study had initially intended to also conduct interviews with the partners of women who had terminated pregnancies. Unfortunately, this was not a possible feat, and thus produced a major limitation to the study. However, acknowledging men's perceptions of contraception and abortion, in a region (sub-Saharan Africa) where men do have some degree of power over women's reproductive rights, could aid in understanding the decision-making processes that go into, what seems like, deliberate contraceptive non-use of some of the respondents, resulting in unintended pregnancies and induced abortions (Dodoo 1998). Once all Ghanaians are adequately informed on issues concerning the components of reproductive health, they can make the necessary changes to become sexually healthier individuals, and this could consequently reduce rates of unintended pregnancies and abortion.

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TABLES

Table 1: Demographic and socio-economic background characteristics of respondents for individual interviews

Background Characteristics	Number	Percentage (%)
Current ages of respondents		
15-19	2	8.7
20-24	8	34.8
25-29	3	13.0
30-34	5	21.7
35+	5	21.7
Age at first abortion		
<15	1	4.3
15-19	12	52.2
20-24	5	21.7
25-29	3	13.0
30-34	1	4.3
35+	1	4.3
Number of abortions*		
1	16	69.6
2	0	0.0
3	3	13.0
4	2	8.7
Number of children prior to first abortion		
0	15	65.2
1	4	17.4
2	1	4.3
3+	3	13.0
Current number of children		
0	4	17.4
1	6	26.1
2	6	26.1
3	4	17.4
4+	3	13.0
Marital status prior to abortion		
Not Married	20	87.0
Married	3	13.0
Separated/Divorced/Widowed	0	0.0
Current marital status		
Not Married	9	39.1
Married	12	52.2
Separated/Divorced/Widowed	2	8.7
Highest educational attainment		
No Education	3	13.0
Primary Incomplete	2	8.7
Primary Complete	0	0.0
JHS Incomplete	8	34.8
JHS Complete	8	34.8
SHS/Higher	2	8.7
Occupation		
Unemployed	4	17.4

Trader	12	52.2
Food vendor	1	4.3
Seamstress/ apprentice	4	17.4
Teacher	2	8.7
Total	**23**	**100.0**

* Number of actual abortions are 21, with 2 attempted abortions

Table 2: Socio-economic backgrounds characteristics of respondents for focus group discussions

Background Characteristics	Number	Percentage (%)
Current Age Groups		
15-19	4	22.2
20-24	4	22.2
25-29	4	22.2
30-34	3	16.7
35-39	1	5.6
40-44	1	5.6
45-49	1	5.6
Highest Educational Level		
No Education	0	0.0
Primary Incomplete	1	5.6
Primary Complete	0	0.0
JSS Incomplete	1	5.6
JSS Complete	4	22.2
SHS/ Higher	12	66.7
Current Marital Status		
Not Married	13	72.2
Married	5	27.8
Total	**18**	**100.0**

APPENDIX A

Coding frame for individual interviews:
Codes were deduced from research questions, question guide and conceptual framework. Codes were inductively generated from transcripts.

Objective 1: To explore the general contraceptive practices among women in Greater Accra

KNOWLEDGE OF CONTRACEPTION PRIOR TO ABORTION = **knowledge**
USE PRIOR TO ABORTION = **use**
Yes (knowledge) and yes (use) = red
Yes (knowledge) and no (use) = yellow
No (knowledge) and no (use) = green

REASONS FOR USE/NON USE OF CONTRACETIVES = **reasons**
Didn't know/ didn't understand = aqua
Stopped because of side effects = yellow
Never used before/ don't want to use = light pink
Used but method failed = green
Other reasons = blue

Matrix of coded data:

Par.	Knowledge	Use	Reasons for use/ non use before abortion
4	yes	No	* raped by boyfriend
6	no	No	* didn't know about it
8	yes - used condom	Yes	* used condom but still got preg
9	yes - mother told her	No	didn't know about it
10	yes - used injections	No	n/a
11	yes - used pill on own	No	n/a
13	yes	Yes	* was using secure (pill) but it failed so got pregnant
15	yes	No	* kept getting her period after using the injectables so stopped
16	yes - uses condom	No	* uses condom - don't know if used that time
K1	yes - used variety	No	* didn't like it bcos of rumors that it would bother you
K2	yes - used variety	no	* at that time didn't understand the need for family planning
K3	not until recently	No	* didn't know about it

K4	not until recently	No	* didn’t know about it until the doctor came recently and told her about it at Korle Bu
K5	yes	No	* didn’t want to use it, a personal decision
K6	yes	No	* never used it and doesn’t want to use it
K7	no	No	* never heard about it until she went to Korle Bu, was sick - the sickness has blocked her stomach so she cant give birth
K8	yes	No	* stopped using it because heart was hurting

Knowledge and Use

yes & yes - knowledge & use
yes & no - knowledge & use
no & no - knowledge & use

Reasons for Use/Non Use

didn't know/understand
stopped because of side effects/ rumors
never used/ don't want to use
used but method failed
other reasons

Notes

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[1] ***Ethical considerations and other contextual factors:*** The question guides used for all interviews were informed by the study's objectives and existing literature. Ethical clearance had to be acquired before any interviews could be conducted. It was obtained through the Institutional Review Board (IRB) at the Noguchi Memorial Institute for Medical Research (NMIMR). They approved the protocol of the study in January, 2008 and also approved the modifications made to the study in July, 2008. An informed consent form was distributed to each participant (excluding the experts) before the interviews or group discussions. The form assured the participants of confidentiality, which was accomplished through a coding method. For the individual interviews, each participant was given a code, for example, P3 (participant 3) and this is how the respondents were referred to in the study. For the group discussions, the first names of the participants were collected in order to refer to people during the discussion; however, the study used the codes assigned to the participants i.e. FG1-1. The informed consent forms also briefly described the study. It stated how ultimately Ghanaian women would benefit from the results obtained, and it required the participants' permission by their signature, before the interview would start. All participants received a token of appreciation for taking part in the study. In addition, refreshments were served after the group discussions.

[2] ***Coding and Analysis:*** A coding frame was developed both deductively and inductively. It was informed primarily by the research objectives and question guides (shown in Appendix A). New codes were then generated after the transcripts were read through. Intra-coder reliability was used while coding the transcripts; hence, the principle investigator coded the transcripts and re-checked them some days after to ensure that there was consistency in the choice of codes. This coding frame provided the codes used to select various existing themes through the 23 individual interview transcripts. A matrix was set up on an Excel spreadsheet with the column heading consisting of the various codes from the coding frame (i.e. knowledge about contraception, reasons for contraceptive non-use, method of abortion etc.). The rows comprised of a list of the 23 participants. Interviewees' responses were placed in the matrix under the corresponding codes. The data were then analyzed manually as responses fell into particular categories representing themes that were either in consensus with or conflicted with each other. Certain unique responses that were discovered as well as expected themes that were absent from the transcripts were also noted. The various themes were highlighted with different colors and the major existing themes through the transcripts were then discussed (see Appendix A). The transcripts from the group discussions and expert interviews were also analyzed using the same generated codes. Statements in line with the identified themes from the individual interviews were included to support the information garnered from those interviews.