THE PERCEIVED REASONS AND THE EFFECTS OF ILLEGAL ABORTION AMONG WOMEN IN SELECTED HOSPITALS IN ACCRA

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Abstract

This study examines the perceived reasons and effects of illegal abortion among women by comparing age, religion and educational differences. A total of 103 females were purposively sampled across four hospitals in Accra. The women were administered with structured questionnaires which collected information on their demographic characteristics, the perceived reasons for abortion and the health effects of abortion on the women. A cross-sectional study design was employed in this study as respondents were contacted at one point in time. The collected data were analysed using the SPSS 20.00. Results from the independent t-tests and One-way ANOVA show that age has a significant effect on the psychological reasons assigned to abortion. Educational level of respondents was found to have a significant effect on social effects of abortion. However, religious affiliation did not have any significant effect on spiritual reasons assigned for abortion among the respondents. Further analysis revealed no significant age differences in health and psychological effects among the respondents.

Key words

Social effects of abortion, psychological reasons, religious affiliation, illegal abortion, selected hospitals in Accra

Introduction

1.1 Background to the study

Abortion is the spontaneous or induced termination of pregnancy before foetal viability (Elias & Sherman, 2007). Popular use of the word abortion implies a deliberate pregnancy termination and some prefer the word miscarriage to refer to spontaneous foetal loss before viability. This definition implies a legal perception of the age at which a foetus can survive out of the womb.

An estimated 44 million abortions are performed globally each year, with slightly under half of those performed unsafely (Sedghet al., 2012). The overall abortion rate in Africa, where the vast majority of abortions are illegal and unsafe, showed no decline between 2003 and 2008, holding at 29 abortions per 1,000 women of childbearing age. The Southern African sub-region, dominated by South Africa, where abortion was legalized in 1997, has the lowest abortion rate of all African sub-regions, at 15 per 1,000 women in 2008. East Africa has the highest rate, at 38, followed by Middle Africa at 36, West Africa at 28 and North Africa at 18 (WHO, 2008).

The abortion law in Ghana, enacted in 1985, states that an abortion performed by a qualified medical practitioner is legal if the pregnancy is the result of rape, incest or "defilement of a female adult;" if continuation of the pregnancy would risk the life of the woman or threaten her physical or mental health; or if there is a substantial risk the child would suffer from a serious physical abnormality or disease (The Criminal Code [Amendment] Law, PNDC Law 102, 1985: para 58(2)] (Morhee&Morhee, 2006).

The legality, prevalence, cultural and religious status of abortion vary substantially around the world. Its legality can depend on specific conditions such as incest, rape, severe foetal defects or the mother's health being at risk. In many parts of the world there is prominent and divisive public controversy over the ethical and legal issues of abortion. Due to the controversial nature of the legality of abortion, many women have various reasons for conducting illegal abortions.

1.1 Problem statement

In Ghana, as in many African countries, unsafe abortion is one of the major contributors to high levels of maternal mortality. Abortion is highly stigmatised and is widely interpreted as being illegal in the country, though it is legally permitted in a wide variety of cases (Aniteye, 2002). Maternal mortality in Ghana is the second most common cause of death among women in Ghana, and more than one in 10 maternal deaths (11%) are the result of unsafe induced abortions [Ghana Maternal Health Survey (GMHS), 2007]. Young women pay anywhere from 3 to 30 Ghana cedis for a hospital or private clinic abortion (Henry &Fayorsey, 2002). In 2007, only 4% of women thought that abortion was legal in Ghana (GMHS, 2007). Even among women with at least a secondary school education, only 11% were aware of this fact.

Despite the liberal nature of the abortion law, most Ghanaian women seeking abortion still seek clandestine abortions which are usually unsafe (Lithur, 2004). According to a national needs assessment on abortion care conducted by the Ghana Health Service in 2005, abortion-related deaths contributed between 22-30% maternal deaths, constituting the single largest contributor to maternal mortality (GHS, 2005).

Some studies have looked at the epidemiological and socio-economic characteristics of women undergoing abortion) and the methods used to induce abortion (Turpin, Danso, Odoi& 2000; Ahiadeke, 2001). However, no known study has been done to assess the perceived reasons why women conduct illegal abortions in Ghana. Understanding of these issues is an important step in understanding what needs to be done to prevent unsafe abortion in Ghana.

1.1.1 Objectives of the study

The study has the following objectives:

1. To describe the perceived reasons for illegal abortions among women
2. To determine the perceived effects of illegal abortions among women
3. To determine the difference in the cause of abortions with regards to their religion.

1.1.1.1 Statement of hypotheses

1. Respondents of age 18years and below will assign more psychological reasons to abortion than those of 19 years and above
2. Those who attend tertiary institutions will attribute social effects to abortion than those in other levels
3. Christians will attribute spiritual reasons for abortion than those of other religions

4. Females of 18years and below are likely to report more health effects of abortion than females of 19years and above
5. Females of 18years and below are likely to experience more psychological effects of abortion than females of 19years and above

1.1.1.1.1. Significance of the study

The study will help nurses, doctors and all health workers to understand the reasons why women commit illegal abortions. This will provide information for the development of information, education and communication (IEC) materials to effectively educate women and the general public on abortion in general and the dangers of illegal abortion. Findings from the study will contribute to the already existing knowledge on the perceived reasons and the effects of illegal abortions among women. The study will also make suggestions for future studies on the prevalence of illegal abortions in Ghana.

2. Literature Review

2.1 Reasons Why Women Conduct Abortion

Although abortion occurs in every society, and a substantial proportion of pregnancies are resolved by abortion worldwide, there is little empirical research on why women obtain abortions. This lack of information is part of an overall scarcity of data on abortion. Legal, moral and ethical issues surrounding abortion make research on all aspects of abortion difficult to undertake, and also affect the quality of the information obtained. Collecting good information on reasons for abortion may be especially difficult, because it requires asking women to articulate the often complex and sensitive process that led to the decision.

Rominski, Gupta, Aborigob, Adongo, Engman, Hodgson and Moyer (2014) conducted a study on female autonomy and reported abortion-seeking in Ghana. The purpose of the study was to investigate factors associated with self-reported pregnancy termination in Ghana. This was a retrospective study where data from the Ghana 2008 Demographic and Health Survey were used to investigate factors associated with self-reported pregnancy termination. Variables on an individual and household level were examined by both bivariate analyses and multivariate logistic regression. A five-point autonomy scale was created to explore the role of female autonomy in reported abortion-seeking behaviour. Of the 4916 women included in the 2008 Ghana DHS, 791 (16.1%) reported having terminated a pregnancy. Factors associated with abortion-seeking included being older, having attended school, and living in an urban versus a rural area. When entered into a logistic regression model with demographic control variables, every step up the autonomy scale (i.e. increasing autonomy) was associated with a 14.0% increased likelihood of reporting the termination of a pregnancy.

Some might argue that we already know why a woman obtains an abortion—she does not want the pregnancy—and that we need look no further. However, while at one level almost all abortions result from unintended pregnancies, there can be many steps between acknowledging an unplanned pregnancy and having an abortion. Moreover, many women who have an unintended pregnancy either do not seriously consider having an abortion or do not consider it at

all. Some will simply adjust to the pregnancy; for others, an initial desire to discontinue a pregnancy can change because they were either ambivalent themselves or because they acceded to the preferences of others. On the other hand, conditions that were either unknown or were less serious before conception may also change, so that a pregnancy wanted at the time of conception is no longer wanted later on (Londo, 1999).

Females engage in induced abortion as a result of several factors that come to influence their decisions. It argued that some of the main reasons for induced abortion are fear of the family and the community, to not interrupt school and financial problems (Yirgu, Solomon &Takele, 2009). According to Berhanu and Nigatu (2010), nearly three quarters of pregnancies in university students are reported as ended with induced abortion. A significant proportion of these abortions are induced in an unsafe way.

A cross-sectional study was conducted by Animaw and Bogale (2011) on abortion in university and college female students in Ethiopia. Female students from one university and three colleges of Arba Minch town were selected by proportional probability sampling method. Quantitative data were collected using a self-administered structured questionnaire and focus group discussions were also conducted.Eight hundred and forty five reproductive age female students from one University and three colleges participated in this study.The study participants' median age was 20, the oldest was 35 and youngest was 17 years old.

Among all study participants 173 (21.3%) reported they had had sexual intercourse. The median, mode and mean age of study participants while performing first sex were reported as 19, 18 and 18.7 years, respectively with the lowest age being 12 and a maximum of 29 years old. More than half (51.6%) of the students reported that their first sexual intercourse was not protected from getting pregnant and only 40% of the students who performed unsafe sex took emergency contraception; others did nothing to prevent pregnancy (Animaw&Bogale, 2011).

Animaw and Bogale (2011) found out that among all study participants 54 (6.6%) students reported they had been pregnant at least once. Of all study participants 2.8% had induced abortion. Out of students who had been pregnant 23 (43.4%) (2.2% among all study participants and 13.3% among students who had sexual intercourse) had induced abortion. Among 23 students who had induced abortion four students (17.3%) had induced abortion in an unsafe way (either in their home by themselves or by a traditional abortionist). More than half of the study participants had performed unsafe sex (sex not protected from pregnancy and sexually transmitted diseases) and only 40% of them took emergency contraceptive; others did nothing to prevent pregnancy. Most of the students' pregnancies were not planned. More than half (55.5%) of the students who had an unintended pregnancy reported that the reason for their unintended pregnancy was that their sexual intercourse was accidental therefore they did nothing to prevent pregnancy, including emergency contraceptive; others said that contraceptive failure, including condom, was responsible (Animaw&Bogale, 2011).

According to Animaw and Bogale (2011), half (50%) of the students who had begun sexual intercourse before the age of 18 years and had been pregnant had an induced abortion, compared with 17 (41.5%) of students who had their first sexual intercourse at 18 or over and had been pregnant; however, the difference is not statistically significant. The majority 41(77.3%) of study

participants who had been pregnant knew that emergency contraceptive was legally available in pharmacies throughout Ethiopia. Eighteen (43.9%) of the students who knew emergency contraceptive was legally available and had been pregnant had induced abortion, compared with 5 (41.7%) who did not know. Knowledge of the availability of emergency contraceptive (EC) is not a statistically significant predictor to the students' practice in inducing abortion.

It was expected that the majority (71.7%) of students who had been pregnant were married. Most (80.0%) of the unmarried students who had been pregnant had induced abortions, whereas only 28.9% of married students who had been pregnant had induced abortion. More than half (56.0%) of students that had been pregnant were living off campus. The majority 69.6%) of students that had been pregnant and who had induced abortion were living on campus as compared with only 23% of students living off campus (Animaw&Bogale, 2011).

Ethiopia has a liberalized safe abortion service with broad criteria since 2006, but only 261 (32.1%) out of 813 university and college students of Arba Minch town knew these criteria after 6 years of liberalization. More than two thirds (68.2%) of students that had been pregnant and knew abortion law had induced abortion as compared with 25.8% who did not know. Students' current living residence and knowledge of abortion law were the identified contributing factors to their abortion practices (Animaw&Bogale, 2011).

In addition, not all women who decide to seek an abortion will succeed in obtaining one. They may face personal and social barriers such as their husband's objections or community values that oppose abortion. In countries where safe abortion services are scarce, only affluent women who can afford the fees of a private doctor will obtain an abortion, along with poorer women who are so determined they are willing to risk their health and life in seeking out unsafe clandestine services. Even though the planning status of a pregnancy does not tell us the full reason why women choose abortion, understanding the prevalence of unplanned pregnancy and its proximate cause – non use of contraceptives or contraceptive failure - is essential for understanding the context within which women seek abortion.

Evidence abounds that a high proportion of women become pregnant unintentionally, in both developed and developing countries. In the United States and in some Eastern European countries for which data are available, about one-half to three-fifths of all pregnancies are unintended, and a large proportion of these are resolved through abortion (Jones, 1999). In many developing countries, the proportion of recent births that are unintended exceeds 40%; even in regions where most couples still want large families, 10-20% of births are unplanned (Alan Guttmacher Institute [AGI], (1997). While unintendedness is clearly a first level of explanation, for many women it covers a wide range of more specific underlying factors (Fikree, 1996).

A study in southern Ghana also found that educated and urban women were more likely than their less educated and rural counterparts to seek an abortion, and that Christian woman were more likely than Muslim women to seek the procedure (Ahiadeke, 2001). The most common reason given by women for seeking an abortion is not having the financial means to take care of a child (21%) (GSS,2007). Other common reasons include wanting to delay childbearing (13%), continue schooling (11%) and continue working (9%). Six percent of women said their partner

did not want the child or denied responsibility for the pregnancy. Health reasons for terminating the pregnancy were cited by about 5% of women (Ahiadeke, 2001).

A study was conducted by Akinrinola, Susheela and Taylor (1998) on the reasons why women have induced abortion. Findings from 32 studies in 27 countries were used to examine the reasons that women give for having an abortion, regional patterns in these reasons and the relationship between such reasons and women's social and demographic characteristics. The data come from a range of sources, including nationally representative surveys, official government statistics, community-based studies and hospital- or clinic-based research. Results showed that worldwide, the most commonly reported reason women cite for having an abortion is to postpone or stop childbearing. The second most common reason - socioeconomic concerns - includes disruption of education or employment; lack of support from the father; desire to provide schooling for existing children; and poverty, unemployment or inability to afford additional children. In addition, relationship problems with a husband or partner and a woman's perception that she is too young constitute other important categories of reasons. Women's characteristics are associated with their reasons for having an abortion: With few exceptions, older women and married women are the most likely to identify limiting childbearing as their main reason for abortion.

There is very little known research on the cost of abortion in Ghana. In one in-depth study in Accra, young women reported paying anywhere from three to 30 new Ghana cedis for a hospital or private clinic abortion (Henry &Fayorsey, 2002). More generally, it has been reported that a safe abortion is prohibitively expensive for many women because few practitioners are available to perform the procedure, and they charge very high fees (Morhee&Morhee, 2006). As a consequence, poor women may be forced to seek risky abortions from untrained providers.

Women who arrive at health facilities seeking treatment of incomplete abortions are often those women who face barriers in accessing health services generally (Kidder, Sonneveldt&Hardee, 2004). Even in settings such as Ethiopia, where abortion is permitted by law, access to safe abortion can be further complicated by such factors as lack of knowledge about reproductive health (including lack of knowledge about the new abortion law) (Erulkar, Mekbib, Amdemikael&Conill, 2007); social and/or religious stigma surrounding abortion; gender norms dictating relationship power, modesty, and childbearing; and the time and cost required to physically reach a health facility where safe abortion services are provided (Grimes, Benson, Singh, Romero, Ganatra&Okonofua, 2006). Facing such tremendous challenges, women often choose to seek pregnancy termination services from traditional providers, or induce abortion themselves, often under dangerous or unsanitary conditions (Kidder, Sonneveldt&Hardee, 2004).

A 2007 study in Nepal, where abortion was also recently legalized, found that even when women had knowledge of safe termination services, in the event of unintended pregnancy they often preferred to seek an unsafe abortion rather than discuss the issue with their husbands (Nyanzi, Nyanzi& Bessie, 2005).

Another study in Uganda documenting men’s views surrounding abortion found that although men acknowledged that the procedure is common, they held highly stigmatized views of abortions and women who seek them, and would want to punish (with violence or social

stigmatization) their wife, girlfriend, or lover if they discovered she had sought or was seeking an abortion (Rasch&Kipingili, 2009).

A recent study in Tanzania found that, despite restrictive laws, women in urban areas had relatively good knowledge of methods of safe termination and easy access to methods of safe pregnancy termination. In contrast, the same study found that women in rural areas were significantly more likely to resort to "less safe methods performed by unskilled providers" (Faundes& Hardy, 1997).

2.1 Effects of Unsafe Abortion

Abortion, when performed by a qualified professional under safe conditions, is an extremely safe procedure. However, clandestine abortions are often unsafe (Grimes, Benson, Singh, Romero, Ganatra, Okonofua& Shah, 2006). Among Ghanaian women who had had an abortion in the five years prior to the GMHS, 13% reported experiencing on or more health problems after their most recent abortion (GSS, 2007). Ten percent of women experienced pain, half of whom reported that the pain was severe; 8% reported bleeding; 6% each experienced fever and foul-smelling discharge, which are both indications of infection; and 1% reported that they suffered a perforation or other injury as a result of the procedure. Some of the most severe complications were not reported in this survey because women did not survive to report them. Of women who experienced a problem following their abortion, 41% received no treatment (GSS, 2007). Almost half (47%) of women with a problem received antibiotics, and 19% received an unspecified treatment.

Gerdts, Prata and Gessessew (2012) explored the risk factors for severe complications following unsafe abortion in Tigray, Ethiopia. Data for this analysis were collected as a part of the Comprehensive Abortion Care (CAC) pilot project. Analyses were based on 266 women who sought services for the treatment of incomplete abortion at the 30 health facilities during the study period. Overall, 81% experienced severe complications. Women who experienced severe complications were similar to those who did not, with the exception that the former were significantly more likely to be married.

Women with severe complications had, on average, more previous pregnancies and higher mean parity than women who did not experience severe complications. At the time of being seen for treatment of incomplete abortion, there was a 1-week difference in mean uterine size between women who did and did not experience severe complications. The 2 groups had similar levels of prior contraceptive use and similar past histories of abortion (Gerdts, Prata&Gessessew, 2012)

According to Gerdts, Prata and Gessessew (2012), the large majority of women in the study were seen at mid-level health facilities (83.8%), and, overwhelmingly, the most common complication observed was cervical bleeding (93.5%), followed by intrauterine foetal death (11.2%), sepsis (7%), and shock (6.5%). The number of living children was significantly associated with higher odds of severe complications in unadjusted analyses but not in adjusted analyses.

Franz and Reardon (1992) observed from their study that greater abortion-related psychological distress, greater feelings of being misinformed at the time about the abortion experience and abortions later in gestation were found among female who aborted when they were adolescents. The participants were also less satisfied with the abortion services received and more likely to believe that they wanted to give birth but circumstances forced them to have an abortion. The researchers further noted that age at abortion positively related with current satisfaction with the abortion decision. The conclusion from this study is that abortion at an adolescent age predisposes the individual to several negative psychological consequences. However, the study failed to examine the level of depression and anxiety among females who have had abortion as adolescents even though depression and anxiety are thought to be the most common forms of psychological problems.

In a related study to examine the factors associated negative emotional outcomes post-abortion among females under 18years of age and those above 18years of age, Pope, Adler and Schann (2001) found that those aged 14-17 reported less comfort with their decision. The total sample showed significant decreases in depression and internally-based negative emotions (such as regret) and increases in positive emotions at 4 week follow-up. The psychological characteristics of this sample of adolescents 4 weeks postabortion appeared similar to those of comparison samples of adolescents. Risk factors for poor postabortion functioning were preabortion adjustment and the amount of partner pressure to have an abortion. Unlike some earlier studies which suggest that adolescents are at increased risk of negative psychological consequences of abortion, Pope, Adler and Schann (2001) concluded that such differences do not exist.

Furthermore, in a study to examine the educational, economic, psychological, and reproductive behavior differences between adolescents who choose abortion and those who choose to carry their pregnancies to term, Zabin, Hirsch and Emerson (1989) sampled a total of 360 low-income African-American women and were administered questionnaires that measure their psychological outcomes. Results from the analysis of the data showed that at baseline, there were few differences between the three groups. However, after two years, women in the abortion group were more likely to have graduated from high school or stayed in school at the appropriate grade level, and more likely to be better off economically than women in either of the two other groups. Levels of anxiety and other psychological outcomes were not significantly different between the three groups at follow-up. Additionally, women who had had abortions were less likely to experience a subsequent pregnancy during the two-year period.

3. Methodology

The Out Patients Departments of four hospitals in Accra served as the research settings. This is because females who are involved in abortion-related activities are easily located at these health facilities that in the general public. This makes the data collection possible as the women were reporting for gynaecological services which would not have been possible in the general population. The cross-sectional survey design was used since we were interested in the views of the clients on their perceived causes and effects of illegal abortion.

The population for this study consisted of all women who have had abortion experience and are reporting at the above mentioned health facilities for medical care. This includes females from

12years and above who have had an abortion.The sample for this study consisted of 103 women. The Purposive sampling technique was adopted for the selection of the respondents in this study as the study solely focused on women who have had a history of abortion which would have been difficult using any other sampling technique.

The main instrument was a self- designed questionnaire which had three sections. The section one consisted of the demographic characteristics of respondents. Section two of the questionnaire consists of the perceived reasons for abortion (Psychosocial, Spiritual and Legal). The section three of the questionnaire consists of the perceived health, psychosocial, social and legal effects of abortion. The Likert response format was used with responses ranging from Strongly Agree, Agree, Not Sure, Disagree to Strongly Disagree. The average scores were computed for each subdomain to obtain domain-specific scores.

4. Results

To test the various hypotheses formulated in this study, independent t-tests and One-way test were used to compare the means of the groups involved.

Hypothesis One:Respondents of age 18years and below will assign more psychological reasons to abortion than those of 19 years and above. To test this hypothesis, the means, standard deviations and independent t-test were computed and the results are summarised in the Table 1.below;

Table 1: Summary of Independent t-test of age differences in psychological reasons for abortion

Age categories	***N***	**Mean**	***SD***	***df***	***t***	***ρ***	**Effect size**
Less than 18years	3	2.52	.45	101	1.95	.03	1.29
19years and above	100	1.85	.58				

An examination of the Table 1 above shows that girls who are 18 years and below reported a mean score of 2.52 with a standard deviation of .45 on their psychological reasons for abortion while females of 19 years and above had a mean score of 1.85 with a standard deviation of .58 on their psychological reasons for abortion. Further analysis of the mean difference between the two age groups shows that females of 18years and below assigned more psychological reasons to abortion than females of 19years and above at the .05 level of significance, [$t(101) = 1.95$, $\rho = .03$, effect size-d = 1.29]. Therefore, hypothesis one that respondents of age 18years and below will assign more psychological reasons to abortion than those of 19 years and above is supported.

Hypothesis Two: Those who attend tertiary institutions will attribute social effects to abortion than those in basic (other) levels. To determine whether significant differences exist between the two groups of educational levels on their perceived social effects of abortion, means, standard deviations and independent t-test were computed and the results are summarised in the Table 2 below;

Table 2: Summary of independent t-test of education and social effects of abortion

Education	N	Mean	*SD*	*df*	*t*	*ρ*	Effect Size
Basic	6	2.12	.75	101	1.91	.03	.79
Tertiary	97	2.72	.65				

An examination of Table 2 above indicates that respondents who attend tertiary institutions had a mean score of 2.72 with a standard deviation of .65 on social effects of abortion while respondents who attend basic levels had a mean score of 2.12 with a standard deviation of .75 on the social effects of abortion. Further analysis using the independent t-tests revealed that the educational level of respondents had a significant effect on their perceived social effects of abortion at the .05 level of significance, [t(101) = 1.91, ρ = .03, Effect size = .79]. This finding of a significant difference in perceived social effects of abortion on respondents confirms the hypothesis two that those who attend tertiary institutions will attribute social effects to abortion than those in basic (other) levels.

Hypothesis Three: Christians will attribute spiritual reasons for abortion than those of other religions. To examine four religious groups of respondents on their perceived spiritual reasons for abortion, the means, standard deviations and One-way analysis of variance was computed and the results are summarised on the Table 3 below;

Table 3: Summary of One-way ANOVA of Religion and Spiritual reasons for abortion

Religion	*N*	Mean	*SD*	*df*	*F*	*ρ*	Effect Size
Christianity	90	3.34	.83	3,99	2.43	.07	.068
Islam	3	3.00	.70				
Traditional	1	1.25	-				
None	9	3.56	.95				

From Tables 3 above, it was observed that Christians had a mean spiritual reason for abortion score of 3.34 with a standard deviation of .83, Moslems had a mean spiritual reason for abortion score of 3.00 with a standard deviation of .70, Traditional believers had a mean spiritual reason for abortion score of 1.25 while those who do not belong to any religious affiliation had a mean spiritual reason for abortion score of 3.56 with a standard deviation of .95. Further analysis using the One-way ANOVA revealed that there is no significant difference among the various religions

on their perceived spiritual reasons for abortion at the .05 level of significance, [F(3,99) = 2.43, ρ = .07, Effect size = .068]. Therefore, the hypothesis three that Christians will attribute spiritual reasons for abortion than those of other religions is not supported.

Hypothesis Four: Females of 18years and below are likely to report more health effects of abortion than females of 19years and above. To test this hypothesis, the independent t-test was used and the summary of the results are presented in the Table 4 below;

Table 4: Summary of independent t-test of health effects of abortion due to age differences

AGE CATEGORY	N	MEAN	*SD*	*df*	*t*	*ρ*	Effect Size
18years and below	3	1.66	.26	101	.27	.40	.00
19years and above	100	1.74	.52				

An examination of the table 4 above shows that females of 18years and below had a mean score of 1.66 with a standard deviation of .26 on the health effects of abortion while females of 19years and above reported a mean score of 1.74 with a standard deviation of .52 on the health effects of abortions. Further analysis of the mean difference between the two groups using the independent t-test revealed that there is no statistically significant difference between the two groups at .05 level, [t(101) = .27, ρ = .40, Effect size = .00]. Therefore, the hypothesis four that females of 18years and below are likely to report more health effects of abortion than females of 19years and above is not supported.

Hypothesis Five: Females of 18years and below are likely to experience more psychological effects of abortion than females of 19years and above. To test this hypothesis, means, standard deviations and independent t-tests were computed and the results are summarised in the Table 5 below;

Table 5: Summary of independent t-tests of psychological effects of abortion due to age differences

DVs	AGE CATEGORY	N	MEAN	*SD*	*df*	*t*	*ρ*	Effect Size
Depression	18years and below	3	2.19	.09	101	.87	.44	.00
	19years and above	100	2.13	.62				
Anxiety	18years and below	3	2.67	.44	101	.24	.12	.00
	19years and above	100	2.13	.76				

From the Table 5 above, it was observed that females of 18years and below had a mean depression score of 2.19 with a standard deviation of .09 while females of 19years and above had a mean depression score of 2.13 with a standard deviation of .62. Comparing the two means with the use of independent t-test revealed no statistically significant difference between the two groups on depression at the .05 level of significance, [t(101) = .87, ρ =.44, Effect size = .00]. Additionally, females of 18years and below had a mean anxiety score of 2.67 with a standard

deviation of .44 while females of 19years and above had a mean anxiety score of 2.13 with a standard deviation of .76. Comparing the two means with the use of independent t-test revealed no statistically significant difference between the two groups on anxiety due to abortion at the .05 level of significance, [t(101) = .24, ρ =.12, Effect size = .00]. Thus, the fifth hypothesis that females of 18years and below are likely to experience more psychological effects of abortion than females of 19years and above is not supported.

5. Discussion, Recommendation and Conclusion

5.1 Introduction

This study seeks to examine the perceived reasons for abortion among women and the health, social and psychological effects of abortion. The study also examined differences in perceived reasons for abortion and its effects on females in terms of their ages, religion and level of education. The main findings are discussed below.

5.1.1 Key Findings

The first objective to determine whether significant age differences exist in the perceived psychological reasons for abortion indicated that it was significant. This means that younger females tend to consider a lot of psychological factors such as peer pressure, taboo, and pregnancy rejection in deciding on abortion than females who are somehow older. This could be due to the fact that the older females are seen in society as adults and capable of handling maternal and its related issues while the younger females are seen as immature and not capable which put some psychological pressure on them. This is consistent with some previous studies that found psychological factors to be crucial in influencing abortion decision (e.g. Grimes, Benson, Singh, Romero, Ganatra & Okonofua, 2006; Kidder, Sonneveldt & Hardee, 2004).

Additionally,the analysis to determine the effect of educational level of the social effects of pregnancy on women showed that females in tertiary institutions attributed more social effect to abortion than those with basic education. The outcome of this finding may be due to the fact that educated peopletend to know of preventive means to avoid unwanted pregnancy and therefore if the females in tertiary institutions become pregnant, they tend to experience low self-esteem, become more sensitive to the topic of abortion and cut social ties as it is regarded as a sin across many circles. This finding is consistent with previous work that found higher education and urban location to be associated with abortion (e.g. Ahiadeke, 2001).

The next objective was to find out whether the respondents' religious affiliations have any significant effect on their perceived spiritual reasons for abortion. However, the results from the ANOVA test showed that religion did not have any significant effect on spiritual reasons for abortion among the respondents. This means that the respondents did not differ on their spiritual reasons for abortion and can be attributed to the fact that almost all the religions practised in Ghana abhor the practice of abortion. To a large extent, all the religions consider abortion not to be morally right. Our culture also emphasizes the preservation of life which could be a major contributing factor in the lack of statistically significant difference among the religious affiliations. Also, majority of the respondents were Christians which could make their responses

homogenous thereby accounting for the insignificant difference in their spiritual reasons for abortion.

Another objective of the study also investigated whether age differences exist in the health effects reported by the respondents(Females< 18years and those above 19years). However, no significant difference in the health effects of abortion between females of 18years and below and females of 19years and above was observed from the results. This finding suggests that all the age groups sampled for the study experience similar health effects associated with abortion. This could be due to the age categorization with small interval which might not really reflect qualitatively in the reproductive system. This result confirms earlier studies that documented physical health problems among females who performed abortion in Ghana (GSS, 2007).

This study also examined the levels of depression and anxiety among the respondents by taking into consideration their age categories.The analysis did not also yield any significant differences in the levels of depression and anxiety due to abortion between females of 18years and below and females of 19years and above. This means that the two age group experience similar negative emotional feelings associated with abortion. Prior research has documented the prevalence of psychological problems among females who have performed abortion with no age differences (e.g. Franz & Reardon, 1992;Gerdts, Prata&Gessessew, 2012). However, it is inconsistent with previous research findings that those aged 14-17 reported less comfort with their decision to abort (Pope, Adler &Schann, 2001).

6. Recommendations

Based on the findings from this study on the perceived reasons why people choose abortion and the effects on them, it is recommended that healthcare workers and psychologists communicate with their clients who turn up for abortion at the health facilities by explaining the social, health, legal and the psychological effects of the practice on them.

It is also recommended that public education is carried out on the topic of abortion regardless of its sensitive nature to educate people on the preventive measures to adopt to avoid going through the ordeal of abortion.

7. Conclusion

The phenomenon of abortion has assumed significant in the health sector as a results of maternal deaths and complications that are being reported at health facilities. This has led to research in the area of why people decide to abort a pregnancy and the complications associated with the act. This study looked at the age, religion and educational factors of females and how these contribute to differences in reasons they assign to abortion and the perceived effects. The study on the whole documents that females who have had abortion differ in the reasons they assigned to abortion but not much differences are noticed in the effect in exception of the social effects which were high among females in tertiary institutions. The study is however, limited by the relatively small sample size used as well as the design which is cross-section survey which does not take into consideration changes in experiences over a period of time.

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